

HIGHLIGHTS OF THIS ISSUE

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

INCOME TAX

T.D. 8812, page 19.

REG-121865-98, page 63.

Final and proposed regulations under section 4980B of the Code relate to continuation coverage requirements applicable to group health plans. A public hearing will be held on June 8, 1999.

T.D. 8816, page 4.

Final regulations under section 408A of the Code relate to Roth IRAs.

T.D. 8817, page 51.

Final regulations under section 6038B of the Code relate to information reporting requirements for certain transfers of property by United States persons to foreign partnerships and relate to reporting requirements for certain transfers of cash to foreign corporations.

REG-106902-98, page 57.

Proposed regulations under section 1502 of the Code relate to consolidated return regulations relating to the treatment of overall foreign losses and separate limitation losses in the computation of the foreign tax credit limitation.

EMPLOYEE PLANS

Notice 99-11, page 56.

Weighted average interest rate update. Guidelines for determining the weighted average interest rate for February 1999 the weighted average interest rate and the resulting permissible range of interest rates used to calculate current liability for purposes of the full funding limitation of section 412(c)(7) of the Code are set forth.

EXEMPT ORGANIZATIONS

Announcement 99-15, page 78.

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

ADMINISTRATIVE

Announcement 99-16, page 80.

New Form 8866, Interest Computation Under the Look-Back Method for Property Depreciated under the Income Forecast Method, is now available.

Finding Lists begin on page 82.



Mission of the Service

Provide America's taxpayers top quality service by helping them understand and meet their tax responsibilities

and by applying the tax law with integrity and fairness to all.

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.

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

Section 408A.—Roth IRAs

26 CFR 1.408A-1: Roth IRAs in general.

T.D. 8816

DEPARTMENT OF THE TREASURY Internal Revenue Service

26 CFR Parts 1 and 602

Roth IRAs

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations

SUMMARY: This document contains final regulations relating to Roth IRAs under section 408A of the Internal Revenue Code (Code). Roth IRAs were created by the Taxpayer Relief Act of 1997 as a new type of IRA that individuals can use beginning in 1998. Section 408A was amended by the Internal Revenue Service Restructuring and Reform Act of 1998. On September 3, 1998, a notice of proposed rulemaking (REG-115393-98 I.R.B. 34) was published in the **Federal Register** (63 F.R. 46937) under Code section 408A. Written comments were received regarding the proposed regulations. On December 10, 1998, a public hearing was held on the proposed regulations. The final regulations affect individuals establishing Roth IRAs, beneficiaries under Roth IRAs, and trustees, custodians or issuers of Roth IRAs.

DATES: *Effective date:* The final regulations are effective on February 3, 1999.

Applicability date: The final regulations are applicable to taxable years beginning on or after January 1, 1998, the effective date for section 408A.

FOR FURTHER INFORMATION CONTACT: Cathy A. Vohs, (202) 622-6030 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in §§1.408A-2, 1.408A-4, 1.408A-5, and 1.408A-7 of the final reg-

ulations have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545-1616. Responses to this collection of information are mandatory.

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.

Estimated average annual burden per respondent/recordkeeper: 1 minute for designating an IRA as a Roth IRA and 30 minutes for recharacterizing an IRA contribution. The estimated burdens for the other reporting/recordkeeping requirements in these final regulations are reflected in the burden of Forms 8606, 1040, 5498, and 1099R.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden 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, OP:FS:FP, Washington, DC 20224.

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

Background

On September 3, 1998, a notice of proposed rulemaking was published in the **Federal Register** (63 F.R. 46937) under section 408A of the Internal Revenue Code (Code). The proposed regulations provide guidance on section 408A of the Code, which was added by section 302 of the Taxpayer Relief Act of 1997, Public Law 105-34 (111 Stat. 788), and established the Roth IRA as a new type of individual retirement plan, effective for taxable years beginning on or after January 1, 1998. The provisions of section 408A were amended by the Internal Revenue

Service Restructuring and Reform Act of 1998, Public Law 105-206 (112 Stat. 685). In addition, Notice 98-50 (1998-44 I.R.B. 10) provides guidance on reconverting an amount that had previously been converted and recharacterized. This notice solicited public comments concerning reconversions.

Written comments were received on the proposed regulations and Notice 98-50. A public hearing was held on the proposed regulations and Notice 98-50 on December 10, 1998. After consideration of all the comments, the proposed regulations under section 408A are adopted as revised by this Treasury decision.

Explanation of Provisions

Overview

A Roth IRA generally is treated under the Code like a traditional IRA with several significant exceptions. Similar to traditional IRAs, income on undistributed amounts accumulated under Roth IRAs is exempt from Federal income tax, and contributions to Roth IRAs are subject to specific limitations. Unlike traditional IRAs, contributions to Roth IRAs cannot be deducted from gross income, but qualified distributions from Roth IRAs are excludable from gross income.

In general, comments received on the proposed regulations did not request significant changes. Thus, the final regulations retain the general structure and substance of the proposed regulations.

General Provisions and Establishment of Roth IRAs

Commentators asked for clarification regarding whether a Roth IRA may be established for the benefit of a minor child or anyone else who lacks the legal capacity to act on his or her own behalf. On this point, the IRS and Treasury intend that the rules for traditional IRAs also apply to Roth IRAs. Thus, for example, a parent or guardian of a minor child may establish a Roth IRA on behalf of the minor child. However, in the case of any contribution to a Roth IRA established for a minor child, the compensation of the child for the taxable year for which the contribution is made must satisfy the

compensation requirements of section 408A(c) and §1.408A-3.

Regular Contributions

Several commentators requested clarification of the treatment of excess Roth IRA contributions under sections 4973, 408(d)(5), and 219(f)(6). Commentators asked for clarification regarding the removal of excess Roth IRA contributions after the contributor's Federal tax return due date has passed. The final regulations clarify that, pursuant to section 4973(f), excess contributions may be applied, on a year-by-year basis, against the annual limit for regular contributions to the extent that the Roth IRA owner is eligible to make regular Roth IRA contributions for a taxable year but does not otherwise do so. However, in response to several requests for clarification, the IRS and Treasury note that the rules under section 408(d)(5) for the tax-free distribution of certain excess traditional IRA contributions after the IRA owner's Federal income tax return due date do not apply to Roth IRAs because Roth IRA contributions are always tax-free on distribution (except to the extent that they accelerate income inclusion under the 4-year spread). Similarly, section 219(f)(6), which provides for the deductibility of excess traditional IRA contributions in subsequent taxable years, has no application to Roth IRAs because contributions to Roth IRAs are never deductible.

Another commentator asked for clarification whether contributions to education IRAs are disregarded for purposes of applying the limitation on regular contributions to Roth IRAs. No change has been made to the final regulations on this point because the final regulations retain the definition of an IRA provided in the proposed regulations, which excludes an education IRA under section 530. Thus, contributions to an education IRA are disregarded in applying the Roth IRA contribution limitation (and in applying the contribution limitation for traditional IRAs).

Conversions

In response to certain comments, the final regulations clarify that conversions and recharacterizations made with the same trustee may be accomplished by re-

designating the account or annuity contract, rather than by the opening of a new account or the issuance of a new annuity contract for each conversion or recharacterization.

As requested by commentators, the final regulations provide that a change in filing status or a divorce does not affect the application of the 4-year spread for 1998 conversions. Thus, if a married Roth IRA owner who is using the 4-year spread files separately or divorces before the full taxable conversion amount has been included in gross income, the remainder must be included in the Roth IRA owner's gross income over the remaining years in the 4-year period, or, if applicable, in the year for which the remainder is accelerated due to distribution or death.

Two commentators questioned why the proposed regulations require that a surviving spouse be the sole beneficiary of all a Roth IRA owner's Roth IRAs in order to elect to continue application of the 4-year spread after the Roth IRA owner's death. The IRS and Treasury view this result as compelled by the statutory language of section 408A(d)(3)-(E)(ii)(II). That section provides that the surviving spouse must acquire the "entire interest" in any Roth IRA to which a conversion contribution to which the 4-year spread applies is "properly allocable." Under the aggregation and ordering rules of section 408A(d)(4), all a Roth IRA owner's Roth IRAs are treated as a single Roth IRA, and a conversion contribution is therefore allocable to all the owner's Roth IRAs. Thus, a surviving spouse must be the sole beneficiary of all a Roth IRA owner's Roth IRAs in order to acquire the entire interest in any Roth IRA to which a 1998 conversion contribution is properly allocable.

Commentators also asked the IRS and Treasury to clarify whether Roth IRA distributions that are part of a series of substantially equal periodic payments begun under a traditional IRA prior to conversion to a Roth IRA are subject to income acceleration during the 4-year spread period and the 10-percent additional tax on early distributions under section 72(t). The final regulations clarify that those distributions are subject to income acceleration to the extent allocable to a 1998 conversion contribution with respect to

which the 4-year spread applies. The final regulations further clarify, however, that the additional 10-percent tax under section 72(t) will not apply, even if the distributions are not qualified distributions (as long as they are part of a series of substantially equal periodic payments).

Under the proposed regulations, if an IRA owner has reached age 70½, any amount distributed (or treated as distributed because of a conversion) from the IRA for a year consists of the required minimum distribution to the extent that an amount equal to the required minimum distribution for that year has not yet been distributed (or treated as distributed); as a required minimum distribution, that amount cannot be converted to a Roth IRA. Although one commentator requested that this rule be retained in the final regulations, other commentators objected to it. A number of commentators asked the IRS and Treasury to adopt a rule allowing an IRA owner who wishes to convert a traditional IRA to a Roth IRA in the year he or she turns 70½ to leave the amount of his or her required minimum distribution with respect to such IRA in the IRA until April 1 of the following year, provided the conversion is accomplished by means of a trustee-to-trustee transfer. The commentators note that this rule applies in the case of trustee-to-trustee transfers between traditional IRAs. The final regulations retain the rule that the required minimum distribution amount is ineligible for rollover, including such a distribution for the year that the individual reaches age 70½, because, pursuant to section 408A(d)(3)(C), a conversion is treated as a distribution regardless of whether the conversion is accomplished by a trustee-to-trustee transfer. Accordingly, the required minimum distribution amount is ineligible for rollover, and as such, is also ineligible to be converted to a Roth IRA.

Additionally, several commentators suggested that the rule in the proposed regulations is inconsistent with section 401(a)(9), which generally requires that IRA distributions begin by April 1 of the calendar year following the calendar year in which the IRA owner reaches age 70½. These commentators argued that, under section 401(a)(9), distributions made during the calendar year in which the IRA

owner reaches age 70½ should not be considered required minimum distributions under sections 401(a)(9) and 408(a)(6) and (b)(3). However, the proposed regulations under sections 401(a)(9) and 408(a)(6) and (b)(3) provide that the first year for which distributions are required under section 401(a)(9) is the year in which the IRA owner reaches age 70½, and that distributions made prior to April 1 of the following calendar year are treated as made for that first year. The regulations under section 402(c) and the proposed regulations under sections 401(a)(9) and 408(a)(6) and (b)(3) provide that the first amount distributed during a calendar year is treated as a required minimum distribution to the extent that the amount required to be distributed for that calendar year under section 401(a)(9) has not been distributed. For these reasons, the final regulations retain the rule of the proposed regulations.

Recharacterizations of IRA Contributions

The final regulations clarify that the computation of net income under §1.408-4(c)(2)(iii) in the case of a commingled IRA may include net losses on the amount to be recharacterized.

Commentators asked the IRS and Treasury to clarify whether an amount converted from a SEP IRA or SIMPLE IRA to a Roth IRA may be recharacterized back to the SEP IRA or SIMPLE IRA from which the amount was converted. The final regulations provide that Roth IRA conversion contributions from a SEP IRA or SIMPLE IRA may be recharacterized to a SEP IRA or SIMPLE IRA (including the original SEP IRA or SIMPLE IRA). Another commentator also asked for clarification whether it is necessary to track the source of assets (i.e., as employer or employee contributions) converted from a SEP IRA or SIMPLE IRA to a Roth IRA for purposes of determining whether such assets may be recharacterized. The prohibition on recharacterizing employer contributions to a SEP IRA or SIMPLE IRA set forth in the final regulations only applies to those contributions at the time they are made to the SEP IRA or SIMPLE IRA. Once such contributions have been made to a SEP IRA or a SIMPLE IRA, the SEP IRA or SIMPLE IRA may be converted to a Roth IRA and subsequently recharacterized (provided, in

the case of a SIMPLE IRA, that the two-year rule has been satisfied prior to the conversion).

Commentators asked for clarification regarding whether an election to recharacterize an IRA contribution may be made on behalf of a deceased IRA owner. The final regulations provide that the election to recharacterize an IRA contribution may be made by the executor, administrator, or other person charged with the duty of filing the decedent's final Federal income tax return.

Commentators also asked whether an excess contribution to an IRA made in a prior year, and applied against the contribution limits in the current year under section 4973, may be recharacterized. Only actual contributions may be recharacterized; thus, excess contributions actually made for a prior year and deemed to be current-year contributions for purposes of section 4973, are not contributions that are eligible to be recharacterized (unless the recharacterization would still be timely with respect to the taxable year for which the contributions were actually made). This rule applies to any excess contribution, whether made to a traditional or a Roth IRA.

Commentators asked for clarification regarding a conduit IRA that is converted to a Roth IRA and subsequently recharacterized back to a traditional IRA. The IRS and Treasury note that a conduit IRA that is converted to a Roth IRA and subsequently recharacterized back to a traditional IRA retains its status as a conduit IRA because the effect of the recharacterization is to treat the amount recharacterized as though it had been transferred directly from the original conduit IRA into another conduit IRA.

Commentators also asked whether a recharacterization is subject to withholding. A recharacterization is not a designated distribution under section 3405 and, therefore, is not subject to withholding.

The final regulations also provide rules regarding the "reconversion" of an amount that has been transferred from a Roth IRA to a traditional IRA by means of a recharacterization after having been earlier converted from a traditional IRA to a Roth IRA. After publication of the proposed regulations, the IRS and Treasury issued Notice 98-50, which provides interim rules regarding Roth IRA reconver-

sions made during 1998 and 1999. Notice 98-50 stated that the interim rules were intended to clarify and supplement the proposed regulations and permitted taxpayers to rely on those rules as if incorporated in the proposed regulations. Notice 98-50 noted that the IRS and Treasury were considering whether the final regulations should provide that a taxpayer is not eligible to reconvert an amount before the end of the taxable year in which the amount was first converted (or the due date for that taxable year), or that a taxpayer who transfers a converted amount back to a traditional IRA in a recharacterization must wait until the passage of a fixed number of days before reconverting. Although Notice 98-50 invited interested parties to submit comments on those approaches, little comment was received on that issue. The final regulations provide reconversion rules for 2000 and subsequent years that generally differ from the interim rules of Notice 98-50. However, for 1998 and 1999, the final regulations continue the interim rules of Notice 98-50.

Effective January 1, 2000, an IRA owner who converts an amount from a traditional IRA to a Roth IRA during any taxable year and then transfers that amount back to a traditional IRA by means of a recharacterization may not reconvert that amount from the traditional IRA to a Roth IRA before the beginning of the taxable year following the taxable year in which the amount was converted to a Roth IRA or, if later, the end of the 30-day period beginning on the day on which the IRA owner transfers the amount from the Roth IRA back to a traditional IRA by means of a recharacterization. As under Notice 98-50, any amount previously converted is adjusted for subsequent net income in determining the amount subject to the limitation on subsequent reconversions.

A reconversion made before the later of the beginning of the next taxable year or the end of the 30-day period that begins on the day of the recharacterization is treated as a "failed conversion" (a distribution from the traditional IRA and a regular contribution to the Roth IRA), subject to correction through a recharacterization back to a traditional IRA. For these purposes, only a failed conversion resulting from a failure to satisfy the statutory re-

quirements for a conversion (e.g., the \$100,000 modified adjusted gross income limit) is treated as a conversion in determining when an IRA owner may make a reconversion. Thus, an IRA owner whose taxable year is the calendar year and who converts an amount to a Roth IRA in 2000 and then transfers that amount back to a traditional IRA on January 18, 2001 because his or her adjusted gross income for 2000 exceeds \$100,000 cannot reconvert that amount until February 17, 2001 (the first day after the end of the 30-day period beginning on the day of the recharacterization transfer) because the failed conversion made in 2000 is treated as a conversion for purposes of the reconversion rules. However, if that IRA owner inadvertently attempts to reconvert that amount before February 17, 2001, the attempted reconversion is not treated as a conversion for purposes of the reconversion rules (although it is otherwise treated as a failed conversion). Therefore, the IRA owner could transfer the amount back to a traditional IRA in a recharacterization and reconvert it at any time on or after February 17, 2001. If the IRA owner does reconvert the amount on or after February 17, 2001, he or she cannot reconvert that amount again until 2002.

As indicated above, the final regulations continue the interim rules of Notice 98-50 applicable for 1998 and 1999. Therefore, an IRA owner who converts an amount from a traditional IRA to a Roth IRA during 1998 and then transfers that amount back to a traditional IRA by means of a recharacterization may reconvert that amount once (but no more than once) on or after November 1, 1998 and on or before December 31, 1998; the IRA owner may also reconvert that amount once (but no more than once) during 1999. Similarly, an IRA owner who converts an amount from a traditional IRA to a Roth IRA during 1999 that has not been converted before and then transfers that amount back to a traditional IRA by means of a recharacterization may reconvert that amount once (but no more than once) on or before December 31, 1999. In contrast to the rule for years after 1999, a failed conversion is not treated as a conversion for these 1998 and 1999 interim rules.

As did Notice 98-50, the final regulations provide that a reconversion made

during 1998 or 1999 for which the IRA owner was not eligible is deemed to be an "excess reconversion" and does not change the IRA owner's taxable conversion amount. Instead, the excess reconversion and the last preceding recharacterization are not taken into account for purposes of determining the IRA owner's taxable conversion amount, and the IRA owner's taxable conversion amount is based on the last reconversion that was not an excess reconversion. An excess reconversion is otherwise treated as a valid reconversion. The final regulations grandfather conversions and reconversions made before November 1, 1998.

Distributions

In response to concerns raised in the comments regarding potential double taxation, the final regulations clarify that a nonqualified distribution from a Roth IRA is taxed only to the extent that the amount of the distribution, when added to all previous distributions (whether or not they were qualified distributions) and reduced by the taxable amount of such previous distributions, exceed the owner's contributions to all his or her Roth IRAs.

Commentators also asked for clarification regarding whether a beneficiary may aggregate his or her inherited Roth IRAs with other Roth IRAs maintained by such beneficiary. The final regulations provide that a beneficiary's inherited Roth IRA may not be aggregated with any other Roth IRA maintained by such beneficiary (except for other Roth IRAs that the beneficiary inherited from the same decedent), unless the beneficiary, as the spouse of the decedent and sole beneficiary of the Roth IRA, elects to treat the Roth IRA as his or her own.

In addition, commentators also asked for clarification regarding whether the 5-taxable-year period for determining whether a distribution is a qualified distribution starts over for subsequent Roth IRA contributions if the entire account balance in a Roth IRA is distributed to the Roth IRA owner before he or she makes any other Roth IRA contributions. In such a case, the 5-taxable-year period does not start over. However, if an initial Roth IRA contribution is made to a Roth IRA that subsequently is revoked within 7 days, or if an initial Roth IRA contribu-

tion is recharacterized, the initial contribution does not start the 5-year period. The final regulations provide that an excess contribution that is distributed in accordance with section 408(d)(4) does not start the 5-year period.

One commentator questioned the rule in the proposed regulations providing that a distribution allocable to a conversion contribution is treated as made first from the portion (if any) that was includible in gross income as a result of the conversion. The IRS and Treasury note that this result is plainly compelled by section 408A(d)(4)(B)(ii). Another commentator inquired about the treatment of all conversions as designated distributions under section 3405; the commentator suggested that conversions effected by means of trustee-to-trustee transfers should not be treated as designated distributions subject to withholding. However, section 408A(d)(3) treats all Roth IRA conversions as distributions regardless of how they are effected.

Reporting Requirements

The final regulations retain the reporting rules set forth in the proposed regulations.

Effective Date

The final regulations are applicable to taxable years beginning on or after January 1, 1998, the effective date for section 408A.

Special Analyses

It has been determined that the final regulations are not a significant regulatory action as defined in Executive Order 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. Further, it is hereby certified, pursuant to sections 603(a) and 605(b) of the Regulatory Flexibility Act, that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. The cost of the collection of information is insignificant because the primary reporting burden is on the individual and not the small entity. Therefore the collection of information will not have

a substantial economic impact. Therefore, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of the final regulations is Cathy A. Vohs, Office of Associate Chief Counsel (Employee Benefits and Exempt Organizations). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding entries in numerical order to read in part as follows:

- Authority: 26 U.S.C. 7805 * * *
- §1.408A-1 also issued under 26 U.S.C. 408A.
- §1.408A-2 also issued under 26 U.S.C. 408A.
- §1.408A-3 also issued under 26 U.S.C. 408A.
- §1.408A-4 also issued under 26 U.S.C. 408A.
- §1.408A-5 also issued under 26 U.S.C. 408A.
- §1.408A-6 also issued under 26 U.S.C. 408A.
- §1.408A-7 also issued under 26 U.S.C. 408A.
- §1.408A-8 also issued under 26 U.S.C. 408A.
- §1.408A-9 also issued under 26 U.S.C. 408A. * * *

Par. 2. Sections 1.408A-0 through 1.408A-9 are added to read as follows:

§1.408A-0 Roth IRAs; table of contents.

This table of contents lists the regulations relating to Roth IRAs under section

408A of the Internal Revenue Code as follows:

- §1.408A-1 Roth IRAs in general.
- §1.408A-2 Establishing Roth IRAs.
- §1.408A-3 Contributions to Roth IRAs.
- §1.408A-4 Converting amounts to Roth IRAs.
- §1.408A-5 Recharacterized contributions.
- §1.408A-6 Distributions.
- §1.408A-7 Reporting.
- §1.408A-8 Definitions.
- §1.408A-9 Effective date.

§1.408A-1 Roth IRAs in general.

This section sets forth the following questions and answers that discuss the background and general features of Roth IRAs:

Q-1 What is a Roth IRA?

A-1. (a) A Roth IRA is a new type of individual retirement plan that individuals can use, beginning in 1998. Roth IRAs are described in section 408A, which was added by the Taxpayer Relief Act of 1997 (TRA 97), Public Law 105-34 (111 Stat. 788).

(b) Roth IRAs are treated like traditional IRAs except where the Internal Revenue Code specifies different treatment. For example, aggregate contributions (other than by a conversion or other rollover) to all an individual's Roth IRAs are not permitted to exceed \$2,000 for a taxable year. Further, income earned on funds held in a Roth IRA is generally not taxable. Similarly, the rules of section 408(e), such as the loss of exemption of the account where the owner engages in a prohibited transaction, apply to Roth IRAs in the same manner as to traditional IRAs.

Q-2. What are the significant differences between traditional IRAs and Roth IRAs?

A-2. There are several significant differences between traditional IRAs and Roth IRAs under the Internal Revenue Code. For example, eligibility to contribute to a Roth IRA is subject to special modified AGI (adjusted gross income) limits; contributions to a Roth IRA are never deductible; qualified distributions from a Roth IRA are not includible in gross income; the required minimum distribution rules under section 408(a)(6) and (b)(3) (which generally incorporate

the provisions of section 401(a)(9)) do not apply to a Roth IRA during the lifetime of the owner; and contributions to a Roth IRA can be made after the owner has attained age 70½.

§1.408A-2 Establishing Roth IRAs.

This section sets forth the following questions and answers that provide rules applicable to establishing Roth IRAs:

Q-1. Who can establish a Roth IRA?

A-1. Except as provided in A-3 of this section, only an individual can establish a Roth IRA. In addition, in order to be eligible to contribute to a Roth IRA for a particular year, an individual must satisfy certain compensation requirements and adjusted gross income limits (see §1.408A-3 A-3).

Q-2. How is a Roth IRA established?

A-2. A Roth IRA can be established with any bank, insurance company, or other person authorized in accordance with §1.408-2(e) to serve as a trustee with respect to IRAs. The document establishing the Roth IRA must clearly designate the IRA as a Roth IRA, and this designation cannot be changed at a later date. Thus, an IRA that is designated as a Roth IRA cannot later be treated as a traditional IRA. However, see §1.408A-4 A-1(b)(3) for certain rules for converting a traditional IRA to a Roth IRA with the same trustee by redesignating the traditional IRA as a Roth IRA, and see §1.408A-5 for rules for recharacterizing certain IRA contributions.

Q-3. Can an employer or an association of employees establish a Roth IRA to hold contributions of employees or members?

A-3. Yes. Pursuant to section 408(c), an employer or an association of employees can establish a trust to hold contributions of employees or members made under a Roth IRA. Each employee's or member's account in the trust is treated as a separate Roth IRA that is subject to the generally applicable Roth IRA rules. The employer or association of employees may do certain acts otherwise required by an individual, for example, establishing and designating a trust as a Roth IRA.

Q-4. What is the effect of a surviving spouse of a Roth IRA owner treating an IRA as his or her own?

A-4. If the surviving spouse of a Roth IRA owner treats a Roth IRA as his or her

own as of a date, the Roth IRA is treated from that date forward as though it were established for the benefit of the surviving spouse and not the original Roth IRA owner. Thus, for example, the surviving spouse is treated as the Roth IRA owner for purposes of applying the minimum distribution requirements under section 408(a)(6) and (b)(3). Similarly, the surviving spouse is treated as the Roth IRA owner rather than a beneficiary for purposes of determining the amount of any distribution from the Roth IRA that is includible in gross income and whether the distribution is subject to the 10-percent additional tax under section 72(t).

§1.408A-3 Contributions to Roth IRAs.

This section sets forth the following questions and answers that provide rules regarding contributions to Roth IRAs:

Q-1. What types of contributions are permitted to be made to a Roth IRA?

A-1. There are two types of contributions that are permitted to be made to a Roth IRA: regular contributions and qualified rollover contributions (including conversion contributions). The term regular contributions means contributions other than qualified rollover contributions.

Q-2. When are contributions permitted to be made to a Roth IRA?

A-2. (a) The provisions of section 408A are effective for taxable years beginning on or after January 1, 1998. Thus, the first taxable year for which contributions are permitted to be made to a Roth IRA by an individual is the individual's taxable year beginning in 1998.

(b) Regular contributions for a particular taxable year must generally be contributed by the due date (not including extensions) for filing a Federal income tax return for that taxable year. (See §1.408A-5 regarding recharacterization of certain contributions.)

Q-3. What is the maximum aggregate amount of regular contributions an individual is eligible to contribute to a Roth IRA for a taxable year?

A-3. (a) The maximum aggregate amount that an individual is eligible to contribute to all his or her Roth IRAs as a regular contribution for a taxable year is the same as the maximum for traditional IRAs: \$2,000 or, if less, that individual's compensation for the year.

(b) For Roth IRAs, the maximum amount described in paragraph (a) of this A-3 is phased out between certain levels of modified AGI. For an individual who is not married, the dollar amount is phased out ratably between modified AGI of \$95,000 and \$110,000; for a married individual filing a joint return, between modified AGI of \$150,000 and \$160,000; and for a married individual filing separately, between modified AGI of \$0 and \$10,000. For this purpose, a married individual who has lived apart from his or her spouse for the entire taxable year and who files separately is treated as not married. Under section 408A(c)(3)(A), in applying the phase-out, the maximum amount is rounded up to the next higher multiple of \$10 and is not reduced below \$200 until completely phased out.

(c) If an individual makes regular contributions to both traditional IRAs and Roth IRAs for a taxable year, the maximum limit for the Roth IRA is the lesser of—

(1) The amount described in paragraph (a) of this A-3 reduced by the amount contributed to traditional IRAs for the taxable year; and

(2) The amount described in paragraph (b) of this A-3. Employer contributions, including elective deferrals, made under a SEP or SIMPLE IRA Plan on behalf of an individual (including a self-employed individual) do not reduce the amount of the individual's maximum regular contribution.

(d) The rules in this A-3 are illustrated by the following examples:

Example 1. In 1998, unmarried, calendar-year taxpayer B, age 60, has modified AGI of \$40,000 and compensation of \$5,000. For 1998, B can contribute a maximum of \$2,000 to a traditional IRA, a Roth IRA or a combination of traditional and Roth IRAs.

Example 2. The facts are the same as in *Example 1*. However, assume that B violates the maximum regular contribution limit by contributing \$2,000 to a traditional IRA and \$2,000 to a Roth IRA for 1998. The \$2,000 to B's Roth IRA would be an excess contribution to B's Roth IRA for 1998 because an individual's contributions are applied first to a traditional IRA, then to a Roth IRA.

Example 3. The facts are the same as in *Example 1*, except that B's compensation is \$900. The maximum amount B can contribute to either a traditional IRA or a Roth (or a combination of the two) for 1998 is \$900.

Example 4. In 1998, unmarried, calendar-year taxpayer C, age 60, has modified AGI of \$100,000 and compensation of \$5,000. For 1998, C contributes \$800 to a traditional IRA and \$1,200 to a

Roth IRA. Because C's \$1,200 Roth IRA contribution does not exceed the phased-out maximum Roth IRA contribution of \$1,340 and because C's total IRA contributions do not exceed \$2,000, C's Roth IRA contribution does not exceed the maximum permissible contribution.

Q-4. How is compensation defined for purposes of the Roth IRA contribution limit?

A-4. For purposes of the contribution limit described in A-3 of this section, an individual's compensation is the same as that used to determine the maximum contribution an individual can make to a traditional IRA. This amount is defined in section 219(f)(1) to include wages, commissions, professional fees, tips, and other amounts received for personal services, as well as taxable alimony and separate maintenance payments received under a decree of divorce or separate maintenance. Compensation also includes earned income as defined in section 401(c)(2), but does not include any amount received as a pension or annuity or as deferred compensation. In addition, under section 219(c), a married individual filing a joint return is permitted to make an IRA contribution by treating his or her spouse's higher compensation as his or her own, but only to the extent that the spouse's compensation is not being used for purposes of the spouse making a contribution to a Roth IRA or a deductible contribution to a traditional IRA.

Q-5. What is the significance of modified AGI and how is it determined?

A-5. Modified AGI is used for purposes of the phase-out rules described in A-3 of this section and for purposes of the \$100,000 modified AGI limitation described in §1.408A-4 A-2(a) (relating to eligibility for conversion). As defined in section 408A(c)(3)(C)(i), modified AGI is the same as adjusted gross income under section 219(g)(3)(A) (used to determine the amount of deductible contributions that can be made to a traditional IRA by an individual who is an active participant in an employer-sponsored retirement plan), except that any conversion is disregarded in determining modified AGI. For example, the deduction for contributions to an IRA is not taken into account for purposes of determining adjusted gross income under section 219 and thus does not apply in determining modified AGI for Roth IRA purposes.

Q-6. Is a required minimum distribution from an IRA for a year included in income for purposes of determining modified AGI?

A-6. (a) Yes. For taxable years beginning before January 1, 2005, any required minimum distribution from an IRA under section 408(a)(6) and (b)(3) (which generally incorporate the provisions of section 401(a)(9)) is included in income for purposes of determining modified AGI.

(b) For taxable years beginning after December 31, 2004, and solely for purposes of the \$100,000 limitation applicable to conversions, modified AGI does not include any required minimum distributions from an IRA under section 408(a)(6) and (b)(3).

Q-7. Does an excise tax apply if an individual exceeds the aggregate regular contribution limits for Roth IRAs?

A-7. Yes. Section 4973 imposes an annual 6-percent excise tax on aggregate amounts contributed to Roth IRAs that exceed the maximum contribution limits described in A-3 of this section. Any contribution that is distributed, together with net income, from a Roth IRA on or before the tax return due date (plus extensions) for the taxable year of the contribution is treated as not contributed. Net income described in the previous sentence is includible in gross income for the taxable year in which the contribution is made. Aggregate excess contributions that are not distributed from a Roth IRA on or before the tax return due date (with extensions) for the taxable year of the contributions are reduced as a deemed Roth IRA contribution for each subsequent taxable year to the extent that the Roth IRA owner does not actually make regular IRA contributions for such years. Section 4973 applies separately to an individual's Roth IRAs and other types of IRAs.

§1.408A-4 Converting amounts to Roth IRAs.

This section sets forth the following questions and answers that provide rules applicable to Roth IRA conversions:

Q-1. Can an individual convert an amount in his or her traditional IRA to a Roth IRA?

A-1. (a) Yes. An amount in a traditional IRA may be converted to an amount in a Roth IRA if two requirements

are satisfied. First, the IRA owner must satisfy the modified AGI limitation described in A-2(a) of this section and, if married, the joint filing requirement described in A-2(b) of this section. Second, the amount contributed to the Roth IRA must satisfy the definition of a qualified rollover contribution in section 408A(e) (i.e., it must satisfy the requirements for a rollover contribution as defined in section 408(d)(3), except that the one-rollover-per-year limitation in section 408(d)(3)(B) does not apply).

(b) An amount can be converted by any of three methods—

(1) An amount distributed from a traditional IRA is contributed (rolled over) to a Roth IRA within the 60-day period described in section 408(d)(3)(A)(i);

(2) An amount in a traditional IRA is transferred in a trustee-to-trustee transfer from the trustee of the traditional IRA to the trustee of the Roth IRA; or

(3) An amount in a traditional IRA is transferred to a Roth IRA maintained by the same trustee. For purposes of sections 408 and 408A, redesignating a traditional IRA as a Roth IRA is treated as a transfer of the entire account balance from a traditional IRA to a Roth IRA.

(c) Any converted amount is treated as a distribution from the traditional IRA and a qualified rollover contribution to the Roth IRA for purposes of section 408 and section 408A, even if the conversion is accomplished by means of a trustee-to-trustee transfer or a transfer between IRAs of the same trustee.

(d) A transaction that is treated as a failed conversion under §1.408A-5 A-9(a)(1) is not a conversion.

Q-2. What are the modified AGI limitation and joint filing requirements for conversions?

A-2. (a) An individual with modified AGI in excess of \$100,000 for a taxable year is not permitted to convert an amount to a Roth IRA during that taxable year. This \$100,000 limitation applies to the taxable year that the funds are paid from the traditional IRA, rather than the year they are contributed to the Roth IRA.

(b) If the individual is married, he or she is permitted to convert an amount to a Roth IRA during a taxable year only if the individual and the individual's spouse file a joint return for the taxable year that the

funds are paid from the traditional IRA. In this case, the modified AGI subject to the \$100,000 limit is the modified AGI derived from the joint return using the couple's combined income. The only exception to this joint filing requirement is for an individual who has lived apart from his or her spouse for the entire taxable year. If the married individual has lived apart from his or her spouse for the entire taxable year, then such individual can treat himself or herself as not married for purposes of this paragraph, file a separate return and be subject to the \$100,000 limit on his or her separate modified AGI. In all other cases, a married individual filing a separate return is not permitted to convert an amount to a Roth IRA, regardless of the individual's modified AGI.

Q-3. Is a remedy available to an individual who makes a failed conversion?

A-3. (a) Yes. See §1.408A-5 for rules permitting a failed conversion amount to be recharacterized as a contribution to a traditional IRA. If the requirements in §1.408A-5 are satisfied, the failed conversion amount will be treated as having been contributed to the traditional IRA and not to the Roth IRA.

(b) If the contribution is not recharacterized in accordance with §1.408A-5, the contribution will be treated as a regular contribution to the Roth IRA and, thus, an excess contribution subject to the excise tax under section 4973 to the extent that it exceeds the individual's regular contribution limit. This is the result regardless of which of the three methods described in A-1(b) of this section applies to this transaction. Additionally, the distribution from the traditional IRA will not be eligible for the 4-year spread and will be subject to the additional tax under section 72(t) (unless an exception under that section applies).

Q-4. Do any special rules apply to a conversion of an amount in an individual's SEP IRA or SIMPLE IRA to a Roth IRA?

A-4. (a) An amount in an individual's SEP IRA can be converted to a Roth IRA on the same terms as an amount in any other traditional IRA.

(b) An amount in an individual's SIMPLE IRA can be converted to a Roth IRA on the same terms as a conversion from a traditional IRA, except that an amount

distributed from a SIMPLE IRA during the 2-year period described in section 72(t)(6), which begins on the date that the individual first participated in any SIMPLE IRA Plan maintained by the individual's employer, cannot be converted to a Roth IRA. Pursuant to section 408(d)(3)(G), a distribution of an amount from an individual's SIMPLE IRA during this 2-year period is not eligible to be rolled over into an IRA that is not a SIMPLE IRA and thus cannot be a qualified rollover contribution. This 2-year period of section 408(d)(3)(G) applies separately to the contributions of each of an individual's employers maintaining a SIMPLE IRA Plan.

(c) Once an amount in a SEP IRA or SIMPLE IRA has been converted to a Roth IRA, it is treated as a contribution to a Roth IRA for all purposes. Future contributions under the SEP or under the SIMPLE IRA Plan may not be made to the Roth IRA.

Q-5. Can amounts in other kinds of retirement plans be converted to a Roth IRA?

A-5. No. Only amounts in another IRA can be converted to a Roth IRA. For example, amounts in a qualified plan or annuity plan described in section 401(a) or 403(a) cannot be converted directly to a Roth IRA. Also, amounts held in an annuity contract or account described in section 403(b) cannot be converted directly to a Roth IRA.

Q-6. Can an individual who has attained at least age 70½ by the end of a calendar year convert an amount distributed from a traditional IRA during that year to a Roth IRA before receiving his or her required minimum distribution with respect to the traditional IRA for the year of the conversion?

A-6. (a) No. In order to be eligible for a conversion, an amount first must be eligible to be rolled over. Section 408(d)(3) prohibits the rollover of a required minimum distribution. If a minimum distribution is required for a year with respect to an IRA, the first dollars distributed during that year are treated as consisting of the required minimum distribution until an amount equal to the required minimum distribution for that year has been distributed.

(b) As provided in A-1(c) of this section, any amount converted is treated as a

distribution from a traditional IRA and a rollover contribution to a Roth IRA and not as a trustee-to-trustee transfer for purposes of section 408 and section 408A. Thus, in a year for which a minimum distribution is required (including the calendar year in which the individual attains age 70½), an individual may not convert the assets of an IRA (or any portion of those assets) to a Roth IRA to the extent that the required minimum distribution for the traditional IRA for the year has not been distributed.

(c) If a required minimum distribution is contributed to a Roth IRA, it is treated as having been distributed, subject to the normal rules under section 408(d)(1) and (2), and then contributed as a regular contribution to a Roth IRA. The amount of the required minimum distribution is not a conversion contribution.

Q-7. What are the tax consequences when an amount is converted to a Roth IRA?

A-7. (a) Any amount that is converted to a Roth IRA is includible in gross income as a distribution according to the rules of section 408(d)(1) and (2) for the taxable year in which the amount is distributed or transferred from the traditional IRA. Thus, any portion of the distribution or transfer that is treated as a return of basis under section 408(d)(1) and (2) is not includible in gross income as a result of the conversion.

(b) The 10-percent additional tax under section 72(t) generally does not apply to the taxable conversion amount. But see §1.408A-6 A-5 for circumstances under which the taxable conversion amount would be subject to the additional tax under section 72(t).

(c) Pursuant to section 408A(e), a conversion is not treated as a rollover for purposes of the one-rollover-per-year rule of section 408(d)(3)(B).

Q-8. Is there an exception to the income-inclusion rule described in A-7 of this section for 1998 conversions?

A-8. Yes. In the case of a distribution (including a trustee-to-trustee transfer) from a traditional IRA on or before December 31, 1998, that is converted to a Roth IRA, instead of having the entire taxable conversion amount includible in income in 1998, an individual includes in gross income for 1998 only one quarter of that amount and one quarter of that

amount for each of the next 3 years. This 4-year spread also applies if the conversion amount was distributed in 1998 and contributed to the Roth IRA within the 60-day period described in section 408(d)(3)(A)(i), but after December 31, 1998. However, see §1.408A-6 A-6 for special rules requiring acceleration of inclusion if an amount subject to the 4-year spread is distributed from the Roth IRA before 2001.

Q-9. Is the taxable conversion amount included in income for all purposes?

A-9. Except as provided below, any taxable conversion amount includible in gross income for a year as a result of the conversion (regardless of whether the individual is using a 4-year spread) is included in income for all purposes. Thus, for example, it is counted for purposes of determining the taxable portion of social security payments under section 86 and for purposes of determining the phase-out of the \$25,000 exemption under section 469(i) relating to the disallowance of passive activity losses from rental real estate activities. However, as provided in §1.408A-3 A-5, the taxable conversion amount (and any resulting change in other elements of adjusted gross income) is disregarded for purposes of determining modified AGI for section 408A.

Q-10. Can an individual who makes a 1998 conversion elect not to have the 4-year spread apply and instead have the full taxable conversion amount includible in gross income for 1998?

A-10. Yes. Instead of having the taxable conversion amount for a 1998 conversion included over 4 years as provided under

A-8 of this section, an individual can elect to include the full taxable conversion amount in income for 1998. The election is made on Form 8606 and cannot be made or changed after the due date (including extensions) for filing the 1998 Federal income tax return.

Q-11. What happens when an individual who is using the 4-year spread dies, files separately, or divorces before the full taxable conversion amount has been included in gross income?

A-11. (a) If an individual who is using the 4-year spread described in A-8 of this section dies before the full taxable conversion amount has been included in gross income, then the remainder must be

included in the individual's gross income for the taxable year that includes the date of death.

(b) However, if the sole beneficiary of all the decedent's Roth IRAs is the decedent's spouse, then the spouse can elect to continue the 4-year spread. Thus, the spouse can elect to include in gross income the same amount that the decedent would have included in each of the remaining years of the 4-year period. Where the spouse makes such an election, the amount includible under the 4-year spread for the taxable year that includes the date of the decedent's death remains includible in the decedent's gross income and is reported on the decedent's final Federal income tax return. The election is made on either Form 8606 or Form 1040, in accordance with the instructions to the applicable form, for the taxable year that includes the decedent's date of death and cannot be changed after the due date (including extensions) for filing the Federal income tax return for the spouse's taxable year that includes the decedent's date of death.

(c) If a Roth IRA owner who is using the 4-year spread and who was married in 1998 subsequently files separately or divorces before the full taxable conversion amount has been included in gross income, the remainder of the taxable conversion amount must be included in the Roth IRA owner's gross income over the remaining years in the 4-year period (unless accelerated because of distribution or death).

Q-12. Can an individual convert a traditional IRA to a Roth IRA if he or she is receiving substantially equal periodic payments within the meaning of section 72(t)(2)(A)(iv) from that traditional IRA?

A-12. Yes. Not only is the conversion amount itself not subject to the early distribution tax under section 72(t), but the conversion amount is also not treated as a distribution for purposes of determining whether a modification within the meaning of section 72(t)(4)(A) has occurred. Distributions from the Roth IRA that are part of the original series of substantially equal periodic payments will be nonqualified distributions from the Roth IRA until they meet the requirements for being a qualified distribution, described in §1.408A-6 A-1(b). The additional 10-percent tax under section 72(t) will not

apply to the extent that these nonqualified distributions are part of a series of substantially equal periodic payments. Nevertheless, to the extent that such distributions are allocable to a 1998 conversion contribution with respect to which the 4-year spread for the resultant income inclusion applies (see A-8 of this section) and are received during 1998, 1999, or 2000, the special acceleration rules of §1.408A-6 A-6 apply. However, if the original series of substantially equal periodic payments does not continue to be distributed in substantially equal periodic payments from the Roth IRA after the conversion, the series of payments will have been modified and, if this modification occurs within 5 years of the first payment or prior to the individual becoming disabled or attaining age 59½, the taxpayer will be subject to the recapture tax of section 72(t)(4)(A).

Q-13. Can a 1997 distribution from a traditional IRA be converted to a Roth IRA in 1998?

A-13. No. An amount distributed from a traditional IRA in 1997 that is contributed to a Roth IRA in 1998 would not be a conversion contribution. See A-3 of this section regarding the remedy for a failed conversion.

§1.408A-5 Recharacterized contributions.

This section sets forth the following questions and answers that provide rules regarding recharacterizing IRA contributions:

Q-1. Can an IRA owner recharacterize certain contributions (i.e., treat a contribution made to one type of IRA as made to a different type of IRA) for a taxable year?

A-1. (a) Yes. In accordance with section 408A(d)(6), except as otherwise provided in this section, if an individual makes a contribution to an IRA (the FIRST IRA) for a taxable year and then transfers the contribution (or a portion of the contribution) in a trustee-to-trustee transfer from the trustee of the FIRST IRA to the trustee of another IRA (the SECOND IRA), the individual can elect to treat the contribution as having been made to the SECOND IRA, instead of to the FIRST IRA, for Federal tax purposes. A transfer between the FIRST IRA and

the SECOND IRA will not fail to be a trustee-to-trustee transfer merely because both IRAs are maintained by the same trustee. For purposes of section 408A(d)(6), redesignating the FIRST IRA as the SECOND IRA will be treated as a transfer of the entire account balance from the FIRST IRA to the SECOND IRA.

(b) This recharacterization election can be made only if the trustee-to-trustee transfer from the FIRST IRA to the SECOND IRA is made on or before the due date (including extensions) for filing the individual's Federal income tax return for the taxable year for which the contribution was made to the FIRST IRA. For purposes of this section, a conversion that is accomplished through a rollover of a distribution from a traditional IRA in a taxable year that, 60 days after the distribution (as described in section 408(d)(3)-(A)(i)), is contributed to a Roth IRA in the next taxable year is treated as a contribution for the earlier taxable year.

Q-2. What is the proper treatment of the net income attributable to the amount of a contribution that is being recharacterized?

A-2. (a) The net income attributable to the amount of a contribution that is being recharacterized must be transferred to the SECOND IRA along with the contribution.

(b) If the amount of the contribution being recharacterized was contributed to a separate IRA and no distributions or additional contributions have been made from or to that IRA at any time, then the contribution is recharacterized by the trustee of the FIRST IRA transferring the entire account balance of the FIRST IRA to the trustee of the SECOND IRA. In this case, the net income (or loss) attributable to the contribution being recharacterized is the difference between the amount of the original contribution and the amount transferred.

(c) If paragraph (b) of this A-2 does not apply, then the net income attributable to the amount of a contribution is calculated in the manner prescribed by §1.408-4(c)(2)(ii) (disregarding the parenthetical clause in §1.408-4(c)(2)(iii)).

Q-3. What is the effect of recharacterizing a contribution made to the FIRST IRA as a contribution made to the SECOND IRA?

A-3. The contribution that is being recharacterized as a contribution to the

SECOND IRA is treated as having been originally contributed to the SECOND IRA on the same date and (in the case of a regular contribution) for the same taxable year that the contribution was made to the FIRST IRA. Thus, for example, no deduction would be allowed for a contribution to the FIRST IRA, and any net income transferred with the recharacterized contribution is treated as earned in the SECOND IRA, and not the FIRST IRA.

Q-4. Can an amount contributed to an IRA in a tax-free transfer be recharacterized under A-1 of this section?

A-4. No. If an amount is contributed to the FIRST IRA in a tax-free transfer, the amount cannot be recharacterized as a contribution to the SECOND IRA under A-1 of this section. However, if an amount is erroneously rolled over or transferred from a traditional IRA to a SIMPLE IRA, the contribution can subsequently be recharacterized as a contribution to another traditional IRA.

Q-5. Can an amount contributed by an employer under a SIMPLE IRA Plan or a SEP be recharacterized under A-1 of this section?

A-5. No. Employer contributions (including elective deferrals) under a SIMPLE IRA Plan or a SEP cannot be recharacterized as contributions to another IRA under A-1 of this section. However, an amount converted from a SEP IRA or SIMPLE IRA to a Roth IRA may be recharacterized under A-1 of this section as a contribution to a SEP IRA or SIMPLE IRA, including the original SEP IRA or SIMPLE IRA.

Q-6. How does a taxpayer make the election to recharacterize a contribution to an IRA for a taxable year?

A-6. (a) An individual makes the election described in this section by notifying, on or before the date of the transfer, both the trustee of the FIRST IRA and the trustee of the SECOND IRA, that the individual has elected to treat the contribution as having been made to the SECOND IRA, instead of the FIRST IRA, for Federal tax purposes. The notification of the election must include the following information: the type and amount of the contribution to the FIRST IRA that is to be recharacterized; the date on which the contribution was made to the FIRST IRA and the year for which it was made; a direction to the trustee of the FIRST IRA to

transfer, in a trustee-to-trustee transfer, the amount of the contribution and net income allocable to the contribution to the trustee of the SECOND IRA; and the name of the trustee of the FIRST IRA and the trustee of the SECOND IRA and any additional information needed to make the transfer.

(b) The election and the trustee-to-trustee transfer must occur on or before the due date (including extensions) for filing the individual's Federal income tax return for the taxable year for which the recharacterized contribution was made to the FIRST IRA, and the election cannot be revoked after the transfer. An individual who makes this election must report the recharacterization, and must treat the contribution as having been made to the SECOND IRA, instead of the FIRST IRA, on the individual's Federal income tax return for the taxable year described in the preceding sentence in accordance with the applicable Federal tax forms and instructions.

(c) The election to recharacterize a contribution described in this A-6 may be made on behalf of a deceased IRA owner by his or her executor, administrator, or other person responsible for filing the final Federal income tax return of the decedent under section 6012(b)(1).

Q-7. If an amount is initially contributed to an IRA for a taxable year, then is moved (with net income attributable to the contribution) in a tax-free transfer to another IRA (the FIRST IRA for purposes of A-1 of this section), can the tax-free transfer be disregarded, so that the initial contribution that is transferred from the FIRST IRA to the SECOND IRA is treated as a recharacterization of that initial contribution?

A-7. Yes. In applying section 408A(d)(6), tax-free transfers between IRAs are disregarded. Thus, if a contribution to an IRA for a year is followed by one or more tax-free transfers between IRAs prior to the recharacterization, then for purposes of section 408A(d)(6), the contribution is treated as if it remained in the initial IRA. Consequently, an individual may elect to recharacterize an initial contribution made to the initial IRA that was involved in a series of tax-free transfers by making a trustee-to-trustee transfer from the last IRA in the series to the SECOND IRA. In this case the contribu-

tion to the SECOND IRA is treated as made on the same date (and for the same taxable year) as the date the contribution being recharacterized was made to the initial IRA.

Q-8. If a contribution is recharacterized, is the recharacterization treated as a rollover for purposes of the one-rollover-per-year limitation of section 408(d)(3)(B)?

A-8. No, recharacterizing a contribution under A-1 of this section is never treated as a rollover for purposes of the one-rollover-per-year limitation of section 408(d)(3)(B), even if the contribution would have been treated as a rollover contribution by the SECOND IRA if it had been made directly to the SECOND IRA, rather than as a result of a recharacterization of a contribution to the FIRST IRA.

Q-9. If an IRA owner converts an amount from a traditional IRA to a Roth IRA and then transfers that amount back to a traditional IRA in a recharacterization, may the IRA owner subsequently reconvert that amount from the traditional IRA to a Roth IRA?

A-9. (a) (1) Except as otherwise provided in paragraph (b) of this A-9, an IRA owner who converts an amount from a traditional IRA to a Roth IRA during any taxable year and then transfers that amount back to a traditional IRA by means of a recharacterization may not reconvert that amount from the traditional IRA to a Roth IRA before the beginning of the taxable year following the taxable year in which the amount was converted to a Roth IRA or, if later, the end of the 30-day period beginning on the day on which the IRA owner transfers the amount from the Roth IRA back to a traditional IRA by means of a recharacterization (regardless of whether the recharacterization occurs during the taxable year in which the amount was converted to a Roth IRA or the following taxable year). Thus, any attempted reconversion of an amount prior to the time permitted under this paragraph (a)(1) is a failed conversion of that amount. However, see §1.408A-4 A-3 for a remedy available to an individual who makes a failed conversion.

(2) For purposes of paragraph (a)(1) of this A-9, a failed conversion of an amount resulting from a failure to satisfy the requirements of §1.408A-4 A-1(a) is treated as a conversion in determining

whether an IRA owner has previously converted that amount.

(b) (1) An IRA owner who converts an amount from a traditional IRA to a Roth IRA during taxable year 1998 and then transfers that amount back to a traditional IRA by means of a recharacterization may reconvert that amount once (but no more than once) on or after November 1, 1998 and on or before December 31, 1998; the IRA owner may also reconvert that amount once (but no more than once) during 1999. The rule set forth in the preceding sentence applies without regard to whether the IRA owner's initial conversion or recharacterization of the amount occurred before, on, or after November 1, 1998. An IRA owner who converts an amount from a traditional IRA to a Roth IRA during taxable year 1999 that has not been converted previously and then transfers that amount back to a traditional IRA by means of a recharacterization may reconvert that amount once (but no more than once) on or before December 31, 1999. For purposes of this paragraph (b)(1), a failed conversion of an amount resulting from a failure to satisfy the requirements of §1.408A-4 A-1(a) is not treated as a conversion in determining whether an IRA owner has previously converted that amount.

(2) A reconversion by an IRA owner during 1998 or 1999 for which the IRA owner is not eligible under paragraph (b)(1) of this A-9 will be deemed an excess reconversion (rather than a failed conversion) and will not change the IRA owner's taxable conversion amount. Instead, the excess reconversion and the last preceding recharacterization will not be taken into account for purposes of determining the IRA owner's taxable conversion amount, and the IRA owner's taxable conversion amount will be based on the last reconversion that was not an excess reconversion (unless, after the excess reconversion, the amount is transferred back to a traditional IRA by means of a recharacterization). An excess reconversion will otherwise be treated as a valid reconversion.

(3) For purposes of this paragraph (b), any reconversion that an IRA owner made before November 1, 1998 will not be treated as an excess reconversion and will not be taken into account in determining

whether any later reconversion is an excess reconversion.

(c) In determining the portion of any amount held in a Roth IRA or a traditional IRA that an IRA owner may not reconvert under this A-9, any amount previously converted (or reconverted) is adjusted for subsequent net income thereon.

Q-10. Are there examples to illustrate the rules in this section?

A-10. The rules in this section are illustrated by the following examples:

Example 1. In 1998, Individual C converts the entire amount in his traditional IRA to a Roth IRA. Individual C thereafter determines that his modified AGI for 1998 exceeded \$100,000 so that he was ineligible to have made a conversion in that year. Accordingly, prior to the due date (plus extensions) for filing the individual's Federal income tax return for 1998, he decides to recharacterize the conversion contribution. He instructs the trustee of the Roth IRA (FIRST IRA) to transfer in a trustee-to-trustee transfer the amount of the contribution, plus net income, to the trustee of a new traditional IRA (SECOND IRA). The individual notifies the trustee of the FIRST IRA and the trustee of the SECOND IRA that he is recharacterizing his IRA contribution (and provides the other information described in A-6 of this section). On the individual's Federal income tax return for 1998, he treats the original amount of the conversion as having been contributed to the SECOND IRA and not the Roth IRA. As a result, for Federal tax purposes, the contribution is treated as having been made to the SECOND IRA and not to the Roth IRA. The result would be the same if the conversion amount had been transferred in a tax-free transfer to another Roth IRA prior to the recharacterization.

Example 2. In 1998, an individual makes a \$2,000 regular contribution for 1998 to his traditional IRA (FIRST IRA). Prior to the due date (plus extensions) for filing the individual's Federal income tax return for 1998, he decides that he would prefer to contribute to a Roth IRA instead. The individual instructs the trustee of the FIRST IRA to transfer in a trustee-to-trustee transfer the amount of the contribution, plus attributable net income, to the trustee of a Roth IRA (SECOND IRA). The individual notifies the trustee of the FIRST IRA and the trustee of the SECOND IRA that he is recharacterizing his \$2,000 contribution for 1998 (and provides the other information described in A-6 of this section). On the individual's Federal income tax return for 1998, he treats the \$2,000 as having been contributed to the Roth IRA for 1998 and not to the traditional IRA. As a result, for Federal tax purposes, the contribution is treated as having been made to the Roth IRA for 1998 and not to the traditional IRA. The result would be the same if the conversion amount had been transferred in a tax-free transfer to another traditional IRA prior to the recharacterization.

Example 3. The facts are the same as in *Example 2*, except that the \$2,000 regular contribution is initially made to a Roth IRA and the recharacterizing transfer is made to a traditional IRA. On the indi-

vidual's Federal income tax return for 1998, he treats the \$2,000 as having been contributed to the traditional IRA for 1998 and not the Roth IRA. As a result, for Federal tax purposes, the contribution is treated as having been made to the traditional IRA for 1998 and not the Roth IRA. The result would be the same if the contribution had been transferred in a tax-free transfer to another Roth IRA prior to the recharacterization, except that the only Roth IRA trustee the individual must notify is the one actually making the recharacterization transfer.

Example 4. In 1998, an individual receives a distribution from traditional IRA 1 and contributes the entire amount to traditional IRA 2 in a rollover contribution described in section 408(d)(3). In this case, the individual cannot elect to recharacterize the contribution by transferring the contribution amount, plus net income, to a Roth IRA, because an amount contributed to an IRA in a tax-free transfer cannot be recharacterized. However, the individual may convert (other than by recharacterization) the amount in traditional IRA 2 to a Roth IRA at any time, provided the requirements of §1.408A-4 A-1 are satisfied.

§1.408A-6 Distributions.

This section sets forth the following questions and answers that provide rules regarding distributions from Roth IRAs:

Q-1. How are distributions from Roth IRAs taxed?

A-1. (a) The taxability of a distribution from a Roth IRA generally depends on whether or not the distribution is a qualified distribution. This A-1 provides rules for qualified distributions and certain other nontaxable distributions. A-4 of this section provides rules for the taxability of distributions that are not qualified distributions.

(b) A distribution from a Roth IRA is not includible in the owner's gross income if it is a qualified distribution or to the extent that it is a return of the owner's contributions to the Roth IRA (determined in accordance with A-8 of this section). A qualified distribution is one that is both—

(1) Made after a 5-taxable-year period (defined in A-2 of this section); and

(2) Made on or after the date on which the owner attains age 59½, made to a beneficiary or the estate of the owner on or after the date of the owner's death, attributable to the owner's being disabled within the meaning of section 72(m)(7), or to which section 72(t)(2)(F) applies (exception for first-time home purchase).

(c) An amount distributed from a Roth IRA will not be included in gross income to the extent it is rolled over to another

Roth IRA on a tax-free basis under the rules of sections 408(d)(3) and 408A(e).

(d) Contributions that are returned to the Roth IRA owner in accordance with section 408(d)(4) (corrective distributions) are not includible in gross income, but any net income required to be distributed under section 408(d)(4) together with the contributions is includible in gross income for the taxable year in which the contributions were made.

Q-2. When does the 5-taxable-year period described in A-1 of this section (relating to qualified distributions) begin and end?

A-2. The 5-taxable-year period described in A-1 of this section begins on the first day of the individual's taxable year for which the first regular contribution is made to any Roth IRA of the individual or, if earlier, the first day of the individual's taxable year in which the first conversion contribution is made to any Roth IRA of the individual. The 5-taxable-year period ends on the last day of the individual's fifth consecutive taxable year beginning with the taxable year described in the preceding sentence. For example, if an individual whose taxable year is the calendar year makes a first-time regular Roth IRA contribution any time between January 1, 1998, and April 15, 1999, for 1998, the 5-taxable-year period begins on January 1, 1998. Thus, each Roth IRA owner has only one 5-taxable-year period described in A-1 of this section for all the Roth IRAs of which he or she is the owner. Further, because of the requirement of the 5-taxable-year period, no qualified distributions can occur before taxable years beginning in 2003. For purposes of this A-2, the amount of any contribution distributed as a corrective distribution under A-1(d) of this section is treated as if it was never contributed.

Q-3. If a distribution is made to an individual who is the sole beneficiary of his or her deceased spouse's Roth IRA and the individual is treating the Roth IRA as his or her own, can the distribution be a qualified distribution based on being made to a beneficiary on or after the owner's death?

A-3. No. If a distribution is made to an individual who is the sole beneficiary of his or her deceased spouse's Roth IRA and the individual is treating the Roth IRA as his or her own, then, in accordance

with §1.408A-2 A-4, the distribution is treated as coming from the individual's own Roth IRA and not the deceased spouse's Roth IRA. Therefore, for purposes of determining whether the distribution is a qualified distribution, it is not treated as made to a beneficiary on or after the owner's death.

Q-4. How is a distribution from a Roth IRA taxed if it is not a qualified distribution?

A-4. A distribution that is not a qualified distribution, and is neither contributed to another Roth IRA in a qualified rollover contribution nor constitutes a corrective distribution, is includible in the owner's gross income to the extent that the amount of the distribution, when added to the amount of all prior distributions from the owner's Roth IRAs (whether or not they were qualified distributions) and reduced by the amount of those prior distributions previously includible in gross income, exceeds the owner's contributions to all his or her Roth IRAs. For purposes of this A-4, any amount distributed as a corrective distribution is treated as if it was never contributed.

Q-5. Will the additional tax under 72(t) apply to the amount of a distribution that is not a qualified distribution?

A-5. (a) The 10-percent additional tax under section 72(t) will apply (unless the distribution is excepted under section 72(t)) to any distribution from a Roth IRA includible in gross income.

(b) The 10-percent additional tax under section 72(t) also applies to a nonqualified distribution, even if it is not then includible in gross income, to the extent it is allocable to a conversion contribution, if the distribution is made within the 5-taxable-year period beginning with the first day of the individual's taxable year in which the conversion contribution was made. The 5-taxable-year period ends on the last day of the individual's fifth consecutive taxable year beginning with the taxable year described in the preceding sentence. For purposes of applying the tax, only the amount of the conversion contribution includible in gross income as a result of the conversion is taken into account. The exceptions under section 72(t) also apply to such a distribution.

(c) The 5-taxable-year period described in this A-5 for purposes of determining

whether section 72(t) applies to a distribution allocable to a conversion contribution is separately determined for each conversion contribution, and need not be the same as the 5-taxable-year period used for purposes of determining whether a distribution is a qualified distribution under A-1(b) of this section. For example, if a calendar-year taxpayer who received a distribution from a traditional IRA on December 31, 1998, makes a conversion contribution by contributing the distributed amount to a Roth IRA on February 25, 1999 in a qualifying rollover contribution and makes a regular contribution for 1998 on the same date, the 5-taxable-year period for purposes of this A-5 begins on January 1, 1999, while the 5-taxable-year period for purposes of A-1(b) of this section begins on January 1, 1998.

Q-6. Is there a special rule for taxing distributions allocable to a 1998 conversion?

A-6. Yes. In the case of a distribution from a Roth IRA in 1998, 1999 or 2000 of amounts allocable to a 1998 conversion with respect to which the 4-year spread for the resultant income inclusion applies (see §1.408A-4 A-8), any income deferred as a result of the election to years after the year of the distribution is accelerated so that it is includible in gross income in the year of the distribution up to the amount of the distribution allocable to the 1998 conversion (determined under A-8 of this section). This amount is in addition to the amount otherwise includible in the owner's gross income for that taxable year as a result of the conversion. However, this rule will not require the inclusion of any amount to the extent it exceeds the total amount of income required to be included over the 4-year period. The acceleration of income inclusion described in this A-6 applies in the case of a surviving spouse who elects to continue the 4-year spread in accordance with §1.408A-4 A-11(b).

Q-7. Is the 5-taxable-year period described in A-1 of this section redetermined when a Roth IRA owner dies?

A-7. (a) No. The beginning of the 5-taxable-year period described in A-1 of this section is not redetermined when the Roth IRA owner dies. Thus, in determining the 5-taxable-year period, the period the Roth IRA is held in the name of a beneficiary, or in the name of a surviving

spouse who treats the decedent's Roth IRA as his or her own, includes the period it was held by the decedent.

(b) The 5-taxable-year period for a Roth IRA held by an individual as a beneficiary of a deceased Roth IRA owner is determined independently of the 5-taxable-year period for the beneficiary's own Roth IRA. However, if a surviving spouse treats the Roth IRA as his or her own, the 5-taxable-year period with respect to any of the surviving spouse's Roth IRAs (including the one that the surviving spouse treats as his or her own) ends at the earlier of the end of either the 5-taxable-year period for the decedent or the 5-taxable-year period applicable to the spouse's own Roth IRAs.

Q-8. How is it determined whether an amount distributed from a Roth IRA is allocated to regular contributions, conversion contributions, or earnings?

A-8. (a) Any amount distributed from an individual's Roth IRA is treated as made in the following order (determined as of the end of a taxable year and exhausting each category before moving to the following category)—

- (1) From regular contributions;
- (2) From conversion contributions, on a first-in-first-out basis; and
- (3) From earnings.

(b) To the extent a distribution is treated as made from a particular conversion contribution, it is treated as made first from the portion, if any, that was includible in gross income as a result of the conversion.

Q-9. Are there special rules for determining the source of distributions under A-8 of this section?

A-9. Yes. For purposes of determining the source of distributions, the following rules apply:

(a) All distributions from all an individual's Roth IRAs made during a taxable year are aggregated.

(b) All regular contributions made for the same taxable year to all the individual's Roth IRAs are aggregated and added to the undistributed total regular contributions for prior taxable years. Regular contributions for a taxable year include contributions made in the following taxable year that are identified as made for the taxable year in accordance with §1.408A-3 A-2. For example, a regular contribution made in 1999 for 1998 is ag-

gregated with the contributions made in 1998 for 1998.

(c) All conversion contributions received during the same taxable year by all the individual's Roth IRAs are aggregated. Notwithstanding the preceding sentence, all conversion contributions made by an individual during 1999 that were distributed from a traditional IRA in 1998 and with respect to which the 4-year spread applies are treated for purposes of A-8(b) of this section as contributed to the individual's Roth IRAs prior to any other conversion contributions made by the individual during 1999.

(d) A distribution from an individual's Roth IRA that is rolled over to another Roth IRA of the individual in accordance with section 408A(e) is disregarded for purposes of determining the amount of both contributions and distributions.

(e) Any amount distributed as a corrective distribution (including net income), as described in A-1(d) of this section, is disregarded in determining the amount of contributions, earnings, and distributions.

(f) If an individual recharacterizes a contribution made to a traditional IRA (FIRST IRA) by transferring the contribution to a Roth IRA (SECOND IRA) in accordance with §1.408A-5, then, pursuant to §1.408A-5 A-3, the contribution to the Roth IRA is taken into account for the same taxable year for which it would have been taken into account if the contribution had originally been made to the Roth IRA and had never been contributed to the traditional IRA. Thus, the contribution to the Roth IRA is treated as contributed to the Roth IRA on the same date and for the same taxable year that the contribution was made to the traditional IRA.

(g) If an individual recharacterizes a regular or conversion contribution made to a Roth IRA (FIRST IRA) by transferring the contribution to a traditional IRA (SECOND IRA) in accordance with §1.408A-5, then pursuant to §1.408A-5 A-3, the contribution to the Roth IRA and the recharacterizing transfer are disregarded in determining the amount of both contributions and distributions for the taxable year with respect to which the original contribution was made to the Roth IRA.

(h) Pursuant to §1.408A-5 A-3, the effect of income or loss (determined in accordance with §1.408A-5 A-2) occurring

after the contribution to the FIRST IRA is disregarded in determining the amounts described in paragraphs (f) and (g) of this A-9. Thus, for purposes of paragraphs (f) and (g), the amount of the contribution is determined based on the original contribution.

Q-10. Are there examples to illustrate the ordering rules described in A-8 and A-9 of this section?

A-10. Yes. The following examples illustrate these ordering rules:

Example 1. In 1998, individual B converts \$80,000 in his traditional IRA to a Roth IRA. B has a basis of \$20,000 in the conversion amount and so must include the remaining \$60,000 in gross income. He decides to spread the \$60,000 income by including \$15,000 in each of the 4 years 1998-2001, under the rules of §1.408A-4 A-8. B also makes a regular contribution of \$2,000 in 1998. If a distribution of \$2,000 is made to B anytime in 1998, it will be treated as made entirely from the regular contributions, so there will be no Federal income tax consequences as a result of the distribution.

Example 2. The facts are the same as in *Example 1*, except that the distribution made in 1998 is \$5,000. The distribution is treated as made from \$2,000 of regular contributions and \$3,000 of conversion contributions that were includible in gross income. As a result, B must include \$18,000 in gross income for 1998: \$3,000 as a result of the acceleration of amounts that otherwise would have been included in later years under the 4-year-spread rule and \$15,000 includible under the regular 4-year-spread rule. In addition, because the \$3,000 is allocable to a conversion made within the previous 5 taxable years, the 10-percent additional tax under section 72(t) would apply to this \$3,000 distribution for 1998, unless an exception applies. Under the 4-year-spread rule, B would now include in gross income \$15,000 for 1999 and 2000, but only \$12,000 for 2001, because of the accelerated inclusion of the \$3,000 distribution.

Example 3. The facts are the same as in *Example 1*, except that B makes an additional \$2,000 regular contribution in 1999 and he does not take a distribution in 1998. In 1999, the entire balance in the account, \$90,000 (\$84,000 of contributions and \$6,000 of earnings), is distributed to B. The distribution is treated as made from \$4,000 of regular contributions, \$60,000 of conversion contributions that were includible in gross income, \$20,000 of conversion contributions that were not includible in gross income, and \$6,000 of earnings. Because a distribution has been made within the 4-year-spread period, B must accelerate the income inclusion under the 4-year-spread rule and must include in gross income the \$45,000 remaining under the 4-year-spread rule in addition to the \$6,000 of earnings. Because \$60,000 of the distribution is allocable to a conversion made within the previous 5 taxable years, it is subject to the 10-percent additional tax under section 72(t) as if it were includible in gross income for 1999, unless an exception applies. The \$6,000 allocable to earnings would be subject to the tax under section 72(t), unless an exception applies. Under the

4-year-spread rule, no amount would be includible in gross income for 2000 or 2001 because the entire amount of the conversion that was includible in gross income has already been included.

Example 4. The facts are the same as in *Example 1*, except that B also makes a \$2,000 regular contribution in each year 1999 through 2002 and he does not take a distribution in 1998. A distribution of \$85,000 is made to B in 2002. The distribution is treated as made from the \$10,000 of regular contributions (the total regular contributions made in the years 1998-2002), \$60,000 of conversion contributions that were includible in gross income, and \$15,000 of conversion contributions that were not includible in gross income. As a result, no amount of the distribution is includible in gross income; however, because the distribution is allocable to a conversion made within the previous 5 years, the \$60,000 is subject to the 10-percent additional tax under section 72(t) as if it were includible in gross income for 2002, unless an exception applies.

Example 5. The facts are the same as in *Example 4*, except no distribution occurs in 2002. In 2003, the entire balance in the account, \$170,000 (\$90,000 of contributions and \$80,000 of earnings), is distributed to B. The distribution is treated as made from \$10,000 of regular contributions, \$60,000 of conversion contributions that were includible in gross income, \$20,000 of conversion contributions that were not includible in gross income, and \$80,000 of earnings. As a result, for 2003, B must include in gross income the \$80,000 allocable to earnings, unless the distribution is a qualified distribution; and if it is not a qualified distribution, the \$80,000 would be subject to the 10-percent additional tax under section 72(t), unless an exception applies.

Example 6. Individual C converts \$20,000 to a Roth IRA in 1998 and \$15,000 (in which amount C had a basis of \$2,000) to another Roth IRA in 1999. No other contributions are made. In 2003, a \$30,000 distribution, that is not a qualified distribution, is made to C. The distribution is treated as made from \$20,000 of the 1998 conversion contribution and \$10,000 of the 1999 conversion contribution that was includible in gross income. As a result, for 2003, no amount is includible in gross income; however, because \$10,000 is allocable to a conversion contribution made within the previous 5 taxable years, that amount is subject to the 10-percent additional tax under section 72(t) as if the amount were includible in gross income for 2003, unless an exception applies. The result would be the same whichever of C's Roth IRAs made the distribution.

Example 7. The facts are the same as in *Example 6*, except that the distribution is a qualified distribution. The result is the same as in *Example 6*, except that no amount would be subject to the 10-percent additional tax under section 72(t), because, to be a qualified distribution, the distribution must be made on or after the date on which the owner attains age 59½, made to a beneficiary or the estate of the owner on or after the date of the owner's death, attributable to the owner's being disabled within the meaning of section 72(m)(7), or to which section 72(t)(2)(F) applies (exception for a first-time home purchase). Under section 72(t)(2), each of these conditions is also an exception to the tax under section 72(t).

Example 8. Individual D makes a \$2,000 regular contribution to a traditional IRA on January 1, 1999, for 1998. On April 15, 1999, when the \$2,000 has

increased to \$2,500, D recharacterizes the contribution by transferring the \$2,500 to a Roth IRA (pursuant to §1.408A-5 A-1). In this case, D's regular contribution to the Roth IRA for 1998 is \$2,000. The \$500 of earnings is not treated as a contribution to the Roth IRA. The results would be the same if the \$2,000 had decreased to \$1,500 prior to the recharacterization.

Example 9. In December 1998, individual E receives a distribution from his traditional IRA of \$300,000 and in January 1999 he contributes the \$300,000 to a Roth IRA as a conversion contribution. In April 1999, when the \$300,000 has increased to \$350,000, E recharacterizes the conversion contribution by transferring the \$350,000 to a traditional IRA. In this case, E's conversion contribution for 1998 is \$0, because the \$300,000 conversion contribution and the earnings of \$50,000 are disregarded. The results would be the same if the \$300,000 had decreased to \$250,000 prior to the recharacterization. Further, since the conversion is disregarded, the \$300,000 is not includible in gross income in 1998.

Q-11. If the owner of a Roth IRA dies prior to the end of the 5-taxable-year period described in A-1 of this section (relating to qualified distributions) or prior to the end of the 5-taxable-year period described in A-5 of this section (relating to conversions), how are different types of contributions in the Roth IRA allocated to multiple beneficiaries?

A-11. Each type of contribution is allocated to each beneficiary on a pro-rata basis. Thus, for example, if a Roth IRA owner dies in 1999, when the Roth IRA contains a regular contribution of \$2,000, a conversion contribution of \$6,000 and earnings of \$1,000, and the owner leaves his Roth IRA equally to four children, each child will receive one quarter of each type of contribution. Pursuant to the ordering rules in A-8 of this section, an immediate distribution of \$2,000 to one of the children will be deemed to consist of \$500 of regular contributions and \$1,500 of conversion contributions. A beneficiary's inherited Roth IRA may not be aggregated with any other Roth IRA maintained by such beneficiary (except for other Roth IRAs the beneficiary inherited from the same decedent), unless the beneficiary, as the spouse of the decedent and sole beneficiary of the Roth IRA, elects to treat the Roth IRA as his or her own (see A-7 and A-14 of this section).

Q-12. How do the withholding rules under section 3405 apply to Roth IRAs?

A-12. Distributions from a Roth IRA are distributions from an individual retirement plan for purposes of section 3405

and thus are designated distributions unless one of the exceptions in section 3405(e)(1) applies. Pursuant to section 3405(a) and (b), nonperiodic distributions from a Roth IRA are subject to 10-percent withholding by the payor and periodic payments are subject to withholding as if the payments were wages. However, an individual can elect to have no amount withheld in accordance with section 3405(a)(2) and (b)(2).

Q-13. Do the withholding rules under section 3405 apply to conversions?

A-13. Yes. A conversion by any method described in §1.408A-4 A-1 is considered a designated distribution subject to section 3405. However, a conversion occurring in 1998 by means of a trustee-to-trustee transfer of an amount from a traditional IRA to a Roth IRA established with the same or a different trustee is not required to be treated as a designated distribution for purposes of section 3405. Consequently, no withholding is required with respect to such a conversion (without regard to whether or not the individual elected to have no withholding).

Q-14. What minimum distribution rules apply to a Roth IRA?

A-14. (a) No minimum distributions are required to be made from a Roth IRA under section 408(a)(6) and (b)(3) (which generally incorporate the provisions of section 401(a)(9)) while the owner is alive. The post-death minimum distribution rules under section 401(a)(9)(B) that apply to traditional IRAs, with the exception of the at-least-as-rapidly rule described in section 401(a)(9)(B)(i), also apply to Roth IRAs.

(b) The minimum distribution rules apply to the Roth IRA as though the Roth IRA owner died before his or her required beginning date. Thus, generally, the entire interest in the Roth IRA must be distributed by the end of the fifth calendar year after the year of the owner's death unless the interest is payable to a designated beneficiary over a period not greater than that beneficiary's life expectancy and distribution commences before the end of the calendar year following the year of death. If the sole beneficiary is the decedent's spouse, such spouse may delay distributions until the decedent would have attained age 70½ or may treat the Roth IRA as his or her own.

(c) Distributions to a beneficiary that are not qualified distributions will be includible in the beneficiary's gross income according to the rules in A-4 of this section.

Q-15. Does section 401(a)(9) apply separately to Roth IRAs and individual retirement plans that are not Roth IRAs?

A-15. Yes. An individual required to receive minimum distributions from his or her own traditional or SIMPLE IRA cannot choose to take the amount of the minimum distributions from any Roth IRA. Similarly, an individual required to receive minimum distributions from a Roth IRA cannot choose to take the amount of the minimum distributions from a traditional or SIMPLE IRA. In addition, an individual required to receive minimum distributions as a beneficiary under a Roth IRA can only satisfy the minimum distributions for one Roth IRA by distributing from another Roth IRA if the Roth IRAs were inherited from the same decedent.

Q-16. How is the basis of property distributed from a Roth IRA determined for purposes of a subsequent disposition?

A-16. The basis of property distributed from a Roth IRA is its fair market value (FMV) on the date of distribution, whether or not the distribution is a qualified distribution. Thus, for example, if a distribution consists of a share of stock in XYZ Corp. with an FMV of \$40.00 on the date of distribution, for purposes of determining gain or loss on the subsequent sale of the share of XYZ Corp. stock, it has a basis of \$40.00.

Q-17. What is the effect of distributing an amount from a Roth IRA and contributing it to another type of retirement plan other than a Roth IRA?

A-17. Any amount distributed from a Roth IRA and contributed to another type of retirement plan (other than a Roth IRA) is treated as a distribution from the Roth IRA that is neither a rollover contribution for purposes of section 408(d)(3) nor a qualified rollover contribution within the meaning of section 408A(e) to the other type of retirement plan. This treatment also applies to any amount transferred from a Roth IRA to any other type of retirement plan unless the transfer is a recharacterization described in §1.408A-5.

Q-18. Can an amount be transferred directly from an education IRA to a Roth

IRA (or distributed from an education IRA and rolled over to a Roth IRA)?

A-18. No amount may be transferred directly from an education IRA to a Roth IRA. A transfer of funds (or distribution and rollover) from an education IRA to a Roth IRA constitutes a distribution from the education IRA and a regular contribution to the Roth IRA (rather than a qualified rollover contribution to the Roth IRA).

Q-19. What are the Federal income tax consequences of a Roth IRA owner transferring his or her Roth IRA to another individual by gift?

A-19. A Roth IRA owner's transfer of his or her Roth IRA to another individual by gift constitutes an assignment of the owner's rights under the Roth IRA. At the time of the gift, the assets of the Roth IRA are deemed to be distributed to the owner and, accordingly, are treated as no longer held in a Roth IRA. In the case of any such gift of a Roth IRA made prior to October 1, 1998, if the entire interest in the Roth IRA is reconveyed to the Roth IRA owner prior to January 1, 1999, the Internal Revenue Service will treat the gift and reconveyance as never having occurred for estate tax, gift tax, and generation-skipping tax purposes and for purposes of this A-19.

§1.408A-7 Reporting.

This section sets forth the following questions and answers that relate to the reporting requirements applicable to Roth IRAs:

Q-1. What reporting requirements apply to Roth IRAs?

A-1. Generally, the reporting requirements applicable to IRAs other than Roth IRAs also apply to Roth IRAs, except that, pursuant to section 408A(d)(3)(D), the trustee of a Roth IRA must include on Forms 1099-R and 5498 additional information as described in the instructions thereto. Any conversion of amounts from an IRA other than a Roth IRA to a Roth IRA is treated as a distribution for which a Form 1099-R must be filed by the trustee maintaining the non-Roth IRA. In addition, the owner of such IRAs must report the conversion by completing Form 8606. In the case of a recharacterization described in §1.408A-5 A-1, IRA owners must report such transactions in the man-

ner prescribed in the instructions to the applicable Federal tax forms.

Q-2. Can a trustee rely on reasonable representations of a Roth IRA contributor or distributee for purposes of fulfilling reporting obligations?

A-2. A trustee maintaining a Roth IRA is permitted to rely on reasonable representations of a Roth IRA contributor or distributee for purposes of fulfilling reporting obligations.

§1.408A-8 Definitions.

This section sets forth the following question and answer that provides definitions of terms used in the provisions of §§1.408A-1 through 1.408A-7 and this section:

Q-1. Are there any special definitions that govern in applying the provisions of §§1.408A-1 through 1.408A-7 and this section?

A-1. Yes, the following definitions govern in applying the provisions of §§1.408A-1 through 1.408A-7 and this section. Unless the context indicates otherwise, the use of a particular term excludes the use of the other terms.

(a) *Different types of IRAs*—(1) *IRA*. Sections 408(a) and (b), respectively, describe an individual retirement account and an individual retirement annuity. The term IRA means an IRA described in either section 408(a) or (b), including each IRA described in paragraphs (a)(2) through (5) of this A-1. However, the term IRA does not include an education IRA described in section 530.

(2) *Traditional IRA*. The term traditional IRA means an individual retirement account or individual retirement annuity described in section 408(a) or (b), respectively. This term includes a SEP IRA but does not include a SIMPLE IRA or a Roth IRA.

(3) *SEP IRA*. Section 408(k) describes a simplified employee pension (SEP) as an employer-sponsored plan under which an employer can make contributions to IRAs established for its employees. The term SEP IRA means an IRA that receives contributions made under a SEP. The term SEP includes a salary reduction SEP (SARSEP) described in section 408(k)(6).

(4) *SIMPLE IRA*. Section 408(p) describes a SIMPLE IRA Plan as an employer-sponsored plan under which an

employer can make contributions to SIMPLE IRAs established for its employees. The term SIMPLE IRA means an IRA to which the only contributions that can be made are contributions under a SIMPLE IRA Plan or rollovers or transfers from another SIMPLE IRA.

(5) *Roth IRA.* The term Roth IRA means an IRA that meets the requirements of section 408A.

(b) *Other defined terms or phrases—*
 (1) *4-year spread.* The term 4-year spread is described in §1.408A-4 A-8.

(2) *Conversion.* The term conversion means a transaction satisfying the requirements of §1.408A-4 A-1.

(3) *Conversion amount or conversion contribution.* The term conversion amount or conversion contribution is the amount of a distribution and contribution with respect to which a conversion described in §1.408A-4 A-1 is made.

(4) *Failed conversion.* The term failed conversion means a transaction in which an individual contributes to a Roth IRA an amount transferred or distributed from a traditional IRA or SIMPLE IRA (including a transfer by redesignation) in a transaction that does not constitute a conversion under §1.408A-4 A-1.

(5) *Modified AGI.* The term modified AGI is defined in §1.408A-3 A-5.

(6) *Recharacterization.* The term recharacterization means a transaction described in §1.408A-5 A-1.

(7) *Recharacterized amount or recharacterized contribution.* The term recharacterized amount or recharacterized contribution means an amount or contribution treated as contributed to an IRA other than the one to which it was originally contributed pursuant to a recharacterization described in §1.408A-5 A-1.

(8) *Taxable conversion amount.* The term taxable conversion amount means the portion of a conversion amount includible in income on account of a conversion, determined under the rules of section 408(d)(1) and (2).

(9) *Tax-free transfer.* The term tax-free transfer means a tax-free rollover described in section 402(c), 402(e)(6), 403(a)(4), 403(a)(5), 403(b)(8), 403(b)(10) or 408(d)(3), or a tax-free trustee-to-trustee transfer.

(10) *Treat an IRA as his or her own.* The phrase treat an IRA as his or her own

means to treat an IRA for which a surviving spouse is the sole beneficiary as his or her own IRA after the death of the IRA owner in accordance with the terms of the IRA instrument or in the manner provided in the regulations under section 408(a)(6) or (b)(3).

(11) *Trustee.* The term trustee includes a custodian or issuer (in the case of an annuity) of an IRA (except where the context clearly indicates otherwise).

§1.408A-9 Effective date.

This section contains the following question and answer providing the effective date of §§1.408A-1 through 1.408A-8:

Q-1. To what taxable years do §§1.408A-1 through 1.408A-8 apply?

A-1 Sections 1.408A-1 through 1.408A-8 apply to taxable years beginning on or after January 1, 1998.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Paragraph 9. The authority citation for part 602 continues to read as follows:

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

Par.10. In §602.101, paragraph (c) is amended by adding an entry in numerical order to the table to read as follows:

§602.101 OMB control numbers.

(c) * * *	* * * * *
CFR part or section where identified and described	Current OMB control no.
* * * * *	
1.408A-2	1545-1616
1.408A-4	1545-1616
1.408A-5	1545-1616
1.408A-7	1545-1616
* * * * *	

Robert E. Wenzel,
 Deputy Commissioner of
 Internal Revenue.

Approved January 25, 1999.

Donald C. Lubick,
 Assistant Secretary of
 the Treasury.

(Filed by the Office of the Federal Register on February 3, 1999, 8:45 a.m., and published in the issue of the Federal Register for February 4, 1999, 64 F.R. 5597)

Section 4980B.—Failure to Satisfy Continuous Coverage Requirements of Group Health Plans

26 CFR 54.4980B-1: COBRA in general.

T.D. 8812

**DEPARTMENT OF THE TREASURY
 Internal Revenue Service
 26 CFR Parts 54 and 602**

Continuation Coverage Requirements Applicable to Group Health Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final rule.

SUMMARY: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added health care continuation requirements that apply to group health plans. Coverage required to be provided under those requirements is referred to as COBRA continuation coverage. Proposed regulations interpreting the COBRA continuation coverage requirements were published in the **Federal Register** of June 15, 1987 and of January 7, 1998. This document contains final regulations based on these two sets of proposed regulations. The final regulations also reflect statutory amendments to the COBRA continuation coverage requirements since COBRA was enacted. A new set of proposed regulations REG-121865-98 addressing additional issues under the COBRA continuation coverage provisions is on page 63 of this Bulletin. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: *Effective Date:* These regulations are effective February 3, 1999.

Applicability Dates: Sections 54.4980B-1 through 54.4980B-8 apply to group health plans with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. See the Effective Date portion of this preamble and Q&A-2 of §54.4980B-1.

FOR FURTHER INFORMATION CONTACT: Yurlinda Mathis, 202-622-4695. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in these final regulations have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) under control number 1545-1581. Responses to these collections of information are mandatory in some cases and required in order to obtain a benefit in other cases. Group health plans are required to provide certain individuals a notice of their COBRA continuation coverage rights when certain qualifying events occur and are required to inform health care providers who contact the plan to confirm the coverage of certain individuals of the individuals' complete rights to coverage. To obtain COBRA continuation coverage or extended coverage, certain individuals are required to notify the plan administrator of certain events or that they are electing COBRA continuation coverage, and plans are required to notify certain individuals of insignificant underpayments if the plan wishes to require the individuals to pay the deficiency. This information will be used to advise employers and plan administrators of their obligation to offer COBRA continuation coverage, or an extended period of such coverage; to advise qualified beneficiaries of their right to elect COBRA continuation coverage and of insignificant errors in payment; and to inform health care providers of individuals' rights to COBRA continuation coverage.

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 control number.

The estimated average annual burden per respondent varies from 30 seconds to 330 hours, depending on individual circumstances, with an estimated average of 14 minutes.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, OP:FS:FP, Washington, DC 20224, and 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.

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

Background

On June 15, 1987, proposed regulations (EE-143-86, 1987-2 C.B. 929) relating to continuation coverage requirements applicable to group health plans were published in the **Federal Register** (52 F.R. 22716). A public hearing was held on November 4, 1987. Written comments were also received. A supplemental set of proposed regulations (REG-209485-86, 1998-11 I.R.B. 21) was published in the **Federal Register** of January 7, 1998 (63 F.R. 708). No public hearing was requested or held after the publication of the supplemental proposed regulations; written comments were received. After consideration of these comments, after review of the reported court decisions under the parallel COBRA continuation coverage provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act, and based on the experience of the IRS in administering the COBRA continuation coverage requirements, a portion of the regulations proposed by EE-143-86 and REG-209485-86 is adopted as revised by this Treasury decision. The revisions are summarized in the explanation below. Also being published elsewhere in this issue of the **Federal Register** is a

new set of proposed regulations, which addresses additional issues.

Explanation of Provisions

Overview

The regulations are intended to provide clear, administrable rules regarding COBRA continuation coverage. The regulations give comprehensive guidance on many questions under COBRA, with a view to enhancing the certainty and reliance available to all parties – including employees, qualified beneficiaries, employers, employee organizations, and group health plans – in determining their COBRA rights and obligations. The guidance is designed to further the protective purposes of COBRA without undue administrative burdens or costs on employers, employee organizations, or group health plans.

For example, the regulations:

- Prevent group health plans from terminating COBRA continuation coverage on the basis of other coverage that a qualified beneficiary had prior to electing COBRA continuation coverage, in accordance with the Supreme Court's decision in *Geissal v. Moore Medical Corp.*
- Give employers and employee organizations significant flexibility in determining, for purposes of COBRA, the number of group health plans they maintain. This will reduce burdens on employers and employee organizations by permitting them to structure their group health plans in an efficient and cost-effective manner and to satisfy their COBRA obligations based upon that structure.
- Provide baseline rules for determining the COBRA liabilities of buyers and sellers of corporate stock and corporate assets and permit buyers and sellers to reallocate and carry out those liabilities by agreement. This will significantly enhance employers' ability to negotiate and to plan appropriately for the treatment of qualified beneficiaries in connection with mergers and acquisitions, while protecting the rights of qualified beneficiaries affected by the transactions.
- Limit the application of COBRA for most health flexible spending

arrangements. This will ensure that COBRA continuation coverage under health flexible spending arrangements is available in appropriate cases without requiring continuation coverage where that would not serve the statutory purposes.

- Eliminate the requirement that group health plans offer qualified beneficiaries the option to elect only core (health) coverage under a group health plan that otherwise provides both core and noncore (vision and dental) coverage.
- Give employers, in determining whether the small-employer plan exception applies, the option of counting by pay period rather than by every business day, and provide, for that exception, for the consistent treatment of part-time employees through the use of full-time equivalents.

The COBRA continuation coverage requirements enacted on April 7, 1986 have been amended by the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), the Tax Reform Act of 1986 (TRA 1986), the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), the Small Business Job Protection Act of 1996 (SBJPA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹ These amendments made numerous clarifications and modifications to the COBRA continuation coverage requirements, moved the requirements from section 162(k) to section 4980B, added various other features, such as the disability extension to the required period of coverage, and significantly altered the sanctions imposed on employers and plans for failing to comply with the requirements. The specific changes made by these amendments are discussed below in connection with the provisions of the regulations that relate to them.

¹ The COBRA continuation coverage requirements have also been affected by an amendment made to the definition of group health plan by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). OBRA 1993 amended the definition of group health plan in section 5000(b)(1), which the COBRA continuation coverage provisions of the Internal Revenue Code incorporate by reference.

The legislative history of COBRA provides that the Department of the Treasury has the authority to interpret the coverage and tax sanction provisions of COBRA and that the Department of Labor has the authority to interpret the reporting and disclosure provisions. Accordingly, these regulations apply in interpreting the coverage provisions of COBRA in Title I of ERISA, as well as those in the Internal Revenue Code. With minor exceptions, the final regulations and the new proposed regulations being published today do not address the notice provisions of the COBRA continuation coverage requirements.

Organization

The final regulations being published today follow the structure of the 1987 proposed regulations, with related questions-and-answers grouped into topics. Each topic is now in a separate section, and sections have been added to the new proposed regulations being published today for (1) business reorganizations and employer withdrawals from multiemployer plans and (2) the interaction of the Family and Medical Leave Act of 1993 (FMLA) and COBRA. The substance of the 1998 proposed regulations has been integrated into the questions-and-answers of the 1987 proposed regulations. The ordering of some of the questions-and-answers has changed, and all of the questions-and-answers relating to the original statutory effective date have been deleted. In addition, in a few cases, the content of two separate questions-and-answers in the 1987 proposed regulations has been combined into a single question-and-answer; in other cases the content of a single question-and-answer has been expanded to two or more questions-and-answers. These changes have resulted in the renumbering of the questions-and-answers. The new proposed regulations being published today are designed to fill gaps designated in the final regulations as reserved.

Effective Date

The 1987 proposed regulations provide that they will be effective upon publication as final regulations. Some commenters suggested that the final regulations should have a delayed effective date.

The final regulations follow this suggestion; they apply with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. For any period before the effective date of the final regulations, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in section 4980B. For the period before the effective date of the final regulations, the IRS will consider compliance with the proposed regulations in §1.162-26 (the 1987 proposed regulations) and §54.4980B-1 (the 1998 proposed regulations) to constitute good faith compliance with a reasonable interpretation of the statutory requirements for the topics that those proposed regulations address, except to the extent inconsistent with a statutory amendment adopted after the dates the proposed regulations were issued, during the period the amendment is effective, or with a decision of the United States Supreme Court released after the proposed regulations were issued, during the period after the decision is released. For any period beginning on or after the effective date of the final regulations with respect to topics not addressed in the final regulations, such as how to calculate the applicable premium, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in section 4980B.

Compliance with the new proposed regulations will constitute good faith compliance with a reasonable interpretation of the statutory requirements addressed in the new proposed regulations until the new proposed regulations are finalized. In addition, actions inconsistent with the terms of the new proposed regulations will not necessarily constitute a lack of good faith compliance with a reasonable interpretation of the statutory requirements addressed in the new proposed regulations; whether there has been good faith compliance with a reasonable interpretation of the statutory requirements will depend on all the facts and circumstances of each case.

The IRS will not assess the excise tax with respect to a plan that operates in good faith compliance with a reasonable interpretation of the statutory requirements, as described in the preceding two paragraphs. Note, however, that in the

case of lawsuits brought by qualified beneficiaries to enforce their COBRA continuation coverage rights under ERISA or the Public Health Service Act, the courts generally have not applied any good faith compliance standard.

Plans That Must Comply

The final regulations provide rules regarding which group health plans are subject to COBRA. These rules are generally similar to those set forth in the 1987 proposed regulations. However, the rules for determining, for purposes of the COBRA continuation coverage requirements, the number of group health plans maintained by an employer have been deleted, and the new proposed regulations set forth substantially different rules, which provide that employers and employee organizations generally have broad discretion to determine the number of group health plans that they maintain. Other significant changes to the 1987 proposed regulations on this point (some of which are set forth in the 1998 proposed regulations) include exceptions for long-term care services and medical savings accounts and new rules regarding the small-employer plan exception.

As in the 1987 proposed regulations, the final regulations provide that, in general, all group health plans are subject to the COBRA continuation coverage requirements. However, small-employer plans (discussed below), church plans (within the meaning of section 414(e)), and governmental plans (within the meaning of section 414(d)) are not subject to COBRA. (The final regulations refer to these as plans excepted from COBRA.) Plans excepted from COBRA are generally not subject to the COBRA continuation coverage requirements or the COBRA excise tax, although group health plans maintained by state or local governments are subject to parallel continuation coverage requirements in the Public Health Service Act (which is administered by the Department of Health and Human Services). Also, the Federal Employees Health Benefit Program is subject to generally similar, although not parallel, temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988.

The final regulations define *group health plan* in a manner generally similar

to that in the 1987 proposed regulations. However, certain changes in terminology have been made to reflect the statutory cross-reference to section 5000(b)(1) set forth in section 4980B(g)(2) (such as the use of the term *health care* and the definition of *employee*). Additionally, the final regulations, in accordance with section 4980B(g)(2), provide that a plan is not a group health plan if substantially all the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). The final regulations allow plans to use any reasonable method in determining whether a plan satisfies this exception. The final regulations also provide, in accordance with section 106(b)(5), that amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan for purposes of COBRA (although a high-deductible health plan will not fail to be a group health plan simply because it covers a holder of a medical savings account).

Under the final regulations, a *group health plan* is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to the families of such individuals. In accordance with section 5000(b)(1), these individuals include employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship. The final regulations generally refer to all individuals covered under a plan by virtue of the performance of services or by virtue of membership in an employee organization as employees. (As discussed below, the term *employee* has a narrower meaning for purposes of the small-employer plan exception.) The final regulations use the term *employer* to refer to a person for whom an individual performs services. Pursuant to section 414(t), the term *employer* also includes, with respect to such a person, any member of a group described in section 414(b), (c), (m), or (o) that includes the person (a controlled group) as well as any successor of the person or of a member of the controlled group.

Under the final regulations, as under the 1987 proposed regulations, a plan

generally is considered to provide health care whether it does so directly or through insurance, reimbursement, or other means and whether it does so through an on-site facility or a cafeteria or other flexible benefit arrangement. Insurance includes group insurance policies and one or more individual policies under an arrangement maintained by the employer or employee organization to provide health care to two or more employees. Under the final regulations, as under the 1987 proposed regulations, in the case of a cafeteria plan or other flexible benefit arrangement, the COBRA continuation coverage requirements apply only to the health care benefits under the cafeteria plan or other flexible benefit arrangement that an employee has actually chosen to receive.

Many commenters on the 1987 proposed regulations requested clarification of the application of COBRA to health care benefits provided under flexible spending arrangements (health FSAs). Some commentators argued that health FSAs should not be subject to COBRA. Health FSAs satisfy the definition of group health plan in section 5000(b)(1) and, accordingly, are generally subject to the COBRA continuation coverage requirements. However, COBRA is intended to ensure that a qualified beneficiary has guaranteed access to coverage under a group health plan and that the cost of that coverage is no greater than 102 percent of the applicable premium.

The IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA for a plan year if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the maximum benefit that the qualified beneficiary could receive under the FSA for that plan year and if the qualified beneficiary could not avoid a break in coverage, for purposes of the HIPAA portability provisions², by electing COBRA coverage under the FSA. Accordingly, the new proposed regulations contain a rule limiting the application of

² Under HIPAA, a qualified beneficiary who maintains coverage after termination of employment under a group health plan that is subject to HIPAA can avoid a break in coverage and thereby avoid becoming subject to a preexisting condition exclusion upon later becoming covered by another another group health plan.

the COBRA continuation coverage requirements in the case of health FSAs.

Under this rule, if the health FSA satisfies two conditions, the health FSA need not make COBRA continuation coverage available to a qualified beneficiary for any plan year after the plan year in which the qualifying event occurs. The first condition that the health FSA must satisfy for this exception to apply is that the health FSA is not subject to the HIPAA portability provisions in sections 9801 through 9833 because the benefits provided under the health FSA are excepted benefits. (See sections 9831 and 9832.)³ The second condition is that, in the plan year in which the qualifying event of a qualified beneficiary occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. It is contemplated that this second condition will be satisfied in most cases.

Moreover, if a third condition is satisfied, the health FSA need not make COBRA continuation coverage available with respect to a qualified beneficiary at all. This third condition is satisfied if, as of the date of the qualifying event, the maximum benefit available to the qualified beneficiary under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require as payment for the remainder of that year to maintain coverage under the health FSA.

A plan is maintained by an employer or employee organization even if the employer or employee organization does not directly or indirectly contribute to it if coverage under the plan would not be available to an individual at the same cost if the individual did not have an employment-related connection to the employer

³ The IRS and Treasury, together with the U.S. Department of Labor and the U.S. Department of Health and Human Services, have issued a notice (62 F.R. 67688) holding that a health FSA is exempt from HIPAA because the benefits provided under it are excepted benefits under sections 9831 and 9833 if the employer also provides another group health plan, the benefits under the other plan are not limited to excepted benefits, and the maximum reimbursement under the health FSA is not greater than two times the employee's salary reduction election (or if greater, the employee's salary reduction election plus five hundred dollars).

or employee organization. The final regulations, for purposes of the definition of a group health plan, use the term *health care* instead of the term *medical care* (which was used in the 1987 proposed regulations). This change reflects the change in the definition of group health plan made by OBRA 1989. However, the final regulations provide that *health care* has the same meaning as the term *medical care* under section 213(d). Like the 1987 proposed regulations, the final regulations set forth a summary of items that do and do not constitute health care.

The final regulations, generally following the 1987 proposed regulations, set forth rules for determining whether a group health plan is a small-employer plan. In general, a group health plan other than a multiemployer plan is a small-employer plan if it is maintained for a calendar year by an employer that normally employed fewer than 20 employees during the preceding calendar year, and a group health plan that is a multiemployer plan is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multiemployer plan or not, the term employer includes all members of a controlled group. An example in the final regulations clarifies that the controlled group includes foreign members, and thus a U.S. subsidiary with fewer than 20 employees is subject to COBRA if the controlled group has 20 or more employees world-wide. The final regulations set forth additional rules for the application of the small-employer plan exception to multiemployer plans, and the new proposed regulations contain the same definition of multiemployer plan that is in section 414(f).

Under the final regulations, an employer is considered to have normally employed fewer than 20 employees during a particular calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. This rule differs from the rule in the 1987 proposed regulations in two ways. First, the 1987 proposed regulations use the term *working days*, whereas the final regulations use the statutory term *typical business days*.

The second difference relates to the term *employee*. Under the 1987 proposed

regulations, self-employed individuals and independent contractors are counted as employees for purposes of the small-employer plan exception if they are covered under a plan of the employer. Commenters argued that only common law employees should be counted for this purpose. Unlike the definition of *covered employee* (amended by OBRA 1989 to make clear that individuals who are not common law employees but who are covered under the group health plan of an employer or employee organization by virtue of the performance of services are still considered covered employees) and the definition of *group health plan* (amended by OBRA 1993 to make clear that a health plan covering individuals who are not common law employees of the employer or employee organization, and who are not family members of common law employees, is still a group health plan) the reference to employees for purposes of the small-employer plan exception have not been amended to include individuals who are not common law employees. Consequently, under the final regulations, only common law employees are taken into account for purposes of the small-employer plan exception; self-employed individuals, independent contractors, and directors are not counted.

Although a small-employer plan is generally excepted from COBRA, a plan that is not a small-employer plan for a period remains subject to COBRA for qualifying events that occurred during that period, even if it subsequently becomes a small-employer plan.

In determining whether a plan is eligible for the small-employer plan exception, part-time employees, as well as full-time employees, must be taken into account. Several commenters on the 1987 proposed regulations requested clarification of how to count part-time employees for the small-employer plan exception, and the new proposed regulations provide guidance on this issue. Under the new proposed regulations, instead of each part-time employee counting as a full employee, each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered a full-time employee. The

number of hours that must be worked to be considered a full-time employee is determined in a manner consistent with the employer's general employment practices, although for this purpose not more than eight hours a day or 40 hours a week may be used. An employer may count employees for each typical business day or may count employees for a pay period and attribute the total number of employees for that pay period to each typical business day that falls within the pay period. The employer must use the same method for all employees and for the entire year for which the small-employer plan determination is made.

In determining whether a multiemployer plan satisfies the requirements for the small-employer plan exception, the 1987 proposed regulations provide a special rule permitting the multiemployer plan to be considered a small-employer plan for a year if any contributing employer that grew to be too large to qualify for the exception during the preceding year ceases to contribute to the plan by February 1 of the current year. Questions have been raised about the need for and the authority for this special rule, and one commenter pointed out the uncertainty of how to deal with a qualified beneficiary experiencing a qualifying event under such a plan in January of the current year if the qualified beneficiary needed confirmation of coverage for urgent services before it was clear that the too-large employer would cease contributing to the multiemployer plan by February 1. Based on these concerns, the final regulations eliminate this special rule for multiemployer plans.

The new proposed regulations provide guidance, for purposes of the COBRA continuation coverage requirements, on how to determine the number of group health plans that an employer or employee organization maintains. Under these rules, the employer or employee organization is generally permitted to establish the separate identity and number of group health plans under which it provides health care benefits to employees. Thus, if an employer or employee organization provides a variety of health care benefits to employees, it generally may aggregate the benefits into a single group health plan or dis-aggregate benefits into separate group health plans. The status of health care

benefits as part of a single group health plan or as separate plans is determined by reference to the instruments governing those arrangements. If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits (other than those for qualified long-term care services) provided by a single entity (determined without regard to the controlled group) constitute a single group health plan.

Under the new proposed regulations, a multiemployer plan and a plan other than a multiemployer plan are always separate plans. In addition, any treatment of health care benefits as constituting separate group health plans will be disregarded if a principal purpose of the treatment is to evade any requirement of law. Of course, an employer's flexibility to treat benefits as part of separate plans may be limited by the operation of other laws, such as the prohibition in section 9802 on conditioning eligibility to enroll in a group health plan on the basis of any health factor of an individual.

The final regulations modify the rules set forth in the 1987 proposed regulations for determining the plan year of a group health plan under COBRA. These modifications are made to be consistent with the rules in the temporary regulations under HIPAA. The definition of plan year is important in applying, for example, the effective date provisions under the final regulations and the rules for health FSAs under the new proposed regulations. Under the final regulations, the plan year is the year designated as such in the plan documents. If the plan documents do not designate a plan year (or if there are no plan documents), the plan year is the deductible/limit year used by the plan. If the plan does not impose deductibles or limits on an annual basis, the plan year is the policy year. If the plan does not impose deductibles or limits on an annual basis and the plan is not insured (or the insurance policy is not renewed annually), the plan year is the taxable year of the employer. In any other case, the plan year is the calendar year.

The final regulations reflect the statutory provisions that provide for the im-

position of an excise tax in the event of a failure by a group health plan to comply with the COBRA continuation coverage requirements of section 4980B(f). In the case of a multiemployer plan, the excise tax is imposed on the plan⁴; in the case of any other plan, the excise tax is imposed on the employer maintaining the plan. In certain circumstances, the excise tax can be imposed on other persons involved with the provision of benefits under the plan, such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. Separate, non-tax remedies may be available in the case of a plan that fails to comply with the COBRA continuation coverage requirements in ERISA.

Qualified Beneficiaries

The rules in the final regulations for determining who is a qualified beneficiary generally follow those set forth in the 1987 proposed regulations, as well as those set forth in the 1998 proposed regulations regarding the status of newborn and adopted children as qualified beneficiaries. However, certain provisions have been added to the final regulations to reflect the special statutory rules that apply in the case of bankruptcy of the employer as a qualifying event. Modifications have also been made to reflect the decision of the Supreme Court in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998), which held that an individual covered under another group health plan at the time she or he elects COBRA continuation coverage cannot be denied COBRA continuation coverage on the basis of that other coverage.

Under the final regulations, a qualified beneficiary is, in general: (1) any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; or (2) any child born to or placed for adoption with a covered employee during a pe-

⁴ In this regard, the U.S. Department of Labor has advised the IRS and Treasury that to the extent a plan fiduciary subjects a plan to liability for the COBRA excise tax on account of her or his imprudent actions, the plan fiduciary may be held personally liable under Title I of ERISA for the amount of the tax.

riod of COBRA continuation coverage. (The final regulations retain the definitions of the terms *placement for adoption* and *being placed for adoption* that were in the 1998 proposed regulations.) For a qualifying event that is the bankruptcy of the employer, any covered employee who retired on or before the date of any substantial elimination of group health plan coverage is a qualified beneficiary; the spouse, surviving spouse, or dependent child of the retired covered employee is also a qualified beneficiary if the spouse, surviving spouse, or dependent child was a beneficiary under the plan on the day before the bankruptcy qualifying event. The final regulations add a provision clarifying that if an individual is denied coverage under a group health plan in violation of applicable law (including HIPAA) and experiences an event that would be a qualifying event if the coverage had not been wrongfully denied, the individual is considered a qualified beneficiary.

A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination (or reduction of hours) of the covered employee's employment or the employer's bankruptcy. As under the 1987 proposed regulations, the final regulations provide that a covered employee is not a qualified beneficiary if her or his status as a covered employee is attributable to certain periods in which she or he was a nonresident alien (in which case the covered employee's spouse and dependent children are also not qualified beneficiaries). Although a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is a qualified beneficiary, a child born to or placed for adoption with a qualified beneficiary other than the covered employee after a qualifying event, or a person who becomes the spouse of a qualified beneficiary (regardless of whether the qualified beneficiary is the covered employee) after a qualifying event is not a qualified beneficiary. The final regulations retain the rule of the 1987 proposed regulations under which an individual is not a qualified beneficiary if, on the day before the qualifying event, the individual is covered under the group health plan solely because of another individual's election of COBRA continuation coverage. How-

ever, consistent with *Geissal*, the final regulations eliminate the rule in the 1987 proposed regulations that an individual is not a qualified beneficiary if, on the day before the qualifying event, the individual was entitled to Medicare benefits.

An individual ceases to be a qualified beneficiary if she or he does not elect COBRA continuation coverage by the end of the election period (discussed below). The final regulations clarify that an individual who elects COBRA continuation coverage ceases to be a qualified beneficiary once the plan's obligation to provide COBRA continuation coverage has ended.

The term *covered employee* is defined in the final regulations in a manner substantially the same as in the 1987 proposed regulations. Although some commenters on the 1987 proposed regulations objected to the inclusion in this definition of individuals other than common law employees, the statutory definition was amended by OBRA 1989 to include such individuals. Under the final regulations, a covered employee generally includes any individual who is or has been provided coverage under a group health plan (other than one excepted from COBRA as of the date of what would otherwise be a qualifying event) because of her or his present or past performance of services for the employer maintaining the group health plan (or by reason of membership in the employee organization maintaining the plan). Thus, retirees and former employees covered by a group health plan are covered employees if the coverage is provided in whole or in part because of the previous employment. Any individual who performs services for the employer maintaining the plan or who is a member of the employee organization maintaining the plan may be a covered employee. Thus, common law employees, self-employed individuals, independent contractors, and corporate directors can be covered employees. Generally, mere eligibility for coverage – as opposed to actual coverage – does not make an individual a covered employee. However, if an individual who otherwise would be a covered employee is denied coverage under a group health plan in violation of applicable law (including HIPAA), the individual is considered a covered employee.

Qualifying Events

The rules regarding qualifying events under the final regulations generally are the same as those in the 1987 proposed regulations. Under the final regulations, a qualifying event is any of a set of specified events that occurs while a group health plan is subject to COBRA and that causes a covered employee (or the spouse or dependent child of the covered employee) to lose coverage under the plan. These specified events are: the death of a covered employee; the termination (other than by reason of gross misconduct), or reduction of hours, of a covered employee's employment; the divorce or legal separation of a covered employee from the covered employee's spouse; a covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; a dependent child's ceasing to be a dependent child of the covered employee under the plan; and a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time. The addition of employer bankruptcy as a qualifying event reflects the amendments made to COBRA by OBRA 1986.

The reasons for which an employee has a termination of employment or a reduction of hours of employment generally are not relevant in determining whether the termination or reduction of hours is a qualifying event. Thus, a voluntary termination, a strike, a lockout, a layoff, or an involuntary discharge each may constitute a qualifying event. However, if an employee is discharged for gross misconduct, the termination of employment does not constitute a qualifying event. The final regulations clarify that a reduction of hours of a covered employee's employment includes any decrease in the number of hours that a covered employee works or is required to work that does not constitute a termination of employment. Thus, if a covered employee takes a leave of absence, is laid off, or otherwise performs no hours of work during a period, the covered employee has experienced a reduction in hours that, if the other applicable requirements are satisfied, constitutes a qualifying event. (But see Notice 94-103 (1994-2 C.B. 569) and the new pro-

posed regulations, described below, for special rules regarding FMLA leave.) A covered employee's loss of coverage by reason of a failure to work the minimum number of hours required for coverage constitutes a reduction of hours of employment.

Under the final regulations, *to lose coverage* means to cease to be covered under the same terms and conditions as in effect immediately before the event. The final regulations clarify that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above. The loss of coverage need not be concurrent with the event; it is enough that the loss of coverage occur at any time before the end of the maximum coverage period (described below). For employer bankruptcies, the term *to lose coverage* also includes a substantial elimination of coverage that occurs within 12 months before or after the date on which the bankruptcy proceeding begins.

Under the final regulations, as under the 1987 proposed regulations, reductions or eliminations in coverage in anticipation of an event are disregarded in determining whether the event results in a loss of coverage. Although several commenters objected to this rule, the final regulations retain the provision in order to protect qualified beneficiaries from being deprived of their COBRA rights because an employer or employee organization transposes a loss or reduction of coverage to a time before the qualifying event. This rule also applies in cases where a covered employee discontinues the coverage of a spouse in anticipation of a divorce or legal separation. In such a case, upon receiving notice of the divorce or legal separation, a plan is required to make COBRA continuation coverage available, effective on the date of the divorce or legal separation (but not for any period before the date of the divorce or legal separation).

Under the final regulations, as under the 1987 proposed regulations, an event must occur while the group health plan is subject to COBRA in order to constitute a qualifying event. A plan that is excepted from COBRA (for example, by reason of the small-employer plan exception) and that later becomes subject to COBRA is not required to provide COBRA continua-

tion coverage to individuals who experienced what would otherwise be a qualifying event during the period when the plan was not subject to COBRA.

Finally, in the case of a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the qualifying event that gives rise to that period of COBRA continuation coverage is the qualifying event applicable to that child. Thus, if a second qualifying event has occurred before such a child is born (for example, if the covered employee dies), the second qualifying event also applies to the newborn child.

COBRA Continuation Coverage

The 1987 proposed regulations generally refer to the coverage that a qualified beneficiary is entitled to as the coverage that was in effect on the day before the qualifying event. While that is generally true, the final regulations have been revised to incorporate the statutory standard that a qualified beneficiary is entitled to the coverage made available to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. The final regulations generally use as a shorthand for this statutory language the phrase "similarly situated non-COBRA beneficiaries" instead of the phrase "similarly situated active employees" used in the 1987 proposed regulations. In certain contexts in the final regulations, though, the phrase "similarly situated active employees" is still used because in those contexts – such as the right to make an independent election for COBRA continuation coverage – qualified beneficiaries who are spouses and dependent children of covered employees are entitled to the rights that employees have (and in those contexts, spouses and dependent children who are not qualified beneficiaries typically do not have the rights that employees have).

The 1987 proposed regulations address in a separate question-and-answer the type of coverage that must be made available to qualified beneficiaries if a change is made in the coverage provided to similarly situated non-COBRA beneficiaries. The final regulations include this rule in the question-and-answer that defines COBRA continuation coverage. In doing

so, the final regulations delete several specific requirements in the 1987 proposed regulations. For example, if coverage for the similarly situated non-COBRA beneficiaries is changed or eliminated, the 1987 proposed regulations require that qualified beneficiaries be permitted to elect coverage under any remaining plan made available to the similarly situated active employees. Many commenters objected that in the case of a mere change in benefits, the requirement to give qualified beneficiaries an election among other plans would give them greater rights than those active employees might have. The final regulations follow the suggestion of the commenters in providing that the general principle – that qualified beneficiaries have the same rights as similarly situated non-COBRA beneficiaries – applies in this situation. The same principle also applies in determining whether credit for deductibles must be carried over from a discontinued plan to a new plan. Nevertheless, if an employer or employee organization providing more than one plan to a group of similarly situated non-COBRA beneficiaries eliminates benefits under one plan without giving the similarly situated non-COBRA beneficiaries the right to enroll in another plan, that option would still have to be made available to qualified beneficiaries if the employer continued to maintain a group health plan because of the employer's obligation to continue to make COBRA continuation coverage available.

The 1987 proposed regulations include detailed rules requiring that qualified beneficiaries generally be offered the option of electing only core coverage or both core and noncore coverage. These rules were based on a reference in the conference report to the Tax Reform Act of 1986. Many commenters expressed the opinion that the reference in the conference report is an insufficient basis for including this concept in the regulations when nothing in the statute itself suggests a distinction between core and noncore coverage. Commenters also contended that the core/noncore distinction would create undue administrative complexity and promote adverse selection. After careful consideration, the IRS and Treasury have decided not to include in either the final or the new proposed regulations any such requirement to offer for core

coverage separately. However, comments are invited on whether such a requirement should be adopted.

The 1987 proposed regulations establish standards for determining the deductibles and limits that apply to COBRA continuation coverage in a period in which an individual or a group of family members has coverage that is not COBRA continuation coverage and then elects COBRA continuation coverage. (Of course, during a period in which an individual or group of family members had only COBRA continuation coverage, the rules for deductibles and limits would apply to them in the same manner as they would to similarly situated nonCOBRA beneficiaries.) Some commenters objected to the provisions of the 1987 proposed regulations for computing deductibles or limits on a family basis in the case of a qualifying event (such as divorce) that splits a family into two (or more) units. The 1987 proposed regulations would require that each resulting family unit be credited with all the expenses incurred by the entire family before the qualifying event. The final regulations revise this rule. Under the final regulations, in computing deductibles and limits for the family unit receiving COBRA coverage, the plan is required to take into account only those expenses incurred before the qualifying event by family members who are part of the resulting family unit after the qualifying event.

The 1987 proposed regulations provide that qualified beneficiaries moving outside the area served by a region-specific plan must be given the right to obtain other coverage from the employer maintaining the region-specific plan. The rule conditions the right to other coverage on the employer having employees in the area to which the qualified beneficiary is moving. This proposed rule unduly limits the application of the rule in the case of an employer or employee organization that could provide other coverage to the qualified beneficiary without having to establish a new plan or enter into a new group insurance contract even though the employer did not have employees or the employee organization did not have members in the area that the qualified beneficiary was moving to. This might be the case, for example, if the employer or

employee organization maintained a self-insured plan or maintained an insured plan through an insurance company licensed to provide that same product in the area that the qualified beneficiary was moving to. The final regulations eliminate the condition that an employer have employees in the area to which the qualified beneficiary is moving and instead require that coverage be made available to the qualified beneficiary if the employer or employee organization would be able to provide coverage to the qualified beneficiary under one of its existing plans. Generally the coverage that must be made available is that made available to the similarly situated nonCOBRA beneficiaries. If, however, the coverage made available to the similarly situated nonCOBRA beneficiaries cannot be made available in the area that the qualified beneficiary is moving to, then the coverage that must be made available is coverage provided to other employees.

The 1987 proposed regulations require, in the case of a plan providing open enrollment rights, that open enrollment rights be extended to qualified beneficiaries if an employer maintains two or more plans. Thus, that rule, by its terms, does not require that open enrollment rights be given if an employer maintains a single plan and allows active employees during open enrollment to switch between categories of coverage such as single and family or among categories such as employee-only, employee-plus-one-dependent, or employee-plus-two-or-more-dependents. The final regulations eliminate the condition that an employer or employee organization maintain two or more plans for a qualified beneficiary to have open enrollment rights. Thus, open enrollment rights must be extended to qualified beneficiaries in any case in which they are extended to similarly situated active employees. (Note that the open enrollment right of employees to enroll when not previously enrolled would not have to be extended to individuals who previously did not elect to receive COBRA continuation coverage because an individual ceases to be a qualified beneficiary if COBRA continuation coverage is not elected.)

The 1987 proposed regulations require that qualified beneficiaries be given the same right to add new family members

that similarly situated active employees have. Many commenters objected to this rule, arguing that it requires more than a mere continuation of coverage. However, COBRA continuation coverage is more than just a continuation of the coverage a qualified beneficiary had before the qualifying event; it includes the same procedural rights to expand or change coverage that similarly situated active employees have. Moreover, the policy behind the 1987 proposed regulations is reflected in the HIPAA amendment to COBRA creating special qualified beneficiary status for certain newborn and adopted children as well as in the HIPAA special enrollment rights in section 9801(f) for new spouses and for newborn and adopted children. Accordingly, the final regulations provide guidance on the application of the HIPAA special enrollment rights to qualified beneficiaries and retain the rule in the 1987 proposed regulations regarding the right of qualified beneficiaries to add new family members (even though not eligible for the HIPAA special enrollment rights) to the same extent that active employees are permitted to add new family members.

Electing COBRA Continuation Coverage

The final regulations set forth rules regarding elections of COBRA continuation coverage by qualified beneficiaries. In general, a group health plan is required to offer a qualified beneficiary the opportunity to elect COBRA continuation coverage at any time during the election period. The election period begins not later than the date the qualified beneficiary would lose coverage by reason of a qualifying event and ends not earlier than 60 days after the later of that date or 60 days after the date on which the qualified beneficiary is provided notice of her or his right to elect COBRA continuation coverage. For purposes of determining whether a qualified beneficiary's election of COBRA continuation coverage is timely, the election is deemed to be made on the date it is sent to the employer or plan administrator. The final regulations clarify that a qualified beneficiary need not herself or himself elect COBRA continuation coverage; that election can be made on behalf of the qualified beneficiary by a third party (including a third party that is not a qualified beneficiary).

Generally, the employer or plan administrator must determine when a qualifying event has occurred, and a qualified beneficiary is not required to give notice of the event. However, a covered employee or qualified beneficiary is required to notify the plan administrator of a qualifying event that is a divorce or legal separation of the covered employee or a dependent child's ceasing to be a dependent child under the plan terms. The 1987 proposed regulations prescribe that the notification should be given to the employer or other plan administrator. The final regulations simply require that the notice be provided to the plan administrator.

The notice must be provided within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. If the notice is not provided, the group health plan is not required to make COBRA continuation coverage available to the qualified beneficiary⁵. In the case of the covered employee's divorce or legal separation, a single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries (that is, the spouse or a dependent child) satisfies the notice requirement for all those who become qualified beneficiaries as a result of the divorce or legal separation.

The group health plan must make COBRA continuation coverage available for the entire election period if the qualified beneficiary elects coverage prior to the end of the period (except in the case of a revoked waiver, as discussed below). An employer or employee organization maintaining a group health plan using an indemnity or reimbursement arrangement can satisfy this requirement by continuing the qualified beneficiary's coverage during the election period or by discontinuing the coverage until the qualified bene-

ficiary elects COBRA and then retroactively reinstating the qualified beneficiary's coverage. Under the final regulations, as under the 1987 proposed regulations, the date of the qualifying event (and thus, the beginning of the maximum coverage period) is not delayed merely because a plan provides coverage during the election period. Claims incurred by the qualified beneficiary during the election period do not have to be paid until COBRA continuation coverage is elected and any payment required for coverage is made.

For a group health plan providing health services – including a health maintenance organization or a walk-in clinic – a qualified beneficiary who has not elected and paid for COBRA continuation coverage can be required to choose either to elect and to pay for coverage or to pay a reasonable and customary charge for plan services (but only if the qualified beneficiary will be reimbursed for that charge within 30 days after she or he elects COBRA continuation coverage and makes any payment for coverage). Alternatively, the plan can treat the qualified beneficiary's use of the plan's health services as a constructive election of COBRA continuation coverage and, if it so notifies the qualified beneficiary prior to the use of services, can require payment for COBRA continuation coverage.

The final regulations adopt the position in *Communications Workers of America v. NYNEX Corp.*, 898 F.2d 887 (2d Cir. 1989), regarding the responses that a group health plan must make with respect to the rights of a qualified beneficiary during that qualified beneficiary's election period. Specifically, the final regulations require that the plan make a complete response to any inquiry from a health care provider regarding the qualified beneficiary's right to coverage under the plan during the election period. Thus, if the qualified beneficiary has not yet elected COBRA continuation coverage but remains covered under the plan during the election period (subject to retroactive cancellation if no election is made), the plan must so inform the health care provider. Conversely, if the qualified beneficiary is not covered during the election period prior to her or his election, the plan must inform the health care provider that the qualified beneficiary does not

have current coverage but will have retroactive coverage if COBRA continuation coverage is elected. (The final regulations also include similar requirements with respect to inquiries made by health care providers during the 30- and 45-day grace periods for paying for COBRA continuation coverage.)

A qualified beneficiary who waives COBRA continuation coverage during the election period can revoke the waiver before the end of the election period, but the group health plan is not then required to provide coverage as of any date prior to the revocation. Although several commenters objected to the rule in the 1987 proposed regulations allowing the revocation during the election period of any previous waiver, the final regulations retain this rule. If the rule permitted irrevocable waivers, plans might induce qualified beneficiaries to execute waivers hastily before becoming fully informed of their rights and having the opportunity to carefully consider whether to elect COBRA. As with the election of COBRA continuation coverage, a waiver or a revocation of a waiver is deemed to be made on the date sent. The employer or employee organization maintaining the group health plan is not permitted to withhold money, benefits, or anything else to which the qualified beneficiary is entitled under any law or agreement in order to induce a qualified beneficiary to make payment for COBRA continuation coverage or to surrender any rights under COBRA. Any waiver of COBRA continuation coverage rights obtained through such means will be invalid. However, the general rules for coverage during the election period apply in the case of waivers and revocations of waivers. Thus, in the case of an indemnity arrangement, the plan can deny coverage for claims until payment for the coverage has been made (as can also be done with those health maintenance organizations or walk-in clinics that adopt this method for complying with the COBRA continuation coverage requirements during the election period).

A group health plan must offer each qualified beneficiary the opportunity to make an independent election to receive COBRA continuation coverage and, during an open enrollment period, to choose among any options available to similarly situated active employees. This require-

⁵ The U.S. Department of Labor has advised the IRS and Treasury that, if a covered employee or qualified beneficiary has not been adequately informed of the obligation to provide notice in the case of a qualifying event that is the divorce or legal separation of the covered employee or that is a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the covered employee's or qualified beneficiary's failure to provide timely notice to the plan administrator will not affect the plan's obligation to make continuation coverage available upon receiving notice of such event.

ment also applies to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. (An election for a minor child may be made by the child's parent or legal guardian.) If a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of other qualified beneficiaries with respect to that qualifying event.

Duration of COBRA Continuation Coverage

The 1987 proposed regulations incorporate the statutory bases for terminating COBRA continuation coverage except the rule (added by OBRA 1989 and amended by HIPAA) that COBRA coverage can be terminated in the month that is more than 30 days after a final determination that a qualified beneficiary is no longer disabled. The new proposed regulations add this statutory basis for terminating COBRA coverage, with two clarifications. First, the new proposed regulations clarify that a determination that a qualified beneficiary is no longer disabled allows termination of COBRA continuation coverage for all qualified beneficiaries who were entitled to the disability extension by reason of the disability of the qualified beneficiary who has been determined to no longer be disabled. Second, the new proposed regulations clarify that such a determination does not allow termination of the COBRA continuation coverage of a qualified beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension.

Section 4980B(f)(2)(B)(iv) provides that a qualified beneficiary's right to COBRA continuation coverage may be terminated when the qualified beneficiary "first becomes," after the date of the COBRA election, covered under another group health plan (subject to certain additional conditions) or entitled to Medicare benefits. The final regulations add two new questions-and-answers that provide guidance on this provision.

The 1987 proposed regulations substitute "is" for the statutory phrase "first becomes." The effect of this substitution was to permit an employer to cut off a qualified beneficiary's right to COBRA continuation coverage based upon other group health plan coverage that the qualified beneficiary first became covered under before she or he elected COBRA coverage. In the case of entitlement to Medicare benefits, the 1987 proposed regulations not only shift the statutory "becomes" to "is," they also exclude from the definition of qualified beneficiary anyone who is entitled to Medicare benefits on the day before the qualifying event. After careful consideration, the IRS and Treasury concluded that the better interpretation of the statute is that other group health plan coverage that a qualified beneficiary has before the COBRA election is not a basis for cutting off the qualified beneficiary's right to COBRA continuation coverage. (The same rule applies for entitlement to Medicare benefits.)

Based upon the recommendation of the IRS, the Solicitor General filed an amicus brief before the Supreme Court urging this position, which was unanimously adopted by the Supreme Court in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998). The final regulations adopt the position urged by the IRS and Treasury and adopted by the Court in *Geissal*. They provide that an employer may cut off the right to COBRA continuation coverage based upon other group health plan coverage or entitlement to Medicare benefits only if the qualified beneficiary first becomes covered under the other group health plan coverage or entitled to the Medicare benefits after the date of the COBRA election.

The statutory rule allowing a plan to discontinue COBRA continuation coverage on account of coverage under another group health plan was amended by OBRA 1989 to prohibit the discontinuance if the qualified beneficiary's other coverage was subject to a preexisting condition exclusion. This amendment was further modified by HIPAA to allow discontinuance of COBRA continuation coverage if the preexisting condition exclusion does not apply or is satisfied by reason of the limitations on preexisting condition ex-

clusions in section 9801. The final regulations reflect this amendment and clarify that coverage under another group health plan includes coverage under a governmental plan.

Many commenters asked whether mere eligibility for Medicare justifies a discontinuance of COBRA continuation coverage. In addition, many inquiries have been received that ask whether the qualified beneficiary must be entitled to both Part A and B of Medicare. The final regulations clarify that entitlement to Medicare benefits means being enrolled in Medicare and does not mean merely being eligible to enroll in Medicare. The final regulations also clarify that being entitled to either Part A or B is sufficient for the plan to discontinue COBRA continuation coverage (assuming that the entitlement to Medicare benefits first arises after COBRA continuation coverage has been elected).

The 1987 proposed regulations allow a plan to discontinue providing COBRA continuation coverage to a qualified beneficiary for cause on the same basis that the plan could terminate for cause the coverage of a similarly situated active employee (except for payments that would be untimely if made by a nonCOBRA beneficiary but that are made within the grace periods provided by COBRA). The final regulations provide that, for example, if a plan terminates the coverage of similarly situated active employees for the submission of a fraudulent claim, then the COBRA continuation coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim.

The 1987 proposed regulations reflect the statutory rules that were then in effect for the maximum period that a plan is required to make COBRA continuation coverage available. Since then the statute has been amended to add the disability extension, to permit plans to extend the notice period if the maximum coverage period is also extended (referred to as the optional extension of the required periods), and to add a special rule in the case of Medicare entitlement preceding a qualifying event that is the termination or reduction of hours of employment. The new proposed regulations reflect these statutory changes. The maximum coverage period

for a qualifying event that is the bankruptcy of the employer has also been added to the new proposed regulations.

The 1998 proposed regulations set forth the requirements for a disability extension to apply to a qualified beneficiary. Those requirements have been incorporated into the final regulations, with one clarification. One of the conditions for a disability extension to apply is that the qualified beneficiary be disabled during the first 60 days of COBRA continuation coverage. In the case of a qualified beneficiary who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the final regulations clarify that the 60-day period is measured from the date of the child's birth or placement for adoption.

The 1987 proposed regulations set forth standards for expanding the maximum coverage period in the case of multiple qualifying events. Since 1987, the statutory rules for multiple qualifying events have been affected by the addition of the disability extension and the optional extension of required periods. The final regulations reflect the statutory changes.

In addition, the final regulations clarify that a termination of employment following a qualifying event that is a reduction of hours of employment does not expand the maximum coverage period. *Accord, Burgess v. Adams Tool & Engineering, Inc.*, 908 F. Supp. 473 (W.D. Mich. 1995); *contra, Gibbs v. Anchorage School District*, 1995 U.S. LEXIS 6290 (D. Ark. 1995). The underlying pattern in the statute is generally to require 18 months (or 29 months, in the case of a disability extension) of coverage for qualifying events that are the termination or reduction of hours of a covered employee's employment and 36 months for other qualifying events. The statutory provision for expansion of the 18-month period to 36 months upon the occurrence of a second qualifying event generally follows this pattern by allowing a qualified beneficiary who would have been entitled to 36 months of coverage if the second qualifying event had occurred first to get a total of 36 months of COBRA continuation coverage. The statute lists six categories of qualifying events, and termination of employment and reduction of hours of employment are in the same category

(just as divorce and legal separation are in the same category of qualifying event). Treating a reduction of hours of employment and a termination of employment as variations of a single qualifying event rather than as two distinct qualifying events is consistent with the overall design of the statute.

The 1987 proposed regulations address situations in which, following a qualifying event, an employer provides alternative coverage, rather than COBRA continuation coverage, to a former employee and her or his spouse and dependent children. The 1987 proposed regulations provide that if the alternative coverage does not satisfy the requirements for COBRA continuation coverage, each qualified beneficiary must be given the opportunity to elect COBRA continuation coverage instead of the alternative coverage. If, however, the alternative coverage would satisfy the requirements for COBRA continuation coverage, the 1987 proposed regulations provide that, at the time of the original qualifying event, the employee, spouse, and dependent children need not be provided with the opportunity to elect COBRA continuation coverage. The final regulations generally retain these rules but also clarify that if the employer increases the employee share of premiums upon the occurrence of a qualifying event, the qualified beneficiaries must be offered the opportunity to elect COBRA continuation coverage.

The 1987 proposed regulations further provide that, if the alternative coverage does not satisfy the requirements for COBRA continuation coverage and if, after the original qualifying event, a qualifying event occurs that would cause a spouse or dependent child to lose the alternative coverage, the spouse or child must be offered COBRA continuation coverage. However, if the alternative coverage satisfies the requirements for COBRA continuation coverage, and if another qualifying event that causes the spouse or dependent child to lose the alternative coverage occurs more than 18 months after the original qualifying event, the 1987 proposed regulations provide that the spouse or dependent child need not be offered COBRA continuation coverage. The final regulations modify the 1987 proposed regulations and provide that if an event such as the death of or di-

voiced from the covered employee would end the right of a spouse or dependent child to receive the alternative coverage (whether during or after the first 18 months of COBRA continuation coverage), then that event is a qualifying event, regardless of whether the alternative coverage would satisfy the requirements for COBRA continuation coverage.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives certain members of the military reserves the right to up to 18 months of continuation coverage when they are called to active duty. Many people have asked if the USERRA and COBRA periods of continuation coverage run concurrently or consecutively. The final regulations clarify that USERRA coverage is alternative coverage. Thus, the periods run concurrently.

The 1987 proposed regulations include the statutory rule requiring that a conversion option otherwise made available under the plan be made available within 180 days before the end of the maximum coverage period. The final regulations adopt this rule without change.

Paying for COBRA Continuation Coverage

The 1987 proposed regulations identify the qualified beneficiary as the person that can be required to pay the applicable premium. Many plans and employers have asked whether they must accept payment on behalf of a qualified beneficiary from third parties, such as a hospital or a new employer. Nothing in the statute requires the qualified beneficiary to pay the amount required by the plan; the statute merely permits the plan to require that payment be made. In order to make clear that any person may make the required payment on behalf of a qualified beneficiary, the final regulations modify the rule in the 1987 proposed regulations to refer to the payment requirement without identifying the person who makes the payment.

The 1998 proposed regulations address the amount that a plan can require to be paid for COBRA continuation coverage during the disability extension. This amount is 150 percent of the applicable premium instead of the limit of 102 percent of the applicable premium that applies for coverage outside the disability

extension. The 1998 proposed regulations specifically reserve the issue of the amount a plan could require to be paid in a case where only nondisabled family members of the disabled individual receive COBRA continuation coverage during the disability extension. The preamble to the 1998 proposed regulations solicited comments on this issue. Commenters suggested that the 150 percent rate could be required if the disabled individual was part of the coverage group but that the limit could be the 102 percent rate if only nondisabled qualified beneficiaries were in the coverage group. The final regulations adopt this suggestion.

The 1987 proposed regulations provide that the amount required to be paid for a qualified beneficiary's COBRA continuation coverage must be fixed in advance for each 12-month determination period. Many commenters suggested exceptions that could be made to this general rule. Section 4980B(f)(4)(C) explicitly requires that the determination of the applicable premium be made for a period of 12 months and that the determination be made before the beginning. Therefore, the final regulations do not permit an increase in the applicable premium during the 12-month determination period. However, the final regulations do revise the general rule from the 1987 proposed regulations to recognize the difference between the applicable premium (which may not be increased during a 12-month determination period and which is the basis for calculating the maximum amount that the plan can require to be paid for COBRA continuation coverage) and the maximum amount that the plan can require to be paid for COBRA continuation coverage. Thus, the final regulations permit a plan to increase the amount it requires to be paid for COBRA continuation coverage during a determination period to take into account the permitted increases during the disability extension, to explicitly permit a plan that is requiring payment of less than the maximum permissible amount to increase the amount required to be paid during the 12-month determination period, and to permit an increase if a qualified beneficiary changes to more expensive coverage (but also to require a reduction if the qualified beneficiary changes to less expensive coverage).

The 1987 proposed regulations set forth the statutory requirement that qualified beneficiaries be allowed to pay for COBRA coverage in monthly installments. The 1987 proposed regulations add that plans may allow payment to be made at other intervals, and specifically mention quarterly or semiannual payment as examples. The final regulations adopt the rule in the 1987 proposed regulations, but the final regulations add weekly payment as an example to make clear that shorter than monthly installments are also permitted.

The 1987 proposed regulations provide that the first payment for COBRA continuation coverage does not apply prospectively only. In order to make clear that a plan is not precluded from allowing a qualified beneficiary to apply the first payment prospectively only, the final regulations provide that qualified beneficiaries need not be given the option of having the first payment for COBRA continuation coverage apply prospectively only.

The 1987 proposed regulations address the issue of timely payment for COBRA continuation coverage, including an interpretation of the statutory grace periods of 45 days for the initial payment and 30 days for all other payments. Commenters pointed out that the application of the statutory grace period rules could produce an anomalous result in some situations, such as allowing a plan to require payment for the third month of COBRA continuation coverage earlier than the plan could require payment for the first two months. OBRA 1989 amended the 45-day grace period rule to prevent this, and the final regulations conform to the OBRA 1989 change. The final regulations also clarify that payment is considered made on the date it is sent.

The final regulations also add a requirement (similar to the one described above for the election period) relating to the response that a plan must give when a health care provider, such as a physician, a hospital, or a pharmacy, contacts the plan to confirm coverage of a qualified beneficiary with respect to whom the required payment has not been made for the current period (but for whom any applicable grace period has not expired). In such a case, the plan is required to inform the health care provider of all of the details of

the qualified beneficiary's right to coverage during the applicable grace periods.

Many individuals have inquired about a plan's right to discontinue their COBRA continuation coverage because the amount of the payment made was short by an amount that is not significant. Sometimes the error has been clearly one of transposed digits on a check tendered for payment; in other instances, payment has been short by such a small amount that it would be unreasonable to attribute the shortfall to anything other than mistake. The final regulations establish a mechanism for the treatment of payments that are short by an insignificant amount. Either the plan must treat the payment as satisfying the plan's payment requirement or it must notify the qualified beneficiary of the amount of the deficiency and grant the qualified beneficiary a reasonable period of time for the deficiency to be paid. The final regulations provide that, as a safe harbor, a period of 30 days is deemed to be a reasonable period for this purpose.

Business Reorganizations

The 1987 proposed regulations provide little direct guidance on the allocation of responsibility for COBRA continuation coverage in the event of corporate transactions, such as a sale of stock of a subsidiary or a sale of substantial assets. Commenters on the 1987 proposed regulations requested further guidance on corporate transactions, pointing out that the existing degree of uncertainty tends to drive up the costs and risks of a transaction to both buyers and sellers. The IRS and Treasury share this view and believe also that greater certainty helps to protect the rights of qualified beneficiaries in these transactions. The IRS has been contacted by many qualified beneficiaries whose COBRA continuation coverage has been dropped or denied in the context of a corporate transaction. In many cases, these qualified beneficiaries have been told by each of the buyer and the seller that the other party is the one responsible for providing them with COBRA continuation coverage.

The preamble to the 1998 proposed regulations requested comments on a possible approach to allocating responsibility for COBRA continuation coverage in corporate transactions. Commenters sug-

gested that, in a stock sale, as in an asset sale, it would be consistent with standard commercial practice to provide that the seller retains liability for all existing qualified beneficiaries, including those formerly associated with the subsidiary being sold. The IRS and Treasury have studied the comments and given consideration to several alternatives with a view to establishing rules that will minimize the administrative burden and transaction costs for the parties to transactions while protecting the rights of qualified beneficiaries and maintaining consistency with the statute.

Accordingly, the new proposed regulations make clear that the parties to a transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the new proposed regulations. So long as the party to whom the contract allocates responsibility performs its obligations, the other party will have no responsibility for providing COBRA continuation coverage. If, however, the party allocated responsibility under the contract defaults on its obligation, and if, under the new proposed regulations, the other party would have the obligation to provide COBRA continuation coverage in the absence of a contractual provision, then the other party would retain that obligation. This approach would avoid prejudicing the rights of qualified beneficiaries to COBRA continuation coverage based upon the provisions of a contract to which they were not a party and under which the employer with the underlying obligation under the regulations to provide COBRA continuation coverage could otherwise contract away that obligation to a party that fails to perform. Moreover, the party with the underlying responsibility under the regulations can insist on appropriate security and, of course, could pursue contractual remedies against the defaulting party.

The new proposed regulations provide, for both sales of stock and sales of substantial assets, such as a division or plant or substantially all the assets of a trade or business, that the seller retains the obligation to make COBRA continuation coverage available to existing qualified beneficiaries. In addition, in situations in which the seller ceases to provide any group

health plan to any employee in connection with the sale – whether such a cessation is in connection with the sale is determined on the basis of the facts and circumstances of each case – and thus is not responsible for providing COBRA continuation coverage, the new proposed regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and in all sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

A particular type of asset sale raises issues for which the new proposed regulations do not provide any special rules. (Thus, the general rules in the new proposed regulations for business reorganizations would apply to this type of transaction.) This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the employees of that business and continues to provide those employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the new proposed regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the employees continuing in employment with the buyer (and to other family members who are qualified beneficiaries). Ordinarily, the continuing employees (or their family members) would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active employees of the buyer.

Consideration is being given to whether, under appropriate circumstances, such an asset sale would be considered not to result in a loss of coverage for those employees who continue in employment with the buyer after the sale. A countervailing concern, however, relates to those qualified beneficiaries who might have a reason to elect COBRA continuation coverage from the seller. An example of such a qualified beneficiary would be an employee who continues in employ-

ment with the buyer, whose family is likely to have medical expenses that exceed the cost of COBRA coverage, and who has significant questions about the solvency of the buyer or other concerns about how long the buyer might continue to provide the same health coverage.

Under one possible approach, a loss of coverage would be considered not to have occurred so long as the purchasing employer in an asset sale continued to maintain the same group health plan coverage that the seller maintained before the sale without charging the employees any greater percentage of the total cost of coverage than the seller had charged before the sale. For this purpose, the coverage would be considered unchanged if there was no obligation to provide a summary of material modifications within 60 days after the change due to a material reduction in covered services or benefits under the rules that apply under Title I of ERISA. If these conditions were satisfied for the maximum coverage period that would otherwise apply to the seller's termination of employment of the continuing employees (generally 18 months from the date of the sale), then those terminations of employment would never be considered qualifying events. If the conditions were not satisfied for the full maximum coverage period, then on the date when they ceased to be satisfied the seller would be obligated to make COBRA continuation coverage available for the balance of the maximum coverage period.

Comments are invited on the utility of such a rule, either in situations in which the seller retains an ownership interest in the buyer after the sale (for example, a sale of assets from a 100-percent owned subsidiary to a 75-percent owned subsidiary) or, more generally, in situations in which the seller and the buyer are unrelated. Suggestions are also solicited for other rules that would protect qualified beneficiaries while providing relief to employers in these situations.

Although the new proposed regulations address how COBRA obligations are affected by a sale of stock (and a sale of substantial assets), the new proposed regulations do not address how the obligation to make COBRA continuation coverage available is affected by the transfer of an ownership interest in a noncorporate en-

tity that causes the noncorporate entity to cease to be a member of a group of trades or businesses under common control (whether or not it becomes a member of a different group of trades or business under common control). Comments are invited on this issue.

Employer Withdrawals From Multiemployer Plans

The new proposed regulations also address COBRA obligations in connection with an employer's cessation of contributions to a multiemployer group health plan. The new proposed regulations provide that the multiemployer plan generally continues to have the obligation to make COBRA continuation coverage available to qualified beneficiaries associated with that employer. (There generally would not be any obligation to make COBRA continuation coverage available to continuing employees in this situation because a cessation of contributions is not a qualifying event.) However, once the employer provides group health coverage to a significant number of employees who were formerly covered under the multiemployer plan, or starts contributing to another multiemployer plan on their behalf, the employer's plan (or the new multiemployer plan) would have the obligation to make COBRA continuation coverage available to the existing qualified beneficiaries. This rule is contrary to the holding in *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994), which held that the multiemployer plan continued to have the COBRA obligations with respect to existing qualified beneficiaries after the withdrawing employer established a plan for the same class of employees previously covered under the multiemployer plan.

Interaction of FMLA and COBRA

The new proposed regulations set forth rules regarding the interaction of the COBRA continuation coverage requirements with the provisions of the Family and Medical Leave Act of 1993 (FMLA). The rules under the new proposed regulations are substantially the same as those set forth in Notice 94-103. The last two questions-and-answers in that notice have not been included in the new proposed regulations because they relate to general

subject matter that is addressed elsewhere in the regulations.

Under the new proposed regulations, the taking of FMLA leave by a covered employee is not itself a qualifying event. Instead, a qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA leave) does not return to work with the employer at the end of FMLA leave and would, but for COBRA continuation coverage, lose coverage under the group health plan. (As under the general rules of COBRA, this would also constitute a qualifying event with respect to the spouse or any dependent child of the employee.) The qualifying event is deemed to occur on the last day of the employee's FMLA leave, and the maximum coverage period generally begins on that day. (The new proposed regulations provide a special rule for cases where coverage is not lost until a later date and the plan provides for the optional extension of the required periods.) In the case of such a qualifying event, the employer cannot condition the employee's rights to COBRA continuation coverage on the employee's reimbursement of any premiums paid by the employer to maintain the employee's group health plan coverage during the period of FMLA leave.

Any lapse of coverage under the group health plan during the period of FMLA leave and any state or local law requiring that group health plan coverage be provided for a period longer than that required by the FMLA are disregarded in determining whether the employee has a qualifying event on the last day of that leave. However, the employee's loss of coverage at the end of FMLA leave will not constitute a qualifying event if, prior to the employee's return from FMLA leave, the employer has eliminated group health plan coverage for the class of employees to which the employee would have belonged if she or he had not taken FMLA leave.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assess-

ment is not required. It is hereby certified that the collections of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based upon the fact that employers with fewer than 20 employees are not subject to the requirements set forth in the final regulations and, thus, the very smallest employers are not affected by the collection of information requirements. Moreover, even for small entities with 20 or more employees who maintain group health plans and who, thus, are subject to the requirements of COBRA, the collections of information will not impose a substantial economic impact. The only collections of information imposed on small entities by the regulations are (1) to notify qualified beneficiaries of their right to elect COBRA continuation coverage upon the occurrence of a qualifying event and (2) to notify certain qualified beneficiaries that make insignificant payment errors of those errors. With respect to this first notice requirement, it is estimated that, on average, in a given year, qualifying events will occur with respect to approximately 10 percent of all covered employees. Thus, an employer with 100 employees would be required to send 10 notices to qualified beneficiaries each year. The average cost of sending such a notice is estimated to be \$.50. Thus, the total estimated cost for 10 notices is \$5.00, which is the estimated annual average burden on an employer with 100 employees. With respect to the second notice requirement, it is estimated that, on average, at any time, the number of qualified beneficiaries is approximately equal to two percent of an employer's workforce. Of that number, approximately 1 in 10 will make an insignificant error in payment each year that requires the employer to send such a notice. For example, an employer with 100 employees will have an average of two qualified beneficiaries at any time. Thus, the employer will receive an insignificant underpayment about once every five years. Even if the employer chose to send out a notice each time such an insignificant underpayment occurred, this would amount to only one notice every five years. The average cost of sending such a notice is estimated to be \$.50, resulting in an average annual burden of \$1.00 for an employer with 100

employees. Thus, the total annual cost of these two notice requirements for an employer with 100 employees is \$6.00, which is not a significant economic impact. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. Pursuant to section 7805(f) of the Internal Revenue Code, the 1998 notice of proposed rulemaking preceding these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Russ Weinheimer, Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations), IRS. However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding the following entries in numerical order to read as follows:

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

Section 54.4980B-1 also issued under 26 U.S.C. 4980B.

Section 54.4980B-2 also issued under 26 U.S.C. 4980B.

Section 54.4980B-3 also issued under 26 U.S.C. 4980B.

Section 54.4980B-4 also issued under 26 U.S.C. 4980B.

Section 54.4980B-5 also issued under 26 U.S.C. 4980B.

Section 54.4980B-6 also issued under 26 U.S.C. 4980B.

Section 54.4980B-7 also issued under 26 U.S.C. 4980B.

Section 54.4980B-8 also issued under 26 U.S.C. 4980B. * * *

Par. 2. Sections 54.4980B-0, 54.4980B-1, 54.4980B-2, 54.4980B-3, 54.4980B-4, 54.4980B-5, 54.4980B-6, 54.4980B-7, and 54.4980B-8 are added to read as follows:

§54.4980B-0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§54.4980B-1 through 54.4980B-8.

LIST OF SECTIONS

§54.4980B-1 COBRA in general.

§54.4980B-2 Plans that must comply.

§54.4980B-3 Qualified beneficiaries.

§54.4980B-4 Qualifying events.

§54.4980B-5 COBRA continuation coverage.

§54.4980B-6 Electing COBRA continuation coverage.

§54.4980B-7 Duration of COBRA continuation coverage.

§54.4980B-8 Paying for COBRA continuation coverage.

LIST OF QUESTIONS

§54.4980B-1 COBRA in general.

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

Q-2: What is the effective date of §§54.4980B-1 through 54.4980B-8?

§54.4980B-2 Plans that must comply.

Q-1: For purposes of section 4980B, what is a group health plan?

Q-2: For purposes of section 4980B, what is the employer?

Q-3: **[Reserved]**

Q-4: What group health plans are subject to COBRA?

Q-5: What is a small-employer plan?

Q-6: **[Reserved]**

Q-7: What is the plan year?

Q-8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

Q-9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

Q-10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

§54.4980B-3 Qualified beneficiaries.

Q-1: Who is a qualified beneficiary?

Q-2: Who is an employee and who is a covered employee?

Q-3: Who are the similarly situated non-COBRA beneficiaries?

§54.4980B-4 Qualifying events.

Q-1: What is a qualifying event?

Q-2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

§54.4980B-5 COBRA continuation coverage.

Q-1: What is COBRA continuation coverage?

Q-2: What deductibles apply if COBRA continuation coverage is elected?

Q-3: How do a plan's limits apply to COBRA continuation coverage?

Q-4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

Q-5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

§54.4980B-6 Electing COBRA continuation coverage.

Q-1: What is the election period and how long must it last?

Q-2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

Q-3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

Q-4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

Q-5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

Q-6: Can each qualified beneficiary make an independent election under COBRA?

§54.4980B-7 Duration of COBRA continuation coverage.

Q-1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

Q-2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

Q-4: **[Reserved]**

Q-5: How does a qualified beneficiary become entitled to a disability extension?

Q-6: Under what circumstances can the maximum coverage period be expanded?

Q-7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

Q-8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the

maximum coverage period for COBRA continuation coverage?

§54.4980B-8 Paying for COBRA continuation coverage.

Q-1: Can a group health plan require payment for COBRA continuation coverage?

Q-2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

Q-3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

Q-4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

Q-5: What is timely payment for COBRA continuation coverage?

§54.4980B-1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

A-1: (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100-647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in §§54.4980B-1 through 54.4980B-8 as COBRA continuation coverage.

(b) COBRA also added parallel continuation coverage requirements to Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161-1168), which is administered by the U.S. Department of

Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties – including qualified beneficiaries who are participants or beneficiaries within the meaning of Title I of ERISA, as well as the Department of Labor – the right to file a lawsuit to redress the noncompliance. The rules in §§54.4980B-1 through 54.4980B-8 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in Title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and Title I of ERISA. In those cases in which the statutory language is not identical, the rules in §§54.4980B-1 through 54.4980B-8 nonetheless apply to the COBRA continuation coverage requirements of Title I of ERISA, except to the extent those rules are inconsistent with the statutory language of Title I of ERISA.

(c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A-4 of §54.4980B-2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term *qualified beneficiary* is defined in Q&A-1 of §54.4980B-3. The term *qualifying event* is defined in Q&A-1 of §54.4980B-4. COBRA continuation coverage is described in §54.4980B-5. The election procedures are described in §54.4980B-6. Duration of COBRA continuation coverage is addressed in §54.4980B-7, and payment for COBRA continuation coverage is addressed in §54.4980B-8. Unless the context indicates otherwise, any reference in §§54.4980B-1 through 54.4980B-8 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q-2: What is the effective date of §§54.4980B-1 through 54.4980B-8?

A-2: Sections 54.4980B-1 through 54.4980B-8 apply with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. For

purposes of section 4980B, with respect to qualifying events that occur in plan years beginning before that date, and with respect to qualifying events that occur in plan years beginning on or after that date for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§54.4980B-1 through 54.4980B-8 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

§54.4980B-2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q-1: For purposes of section 4980B, what is a group health plan?

A-1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or em-

ployee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1.

(b) For purposes of §§54.4980B-1 through 54.4980B-8, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132

(relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

(d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if –

(1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

(2) The health care is available only to current employees; and

(3) Employees are not charged for the use of the facility.

(e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.

(f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q-2: For purposes of section 4980B, what is the employer?

A-2: For purposes of section 4980B, *employer* refers to –

(a) A person for whom services are performed;

(b) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a) of this Q&A-2; and

(c) Any successor of a person described in paragraph (a) or (b) of this Q&A-2.

Q-3: **[Reserved]**

A-3: **[Reserved]**

Q-4: What group health plans are subject to COBRA?

A-4: (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A-4. Group health plans described in paragraph (b) of this Q&A-4 are referred to in §§54.4980B–1 through 54.4980B–8 as excepted from COBRA.

(b) The following group health plans are excepted from COBRA –

(1) Small-employer plans (see Q&A-5 of this section);

(2) Church plans (within the meaning of section 414(e)); and

(3) Governmental plans (within the meaning of section 414(d)).

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A-5 of this section).

(d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb–1 through 300bb–8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary con-

tinuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q-5: What is a small-employer plan?

A-5: (a) Except in the case of a multi-employer plan, a *small-employer plan* is a group health plan maintained by an employer (within the meaning of Q&A-2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A-5) during the preceding calendar year. In the case of a multiemployer plan, a *small-employer plan* is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. The rules of this paragraph (a) are illustrated in the following example:

Example. (i) Corporation *S* employs 12 employees, all of whom work and reside in the United States. *S* maintains a group health plan for its employees and their families. *S* is a wholly-owned subsidiary of *P*. In the previous calendar year, the controlled group of corporations including *P* and *S* employed more than 19 employees, although the only employees in the United States of the controlled group that includes *P* and *S* are the 12 employees of *S*.

(ii) Under §1.414(b)–1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by *S* is not a small-employer plan during the current calendar year because the controlled group including *S* normally employed at least 20 employees in the preceding calendar year.

(b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

(c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A-5 even though they are referred to as employees for all other purposes of §§54.4980B–1 through 54.4980B–8 –

(1) Self-employed individuals (within the meaning of section 401(c)(1));

(2) Independent contractors (and their employees and independent contractors); and

(3) Directors (in the case of a corporation).

(d) **[Reserved]**

(e) **[Reserved]**

(f) **[Reserved]**

(g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee *E* resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, *E* is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for *E*. *E* timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to *E* during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of §54.4980B–7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of *E*'s qualifying event, or longer if *E* is eligible for a disability extension.

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of §54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under

the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

Q-6: [Reserved]

A-6: [Reserved]

Q-7: What is the plan year?

A-7: (a) The *plan year* is the year that is designated as the plan year in the plan documents.

(b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).

(1) The plan year is the deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

(4) In any other case, the plan year is the calendar year.

Q-8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

A-8: The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. The rules of this Q&A-8 are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indem-

nity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. *B* and *C* are unmarried employees. *B* has chosen the life insurance coverage, and *C* has chosen the indemnity arrangement.

(ii) *B* does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to *B*. However, if *C* terminates employment and the termination constitutes a qualifying event, *C* must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If *C* makes such an election and an open enrollment period for active employees occurs while *C* is still receiving the COBRA continuation coverage, *C* must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

Q-9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

A-9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q-10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

A-10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan the excise tax is imposed on the plan.

(b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person

provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A-3 of §54.4980B-3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

§54.4980B-3 *Qualified beneficiaries.*

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q-1: Who is a qualified beneficiary?

A-1: (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A-1, a qualified beneficiary is –

(i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or

(ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

(2) In the case of a qualifying event that is the bankruptcy of the employer, a covered employee who had retired on or before the date of substantial elimination of group health plan coverage is also a qualified beneficiary, as is any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan.

(3) In general, an individual (other than a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation cover-

age) who is not covered under a plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event, and the reason for the individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered coverage under a plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101–12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§54.4980B–1 through 54.4980B–8, the individual will be considered to have had the coverage that was wrongfully denied or not offered.

(4) Paragraph (b) of this Q&A-1 describes how certain family members are not qualified beneficiaries even if they become covered under the plan; paragraphs (c), (d), and (e) of this Q&A-1 place limits on the general rules of this paragraph (a) concerning who is a qualified beneficiary; paragraph (f) of this Q&A-1 provides when an individual who has been a qualified beneficiary ceases to be a qualified beneficiary; paragraph (g) of this Q&A-1 defines *placed for adoption*; and paragraph (h) of this Q&A-1 contains examples.

(b) In contrast to a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered employee) are not qualified beneficiaries by virtue of the marriage, birth, or placement for adoption or by virtue of the individual's status as the spouse or the child's status as a dependent of the qualified beneficiary. These new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A-5 of

§54.4980B–5, paragraph (c) in Q&A-4 of §54.4980B–5, section 9801(f)(2), and §54.9801–6T(b).)

(c) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A-1, the individual is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event.

(d) A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination, or reduction of hours, of the covered employee's employment, or that is the bankruptcy of the employer.

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A-1 of §54.4980B–6). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases

under the rules of §54.4980B–7, the individual ceases to be a qualified beneficiary.

(g) For purposes of §§54.4980B–1 through 54.4980B–8, *placement for adoption* or *being placed for adoption* means the assumption and retention by the covered employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement for adoption with the covered employee terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by the covered employee without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.

(h) The rules of this Q&A-1 are illustrated by the following examples:

Example 1. (i) *B* is a single employee who voluntarily terminates employment and elects COBRA continuation coverage under a group health plan. To comply with the requirements of section 9801(f) and §54.9801–6T(b), the plan permits a covered employee who marries to have her or his spouse covered under the plan. One month after electing COBRA continuation coverage, *B* marries and chooses to have *B*'s spouse covered under the plan.

(ii) *B*'s spouse is not a qualified beneficiary. Thus, if *B* dies during the period of COBRA continuation coverage, the plan does not have to offer *B*'s surviving spouse an opportunity to elect COBRA continuation coverage.

Example 2. (i) *C* is a married employee who terminates employment. *C* elects COBRA continuation coverage for *C* but not *C*'s spouse, and *C*'s spouse declines to elect such coverage. *C*'s spouse thus ceases to be a qualified beneficiary. At the next open enrollment period, *C* adds the spouse as a beneficiary under the plan.

(ii) The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan thus will not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of *C*.

Example 3. (i) Under the terms of a group health plan, a covered employee's child, upon attaining age 19, ceases to be a dependent eligible for coverage.

(ii) At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse is not a qualified beneficiary.

Example 4. (i) *D* is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, *D* ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time). *D* marries *E* during

the period of retiree health coverage and, under the terms of that coverage, *E* becomes covered under the plan.

(ii) If a divorce from or death of *D* will result in *E*'s losing coverage, *E* will be a qualified beneficiary because *E*'s coverage under the plan on the day before the qualifying event (that is, the divorce or death) will have been by reason of *D*'s acceptance of 12 months of employer-paid coverage after the prior qualifying event (*D*'s retirement) rather than by reason of an election of COBRA continuation coverage.

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause *E* to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

(ii) *E* does not have to be allowed to elect COBRA continuation coverage because the loss of coverage at the end of the 12-month period is not caused by the divorce or death, and thus the divorce or death does not constitute a qualifying event. See Q&A-1 of §54.4980B-4.

Q-2: Who is an employee and who is a covered employee?

A-2: (a)(1) For purposes of §§54.4980B-1 through 54.4980B-8 (except for purposes of Q&A-5 in §54.4980B-2, relating to the exception from COBRA for plans maintained by an employer with fewer than 20 employees), an *employee* is any individual who is eligible to be covered under a group health plan by virtue of the performance of services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan. Thus, for purposes of §§54.4980B-1 through 54.4980B-8 (except for purposes of Q&A-5 in §54.4980B-2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan –

(i) Self-employed individuals (within the meaning of section 401(c)(1));

(ii) Independent contractors (and their employees and independent contractors); and

(iii) Directors (in the case of a corporation).

(2) Similarly, whenever reference is made in §§54.4980B-1 through 54.4980B-8 (except in Q&A-5 of §54.4980B-2) to an employment relationship (such as by referring to the termination of employment of an employee or to an employee's being employed by an employer), the reference includes the relationship of those individuals who are employees within the meaning of this paragraph (a). See paragraph (c) in

Q&A-5 of §54.4980B-2 for a narrower meaning of employee solely for purposes of Q&A-5 of §54.4980B-2.

(b) For purposes of §§54.4980B-1 through 54.4980B-8, a *covered employee* is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A-4 of §54.4980B-2) by virtue of being or having been an employee. For example, a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment. An employee (or former employee) who is merely eligible for coverage under a group health plan is generally not a covered employee if the employee (or former employee) is not actually covered under the plan. In general, the reason for the employee's (or former employee's) lack of actual coverage (such as having declined participation in the plan or having failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the employee (or former employee) is denied or not offered coverage under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101 through 12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§54.4980B-1 through 54.4980B-8, the employee (or former employee) will be considered to have had the coverage that was wrongfully denied or not offered.

Q-3: Who are the similarly situated nonCOBRA beneficiaries?

A-3: For purposes of §§54.4980B-1 through 54.4980B-8, *similarly situated nonCOBRA beneficiaries* means the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of

the qualified beneficiary immediately before the qualifying event.

§54.4980B-4 Qualifying events.

The determination of what constitutes a qualifying event is addressed in the following questions-and-answers:

Q-1: What is a qualifying event?

A-1: (a) A *qualifying event* is an event that satisfies paragraphs (b), (c), and (d) of this Q&A-1. Paragraph (e) of this Q&A-1 further explains a reduction of hours of employment, paragraph (f) of this Q&A-1 describes the treatment of children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and paragraph (g) of this Q&A-1 contains examples.

(b) An event satisfies this paragraph (b) if the event is any of the following –

(1) The death of a covered employee;

(2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;

(3) The divorce or legal separation of a covered employee from the employee's spouse;

(4) A covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg);

(5) A dependent child's ceasing to be a dependent child of a covered employee under the generally applicable requirements of the plan; or

(6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

(c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to *lose coverage* means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. Any increase in the premium or contribution that must be paid by a covered employee (or the spouse or dependent child of a covered employee) for coverage under a group health plan that results from the occurrence of one of the events listed in paragraph (b) of this

Q&A-1 is a *loss of coverage*. In the case of an event that is the bankruptcy of the employer, lose coverage also means any substantial elimination of coverage under the plan, occurring within 12 months before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage or for any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan. For purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period (see Q&A-1 and Q&A-6 of §54.4980B-7). However, if neither the covered employee nor the spouse or a dependent child of the covered employee loses coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c). If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A-4 of §54.4980B-2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A-5 of §54.4980B-2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a

small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A-7 of §54.4980B-7 regarding the maximum coverage period in such a case.

(e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works, but only if the decrease is not accompanied by an immediate termination of employment. This is true regardless of whether the covered employee continues to perform services following the reduction of hours of employment. For example, an absence from work due to disability, a temporary layoff, or any other reason is a reduction of hours of a covered employee's employment if there is not an immediate termination of employment. If a group health plan measures eligibility for the coverage of employees by the number of hours worked in a given time period, such as the preceding month or quarter, and an employee covered under the plan fails to work the minimum number of hours during that time period, the failure to work the minimum number of required hours is a reduction of hours of that covered employee's employment.

(f) The qualifying event of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the qualifying event giving rise to the period of COBRA continuation coverage during which the child is born or placed for adoption. If a second qualifying event has occurred before the child is born or placed for adoption (such as the death of the covered employee), then the second qualifying event also applies to the newborn or adopted child. See Q&A-6 of §54.4980B-7.

(g) The rules of this Q&A-1 are illustrated by the following examples, in each of which the group health plan is subject to COBRA:

Example 1. (i) An employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, beginning with the day after the last day of employment, is given 3 months of employer-paid coverage under the same terms and conditions as before that date. At the end of the three months, the coverage terminates.

(ii) The loss of coverage at the end of the three months results from the termination of employment and, thus, the termination of employment is a qualifying event.

Example 2. (i) An employee who is covered by a group health plan retires (which is a termination of employment other than by reason of the employee's gross misconduct) and, upon retirement, is required to pay an increased amount for the same group health coverage that the employee had before retirement.

(ii) The increase in the premium or contribution required for coverage is a loss of coverage under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event.

Example 3. (i) An employee and the employee's spouse are covered under an employer's group health plan. The employee retires and is given identical coverage for life. However, the plan provides that the spousal coverage will not be continued beyond six months unless a higher premium for the spouse is paid to the plan.

(ii) The requirement for the spouse to pay a higher premium at the end of the six months is a loss of coverage under paragraph (c) of this Q&A-1. Thus, the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse becomes covered under the plan. (See Q&A-5 in §54.4980B-5, paragraph (c) in Q&A-4 of §54.4980B-5, section 9801(f)(2), and §54.9801-6T(b).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

(ii) *G*'s death is not a qualifying event because *G* is not a covered employee.

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to eliminate coverage for retired employees effective January 1, 2002. On that date, several retired em-

ployees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their spouses and dependent children) under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event. The plan must make COBRA continuation coverage available to them for the balance of the maximum coverage period that applies to them in connection with the retirement.

Q-2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

A-2: Apart from facts constituting gross misconduct, the facts surrounding the termination or reduction of hours are irrelevant in determining whether a qualifying event has occurred. Thus, it does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or a lockout is a termination or reduction of hours that constitutes a qualifying event if the strike or lockout results in a loss of coverage as described in paragraph (c) of Q&A-1 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

§54.4980B-5 COBRA continuation coverage.

The following questions-and-answers address the requirements for coverage to constitute COBRA continuation coverage:

Q-1: What is COBRA continuation coverage?

A-1: (a) If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the qualified beneficiary had on the day before the qualifying event). See Q&A-3 of §54.4980B-3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage under the plan is modified for similarly situated

nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A-1 of §54.4980B-4 is disregarded for purposes of this Q&A-1 and for purposes of any other reference in §§54.4980B-1 through 54.4980B-8 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A-4 of this section.

Q-2: What deductibles apply if COBRA continuation coverage is elected?

A-2: (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A-2. Special

rules are set forth in paragraph (e) of this Q&A-2, and examples appear in paragraph (f) of this Q&A-2.

(b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.

(c) If a deductible is computed on a family basis, the remaining deductible for the family on the date that COBRA continuation coverage begins depends on the members of the family electing COBRA continuation coverage. In computing the family deductible that remains on the date COBRA continuation coverage begins, only the expenses of those family members receiving COBRA continuation coverage need be taken into account. If the qualifying event results in there being more than one family unit (for example, because of a divorce), the family deductible may be computed separately for each resulting family unit based on the members in each unit. These rules apply regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.

(d) Deductibles that are not described in paragraph (b) or (c) of this Q&A-2 must be treated in a manner consistent with the principles set forth in those paragraphs.

(e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount and the employee remains employed during the period of COBRA continuation coverage, the plan is permitted to choose whether to apply the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began, or to apply the deductible by taking the employee's actual compensation into account. In applying a deductible that is computed on the basis of the covered employee's compensation instead of being a fixed dollar amount, for periods of COBRA continuation coverage in which the employee is not employed by the em-

ployer, the plan is required to compute the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage either at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began or at the level that was used to compute the deductible in effect immediately before the employee's employment was terminated.

(f) The rules of this Q&A-2 are illustrated by the following examples; in each example, deductibles under the plan are determined on a calendar year basis:

Example 1. (i) A group health plan applies a separate \$100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred \$80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred \$120 of covered expenses (and therefore has already satisfied the deductible).

(ii) At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of \$20, the older child still has the full \$100 deductible, and the younger one has no further deductible.

Example 2. (i) A group health plan applies a separate \$200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred \$500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated \$420 of covered expenses before the divorce, as follows: \$70 by each parent, \$200 by the oldest child, \$80 by the youngest child, and none by the other two children.

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of \$270 of covered expenses, and thus the remaining deductible for that family could be as high as \$230 (because the plan would not have to count the incurred expenses of the covered employee and the youngest child). The remaining deductible for the resulting family consisting of the covered employee and the two youngest children is not subject to the rules of this Q&A-2 because their coverage is not COBRA continuation coverage.

Example 3. Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits during the

year. A qualified beneficiary whose election of COBRA continuation coverage takes effect beginning August 1, 2001 and who has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 2001.

Example 4. (i) A group health plan has a \$250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of \$150 from January through September of 2001 and \$40 during October elects COBRA continuation coverage beginning November 1, 2001.

(ii) The remaining deductible amount for this qualified beneficiary is \$60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of \$50 in November and December of 2001 combined (so that the \$250 deductible for 2001 is not satisfied), the \$90 incurred from October through December of 2001 are credited toward satisfaction of the deductible amount for 2002.

Q-3: How do a plan's limits apply to COBRA continuation coverage?

A-3: (a) Limits are treated in the same way as deductibles (see Q&A-2 of this section). This rule applies both to limits on plan benefits (such as a maximum number of hospital days or dollar amount of reimbursable expenses) and limits on out-of-pocket expenses (such as a limit on copayments, a limit on deductibles plus copayments, or a catastrophic limit). This rule applies equally to annual and lifetime limits and applies equally to limits on specific benefits and limits on benefits in the aggregate under the plan.

(b) The rule of this Q&A-3 is illustrated by the following examples; in each example limits are determined on a calendar year basis:

Example 1. (i) A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 2001 terminates employment and elects COBRA continuation coverage as of that date.

(ii) During the remainder of the year 2001 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2. (i) A group health plan reimburses a maximum of \$20,000 of covered expenses per family per year, and the same \$20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 2001, and the spouse elects COBRA continuation coverage as of that date. In 2001, the employee had incurred \$5,000 of expenses and the spouse had incurred \$8,000 before May 1.

(ii) The plan can limit its reimbursement of the amount of expenses incurred by the spouse on and

after May 1 for the remainder of the year to \$12,000 (\$20,000 - \$8,000 = \$12,000). The remaining limit for the employee is not subject to the rules of this Q&A-3 because the employee's coverage is not COBRA continuation coverage.

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a \$100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of \$2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred \$600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of \$1,100. This resulted in total out-of-pocket costs for these three individuals of \$800 (\$300 total for the three deductibles, plus \$500 for 20 percent of the other \$2,500 in incurred expenses [$\$600 + \$1,100 + \$1,100 = \$2,800$; $\$2,800 - \$300 = \$2,500$]).

(ii) For the remainder of 2001, the resulting family consisting of the spouse and two children has an out-of-pocket limit of \$1,200 ($\$2,000 - \$800 = \$1,200$). The remaining out-of-pocket limit for the resulting family consisting of the employee and one child is not subject to the rules of this Q&A-3 because their coverage is not COBRA continuation coverage.

Q-4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

A-4: (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific health maintenance organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A-4 and in Q&A-1 of this section (regarding changes to or elimination of the coverage provided to similarly situated nonCOBRA beneficiaries).

(b) If a qualified beneficiary participates in a region-specific benefit package

(such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).

(c) If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members.

(d) The rules of this Q&A-4 are illustrated by the following examples:

Example 1. (i) *E* is an employee who works for an employer that maintains several group health plans. Under the terms of the plans, if an employee chooses to cover any family members under a plan,

all family members must be covered by the same plan and that plan must be the same as the plan covering the employee. Immediately before *E*'s termination of employment (for reasons other than gross misconduct), *E* is covered along with *E*'s spouse and children by a plan. The coverage under that plan will end as a result of the termination of employment.

(ii) Upon *E*'s termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when *E* terminates employment.

(iii) COBRA continuation coverage is elected for each of the four family members. Three months after *E*'s termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage.

(iv) During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each qualified beneficiary were an individual employee). For example, each member of *E*'s family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, the plan can require payment for each family member that is based on the applicable premium for individual coverage under that separate plan. See Q&A-1 of §54.4980B-8.

Example 2. (i) The facts are the same as in *Example 1*, except that *E*'s family members are not covered under *E*'s group health plan when *E* terminates employment.

(ii) Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, *E* must be allowed to add them to *E*'s COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A-1 of §54.4980B-3).

Q-5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

A-5: (a) Yes. Under section 9801 and §54.9801-6T, employees eligible to participate in a group health plan (whether or not participating), as well as former employees participating in a plan (referred to in those rules as participants), are entitled to special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for

adoption, if certain requirements are satisfied. Employees not participating in the plan also can obtain rights for self-enrollment under those rules. Once a qualified beneficiary is receiving COBRA continuation coverage (that is, has timely elected and made timely payment for COBRA continuation coverage), the qualified beneficiary has the same right to enroll family members under those special enrollment rules as if the qualified beneficiary were an employee or participant within the meaning of those rules. However, neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.

(b) In addition to the special enrollment rights described in paragraph (a) of this Q&A-5, if the plan covering the qualified beneficiary provides that new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary.

(c) If the addition of a new family member will result in a higher applicable premium (for example, if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the payment of a correspondingly higher amount for the COBRA continuation coverage. See Q&A-1 of §54.4980B-8.

(d) The right to add new family members under this Q&A-5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A-1 in §54.4980B-3.

§54.4980B-6 Electing COBRA continuation coverage.

The following questions-and-answers address the manner in which COBRA continuation coverage is elected:

Q-1: What is the election period and how long must it last?

A-1: (a) A group health plan can condition the availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA

continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A-1 of §54.4980B-4 for the meaning of lose coverage.) The election period must not end before the date that is 60 days after the later of –

(1) The date the qualified beneficiary would lose coverage on account of the qualifying event; or

(2) The date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage.

(b) An election is considered to be made on the date it is sent to the plan administrator.

(c) The rules of this Q&A-1 are illustrated by the following example:

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under section 4980B(f)(8)).

(ii) *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment, and in certain circumstances might be provided for a shorter period (see Q&A-1 of §54.4980B-7).

Q-2: Is a covered employee or qualified beneficiary responsible for informing

the plan administrator of the occurrence of a qualifying event?

A-2: (a) In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan or a divorce or legal separation of a covered employee. The group health plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the plan administrator within 60 days after the later of –

(1) The date of the qualifying event; or

(2) The date the qualified beneficiary would lose coverage on account of the qualifying event.

(b) For purposes of this Q&A-2, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of those qualified beneficiaries will be sufficient to preserve the election rights of all of the qualified beneficiaries.

Q-3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

A-3: (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A-4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A-3.

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the

qualified beneficiary and reinstate her or him when the election is made. Claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made. If a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights during the election period. For example, if the plan provides coverage during the election period but cancels coverage retroactively if COBRA continuation coverage is not elected, then the plan must inform a provider that a qualified beneficiary for whom coverage has not been elected is covered but that the coverage is subject to retroactive termination. Similarly, if the plan cancels coverage but then retroactively reinstates it once COBRA continuation coverage is elected, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA continuation coverage is elected. (See paragraph (c) of Q&A-5 in §54.4980B-8 for similar rules that a plan must follow in confirming coverage during a period when the plan has not received payment but that is still within the grace period for a qualified beneficiary for whom COBRA continuation coverage has been elected.)

(c)(1) In the case of a group health plan that provides health services (such as a health maintenance organization or a walk-in clinic), the plan can require with respect to a qualified beneficiary who has not elected and paid for COBRA continuation coverage that the qualified beneficiary choose between –

(i) Electing and paying for the coverage; or

(ii) Paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after the election of COBRA continuation coverage (and, if applicable, the payment of any balance due for the coverage).

(2) In the alternative, the plan can provide continued coverage and treat the

qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed that use of the facility will be a constructive election before using the facility.

Q-4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

A-4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

Q-5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

A-5: No. An employer, and an employee organization, must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

Q-6: Can each qualified beneficiary make an independent election under COBRA?

A-6: Yes. Each qualified beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to

make an independent election to receive COBRA continuation coverage. If the plan allows similarly situated active employees with respect to whom a qualifying event has not occurred to choose among several options during an open enrollment period (for example, to switch to another group health plan or to another benefit package under the same group health plan), then each qualified beneficiary must also be offered an independent election to choose during an open enrollment period among the options made available to similarly situated active employees with respect to whom a qualifying event has not occurred. If a qualified beneficiary who is either a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to that qualifying event. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. (See also Q&A-5 of §54.4980B-7 relating to the independent right of each qualified beneficiary with respect to the same qualifying event to receive COBRA continuation coverage during the disability extension.) The rules of this Q&A-6 are illustrated by the following examples; in each example each group health plan is subject to COBRA:

Example 1. (i) Employee *H* and *H*'s spouse are covered under a group health plan immediately before *H*'s termination of employment (for reasons other than gross misconduct). Coverage under the plan will end as a result of the termination of employment.

(ii) Upon *H*'s termination of employment, both *H* and *H*'s spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, *H* might elect COBRA continuation coverage while the spouse declines to elect such coverage, or *H* might elect COBRA continuation coverage for both of them. In contrast, *H* cannot decline COBRA continuation coverage on behalf of *H*'s spouse. Thus, if *H* does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2. (i) An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the employee share of the cost for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars.

(ii) If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's coverage was paid for before the qualifying event.

§54.4980B-7 Duration of COBRA continuation coverage.

The following questions-and-answers address the duration of COBRA continuation coverage:

Q-1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

A-1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A-4 of §54.4980B-6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates –

(1) The last day of the maximum required period under section 4980B(f)(2)(B)(i) (the maximum coverage period) and, if applicable, section 4980B(f)(8) (relating to the optional extension of required periods in a case where coverage is lost after the date of, instead of on the date of, the qualifying event);

(2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-5 in §54.4980B-8);

(3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A-2 of this section; and

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare bene-

fits, as described in Q&A-3 of this section.

(b) However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries. For example, if a group health plan terminates the coverage of active employees for the submission of a fraudulent claim, then the coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim. Notwithstanding the preceding two sentences, the coverage of a qualified beneficiary can be terminated for failure to make timely payment to the plan only if payment is not timely under the rules of Q&A-5 in §54.4980B-8.

(c) In the case of an individual who is not a qualified beneficiary and who is receiving coverage under a group health plan solely because of the individual's relationship to a qualified beneficiary, if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q-2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

A-2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A-2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) The requirement of this paragraph (b) is satisfied if the qualified beneficiary is actually covered, rather than merely eligible to be covered, under the other group health plan.

(c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.

(d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).

(e) The rules of this Q&A-2 are illustrated by the following examples:

Example 1. (i) Employer *X* maintains a group health plan subject to COBRA. *C* is an employee covered under the plan. *C* is also covered under a group health plan maintained by Employer *Y*, the employer of *C*'s spouse. *C* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *C* to lose coverage under *X*'s plan (and, thus, is a qualifying event). *C* elects to receive COBRA continuation coverage under *X*'s plan.

(ii) Under these facts, *X*'s plan cannot terminate *C*'s COBRA continuation coverage on the basis of *C*'s coverage under *Y*'s plan.

Example 2. (i) Employer *W* maintains a group health plan subject to COBRA. *D* is an employee covered under the plan. *D* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *D* to lose coverage under *W*'s plan (and, thus, is a qualifying event). *D* elects to receive COBRA continuation coverage under *W*'s plan. Later *D* becomes employed by Employer *V* and is covered under *V*'s group health plan. *D*'s coverage under *V*'s plan is not subject to any exclusion or limitation with respect to any preexisting condition of *D*.

(ii) Under these facts, *W* can terminate *D*'s COBRA continuation coverage on the date *D* becomes covered under *V*'s plan.

Example 3. (i) The facts are the same as in *Example 2*, except that *D* becomes employed by *V* and becomes covered under *V*'s group health plan before *D* elects COBRA continuation coverage under *W*'s plan.

(ii) Because the termination of employment is a qualifying event, *D* must be offered COBRA continuation coverage under *W*'s plan, and *W* is not permitted to terminate *D*'s COBRA continuation coverage on account of *D*'s coverage under *V*'s plan because *D* first became covered under *V*'s plan before COBRA continuation coverage was elected for *D*.

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

A-3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Q-4: **[Reserved]**

A-4: **[Reserved]**

Q-5: How does a qualified beneficiary become entitled to a disability extension?

A-5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A-5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently with respect to each of the qualified beneficiaries. See Q&A-1 in §54.4980B-8, which permits a plan to require payment of an increased amount during the disability extension.

(b) The requirement of this paragraph (b) is satisfied if a qualifying event occurs that is a termination, or reduction of hours, of a covered employee's employment.

(c) The requirement of this paragraph (c) is satisfied if an individual (whether or

not the covered employee) who is a qualified beneficiary in connection with the qualifying event described in paragraph (b) of this Q&A-5 is determined under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) to have been disabled at any time during the first 60 days of COBRA continuation coverage. For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A-5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods in accordance with section 4980B(f)(8), then the period of the first 60 days of COBRA continuation coverage is measured from the date on which the coverage would be lost). However, in the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (c), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.

(d) The requirement of this paragraph (d) is satisfied if any of the qualified beneficiaries affected by the qualifying event described in paragraph (b) of this Q&A-5 provides notice to the plan administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the qualifying event.

Q-6: Under what circumstances can the maximum coverage period be expanded?

A-6: (a) The maximum coverage period can be expanded if the requirements of Q&A-5 of this section (relating to the

disability extension) or paragraph (b) of this Q&A-6 are satisfied.

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of the employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003.

Q-7: If health coverage is provided to a qualified beneficiary after a qualifying

event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

A-7: (a) No. The end of the maximum coverage period is measured solely as described in Q&A-1 and Q&A-6 of this section, which is generally from the date of the qualifying event.

(b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries for the coverage that the qualified beneficiary can elect to receive as COBRA continuation coverage, the plan covering the qualified beneficiary immediately before the qualifying event must offer the qualified beneficiary receiving the alternative coverage the opportunity to elect COBRA continuation coverage. See Q&A-1 of §54.4980B-6.

(c) If an individual rejects COBRA continuation coverage in favor of alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if the individual receiving alternative coverage is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

Q-8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

A-8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expi-

ration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

§54.4980B-8 Paying for COBRA continuation coverage.

The following questions-and-answers address paying for COBRA continuation coverage:

Q-1: Can a group health plan require payment for COBRA continuation coverage?

A-1: (a) Yes. For any period of COBRA continuation coverage, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. (See paragraph (b) of this Q&A-1 for a rule permitting a plan to require payment of an increased amount due to the disability extension.) The *applicable premium* is defined in section 4980B(f)(4). A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A-1 of §54.4980B-7). For the meaning of *timely payment*, see Q&A-5 of this section.

(b) A group health plan is permitted to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary (for example, whether single or family coverage) if the coverage would not be required to be made available in the absence of a disability extension. (See Q&A-5 of §54.4980B-7 for rules to determine whether a qualified beneficiary is entitled to a disability extension.) A plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage to which a qualified beneficiary is entitled without regard to the disability extension. Thus, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event within the original 18-month maxi-

um coverage period, then the plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage. By contrast, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event after the end of the original 18-month maximum coverage period, then the plan may require the payment of an amount that is up to 150 percent of the applicable premium for the remainder of the period of COBRA continuation coverage (that is, from the beginning of the 19th month through the end of the 36th month) as long as the disabled qualified beneficiary is included in that coverage. The rules of this paragraph (b) are illustrated by the following examples; in each example the group health plan is subject to COBRA:

Example 1. (i) An employer maintains a group health plan. The plan determines the cost of covering individuals under the plan by reference to two categories, individual coverage and family coverage, and the applicable premium is determined for those two categories. An employee and members of the employee's family are covered under the plan. The employee experiences a qualifying event that is the termination of the employee's employment. The employee's family qualifies for the disability extension because of the disability of the employee's spouse. (Timely notice of the disability is provided to the plan administrator.) Timely payment of the amount required by the plan for COBRA continuation coverage for the family (which does not exceed 102 percent of the cost of family coverage under the plan) was made to the plan with respect to the employee's family for the first 18 months of COBRA continuation coverage, and the disabled spouse and the rest of the family continue to receive COBRA continuation coverage through the 29th month.

(ii) Under these facts, the plan may require payment of up to 150 percent of the applicable premium for family coverage in order for the family to receive COBRA continuation coverage from the 19th month through the 29th month. If the plan determined the cost of coverage by reference to three categories (such as employee, employee-plus-one-dependent, employee-plus-two-or-more-dependents) or more than three categories, instead of two categories, the plan could still require, from the 19th month through the 29th month of COBRA continuation coverage, the payment of 150 percent of the cost of coverage for the category of coverage that included the disabled spouse.

Example 2. (i) The facts are the same as in *Example 1*, except that only the covered employee elects and pays for the first 18 months of COBRA continuation coverage.

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the

plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

(c) A group health plan does not fail to comply with section 9802(b) and §54.9802-1T(b) (which generally prohibit an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A-1.

Q-2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

A-2: (a) The applicable premium for each determination period must be computed and fixed by a group health plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. The determination period is a single period for any benefit package. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified beneficiary.

(b) During a determination period, a plan can increase the amount it requires to be paid for a qualified beneficiary's COBRA continuation coverage only in the following three cases:

(1) The plan has previously charged less than the maximum amount permitted under Q&A-1 of this section and the increased amount required to be paid does not exceed the maximum amount permitted under Q&A-1 of this section;

(2) The increase occurs during the disability extension and the increased amount required to be paid does not ex-

ceed the maximum amount permitted under paragraph (b) of Q&A-1 of this section; or

(3) A qualified beneficiary changes the coverage being received (see paragraph (c) of this Q&A-2 for rules on how the amount the plan requires to be paid may or must change when a qualified beneficiary changes the coverage being received).

(c) If a plan allows similarly situated active employees who have not experienced a qualifying event to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage being received on the same terms as the similarly situated active employees. (See Q&A-4 in §54.4980B-5.) If a qualified beneficiary changes coverage from one benefit package (or a group of benefit packages) to another benefit package (or another group of benefit packages), or adds or eliminates coverage for family members, then the following rules apply. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as family coverage, self-plus-one-dependent, or self-plus-two-or-more-dependents) for which the applicable premium is higher, then the plan may increase the amount that it requires to be paid for COBRA continuation coverage to an amount that does not exceed the amount permitted under Q&A-1 of this section as applied to the new coverage. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as individual or self-plus-one-dependent) for which the applicable premium is lower, then the plan cannot require the payment of an amount that exceeds the amount permitted under Q&A-1 of this section as applied to the new coverage.

Q-3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

A-3: Yes. A group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow the alternative of payment for COBRA continuation coverage being made at other intervals (for example, weekly, quarterly, or semiannually).

Q-4: Is a plan required to allow a qual-

ified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

A-4: No. A plan is permitted to apply the first payment for COBRA continuation coverage to the period of coverage beginning immediately after the date on which coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to the period of the waiver.

Q-5: What is timely payment for COBRA continuation coverage?

A-5: (a) Except as provided in this paragraph (a) or in paragraph (b) or (d) of this Q&A-5, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered timely payment if either –

(1) Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or

(2) Under the terms of an arrangement between the employer or employee organization and an insurance company, health maintenance organization, or other entity that provides plan benefits on the employer's or employee organization's behalf, the employer or employee organization is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.

(b) Notwithstanding paragraph (a) of this Q&A-5, a plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary.

(c) If, after COBRA continuation coverage has been elected for a qualified beneficiary, a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary for a period for which the plan has not yet received pay-

ment, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights, if any, described in paragraphs (a), (b), and (d) of this Q&A-5. For example, if the plan provides coverage during the 30- and 45-day grace periods described in paragraphs (a) and (b) of this Q&A-5 but cancels coverage retroactively if payment is not made by the end of the applicable grace period, then the plan must inform a provider with respect to a qualified beneficiary for whom payment has not been received that the qualified beneficiary is covered but that the coverage is subject to retroactive termination if timely payment is not made. Similarly, if the plan cancels coverage if it has not received payment by the first day of a period of coverage but retroactively reinstates coverage if payment is made by the end of the grace period for that period of coverage, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the first date of the period if timely payment is made. (See paragraph (b) of Q&A-3 in §54.4980B-6 for similar rules that the plan must follow in confirming coverage during the election period.)

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time.

(e) Payment is considered made on the date on which it is sent to the plan.

PART 602 – OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

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

Authority: 26 U.S.C. 7805.

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

§602.101 OMB Control numbers.

* * * * *

(c) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
54.4980B-6	1545-1581
54.4980B-7	1545-1581
54.4980B-8	1545-1581
* * * * *	

Robert E. Wenzel,
Deputy Commissioner of
Internal Revenue.

Approved December 28, 1998.

Donald C. Lubick,
Assistant Secretary of
the Treasury
(Tax Policy).

(Filed by the Office of the Federal Register on February 2, 1999, 8:45 a.m., and published in the issue of the Federal Register for February 3, 1999, 64 F.R. 5160)

Section 6038B.—Notice of Certain Transfers to Foreign Persons

26 CFR 1.6038B-2: Reporting of certain transfers to foreign partnerships.

T.D. 8817

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

Notice of Certain Transfers to Foreign Partnerships and Foreign Corporations

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations under section 6038B relating to information reporting require-

ments for certain transfers by United States persons to foreign partnerships. The regulations implement amendments made by the Taxpayer Relief Act of 1997 that require a United States person who transfers property to a foreign partnership to furnish certain information with respect to such transfer. This document also contains final regulations that require certain cash transfers to foreign corporations to be reported. The regulations provide guidance needed to comply with the reporting requirements with respect to transfers of cash to foreign corporations and transfers of property to foreign partnerships.

DATES: Effective Dates: These regulations are effective January 1, 1998, except that the amendments to §1.6038B-1 are effective February 5, 1999.

Dates of Applicability: For dates of applicability of the amendments to §1.6038B-1, see §1.6038B-1(g). For dates of applicability of §1.6038B-2, see §1.6038B-2(j).

FOR FURTHER INFORMATION CONTACT: Eliana Dolgoff, 202-622-3860 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in these final regulations have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-1615. Responses to these collections of information are mandatory.

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

The collections of information contained in these final regulations are in §§1.6038B-1(b) and 1.6038B-2. The burden of complying with the collection of information required to be reported on Form 8865 is reflected in the burden for Form 8865. The burden of complying with the collection of information required to be reported on Form 926 is reflected in the burden for Form 926.

Comments concerning the accuracy of the burden estimates and suggestions for reducing the burden should be sent to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, OP:FS:FP, Washington, DC 20224, and 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.

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

Background

On September 9, 1998, the IRS published in the **Federal Register** proposed regulations (REG-118926-97, 1998-39 I.R.B. 23) relating to the reporting of certain transfers to foreign corporations and foreign partnerships under section 6038B. A public hearing was held on November 10, 1998, even though no requests to speak at the hearing were received. Written comments regarding the proposed regulations, however, were received. After consideration of all of the comments received, the proposed regulations under section 6038B are adopted as revised by this Treasury decision. The revisions are discussed below.

Public Comments

Some commentators suggested that the final regulations provide that state and local government employee retirement plans be exempt from the section 6038B reporting requirements, asserting that contributions from such plans to foreign partnerships will not have federal income tax consequences. The final regulations provide that trusts relating to state and local government employee retirement plans are not required to report transfers to foreign partnerships under section 6038B, unless required to do so in the instructions to Form 8865.

One commentator noted that under the proposed regulations, if a United States person transfers property other than cash with a value in excess of \$100,000 to a foreign partnership, such person must report the names and addresses of all the

other partners of the partnership, regardless of the size of the person's ownership interest in the foreign partnership after the transfer. The commentator requested that the final regulations provide that if a United States person owns less than a 10 percent interest in the foreign partnership after the transfer, regardless of the type of property transferred, such person does not have to report the names and addresses of all the other partners. Alternatively, the commentator requested that it be recognized that a person that makes a good faith effort to obtain such information will have reasonable cause preventing the imposition of any penalties under section 6038B if such person fails to obtain and submit the information.

The final regulations do not adopt the commentator's recommendations. As in the proposed regulations, the final regulations contain a reasonable cause exception that, if satisfied, prevents the IRS from imposing penalties under section 6038B. Whether reasonable cause exists for a failure to comply with the requirements of section 6038B is determined by the district director under all the facts and circumstances. Although the final regulations do not explicitly say so, a failure to submit the names and addresses of the other partners will constitute a failure to comply with the requirements of section 6038B and therefore will always be subject to the reasonable cause exception.

Commentators also questioned whether United States persons must report indirect transfers from a foreign partnership to another foreign partnership. The final regulations reserve on such reporting. If a foreign partnership transfers property to another foreign partnership, a United States person that is a partner of the transferor partnership is not required to report that transfer until such time as the IRS and Treasury implement rules requiring such reporting. However, the IRS remains concerned about transfers from one foreign partnership to another. In conjunction with its study of section 721(c), the IRS is evaluating whether there is a need for the reporting of transfers from foreign partnerships to foreign partnerships.

The final regulations also clarify that if a domestic partnership contributes property to a foreign partnership, the partners of the domestic partnership will be considered to have contributed a proportion-

ate share of the property transferred. Therefore, the partners of the transferor domestic partnership may be required to report under section 6038B transfers made by the transferor partnership. The proposed regulations provide, however, that an indirect transferor does not have to report the contribution on Form 8865 if certain conditions are satisfied, including the filing by the indirect transferor of a statement with the IRS. In an attempt to reduce the burden imposed on taxpayers, the final regulations eliminate the requirement that indirect transferors must file a statement. If the domestic transferor partnership properly reports the transfer of property to a foreign partnership, a United States person that is an indirect transferor need not report the transfer.

The final regulations also modify the reporting requirements with respect to deemed contributions. The proposed regulations provided that if by reason of an adjustment under section 482 a contribution required to be reported under section 6038B is deemed to have been made, the information required to be reported will be furnished timely if filed by the due date (including extensions) of the income tax return for the taxable year during which the adjustment is made. The final regulations provide that deemed contributions resulting from IRS-initiated section 482 adjustments are not required to be reported under section 6038B. However, taxpayers must report deemed contributions resulting from taxpayer-initiated adjustments. Such information will be furnished timely if filed by the due date, including extensions, for filing the taxpayer's income tax return for the year in which the taxpayer makes the section 482 adjustment.

Additionally, the final regulations clarify that a transfer to a foreign partnership made on or after January 1, 1998, but before January 1, 1999, will be considered timely reported either if it is reported on a Form 8865 attached to the taxpayer's income tax return for the first taxable year beginning on or after January 1, 1999, or it is reported on a Form 926 attached to the taxpayer's income tax return for the taxable year in which the transfer occurred.

The final regulations also clarify that transfers that were made between August 5, 1997, and January 1, 1998, may be reported in accordance with the provisions

of the final section 6038B regulations or in accordance with Notice 98-17(1998-11 IRB 6).

Special Analyses

It has been determined that this regulation is not a significant regulatory action as defined in EO 12866. Therefore, a regulatory assessment is not required. It is hereby certified that the collections of information contained in this regulation will not have a significant economic impact on a substantial number of small entities. This certification is based upon the fact that these final regulations reduce or eliminate the reporting requirements for certain United States persons. Moreover, in general, only a United States person that owns a significant interest in a foreign partnership, or transfers a substantial amount to a foreign partnership, will be subject to these regulations. Thus, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on the impact of the proposed regulations on small business.

Drafting Information

The principal authors of these regulations are Eliana Dolgoff and Philip Tretiak of the Office of Associate Chief Counsel (International). However, other personnel from the IRS and Treasury Department participated in their development.

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Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding entries in numerical order to read in part as follows:

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

Section 1.6038B-1 also issued under 26 U.S.C. 6038B.

Section 1.6038B-2 also issued under 26 U.S.C. 6038B. * * *

Par. 2. Section 1.6038B-1 is amended as follows:

1. The section heading is revised.
2. Paragraph (b)(1)(i), first sentence, is revised.
3. The text of paragraph (b)(3) is added.
4. Paragraph (c), first sentence, is revised
5. Paragraph (g) is revised.

The additions and revisions read as follows:

§1.6038B-1 Reporting of certain transfers to foreign corporations.

* * * * *

(b) *Time and manner of reporting*—(1) *In general*—(i) *Reporting procedure*. Except for stock or securities qualifying under the special reporting rule of paragraph (b)(2) of this section, or cash, which is subject to special rules contained in paragraph (b)(3) of this section, any U.S. person that makes a transfer described in section 6038B(a)(1)(A), 367(d) or (e)(1), is required to report pursuant to section 6038B and the rules of this section and must attach the required information to Form 926, “Return by Transferor of Property to a Foreign Corporation.” * * *

* * * * *

(3) *Special rule for transfers of cash*. A U.S. person that transfers cash to a foreign corporation must report the transfer if—

- (i) Immediately after the transfer such person holds directly, indirectly, or by attribution (determined under the rules of section 318(a), as modified by section 6038(e)(2)) at least 10 percent of the total voting power or the total value of the foreign corporation; or
- (ii) The amount of cash transferred by such person or any related person (determined under section 267(b)(1) through (3) and (10) through (12)) to such foreign corporation during the 12-month period ending on the date of the transfer exceeds \$100,000. * * * * *

(c) *Information required with respect to transfers described in section 6038B(a)(1)(A)*. A United States person that transfers property to a foreign corporation in an exchange described in section 6038B(a)(1)(A) (including cash and other unappreciated property) must provide the

following information, in paragraphs labeled to correspond with the number or letter set forth in this paragraph (c) and §1.6038B-1T(c)(1) through (5). * * *

* * * * *

(g) *Effective dates*. This section applies to transfers occurring on or after July 20, 1998, except that the first sentence of paragraph (b)(1)(i), paragraph (b)(3), and the first sentence of paragraph (c) apply to transfers occurring in taxable years beginning after February 5, 1999. See §1.6038B-1T for transfers occurring prior to July 20, 1998.

Par. 3. Section 1.6038B-2 is added to read as follows:

§1.6038B-2 Reporting of certain transfers to foreign partnerships.

(a) *Reporting requirements*—(1) *Requirement to report transfers*. A United States person that transfers property to a foreign partnership in a contribution described in section 721 (including section 721(b)) must report that transfer on Form 8865 “Information Return of U.S. Persons With Respect To Certain Foreign Partnerships” pursuant to section 6038B and the rules of this section, if—

- (i) Immediately after the transfer, the United States person owns, directly, indirectly, or by attribution, at least a 10-percent interest in the partnership, as defined in section 6038(e)(3)(C) and the regulations thereunder; or
- (ii) The value of the property transferred, when added to the value of any other property transferred in a section 721 contribution by such person (or any related person) to such partnership during the 12-month period ending on the date of the transfer, exceeds \$100,000.

(2) *Indirect transfer through a domestic partnership*—For purposes of this section, if a domestic partnership transfers property to a foreign partnership in a section 721 transaction, the domestic partnership’s partners shall be considered to have transferred a proportionate share of the property to the foreign partnership. However, if the domestic partnership properly reports all of the information required under this section with respect to the contribution, no partner of the transferor partnership, whether direct or indirect (through tiers of partnerships), is also

required to report under this section. For illustrations of this rule, see *Examples 4* and 5 of paragraph (a)(7) of this section.

(3) *Indirect transfer through a foreign partnership*. [Reserved]

(4) *Requirement to report dispositions*—(i) *In general*. If a United States person was required to report a transfer to a foreign partnership of appreciated property under paragraph (a)(1) or (2) of this section, and the foreign partnership disposes of the property while such United States person remains a direct or indirect partner, that United States person must report the disposition by filing Form 8865. The form must be attached to, and filed by the due date (including extensions) of, the United States person’s income tax return for the year in which the disposition occurred.

(ii) *Disposition of contributed property in nonrecognition transaction*. If a foreign partnership disposes of contributed appreciated property in a nonrecognition transaction and substituted basis property is received in exchange, and the substituted basis property has built-in gain under §1.704-3(a)(8), the original transferor is not required to report the disposition. However, the transferor must report the disposition of the substituted basis property in the same manner as provided for the contributed property.

(5) *Time for filing Form 8865*—(i) *General rule*. The Form 8865 on which a transfer is reported must be attached to the transferor’s timely filed (including extensions) income tax return (including a partnership return of income) for the tax year that includes the date of the transfer.

(ii) *Time for filing when transferor also required to report information about the partnership under section 6038*. If the United States person required to file under this section is also required to file a Form 8865 under section 6038 for the period in which the transfer occurs, then the United States person must report under this section on the Form 8865 for the foreign partnership’s annual accounting period in which the transfer occurred (not its own taxable year) and file with its income tax return for that year as provided in Section 6038 and the regulations thereunder.

(6) *Returns to be made*—(i) *Separate returns for each partnership*. If a United States person transfers property reportable under this section to more than

one foreign partnership in a taxable year, the United States person must submit a separate Form 8865 for each partnership.

(ii) *Duplicate form to be filed.* If required by the instructions accompanying Form 8865, a duplicate Form 8865 (including attachments and schedules) must also be filed by the due date for submitting the original Form 8865 under paragraph (a)(5)(i) or (ii) of this section, as applicable.

(7) *Examples.* The application of this paragraph (a) may be illustrated by the following examples:

Example 1. On November 1, 2001, *US*, a United States person that uses the calendar year as its taxable year, contributes \$200,000 to *FP*, a foreign partnership, in a transaction subject to section 721. After the contribution, *US* owns a 5% interest in *FP*. *US* must report the contribution by filing Form 8865 for its taxable year ending December 31, 2001. On March 1, 2002, *US* makes a \$40,000 section 721 contribution to *FP*, after which *US* owns a 6% interest in *FP*. *US* must report the \$40,000 contribution by filing Form 8865 for its taxable year ending December 31, 2002, because the contribution, when added to the value of the other property contributed by *US* to *FP* during the 12-month period ending on the date of the transfer, exceeds \$100,000.

Example 2. *F*, a nonresident alien, is the brother of *US*, a United States person. *F* owns a 15% interest in *FP*, a foreign partnership. *US* contributes \$99,000 to *FP*, in exchange for a 1-percent partnership interest. Under sections 6038(e)(3)(C) and 267(c)(2), *US* is considered to own at least a 10-percent interest in *FP* and, therefore, *US* must report the \$99,000 contribution under this section.

Example 3. *US*, a United States person, owns 40 percent of *FC*, a foreign corporation. *FC* owns a 20-percent interest in *FP*, a foreign partnership. Under section 267(c)(1), *US* is considered to own 8 percent of *FP* due to its ownership of *FC*. *US* contributes \$50,000 to *FP* in exchange for a 5-percent partnership interest. Immediately after the contribution, *US* is considered to own at least a 10-percent interest in *FP* and, therefore, must report the \$50,000 contribution under this section.

Example 4. *US*, a United States person, owns a 60-percent interest in *USP*, a domestic partnership. On March 1, 2001, *USP* contributes \$200,000 to *FP*, a foreign partnership, in exchange for a 5-percent partnership interest. Under paragraph (a)(2) of this section, *US* is considered as having contributed \$120,000 to *FP* ($\$200,000 \times 60\%$). However, under paragraph (a)(2), if *USP* properly reports the contribution to *FP*, *US* is not required to report its \$120,000 contribution. If *US* directly contributes \$5,000 to *FP* on June 10, 2001, *US* must report the \$5,000 contribution because *US* is considered to have contributed more than \$100,000 to *FP* in the 12-month period ending on the date of the \$5,000 contribution.

Example 5. *US*, a United States person, owns an 80-percent interest in *USP*, a domestic partnership. *USP* owns an 80-percent interest in *USP1*, a domestic partnership. On March 1, 2001, *USP1* con-

tributes \$200,000 to *FP*, a foreign partnership, in exchange for a 3-percent partnership interest. Under paragraph (a)(2) of this section, *USP* is considered to have contributed \$160,000 ($\$200,000 \times 80\%$) to *FP*. *US* is considered to have contributed \$128,000 to *FP* ($\$200,000 \times 80\% \times 80\%$). However, if *USP1* reports the transfer of the \$200,000 to *FP*, neither *US* nor *USP* are required to report under this section the amounts they are considered to have contributed. Additionally, regardless of whether *USP1* reports the \$200,000 contribution, if *USP* reports the \$160,000 contribution it is considered to have made, *US* does not have to report under this section the \$128,000 contribution *US* is considered to have made.

(b) *Transfers by trusts relating to state and local government employee retirement plans.* Trusts relating to state and local government employee retirement plans are not required to report transfers under this section, unless otherwise specified in the instructions to Form 8865.

(c) *Information required with respect to transfers of property.* With respect to transfers required to be reported under paragraph (a)(1) or (2) of this section, the return must contain information in such form or manner as Form 8865 (and its accompanying instructions) prescribes with respect to reportable events, including—

(1) The name, address, and U.S. taxpayer identification number of the United States person making the transfer;

(2) The name, U.S. taxpayer identification number (if any), and address of the transferee foreign partnership, and the type of entity and country under whose laws the partnership was created or organized;

(3) A general description of the transfer, and of any wider transaction of which it forms a part, including the date of transfer;

(4) The names and addresses of the other partners in the foreign partnership, unless the transfer is solely of cash and the transferor holds less than a 10-percent interest in the transferee foreign partnership immediately after the transfer;

(5) A description of the partnership interest received by the United States person, including a change in partnership interest;

(6) A separate description of each item of contributed property that is appreciated property subject to the allocation rules of section 704(c) (except to the extent that the property is permitted to be aggregated in making allocations under section

704(c)), or is intangible property, including its estimated fair market value and adjusted basis.

(7) A description of other contributed property, not specified in paragraph (c)(6) of this section, aggregated by the following categories (with, in each case, a brief description of the property)—

(i) Stock in trade of the transferor (inventory);

(ii) Tangible property (other than stock in trade) used in a trade or business of the transferor;

(iii) Cash;

(iv) Stock, notes receivable and payable, and other securities; and

(v) Other property.

(d) *Information required with respect to dispositions of property.* In respect of dispositions required to be reported under paragraph (a)(4) of this section, the return must contain information in such form or manner as Form 8865 (and its accompanying instructions) prescribes with respect to reportable events, including—

(1) The date and manner of disposition;

(2) The gain and depreciation recapture amounts, if any, realized by the partnership; and

(3) Any such amounts allocated to the United States person.

(e) *Method of reporting.* Except as otherwise provided on Form 8865, or the accompanying instructions, all amounts reported as required under this section must be expressed in United States currency, with a statement of the exchange rates used. All statements required on or with Form 8865 pursuant to this section must be in the English language.

(f) *Reporting under this section not required of partnerships excluded from the application of subchapter K—(1) Election to be wholly excluded.* The reporting requirements of this section will not apply to any United States person in respect of an eligible partnership as described in §1.761-2(a), if such partnership has validly elected to be excluded from all of the provisions of subchapter K of chapter 1 of the Internal Revenue Code in the manner specified in §1.761-2(b)(2)(i).

(2) *Deemed excluded.* The reporting requirements of this section will not apply to any United States person in respect of an eligible partnership as described in §1.761-2(a), if such partnership is validly

deemed to have elected to be excluded from all of the provisions of subchapter K of chapter 1 of the Internal Revenue Code in accordance with the provisions of §1.761-2(b)(2)(ii).

(g) *Deemed contributions.* Deemed contributions resulting from IRS-initiated section 482 adjustments are not required to be reported under section 6038B. However, taxpayers must report deemed contributions resulting from taxpayer-initiated adjustments. Such information will be furnished timely if filed by the due date, including extensions, for filing the taxpayer's income tax return for the year in which the adjustment is made.

(h) *Failure to comply with reporting requirements—(1) Consequences of failure.* If a United States person is required to file a return under paragraph (a) of this section and fails to comply with the reporting requirements of section 6038B and this section, then such person is subject to the following penalties:

(i) The United States person is subject to a penalty equal to 10 percent of the fair market value of the property at the time of the contribution. Such penalty with respect to a particular transfer is limited to \$100,000, unless the failure to comply with respect to such transfer was due to intentional disregard.

(ii) The United States person must recognize gain (reduced by the amount of any gain recognized, with respect to that property, by the transferor after the transfer) as if the contributed property had been sold for fair market value at the time of the contribution. Adjustments to the basis of the partnership's assets and any relevant partner's interest as a result of gain being recognized under this provision will be made as though the gain was recognized in the year in which the failure to report was finally determined.

(2) *Failure to comply.* A failure to comply with the requirements of section 6038B includes—

(i) The failure to report at the proper time and in the proper manner any information required to be reported under the rules of this section; and

(ii) The provision of false or inaccurate information in purported compliance with the requirements of this section.

(3) *Reasonable cause exception.* Under section 6038B(c)(2) and this sec-

tion, the provisions of paragraph (h)(1) of this section will not apply if the transferor shows that a failure to comply was due to reasonable cause and not willful neglect. The transferor may attempt to do so by providing a written statement to the district director having jurisdiction of the taxpayer's return for the year of the transfer, setting forth the reasons for the failure to comply. Whether a failure to comply was due to reasonable cause will be determined by the district director under all the facts and circumstances.

(4) *Statute of limitations.* For exceptions to the limitations on assessment in the event of a failure to provide information under section 6038B, see section 6501(c)(8).

(i) *Definitions—(1) Appreciated property.* Appreciated property is property that has a fair market value in excess of basis.

(2) *Domestic partnership.* A domestic partnership is a partnership described in section 7701(a)(4).

(3) *Foreign partnership.* A foreign partnership is a partnership described in section 7701(a)(5).

(4) *Related person.* Persons are related persons if they bear a relationship described in section 267(b)(1) through (3) or (10) through (12), after application of section 267(c) (except for (c)(3)), or in section 707(b)(1)(B).

(5) *Substituted basis property.* Substituted basis property is property described in section 7701(a)(42).

(6) *Taxpayer-initiated adjustment.* A taxpayer-initiated adjustment is a section 482 adjustment that is made by the taxpayer pursuant to §1.482-1(a)(3).

(7) *United States person.* A United States person is a person described in section 7701(a)(30).

(j) *Effective dates—(1) In general.* This section applies to transfers made on or after January 1, 1998. However, for a transfer made on or after January 1, 1998, but before January 1, 1999, the filing requirements of this section may be satisfied by—

(i) Filing a Form 8865 with the taxpayer's income tax return (including a partnership return of income) for the first taxable year beginning on or after January 1, 1999; or

(ii) Filing a Form 926 with the tax-

payer's income tax return (including a partnership return of income) for the taxable year in which the transfer occurred.

(2) Transfers made between August 5, 1997 and January 1, 1998. A United States person that made a transfer of property between August 5, 1997, and January 1, 1998, that is required to be reported under section 6038B may satisfy its reporting requirement by reporting in accordance with the provisions of this section or in accordance with the provisions of Notice 98-17 (1998-11 IRB 6)(see §601.601(d)(2) of this chapter).

* * * * *

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 4. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 5. In §602.101, paragraph (c) is amended by adding an entry in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(c) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
1.6038B-1	1545-1615
* * * * *	
1.6038B-2	1545-1615

Robert E. Wenzel,
Deputy Commissioner of
Internal Revenue.

Approved January 29, 1999.

Donald C. Lubick,
Assistant Secretary of
the Treasury.

(Filed by the Office of the Federal Register on February 4, 1999, 8:45 a.m., and published in the issue of the Federal Register for February 5, 1999, 64 F.R. 5713)

Part III. Administrative, Procedural, and Miscellaneous

Weighted Average Interest Rate Update

Notice 99-11

Notice 88-73 provides guidelines for determining the weighted average interest rate and the resulting permissible range of

interest rates used to calculate current liability for the purpose of the full funding limitation of § 412(c)(7) of the Internal Revenue Code as amended by the Omnibus Budget Reconciliation Act of 1987 and as further amended by the Uruguay Round Agreements Act, Pub. L. 103-465 (GATT).

The average yield on the 30-year Treasury Constant Maturities for January 1999 is 5.16 percent.

The following rates were determined for the plan years beginning in the month shown below.

Month	Year	Weighted Average	90% to 105% Permissible Range	90% to 110% Permissible Range
February	1999	6.19	5.57 to 6.50	5.57 to 6.81

Drafting Information

The principal author of this notice is Todd Newman of the Employee Plans Di-

vision. For further information regarding this notice, call (202) 622-6076 between 2:30 and 3:30 p.m. Eastern time (not a

toll-free number). Mr. Newman's number is (202) 622-8458 (also not a toll-free number).

Part IV. Items of General Interest

Notice of Proposed Rulemaking and Notice of Public Hearing

Consolidated Returns — Consolidated Overall Foreign Losses and Separate Limitation Losses

REG-106902-98

AGENCY: Internal Revenue Service (IRS), Treasury.

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

SUMMARY: This document contains proposed consolidated return regulations relating to the treatment of overall foreign losses and separate limitation losses in the computation of the foreign tax credit limitation. The proposed rules are necessary to modify existing guidance with respect to overall foreign losses and to provide guidance with respect to separate limitation losses. These proposed regulations affect consolidated groups that compute the foreign tax credit limitation or that dispose of property used in a foreign trade or business. This document also provides notice of a public hearing on these proposed regulations.

DATES: Written comments must be received by February 10, 1999. Outlines of oral comments to be discussed at the public hearing scheduled for 10 a.m. on February 17, 1999, must be received by January 27, 1999.

ADDRESSES: Send submissions to CC:DOM:CORP:R (REG-106902-98), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-106902-98), 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 In-

ternet site at http://www.irs.ustreas.gov/prod/tax_reg/comments.html. The public hearing will be held in room 2615, Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations in general, Trina Dang of the Office of Associate Chief Counsel (International), (202) 622-3850; concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing, LaNita Van Dyke, (202) 622-7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). 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, OP:FS:FP, Washington, DC 20224. Comments on the collection of information should be received by March 1, 1999. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance 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 below);

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

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

Estimates of capital or start-up costs and costs of operation, maintenance, and pur-

chase of service to provide information.

The collection of information in this proposed regulation is in §1.1502-9(c)-(2)(iv). This information is required to help the Internal Revenue Service monitor compliance with the provisions of the proposed regulations and to ensure that taxpayers use consistent asset valuations in applying the proposed regulations. This information will be used for tax administration purposes. The collection of information is mandatory. The likely respondents are business or other for-profit institutions.

Estimated total annual reporting burden: 3,000 hours.

Estimated average annual burden per respondent: 1.5 hours.

Estimated number of respondents: 2,000.

Estimated annual frequency of responses: on occasion.

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

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

Background

This document contains proposed consolidated return regulations under section 1502 of the Internal Revenue Code. The regulations provide guidance concerning the application of the overall foreign loss (OFL) and separate limitation loss (SLL) rules of section 904(f) in the context of a consolidated group.

On January 12, 1998, the IRS and Treasury published in the **Federal Register** (T.D. 8751, 63 FR 1740, 1998-10 I.R.B. 23) temporary regulations modifying the rules governing the absorption of certain tax attributes, including OFL accounts and foreign tax credit carryovers and carrybacks. The temporary regulations eliminated the limitation on OFL recapture and foreign tax credit utilization with respect to separate return limitation years (SRLYs). As explained in the preamble to

those temporary regulations, one reason for the repeal of the SRLY limitation for the foreign tax credit attributes was the conceptual and practical difficulty of measuring a member's contribution to a group's ability to absorb these attributes in light of foreign tax credit provisions that allocate interest expense and certain other expenses (and intercompany interest income) of a member based upon the entire group's assets or activities. The preamble to those regulations noted that these expense allocation provisions also create similar problems with respect to the notional account method of apportioning OFL accounts to a member ceasing to be a member of a group and stated that the IRS and Treasury expected to modify these rules in the near future.

Overview

The proposed regulations modify the existing regulations under §1.1502-9, which were promulgated in 1987 (the 1987 regulations). The 1987 regulations are proposed to be amended in three major respects: the notional account method for apportioning OFL accounts to a departing member is replaced by an asset-based allocation method, the interaction between the intercompany transaction rules and the disposition rules of section 904(f)(3) and (5)(F) is simplified and refined, and guidance is provided concerning the computation of a group's SLLs (whereas the 1987 regulations addressed only OFLs).

The 1987 regulations allocated an OFL account to a departing member based upon the member's "notional" OFL account. A separate notional account was established for each member of a group that contributed to a consolidated OFL account. The accounts were adjusted annually. A member was considered to have contributed to a group's OFL account if the member had an overall foreign loss (deductions allocated against foreign-source income exceeded foreign-source gross income) in a year in which the group added to its consolidated OFL account.

At the time the 1987 regulations were being drafted, however, Congress substantially changed the rules for allocating interest expense in the Tax Reform Act of 1986. Congress believed that corpora-

tions were borrowing in ways designed to inappropriately minimize the amount of interest expense allocated against foreign-source income, thus inflating the amount of foreign-source income that could be sheltered from U.S. tax by foreign tax credits. In the case of an affiliated group, Congress was concerned that interest expense allocation could be manipulated by placing the borrowing function in group members with no foreign assets, while diverting available equity in the group to members with substantial foreign assets. Congress therefore enacted section 864(e), which requires an affiliated group to allocate interest expense of each member as if all such members were a single corporation. Under this rule, although the borrowing corporation incurs the interest expense, that expense is allocated among U.S. and foreign income based upon the assets of the group as a whole. (Group-based expense allocation is also required for research and experimental expenditures under section 864(f) and expenses not directly allocable to specific income under section 864(e)(6).)

Due in large measure to these group-based expense allocation provisions, the notional account method can result in a member taking from a group an OFL or SLL account that is unrelated to either the member's activities or future income. For example, assume that P holds all the stock of S and S holds all the stock of R. P, S, and R file a consolidated return. P has no assets other than the stock of S. S's operations are foreign and R's operations are entirely domestic. S's assets have a tax book value of \$600 and R's assets have a tax book value of \$400. S is entirely equity financed, but R borrows funds from an unrelated lender. S earns \$100 foreign-source income and incurs \$100 of foreign-allocated expense. R earns \$200 U.S.-source income and incurs \$100 of interest expense. Under section 864(e)(1) and §1.861-11T, the \$100 of interest expense is allocated to R's U.S. and foreign-source gross income based upon the assets of the group as a whole. Thus R, with no foreign operations, is treated as having a \$60 foreign loss (no foreign income and \$60 foreign expense), but S, the only member with foreign operations, does not have a foreign loss. R's notional OFL account would thus be \$60 (100 percent of the consolidated OFL account) and, if R

left the group, R would take the entire consolidated OFL account with it. The group, however, would retain the foreign assets and the OFL account might never be recaptured.

As described in more detail below, the proposed regulations do not apply the notional account approach, but instead apportion accounts to a departing member based upon the member's share of the group's foreign assets that produce foreign-source income that would be subject to recapture. The new approach does not attempt to measure a member's "contribution" to the group's consolidated account; rather, the asset approach associates an OFL or SLL account with a member's foreign assets that produce income subject to recapture and measures each member's share of the group OFL or SLL account based upon the member's share of these assets. This approach is more in keeping with the interest allocation provisions for affiliated groups enacted in 1986.

The proposed regulations also modify the interaction between section 904(f) and the intercompany transaction rules of §1.1502-13. Under the 1987 regulations, a consolidated OFL account could trigger gain recognition with respect to an otherwise tax-free intercompany transaction (such as a member's contribution under section 351 to another member of the group) that is a disposition subject to section 904(f)(3) or (5)(F). This gain recognition could occur even though the gain would not be taken into account currently under §1.1502-13. Because the gain is not taken into account, however, the consolidated OFL account is not reduced. Since the consolidated OFL account is not reduced, it can continue to recharacterize foreign-source income or trigger gain recognition with respect to subsequent dispositions subject to section 904(f)(3) or (5)(F). This regime thus has the potential to multiply the effects of a consolidated OFL account. This rule was necessary under the notional account system of apportioning OFL accounts to a departing member because otherwise a member with a notional OFL account could contribute appreciated foreign assets to a new subsidiary, and the new subsidiary could then leave the group unencumbered by the OFL account, contrary to the purpose of section 904(f)(3). As described in more detail below, the proposed regula-

tions ease the section 904(f)(3) and (5)(F) disposition rules in the case of intercompany transactions.

Finally, the proposed regulations provide computational rules and nomenclature for SLLs as well as OFLs. Because the regulations issued in 1987 were actually drafted prior to the enactment of the SLL rules in 1986, the 1987 regulations provide rules only for OFLs, although rules for SLLs could be derived by analogy.

Explanation of Provisions

The proposed regulations do not provide comprehensive guidance under section 904(f) and address only particular section 904(f) issues that arise in the context of a consolidated group. The proposed regulations must be read in conjunction with general guidance under section 904(f), such as Notice 89-3 (1989-1 C.B. 623).

Proposed §1.1502-9(b)(1) through (4) provides computational rules for consolidated OFL and SLL accounts. Generally, a group applies section 904(f) on a group-wide basis. Thus, it nets together all members' income and losses from the same separate limitation income category (or basket) to determine its consolidated separate limitation income or loss for the basket. Pursuant to section 904(f)(5), the group then nets any consolidated separate limitation loss for a basket (a loss basket) against consolidated separate limitation income for all other baskets (the income baskets) on a proportionate basis. Such netting creates a consolidated SLL account (a CSLL account) for the loss basket with respect to one or more income baskets. The group then nets any remaining consolidated separate limitation loss for a loss basket against its U.S.-source income. Such netting creates a consolidated OFL account (a COFL account) for the loss basket. The group recaptures a COFL or CSLL account as required by section 904(f).

Proposed §1.1502-9(b)(5) addresses the interaction between section 904(f) and the intercompany transaction rules. In the case of an intercompany transaction in which gain is recognized but not currently taken into account, the gain is treated as subject to section 904(f)(3) or (5)(F) only when taken into account under §1.1502-13, to the extent of the COFL or CSLL ac-

count existing at that time. In the case of an intercompany transaction in which gain is not recognized (such as a section 351 contribution), section 904(f) will not trigger gain recognition.

Proposed §1.1502-9(c) provides rules for members becoming or ceasing to be members of a group. Consistent with the temporary regulations issued in January 1998, and modified in March 1998 and in temporary regulations T.D. 8800, 1999-4 I.R.B. 20, a member that enters a group with an OFL or SLL account adds this account to the consolidated account, without any SRLY limitation. A departing member takes a portion of the group's COFL and CSLL accounts based upon the member's share of the group's assets that generate income subject to recapture (i.e., assets that generate income in the same basket as the loss basket). The proposed regulations rely on the characterization principles of §§1.861-9T(g)(3) and 1.861-12T to identify the member's share of assets that generate foreign-source income subject to recapture in each basket. The value of the foreign assets is determined under the asset valuation rules of §1.861-9T(g)(1) and (2) using either tax book value or fair market value under the method chosen by the group for purposes of interest apportionment as provided in §1.861-9T(g)(1)(ii). Although actual market values generally provide a better means of apportioning accounts than tax book values (since market values more accurately represent the projected future earnings of an asset), apportionment based upon tax book value is permitted in the interest of administrative convenience. For groups using tax book value, however, an upper limitation is placed upon a member's share of the consolidated accounts to prevent extreme situations in which disparities between tax book value and fair market value could result in the removal of excessive OFL or SLL accounts from the group. The proposed regulations provide an anti-abuse rule that is designed to prevent taxpayers from manipulating the COFL and CSLL account apportionment rules to achieve results inconsistent with the purpose of the OFL and SLL rules.

Proposed §1.1502-9(c)(2)(i) provides that a group apportions COFL and CSLL accounts to a departing member only after the group makes the annual additions or

reductions to the accounts to reflect current-year foreign-source income or loss. To the extent this rule conflicts with the ordering rules of §1.904(f)-1(e)(1), the proposed rule, when finalized, is intended to supersede the existing regulations.

Proposed Effective Dates

These regulations are proposed to apply to consolidated return years for which a return is due after the date final regulations are published in the **Federal Register**. However, §1.1502-9(b)(5) (intercompany transactions) is not applicable for intercompany transactions that occur before January 28, 1999. Also, §1.1502-9(c)(2) (apportionment of consolidated account to departing member) is not applicable for members ceasing to be members of a group before January 28, 1999.

Election to Defer Repeal of SRLY Limitation

Temporary regulations T.D. 8800 permit consolidated groups to elect to continue to apply the SRLY limitation for overall foreign loss accounts for consolidated years beginning before January 1, 1998, as announced in Notice 98-40 (1998-35 I.R.B. 7). 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 Executive Order 12866. Therefore, a regulatory impact analysis is not required. It is hereby certified that these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that these regulations principally affect corporations filing consolidated federal income tax returns that have overall foreign losses or separate limitation losses. Available data indicates that many consolidated return filers are large companies (not small businesses). In addition, the data indicates that an insubstantial number of consolidated return filers that are smaller companies have overall foreign losses or separate limitation losses. Therefore, a Regulatory Flexibility Analysis under the

Regulatory Flexibility Act (5 U.S.C. chapter 6) 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 businesses.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments that are submitted timely to the IRS (a signed original and eight (8) copies). In particular, the IRS and Treasury request comments on the clarity of the proposed rules and how they may be made easier to understand. All comments will be available for public inspection and copying.

A public hearing has been scheduled for February 17, 1999, beginning at 10 a.m. in room 2615 of the Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Due to building security procedures, visitors must enter at the 10th Street entrance, located between Constitution and Pennsylvania Avenues, NW. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written comments and an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by January 27, 1999. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal authors of these regulations are Seth B. Goldstein and Trina

Dang, of the Office of the Associate Chief Counsel (International), IRS. However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Proposed Amendments to the Regulations

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

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *
Section 1.1502-9 also issued under 26 U.S.C. 1502. * * *
Section 1.1502-9A also issued under 26 U.S.C. 1502. * * *

Par. 2. Section 1.1502-3, as proposed to be amended at 63 F.R. 12717, March 16, 1998, is further amended by removing the last sentence of paragraph (c)(4) and adding two sentences in its place to read as follows:

§1.1502-3 Consolidated investment credit.

* * * * *

(c) * * *

(4) * * * [The last two sentences of proposed paragraph (c)(4) is the same as the last two sentences of §1.1502-3T(c)(4) published in T.D. 8800.]

* * * * *

Par. 3. Immediately following §1.1504-4 an undesignated center heading is added to read as follows:

REGULATIONS APPLICABLE FOR TAX YEARS FOR WHICH A RETURN IS DUE ON OR BEFORE THE DATE FINAL REGULATIONS ARE PUBLISHED IN THE FEDERAL REGISTER

Par. 4. Section 1.1502-9 is redesignated as §1.1502-9A and added under the new undesignated center heading.

Par. 5. Newly designated §1.1502-9A is amended by:

1. Revising the section heading.
2. Redesignating the heading and text of paragraph (a) as the heading and text of paragraph (a)(2).

3. Adding a new heading to paragraph (a), and new paragraphs (a)(1), (b)(1)(v) and (b)(1)(vi).

The revisions and additions read as follows:

§1.1502-9A Application of overall foreign loss recapture rules to corporations filing consolidated returns due on or before the date final regulations are published in the Federal Register.

(a) *Scope—(1) Effective date.* This section applies only to consolidated return years for which the due date of the income tax return (without extensions) is on or before the date final regulations are published in the **Federal Register**.

(2) *In general.* * * *

(b) * * *

(1) * * *

(v) [The text of this proposed paragraph (b)(1)(v) is the same as the text of §1.1502-9T(b)(1)(v) published in T.D. 8800.]

(vi) [The text of this proposed paragraph (b)(1)(vi) is the same as the text of §1.1502-9T(b)(1)(vi) published in T.D. 8800.]

* * * * *

Par. 6. New §1.1502-9 is added to read as follows:

§1.1502-9 Consolidated overall foreign losses and separate limitation losses.

(a) *In general.* This section provides rules for applying section 904(f) (including its definitions and nomenclature) to a group and its members. Generally, section 904(f) concerns rules relating to overall foreign losses (OFLs) and separate limitation losses (SLLs) and the consequences of such losses. As provided in section 904(f)(5), losses are computed separately in each category of income described in section 904(d)(1) (basket). Paragraph (b) of this section defines terms and provides computational and accounting rules, including rules regarding recapture. Paragraph (c) of this section provides rules that apply to OFLs and SLLs when a member becomes or ceases to be a member of a group. Paragraph (d) of this section provides a predecessor and successor rule. Paragraph (e) of this section provides effective dates.

(b) *Consolidated application of section 904(f)*. A group applies section 904(f) for a consolidated return year in accordance with that section, subject to the following rules:

(1) *Computation of CSLI or CSLL and consolidated U.S. source income or loss*. The group computes its consolidated separate limitation income (CSLI) or consolidated separate limitation loss (CSLL) for each basket under the principles of §1.1502-11 by aggregating each member's foreign-source taxable income or loss in such basket computed under the principles of §1.1502-12, and taking into account the foreign portion of the consolidated items described in §1.1502-11(a)(2) through (8) for such basket. The group computes its consolidated U.S.-source taxable income or loss under similar principles.

(2) *Netting CSLLs, CSLIs, and consolidated U.S. source taxable income or loss*. The group applies section 904(f)(5) to determine the extent to which a CSLL for a basket reduces CSLI for another basket or consolidated U.S.-source taxable income.

(3) *CSLL and COFL accounts*. To the extent provided in section 904(f), the amount by which a CSLL for a basket (the loss basket) reduces CSLI for another basket (the income basket) shall result in the creation of (or addition to) a CSLL account for the loss basket with respect to the income basket. Likewise, the amount by which a CSLL for a loss basket reduces consolidated U.S.-source income will create (or add to) a consolidated overall foreign loss account (a COFL account).

(4) *Recapture of COFL and CSLL accounts*. In the case of a COFL account for a loss basket, section 904(f)(1) and (3) recharacterizes some or all of the foreign-source income in the loss basket as U.S.-source income. In the case of a CSLL account for a loss basket with respect to an income basket, section 904(f)(5)(C) and (F) recharacterizes some or all of the foreign-source income in the loss basket as foreign-source income in the income basket. The COFL account or CSLL account is reduced to the extent amounts are recharacterized with respect to such account.

(5) *Intercompany transactions*—(i) *Nonapplication of section 904(f) disposition rules*. Neither section 904(f)(3) (in

the case of a COFL account) nor (5)(F) (in the case of a CSLL account) applies at the time of a disposition that is an intercompany transaction to which §1.1502-13 applies. Instead, section 904(f)(3) and (5)(F) applies only at such time and only to the extent that the group is required under §1.1502-13 (without regard to section 904(f)(3) and (5)(F)) to take into account any intercompany items resulting from the disposition, based on the COFL or CSLL account existing at the end of the consolidated return year during which the group takes the intercompany items into account.

(ii) *Example*. Paragraph (b)(5)(i) of this section is illustrated by the following examples. The identity of the parties and the basic assumptions set forth in §1.1502-13(c)(7)(i) apply to the examples. Except as otherwise stated, assume further that the consolidated group recognizes no foreign-source income other than as a result of the transactions described. The examples are as follows:

Example 1. (i) On June 10, Year 1, S transfers nondepreciable property with a basis of \$100 and a fair market value of \$250 to B in a transaction to which section 351 applies. The property was predominantly used without the United States in a trade or business, within the meaning of section 904(f)(3). B continues to use the property without the United States. The group has a COFL account in the relevant loss basket of \$120 as of December 31, Year 1.

(ii) Because the contribution from S to B is an intercompany transaction, section 904(f)(3) does not apply to result in any gain recognition in Year 1. See paragraph (b)(5)(i) of this section.

(iii) On January 10, Year 4, B ceases to be a member of the group. Because S did not recognize gain in Year 1 under section 351, no gain is taken into account in Year 4 under §1.1502-13(d). Thus, no portion of the group's COFL account is recaptured in Year 4. For rules requiring apportionment of a portion of the COFL account to B, see paragraph (c)(2) of this section.

Example 2. (i) The facts are the same as in paragraph (i) of *Example 1*. On January 10, Year 4, B sells the property to X for \$300. As of December 31, Year 4, the group's COFL account is \$40. (The COFL account was reduced between Year 1 and Year 4 due to unrelated foreign-source income taken into account by the group.)

(ii) B takes into account gain of \$200 in Year 4. The \$40 COFL account in Year 4 recharacterizes \$40 of the gain as U.S. source. See section 904(f)(3).

Example 3. (i) On June 10, Year 1, S sells nondepreciable property with a basis of \$100 and a fair market value of \$250 to B for \$250 cash. The property was predominantly used without the United States in a trade or business, within the meaning of section 904(f)(3). The group has a COFL account in

the relevant loss basket of \$120 as of December 31, Year 1. B predominately uses the property in a trade or business without the United States.

(ii) Because the sale is an intercompany transaction, section 904(f)(3) does not require the group to take into account any gain in Year 1. Thus, under paragraph (b)(5)(i) of this section, the COFL account is not reduced in Year 1.

(iii) On January 10, Year 4, B sells the property to X for \$300. As of December 31, Year 4, the group's COFL account is \$60. (The COFL account was reduced between Year 1 and Year 4 due to unrelated foreign-source income taken into account by the group.)

(iv) In Year 4, S's \$150 intercompany gain and B's \$50 corresponding gain are taken into account to produce the same effect on consolidated taxable income as if S and B were divisions of a single corporation. See §1.1502-13(c). All of B's \$50 corresponding gain is recharacterized under section 904(f)(3). If S and B were divisions of a single corporation and the intercompany sale were a transfer between the divisions, B would succeed to S's \$100 basis in the property and would have \$200 of gain (\$60 of which would be recharacterized under section 904(f)(3)), instead of a \$50 gain. Consequently, S's \$150 intercompany gain and B's \$50 corresponding gain are taken into account, and \$10 of S's gain is recharacterized under section 904(f)(3) as U.S. source to reflect the \$10 difference between B's \$50 recharacterized gain and the \$60 recomputed gain that would have been recharacterized.

(c) *Becoming or ceasing to be a member of a group*—(1) *Adding separate accounts on becoming a member*. At the time that a corporation becomes a member of a group (a new member), the group adds to the balance of its COFL or CSLL account the balance of the new member's corresponding OFL account or SLL account. A new member's OFL account corresponds to a COFL account if the account is for the same loss basket. A new member's SLL account corresponds to a CSLL account if the account is for the same loss basket and with respect to the same income basket. If the group does not have a COFL or CSLL account corresponding to the new member's account, it creates a COFL or CSLL account with a balance equal to the balance of the member's account.

(2) *Apportionment of consolidated account to departing member*—(i) *In general*. A group apportions to a member that ceases to be a member (a departing member) a portion of each COFL and CSLL account as of the end of the year during which the member ceases to be a member and after the group makes the additions or reductions to such account required under paragraphs (b)(3), (b)(4) and

(c)(1) of this section (other than an addition under paragraph (c)(1) of this section attributable to a member becoming a member after the departing member ceases to be a member). The group computes such portion under paragraph (c)(2)(ii) of this section, as limited by paragraph (c)(2)(iii) of this section. The departing member carries such portion to its first separate return year after it ceases to be a member. Also, the group reduces each account by such portion and carries such reduced amount to its first consolidated return year beginning after the year in which the member ceases to be a member. If two or more members cease to be members in the same year, the group computes the portion allocable to each such member (and reduces its accounts by such portion) in the order that the members cease to be members.

(ii) *Departing member's portion of group's account.* A departing member's portion of a group's COFL or CSLL account for a loss basket is computed based upon the member's share of the group's assets that generate income subject to recapture at the time that the member ceases to be a member. Under the characterization principles of §§1.861-9T(g)(3) and 1.861-12T, the group identifies the assets of the departing member and the remaining members that generate foreign-source income (foreign assets) in each basket. The assets are characterized based upon the income that the assets are reasonably expected to generate after the member ceases to be a member. The member's portion of a group's COFL or CSLL account for a loss basket is the group's COFL or CSLL account, respectively, multiplied by a fraction, the numerator of which is the value of the member's foreign assets for the loss basket and the denominator of which is the value of the foreign assets of the group (including the departing member) for the loss basket. The value of the foreign assets is determined under the asset valuation rules of §1.861-9T(g)(1) and (2) using either tax book value or fair market value under the method chosen by the group for purposes of interest apportionment as provided in §1.861-9T(g)(1)(ii). For purposes of this paragraph (c)(2)(ii), §1.861-9T(g)(2)(iv) (assets in intercompany transactions) shall apply, but §1.861-9T(g)(2)(iii) (adjustments for directly allocated interest)

shall not apply. If the group uses the tax book value method, the member's portions of COFL and CSLL accounts are limited by paragraph (c)(2)(iii) of this section. The assets should be valued at the time the member ceases to be a member, but values on other dates may be used unless this creates substantial distortions. For example, if a member ceases to be a member in the middle of the group's consolidated return year, an average of the values of assets at the beginning and end of the year (as provided in §1.861-9T(g)(2)) may be used or, if a member ceases to be a member in the early part of the group's consolidated return year, values at the beginning of the year may be used, unless this creates substantial distortions.

(iii) *Limitation on member's portion for groups using tax book value method.* If a group uses the tax book value method of valuing assets for purposes of paragraph (c)(2)(ii) of this section and the aggregate of a member's portions of COFL and CSLL accounts for a loss basket (with respect to one or more income baskets) determined under paragraph (c)(2)(ii) of this section exceeds 150 percent of the actual fair market value of the member's foreign assets in the loss basket, the member's portion of the COFL or CSLL accounts for the loss basket shall be reduced (proportionately, in the case of multiple accounts) by such excess. This rule does not apply if the departing member and all other members that cease to be members as part of the same transaction own all (or substantially all) the foreign assets in the loss basket.

(iv) *Determination of values of foreign assets binding on departing member.* The group's determination of the value of the member's and the group's foreign assets for a loss basket is binding on the member, unless the District Director concludes that the determination is not appropriate. The common parent of the group must attach a statement to the return for the taxable year that the departing member ceases to be a member of the group that sets forth the name and taxpayer identification number of the departing member, the amount of each COFL or CSLL for each loss basket that is apportioned to the departing member under this paragraph (c)(2), the method used to determine the value of the member's and the group's

foreign assets in each such loss basket, and the value of the member's and the group's foreign assets in each such loss basket. The common parent must also furnish a copy of the statement to the departing member.

(v) *Anti-abuse rule.* If a corporation becomes a member and ceases to be a member, and a principal purpose of the corporation becoming and ceasing to be a member is to transfer the corporation's OFL account or SLL account to the group or to transfer the group's COFL or CSLL account to the corporation, appropriate adjustments will be made to eliminate the benefit of such a transfer of accounts. Similarly, if any member acquires assets or disposes of assets (including a transfer of assets between members of the group and the departing member) with a principal purpose of affecting the apportionment of accounts under paragraph (c)(2)(i) of this section, appropriate adjustments will be made to eliminate the benefit of such acquisition or disposition.

(vi) *Examples.* The following examples illustrate this paragraph (c):

Example 1. (i) On November 6, Year 1, S, a member of the P group, a consolidated group with a calendar consolidated return year, ceases to be a member of the group. On December 31, Year 1, the P group has a \$40 COFL account for the general limitation basket, a \$20 CSLL account for the general limitation basket (i.e., the loss basket) with respect to the passive basket (i.e., the income basket), and a \$10 CSLL account for the shipping income basket (i.e., the loss basket) with respect to the passive basket, (i.e., the income basket). No member of the group has foreign-source income or loss in Year 1. The group apportions its interest expense according to the tax book value method.

(ii) On November 6, Year 1, the group identifies S's assets and its own assets (including S's assets) expected to produce foreign general limitation income. Use of end-of-the-year values will not create substantial distortions in determining the relative values of S's and the group's relevant assets on November 6, Year 1. The group determines that S's relevant assets have a tax book value of \$2,000 and a fair market value of \$2,200. Also, the group's relevant assets (including S's assets) have a tax book value of \$8,000. On November 6, Year 1, S has no assets expected to produce foreign shipping income.

(iii) Under paragraph (c)(2)(ii) of this section, S takes a \$10 COFL account for the general limitation basket ($\$40 \times \$2000/\$8000$) and a \$5 CSLL account for the general limitation basket with respect to the passive basket ($\$20 \times \$2000/\$8000$). S does not take any portion of the shipping income basket CSLL account. The limitation described in paragraph (c)(2)(iii) of this section does not apply because the aggregate of the COFL and CSLL accounts for the general limitation basket that are

apportioned to S (\$15) is less than 150 percent of the actual fair market value of S's general limitation foreign assets ($\$2,200 \times 150\%$).

Example 2. (i) Assume the same facts as in *Example 1*, except that the fair market value of S's general limitation foreign assets is \$4 as of November 6, Year 1.

(ii) Under paragraph (c)(2)(iii) of this section, S's COFL and CSLL accounts for the general limitation basket must be reduced by \$9, which is the excess of \$15 (the aggregate amount of the accounts apportioned under paragraph (c)(2)(ii) of this section) over \$6 (150 percent of the \$4 actual fair market value of S's general limitation foreign assets). S thus takes a \$4 COFL account for the general limitation basket ($\$10 - (\$9 \times \$10/\$15)$) and a \$2 CSLL account for the general limitation basket with respect to the passive basket ($\$5 - (\$9 \times \$5/\$15)$).

(d) *Predecessor and successor.* A reference to a member includes, as the context may require, a reference to a predecessor or successor of the member. See §1.1502-1(f).

(e) *Effective dates.* This section applies to consolidated return years for which the due date of the income tax return (without extensions) is after the date final regulations are published in the **Federal Register**. However, paragraph (b)(5) of this section (intercompany transactions) is not applicable for intercompany transactions that occur before January 28, 1999. A group applies the principles of §1.1502-9A(e) to a disposition which is an intercompany transaction to which §1.1502-13 applies and that occurs before January 28, 1999. Also, paragraph (c)(2) of this section (apportionment of consolidated account to departing member) is not applicable for members ceasing to be members of a group before January 28, 1999. A group applies the principles of §1.1502-9A (rather than paragraph (c)(2) of this section) to determine the amount of a consolidated account that is apportioned to a member that ceases to be a member of the group before January 28, 1999 (and reduces its consolidated account by such apportioned amount) before applying paragraph (c)(2) of this section to members that cease to be members on or after January 28, 1999.

Robert E. Wenzel,
*Deputy Commissioner of
Internal Revenue.*

(Filed by the Office of the Federal Register on December 28, 1998, 8:45 a.m., and published in the issue of the Federal Register for December 29, 1998, 63 F.R. 71609)

Notice of Proposed Rulemaking and Notice of Public Hearing

Continuation Coverage Requirements Applicable to Group Health Plans

REG-121865-98

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations that provide guidance under section 4980B of the Internal Revenue Code relating to the COBRA continuation coverage requirements applicable to group health plans. The proposed regulations in this document supplement final regulations being published in T.D. 8812, page 19 of this Bulletin. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: Written or electronic comments and outlines of topics to be discussed at the public hearing scheduled for June 8, 1999 at 10 a.m. must be received by May 14, 1999.

ADDRESSES: Send Submissions to: CC:DOM:CORP:R (REG-121865-98), 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-121865-98), 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. The public hearing scheduled for June 8, 1999 will be held in room 2615 of the Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Yurlinda Mathis at 202-622-4695; con-

cerning submissions of comments, the hearing, or to be placed on the building access list to attend the hearing, LaNita Van Dyke at 202-622-7190 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Internal Revenue Code (Code) to add health care continuation coverage requirements. These provisions, now set forth in section 4980B,¹ generally apply to a group health plan maintained by an employer or employee organization, with certain exceptions, and require such a plan to offer each qualified beneficiary who would otherwise lose coverage as a result of a qualifying event an opportunity to elect, within the applicable election period, COBRA continuation coverage. The COBRA continuation coverage requirements were amended on various occasions,² most recently under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Proposed regulations providing guidance under the continuation coverage requirements as originally enacted by COBRA, and as amended by the Tax Reform Act of 1986, were published as proposed Treasury Regulation §1.162-26 in the **Federal Register** of June 15, 1987

¹ The COBRA continuation coverage requirements were initially set forth in section 162(k), but were moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988 (TAMRA). TAMRA changed the sanction for failure to comply with the continuation coverage requirements of the Internal Revenue Code from disallowance of certain employer deductions under section 162 (and denial of the income exclusion under section 106(a) to certain highly compensated employees of the employer) to an excise tax under section 4980B.

² Changes affecting the COBRA continuation coverage provisions were made under the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Technical and Miscellaneous Revenue Act of 1988, the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, the Small Business Job Protection Act of 1996, and the Health Insurance Portability and Accountability Act of 1996. The statutory continuation coverage requirements have also been affected by an amendment made to the definition of group health plan in section 5000(b)(1) by the Omnibus Budget Reconciliation Act of 1993; that definition is incorporated by reference in section 4980B(g)(2).

(52 F.R. 22716). Supplemental proposed regulations were published as proposed Treasury Regulation §54.4980B-1 in the **Federal Register** of January 7, 1998 (63 F.R. 708). Final regulations are being published in T.D. 8812.

The new set of proposed regulations being published in this notice of proposed rulemaking addresses how the COBRA continuation coverage requirements apply in business reorganizations. Also proposed are rules relating to the interaction of the COBRA continuation coverage requirements and the Family and Medical Leave Act of 1993, which were previously published as Notice 94-103 (1994-2 C.B. 569), and certain other issues. These provisions in the new set of proposed regulations are summarized in the explanation below. For a summary of the new proposed regulations integrated with a summary of the final regulations, see the "Explanation of Provisions" section of the preamble to the final regulations published in T.D. 8812.

Explanation of Provisions

Plans That Must Comply

The new proposed regulations would make a number of changes to the section in the final regulations that addresses which plans must comply with the COBRA continuation coverage requirements. The principal changes being proposed are to add rules simplifying the determination of whether the small-employer plan exception applies, giving employers and employee organizations broad discretion to determine the number of group health plans that they maintain, and providing an exception for certain health flexible spending accounts.

In determining whether a plan is eligible for the small-employer plan exception, part-time employees, as well as full-time employees, must be taken into account. Several commenters on the 1987 proposed regulations requested clarification of how to count part-time employees for the small-employer plan exception, and the new proposed regulations provide guidance on this issue. Under the new proposed regulations, instead of each part-time employee counting as a full employee, each part-time employee counts as a fraction of an employee, with the

fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered a full-time employee. The number of hours that must be worked to be considered a full-time employee is determined in a manner consistent with the employer's general employment practices, although for this purpose not more than eight hours a day or 40 hours a week may be used. An employer may count employees for each typical business day or may count employees for a pay period and attribute the total number of employees for that pay period to each typical business day that falls within the pay period. The employer must use the same method for all employees and for the entire year for which the small-employer plan determination is made.

The new proposed regulations provide guidance, for purposes of the COBRA continuation coverage requirements, on how to determine the number of group health plans that an employer or employee organization maintains. Under these rules, the employer or employee organization is generally permitted to establish the separate identity and number of group health plans under which it provides health care benefits to employees. Thus, if an employer or employee organization provides a variety of health care benefits to employees, it generally may aggregate the benefits into a single group health plan or disaggregate benefits into separate group health plans. The status of health care benefits as part of a single group health plan or as separate plans is determined by reference to the instruments governing those arrangements. If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits (other than those for qualified long-term care services) provided by a single entity (determined without regard to the controlled group rules) constitute a single group health plan.

Under the new proposed regulations, a multiemployer plan and a plan other than a multiemployer plan are always separate

plans. In addition, any treatment of health care benefits as constituting separate group health plans will be disregarded if a principal purpose of the treatment is to evade any requirement of law. Of course, an employer's flexibility to treat benefits as part of separate plans may be limited by the operation of other laws, such as the prohibition in section 9802 on conditioning eligibility to enroll in a group health plan on the basis of any health factor of an individual.

Many commenters on the 1987 proposed regulations requested clarification of the application of COBRA to health care benefits provided under flexible spending arrangements (health FSAs). Some commentators argued that health FSAs should not be subject to COBRA. Health FSAs satisfy the definition of group health plan in section 5000(b)(1) and, accordingly, are generally subject to the COBRA continuation coverage requirements. However, COBRA is intended to ensure that a qualified beneficiary has guaranteed access to coverage under a group health plan and that the cost of that coverage is no greater than 102 percent of the applicable premium.

The IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA for a plan year if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the maximum benefit that the qualified beneficiary could receive under the FSA for that plan year and if the qualified beneficiary could not avoid a break in coverage, for purposes of the HIPAA portability provisions³, by electing COBRA coverage under the FSA. Accordingly, the new proposed regulations contain a rule limiting the application of the COBRA continuation coverage requirements in the case of health FSAs.

Under this proposed rule, if the health FSA satisfies two conditions, the health FSA need not make COBRA continuation coverage available to a qualified beneficiary for any plan year after the plan year

³ Under HIPAA, a qualified beneficiary who maintains coverage after termination of employment under a group health plan that is subject to HIPAA can avoid a break in coverage and thereby avoid becoming subject to a preexisting condition exclusion upon later becoming covered by another health plan.

in which the qualifying event occurs. The first condition that the health FSA must satisfy for this exception to apply is that the health FSA is not subject to the HIPAA portability provisions in sections 9801 through 9833 because the benefits provided under the health FSA are excepted benefits. (See sections 9831 and 9832.)⁴ The second condition is that, in the plan year in which the qualifying event of a qualified beneficiary occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. It is contemplated that this second condition will be satisfied in most cases.

Moreover, if a third condition is satisfied, the health FSA need not make COBRA continuation coverage available with respect to a qualified beneficiary at all. This third condition is satisfied if, as of the date of the qualifying event, the maximum benefit available to the qualified beneficiary under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require as payment for the remainder of that year to maintain coverage under the health FSA.

Duration of COBRA Continuation Coverage

The new proposed regulations would make two principal changes to the section in the final regulations addressing the duration of COBRA continuation coverage.

The 1987 proposed regulations reflect the statutory rules that were then in effect for the maximum period that a plan is required to make COBRA continuation coverage available. Since then the statute has been amended to add the disability extension, to permit plans to extend the notice

⁴ The IRS and Treasury together with the U.S. Department of Labor and the U.S. Department of Health and Human Services, have issued a notice (62 F.R. 67688) holding that a health FSA is exempt from HIPAA because the benefits provided under it are excepted benefits under sections 9831 and 9832 if the employer also provides another group health plan, the benefits under the other plan are not limited to excepted benefits, and the maximum reimbursement under the health FSA is not greater than two times the employee's salary reduction election (or if greater, the employee's salary reduction election plus five hundred dollars).

period if the maximum coverage period is also extended (referred to as the optional extension of the required periods), and to add a special rule in the case of Medicare entitlement preceding a qualifying event that is the termination or reduction of hours of employment. The new proposed regulations reflect these statutory changes. The maximum coverage period for a qualifying event that is the bankruptcy of the employer has also been added to the new proposed regulations.

The 1987 proposed regulations incorporate the statutory bases for terminating COBRA continuation coverage except the rule (added in 1989 and amended in 1996) that COBRA coverage can be terminated in the month that is more than 30 days after a final determination that a qualified beneficiary is no longer disabled. The new proposed regulations add this statutory basis for terminating COBRA coverage, with two clarifications. First, the new proposed regulations clarify that a determination that a qualified beneficiary is no longer disabled allows termination of COBRA continuation coverage for all qualified beneficiaries who were entitled to the disability extension by reason of the disability of the qualified beneficiary who has been determined to no longer be disabled. Second, the new proposed regulations clarify that such a determination does not allow termination of the COBRA continuation coverage of a qualified beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension.

Business Reorganizations

The 1987 proposed regulations provide little direct guidance on the allocation of responsibility for COBRA continuation coverage in the event of corporate transactions, such as a sale of stock of a subsidiary or a sale of substantial assets. Commenters on the 1987 proposed regulations requested further guidance on corporate transactions, pointing out that the existing degree of uncertainty tends to drive up the costs and risks of a transaction to both buyers and sellers. The IRS and Treasury share this view and believe also that greater certainty helps to protect the rights of qualified beneficiaries in these transactions. The IRS has been contacted by many qualified beneficiaries

whose COBRA continuation coverage has been dropped or denied in the context of a corporate transaction. In many cases, these qualified beneficiaries have been told by each of the buyer and the seller that the other party is the one responsible for providing them with COBRA continuation coverage.

The preamble to the 1998 proposed regulations requested comments on a possible approach to allocating responsibility for COBRA continuation coverage in corporate transactions. Commenters suggested that, in a stock sale, as in an asset sale, it would be consistent with standard commercial practice to provide that the seller retains liability for all existing qualified beneficiaries, including those formerly associated with the subsidiary being sold. The IRS and Treasury have studied the comments and given consideration to several alternatives with a view to establishing rules that will minimize the administrative burden and transaction costs for the parties to transactions while protecting the rights of qualified beneficiaries and maintaining consistency with the statute.

Accordingly, the new proposed regulations make clear that the parties to a transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the new proposed regulations. So long as the party to whom the contract allocates responsibility performs its obligations, the other party will have no responsibility for providing COBRA continuation coverage. If, however, the party allocated responsibility under the contract defaults on its obligation, and if, under the new proposed regulations, the other party would have the obligation to provide COBRA continuation coverage in the absence of a contractual provision, then the other party would retain that obligation. This approach would avoid prejudicing the rights of qualified beneficiaries to COBRA continuation coverage based upon the provisions of a contract to which they were not a party and under which the employer with the underlying obligation under the regulations to provide COBRA continuation coverage could otherwise contract away that obligation to a party that fails to perform. Moreover, the party with the underlying responsibility under

the regulations can insist on appropriate security and, of course, could pursue contractual remedies against the defaulting party.

The new proposed regulations provide, for both sales of stock and sales of substantial assets, such as a division or plant or substantially all the assets of a trade or business, that the seller retains the obligation to make COBRA continuation coverage available to existing qualified beneficiaries. In addition, in situations in which the seller ceases to provide any group health plan to any employee in connection with the sale – whether such a cessation is in connection with the sale is determined on the basis of the facts and circumstances of each case – and thus is not responsible for providing COBRA continuation coverage, the new proposed regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and in all sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

A particular type of asset sale raises issues for which the new proposed regulations do not provide any special rules. (Thus, the general rules in the new proposed regulations for business reorganizations would apply to this type of transaction.) This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the employees of that business and continues to provide those employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the new proposed regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the employees continuing in employment with the buyer (and to other family members who are qualified beneficiaries). Ordinarily, the continuing employees (or their family members) would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active employees of the buyer.

Consideration is being given to whether, under appropriate circumstances, such an asset sale would be considered not to result in a loss of coverage for those employees who continue in employment with the buyer after the sale. A countervailing concern, however, relates to those qualified beneficiaries who might have a reason to elect COBRA continuation coverage from the seller. An example of such a qualified beneficiary would be an employee who continues in employment with the buyer, whose family is likely to have medical expenses that exceed the cost of COBRA coverage, and who has significant questions about the solvency of the buyer or other concerns about how long the buyer might continue to provide the same health coverage.

Under one possible approach, a loss of coverage would be considered not to have occurred so long as the purchasing employer in an asset sale continued to maintain the same group health plan coverage that the seller maintained before the sale without charging the employees any greater percentage of the total cost of coverage than the seller had charged before the sale. For this purpose, the coverage would be considered unchanged if there was no obligation to provide a summary of material modifications within 60 days after the change due to a material reduction in covered services or benefits under the rules that apply under Title I of ERISA. If these conditions were satisfied for the maximum coverage period that would otherwise apply to the seller's termination of employment of the continuing employees (generally 18 months from the date of the sale), then those terminations of employment would never be considered qualifying events. If the conditions were not satisfied for the full maximum coverage period, then on the date when they ceased to be satisfied the seller would be obligated to make COBRA continuation coverage available for the balance of the maximum coverage period.

Comments are invited on the utility of such a rule, either in situations in which the seller retains an ownership interest in the buyer after the sale (for example, a sale of assets from a 100-percent owned subsidiary to a 75-percent owned subsidiary) or, more generally, in situations in which the seller and the buyer are unre-

lated. Suggestions are also solicited for other rules that would protect qualified beneficiaries while providing relief to employers in these situations.

Although the new proposed regulations address how COBRA obligations are affected by a sale of stock (and a sale of substantial assets), the new proposed regulations do not address how the obligation to make COBRA continuation coverage available is affected by the transfer of an ownership interest in a noncorporate entity that causes the noncorporate entity to cease to be a member of a group of trades or businesses under common control (whether or not it becomes a member of a different group of trades or business under common control). Comments are invited on this issue.

Employer Withdrawals From Multiemployer Plans

The new proposed regulations also address COBRA obligations in connection with an employer's cessation of contributions to a multiemployer group health plan. The new proposed regulations provide that the multiemployer plan generally continues to have the obligation to make COBRA continuation coverage available to qualified beneficiaries associated with that employer. (There generally would not be any obligation to make COBRA continuation coverage available to continuing employees in this situation because a cessation of contributions is not a qualifying event.) However, once the employer provides group health coverage to a significant number of employees who were formerly covered under the multiemployer plan, or starts contributing to another multiemployer plan on their behalf, the employer's plan (or the new multiemployer plan) would have the obligation to make COBRA continuation coverage available to the existing qualified beneficiaries. This rule is contrary to the holding in *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994), which held that the multiemployer plan continued to have the COBRA obligations with respect to existing qualified beneficiaries after the withdrawing employer established a plan for the same class of employees previously covered under the multiemployer plan.

Interaction of FMLA and COBRA

The new proposed regulations set forth rules regarding the interaction of the COBRA continuation coverage requirements with the provisions of the Family and Medical Leave Act of 1993 (FMLA). The rules under the new proposed regulations are substantially the same as those set forth in Notice 94-103. The last two questions-and-answers in that notice have not been included in the new proposed regulations because they relate to general subject matter that is addressed elsewhere in the regulations.

Under the new proposed regulations, the taking of FMLA leave by a covered employee is not itself a qualifying event. Instead, a qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA leave) does not return to work with the employer at the end of FMLA leave and would, but for COBRA continuation coverage, lose coverage under the group health plan. (As under the general rules of COBRA, this would also constitute a qualifying event with respect to the spouse or any dependent child of the employee.) The qualifying event is deemed to occur on the last day of the employee's FMLA leave, and the maximum coverage period generally begins on that day. (The new proposed regulations provide a special rule for cases where coverage is not lost until a later date and the plan provides for the optional extension of the required periods.) In the case of such a qualifying event, the employer cannot condition the employee's rights to COBRA continuation coverage on the employee's reimbursement of any premiums paid by the employer to maintain the employee's group health plan coverage during the period of FMLA leave.

Any lapse of coverage under the group health plan during the period of FMLA leave and any state or local law requiring that group health plan coverage be provided for a period longer than that required by the FMLA are disregarded in determining whether the employee has a qualifying event on the last day of that leave. However, the employee's loss of coverage at the end of FMLA leave will not constitute a qualifying event if, prior to the employee's return from FMLA

leave, the employer has eliminated group health plan coverage for the class of employees to which the employee would have belonged if she or he had not taken FMLA leave.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 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 the regulations do not impose a collection of information requirement on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) 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 that are submitted timely (a signed original and eight (8) copies) to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying.

A public hearing has been scheduled for June 8, 1999, beginning at 10 a.m. in room 2615 of the Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Due to building security procedures, visitors must enter at the 10th Street entrance, located between Constitution and Pennsylvania Avenues, NW. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the

“FOR FURTHER INFORMATION CONTACT” section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written comments and an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by May 14, 1999. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these proposed regulations is Russ Weinheimer, Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations). However, other personnel from the IRS and Treasury Department participated in their development.

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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 in part by adding entries in numerical order to read as follows:

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

Section 54.4980B-9 also issued under 26 U.S.C. 4980B.

Section 54.4980B-10 also issued under 26 U.S.C. 4980B. * * *

Par. 2. Section 54.4980B-0 is amended by:

1. Revising the introductory text.
2. Adding entries for §§54.4980B-9 and 54.4980B-10 at the end of the list of sections.
3. Revising the entries for Q-3 and Q-6 of §54.4980B-2 in the list of questions.
4. Revising the entry for Q-4 of §54.4980B-7 in the list of questions.
5. Adding an entry for the section heading for §54.4980B-9 in the list of questions.
6. Adding an entry for the section heading for §54.4980B-10 in the list of questions.

The additions and revisions read as follows:

§54.4980B-0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§54.4980B-1 through 54.4980B-10.

LIST OF SECTIONS

* * * * *

§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

§54.4980B-10 Interaction of FMLA and COBRA.

LIST OF QUESTIONS

* * * * *

§54.4980B-2 Plans that must comply.

* * * * *

Q-3: What is a multiemployer plan?

* * * * *

Q-6: For purposes of COBRA, how is the number of group health plans that an employer or employee organization maintains determined?

* * * * *

§54.4980B-7 Duration of COBRA continuation coverage.

* * * * *

Q-4: When does the maximum coverage period end?

* * * * *

§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

Q-1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

Q-2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

Q-3: In the case of an asset sale, what are the selling group and the buying group?

Q-4: Who is an M&A qualified beneficiary?

Q-5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

Q-6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

Q-7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

Q-8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

Q-9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

Q-10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

§54.4980B-10 Interaction of FMLA and COBRA.

Q-1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

Q-2: If a qualifying event described in Q&A-1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

Par. 3. Section 54.4980B-1, A-1 is amended by:

1. Removing the language “54.4980B-8” and adding “54.4980B-10” in its place in the last sentence of paragraph (a).

2. Removing the language “54.4980B-8” and adding “54.4980B-10” in its place in the third sentence and last sentence of paragraph (b).

3. Removing the last sentence of paragraph (c) and adding two sentences in its place to read as follows:

§54.4980B-1 COBRA in general.

* * * * *

A-1: * * *

(c) * * * Section 54.4980B-9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and §54.4980B-10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in §§54.4980B-1 through §54.4980B-10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

* * * * *

Par. 4. Section 54.4980B-2 is amended by:

1. Revising paragraph (a) in A-1.
2. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the first sentence of paragraph (b) in A-1.
3. Revising A-2.
4. Adding Q&A-3.
5. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the last sentence of paragraph (a) in A-4.
6. Adding a sentence immediately before the last sentence of the introductory text of paragraph (a) in A-5.
7. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the last sentence of paragraph (c) in A-5.
8. Adding paragraphs (d), (e), and (f) in A-5.
9. Adding Q&A-6.
10. Revising A-8.
11. Revising paragraph (a) in A-10.

The additions and revisions read as follows:

§54.4980B-2 Plans that must comply.

* * * * *

A-1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A-8 of this section for rules regarding the application of the COBRA continuation coverage requirements to certain health

flexible spending arrangements.) For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1. See Q&A-6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

* * * * *

A-2: (a) For purposes of section 4980B, employer refers to -

- (1) A person for whom services are performed;
 - (2) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a)(1) of this Q&A-2; and
 - (3) Any successor of a person described in paragraph (a)(1) or (2) of this Q&A-2.
- (b) An employer is a successor employer if it results from a consolidation, merger, or similar restructuring of the employer or if it is a mere continuation of the employer. See paragraph (c) in Q&A-8 of §54.4980B-9 for rules describing the circumstances in which a purchaser of substantial assets is a successor employer to the employer selling the assets.

Q-3: What is a multiemployer plan?

A-3: For purposes of §§54.4980B-1 through 54.4980B-10, a multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more col-

lective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. Whenever reference is made in §§54.4980B-1 through 54.4980B-10 to a plan of or maintained by an employer or employee organization, the reference includes a multiemployer plan.

* * * * *

A-5: (a) * * * See Q&A-6 of this section for rules to determine the number of plans that an employer or employee organization maintains. * * *

* * * * *

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A-5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of hours that must be worked on a typical business day in order to be considered a full-time employee. If an employer determines the number of its employees on a pay period basis, it must determine the actual number of full-time employees employed during that pay period and the actual number of part-time employees employed and the hours worked by each of those part-time employees during the pay period. For each day of that pay pe-

riod, each full-time employee counts as one employee and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee during that pay period and the denominator equal to the number of hours that must be worked during that pay period in order to be considered a full-time employee. The determination of the number of hours required to be considered a full-time employee is based upon the employer's employment practices, except that in no event may the hours required to be considered a full-time employee exceed eight hours for any day or 40 hours for any week.

(f) In the case of a multiemployer plan, the determination of whether the plan is a small-employer plan on any particular date depends on which employers are contributing to the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer contributing to the plan, the plan ceases to be excepted from COBRA on the January 1 immediately following the calendar year in which the employer's workforce increased.

* * * * *

Q-6: For purposes of COBRA, how is the number of group health plans that an employer or employee organization maintains determined?

A-6: (a) The rules of this Q&A-6 apply, for purposes of COBRA, in determining the number of group health plans that an employer or employee organization maintains. Except as provided in paragraph (c) of this Q&A-6, in the case of health care benefits provided under an arrangement or arrangements of an employer or employee organization, the number of group health plans pursuant to

which those benefits are provided is determined by the instruments governing the arrangement or arrangements. However, a multiemployer plan and a nonmultiemployer plan are always separate plans. All references elsewhere in §§54.4980B-1 through 54.4980B-10 to a group health plan are references to a group health plan as determined under Q&A-1 of this section and this Q&A-6.

(b) If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits, except benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan.

(c) Notwithstanding paragraph (a) of this Q&A-6, if a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

(d) The significance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1. (i) Employer X maintains a single group health plan, which provides major medical and prescription drug benefits. Employer Y maintains two group health plans; one provides major medical benefits and the other provides prescription drug benefits.

(ii) X's plan could comply with the COBRA continuation coverage requirements by giving a qualified beneficiary experiencing a qualifying event with respect to X's plan the choice of either electing both major medical and prescription drug benefits or not receiving any COBRA continuation coverage under X's plan. By contrast, for Y's plans to comply with the COBRA continuation coverage requirements, a qualified beneficiary experiencing a qualifying event with respect to each of Y's plans must be given the choice of electing COBRA continuation coverage under either the major medical plan or the prescription drug plan or both.

Example 2. If a joint board of trustees administers one multiemployer plan, that plan will fail to qualify for the small-employer plan exception if any one of the employers whose employees are covered under the plan normally employed 20 or more employees during the preceding calendar year. However, if the joint board of trustees maintains two or more multiemployer plans, then the exception would be available with respect to each of those plans in

which each of the employers whose employees are covered under the plan normally employed fewer than 20 employees during the preceding calendar year.

* * * * *

A-8: (a) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A-8 for rules limiting the obligations of certain health flexible spending arrangements. The rules of this paragraph (a) are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. B and C are unmarried employees. B has chosen the life insurance coverage, and C has chosen the indemnity arrangement.

(ii) B does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to B. However, if C terminates employment and the termination constitutes a qualifying event, C must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If C makes such an election and an open enrollment period for active employees occurs while C is still receiving the COBRA continuation coverage, C must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

(b) If a health flexible spending arrangement (health FSA), within the meaning of regulations project EE-130-86 (1989-1 C.B. 944, 986) (see §601.601(d)(2) of this chapter), satisfies the two conditions in paragraph (c) of this

Q&A-8 for a plan year, the obligation of the health FSA to make COBRA continuation coverage available to a qualified beneficiary who experiences a qualifying event in that plan year is limited in accordance with paragraphs (d) and (e) of this Q&A-8, as illustrated by an example in paragraph (f) of this Q&A-8.

(c) The conditions of this paragraph (c) are satisfied if –

(1) Benefits provided under the health FSA are excepted benefits within the meaning of sections 9831 and 9832; and

(2) The maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A-1 of §54.4980B-8 equals or exceeds the maximum benefit available under the health FSA for the year.

(d) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, then the health FSA is not obligated to make COBRA continuation coverage available for any subsequent plan year to any qualified beneficiary who experiences a qualifying event during that plan year.

(e) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

(f) The rules of paragraphs (b), (c), (d), and (e) of this Q&A-8 are illustrated by the following example:

Example: (i) An employer maintains a group health plan providing major medical benefits and a

group health plan that is a health FSA, and the plan year for each plan is the calendar year. Both the plan providing major medical benefits and the health FSA are subject to COBRA. Under the health FSA, during an open season before the beginning of each calendar year, employees can elect to reduce their compensation during the upcoming year by up to \$1200 per year and have that same amount contributed to a health flexible spending account. The employer contributes an additional amount to the account equal to the employee's salary reduction election for the year. Thus, the maximum amount available to an employee under the health FSA for a year is two times the amount of the employee's salary reduction election for the year. This amount may be paid to the employee during the year as reimbursement for health expenses not covered by the employer's major medical plan (such as deductibles, copayments, prescription drugs, or eyeglasses). The employer determined, in accordance with section 4980B(f)(4), that a reasonable estimate of the cost of providing coverage for similarly situated non-COBRA beneficiaries for 2002 under this health FSA is equal to two times their salary reduction election for 2002 and, thus, that two times the salary reduction election is the applicable premium for 2002.

(ii) Because the employer provides major medical benefits under another group health plan, and because the maximum benefit that any employee can receive under the health FSA is not greater than two times the employee's salary reduction election for the plan year, benefits under this health FSA are excepted benefits within the meaning of sections 9831 and 9832. Thus, the first condition of paragraph (c) of this Q&A-8 is satisfied for the year. The maximum amount that a plan can require to be paid for coverage (outside of coverage required to be made available due to a disability extension) under Q&A-1 of §54.4980B-8 is 102 percent of the applicable premium. Thus, the maximum amount that the health FSA can require to be paid for coverage for the 2002 plan year is 2.04 times the employee's salary reduction election for the plan year. Because the maximum benefit available under the health FSA is 2.0 times the employee's salary reduction election for the year, the maximum benefit available under the health FSA for the year is less than the maximum amount that the health FSA can require to be paid for coverage for the year. Thus, the second condition in paragraph (c) of this Q&A-8 is also satisfied for the 2002 plan year. Because both conditions in paragraph (c) of this Q&A-8 are satisfied for 2002, with respect to any qualifying event occurring in 2002, the health FSA is not obligated to make COBRA continuation coverage available for any year after 2002.

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by \$1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is \$2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002.

As of that date, *B* had submitted \$300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is \$2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times \$1200, or \$2448. One-twelfth of \$2448 is \$204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times \$204, or \$1428. Because \$1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year (\$2100), the health FSA is required to make COBRA continuation coverage available to *B* for the remainder of 2002 (but not for any subsequent year).

(iv) *Case 2:* The facts are the same as in *Case 1* except that *B* had submitted \$1000 of reimbursable expenses as of the date of the qualifying event. In that case, the maximum benefit available to *B* for the remainder of the year would be \$1400 instead of \$2100. Because the maximum amount that the health FSA can require to be paid for *B*'s coverage is \$1428, and because the \$1400 maximum benefit for the remainder of the year does not exceed \$1428, the health FSA is not obligated to make COBRA continuation coverage available to *B* in 2002 (or any later year). (Of course, the administrator of the health FSA is permitted to make COBRA continuation coverage available to every qualified beneficiary in the year that the qualified beneficiary's qualifying event occurs in order to avoid having to determine the maximum benefit available for each qualified beneficiary for the remainder of the plan year.)

* * * * *

A-10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan (see Q&A-3 of this section for a definition of multiemployer plan) the excise tax is imposed on the plan.

* * * * *

Par. 5. In §54.4980B-3, the language "54.4980B-8" is removed and "54.4980B-10" is added in its place in the last sentence of paragraph (a)(3) and the first sentence of paragraph (g) in A-1; in the first and second sentences of paragraph (a)(1), the first sentence of paragraph (a)(2), and the first and last sentences in paragraph (b) in A-2; and in A-3.

Par. 6. Section 54.4980B-4 is amended by:

1. Adding a sentence at the end of paragraph (a) in A-1.

2. Removing the language “Q&A-1” and adding “Q&A-4” in its place in the fifth sentence of paragraph (c) of A-1.

3. Revising the third sentence in paragraph (e) of A-1.

The addition and revision read as follows:

§54.4980B-4 Qualifying events.

* * * * *

A-1: (a) * * * See Q&A-1 through Q&A-3 of §54.4980B-10 for special rules in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601-2619).

* * * * *

(e) * * * For example, an absence from work due to disability, a temporary layoff, or any other reason (other than due to leave that is FMLA leave; see §54.4980B-10) is a reduction of hours of a covered employee’s employment if there is not an immediate termination of employment. * * *

* * * * *

Par. 7. In §54.4980B-5, the penultimate sentence in paragraph (a) of A-1 is amended by removing the language “54.4980B-8” and adding “54.4980B-10” in its place.

Par. 8. In §54.4980B-6, the Example in paragraph (c) of A-1 is revised to read as follows:

§54.4980B-6 Electing COBRA continuation coverage.

* * * * *

A-1: * * *

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under paragraph (b) of Q&A-4 of §54.4980B-7).

(ii) Case 1: If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) Case 2: If the plan provides that the employer-paid coverage does not end until 6 months

after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) Case 3: If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment (see Q&A-4 of §54.4980B-7), and in certain circumstances might be provided for a shorter period (see Q&A-1 of §54.4980B-7).

* * * * *

Par. 9. Section 54.4980B-7 is amended by:

- 1. Revising paragraph (a) of A-1.
2. Adding Q&A-4.
3. Revising the second sentence in paragraph (c) of A-5.
4. Revising paragraph (b) of Q&A-6.
5. Removing the language “Q&A-1” and adding “Q&A-4” in its place in paragraph (a) of A-7.

The addition and revisions read as follows:

§54.4980B-7 Duration of COBRA continuation coverage.

* * * * *

A-1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A-4 of §54.4980B-6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates –

- (1) The last day of the maximum coverage period (see Q&A-4 of this section);
(2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-5 in §54.4980B-8);
(3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A-2 of this section;

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits, as described in Q&A-3 of this section; and

(6) In the case of a qualified beneficiary entitled to a disability extension (see Q&A-5 of this section), the later of—

- (i) Either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act (42 U.S.C. 401-433 or 1381-1385) that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary’s being entitled to the disability extension is no longer disabled, whichever is earlier; or
(ii) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

* * * * *

Q-4: When does the maximum coverage period end?

A-4: (a) Except as otherwise provided in this Q&A-4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A-4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A-4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A-4 in a case where a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination

of employment or reduction of hours of employment, and in paragraph (e) of this Q&A-4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A-8 of §54.4980B-2 for limitations that apply to certain health flexible spending arrangements. See also Q&A-6 of this section in the case of multiple qualifying events. Nothing in §§54.4980B-1 through 54.4980B-10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

(b)(1) The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until a later date. If, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost. A plan provides for the extension of the required periods if it provides both –

(i) That the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event; and

(ii) That the end of the maximum coverage period is measured from the date of the loss of coverage rather than from the date of the qualifying event.

(2) In the case of a plan that provides for the extension of the required periods, whenever the rules of §§54.4980B-1 through 54.4980B-10 refer to the measurement of a period from the date of the qualifying event, those rules apply in such a case by measuring the period instead from the date of the loss of coverage.

(c) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is no disability extension, and 29 months after the qualifying event if there is a disability extension. See Q&A-5 of this section for rules to determine if there is a disability extension. If there is a disability extension and the disabled qualified benefi-

ciary is later determined to no longer be disabled, then a plan may terminate the COBRA continuation coverage of an affected qualified beneficiary before the end of the disability extension; see paragraph (a)(6) in Q&A-1 of this section.

(d)(1) If a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of –

(i) 36 months after the date the covered employee became entitled to Medicare benefits; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

(2) See paragraph (b) of Q&A-3 of this section regarding when a covered employee becomes entitled to Medicare benefits.

(e) In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of –

(1) The date of the qualified beneficiary's death; or

(2) The date that is 36 months after the death of the retired covered employee.

* * * * *

A-5: * * *

(c) * * * For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A-5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods (as described in paragraph (b) of Q&A-4 of this section) then the period of the first 60 days of COBRA continuation

coverage is measured from the date on which the coverage would be lost). * * *

* * * * *

A-6: * * *

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A-4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for

some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A-8(b) of §54.4980B-2 for a special rule that applies to certain health flexible spending arrangements.

* * * * *

Par. 10. Sections 54.4980B-9 and 54.4980B-10 are added to read as follows:

§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries in the context of business reorganizations and employer withdrawals from multiemployer plans:

Q-1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

A-1: For purposes of this section:

(a) A *business reorganization* is a stock sale or an asset sale.

(b) A *stock sale* is a transfer of stock in a corporation that causes the corporation to become a different employer or a member of a different employer. (See Q&A-2 of §54.4980B-2, which defines *employer* to include all members of a controlled group of corporations.) Thus, for example, a sale or distribution of stock in a corporation that causes the corporation to cease to be a member of one controlled group of corporations, whether or not it becomes a member of another controlled group of corporations, is a stock sale.

(c) An *asset sale* is a sale of substantial assets, such as a plant or division or substantially all the assets of a trade or business.

(d) The rules of §1.414(b)-1 of this chapter apply in determining what constitutes a controlled group of corporations, and the rules of §§1.414(c)-1 through 1.414(c)-5 of this chapter apply in determining what constitutes a group of trades or businesses under common control.

Q-2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

A-2: In the case of a stock sale –

(a) The *selling group* is the controlled group of corporations, or the group of

trades or businesses under common control, of which a corporation ceases to be a member as a result of the stock sale;

(b) The *acquired organization* is the corporation that ceases to be a member of the selling group as a result of the stock sale; and

(c) The *buying group* is the controlled group of corporations, or the group of trades or businesses under common control, of which the acquired organization becomes a member as a result of the stock sale. If the acquired organization does not become a member of such a group, the buying group is the acquired organization.

Q-3: In the case of an asset sale, what are the selling group and the buying group?

A-3: In the case of an asset sale –

(a) The *selling group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets; and

(b) The *buying group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.

Q-4: Who is an M&A qualified beneficiary?

A-4: (a) Asset sales: In the case of an asset sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

(c) In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to her or his current right to COBRA continuation coverage, the qualifying event referred to in paragraphs (a) and (b) of this Q&A-4 is the first qualifying event.

Q-5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

A-5: No. A covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children, regardless of whether they are provided with group health coverage after the sale, and neither the covered employee, nor the covered employee's spouse or dependent children, become qualified beneficiaries as a result of the sale.

Q-6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

A-6: (a) Yes, unless –

(1) The buying group is a successor employer under paragraph (c) of Q&A-8 of this section or Q&A-2 of §54.4980B-2, and the covered employee is employed by the buying group immediately after the sale; or

(2) The covered employee (or the spouse or any dependent child of the covered employee) does not lose coverage (within the meaning of paragraph (c) in Q&A-1 of §54.4980B-4) under a group health plan of the selling group after the sale.

(b) Unless the conditions in paragraph (a)(1) or (2) of this Q&A-6 are satisfied, such a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of whether the covered employee is employed by the buying group or whether the covered employee's employment is associated with the purchased assets after the sale. Accordingly, the covered employee, and the spouse and dependent children of the covered em-

ployee who lose coverage under a plan of the selling group in connection with the sale, are M&A qualified beneficiaries in connection with the sale.

Q-7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

A-7: Yes. Nothing in this section prohibits a selling group and a buying group from allocating to one or the other of the parties in a purchase agreement the responsibility to provide the coverage required under §§54.4980B-1 through 54.4980B-10. However, if and to the extent that the party assigned this responsibility under the terms of the contract fails to perform, the party who has the obligation under Q&A-8 of this section to make COBRA continuation coverage available to M&A qualified beneficiaries continues to have that obligation.

Q-8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

A-8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A-8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A-8 contains these rules for stock sales, and paragraph (c) of this Q&A-8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the

later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in §54.4980B-7, relating to the duration of COBRA continuation coverage) –

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the stock sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the stock sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the stock sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(c)(1) In the case of an asset sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale and if the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer to the selling group in connection with that asset sale. If the buying group is a successor employer, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in §54.4980B-7, relating to the duration of COBRA continuation coverage) –

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the asset sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the asset sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the asset sale, have an obligation to make COBRA continuation coverage available to those

qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(d) The rules of Q&A-1 through Q&A-7 of this section and this Q&A-8 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Stock Sale Examples

Example 1. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 48 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 15 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other 33 qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.)

(ii) Under these facts, *S*'s plan continues to have the obligation to make COBRA continuation coverage available to the 15 M&A qualified beneficiaries under *S*'s plan after the sale of *C* to *P*. The employees who continue in employment with *C* do not experience a qualifying event by virtue of *P*'s acquisition of *C*. If they experience a qualifying event after the sale, then the group health plan of *P* has the obligation to make COBRA continuation coverage available to them.

Example 2. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Each of *A*, *B*, and *C* maintains a group health plan for its employees (and their families). Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under *C*'s plan. *C* continues to employ all of its employees and continues to maintain its group health plan after being acquired by *P* on July 1, 2002.

(ii) Under these facts, *C* is an acquired organization and the 14 qualified beneficiaries under *C*'s plan are M&A qualified beneficiaries. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. *S* and *P* could negotiate to have *C*'s plan continue to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. In such a case, neither *A*'s plan nor *B*'s plan would make COBRA continuation coverage available to the 14 M&A qualified beneficiaries unless *C*'s plan failed to fulfill its contractual responsibility to make COBRA continuation coverage available to the M&A qualified beneficiaries. *C*'s employees (and their spouses and dependent children) do not experience a qualifying event

in connection with *P*'s acquisition of *C*, and consequently no plan maintained by either *P* or *S* has any obligation to make COBRA continuation coverage available to *C*'s employees (or their spouses or dependent children) in connection with the transfer of stock in *C* from *S* to *P*.

Example 3. (i) The facts are the same as in *Example 2*, except that *C* ceases to employ two employees on June 30, 2002, and those two employees never become covered under *P*'s plan.

(ii) Under these facts, the two employees experience a qualifying event on June 30, 2002 because their termination of employment causes a loss of group health coverage. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the two employees (and to any spouse or dependent child of the two employees who loses coverage under *C*'s plan in connection with the termination of employment of the two employees) because they are M&A qualified beneficiaries with respect to the sale of *C*.

Example 4. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 25 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 20 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other five qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.) *S* terminates its group health plan effective June 30, 2002 and begins to liquidate the assets of *A* and *B* and to lay off the employees of *A* and *B*.

(ii) Under these facts, *S* ceases to provide a group health plan to any employee in connection with the sale of *C* to *P*. Thus, beginning July 1, 2002 *P*'s plan has the obligation to make COBRA continuation coverage available to the 20 M&A qualified beneficiaries, but *P* is not obligated to make COBRA continuation coverage available to the other 5 qualified beneficiaries with respect to *S*'s plan as of June 30, 2002 or to any of the employees of *A* or *B* whose employment is terminated by *S* (or to any of those employees' spouses or dependent children).

Asset Sale Examples

Example 5. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells the assets of one of its divisions to Buying Group *P*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan. Immediately before the sale, there are two qualified beneficiaries receiving COBRA continuation coverage under a group health

plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These two qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, a group health plan of *S* retains the obligation to make COBRA continuation coverage available to these two M&A qualified beneficiaries. In addition, the one employee *P* does not hire as well as all of the employees *P* hires (and the spouses and dependent children of these employees) who were covered under a group health plan of *S* on the day before the sale are M&A qualified beneficiaries with respect to the sale. A group health plan of *S* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*, and *S* ceases to provide any group health plan to any employee on the date of the sale. *P* hires all but one of *S*'s employees on the date of the asset sale by *S*, gives those employees the same positions that they had with *S* before the sale, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These 10 qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, *P* is a successor employer described in paragraph (c) of this Q&A-8. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to these 10 M&A qualified beneficiaries.

(iii) The one employee that *P* does not hire and the family members of that employee are also M&A qualified beneficiaries with respect to the sale. A group health plan of *P* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

(iv) The employees who continue in employment in connection with the asset sale (and their family members) and who were covered under a group health plan of *S* on the day before the sale are not M&A qualified beneficiaries because *P* is a successor employer to *S* in connection with the asset sale. Thus, no group health plan of *P* has any obligation to make COBRA continuation coverage available to these continuing employees with respect to the qualifying event that resulted from their losing coverage under *S*'s plan in connection with the asset sale.

Example 7. (i) Selling Group *S* provides group health plan coverage to employees at each of its two operating divisions. *S* sells the assets of one of its divisions to Buying Group *P1*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P1* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan.

(ii) Under these facts, a group health plan of *S* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale to *P1*. (If an M&A qualified beneficiary first became covered under *P1*'s plan after electing COBRA continuation coverage under *S*'s plan, then *S*'s plan could terminate the COBRA continuation coverage once the M&A qualified beneficiary became covered under *P1*'s plan, provided that the remaining conditions of Q&A-2 of §54.4980B-7 were satisfied.)

(iii) Several months after the sale to *P1*, *S* sells the assets of its remaining division to Buying Group *P2*, and *S* ceases to provide any group health plan to any employee on the date of that sale. Thus, under Q&A-1 of §54.4980B-7, *S* ceases to have an obligation to make COBRA continuation coverage available to any qualified beneficiary on the date of the sale to *P2*. *P1* and *P2* are unrelated organizations.

(iv) Even if it was foreseeable that *S* would sell its remaining division to an unrelated third party after the sale to *P1*, under these facts the cessation of *S* to provide any group health plan to any employee on the date of the sale to *P2* is not in connection with the asset sale to *P1*. Thus, even after the date *S* ceases to provide any group health plan to any employee, no group health plan of *P1* has any obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. If *P2* is a successor employer under the rules of paragraph (c) of this Q&A-8 and maintains one or more group health plans after the sale, then a group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P2* by *S* (but in such a case employees of *S* before the sale who continued working for *P2* after the sale would not be M&A qualified beneficiaries). However, even in such a case, no group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. Thus, under these facts, after *S* has ceased to provide any group health plan to any employee, no plan has an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1*.

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by *S* to provide any group health plan to any employee is in connection with the asset sale to *P*. Because of this, and because *P* continued the business operations as-

sociated with those assets without substantial change or interruption, *P* is a successor employer to *S* with respect to the asset sale. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale beginning on the date that *S* ceases to provide any group health plan to any employee. (A group health plan of *S* retains this obligation for the several weeks after the date of the sale until *S* ceases to provide any group health plan to any employee.)

Q-9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

A-9: The cessation of contributions by an employer to a multiemployer group health plan is not itself a qualifying event, even though the cessation of contributions may cause current employees (and their spouses and dependent children) to lose coverage under the multiemployer plan. An event coinciding with the employer's cessation of contributions (such as a reduction of hours of employment in the case of striking employees) will constitute a qualifying event if it otherwise satisfies the requirements of Q&A-1 of §54.4980B-4.

Q-10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

A-10: (a) In general, yes. (See Q&A-3 of §54.4980B-2 for a definition of *multiemployer* plan.) If, however, the employer that stops contributing to the multiemployer plan establishes one or more group health plans (or starts contributing to another multiemployer plan that is a group health plan) covering a significant number of the employer's employees formerly covered under the multiemployer plan, the plan established by the employer (or the other multiemployer plan) has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee

whose last employment prior to the qualifying event was with the employer.

(b) The rules of Q&A-9 of this section and this Q&A-10 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Example 1. (i) Employer *Z* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Z* has been making contributions to *M*. *Z* experiences financial difficulties and stops making contributions to *M* but continues to employ all of the employees covered by the collective bargaining agreement. *Z*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Z* does not establish any group health plan covering any of the employees covered by the collective bargaining agreement.

(ii) After *Z* stops contributing to *M*, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*. The loss of coverage under *M* for those employees of *Z* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 2. (i) Employer *Y* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Y* has been making contributions to *M*. *Y* experiences financial difficulties and is forced into bankruptcy by its creditors. *Y* continues to employ all of the employees covered by the collective bargaining agreement. *Y* also continues to make contributions to *M* until the current collective bargaining agreement expires, on June 30, 2001, and then *Y* stops making contributions to *M*. *Y*'s employees (and their spouses and dependent children) lose coverage under *M* effective July 1, 2001. *Y* does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, *Y* establishes a group health plan covering the class of employees formerly covered by the collective bargaining agreement. The group health plan also covers their spouses and dependent children.

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by *Y* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A-1 of §54.4980B-7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Y*. The loss of coverage under *M* for those employees of *Y* who continue in em-

ployment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 3. (i) Employer *X* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *X* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

§54.4980B-10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601-2619) affects the COBRA continuation coverage requirements:

Q-1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A-1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A-1 of §54.4980B-4 occurs, however, if -

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A-1 does not constitute a qualifying

event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q-2: If a qualifying event described in Q&A-1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A-2: A qualifying event described in Q&A-1 of this section occurs on the last day of FMLA leave. The maximum coverage period (see Q&A-4 of §54.4980B-7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A-4 of §54.4980B-7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A-2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A-3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§825.100-825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A-3 of this section.)

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

A-3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A-1 of this section or when such a qualifying event occurs under Q&A-2 of this section.

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

A-4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A-1 through Q&A-3 of this section.

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

A-5: No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

Robert E. Wenzel,
*Deputy Commissioner of
Internal Revenue.*

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of the Federal Register for February 3, 1999, 64 F.R. 5237)

Foundations Status of Certain Organizations

Announcement 99-15

The following organizations have failed to establish or have been unable to maintain their status as public charities or as operating foundations. Accordingly, grantors and contributors may not, after this date, rely on previous rulings or designations in the Cumulative List of Organizations (Publication 78), or on the presumption arising from the filing of notices under section 508(b) of the Code. This listing does *not* indicate that the organizations have lost their status as organizations described in section 501(c)(3), eligible to receive deductible contributions.

Former Public Charities. The following organizations (which have been treated as organizations that are not private foundations described in section 509(a) of the Code) are now classified as private foundations:

E Doris Carney Scholarship Fund Inc.,
Warwick, RI
Eagle Council of North Carolina,
Charlotte, NC
Eagles – Drugs & AIDS HIV Support
Group, Bloomfield, CT
Early Childhood Facilities Fund of New
Jersey Inc., Pennington, NJ
Early Nutrition Training Pays Inc., San
Antonio, TX
Earth Angels Center Inc., Olathe, KS
Earth Living Foundation, Glenwood
Springs, CO
Earth Reclamation Institute Inc.,
Grapevine, TX
Earthbond, Irvine, CA
Earthcare San Diego Inc., Badger, CA
East Carroll Rural Housing Inc., Lake
Providence, LA
East High Band Boosters, Rockford, IL
East Hills Association No. 1 Youth
Institute, Pittsburgh, PA
East Main Street Revitalization
Association Inc., Bridgeport, CT
East Mound Community Development
Corporation, Newark, OH
East Orange Rowley Park Economic
Development Corporation, East
Orange, NJ

East Tennessee Initiative Inc., Knoxville, TN

East Texas Cheerful Giving Helping Hand Association, Gilmer, TX

East-West Center At-Aspen Ltd., Aspen, CO

Eastern Pennsylvania Renewal Fellowship, Ambler, PA

Easton Cultural Education Foundation, Easton, CT

Eastside Fighting Crime, San Antonio, TX

Eastside Local Community Development Corp EL-CDC, New York, NY

Ecosail Inc., Englewood, FL

Ecumenical Catholic Church of America, Lincoln, NE

Ecumenical Trust of the World Council of Churches and National C., New York, NY

Edge Productions Inc., Philadelphia, PA

Edgebrook-Sauganash Athletic Association, Chicago, IL

Edison Education Foundation a New Jersey Nonprofit Corporation, Edison, NJ

Edison High School 1964 Alumni Association Inc., Tulsa, OK

Edmonson County Middle-School Academic Boosters, Brownsville, KY

Education Foundation for Brighton Schools, Brighton, CO

Educational Advancement and Supportive Efforts Foundation Inc., Tallahassee, FL

Educational Concepts Inc. 02-08-93, Fort Collins, CO

Educational Leadership Foundation, Washington, DC

Educational Publications Foundation, Florence, OR

Elm Street Arts Inc., Manchester Center, VT

Emanuel County Historic Preservation Society Inc., Swainsboro, GA

Educational Resource Center a New Jersey Non-Profit Corporation, Willingboro, NJ

Educational Resource Foundation, Normal, IL

Educational Solutions, Redwood City, GA

Educational Support Organization Inc., New Orleans, LA

Educational Technology Systems, Washington, DC

Edward J Bloustein School of Planning and Public Policy Alumni, New Brunswick, NJ

Edwin W Freitag Memorial Scholarship, Ypsilanti, MI

Eels on Wheels Adaptive Scuba Club, Austin, TX

EIBT Equality in Bank Treatment, Laurel, MS

Eighth District Association Development Board Inc., Alexandria, LA

El Andar Foundation, Santa Cruz, GA

El Campo Community Theatre, El Campo, TX

El Futuro Del Latino, Chicago, IL

El Paso Juniors Volleyball Club, El Paso, TX

Elder P A T H Inc., Baltimore, MD

Elder-Ride Inc., Lehigh Acres, FL

Electro-Drive Research Institute, Tucson, AZ

Eleuthra Animal Rescue Association Inc., Boston, MA

Elf Cocoon Research & Technology Int Ltd., Mt. Carmel, IL

Elgin Community Youth Soccer Association Inc., Elgin, TX

Elgin Sharks Track Club, Elgin, IL

Eligeti Family Foundation Inc., Ocala, FL

Elizabeth James Senior Housing, Seattle, WA

Elizabeth S Henderson Living Challenge Scholarship Fund, Charlotte, NC

Elkhorn American Legion Baseball Association, Elkhorn, NE

Elkhorn Valley Recreational Project-Kimball-Vivian Inc., Kimball, WV

Elm Fork Nature Preserve Association, Carrollton, TX

Emergency Communicators Association of Southeastern Minnesota, Rochester, MN

Emergency Food Center Inc., Chicago, IL

Emergency Medical Search and Rescue, Meriden, CT

Emerging Business Institute, San Francisco, CA

Emily Foster Enterprises Inc., Mt. Pleasant, SC

Emmanuel El Shaddai Inc., West Monroe, LA

Emmanuel House Inc., Dayton, TN

Emotional Ecology, Sheridan, WY

Employment Link Inc., Fort Worth, TX

Empowerment for a Diverse Community Inc., Cleveland, OH

Empowerment Inc., Norristown, PA

Endangered Wildlife Fund, Newport Beach, CA

Endowment for Children in Crises Inc., Brookline, MA

Enhancing Life for Our Homeless Inc., Irving, TX

Enlightenment, Detroit, MI

Ensign Foundation, Sandy, UT

Entrepreneur Corps Inc., New York, NY

Enviro League, Peoria, IL

Environmental Research & Awareness Corp., Gautier, MS

Environmental Career Center Inc., Hampton, VA

Environmental Contribution Center, San Diego, CA

Equal Vote, Brooklyn, NY

Equi Therapy Inc., West Babylon, NY

Eric Schiffer Youth Foundation Inc., San Jose, CA

Ernest Thompson Seton Foundation, Sante Fe, NM

ERTEP Inc., Atlanta, GA

ERUV of San Antonio Inc., San Antonio, TX

Escambia Released Time Bible Classes Inc., Pensacola, FL

Escondido Community Dialogue, Escondido, CA

Eskews Jack & Jill Day Care Center Inc., Waynesboro, GA

Estelle Brown Community Center, Dittmer, MO

Estrellas Nacientes Inc., Brooklyn, NY

ETA Omega Foundation Inc., Louisville, KY

Ethical Technologies Inc., Lexington, KY

ETS Youth Division Inc., Freeport, NY

Eugene Hash Ministries, Charlotte, NC

Evelyn Morris Parent Teacher Partnership, Lincoln, DE

Everlasting Gospel, Des Plaines, IL

Excel Eco Inc., Houston, TX

Excel Programs Incorporated, Wilmington, DE

Exceptional Family Resource Center Inc., San Diego, CA

Exchange Club Center for the Prevent of Child Abuse of Shrv Bossier Inc., Bossier City, LA

Exchange Club of Chambersburg Fndtn for the Prev of Child Abuse Inc., Chambersburg, PA

Expressive Women Inc., Plano, TX
 Extra Virgin Performance Corporation
 Inc., Richardson, TX
 Eye Research Foundation, Albany, NY
 Eyes & Ears of Nevada Inc., Las Vegas,
 NV

Eyewitness for Life Ltd., Cedarburg, WI
 Ezras Mamesh TR, Brooklyn, NY

If an organization listed above submits information that warrants the renewal of its classification as a public charity or as a private operating foundation, the Internal Revenue Service will issue a ruling or determination letter with the revised classification as to foundation status. Grantors and contributors may thereafter rely upon such ruling or determination letter as provided in section 1.509(a)-7 of the Income

Tax Regulations. It is not the practice of the Service to announce such revised classification of foundation status in the Internal Revenue Bulletin

New Form 8866, Interest Computation Under the Look-Back Method for Property Depreciated Under the Income Forecast Method, Is Now Available

Announcement 99-16

New Form 8866, Interest Computation Under the Look-Back Method for Property Depreciated Under the Income Fore-

cast Method, is now available. The purpose of the form is to figure the interest due or refundable under the look-back method of Internal Revenue Code section 167(g)(2).

If you depreciated certain property placed in service after September 13, 1995, under the income forecast method, you generally must file Form 8866 for the 3rd and 10th tax years beginning after the tax year the property was placed in service. If interest is due, file the form with your Federal income tax return for that year. If interest is to be refunded, file the form separately.

You can obtain Form 8866 and its separate instructions by telephone or by using IRS electronic information services.

Request by—	Number or Address
Telephone	1-800-TAX-FORM (1-800-829-3676)
Personal computer: World Wide Web File Transfer Protocol Telnet	www.irs.ustreas.gov ftp.irs.ustreas.gov iris.irs.ustreas.gov
Direct Dial (by modem)	703-321-8020

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 1998-1 through 1998-52 will be found in Internal Revenue Bulletin 1999-1, dated January 4, 1999.

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