Internal Revenue
bulletin

Bulletin No. 2010-22
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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

Notice 2010–41, page 715.
This notice provides that the Treasury Department and the IRS intend to issue regulations under section 7701(a)(4) of the Code that will classify certain domestic partnerships as foreign, solely for the purposes of identifying which U.S. shareholders are required to include amounts in gross income under section 951(a).

Notice 2010–44, page 717.
Section 45R provides a federal income tax credit to certain small employers that make nonelective contributions towards their employees' health insurance premiums under an arrangement that meets certain requirements. This notice provides guidance on the credit, including guidance for determining eligibility for the credit, calculating the credit, and claiming the credit.

EMPLOYEE PLANS

T.D. 9482, page 698.
REG–114494–10, page 723.
Temporary and proposed regulations under section 9815 of the Code provide guidance on the requirements imposed on group health plans and health insurance issuers under the Patient Protection and Affordable Care Act to continue the dependent coverage of children to age 26.

EXEMPT ORGANIZATIONS

Announcement 2010–40, page 725.
The IRS has revoked its determination that Action for Affordable Housing of Englewood, CO; All Gods Creatures Shelter for Abused & Abandoned Animals of Tampa, FL; Carranor Hunt & Polo Club of Perrysburg, OH; Debt Monster Credit Counseling Services, Inc., of Rancho Santa Margarita, CA; Farm Mutual Insurance of Baltic, SC; Germania Purchasing Group of Brenham, TX; Orchard Living View, Inc., of Sterling Heights, MI; Silver Ridge Park Golden Oldies of Toms River, NJ; WJ Consumer Credit of Texas of Kyle, TX; Eastland Praise and Worship of Aiken, NC; The Second Chance Foundation, Inc., of Vineyard Haven, MA; Currier Family Foundation of Salt Lake City, UT; Chipper Preschool & Kindergarten of Chicago, IL; Desilynn Multiple Sclerosis Foundation of Layton, UT; Hawaii Consumer Credit Counseling Services of Honolulu, HI; The Leonard & Beverly Graham Foundation for the Arts of Salt Lake City, UT; Panther's House of Pride, Inc., of Decatur, GA; Seed America Foundation of Cummings, GA; Carey C. Jones Memorial Park of Apex, NC; and the Capital Athletic Foundation of Silver Spring, MD, qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Code.

EXCISE TAX

T.D. 9482, page 698.
REG–114494–10, page 723.
Temporary and proposed regulations under section 9815 of the Code provide guidance on the requirements imposed on group health plans and health insurance issuers under the Patient Protection and Affordable Care Act to continue the dependent coverage of children to age 26.

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Actions Relating to Court Decisions is on the page following the Introduction.
Finding Lists begin on page ii.
Index for January through June begins on page v.

Department of the Treasury
Internal Revenue Service

ADMINISTRATIVE

Notice 2010–43, page 716.

The Department of Treasury and the Service invite public comments on recommendations for items that should be included on the 2010–2011 Guidance Priority List. Taxpayers may submit recommendations for guidance at any time during the year. Recommendations submitted by June 11, 2010, will be reviewed for possible inclusion on the original 2010–2011 Guidance Priority List. Recommendations received after June 11, 2010, will be reviewed for inclusion in the next periodic update.

Announcement 2010–39, page 724.

This document contains a correction to final regulations (T.D. 9350, 2007–2 C.B. 614) that modify the rules relating to the disclosure of reportable transactions under section 6011 of the Code.

The IRS Mission

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.

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

The Bulletin is divided into four parts as follows:

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

Part II.—Treaties and Tax Legislation.
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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

Actions Relating to Decisions of the Tax Court

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

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

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

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

The Actions on Decisions published in the weekly Internal Revenue Bulletin are consolidated semiannually and appear in the first Bulletin for July and the Cumulative Bulletin for the first half of the year. A semiannual consolidation also appears in the first Bulletin for the following January and in the Cumulative Bulletin for the last half of the year.

The Commissioner nonacquiesces in the following decision:

Tidewater Inc. and Subsidiaries and Tidewater Foreign Sales Corporation v. United States,[1]
565 F. 3d. 299 (5th Cir. 2009),
aff'g No. 06-875, 2007 U.S. Dist. LEXIS 77147
(E.D. La. October 17, 2007)

[1] Nonacquiesces to whether certain charters entered into between members of Taxpayer's controlled group and unrelated customers are leases under I.R.C. section 7701(e).

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

Section 9815.—Eligibility of Children Until at Least Age 26

26 CFR 54.9815–2714T: Eligibility of children until at least age 26 (temporary).

T.D. 9482

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

DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590
RIN 1210–AB41

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary
OCIIO–4150–IFC
45 CFR Parts 144, 146, and 147
RIN 0991–AB66

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final regulations implementing the requirements for group health plans and health insurance issuers in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding dependent coverage of children who have not attained age 26.

DATES: *Effective Date*. These interim final regulations are effective on July 12, 2010.

Comment date. Comments are due on or before August 11, 2010.

Applicability date. These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010. These interim final regulations generally apply to individual health insurance issuers for policy years beginning on or after September 23, 2010.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. ***WARNING***: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210–AB41, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Email*: *E-OHPSCA.EBSA@dol.gov*.
- *Mail or Hand Delivery*: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention*: RIN 1210–AB41.

Comments received by the Department of Labor will be posted without change to *www.regulations.gov* and *www.dol.gov/ebsa*, and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIIO–4150–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the "More Search Options" tab.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services,
Attention: OCIIO–4150–IFC,
P.O. Box 8016,
Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Office of Consumer Information and Insurance Oversight,
Department of Health and Human Services,
Attention: OCIIO–4150–IFC,
Mail Stop C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Office of Consumer Information and Insurance Oversight,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244–1850

If you intend to deliver your comments to the Baltimore address, please call (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

Internal Revenue Service. Comments to the IRS, identified by REG–114494–10, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail*: CC:PA:LPD:PR (REG–114494–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–114494–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Jim Mayhew, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (410) 786–1565.

CUSTOMER SERVICE INFORMATION: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's website (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*).

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111–152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715 to the Employee Retirement Income Security Act (ERISA) and section 9815 to the Internal Revenue Code (the Code) to make the provisions of part A of title XXVII of the PHS Act applicable under ERISA and the Code to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if those provisions of the PHS Act were included in ERISA and the Code. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (*i.e.*, grandfathered health plans) are subject to only certain provisions.

[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724[2] (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of the Affordable Care Act are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers stricter requirements than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) expect to issue regulations implementing the revised PHS Act sections 2701 through 2719A in several phases. The first publication in this series was a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the **Federal Register** on April 14, 2010 (75 FR 19297). These interim final regulations are being published to implement PHS Act section 2714 (requiring dependent coverage of children to age 26). PHS Act section 2714 generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act.[3] The implementation of other provisions of PHS Act sections 2701 through 2719A and section 1251 of the Affordable Care Act will be addressed in future regulations.

Because subtitles A and C of title I of the Affordable Care Act contain requirements that are applicable to both the group and individual health insurance markets, it would be duplicative to insert the requirements into both the existing 45 CFR part 146 (Requirements for the Group Health Insurance Market) and 45 CFR part 148 (Requirements for the Individual Health Insurance Market). Accordingly, these interim final regulations create a new part 147 in subchapter B of 45 CFR to implement the provisions of the Affordable Care Act. The provisions of the Affordable Care Act, to the extent that they apply to group health plans and group health insurance coverage, are also implemented under new regulations added to 29 CFR part 2590 and 26 CFR part 54.

II. Overview of the Regulations

A. *PHS Act Section 2714, Continued Eligibility of Children until Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120)*

Section 2714 of the PHS Act, as added by the Affordable Care Act (and amended by the Reconciliation Act), and these interim final regulations provide that a plan or issuer that makes available dependent coverage[4] of children must make such coverage available for children until attainment of 26 years of age. The statute also requires the issuance of regulations to "define the dependents to which coverage shall be made available" under this rule.

Many group health plans that provide dependent coverage limit the coverage to health coverage excludible from employees' gross income for income tax purposes. Thus, dependent coverage is limited to employees' spouses and employees' children that qualify as dependents for income tax purposes. Consequently, these plans often condition dependent coverage, in addition to the age of the child, on student status, residency, and financial support or other factors indicating dependent status. However, with the expansion of dependent coverage required by the Affordable Care Act to children until age 26, conditioning coverage on whether a child is a tax dependent or a student, or resides with or receives financial support from the parent, is no longer appropriate in light of the correlation between age and these factors. Therefore, these interim final regulations do not allow plans or coverage to use these requirements to deny dependent coverage to children. Because the statute does not distinguish between coverage for minor children and coverage for adult children under age 26, these factors also may not be used to determine eligibility for dependent coverage for minor children.

Accordingly, these interim final regulations clarify that, with respect to children who have not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant (in the individual market, the primary subscriber). Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency on the participant or primary subscriber (or any other person), residency with the participant or primary subscriber (or any other person), student status, employment, eligibility for other coverage, or any combination of these. These interim final regulations also provide that the terms of the plan or policy for dependent coverage cannot vary based on the age of a child, except for children age 26 or older. Examples illustrate that surcharges for coverage of children under age 26 are not allowed except where the surcharges apply regardless of the age of the child (up to age 26) and that, for children under age 26, the plan cannot vary benefits based on the age of the child. The Affordable Care Act, as originally enacted, required plans and issuers to make dependent coverage available only to a child "who is not married." This language was struck by section 2301(b) of the Reconciliation Act. Accordingly, under these interim final regulations, plans and issuers may not limit dependent coverage based on whether a child is married. (However, a plan or issuer is not required under these interim final regulations to cover the spouse of an eligible child).

The statute and these interim final regulations provide that nothing in PHS Act

[2] Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there were no express preemption provisions in chapter 100 of the Code.

[3] *See* section 1004 of the Affordable Care Act.

[4] For purposes of these interim final regulations, dependent coverage means coverage of any individual under the terms of a group health plan, or group or individual health insurance coverage, because of the relationship to a participant (in the individual market, primary subscriber).

section 2714 requires a plan or issuer to make available coverage for a child of a child receiving dependent coverage.

Under section 1004(d) of the Reconciliation Act and IRS Notice 2010–38 (released to the public on April 27, 2010 and scheduled to be published in 2010–20 Internal Revenue Bulletin, May 17, 2010), employers may exclude from the employee's income the value of any employer-provided health coverage for an employee's child for the entire taxable year the child turns 26 if the coverage continues until the end of that taxable year. This means that if a child turns 26 in March, but stays on the plan past December 31st (the end of most people's taxable year), the health benefits up to December 31st can be excluded for tax purposes.

Application to grandfathered health plans. Under the statute and these interim final regulations, the requirement to make available dependent coverage for children who have not attained age 26 generally applies to all group health plans and health insurance issuers offering group or individual health insurance coverage whether or not the plan or health insurance coverage qualifies as a grandfathered health plan[5] under section 1251 of the Affordable Care Act, for plan years (in the individual market, policy years) beginning on or after September 23, 2010. However, in accordance with section 2301(a) of the Reconciliation Act, for plan years beginning before January 1, 2014, these interim final regulations provide that a grandfathered health plan that is a group health plan that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the child is eligible to enroll in an employer-sponsored health plan (as defined in section 5000A(f)(2) of the Code) other than a group health plan of a parent. In the case of an adult child who is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent's employer.

Regulations relating to grandfathered health plans under section 1251 of the Affordable Care Act are expected to be published in the very near future. The Departments anticipate that the regulations will make clear that changes to plan or policy terms to comply with PHS Act section 2714 and these interim final regulations, including voluntary compliance before plan years (in the individual market, policy years) beginning on or after September 23, 2010, will not cause a plan or health insurance coverage to lose grandfathered health plan status for any purpose under the Affordable Care Act, as amended.

Transitional Rule. Prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan or health insurance coverage as a dependent may have lost eligibility under the plan (or coverage) due to age prior to age 26. Moreover, if, when a parent first became eligible for coverage, a child was under age 26 but older than the age at which the plan (or coverage) stopped covering children, the child would not have become eligible for the plan (or coverage). When the provisions of section 2714 become applicable, a plan or issuer can no longer exclude coverage for the child prior to age 26 irrespective of whether or when that child was enrolled in the plan (or coverage). Also, a child of a primary subscriber with family coverage in the individual market may be entitled to an opportunity to enroll if the child previously lost coverage due to age while other family members retained the coverage.[6]

Accordingly, these interim final regulations provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26.

These interim final regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. Thus, many plans can use their existing annual enrollment periods (which commonly begin and end before the start of the plan year) to satisfy the enrollment opportunity requirement. If the child is enrolled, coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. In subsequent years, dependent coverage may be elected for an eligible child in connection with normal enrollment opportunities under the plan or coverage.

Under these interim final regulations, the notice may be provided to an employee on behalf of the employee's child (in the individual market, to a primary subscriber on behalf of the primary subscriber's child). In addition, for a group health plan or group health insurance coverage, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For a group health plan or group health insurance coverage, if a notice satisfying these requirements is provided to an employee whose child is entitled to an enrollment opportunity, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and the issuer.

Any child enrolling in group health plan coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under the regulations interpreting the HIPAA portability provisions.[7] Accordingly, the child must be offered all the benefit packages available to similarly sit-

[5] Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the March 23, 2010 date of enactment (*i.e.*, grandfathered health plans) are subject to only certain provisions.

[6] In the group market, section 9802(a) of the Code, section 702(a) of ERISA, and section 2705 of the PHS Act provide that a plan or issuer cannot impose any rule for eligibility for benefits (including any rule excluding coverage) based on a health factor, including a preexisting condition. These rules were added by HIPAA and generally became applicable for group health plans for plan years beginning on or after July 1, 1997. Similar guidance regarding re-enrollment rights for individuals previously denied coverage due to a health factor was issued by the Departments of the Treasury, Labor, and HHS on December 29, 1997, at 62 FR 67689 and on January 8, 2001 at 66 FR 1378, 1403, 1410, 1418.

[7] HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191). Regulations regarding the treatment of HIPAA special enrollees are included at 26 CFR 54.9801–6(d), 29 CFR 2590.701–6(d), and 45 CFR 146.117(d).

uated individuals who did not lose coverage by reason of cessation of dependent status. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

The Departments have been informed that many health insurance issuers have announced that they will allow continued coverage of adult children before such coverage is required by the Affordable Care Act. A plan or issuer that allows continued coverage of adult children before being required to do so by the Affordable Care Act is not required to provide the enrollment opportunity with respect to children who do not lose coverage.

Examples in these interim final regulations illustrate the application of these transitional rules. One example illustrates that, if a child qualifies for an enrollment opportunity under this section and the parent is not enrolled but is otherwise eligible for enrollment, the plan must provide an opportunity to enroll the parent, in addition to the child. Similarly, another example illustrates that, if a plan has more than one benefit package option, a child qualifies for enrollment under this section, and the parent is enrolled in one benefit package option, the plan must provide an opportunity to enroll the child in any benefit package option for which the child is otherwise eligible (thus allowing the parent to switch benefit package options). Another example illustrates that a child who qualifies for an enrollment opportunity under this section and who is covered under a COBRA continuation provision must be given the opportunity to enroll as a dependent of an active employee (*i.e.*, other than as a COBRA-qualified beneficiary). In this situation, if the child loses eligibility for coverage due to a qualifying event (including aging out of coverage at age 26), the child has another opportunity to elect COBRA continuation coverage. (If the qualifying event is aging out, the COBRA continuation coverage could last 36 months from the loss of eligibility that relates to turning age 26.) The final example in this section illustrates that an employee who joined a plan prior to the applicability date of PHS Act section 2714, and has a child who never enrolled because the child was too old under the terms of the plan but has not yet turned 26, must be provided an opportunity to enroll the child under this section even though the child was not previously covered under the plan. If the parent is no longer eligible for coverage under the plan (for example, if the parent has ceased employment with the plan sponsor) as of the first date on which the enrollment opportunity would be required to be given, the plan would not be required to enroll the child.

B. *Conforming Changes under the PHS Act*

1. *References to the Public Health Service Act*

Conforming changes to references to sections of title XXVII of the PHS Act are made throughout parts 144 and 146 of title 45 of the Code of Federal Regulations to reflect the renumbering of certain sections by the Affordable Care Act.

2. *Definitions (45 CFR 144.103)*

These interim final regulations define "policy year" as the 12-month period that is designated in the policy documents of individual health insurance coverage. If the policy document does not designate a policy year (or no such document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. The Affordable Care Act uses the term "plan year" in referring to the period of coverage in both the individual and group health insurance markets. The term "plan year", however, is generally used in the group health insurance market. Accordingly, these interim final regulations substitute the term "policy year" for "plan year" in defining the period of coverage in the individual health insurance market.

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA was applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process is completed. The statutory requirement implemented in these interim final regulations was enacted on March 23, 2010, and applies for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Having a binding rule in effect is critical to ensuring that individuals entitled to the new protections being implemented have these protections uniformly applied.

Moreover, the provisions in these interim final regulations require lead time for implementation. These interim final regulations require that an enrollment period be provided no later than the first day the obligation to allow dependent children to enroll until attainment of age 26 takes effect. Preparations presumably would have to be made to put such an enrollment process in place. Group health plans and health insurance issuers also would have to take the cost associated with this new obligation into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits, and any such premiums and changes would have to receive necessary approvals in advance of the plan or policy year in question.

For the foregoing reasons, the Departments have determined that it is essential to provide certainty about what will be required of group health plans and health insurance issuers under the statutory requirements implemented in binding regulations as far in advance of

September 23, 2010 as possible. This makes it impracticable to engage in full notice and comment rulemaking before putting regulations into effect, and in the public interest to do so through interim final regulations under which the public will have an opportunity for comment, but that opportunity will not delay putting rules in effect (a delay that could possibly last past September 23, 2010).

Issuance of proposed regulations would not be sufficient because the proposed regulations would not be binding, and different group health plans or health insurance issuers could interpret the statutory language in different ways. Had the Departments published a notice of proposed rulemaking, provided for a 60-day comment period, and only then prepared final regulations, which would be subject to a 60-day delay in effective date, it is unlikely that it would have been possible to have final regulations in effect before late September, when these requirements could be in effect for some plans or policies. It therefore is in the public interest that these interim final regulations be in effect and apply when the statutory protections being implemented apply.

IV. Economic Impact and Paperwork Burden

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

As stated earlier in this preamble, these interim final regulations implement PHS Act section 2714, which requires plans or issuers that make dependent coverage available for children to continue to make such coverage available for an adult child until the attainment of age 26. The regulation also provides an enrollment opportunity to individuals who lost or were not eligible for dependent coverage before age 26.[8] This provision generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act.

The Departments have crafted these interim final regulations to secure the protections intended by Congress in the most economically efficient manner possible. The Departments have quantified costs where possible and provided a qualitative discussion of the economic benefits and some of the transfers and costs that may stem from these interim final regulations.

B. *Executive Order 12866—Department of Labor and Department of Health and Human Services*

Under Executive Order 12866 (58 FR 51735), this regulatory action has been determined "significant" and therefore subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this regulation is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual effect on the economy of $100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs, benefits, and transfers associated with the regulatory provision below. The Departments invite comments on this assessment and its conclusions.

1. *Need for Regulatory Action*

PHS Act section 2714, as added by the Affordable Care Act and amended by the Reconciliation Act requires group health plans and health insurance issuers offering group or individual health insurance coverage that make dependent coverage available for children to continue to make coverage available to such children until the attainment of age 26. With respect to a child receiving dependent coverage, coverage does not have to be extended to a child or children of the child or a spouse of the child. In addition, as provided by the Reconciliation Act, grandfathered group health plans are not required to offer dependent coverage to a child under 26 who is otherwise eligible for employer-sponsored insurance other than a group health plan of a parent for plan years beginning before January 1, 2014. PHS Act section 2714 generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Thus, these interim final regulations are necessary to amend the Departments' existing regulations to implement these statutorily mandated changes.

2. *Summary of Impacts*

In this section, the Departments estimate the number of individuals affected by these interim final regulations, and the impact of the regulations on health insurance premiums in the group and individual markets. Beginning with the population of individuals age 19–25, the number of individuals potentially affected is estimated by applying several criteria including whether their parents have existing employer-sponsored insurance (ESI) or an individual market policy; and whether the individuals are themselves uninsured, have ESI, individual market policies or other forms of coverage. A range of assumptions concerning the percentage of the potentially affected individuals that will accept the offer of new dependent coverage — "take-up" rates— is then applied to estimate the number of newly covered individuals. The premium impact is calculated by using an estimated incremental insurance cost per newly-covered individual as a percent of average family premiums.

[8] The Affordable Care Act adds section 715 and Code section to make the provisions of part A of title XXVII of the PHS Act applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, under ERISA and the Code as if those provisions of the PHS Act were included in ERISA and the Code. The PHS Act sections incorporated by this reference are sections 2701 through 2728. Section 1251 of the Affordable Care Act provides rules for grandfathered health plans, and these rules are further clarified in section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act.

In accordance, with OMB Circular A–4,[9] Table 1 below depicts an accounting statement showing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

TABLE 1.—*Accounting Table*

Benefits		
Annualized Quantified:	low estimate	0.19 million previously uninsured individuals gain coverage in 2011
	mid-range estimate	0.65 million previously uninsured individuals gain coverage in 2011
	high estimate	1.64 million previously uninsured individuals gain coverage in 2011

Qualitative: Expanding coverage options of the 19–25 population should decrease the number uninsured, which in turn should decrease the cost-shifting of uncompensated care onto those with insurance, increase the receipt of preventive health care and provide more timely access to high quality care, resulting in a healthier population. Allowing extended dependent coverage will also permit greater job mobility for this population as their insurance coverage will no longer be tied to their own jobs or student status. Dependents aged 19–25 that have chronic or other serious health conditions would still be able to continue their current coverage through a parent's plan. To the extent there is an increase in beneficial utilization of healthcare, health could improve.

Costs[10]	**Low Estimate**	**Mid-range Estimate**	**High Estimate**	**Year Dollar**	**Discount Rate**	**Period Covered**[11]
Annualized Monetized ($millions/year)	11.2	11.2	11.2	2010	7%	2011–2013
	10.4	10.4	10.4	2010	3%	2011–2013

A one-time notice of right to enroll must be sent to those affected.

Qualitative: To the extent additional coverage increases utilization of health care services, there will be additional costs incurred to achieve the health benefits.

Transfer[12]						
Annualized Monetized ($millions/year)	3,459.3	5,250.2	6,893.9	2010	7%	2011–2013
	3,482.5	5,274.5	6,895.4	2010	3%	2011–2013

Qualitative: If the rule causes family health insurance premiums to increase, there will be a transfer from individuals with family health insurance coverage who do not have dependents aged 19–25 to those individuals with family health insurance coverage that have dependents aged 19–25. To the extent that these higher premiums result in lower profits or higher prices for the employer's product, then the higher premiums will result in a transfer either from stockholders or consumers.

3. *Estimated Number of Affected Individuals*

The Departments' estimates in this section are based on the 2004–2006 Medical Expenditure Panel Survey Household Component (MEPS-HC) which was projected and calibrated to 2010 to be consistent with the National Health Accounts projections. The Departments estimate that in 2010, there are approximately 29.5 million individuals aged 19–25 (young adults) in the United States. Of those individuals, 9.3 million young adults (of whom 3.1 million are uninsured) do not have a parent who has either ESI or non-group insurance, and thus they have no access to dependent coverage. As shown in Table 2, among the remaining 20.2 million young adults whose parents are covered either by ESI or by non-group insurance:

- 3.44 million are currently uninsured,
- 2.42 million are covered by their own non-group insurance,
- 5.55 million are covered by their own ESI,
- 5.73 million are already on their parent's or spouse's ESI, and
- 3.01 million have some other form of coverage such as Medicaid or TRICARE.

[9] Available at http://www.whitehouse.gov/omb/circulars/a004/a–4.pdf.

[10] The cost estimates are annualize across the years 2011–2013, and reflects a single point estimate of the cost to send out a notice in the first year only.

[11] The Departments limited the period covered by the RIA to 2011–2013, because it only has reliable data to make projections over this period due to the fact that in 2014, things will change drastically when the subsidies and tax credits to offset premium increases and the exchanges are in effect.

[12] The estimates in this table reflect the annualized discounted value in 2010 of the additional premium costs for family policies calculated as the product of the newly covered dependents in each year from 2011–2013 (see below) and an incremental cost per newly-covered person in those years (see below).

Table 2.—*Young Adults Aged 19–25 by Insurance Status*

	Uninsured	Non-Group	Own ESI	ESI as a Dependent	Other	Total
Total U.S. Population						
Aged 19–25	**6.59**	**2.69**	6.98	5.75	7.5	29.5
All Young Adults in U.S. with a Parent with a Policy by Young Adult Insurance Status						
Parents have ESI	**3.28**	**2.03**	5.32	5.73	2.91	19.27
Parents have non-group	**0.16**	**0.40**	0.23	—	0.10	0.88
Subtotal A	**3.44**	**2.42**	5.55	5.73	3.01	20.15

*The **bolded** numbers are potentially affected by the regulation.

Source: MEPS 2004–2006 HC Surveys, controlled to 2010 consistent with the National Health Accounts. Note: Total number of young adults, age 19–25 is 29.5 million; the 20.15 million in this Table are the subset whose parents have either ESI or non-group coverage.

Initially, the subset of this group of young adults that will be affected by these interim final regulations are those who are either uninsured (3.44 million) or covered by individual coverage (2.42 million). The statute does not require grandfathered group health plans to offer coverage to young adults who currently have their own ESI or an offer of an ESI. For the purposes of this analysis, it is assumed that all plans begin 2011 with grandfathered status. These impacts could change if plans lose their Grandfathered status.

Of these 5.86 million young adults, as shown in Table 3, 3.49 million are also unlikely to switch to their parents' coverage because:

- They are already allowed to enroll in extended dependent coverage for young adults through their State's existing laws, but have chosen not to (2.61 million). Thirty-seven states already have requirements concerning dependent coverage in the group market, although most of these are substantially more restrictive than those contained in this regulation.[13] Using information about State laws obtained from the Kaiser Family Foundation,[14] a State by State profile of State required coverage based on a person's State of residence, age, student status, and living situation was developed. This profile was then overlaid on MEPS data to obtain an estimate of the number of individuals that would newly become eligible for coverage due to these interim final regulations.
- They have an offer of ESI and have parents who are covered by ESI (0.48 million). For the purposes of this regulatory impact statement, the Departments assume that the parents of these young adults will be in grandfathered group health plans, and thus that these young adults will not be affected by the provisions of these interim final regulations. To the extent that some of the coverage in which these parents are enrolled is not grandfathered, the effect of these interim final regulations will be larger than the estimates provided here.
- Finally, there are 0.40 million young adults who have non-group coverage and whose parents have non-group coverage. Because the parents' non-group coverage is underwritten, there is not likely to be any financial benefit to the family in moving the young adult onto the parents' coverage, and the Departments assume that these young adults will not be affected by the regulation.

[13] Restrictions include requirements for financial dependency, student status, and age limits.

[14] As described in Kaiser Family Foundation, Definition of Dependency by Age, 2010, KFF State Health Facts, at http://www.statehealthfacts.org/comparetable.jsp?ind=601&cat=7.

TABLE 3.—*"Uninsured" and "Non-group" Young Adults Unlikely to be Affected by Extending Dependent Coverage to Age 26*

	Uninsured	Non-Group Coverage	Total
1) Young adults potentially covered by parent ESI due to state law	1.30	1.31	2.61
2) Young adults with an offer of ESI whose parents have ESI	0.31	0.17	0.48
3) Young adults with non-group coverage whose parents have non-group coverage		0.40	0.40
Subtotal B	1.61	1.88	3.49

As shown in Table 4, this leaves approximately 2.37 million young adults who might be affected by this provision, or approximately eight percent of the 29.5 million young adults in the age group. Among the approximately 2.37 million young adults who are estimated to be potentially affected by this provision, approximately 1.83 million are currently uninsured, and 0.55 million are currently covered by their own non-group coverage.

TABLE 4 .—Young Adults Potentially Affected by Extending Dependent Coverage to Age 26

	Uninsured	Non-Group Coverage	Total
Parents have ESI	1.67	0.55	2.21
Parents have non-group	0.16		0.16
Total (Subtotal A-Subtotal B)*	1.83	0.55	2.37

Source: MEPS 2004–2006 HC Surveys, controlled to 2010 consistent with projections of the National Health Accounts.

*Subtotal A is in Table 2 and Subtotal B is in Table 3.

It is difficult to estimate precisely what fraction of the 2.37 million young adults who might potentially be affected by the provision will actually enroll on their parents' coverage. A study by Monheit and Cantor of the early experience in States that have extended coverage to dependents suggests that few uninsured children in these States shift to their parents' policy.[15] However, data and methodological difficulties inevitably lead to substantial uncertainty about the finding.

The Departments considered two other points of reference to estimate take-up rates. One is the work that has analyzed take-up rates among people made newly eligible for public coverage by Medicaid expansions. These studies suggest take-up rates in the range of 10–34 percent.[16] However, the populations eligible for these expansions have different socio-demographic compositions than those eligible for the dependent coverage provisions covered under these interim final regulations, and the decision to take-up Medicaid is clearly different than the decision to cover a child on a parent's private insurance policy. A second point of reference are estimates from the Kaiser/HRET Employer Health benefits Survey[17] which suggest that, depending on the size of the worker contribution, between 77 percent and 90 percent of employees accept offers of family policies. Again, these estimates would be based on a group that differs in characteristics from those eligible for new dependent coverage. These concerns notwithstanding, the analyses of Medicaid expansions and employee take-up of employer sponsored coverage provide useful points of reference.

Recognizing the uncertainty in the area, the Departments produced a range of assumptions concerning take-up rates. In developing the range of take-up rates, the Departments assume that these rates will vary by the following factors: (1) the young adult's current health coverage status (uninsured young adults are less likely to take advantage of the dependent coverage option than young adults

[15] Monheit, A., J. Cantor, et al, "State Policies Expanding Dependent Coverage to Young Adults in Private Health Insurance Plans," presented at the Academy Health State Health Research and Policy Interest Group Meeting, Chicago IL, June 27, 2009.

[16] Bansak, Cynthia and Steven Raphael. "The Effects of State Policy Design Features on Take-Up and Crowd-out Rates fro the State Children's Health Insurance Program." Journal of Policy Analysis and Management, Vol. 26, No. 1, 149–175. 2006. Find that for the time period 1998–2002 take-up rates for SCHIP were about 10 percent.

Currie, Janet and Jonathan Gruber. "Saving babies: The Efficacy and Cost of Recent Changes in Medicaid Eligibility of Pregnant Women." The Journal of Political Economy, Vol. 104, No. 6, Dec. 1996, pp. 1263–1296. Find for Medicaid expansions during the 1979–1992 period the take-up rate for eligible pregnant women was 34 percent.

Cutler, David and Jonathan Gruber. "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics, Vol. 111, No. 2, May 1996, pp. 391–430. Find that for the Medicaid expansions from 1987–1992 the take-up rate for the uninsured is close to 30 percent, while for pregnant women it was seven percent.

Gruber, Jonathan and Kosali Simon. "Crowd-Out Ten years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" NBER Working Paper 12858. January 2007. Find that for the Medicaid expansions during 1996–2002 the take-up rate was 7 percent across all children, but nearly one-third for uninsured children.

[17] Found at http://www.kff.org/insurance/snapshot/chcm020707oth.cfm

already covered by non-group insurance, because young adults who have purchased non-group insurance have shown a strong preference for coverage, and can almost always save money and get better coverage by switching to their parents' policy); (2) the young adult's health status (young adults in fair or poor health are more likely to take advantage of the option than those in excellent, very good or good health), and (3) the young adult's living situation (those living with their parents are more likely to take up the option than those not living with their parents).

The almost fully covered or "high" take-up rate scenario assumes that regardless of health or insurance status, 95 percent of young adults living at home and 85 percent of those not living at home would move to dependent coverage. For the mid-range scenario, the Departments assume that relative to the high take-up rate scenario, 90 percent of the uninsured whose health status was fair or poor health and 50 percent of those in good to excellent health would move to dependent coverage. In the low take-up rate scenario, the Departments adjusted the percentages to 80 percent and 10 percent of the high take-up rate scenario. In all three scenarios, the same assumptions apply to individuals with non-group policies whose parents have ESI — 95 percent of those living at home and 85 percent of those living elsewhere would move to dependent coverage.

In the low take-up rate scenario, the assumptions lead to the result that approximately 30 percent of eligibles will enroll in dependent coverage. In the mid-range scenario, they result in an approximate 50 percent take-up rate, and in the high take-up scenario, they result in an approximate 90 percent take-up rate. The Departments are uncertain regarding which of these scenarios is most likely but are confident that they bracket the expected outcome.

Table 5.—*Number of Individuals with New Dependent Coverage and Impact on Group Insurance Premiums, 2011–2013*

	Low Estimate			**Mid-range Estimate**			**High Estimate**		
	2011	**2012**	**2013**	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
Individuals with New Dependent Coverage (millions)	0.68	0.97	1.08	1.24	1.60	1.65	2.12	2.07	1.98
From Uninsured (millions)	0.19	0.29	0.33	0.65	0.94	0.91	1.64	1.42	1.21
Incremental Premium Cost Per Individual Coverage	$3,670	$3,800	$4,000	$3,380	$3,500	$3,690	$3,220	$3,340	$3,510
Impact on Group Insurance Premiums (%)	0.5	0.7	0.7	0.7	1.0	1.0	1.2	1.2	1.1

These take-up rate assumptions are then applied to the number of potentially affected individuals displayed in Table 3. The resulting number of individuals with new dependent coverage is summarized in Table 5. Under the mid-range take-up rate assumption, the Departments estimate that in 2011, 1.24 million young adults will newly be covered by their parents' ESI or non group market policies, of whom 0.65 million were previously uninsured, and 0.6 million were previously covered by non-group coverage. The number of individuals newly covered by their parents' plans would be 0.7 and 2.12 million under the high and low take-up rate assumptions respectively, with 0.2 and 1.64 million of these individuals being previously uninsured. Relative to the individuals covered under the high take-up rate assumption, higher proportions of the low- and mid-range assumption groups are accounted for by people who previously had non-group coverage (72 percent and 48 percent respectively in contrast to 23 percent for the high take-up rate group). This difference is a result of the Departments' assumption for the low- and mid-range take-up rates that people with non-group coverage will be more likely than healthy people who were uninsured to take advantage of the dependent coverage option.

Under the mid-range take-up rate assumptions, the estimated number of young adults covered by their parents' plans in 2012 increases somewhat over the 2011 estimate to 1.6 million in total, of whom approximately 0.9 million would have been uninsured. The increase in the estimate for 2012 results from the assumption that as children reach the age that would have caused them to be excluded from their parents' policy before the implementation of these interim final regulations, a large fraction of them now will remain on their parents' policy. Similarly, the estimated number of young adults enrolling in their parents' non-group policy increases from just under 75,000 in 2011 to approximately 100,000 in 2012, and 120,000 in 2013.

4. *Benefits*

The benefits of these interim final regulations are expected to outweigh the costs to the regulated community. In the mid-range take-up rate assumption, the Departments estimate that in 2011, 0.65 million

previously uninsured individuals will now be covered on their parents policies due to these interim final regulations and 1.24 million individuals total will now be covered on their parent's coverage. Expanding coverage options for the 19–25 population should decrease the number uninsured, which in turn should decrease the cost-shifting of uncompensated care onto those with coverage, increase the receipt of preventive health care and provide more timely access to high quality care, resulting in a healthier population. In particular, children with chronic conditions or other serious health issues will be able to continue coverage through a parent's plan until age 26. Allowing extended dependent coverage also will permit greater job mobility for this population as their health coverage will no longer be tied to their own jobs or student status.

5. *Costs and Transfers Associated with the Rule*

Estimates for the incremental annual premium costs for the newly covered individuals are developed based on expenditure data from MEPS and vary based on the take-up rate assumptions. These incremental costs are lowest for the high take-up rate assumption since the newly covered group would contain a relatively high percentage of individuals whose health status was good to excellent. Conversely, the low take-up rate assumption results in the highest incremental costs because a higher percentage of the newly covered individuals would be those whose health status was fair to poor. For those enrolling in their parents' ESI, the expected annual premium cost under the mid-range take-up rate assumption would be $3,380 in 2011, $3,500 in 2012 and $3,690 in 2013. If these costs were distributed among all family ESI plans, family premiums would be expected to rise by 0.7 percent in 2011, 1.0 percent in 2012, and 1.0 percent in 2013 due to these interim final regulations.[18] The comparable incremental costs and premium effects for the low and high take-up rate assumptions are summarized in Table 5. To the extent that these increases are passed on to workers in the form of higher premiums for all workers purchasing family policies or in the form of lower wages for all workers, there will be a transfer from workers who do not have newly covered dependents to those who do. To the extent that these higher premiums result in lower profits or higher prices for the employer's product, the higher premiums will result in a transfer either from stockholders or consumers.

In addition, to the extent that these interim final regulations result in a decrease in the number of uninsured, the Departments expect a reduction in uncompensated care, and a reduction in liability for those who fund uncompensated care, including public programs (primarily Medicaid and State and local general revenue support for public hospitals), as well as the portion of uncompensated care that is paid for by the cost shift from private premium payers. Such effects would lead to lower premiums for the insured population, both with or without newly covered children.

For the small number of children (75,000 in 2011) enrolling in their parents' non-group insurance policy under the mid-range take-up assumption, the Departments expect estimated annual premium cost to be $2,360 in 2011, $2,400 in 2012 and $2,480 in 2013. To a large extent, premiums in the non-group market are individually underwritten, and the Departments expect that most of the premium cost will be borne by the parents who are purchasing the policy to which their child is added. If, instead, these costs were distributed over the entire individual market (as would be the case in a pure community-rated market), then individual premiums would be expected to rise 0.7 percent in 2011, 1.0 percent in 2012, and 1.2 percent in 2013 due to these interim final regulations. However, the Departments expect the actual increase across the entire individual market, if any, will be much smaller than these estimates, because they expect that the costs largely will be borne by the subscribers who are directly affected rather than distributed across the entire individual market.

6. *Enrollment Opportunity*

These interim final regulations provide an enrollment opportunity for children excluded from coverage because of age before the effective date of the rule. The Departments estimate that this information collection request will result in approximately 105,000,000 notices being distributed with an hour burden of approximately 1,100,000 hours and cost burden of approximately $2,010,500. For a discussion of this enrollment opportunity, see the Paperwork Reduction Act section later in this preamble.

7. *Regulatory Alternatives*

Section 6(a)(3)(C)(iii) of Executive Order 12866 requires an economically significant regulation to include an assessment of the costs and benefits of potentially effective and reasonable alternatives to the planned regulation, and an explanation of why the planned regulatory action is preferable to the potential alternatives. The Departments carefully considered limiting the flexibility of plans and policies to define who is a child. However, the Departments concluded, as they have in other regulatory contexts, that plan sponsors and issuers should be free to determine whether to cover children or which children should be covered by their plans and policies (although they must comply with other applicable Federal or State law mandating coverage, such as ERISA section 609). Therefore, these interim final regulations have not limited a plan's or policy's flexibility to define who is a child for purposes of the determination of children to whom coverage must be made available.

C. *Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services*

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are

[18] For purposes of this regulatory impact analysis, the Departments assume that there would be no effect on premiums for employee-only policies.

impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the regulations would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the regulations on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of PHS Act section 2714 and minimize the impact on small entities.

D. *Special Analyses-Department of the Treasury*

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these interim final regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. *Paperwork Reduction Act*

1. *Department of Labor and Department of Treasury: Affordable Care Act*

Enrollment Opportunity Notice Relating to Extended Dependent Coverage

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

As discussed earlier in this preamble, prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan (or group health insurance coverage) may have lost eligibility for coverage under the plan due to age before age 26. Moreover, if a child was under age 26 when a parent first became eligible for coverage, but older than the age at which the plan stopped covering children, the child would not have become eligible for coverage. When the provisions of PHS Act section 2714 become applicable to the plan (or coverage), the plan or coverage can no longer exclude coverage for the individual until age 26.

Accordingly, these interim final regulations require plans to provide a notice of an enrollment opportunity to individuals whose coverage ended, or who were denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010 (which is the applicability date of PHS Act section 2714). Coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.[19]

The Affordable Care Act dependent coverage enrollment opportunity notice is an information collection request (ICR) subject to the PRA. Currently, the Departments are soliciting public comments for 60 days concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395–7285 or by email to *oira_submission@omb.eop.gov*. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–4745. These are not toll-free numbers. E-mail:

[19] Any individual enrolling in coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under HIPAA portability rules. Accordingly, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

ebsa.opr@dol.gov. ICRs submitted to OMB also are available at reginfo.gov (*http://www.reginfo.gov/public/do/*PRA-Main).

The Departments assume that 2,800,000 ERISA covered plans will send the enrollment opportunity notice to all 79,573,000 employees eligible for group health insurance coverage. The Departments estimate that preparing the enrollment notice will require 30 minutes of legal professional time at a labor rate of $119 per hour[20] and one minute of clerical time at $26 per hour per paper notice to distribute the notices.[21] This results in an hour burden of nearly 822,000 hours and an associated equivalent cost of nearly $21,513,000.

The Departments estimate that the cost burden associated with distributing the approximately 79,573,000 notices will be approximately $2,467,000 based on one minute of clerical time, and $.05 per page for material and printing costs. The Departments assumed that 38 percent of the notices would be sent electronically.[22] In addition, plans can send these notices with other plan documents, such as open enrollment materials. Therefore, the Departments have not included postage costs in this estimate. The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.[23]

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Affordable Care Act Enrollment Opportunity Notice Relating to Extended Dependent Coverage.

OMB Number: 1210–0139; 1545–2172.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents:2,800,000.

Total Responses:79,573,000.

Frequency of Response: One-time.

Estimated Total Annual Burden Hours: 411,000 hours (Employee Benefits Security Administration); 411,000 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: $1,233,500 (Employee Benefits Security Administration); $1,233,500 (Internal Revenue Service).

2. *Department of Health and Human Services: Affordable Care Act Enrollment Opportunity Notice Relating to Extended Dependent Coverage*

We are soliciting public comment on the following sections of this document that contain information collection requirements (ICR) regarding the Affordable Care Act — ICR Relating to Enrollment Opportunity Notice — Dependent Coverage. As discussed earlier in this preamble, the Affordable Care Act and these interim final regulations require issuers in the individual market and group health plans sponsored by State and local governments to notify participants regarding an enrollment opportunity related to the extension of dependent coverage. Prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan (or group health insurance coverage) as a dependent may have lost eligibility for coverage under the plan due to age before age 26. Moreover, if, when a parent first became eligible for coverage, a child was under age 26 but older than the age at which the plan stopped covering children, the child would not have become eligible for coverage. When the provisions of PHS Act section 2714 become applicable to the plan (or coverage), the plan or coverage can no longer exclude coverage for the individual until age 26.

Accordingly, these interim final regulations require issuers in the individual insurance market and group health plans sponsored by State and local governments to provide a notice of an enrollment opportunity to individuals whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010 (which is the applicability date of PHS Act section 2714). Coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.[24]

The Department estimates that 126,000 State and local governmental plans would have to send 19,627,000 notices to eligible employees and 490 insurers in the individual market would have to send approximately 5,444,000 notices to individuals with policies covering dependents.[25] For purposes of this estimate, the Department assumes that it will take a legal profes-

[20] Hourly wage estimates are based on data from the Bureau of Labor Statistics Occupational Employment Survey (May 2008) and the Bureau of Labor Statistics Employment Cost Index (June 2009). All hourly wage rates include wages and benefits. Clerical wage and benefits estimates are based on metropolitan wage rates for executive secretaries and administrative assistants. Legal professional wage and benefits estimates are based on metropolitan wage rates for lawyers.

[21] While plans could prepare their own notice, the Departments assume that the notices will be prepared by service providers. The Departments have previously estimated that there are 630 health insurers (460 providing coverage in the group market, and 490 providing coverage in the individual market.). These estimates are from NAIC 2007 financial statements data and the California Department of Managed Healthcare (2009), at http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx. Because the hour and cost burden is shared between the Departments of Labor/Treasury and the Department of Health and Human Services, the burden to prepare the notices is calculated using half the number of insurers (315).

[22] For purposes of this burden estimate, the Departments assume that 38 percent of the disclosures will be provided through electronic means in accordance with the Department of Labor's standards for electronic communication of required information provided under 29 CFR 2520.104b–1(c).

[23] 5 CFR 1320.1 through 1320.18.

[24] Any individual enrolling in coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under HIPAA portability rules. Accordingly, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

[25] The number of individual insurance notices was based on the number of individual policy holders with dependents on that policy according to the 2009 March Current Population Survey (CPS).

sional, on average, 30 minutes to prepare the notice at a labor rate of $119 per hour[26], and one minute, on average, of a clerical professional's time at $26 per hour to copy and mail the notice.[27] While plans could prepare their own notice, the Department assumes that the notices will be prepared by service providers. The Department has previously estimated that there are 630 health insurers[28] (460 providing coverage in the group market, and 490 providing coverage in the individual market.). Because the hour and cost burden is shared among the Departments of Labor/Treasury and the Department of Health and Human Services, the burden to prepare the notices is calculated using half the number of insurers (315). The Department assumes that 38 percent of the notices would be sent electronically.[29] Notices that are sent electronically do not require any of the clerical worker's time to mail the notice. This results in an hour burden of approximately 259,000 hours and an associated equivalent cost of about $6,791,000 to prepare and distribute 25,071,000 notices. The Department estimates that the cost burden associated with distributing the notices will be approximately $777,000.[30] The Department assumes that 38 percent of the notices would be sent electronically.[31] In addition, plans and issuers can send these notices with other plan documents (for example, during open enrollment for the government plans, or other communication at reenrollment in the individual market). Therefore, the Department did not include postage costs in this estimate. The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.[32]

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agency: Department of Health and Human Services.

Title: Notice of Special Enrollment Opportunity under the Affordable Care Act Relating to Dependent Coverage.

OMB Number: 0938–1089.

Affected Public: Business; State, Local, or Tribal Governments.

Respondents: 126,000.

Responses: 25,071,000.

Frequency of Response: One-time.

Estimated Total Annual Burden Hours: 259,000 hours.

Estimated Total Annual Burden Cost: $777,000.

If you comment on this information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, 4140–IFC

Fax: (202) 395–6974; or

Email: *OIRA_submission@omb.eop.gov*

F. *Congressional Review Act*

These interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq*.) and have been transmitted to Congress and the Comptroller General for review.

G. *Unfunded Mandates Reform Act*

The Unfunded Mandates Reform Act of 1995 (Public Law 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act, because they are being issued as an interim final regulation. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. *Federalism Statement—Department of Labor and Department of Health and Human Services*

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

In the Departments' view, these interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regu-

[26] Estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

[27] These estimates are from NAIC 2007 financial statements data and the California Department of Managed Healthcare (2009), at http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx.

[28] For purposes of this burden estimate, the Department assumes that 38 percent of the disclosures will be provided through electronic means.

[29] This estimate is based on an average document size of one page and $.05 cents per page for material and printing costs.

[30] For purposes of this burden estimate, the Department assumes that 38 percent of the disclosures will be provided through electronic means.

[31] 5 CFR 1320.1 through 1320.18.

lating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be ''construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement'' of a federal standard. The conference report accompanying HIPAA indicates that this is intended to be the ''narrowest'' preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to ''prevent the application of'' the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Office of Consumer Information and Insurance Oversight have complied with the requirements of Executive Order 13132 for the attached regulation in a meaningful and timely manner.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

* * * * *

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Steven T. Miller,
Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved May 7, 2010.

Michael F. Mundaca,
Acting Secretary of the Treasury (Tax Policy).

Signed this 6^{th} day of *May*, 2010.

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

Approved: *May 4, 2010*

Jay Angoff,
Director,
Office of Consumer Information and Insurance Oversight.

Approved: *May 7, 2010*

Kathleen Sebelius,
Secretary.

Internal Revenue Service

26 CFR Chapter 1

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

PART 54—PENSION EXCISE TAXES

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

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

Par. 2. Section 54.9815–2714T is added to read as follows:

§54.9815–2714T Eligibility of children until at least age 26 (temporary).

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts*. For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion*. In this *Example*, the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent*. With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors. In addition, a plan or issuer may not deny or restrict coverage of a child based on eligibility for other coverage, except that paragraph (g) of this section provides a special rule for plan years beginning before January 1, 2014 for grandfathered health plans that are group health plans. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may mandate coverage of certain children.)

(c) *Coverage of grandchildren not required*. Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age*. The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples*. The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion*. In this *Example 1*, the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts*. A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion*. In this *Example 2*, the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3. (i) *Facts*. A group health plan offers two benefit packages — an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion*. In this *Example 3*, the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

(f) *Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility threshold*—(1) *In general*. The relief provided in the transitional rules of this paragraph (f) applies with respect to any child—

(i) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010 by reason of the application of this section.

(2) *Opportunity to enroll required*. (i) If a group health plan, or group health insurance coverage, in which a child described in paragraph (f)(1) of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph (f)(1)(i) of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

(ii) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying the requirements of this paragraph (f)(2) is provided to an employee whose child is entitled to an enrollment opportunity under this paragraph (f), the obligation to provide the notice of enrollment opportunity under this paragraph (f)(2) with respect to that child is satisfied for both the plan and the issuer.

(3) *Effective date of coverage*. In the case of an individual who enrolls under paragraph (f)(2) of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan*. Any child enrolling in a group health plan pursuant to paragraph (f)(2) of this section must be treated as if the child were a special enrollee, as provided under the rules of §54.9801–6(d). Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

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

Example 1. (i) *Facts*. Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual B, an employee of Y, and Individual C, B's child and a full-time student, were enrolled in Y's group health plan at the beginning of the 2010 plan year. On June 10, 2010, C turns 23 years old and loses dependent coverage under Y's plan. On or before January 1, 2011, Y's group health plan gives B written notice that individuals who lost coverage by reason of ceasing to be a dependent before attainment of age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion*. In this *Example 1*, the plan has complied with the requirements of this paragraph (f) by providing an enrollment opportunity to C that lasts at least 30 days.

Example 2. (i) *Facts*. Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual D, an employee of Z, and Individual E, D's child, are enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, E turns 22 years old and ceases to be eligible as a dependent under Z's plan and loses coverage. D drops coverage but remains an employee of Z.

(ii) *Conclusion*. In this *Example 2*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts*. Same facts as *Example 2*, except that D did not drop coverage. Instead, D switched to a lower-cost benefit package option.

(ii) *Conclusion*. In this *Example 3*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

Example 4. (i) *Facts*. Same facts as *Example 2*, except that E elected COBRA continuation coverage.

(ii) *Conclusion*. In this *Example 4*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 5. (i) *Facts*. Employer X maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

(ii) *Conclusion*. In this *Example 5*, notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2)) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date*. The provisions of this section apply for plan years beginning on or after September 23, 2010.

(i) *Expiration date*. This section expires on or before May 13, 2013.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

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

Authority: 26 U.S.C. 7805.

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

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where Identified and described	Current OMB control No.
* * * * *	
54.9815–2714T	1545–2172
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(Filed by the Office of the Federal Register on May 10, 2010, 4:15 p.m., and published in the issue of the Federal Register for May 13, 2010, 75 F.R. 27121)

Part III. Administrative, Procedural, and Miscellaneous

Definition of Foreign Partnership — Sections 7701(a) and 7805

Notice 2010–41

SECTION 1. OVERVIEW

The Treasury Department and Internal Revenue Service (IRS) intend to issue regulations that will classify certain domestic partnerships as foreign for purposes of identifying the United States shareholders (as defined in § 951(b) of the Internal Revenue Code (Code)) of a controlled foreign corporation (as defined in § 957(a)) that are required to include in gross income the amounts specified under § 951(a) of such controlled foreign corporation. The regulations to be issued pursuant to this notice shall apply to taxable years of a domestic partnership ending on or after May 14, 2010.

SECTION 2. TRANSACTION AT ISSUE

On December 29, 2008, the Treasury Department and the IRS issued Notice 2009–7, 2009–3 I.R.B. 312, identifying the following transaction (and substantially similar transactions) as a transaction of interest for purposes of § 1.6011–4(b)(6) and §§ 6111 and 6112 of the Code. A United States taxpayer (Taxpayer) wholly owns two controlled foreign corporations (CFC1 and CFC2), each of which owns 50 percent of another controlled foreign corporation (CFC3) through a domestic partnership. CFC3 has amounts described in § 951(a)(1). Taxpayer takes the position that it does not have an income inclusion under § 951(a) with respect to CFC3 because the domestic partnership is the first United States person in the chain of ownership of CFC3. As stated in Notice 2009–7, the Treasury Department and IRS believe that Taxpayer's position is contrary to the purpose and intent of § 951 of the Code.

SECTION 3. BACKGROUND

Section 951(a) provides that if a foreign corporation is a CFC for an uninterrupted period of 30 days or more during any taxable year, then each United States shareholder (as defined in § 951(b)) of such corporation that owns, within the meaning of § 958(a), stock in the corporation on the last day in such year on which it is a CFC must include in gross income its pro rata share of the corporation's subpart F income (as defined in § 952) as well as any amount determined under § 956 with respect to such shareholder. See also § 951(a)(1)(A)(ii) and (iii) for other required inclusions.

Section 951(b) defines a United States shareholder, with respect to any foreign corporation, as a United States person (as defined in § 957(c)) that owns (within the meaning of § 958(a)) or is considered as owning under § 958(b), 10 percent or more of the total combined voting power of all classes of stock entitled to vote of the foreign corporation.

With certain modifications, § 957(c) defines a United States person by reference to § 7701(a)(30). Section 7701(a)(30)(B) defines a United States person to include a domestic partnership. Section 7701(a)(5) defines the term foreign when applied to a corporation or partnership as a corporation or partnership that is not domestic. Section 7701(a)(4) provides that the term domestic when applied to a corporation or partnership means created or organized in the United States or under the law of the United States or of any State unless, in the case of a partnership, the Secretary provides otherwise by regulations. However, § 7701(a) provides that any general definition included therein does not apply where such definition is manifestly incompatible with the intent of the relevant Code provision.

SECTION 4. REGULATIONS CONCERNING THE DEFINITION OF A FOREIGN PARTNERSHIP UNDER SECTION 7701

If the general definition of a United States person provided by § 7701(a)(30)(B) (which incorporates the general definition of a domestic partnership under § 7701(a)(4)) applies to the facts described above in Section 2 (and in Notice 2009–7), the domestic partnership is the United States shareholder required to include in gross income the amounts determined under § 951(a) with respect to CFC3. However, the domestic partnership's gross income inclusion may have little or no tax consequences, depending on the treatment of each partner's (CFC1 and CFC2) distributive share of such income. As stated in Notice 2009–7, the Treasury Department and the IRS believe that the Taxpayer's position in the transaction described therein is contrary to the purpose and intent of § 951. Therefore, consistent with § 7701(a), the Treasury Department and the IRS have determined that the general definition of a domestic partnership under § 7701(a)(4), in the case of certain partnerships owned wholly or partly by foreign corporations, is manifestly incompatible with the intent of § 951.

SECTION 4.01. DOMESTIC PARTNERSHIP TREATED AS FOREIGN FOR CERTAIN PURPOSES

The Treasury Department and the IRS intend to issue regulations that, under certain circumstances, will classify an otherwise domestic partnership as foreign solely for purposes of identifying the United States shareholders of a CFC required to include in gross income the amounts determined under § 951(a) with respect to such CFC. Specifically, the regulations to be issued shall treat a domestic partnership as foreign for this purpose if the following conditions are satisfied:

1. The partnership is a United States shareholder of a foreign corporation that is a CFC (within the meaning of § 957(a) or 953(c)); and
2. If the partnership were treated as foreign,
   a. That foreign corporation would continue to be a CFC; and
   b. At least one United States shareholder of the CFC,
      i. Would be treated under § 958(a) as indirectly owning stock of the CFC owned by the partnership that is indirectly owned by a foreign corporation; and
      ii. Would be required to include an amount in gross income

under § 951(a) with respect to the CFC.

The regulations to be issued will provide similar results in the case of tiered-partnership structures.

SECTION 4.02. SCOPE OF TREATMENT AS A FOREIGN PARTNERSHIP

The regulations to be issued shall classify a domestic partnership described in § 4.01 of this notice as foreign solely for purposes of identifying the United States shareholders of a CFC required to include in gross income the amounts determined under § 951(a) with respect to such CFC. Therefore, a domestic partnership to which the regulations to be issued apply shall continue to be classified as domestic for all other purposes of the Code. For example, the regulations to be issued shall not otherwise affect the classification of the partnership as domestic for purposes of determining the source of income and expenses, the definition of "United States property" under § 956(c)(1)(C), and the application of § 1248(a). Similarly, the partnership remains a domestic partnership for purposes of determining its information reporting obligations, including the filing of a Form 1065, *U.S. Return of Partnership Income*, and Form 5471, *Information Return of U.S. Persons With Respect To Certain Foreign Corporations*.

The following demonstrates the application of the regulations described in this Notice to the facts described above in Section 2. Under the regulations to be issued, the domestic partnership described in Notice 2009–7 and in Section 2 above would be treated as foreign because the partnership would be a United States shareholder of a foreign corporation that is a CFC (CFC3) if the regulations to be issued did not apply; and if the domestic partnership were treated as foreign, (1) CFC3 would continue to be a CFC, and (2) under § 958(a) Taxpayer (a United States shareholder of CFC3) would be treated as indirectly owning the stock of CFC3 owned by the partnership that is indirectly owned by CFC1 and CFC2, and would be required to include in gross income the amounts determined under § 951(a) with respect to CFC3. The result would be the same if the Taxpayer were a partner in the partnership (in addition to CFC1 and CFC2), or also owned directly stock of CFC3.

SECTION 5. EFFECT ON OTHER DOCUMENTS

Notice 2009–7 shall continue to apply, as appropriate.

SECTION 6. EFFECTIVE DATE

The regulations to be issued as described in this notice shall apply to taxable years of a domestic partnership ending on or after May 14, 2010. No inference is intended as to the treatment of a domestic partnership for any taxable year ending before May 14, 2010. As stated in Notice 2009–7, the IRS may challenge the positions taken by taxpayers with respect to such transactions, including under the provisions of subpart F and subchapter K of the Code, or under judicial doctrines including the sham transaction, substance over form, and economic substance doctrines.

SECTION 7. DRAFTING INFORMATION

For further information regarding this notice, contact Susan E. Massey at (202) 622–3840 (not a toll-free call).

Public Comment Invited on Recommendations for 2010–2011 Guidance Priority List

Notice 2010–43

The Department of Treasury and Internal Revenue Service invite public comment on recommendations for items that should be included on the 2010–2011 Guidance Priority List.

The Treasury Department's Office of Tax Policy and the Service use the Guidance Priority List each year to identify and prioritize the tax issues that should be addressed through regulations, revenue rulings, revenue procedures, notices, and other published administrative guidance. The 2010–2011 Guidance Priority List will establish the guidance that the Treasury Department and the Service intend to issue from July 1, 2010, through June 30, 2011. The Treasury Department and the Service recognize the importance of public input to formulate a Guidance Priority List that focuses resources on guidance items that are most important to taxpayers and tax administration. Published guidance plays an important role in increasing voluntary compliance by helping to clarify ambiguous areas of the tax law.

As is the case whenever significant legislation is enacted, the Treasury Department and the Service have continued to dedicate substantial resources during the current plan year to published guidance projects necessary to implement the provisions of the multitude of Tax Acts that have been enacted over the past several years including, but not limited to, the Pension Protection Act of 2006, Pub. L. No. 109–280, 120 Stat. 780, which was enacted on August 17, 2006; the Emergency Economic Stabilization Act of 2008, Energy Improvement and Extension Act of 2008, and Tax Extenders and Alternative Minimum Tax Relief Act of 2008, Pub. L. No. 110–343, 122 Stat. 3765, which were enacted on October 3, 2008; the American Recovery and Reinvestment Tax Act of 2009, Pub. L. No. 111–5, 123 Stat. 115, which was enacted on February 17, 2009; the Hiring Incentives to Restore Employment Act, Pub. L. No. 111–147, 124 Stat. 71, which was enacted on March 18, 2010; the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119, which was enacted on March 23, 2010; and the Health Care and Education Reconciliation Act, Pub. L. 111–152, 124 Stat. 1029, which was enacted on March 30, 2010. The Treasury Department and the Service will continue to evaluate the priority of each guidance project in light of the above-mentioned tax legislation and other developments occurring during the 2010–2011 plan year.

In reviewing recommendations and selecting projects for inclusion on the 2010–2011 Guidance Priority List, the Treasury Department and the Service will consider the following:

1. Whether the recommended guidance resolves significant issues relevant to many taxpayers;

2. Whether the recommended guidance promotes sound tax administration;

3. Whether the recommended guidance can be drafted in a manner that will enable taxpayers to easily understand and apply the guidance;

4. Whether the Service can administer the recommended guidance on a uniform basis; and

5. Whether the recommended guidance reduces controversy and lessens the burden on taxpayers or the Service.

Taxpayers may submit recommendations for guidance at any time during the year. Please submit recommendations by June 11, 2010, for possible inclusion on the original 2010–2011 Guidance Priority List. The Treasury Department and the Service may update the 2010–2011 Guidance Priority List periodically to reflect additional guidance that the Treasury Department and the Service intend to publish during the plan year. The periodic updates allow the Treasury Department and the Service to respond to the need for additional guidance that may arise during the plan year. Recommendations for guidance received after June 11, 2010, will be reviewed for inclusion in the next periodic update.

Taxpayers are not required to submit recommendations for guidance in any particular format. Taxpayers should, however, briefly describe the recommended guidance and explain the need for the guidance. In addition, taxpayers may include an analysis of how the issue should be resolved. It would be helpful if taxpayers suggesting more than one guidance project prioritize the projects by order of importance. If a large number of projects are being suggested, it also would be helpful if the projects were grouped in terms of high, medium or low priority.

Taxpayers should send written comments to:

Internal Revenue Service
Attn: CC:PA:LPD:PR
(Notice 2010–43)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

or hand deliver comments Monday through Friday between the hours of 8 a.m. and 4 p.m. to:

Courier's Desk
Internal Revenue Service
Attn: CC:PA:LPD:PR
(Notice 2010–43)
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Alternatively, taxpayers may submit comments electronically via e-mail to the following address: *Notice.Comments@irscounsel.treas.gov.* Taxpayers should include "Notice 2010–43" in the subject line. All comments submitted by the public will be available for public inspection and copying in their entirety.

For further information regarding this notice, contact Henry Schneiderman of the Office of Associate Chief Counsel (Procedure and Administration) at (202) 622–3400 (not a toll-free call).

Tax Credit for Employee Health Insurance Expenses of Small Employers

Notice 2010–44

I. PURPOSE AND BACKGROUND

Section 45R of the Internal Revenue Code (Code) offers a tax credit to certain small employers that provide health insurance coverage to their employees. It is effective for taxable years beginning in 2010. Both taxable employers and employers that are organizations described in section 501(c) that are exempt from tax under section 501(a) (tax-exempt employers) may be eligible for the section 45R credit. Employers that satisfy the requirements for the credit are referred to in this notice as "eligible small employers."

Section 45R was added to the Code by section 1421 of the Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, Pub. L. No. 111–148. This notice provides guidance on section 45R as in effect for taxable years beginning before January 1, 2014, and also includes transition relief for taxable years beginning in 2010 with respect to the requirements for a qualifying arrangement under section 45R.

II. EMPLOYERS ELIGIBLE FOR THE CREDIT

A. Overview of Requirements for Eligibility

In order to be an eligible small employer, (1) the employer must have fewer than 25 full-time equivalent employees (FTEs) for the taxable year; (2) the average annual wages of its employees for the year must be less than $50,000 per FTE; and (3) the employer must maintain a "qualifying arrangement."[1] A qualifying arrangement is an arrangement under which the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage (but see section V of this notice for transition relief for taxable years beginning in 2010 with respect to the requirements for a qualifying arrangement). An employer that is an agency or instrumentality of the federal government, or of a State, local or Indian tribal government, is not an eligible small employer for purposes of section 45R unless it is an organization described in section 501(c) that is exempt from tax under section 501(a).

The following steps must be followed to determine whether an employer is eligible for a credit under section 45R:

1. Determine the employees who are taken into account for purposes of the credit.

2. Determine the number of hours of service performed by those employees.

3. Calculate the number of the employer's FTEs.

4. Determine the average annual wages paid per FTE.

5. Determine the premiums paid by the employer that are taken into account for purposes of the credit. Specifically, the premiums must be paid by an employer under a qualifying arrangement and must be paid for health insurance that meets the requirements of section 45R.

The remainder of this section II explains the steps involved in determining whether an employer is eligible for the credit. Section III of this notice explains how to calculate the credit, and section IV

[1] Although the term "eligible small employer" is defined in section 45R(d)(1) to include employers with "no more than" 25 FTEs and average annual wages that "do not exceed" $50,000, the phaseout of the credit amount under section 45R(c) operates in such a way that an employer with exactly 25 FTEs or with average annual wages exactly equal to $50,000 is not in fact eligible for the credit.

explains how to claim the credit. Finally, section V provides transition relief for taxable years beginning in 2010 with respect to certain requirements for qualifying arrangements.

B. Determining the Employees Taken into Account

In general, employees who perform services for the employer during the taxable year are taken into account in determining the employer's FTEs, average wages, and premiums paid, with certain individuals excluded and with employees of certain related employers included. This section describes these rules.

Partners in a business and certain owners are not taken into account as employees for purposes of section 45R. Specifically, sole proprietors, partners in a partnership, shareholders owning more than two percent of an S corporation, and any owners of more than five percent of other businesses are not taken into account as employees for purposes of the credit. Family members of these owners and partners are also not taken into account as employees. For purposes of section 45R, a family member is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law. Finally, any other member of the household of these owners and partners who qualifies as a dependent under section 152(d)(2)(H) is not taken into account as an employee for purposes of section 45R.

Accordingly, the wages and hours of these business owners and partners, and of their family members and dependent members of their household, are disregarded in determining FTEs and average annual wages, and the premiums paid on their behalf are not counted in determining the amount of the section 45R credit.

Seasonal workers are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the taxable year, although premiums paid on their behalf may be counted in determining the amount of the section 45R credit.

All employers treated as a single employer under section 414(b), (c), (m) or (o) are treated as a single employer for purposes of section 45R. Thus, all employees of a controlled group under section 414(b) or (c), or an affiliated service group under section 414(m) (except employees not taken into account as described above), and all wages paid to, and premiums paid for, employees by the members of the controlled group or affiliated service group (except employees not taken into account as described above), are taken into account in determining whether any member of the controlled group or affiliated service group is an eligible small employer.

C. Determining the Number of Hours of Service Worked by Employees for the Taxable Year

An employee's hours of service for a year include the following: (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during the employer's taxable year; and (2) each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (except that no more than 160 hours of service are required to be counted for an employee on account of any single continuous period during which the employee performs no duties).

In calculating the total number of hours of service which must be taken into account for an employee for the year, the employer may use any of the following methods: (1) determine actual hours of service from records of hours worked and hours for which payment is made or due (payment is made or due for vacation, holiday, illness, incapacity, etc., as described above); (2) use a days-worked equivalency whereby the employee is credited with 8 hours of service for each day for which the employee would be required to be credited with at least one hour of service under rule (1) or (2) in the preceding paragraph; or (3) use a weeks-worked equivalency whereby the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service under rule (1) or (2) in the preceding paragraph.

Examples. In all of the examples in this notice, none of the employees is an owner, partner in a business or otherwise excluded from being taken into account under section 45R.

Example 1 — Counting hours of service by hours actually worked or for which payment is made or due. (i) For the 2010 taxable year, an employer's payroll records indicate that Employee A worked 2,000 hours and was paid for an additional 80 hours on account of vacation, holiday and illness. The employer counts hours actually worked.

(ii) Under this method of counting hours, Employee A must be credited with 2,080 hours of service (2,000 hours worked and 80 hours for which payment was made or due).

Example 2 — Counting hours of service under weeks-worked equivalency. (i) For the 2010 taxable year, Employee B worked 49 weeks, took 2 weeks of vacation with pay, and took 1 week of leave without pay. The employer uses the weeks-worked equivalency.

(ii) Under this method of counting hours, Employee B must be credited with 2,040 hours of service (51 weeks multiplied by 40 hours per week).

D. Determining the Number of an Employer's FTEs

The number of an employer's FTEs is determined by dividing (1) the total hours of service, determined in accordance with section II.C of this notice, credited during the year to employees taken into account under section II.B of this notice (but not more than 2,080 hours for any employee) by (2) 2,080. The result, if not a whole number, is then rounded to the next lowest whole number. In some circumstances, an employer with 25 or more employees may qualify for the credit if some of its employees work part-time. For example, an employer with 46 half-time employees (meaning they are paid wages for 1,040 hours) has 23 FTEs and, therefore, may qualify for the credit.

Example 3 — Determining the number of FTEs. (i) For the 2010 taxable year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours. The employer does not use an equivalency method to determine hours of service for any of these employees.

(ii) The employer's FTEs would be calculated as follows:

(1) Total hours of service not exceeding 2,080 per employee is the sum of:

a. 10,400 hours of service for the 5 employees paid for 2,080 hours each (5 x 2,080)

b. 3,120 hours of service for the 3 employees paid for 1,040 hours each (3 x 1,040), and

c. 2,080 hours of service for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080).

d. The sum of a, b and c equals 15,600 hours of service.

(2) FTEs equal 7 (15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number).

Example 4 — Determining the number of FTEs: (i) For the 2010 taxable year, an employer has 26 FTEs with average annual wages of $23,000 per FTE. Only 20 of the employer's employees are enrolled in the employer's health insurance plan.

(ii) The hours of service and wages of all employees are taken into consideration in determining whether the employer is an eligible small employer for purposes of the credit. Because the employer does not have fewer than 25 FTEs for the taxable year, the employer is not an eligible small employer for purposes of the credit.

E. Determining the Employer's Average Annual Wages for the Taxable Year

The average annual wages paid by an employer for a taxable year is determined by dividing (1) the total wages paid by the employer during the employer's taxable year to employees taken into account under section II.B of this notice by (2) the number of the employer's FTEs for the year. The result is then rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). For purposes of determining the employer's average annual wages for the taxable year, only wages that are paid for hours of service determined under section II.C of this notice are taken into account. Wages for this purpose means wages as defined under section 3121(a) for purposes of the Federal Insurance Contributions Act (FICA), determined without regard to the wage base limitation under section 3121(a)(1).

Example 5 — Determining the amount of average annual wages. (i) For the 2010 taxable year, an employer pays $224,000 in wages and has 10 FTEs.

(ii) The employer's average annual wages is: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000).

F. Premium Payments by the Employer for the Taxable Year

Only premiums paid by the employer for health insurance coverage are counted in calculating the credit. If an employer pays only a portion of the premiums for the coverage provided to employees (with employees paying the rest), only the portion paid by the employer is taken into account. For example, if an employer pays 80 percent of the premiums for employees' coverage (with employees paying the other 20 percent), the 80 percent paid by the employer is taken into account in calculating the credit. For purposes of this credit, any premium paid pursuant to a salary reduction arrangement under a section 125 cafeteria plan is not treated as paid by the employer. In calculating the credit for a taxable year beginning in 2010, an employer may count all premiums paid by the employer in the 2010 tax year, including premiums that were paid in the 2010 tax year before the Affordable Care Act was enacted.

G. Premiums for Health Insurance Coverage under a Qualifying Arrangement

An employer's premium payments are not taken into account for purposes of the section 45R credit unless they are paid for health insurance coverage under a qualifying arrangement. As noted in section II.A of this notice, a qualifying arrangement is an arrangement under which the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage (but see section V of this notice for transition relief for taxable years beginning in 2010 with respect to certain requirements for a qualifying arrangement).

For years prior to 2014, health insurance coverage for purposes of the credit means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. See section 9832(b)(1). Health insurance coverage for purposes of the section 45R credit also includes the following plans described in section 9832(c)(2), (3) and (4): limited scope dental or vision; long-term care, nursing home care, home health care, community-based care, or any combination thereof; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental health insurance; certain other supplemental coverage, and similar supplemental coverage provided to coverage under a group health plan. Health insurance coverage does not include the benefits listed in section 9832(c)(1).[2] If an eligible small employer offers any of the plans described in section 9832(b)(1) or 9832(c)(2), (3) or (4), the premiums paid by the employer for that plan can be counted in calculating the credit if the premiums are paid under a qualifying arrangement.

Different types of health insurance plans are not aggregated for purposes of meeting the qualifying arrangement requirement. So, for example, if an employer offers a major medical insurance plan and a stand-alone vision plan, the employer must separately satisfy the requirements for a qualifying arrangement with respect to each type of coverage.

The amount of an employer's premium payments that are taken into account in calculating the credit is limited to the premium payments the employer would have made under the same arrangement if the average premium for the small group market in the State (or an area within the State) in which the employer offers coverage were substituted for the actual premium. For example, if an eligible small employer pays 80 percent of the premiums for coverage provided to employees (and employees pay the other 20 percent), the premiums taken into account for purposes of the credit are the lesser of 80 percent of the total actual premiums paid or 80 percent of the premiums that would have been paid for the coverage if the average premium for the small group market in the State (or an area within the State) were substituted for the actual premium. See Rev. Rul. 2010–13, 2010–21 I.R.B. 691, for the average premium for the small group market in a State for the 2010 taxable year.

The average premium for the small group market in the State does not apply separately to each type of coverage described in section 9832(b)(1), (c)(2), (c)(3) and (c)(4), but rather provides an overall

[2] Section 9832(c)(1) includes the following benefits: (A) coverage only for accident, or disability income insurance, or any combination thereof; (B) coverage issued as a supplement to liability insurance; (C) liability insurance, including general liability insurance and automobile liability insurance; (D) worker's compensation or similar insurance; (E) automobile medical payment insurance; (F) credit-only insurance; (G) coverage for on-site medical clinics; and (H) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

cap for all health insurance coverage provided by an eligible small employer.

Example 6 — Determining amount of premium payments for purposes of the credit. (i) For the 2010 taxable year, an eligible small employer offers a health insurance plan with single and family coverage. Employer has 9 FTEs with average annual wages of $23,000 per FTE. Four employees are enrolled in single coverage and 5 are enrolled in family coverage.

(ii) The employer pays 50% of the premiums for all employees enrolled in single coverage and 50% of the premiums for all employees enrolled in family coverage (and the employee is responsible for the remainder in each case). The premiums are $4,000 a year for single coverage and $10,000 a year for family coverage. The average premium for the small group market in employer's State is $5,000 for single coverage and $12,000 for family coverage.

(iii) The employer's premium payments for each FTE ($2,000 for single coverage and $5,000 for family coverage) do not exceed 50% of the average premium for the small group market in employer's State ($2,500 for single coverage and $6,000 for family coverage).

(iv) Thus, the amount of premiums paid by the employer for purposes of computing the credit equals $33,000 ((4 x $2,000) plus (5 x $5,000)).

Example 7 — Premium payments exceeding average premium for small group market. (i) Same facts as *Example 6*, except that the premiums are $6,000 for single coverage and $14,000 for family coverage.

(ii) The employer's premium payments for each employee ($3,000 for single coverage and $7,000 for family coverage) exceed 50% of the average premium for the small group market in the employer's State ($2,500 for single coverage and $6,000 for family coverage).

(iii) Thus, the amount of premiums paid by the employer for purposes of computing the credit equals $40,000 ((4 x $2,500) plus (5 x $6,000)).

Example 8 — Offering health insurance plan and dental plan. (i) For the 2010 taxable year, an eligible small employer offers a major medical plan and a dental plan. The employer pays 50% of the premium cost for single coverage for all employees enrolled in the major medical plan and 50% of the premium cost for single coverage for all employees enrolled in the dental plan.

(ii) For purposes of calculating the credit, the employer can take into consideration the premiums paid by the employer for both the major medical plan and the dental plan, but only up to 50% of the amount of the average premium for single coverage for the small group market in the employer's State.

Example 9 — Meeting qualifying arrangement requirement. (i) Same facts as *Example 8*, except that the employer pays 40% of the premium cost for single coverage for all employees enrolled in the dental plan.

(ii) For purposes of calculating the credit, the employer can take into consideration only the premiums paid by the employer for the major medical plan, and only up to 50% of the amount of the average premium for single coverage for the small group market in the employer's State. The employer cannot take into consideration premiums paid for the dental plan.

III. CALCULATING THE CREDIT

A. In General

The following steps are followed to calculate the section 45R credit:

1. Calculate the maximum amount of the credit (section III.B);

2. Reduce the maximum credit in step 1 in accordance with the phaseout rule (section III.C), if necessary; and

3. For employers receiving a State credit or subsidy for health insurance, determine the employer's actual premium payment (section III.D).

B. Maximum Credit

For taxable years beginning in 2010 through 2013, the maximum credit is 35 percent of a taxable eligible small employer's premium payments taken into account for purposes of the credit. For a tax-exempt eligible small employer for those years, the maximum credit is 25 percent of the employer's premium payments taken into account for purposes of the credit. However, for a tax-exempt employer, the amount of the credit cannot exceed the total amount of income tax under section 3402 and Medicare (*i.e.*, Hospital Insurance) tax under section 3101(b) that the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax under section 3111(b) on employees' wages for the year.

C. Credit Phaseout

The credit phases out gradually (but not below zero) for eligible small employers if the number of FTEs exceeds 10 or if the average annual wages exceed $25,000. If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed $25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding $25,000, the total reduction is the sum of the two reductions. This may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than $50,000.

Example 10 — Calculating the maximum credit for a taxable eligible small employer. (i) For the 2010 taxable year, a taxable eligible small employer has 9 FTEs with average annual wages of $23,000 per FTE. The employer pays $72,000 in health insurance premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit.

(ii) The credit for 2010 equals $25,200 (35% x $72,000).

Example 11 — Calculating the maximum credit for a tax-exempt eligible small employer. (i) For the 2010 taxable year, a tax-exempt eligible small employer has 10 FTEs with average annual wages of $21,000 per FTE. The employer pays $80,000 in health insurance premiums for its employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit. The total amount of the employer's income tax and Medicare tax withholding plus the employer's share of the Medicare tax equals $30,000 in 2010.

(ii) The credit is calculated as follows:

(1) Initial amount of credit determined before any reduction: (25% x $80,000) = $20,000

(2) Employer's withholding and Medicare taxes: $30,000

(3) Total 2010 tax credit equals $20,000 (the lesser of $20,000 and $30,000).

Example 12 — Calculating the credit phase-out if the number of FTEs exceeds 10 or average annual wages exceed $25,000. (i) For the 2010 taxable year, a taxable eligible small employer has 12 FTEs and average annual wages of $30,000. The employer pays $96,000 in health insurance premiums for its employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit.

(ii) The credit is calculated as follows:

(1) Initial amount of credit determined before any reduction: (35% x $96,000) = $33,600

(2) Credit reduction for FTEs in excess of 10: ($33,600 x 2/15) = $4,480

(3) Credit reduction for average annual wages in excess of $25,000: ($33,600 x $5,000/$25,000) = $6,720

(4) Total credit reduction: ($4,480 + $6,720) = $11,200

(5) Total 2010 tax credit equals $22,400 ($33,600 - $11,200).

D. State Credits and State Subsidies for Health Insurance

Some States offer tax credits to certain small employers that provide health insurance to their employees. Some of these are refundable credits and others are

nonrefundable credits. In addition, some States offer premium subsidy programs for certain small employers under which the State makes a payment equal to a portion of the employees' health insurance premiums under the employer-provided health insurance plan. Generally, the State pays this premium subsidy either directly to the employer or to the employer's insurance company (or another entity licensed under State law to engage in the business of insurance). If the employer is entitled to a State tax credit (whether refundable or nonrefundable) or a premium subsidy that is paid directly to the employer, the premium payment made by the employer is not reduced by the credit or subsidy for purposes of determining whether the employer has satisfied the "qualifying arrangement" requirement to pay an amount equal to a uniform percentage (not less than 50 percent) of the premium cost. Also, except as described below in this section III.D, the maximum amount of the section 45R credit is not reduced by reason of a State tax credit (whether refundable or nonrefundable) or by reason of payments by a State directly to an employer.

Generally, if a State makes payments directly to an insurance company (or another entity licensed under State law to engage in the business of insurance) to pay a portion of the premium for coverage of an employee under employer-provided health insurance (State direct payments), the State is treated as making these payments on behalf of the employer for purposes of determining whether the employer has satisfied the "qualifying arrangement" requirement to pay an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of coverage. Also, except as described below in this section III.D, these premium payments by the State are treated as an employer contribution under section 45R for purposes of calculating the credit.

Although State tax credits and payments to an employer generally do not reduce an employer's otherwise applicable credit under section 45R, and although State direct payments are generally treated as paid on behalf of an employer, in no event may the amount of the section 45R credit exceed the amount of the employer's net premium payments. In the case of a State tax credit for an employer or a State subsidy paid directly to an employer, the employer's net premium payments are calculated by subtracting the State tax credit or subsidy from the employer's actual premium payments. In the case of a State payment directly to an insurance company (or another entity licensed under State law to engage in the business of insurance), the employer's net premium payments are the employer's actual premium payments.

If a State-administered program (such as Medicaid or another program that makes payments directly to a health care provider or insurance company on behalf of individuals and their families who meet certain eligibility guidelines) makes payments that are not contingent on the maintenance of an employer-provided group health plan, those payments are not taken into account in determining the credit under section 45R.

Example 13 — State premium subsidy paid directly to employer. (i) Employer's State provides a health insurance premium subsidy of up to 40% of the health insurance premiums for each eligible employee. The State pays the subsidy directly to the employer.

(ii) Employer has one employee, Employee D. Employee D's health insurance premiums are $100 per month and are paid as follows: $80 by the employer and $20 by Employee D through salary reductions to a cafeteria plan. The State pays Employer $40 per month as a subsidy for Employer's payment of insurance premiums on behalf of Employee D. Employer is otherwise an eligible small employer that meets the requirements for the section 45R credit.

(iii) For purposes of the requirements for a qualifying arrangement, and for purposes of calculating the amount of the section 45R credit, the amount of premiums paid by the employer is $80 per month (the premium payment by the Employer without regard to the subsidy from the State).

Example 14 — State premium subsidy paid directly to employer's insurance company. (i) Employer's State provides a health insurance premium subsidy of up to 50% for each eligible employee. The State pays the premium directly to the employer's health insurance provider.

(ii) Employer has one employee, Employee E. Employee E is enrolled in single coverage under Employer's health insurance plan.

(iii) Employee E's health insurance premiums are $100 per month and are paid as follows: $30 by the employer; $50 by the State and $20 by the employee. The State pays the $50 per month directly to the insurance company and the insurance company bills the employer for the employer and employee's share, which equal $50 per month. Employer is otherwise an eligible small employer that meets the requirements for the section 45R credit.

(iv) For purposes of the requirements for a qualifying arrangement, and for purposes of calculating the amount of the section 45R credit, the amount of premiums paid by the employer is $80 per month (the sum of the employer's payment and the State's payment).

Example 15 — Credit limited by employer's net premium payment. (i) Employer's State provides a health insurance premium subsidy of up to 50% for each eligible employee. The State pays the premium directly to the employer's health insurance provider. Employer has one employee, Employee F. Employee F is enrolled in single coverage under Employer's health insurance plan. Employee F's health insurance premiums are $100 per month and are paid as follows: $20 by the employer; $50 by the State and $30 by the employee. The State pays the $50 per month directly to the insurance company and the insurance company bills the employer for the employer's and employee's shares, which total $50 per month. Employer is otherwise an eligible small employer that meets the requirements for the section 45R credit.

(ii) The amount of premiums paid by the employer for purposes of determining whether the employer meets the qualifying arrangement requirement (the sum of the employer's payment and the State's payment) is $70 per month, which is more than 50% of the $100 monthly premium payment. The amount of the premium for calculating the maximum section 45R credit is also $70 per month. The maximum credit is $24.50 ($70 x 35%).

(iii) The employer's net premium payment is $20 (the amount actually paid by the employer excluding the State subsidy). After applying the limit for the employer's net premium payment , the section 45R credit is $20 per month, (the lesser of $24.50 or $20).

IV. CLAIMING THE CREDIT AND EFFECT ON ESTIMATED TAX, ALTERNATIVE MINIMUM TAX AND DEDUCTIONS

The section 45R credit is claimed on an eligible small employer's annual income tax return and offsets an employer's actual tax liability for the year. For a tax-exempt eligible small employer, the IRS will provide further information on how to claim the credit. For an eligible small employer that is not a tax-exempt employer, the credit is a general business credit and, thus, any unused credit amount can be carried back one year and carried forward 20 years (however, because an unused credit amount cannot be carried back to a year before the effective date of the credit, any unused credit amounts for taxable years beginning in 2010 can only be carried forward). For a tax-exempt eligible small employer, the credit is a refundable credit, so that even if the employer has no taxable income, the employer may receive a refund (so long as it does not exceed the tax-exempt eligible small employer's total income tax withholding and Medicare tax liability for the year).

The credit can be reflected in determining estimated tax payments for the year in which the credit applies in accordance

with regular estimated tax rules. The credit can also be used to offset an employer's alternative minimum tax (AMT) liability for the year, subject to certain limitations based on the amount of an employer's regular tax liability, AMT liability and other allowable credits. See section 38(c)(1), as modified by section 38(c)(4)(B)(vi). However, because the credit applies against income tax, an employer may not reduce employment tax (*i.e.*, withheld income tax, social security tax under sections 3101(a) and 3111(a), and Medicare tax) deposits and payments during the year in anticipation of the credit. Finally, no deduction is allowed for the employer under section 162 for that portion of the health insurance premiums which is equal to the amount of the section 45R credit.

V. TRANSITION RELIEF FOR TAXABLE YEARS BEGINNING IN 2010

Because the section 45R credit applies to taxable years beginning in 2010 (including the period in 2010 before enactment of the Affordable Care Act), an employer that satisfies the requirements for the transition relief in this section V will be deemed to satisfy the requirement for a qualifying arrangement that the employer pay a uniform percentage (not less than 50 percent) of the premium cost of the health insurance coverage (uniformity requirement). Specifically, for taxable years beginning in 2010, an employer that pays an amount equal to at least 50 percent of the premium for single (employee-only) coverage for each employee enrolled in coverage offered to employees by the employer will be deemed to satisfy the uniformity requirement for a qualifying arrangement, even if the employer does not pay the same percentage of the premium for each such employee. Thus, an employer will be deemed to satisfy the uniformity requirement for a qualifying arrangement if it pays at least 50 percent of the premium for single coverage for each employee receiving single coverage, and, if the employer offers coverage that is more expensive than single coverage (such as family or self-plus-one coverage), if it pays an amount for each employee receiving that more expensive coverage that is no less than 50 percent of the premium for single coverage for that employee (even if it is less than 50 percent of the premium for the more expensive coverage the employee is actually receiving).

Example 16 — Transition relief rule for a qualifying arrangement. (i) For the 2010 taxable year, an eligible small employer has 9 FTEs with average annual wages of $23,000 per FTE. Six employees are enrolled in single coverage and 3 employees are enrolled in family coverage.

(ii) The premiums are $8,000 for single coverage for the year and $14,000 for family coverage for the year (which do not exceed the average premiums for the small group market in the employer's State). The employer pays 50% of the premium for single coverage for each employee enrolled in single or family coverage (50% x $8,000 = $4,000 for each employee).

(iii) Thus, the employer pays $4,000 of the premium for each of the 6 employees enrolled in single coverage and $4,000 of the premium for each of the 3 employees enrolled in family coverage.

(iv) The employer is deemed to satisfy the uniformity requirement for a qualifying arrangement under the transition relief rule.

Example 17 — Arrangement that does not satisfy requirement for transition relief. (i) Same facts as *Example 16*, except that the employer pays 50% of the premium for employees enrolled in single coverage ($4,000 for each of those 6 employees) but pays none of the premium for employees enrolled in family coverage.

(ii) The employer does not satisfy the uniformity requirement for a qualifying arrangement.

VI. EFFECTIVE DATE

Section 45R is effective for taxable years beginning after December 31, 2009.

REQUEST FOR COMMENTS

The IRS and Treasury intend to issue future guidance that will address additional issues under section 45R, including the application of the uniformity requirement and the 50-percent requirement for taxable years beginning after 2010. Comments are requested on issues that should be addressed in that future guidance.

Comments should be submitted on or before September 1, 2010, and should include a reference to Notice 2010–44. Send submissions to CC:PA:LPD:PR (Notice 2010–44), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered **Monday through Friday** between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2010–44), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044, or sent electronically, via the following e-mail address: *Notice.comments@irscounsel.treas.gov*. Please include "Notice 2010–44" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

DRAFTING INFORMATION

The principal author of this notice is Mireille Khoury of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Khoury at (202) 622–6080 (not a toll-free call).

Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

Group Health Plans and Health Insurance Issuers Providing Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

REG–114494–10

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: Elsewhere in this issue of the Bulletin, the IRS is issuing temporary regulations (T.D. 9482) under the provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act) dealing with coverage of dependent children to age 26. The IRS is issuing the temporary regulations at the same time that the Employee Benefits Security Administration of the U.S. Department of Labor and the Office of Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services are issuing substantially similar interim final regulations with respect to group health plans and health insurance coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers, group health plans, and health insurance issuers providing group health insurance coverage. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written or electronic comments and requests for a public hearing must be received by August, 11. 2010.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–114494–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:PA:LPD:PR (REG–114494–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–114494–10).

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Karen Levin at 202–622–6080; concerning submissions of comments, *Richard.A.Hurst@irscounsel.treas.gov*, 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, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by July 12, 2010. Comments are specifically requested concerning:

- Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;
- The accuracy of the estimated burdens associated with the proposed collection of information (see the preamble to the temporary regulations published elsewhere in this issue of the Bulletin);
- How to enhance the quality, utility, and clarity of the information to be collected;
- How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and
- Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information is in §54.9815–2714T(f) (see the temporary regulations published elsewhere in this issue of the Bulletin). The temporary regulations require that group health plans and group health insurance coverage offer an enrollment opportunity (including written notice of the enrollment opportunity) to certain individuals who did not obtain coverage under a group health plan or group health insurance coverage prior to the effective date of amendments made by the Affordable Care Act to section 2714 of the Public Health Service Act (which is incorporated by reference into section 9815 of the Code). The individuals to whom the enrollment opportunity must be given are those who were not eligible for dependent coverage of a child below the age of 26 but, after the effective date of section 2714 of the Public Health Service Act, are entitled to be eligible for coverage under a group health plan or group health insurance coverage. The likely respondents are business or other for-profit institutions, and nonprofit institutions. 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.

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

The temporary regulations published elsewhere in this issue of the Bulletin add

§54.9815–2714T to the Miscellaneous Excise Tax Regulations. The proposed and temporary regulations are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and Human Services (the joint rulemaking). The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations.

Special Analyses

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 has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that the collection of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required. The temporary regulations require both group health insurance issuers and group health plans to provide a notice of opportunity to enroll to certain individuals who, prior to the effective date of the amendments made to section 2714 of the Public Health Service Act, were not eligible to enroll for dependent coverage of children but who are eligible after those amendments take effect. Under the temporary regulations, if a health insurance issuer satisfies this notice obligation, it is satisfied not just for the issuer but also for the group health plan. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will satisfy this notice obligation for both the plan and the issuer in almost all cases. For this reason, the information collection requirement will not impose a significant impact on a substantial number of small entities. For further information and for analyses relating to the joint rulemaking, see the preamble to the joint rulemaking. Pursuant to section 7805(f) of the Internal Revenue Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely 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 may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Karen Levin, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), IRS. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and the U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

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

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

Section 54.9815–2714 also issued under 26 U.S.C. 9833. * * *

Par. 2. Section 54.9815–2714 is added to read as follows:

§54.9815–2714 Eligibility of children until at least age 26.

[The text of proposed §54.9815–2714 is the same as the text of §54.9815–2714T published elsewhere in this issue of the Bulletin].

Steven T. Miller,
Deputy Commissioner for Services and Enforcement.

(Filed by the Office of the Federal Register on May 10, 2010, 4:15 p.m., and published in the issue of the Federal Register for May 13, 2010, 75 F.R. 27141)

AJCA Modifications to the Section 6011 Regulations; Correction

Announcement 2010–39

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Correcting amendment.

SUMMARY: This document contains a correction to final regulations (T.D. 9350, 2007–2 C.B. 614) which were published in the **Federal Register** on Friday, August 3, 2007 (72 FR 43146) that modify the rules relating to the disclosure of reportable transactions under section 6011.

DATES: This correction is effective on May 11, 2010, and is applicable on August 3, 2007.

FOR FURTHER INFORMATION CONTACT: Charles D. Wien or Michael H. Beker, (202) 622–3070 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations (T.D. 9350) that are the subject of this document are under section 6011 of the Internal Revenue Code.

Need for Correction

As published, the final regulations (T.D. 9350) contain an error that may prove to be misleading and is in need of clarification.

* * * * *

Correction of Publication

Accordingly, 26 CFR part 1 is corrected by making the following correcting amendment:

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.6011–4 is amended by revising the fifth sentence of paragraph (e)(1) to read as follows:

§1.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.

* * * * *

(e) * * *

(1) * * * In the case of a taxpayer that is a partnership, an S corporation, or a trust, the disclosure statement for a reportable transaction must be attached to the partnership, S corporation, or trust's tax return for each taxable year in which the partnership, S corporation, or trust participates in the transaction under the rules of paragraph (c)(3)(i) of this section. * * *

LaNita Van Dyke,
Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel, (Procedure and Administration).

(Filed by the Office of the Federal Register on May 10, 2010, 8:45 a.m., and published in the issue of the Federal Register for May 11, 2010, 75 F.R. 26061)

Deletions From Cumulative List of Organizations Contributions to Which are Deductible Under Section 170 of the Code

Announcement 2010–40

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the Service will not disallow deductions for contributions made to a listed organization on or before the date of announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the Service is not precluded from disallowing a deduction for any contributions made after an organization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, contributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on **June 1, 2010** and would end on the date the court first determines that the organization is not described in section 170(c)(2) asmore particularly set forth in section 7428(c)(1). For individual contributors, the maximum deduction protected is $1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in whole or in part, for the acts or omissions of the organization that were the basis for revocation.

Action for Affordable Housing
Englewood, CO

All Gods Creatures Shelter for Abused & Abandoned Animals
Tampa, FL

Carranor Hunt & Polo Club
Perrysburg, OH

Debt Monster Credit Counseling Services, Inc.
Rancho Santa Margarita, CA

Farm Mutual Insurance
Baltic, SC

Germania Purchasing Group
Brenham, TX

Orchard Living View, Inc.,
Sterling Heights, MI

Silver Ridge Park Golden Oldies
Toms River, NJ

WJ Consumer Credit of Texas
Kyle, TX

Eastland Praise and Worship
Aiken, NC

The Second Chance Foundation, Inc.
Vineyard Haven, MA

Currier Family Foundation
Salt Lake City, UT

Chipper Preschool & Kindergarten
Chicago, IL

Desilynn Multiple Sclerosis Foundation
Layton, UT

Hawaii Consumer Credit Counseling
Honolulu, HI

The Leonard & Beverly Graham Foundation for the Arts
Salt Lake City, UT

Panther's House of Pride, Inc.,
Decatur, GA

Seed America Foundation
Cummings, GA

Carey C. Jones Memorial Park
Apex, NC

Capital Athletic Foundation
Silver Spring, MD

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the 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 Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D. —Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z —Corporation.

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Key to Abbreviations:

Ann	Announcement
CD	Court Decision
DO	Delegation Order
EO	Executive Order
PL	Public Law
PTE	Prohibited Transaction Exemption
RP	Revenue Procedure
RR	Revenue Ruling
SPR	Statement of Procedural Rules
TC	Tax Convention
TD	Treasury Decision
TDO	Treasury Department Order

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