Internal Revenue
bulletin

Bulletin No. 2014–11
March 10, 2014

HIGHLIGHTS OF THIS ISSUE

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

INCOME TAX

Rev. Rul. 2014–8, page 624.

Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate. For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for March 2014.

Rev. Proc. 2014–21, page 641.

This revenue procedure provides the depreciation deduction limitations for owners of passenger automobiles (including trucks and vans) first placed in service during calendar year 2014 and amounts to be included in income by lessees of passenger automobiles first leased during calendar year 2014.

EMPLOYEE PLANS

REG–122706–12, page 647.

This document contain proposed regulations concerning the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as incorporated into the Internal Revenue Code. Written comments must be received by April 25, 2014.

T.D. 9656, page 626.

This document contains final regulations to implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, incorporated into the Internal Revenue Code. The rules also finalize amendments to existing regulations to conform to Affordable Care Act provision including some of the portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because those provision of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by the Affordable Care Act.

EXEMPT ORGANIZATIONS

Rev. Proc. 2014–22, page 646.

This revenue procedure revokes Revenue Procedure 79–6. Revenue Procedure 79–6 has not been used since the redesign of the Form 990 and the issuance of the implementing regulations. The revenue procedure is inconsistent with the redesigned Form 990 since the new 990 redesign no longer permitted the substitute of another form such as the Form 5500 or 5500–C, Annual Return/Report of Employee Benefit Plan, in place of the income and balance statements in the Form 990.

EXCISE TAX

REG–122706–12, page 647.

This document contain proposed regulations concerning the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as incorporated into the Internal Revenue Code. Written comments must be received by April 25, 2014.

T.D. 9656, page 626.

This document contains final regulations to implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, incorporated into the Internal Revenue Code. The rules also finalize amendments to existing regulations to conform to Affordable Care Act provision including some of the portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because those provision of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by the Affordable Care Act.

Finding Lists begin on page ii.
Index for July through March begins on page iv.

Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

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

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

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

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.

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

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 468.— Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 1274.—Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)

Rev. Rul. 2014–8

This revenue ruling provides various prescribed rates for federal income tax purposes for March 2014 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2014, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2014–8 TABLE 1

Applicable Federal Rates (AFR) for March 2014

	Period for Compounding			
	Annual	*Semiannual*	*Quarterly*	*Monthly*
		Short-term		
AFR	.28%	.28%	.28%	.28%
110% AFR	.31%	.31%	.31%	.31%
120% AFR	.34%	.34%	.34%	.34%
130% AFR	.36%	.36%	.36%	.36%
		Mid-term		
AFR	1.84%	1.83%	1.83%	1.82%
110% AFR	2.02%	2.01%	2.00%	2.00%
120% AFR	2.21%	2.20%	2.19%	2.19%
130% AFR	2.39%	2.38%	2.37%	2.37%
150% AFR	2.77%	2.75%	2.74%	2.73%
175% AFR	3.23%	3.20%	3.19%	3.18%
		Long-term		
AFR	3.36%	3.33%	3.32%	3.31%
110% AFR	3.69%	3.66%	3.64%	3.63%
120% AFR	4.04%	4.00%	3.98%	3.97%
130% AFR	4.38%	4.33%	4.31%	4.29%

REV. RUL. 2014–8 TABLE 2

Adjusted AFR for March 2014

	Period for Compounding			
	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-term adjusted AFR	.28%	.28%	.28%	.28%
Mid-term adjusted AFR	1.84%	1.83%	1.83%	1.82%
Long-term adjusted AFR	3.36%	3.33%	3.32%	3.31%

REV. RUL. 2014–8 TABLE 3

Rates Under Section 382 for March 2014

Adjusted federal long-term rate for the current month	3.36%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	3.56%

REV. RUL. 2014–8 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for March 2014

Note: Under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2014, shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	7.60%
Appropriate percentage for the 30% present value low-income housing credit	3.26%

REV. RUL. 2014–8 TABLE 5

Rate Under Section 7520 for March 2014

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	2.2%

Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 7520—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of March 2014. See Rev. Rul. 2014–8, page 624.

Section 9815.—Additional market reforms

TD 9656

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54

Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: These final regulations implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (Affordable Care Act), as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. These regulations also finalize amendments to existing regulations to conform to Affordable Care Act provisions. Specifically, these rules amend regulations implementing existing provisions such as some of the portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because those provisions of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by the Affordable Care Act.

DATES: *Effective date*. These final regulations are effective on March 26, 2014.

Applicability date. The 90-day waiting period limitation provisions of these final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. The amendments made by these final regulations to the evidence of creditable coverage provisions of 26 CFR 54.9801–5, 29 CFR 2590.701–5, and 45 CFR 146.115 apply beginning December 31, 2014. All other amendments made by these final regulations apply to group health plans and health insurance issuers for plan years beginning on or after April 25, 2014. Until the amendments to the existing HIPAA final regulations become applicable, plans and issuers must continue to comply with the existing regulations, as applicable.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-6846; or Cam Moultrie Clemmons, Centers for Medicare & Medicaid Services, 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 (*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 (*www.cciio.cms.gov/*) and information on health reform can be found at *www.HealthCare.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Pub. L. 111–152, was enacted on March 30, 2010. (They are collectively known as the "Affordable Care Act".) The Affordable Care Act reorganizes, amends, and adds 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(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

PHS Act section 2708, as added by the Affordable Care Act and incorporated into ERISA and the Code, provides that a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in PHS Act section 2704(b)(4)) that exceeds 90 days. PHS Act section 2704(b)(4), ERISA section 701(b)(4), and Code section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan. In 2004 regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) portability provisions (2004 HIPAA regulations), the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments[2]) defined a waiting period to mean the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.[3] PHS Act section 2708 does not require an employer to offer coverage to any particular individual or class of individuals, including part-time employees. PHS Act section 2708 merely prevents an otherwise eligible employee (or dependent) from being required to wait more than 90 days before coverage becomes effective. PHS Act section 2708 applies to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after January 1, 2014.

On February 9, 2012, the Departments issued guidance[4] outlining various approaches under consideration with respect to both the 90-day waiting period limitation and the employer shared responsibility provisions under Code section 4980H (February 2012 guidance) and requested public comment. On August 31, 2012, following their review of the comments on the February 2012 guidance, the Departments provided temporary guidance,[5] to remain in effect at least through the end of 2014, regarding the 90-day waiting period limitation, and described the approach they intended to propose in future rulemaking (August 2012 guidance). After consideration of all of the comments received in response to the February 2012 guidance and August 2012 guidance, the Departments issued proposed regulations on March 21, 2013 (78 FR 17313).

Under the proposed regulations, a group health plan and a health insurance issuer offering group health insurance coverage may not apply any waiting period that exceeds 90 days. The regulations proposed to define "waiting period" as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms). Eligibility conditions that are based solely on the lapse of a time period would be permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan (that is, those that are not based solely on the lapse of a time period) are generally permissible under PHS Act section 2708 and the proposed regulations unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

Among other things, the proposed regulations addressed application of waiting periods to certain plan eligibility conditions. The proposed regulations provided that if a group health plan conditions eli-

[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.

[2]Note, however, that in the Economic Analysis and Paperwork Burden section of this preamble, in sections under headings listing only two of the three Departments, the term "Departments" generally refers only to the two Departments listed in the heading.

[3]26 CFR 54.9801–3(a)(3)(iii), 29 CFR 2590.701–3(a)(3)(iii), and 45 CFR 146.111(a)(3)(iii).

[4]Department of Labor Technical Release 2012–01, IRS Notice 2012–17, and HHS FAQs issued February 9, 2012.

[5]Department of Labor Technical Release 2012–02, IRS Notice 2012–59, and HHS FAQs issued August 31, 2012.

gibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period[6] of no more than 12 months that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month, and no waiting period that exceeds 90 days is imposed in addition to the measurement period.

The proposed regulations also addressed cumulative hours-of-service requirements, which use more than solely the passage of a time period in determining whether employees are eligible for coverage. Under the proposed regulations, if a group health plan or group health insurance issuer conditions eligibility on the completion by an employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.[7] Under the proposed regulations, the plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement and may not exceed 90 days. The preamble to the proposed regulations stated that this provision is designed to be a one-time eligibility requirement only and that the proposed regulations do not permit, for example, re-application of such a requirement to the same individual each year.[8] The preamble to the proposed regulations also provided that the Departments would consider compliance with these proposed regulations to constitute compliance with PHS Act section 2708 at least through the end of 2014.[9]

The proposed regulations also included proposed amendments to conform to Affordable Care Act provisions already in effect as well as those that would become effective in 2014. The regulations proposed amending the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA), to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.[10] Additionally, the regulations proposed to amend examples and provisions in 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Parts 144 and 146 to conform to other changes made by the Affordable Care Act, such as the elimination of lifetime and annual limits under PHS Act section 2711 and its implementing regulations,[11] as well as the provisions governing dependent coverage of children to age 26 under PHS Act section 2714 and its implementing regulations.[12]

After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations.

II. Overview of the Final Regulations

A. *Prohibition on Waiting Periods That Exceed 90 Days*

These final regulations provide that a group health plan, and a health insurance issuer offering group health insurance coverage, may not apply a waiting period that exceeds 90 days. (Nothing in these final regulations requires a plan or issuer to have any waiting period, or prevents a plan or issuer from having a waiting period that is shorter than 90 days.) If, under the terms of the plan, an individual[13] can elect coverage that becomes effective on a date that does not exceed 90 days, the coverage complies with the 90-day waiting period limitation, and the plan or issuer will not be considered to violate the waiting period rules merely because individuals may take additional time (beyond the end of the 90-day waiting period) to elect coverage.

These final regulations continue to define "waiting period" as the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. These final regulations also continue to include the clarification that, if an individual enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period. The effective date of coverage for special enrollees continues to be that set forth in the Departments' 2004 HIPAA regulations governing special enrollment[14] (and, if applicable, in HHS

[6] *See* 26 CFR 54.4980H–3(d)(3)(i), at 79 FR 8544 (February 12, 2014).

[7] *See* section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.

[8] 78 FR 17313, 17316 (March 21, 2013). *See also* Code section 36B and its implementing regulations, and *www.healthcare.gov* for information on an individual's eligibility for premium tax credits in the Affordable Insurance Exchange or "Exchange (also referred to as Health Insurance Marketplace or "Marketplace) generally, as well as during a waiting period for coverage under a group health plan.

[9] The preamble to the proposed regulations stated that the proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance. *See* 78 FR 17313, 17317 (March 21, 2013). The August 2012 guidance similarly provided that group health plans and group health insurance issuers may rely on the compliance guidance through at least the end of 2014. *See* Department of Labor Technical Release 2012–02, IRS Notice 2012–59, and HHS FAQs issued August 31, 2012.

[10] Affordable Care Act section 1201 also moved those provisions from PHS Act section 2701 to PHS Act section 2704. See also 75 FR 37188 (June 28, 2010).

[11] 75 FR 37188 (June 28, 2010).

[12] 75 FR 27122 (May 13, 2010).

[13] The proposed regulations used several different terms when referencing individuals, such as employees and dependents, and participants and beneficiaries. Where it is appropriate, the final regulations replace these references with the term "individual" for consistency purposes. This is merely a change to eliminate any confusion that may occur as a result of using multiple terms interchangeably and does not change the substance of the rules as PHS Act section 2708 limits applying a waiting period that exceeds 90 days to any individual who is otherwise eligible to enroll under the terms of the plan.

[14] 26 CFR 54.9801–6, 29 CFR 2590.701–6, and 45 CFR 146.117.

regulations addressing guaranteed availability[15]).

The final regulations set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, these final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). The 90-day waiting period limitation generally does not require the plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, these final regulations prohibit requiring otherwise eligible individuals to wait more than 90 days before coverage becomes effective.[16]

Under these final regulations, eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan (that is, those that are not based solely on the lapse of a time period) are generally permissible under PHS Act section 2708 and these final regulations, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

The proposed regulations included an approach when applying waiting periods to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. In general, the proposed regulations provided that, except for cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether a variable-hour employee meets the plan's hours of service per period eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

Some commenters requested a rule permitting plans to impose a 90-day waiting period in addition to the 12-month measurement period, arguing that restricting the period to 13 months plus the time remaining until the first day of the next calendar month would in effect be a one month waiting period and impose administrative hardship. Other commenters requested that the final regulations eliminate the allowance of a measurement period and require coverage to begin no later than 90 days from the employee's start date. These final regulations retain the approach in the proposed regulations and provide that if a group health plan conditions eligibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition, which may include a measurement period of no more than 12 months that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date. (This is consistent with the timeframe permitted for such determinations under Code section 4980H and its implementing regulations.) Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether a variable-hour employee meets the plan's hours of service per period eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date, plus if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

The proposed regulations also addressed cumulative hours-of-service requirements, which use more than solely the passage of a time period in determining whether employees are eligible for coverage. These final regulations retain the provisions of the proposed regulations, described earlier in this preamble, without change. Therefore, under these final regulations, if a group health plan or group health insurance issuer conditions eligibility on the completion by an employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours. Under the final regulations, the plan's waiting period must begin on the first day after the employee satisfies the plan's cumulative hours-of-service requirement and may not exceed 90 days. Furthermore, this provision continues to be designed to be a one-time eligibility requirement only; these final regulations do not permit, for example, re-application of such a requirement to the same individual each year.

In response to the proposed regulations, commenters requested additional clarifications to allow plans and issuers to better coordinate the 90-day waiting period requirements with the rules under Code section 4980H, which, in the case of full-time employees of applicable large employers, generally requires as a condition for avoiding a penalty that health benefits begin by the first day of the fourth calendar month following the month in which the full-time employee begins employment. Commenters argued that, without coordination, the PHS Act section 2708 waiting period limitation could effectively require coverage to begin sooner than required under the rules implementing section 4980H of the Code and undermine the entire Code section 4980H framework, which Congress could not

[15] 45 CFR 147.104(b)(5).

[16] *See also* section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees (and their dependents).

have intended. Other commenters argued that some employers might offer coverage to employees only because of their obligations under Code section 4980H, so that an eligibility provision that makes an offer of coverage consistent with section 4980H should be permissible without requiring coverage to begin sooner than the regulations implementing section 4980H require.

Some commenters stated that their systems are not capable of beginning coverage other than at the beginning of a month, and it is thus common practice to have a 90-day waiting period with coverage effective the first day of the first month following a 90-day waiting period. These commenters requested the flexibility to continue this approach. Similarly, several commenters specifically requested that plans be permitted to impose a waiting period of three calendar months instead of 90 days, as it would be less confusing to participants and easier for plans and issuers to administer.

Under these final regulations, after an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.[17] However, as noted above, the final regulations provide that a requirement to successfully complete a reasonable and bona fide employment-based orientation period may be imposed as a condition for eligibility for coverage under a plan. Specifically, the final regulations add an example of permissible substantive eligibility conditions under a group health plan. The proposed regulations had included being in an eligible job classification and achieving job-related licensure requirements specified in the plan's terms. The final regulations add a third example regarding the satisfaction of a reasonable and bona fide employment-based orientation period. The final regulations do not specify the circumstances under which the duration of an orientation period would not be considered "reasonable or bona fide." However, proposed regulations published elsewhere in this issue of the Bulletin propose one month as the maximum length of any orientation period meaning generally a period that begins on any day of a calendar month and is determined by adding one calendar month and then subtracting one calendar day).[18] Comments are invited on those proposed regulations and may be submitted as described in the proposed regulations. The Departments will consider compliance with those proposed regulations to constitute a reasonable and bona fide employment-based orientation period under PHS Act section 2708 at least through the end of 2014. To the extent final regulations or other guidance with respect to the application of the 90-day waiting period limitation to orientation periods is more restrictive on plans and issuers, the final regulations or other guidance will not be effective prior to January 1, 2015, and plans and issuers will be given a reasonable time period to comply.

In response to the proposed regulations, several commenters requested clarification regarding application of the rules to employees that are terminated from employment and then rehired by the same employer. Similarly, commenters requested clarification regarding application of the rules when an employee moves between a job classification that is or is not an eligible job classification for coverage under the plan.

After consideration of the comments, these final regulations provide that a former employee who is rehired may be treated as newly eligible for coverage upon rehire and, therefore, a plan or issuer may require that individual to meet the plan's eligibility criteria and to satisfy the plan's waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation). The same analysis would apply to an individual who moves to a job classification that is ineligible for coverage under the plan but then later moves back to an eligible job classification.

Many commenters raised administrative concerns relating to the application of the rules to multiemployer plans. In the preamble to the proposed regulations, the Departments recognized that multiemployer plans maintained pursuant to collective bargaining agreements have unique operating structures and may include different eligibility conditions based on the participating employer's industry or the employee's occupation. For example, some multiemployer plans determine eligibility based on complex formulas for earnings and residuals or use "hours banks" in which workers' excess hours from one measurement period are credited against any shortage of hours in a succeeding measurement period, functioning as buy-in provisions to prevent lapses in coverage. Some commenters on the proposed regulations pointed out that collectively bargained plans, owing to the nature of the bargaining process, often have detailed and coordinated eligibility provisions (some requiring aggregation of data from multiple contributing employers). Others stated that the unique operating structure of multiemployer plans often allows for continued coverage after an employee's employment terminates (or after an employee's hours are reduced) until the end of the quarter.

On September 4, 2013, the Departments issued a set of frequently asked questions (FAQs) stating that, "under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation."[19] The FAQs further provide that, " [t]herefore, for example, if a multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for

[17]These final regulations also note that a plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

[18]The proposed regulations provide that if there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

[19]*See* FAQs about Affordable Care Act Implementation (Part XVI), Q2, available at *http://www.dol.gov/ebsa/faqs/faq-aca16.html* and *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs16.html*.

coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation)." These final regulations include an example consistent with this FAQ.

While the requirements of PHS Act section 2708 and these final regulations apply to both the plan and issuer offering coverage in connection with such plan, to the extent coverage under a group health plan is insured by a health insurance issuer, paragraph (f) of these regulations provides that the issuer can rely on the eligibility information reported to it by an employer (or other plan sponsor) and will not be considered to violate the requirements of these final regulations in administering the 90-day waiting period limitation if: (1) the issuer requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor before an individual is eligible to become covered under the terms of the plan (and requires the plan sponsor to update this representation with any applicable changes); and (2) the issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

Consistent with the statutory effective date of PHS Act section 2708, the Departments proposed that the 90-day waiting period limitation would become applicable for plan years beginning on or after January 1, 2014, for both grandfathered and non-grandfathered group health plans and health insurance issuers offering group health insurance coverage. As with the applicability of the 2004 HIPAA regulations, the proposed regulations stated that, with respect to individuals who are in a waiting period for coverage before the applicability date of the regulations, beginning on the first day these rules apply to the plan, any waiting period can no longer apply in a manner that exceeds 90 days from the beginning of the waiting period, even if the waiting period began before the first day the rules apply to the plan.

The August 2012 guidance provided that group health plans and health insurance issuers may rely on the compliance guidance through at least the end of 2014. The preamble to the proposed regulations stated that, in the Departments' view, the proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance, and that therefore, the Departments will consider compliance with the proposed regulations to constitute compliance with PHS Act section 2708 at least through the end of 2014. The 90-day waiting period provisions of these final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. For plan years beginning in 2014, the Departments will consider compliance with either the proposed regulations or these final regulations to constitute compliance with PHS Act section 2708.[20]

B. *Conforming Changes to Existing Regulations*

The proposed regulations included proposed conforming amendments to the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA), to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704 (as added by the Affordable Care Act) and the implementing regulations, including elimination of the requirement to issue certificates of creditable coverage. The regulations proposed that these amendments would become applicable after issuance of the final regulations; however, the proposal to eliminate the requirement to issue certificates of creditable coverage was proposed to apply beginning December 31, 2014, so that individuals needing to offset a preexisting condition exclusion under a plan that will become subject to the prohibition on preexisting conditions starting with a plan year beginning on December 31, 2014 would still have access to the certificate for proof of coverage until that time. Commenters requested that the requirement to provide certificates of creditable coverage be eliminated beginning in 2014 because the certificates are no longer necessary. Commenters explained that the need for certificates after 2013 would be relatively rare and requested that plans and issuers be required to provide certificates in 2014 only upon request.

These final regulations adopt without substantive change the proposed conforming amendments. A minor clarification was added to the Example 7 of the rules regarding limitations on preexisting condition exclusion periods,[21] and Example 4 of the rules prohibiting discrimination against participants and beneficiaries based on a health factor,[22] to clarify that any reference to essential health benefit for purposes of the individual and small group markets is dependent upon the State essential health benefits benchmark plan as defined in HHS regulations at 45 CFR 156.20. Additionally, HHS is not finalizing the proposed amendments to 45 CFR 146.145(b) because the provision was stricken in previous rulemaking (78 FR at 65092, October 30, 2013).

The prohibition with respect to adults on preexisting condition exclusions applies for plan years (or, in the individual market, policy years) beginning on or after January 1, 2014. If a plan had a plan year beginning December 31, 2013, the plan could impose a preexisting condition exclusion, and an individual could need a certificate of creditable coverage, through December 30, 2014.

All other amendments made by these final regulations to the 2004 HIPAA reg-

[20]The Departments note that, with respect to individuals who are in a waiting period for coverage before the statutory effective date of PHS Act section 2708, beginning on the first day the statute applies to the plan, any waiting period can no longer apply in a manner that exceeds 90 days. This clarification was included in the proposed regulations, but has not been retained in the final regulations, because individuals will not be in a waiting period that exceeds 90 days by the applicability date of the final regulations.

[21]26 CFR 54.9801–3(a)(2) Example 8; 29 CFR 2590.701–3(a)(2) Example 8, and 45 CFR 146.111(a)(2) Example 8.

[22]26 CFR 54.9802–1(b)(2)(i)(D) Example 4, 29 CFR 2590.702(b)(2)(i)(D) Example 4, and 45 CFR 146.121(b)(2)(i)(D) Example 4.

ulations apply to group health plans and health insurance issuers for plan years beginning on or after April 25, 2014. Until the amendments to the existing HIPAA final regulations become applicable, plans and issuers must continue to comply with the existing regulations, to the extent consistent with amendments to the statute.

III. Economic Impact and Paperwork Burden

A. *Executive Order 12866 and 13563 – Department of Labor and Department of Health and Human Services*

Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing and streamlining rules, and of promoting flexibility. It also requires federal agencies to develop a plan under which the agencies will periodically review their existing significant regulations to make the agencies' regulatory programs more effective or less burdensome in achieving their regulatory objectives.

Under Executive Order 12866, a regulatory action deemed "significant" is subject to the requirements of the Executive Order and 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, 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 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.

These final regulations are not economically significant within the meaning of section 3(f)(1) of the Executive Order. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these final regulations, and the Departments[23] have provided the following assessment of their impact.

1. *Summary*

As stated earlier in this preamble, these final regulations implement PHS Act section 2708, which provides that a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. A waiting period is defined to mean the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. The final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

The Departments have crafted these final regulations to secure the protections intended by Congress in an economically efficient manner. The Departments lack sufficient data to quantify the regulations' economic cost or benefits; therefore, the proposed regulations provided a qualitative discussion of their economic impacts and requested detailed comment and data that would allow for quantification of the costs, benefits, and transfers. While comments were received expressing concern about the cost to employers that currently have waiting periods longer than 90 days of having to change their practices and provide coverage sooner to comply with the 90-day waiting period limitation, no comments provided additional data that would help in estimating the economic impacts of the final regulations.

2. *Estimated Number of Affected Entities*

The Departments estimate that 4.1 million new employees receive group health insurance coverage through private sector employers and 1.0 million new employees receive group health insurance coverage through public sector employers annually.[24] The 2013 Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits Annual Survey (the "2013 Kaiser Survey") finds that only nine percent of covered workers were subject to waiting periods of four months or more.[25] If nine percent of new employees receiving health care coverage from their employers are subject to a waiting period of four months or more, then 459,000 new employees (5.1 million x 0.09) would potentially be affected by these regulations.[26] However, it is unlikely that the survey defines the term "waiting period" in the same manner as these final regulations. For example, waiting period may have been defined by reference to an employee's start date, and it seems unlikely that the 2013 Kaiser Survey would have included the clarifications included in these final regulations regarding the measurement period for variable-hour employees or the clarification regarding cumulative hours-of-service requirements.

3. *Benefits*

Before Congress enacted PHS Act section 2708, Federal law did not prescribe any limits on waiting periods for group health coverage.

If employees delay health care treatment until the expiration of a lengthy waiting period, detrimental health effects could result, especially for employees and their dependents requiring higher levels of health care, such as older Americans, pregnant women, young children, and those with chronic conditions. This could lead to lower work productivity and missed school days. Low-wage workers also are vulnerable, because they have less income to spend out-of-pocket to cover

[23]In section III of this preamble, some subsections have a heading listing one or two of the three Departments. In those subsections, the term "Departments" generally refers only to the Departments listed in the heading.

[24]This estimate is based upon internal Department of Labor calculations derived from the 2009 Medical Expenditure Panel Survey.

[25]*See e.g.,* Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2013 Annual Survey* (2013) available at *http://ehbs.kff.org/pdf/2013/8345.pdf*

[26]Approximately 373,000 private sector employees and 87,000 State and local public sector employees.

medical expenses. The Departments anticipate that these final regulations can help reduce these effects.

As discussed earlier in this preamble, these final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act. These amendments would provide a benefit to plans by reducing the burden associated with complying with the several Paperwork Reduction Act (PRA) information collections that are associated with the superseded regulations. For a discussion of the affected information collections and the estimated cost and burden hour reduction, please see the PRA section, later in this preamble.

4. *Transfers*

The possible transfers associated with these final regulations would arise if employers begin to pay their portion of premiums or contributions sooner than they otherwise would in the absence of PHS Act section 2708 and these final regulations. Recipients of the transfers would be covered employees and their dependents who would, after these final regulations become applicable, not be subject to excessive waiting periods during which they must forgo health coverage, purchase COBRA continuation coverage, or obtain an individual health insurance policy – all of which are options that could lead to higher out-of-pocket costs for employees to cover their healthcare expenditures. As discussed above, Federal law did not limit the duration of waiting periods in the group market before the enactment of PHS Act section 2708.

The Departments do not believe that these final regulations, on their own, will cause more than a marginal number of employers to offer coverage earlier to their employees. That is because a relatively small fraction of workers have waiting periods that exceed four months and these final regulations afford employers flexibility to maintain or revise their current group health plan eligibility conditions. For example, as described earlier, if a group health plan or group health insurance issuer conditions eligibility on the completion by an employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours. Additionally, the final regulations allow for a reasonable and bona fide employment-based orientation period to be imposed as a condition for eligibility for coverage under a plan. These provisions are intended to provide plan sponsors with flexibility to continue the common practice of utilizing a probationary or trial period to determine whether a new employee will be able to handle the duties and challenges of the job, while providing protections against excessive waiting periods for such employees. Under these final regulations, the plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement or orientation period and may not exceed 90 days.

Because the 2013 Kaiser Survey reports that only nine percent of covered workers are in plans with waiting periods of four months or more and the overall average waiting period is only 1.8 months, the Departments are confident that such long waiting periods are rare.

B. *Paperwork Reduction Act*

1. *Department of Labor and Department of the Treasury*

As described earlier in this preamble, these final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.

The Departments are discontinuing the following Information Collection Requests (ICRs) that are associated with the superseded regulations: The Notice of Preexisting Condition Exclusion under Group Health Plans, which is approved under OMB Control Number 1210-0102 through January 31, 2016, and Establishing Creditable Coverage under Group Health Plans, which is approved under OMB Control Number 1210-0103 through January 31, 2016. Additionally, the Departments are revising Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV, which is approved under OMB Control Number 1545-1537 through February 28, 2014, to remove the Health Plans Imposing Pre-existing Condition Notification Requirements, Certification Requirements, and Exclusion Period Notification Information Collections within this ICR because they are associated with the superseded regulation.

Discontinuing and revising these ICRs would result in a total burden reduction of approximately 341,000 hours (5,000 hours attributable to OMB Control Number 1210-0102, 74,000 hours attributable to OMB Control Number 1210-0103, and 262,000 hours attributable to OMB Control Number 1545-1537) and a total cost burden reduction of approximately $32.7 million ($1.1 million attributable to OMB Control Number 1210-0102, $12.4 million attributable to OMB Control Number 1210-0103, and $19.2 million attributable to OMB Control Number 1545-1537).

2. *Department of Health and Human Services*

These final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.

HHS will discontinue the following ICRs that are associated with the superseded regulations, beginning January 1, 2015: The Notice of Preexisting Condition Exclusion and Certifications of Creditable Coverage under group health plans, which are approved under OMB Control Number 0938-0702.

Discontinuing these ICRs will result in a total annual burden reduction of approximately 2,908,569 hours and a total cost burden reduction of approximately $89.2 million.

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) applies to most Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.). Unless an agency certifies that such a rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions. In accordance with the RFA, the Departments prepared an initial regulatory flexibility analysis at the proposed rule stage and requested comments on the analysis. No comments were received. Below is the Department's final regulatory flexibility analysis and its certification that these final regulations do not have a significant economic impact on a substantial number of small entities. The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments lack data to focus only on the impacts on small business. However, the Departments believe that the final regulations include flexibility that would allow small employers to minimize the transfers in health insurance premiums that they would have to pay to employees. Based on the foregoing, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

D. *Special Analyses—Department of the Treasury*

For purposes of the Department of the Treasury, it has been determined that this final rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. 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 these final regulations, and, because these final regulations do not impose a collection of information requirement on small entities, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to Code section 7805(f), this final rule has been submitted to the Small Business Administration for comment on its impact on small business.

E. *Congressional Review Act*

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

F. *Unfunded Mandates Reform Act*

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or by the private sector, of $100 million or more adjusted for inflation ($141 million in 2013).

G. *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 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. In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating 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 consumer protective than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and therefore are unlikely to be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997 (62 FR 16904), and December 30, 2004 (69 FR 78720), and these final regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute.

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.

Throughout the process of developing these 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.

IV. Statutory Authority

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

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Public Law 111–148, 124 Stat. 119, as amended by Public Law 111–152, 124 Stat. 1029; Secretary of Labor's Order 3–2010, 75 FR 55354 (September 10, 2010).

The Department of Health and Human Services regulations are adopted, with respect to 45 CFR Parts 144 and 146, pursuant to the authority contained in sections 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92), and, with respect to 45 CFR Part 147, pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

* * * * *

* * * * *

* * * * *

* * * * *

John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved February 18, 2014.

Mark J. Mazur
Assistant Secretary of the Treasury.

(Filed by the Office of the Federal Register on February 20, 2014, 11:15 a.m., and published in the issue of the Federal Register for February 24, 2014, 79 F.R. 10296)

Dated: *February 11, 2014*

Marilyn Tavenner,
Administrator, Centers for Medicare & Medicaid Services.

Dated: *February 13, 2014*

Kathleen Sebelius,
Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY
Internal Revenue Service

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54 – PENSION EXCISE TAXES

Paragraph 1. The authority citation for Part 54 is amended by adding an entry for § 54.9815–2708 in numerical order to read in part as follows:

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

Section 54.9815–2708 is also issued under 26 U.S.C. 9833.

* * * * *

Par. 2. Section 54.9801–1 is amended by revising paragraph (b) to read as follows:

§ 54.9801–1 Basis and scope.

* * * * *

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part 54. This part 54 sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, are set forth in this part 54.

* * * * *

Par. 3. Section 54.9801–2 is amended by revising the definitions of "*enrollment date*", "*late enrollment*", and "*waiting period*", and by adding definitions of "*first day of coverage*" and "*late enrollee*" in alphabetical order, to read as follows:

§ 54.9801–2 Definitions.

* * * * *

Enrollment date means the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

* * * * *

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

* * * * *

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the

individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

* * * * *

Waiting period means *waiting period* within the meaning of § 54.9815–2708(b).

* * * * *

Par. 4. Section 54.9801–3 is amended by:

A. Revising the section heading.

B. Removing paragraphs (a)(2), (a)(3), (c), (d), (e), and (f).

C. Revising the heading to paragraph (a).

D. Removing the heading to paragraph (a)(1), and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

E. Amending newly designated paragraph (a)(2) by revising paragraph (ii) of Examples 1 and 2, by revising Example 3 and Example 4, and by revising paragraph (ii) of Examples 5, 6, 7 and 8.

F. Revising paragraph (b).

The revisions read as follows:

§ 54.9801–3 Preexisting condition exclusions.

(a) *Preexisting condition exclusion defined—*

* * * * *

(2) * * *

Example 1. * * *

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. The exclusion of benefits, therefore, is prohibited.

Example 2. * * *

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) *Conclusion.* In this *Example 3*, the requirement to obtain advance approval of a treatment plan is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 4. (i) *Facts.* A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 5. * * *

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 6. * * *

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. * * *

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not prohibited. (But see 45 CFR 147.150, which may require coverage of cleft palate as an essential health benefit for health insurance coverage in the individual or small group market, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20).

Example 8. * * *

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

(b) *General rules. See* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

Par. 5. Section 54.9801–4 is amended by removing paragraphs (a)(3) and (c), and revising paragraph (b) to read as follows:

§ 54.9801–4 Rules relating to creditable coverage.

* * * * *

(b) *Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion. See* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

Par. 6. Section 54.9801–5 is revised to read as follows:

§ 54.9801–5 Evidence of creditable coverage.

(a) *In general.* The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. *See* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

(b) *Applicability.* The provisions of this section apply beginning December 31, 2014.

Par. 7. Section 54.9801–6 is amended by removing paragraph (a)(3)(i)(E) and revising paragraphs (a)(3)(i)(C), (a)(3)(i)(D), (a)(4)(i), and (d)(2) to read as follows:

§ 54.9801–6 Special enrollment periods.

(a) * * *

(3) * * *

(i) * * *

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in §54.9802–1(d)) that includes the individual.

* * * * *

(4) * * *

(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section to request enrollment (for the employee or the employee's dependent).

* * * * *

(d) * * *

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

* * * * *

Par. 8. Section 54.9802–1 is amended by:

A. Revising paragraphs (b)(1)(i) and (b)(2)(i)(B).

B. Revising Example 1, paragraph (i) of Example 2, paragraph (ii) of Example 4, paragraph (ii) of Example 5, and removing Example 8, in paragraph (b)(2)(i)(D).

C. Removing paragraph (b)(3).

D. Revising Example 2 and paragraph (i) of Example 5 in paragraph (d)(4).

E. Revising paragraph (ii) of Example 2 in paragraph (e)(2)(i)(B).

F. Revising Example 1 in paragraph (g)(1)(ii).

The revisions read as follows:

§ 54.9802–1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

* * * * *

(b) * * *

(1) * * *

(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

* * * * *

(2) * * *

(i) * * *

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under ERISA, the Affordable Care Act (including the requirements related to essential health benefits), the Americans with Disabilities Act, or any other law, whether State or Federal.)

* * * * *

(D) * * *

Example 1. (i) *Facts.* A group health plan applies a $10,000 annual limit on a specific covered benefit that is not an essential health benefit to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because coverage of the specific, non-essential health benefit up to $10,000 is available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a $500 deductible on all benefits for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a $2,000 deductible on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

* * * * *

Example 4. * * *

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries. (However, applying a lifetime limit on TMJ may violate PHS Act section 2711 and its implementing regulations, if TMJ coverage is an essential health benefit, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

Example 5. * * *

(ii) *Conclusion.* In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals. Additionally, this plan provision is prohibited under PHS Act section 2711 and its implementing regulations because it imposes a lifetime limit on essential health benefits.

* * * * *

(d) * * *

(4) * * *

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this Example 2, treating spouses and children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

* * * * *

Example 5. (i) *Facts*. An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a higher deductible than in the benefit package made available to the other six employees.

* * * * *

(e) * * *

(2) * * *

(i) * * *

(B) * * *

Example 2. * * *

(ii) *Conclusion*. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

* * * * *

(g) * * *

(1) * * *

(ii) * * *

Example 1. (i) *Facts*. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) *Conclusion*. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 satisfies this paragraph (g)(1) (and thus does not violate this section).

* * * * *

Par. 9. Section 54.9815–2708 is added to read as follows:

§ 54.9815–2708 Prohibition on waiting periods that exceed 90 days.

(a) *General rule*. A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.

(b) *Waiting period defined*. For purposes of this part, a waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an individual enrolls as a late enrollee (as defined under § 54.9801–2) or special enrollee (as described in § 54.9801–6), any period before such late or special enrollment is not a waiting period.

(c) *Relation to a plan's eligibility criteria* – (1) *In general*. Except as provided in paragraphs (c)(2) and (c)(3) of this section, being otherwise eligible to enroll under the terms of a group health plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). Moreover, except as provided in paragraphs (c)(2) and (c)(3) of this section, nothing in this section requires a plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible individuals to wait more than 90 days before coverage is effective. *See also* section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.

(2) *Eligibility conditions based solely on the lapse of time*. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

(3) *Other conditions for eligibility*. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation, determined in accordance with the rules of this paragraph (c)(3).

(i) *Application to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition*. If a group health plan conditions eligibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether such an employee meets the plan's eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

(ii) *Cumulative service requirements*. If a group health plan or health insurance issuer conditions eligibility on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(d) *Application to rehires*. A plan or issuer may treat an employee whose employment has terminated and who then is rehired as newly eligible upon rehire and, therefore, required to meet the plan's eligibility criteria

and waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

(e) *Counting days*. Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 54.9801–2), including weekends and holidays. A plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

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

Example 1. (i) *Facts*. A group health plan provides that full-time employees are eligible for coverage under the plan. Employee *A* begins employment as a full-time employee on January 19.

(ii) *Conclusion*. In this *Example 1*, any waiting period for *A* would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2. (i) *Facts*. A group health plan provides that only employees with job title *M* are eligible for coverage under the plan. Employee *B* begins employment with job title *L* on January 30.

(ii) *Conclusion*. In this *Example 2*, *B* is not eligible for coverage under the plan, and the period while *B* is working with job title *L* and therefore not in an eligible class of employees, is not part of a waiting period under this section.

Example 3. (i) *Facts*. Same facts as in *Example 2*, except that *B* transfers to a new position with job title *M* on April 11.

(ii) *Conclusion*. In this *Example 3*, *B* becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for *B* begins on April 11 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than July 10.

Example 4. (i) *Facts*. A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee *C* is hired on May 3 and meets the plan's eligibility criteria on September 22.

(ii) *Conclusion*. In this *Example 4*, *C* becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for *C* would begin on September 22 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than December 21.

Example 5. (i) *Facts*. A group health plan provides that employees are eligible for coverage after one year of service.

(ii) *Conclusion*. In this *Example 5*, the plan's eligibility condition is based solely on the lapse of time and, therefore, is impermissible under paragraph (c)(2) of this section because it exceeds 90 days.

Example 6. (i) *Facts*. Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date and may be completed within 90 days. Employee *D* is hired and starts on October 31, which is the first day of a pay period. *D* completes the enrollment forms and submits them on the 90th day after *D*'s start date, which is January 28. Coverage is made effective 7 days later, February 4, which is the first day of the next pay period.

(ii) *Conclusion*. In this *Example 6*, under the terms of *V*'s plan, coverage may become effective as early as October 31, depending on when *D* completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective depends solely on the length of time taken by *D* to complete the enrollment materials. Therefore, under the terms of the plan, *D* may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with this section.

Example 7. (i) *Facts*. Under Employer *W*'s group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee *E* begins employment for Employer *W* on November 26 of Year 1. *E*'s hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and *E*'s availability. Therefore, it cannot be determined at *E*'s start date that *E* is reasonably expected to work full-time. Under the terms of the plan, variable-hour employees, such as *E*, are eligible to enroll in the plan if they are determined to be a full-time employee after a measurement period of 12 months that begins on the employee's start date. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. *E*'s 12-month measurement period ends November 25 of Year 2. *E* is determined to be a full-time employee and is notified of *E*'s plan eligibility. If *E* then elects coverage, *E*'s first day of coverage will be January 1 of Year 3.

(ii) *Conclusion*. In this *Example 7*, the measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation. The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided that (a) the period of time is no longer than 12 months; (b) the period of time begins on a date between the employee's start date and the first day of the next calendar month (inclusive); (c) coverage is made effective no later than 13 months from *E*'s start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month; and (d) in addition to the measurement period, no more than 90 days elapse prior to the employee's eligibility for coverage.

Example 8. (i) *Facts*. Employee *F* begins working 25 hours per week for Employer *X* on January 6 and is considered a part-time employee for purposes of *X*'s group health plan. *X* sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. *F* satisfies the plan's cumulative hours of service condition on December 15.

(ii) *Conclusion*. In this *Example 8*, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for *F* under the plan must begin no later than the 91st day after *F* completes 1,200 hours. (If the plan's cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

Example 9. (i) *Facts*. A multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working a specified number of hours of covered employment for multiple contributing employers. The plan aggregates hours in a calendar quarter and then, if enough hours are earned, coverage begins the first day of the next calendar quarter. The plan also permits coverage to extend for the next full calendar quarter, regardless of whether an employee's employment has terminated.

(ii) *Conclusion*. In this *Example 9*, these eligibility provisions are designed to accommodate a unique operating structure, and, therefore, are not considered to be designed to avoid compliance with the 90-day waiting period limitation, and the plan complies with this section.

Example 10. (i) *Facts*. Employee *G* retires at age 55 after 30 years of employment with Employer *Y* with no expectation of providing further services to Employer *Y*. Three months later, *Y* recruits *G* to return to work as an employee providing advice and transition assistance for *G*'s replacement under a one-year employment contract. *Y*'s plan imposes a 90-day waiting period from an employee's start date before coverage becomes effective.

(ii) *Conclusion*. In this *Example 10*, *Y*'s plan may treat *G* as newly eligible for coverage under the plan upon rehire and therefore may impose the 90-day waiting period with respect to *G* for coverage offered in connection with *G*'s rehire.

(g) *Special rule for health insurance issuers*. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is permitted to rely on the eligibility information reported to it by the employer (or other plan sponsor) and will not be considered to violate the requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:

(1) The issuer requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor before an individual is eligible to become covered under the terms of the plan (and requires the plan sponsor to update this representation with any changes), and

(2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

(h) *No effect on other laws*. Compliance with this section is not determinative of compliance with any other provision of State or Federal law (including ERISA, the Code, or other provisions of the Patient Protection and Affordable Care Act). *See e.g.*, § 54.9802–1, which prohibits discrimination in eligibility for coverage based on a health factor and section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(i) *Applicability date*. The provisions of this section apply for plan years beginning on or after January 1, 2015. *See* section 1251 of the Affordable Care Act, as amended by section 10103 of the Affordable Care Act and section 2301 of the Health Care and Education Reconciliation Act, and its implementing regulations providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and group health insurance issuers, including grandfathered health plans.

§ 54.9831–1 [Amended]

Par. 10. Section 54.9831–1 is amended by removing paragraph (b)(2)(i), and redesignating paragraphs (b)(2)(ii) through (b)(2)(viii) as (b)(2)(i) through (b)(2)(vii).

Part III. Administrative, Procedural, and Miscellaneous

26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also: Part I, §§ 280F; 1.280F–7.)

Rev. Proc. 2014–21

SECTION 1. PURPOSE

This revenue procedure provides: (1) limitations on depreciation deductions for owners of passenger automobiles first placed in service by the taxpayer during calendar year 2014, including separate tables of limitations on depreciation deductions for trucks and vans; and (2) the amounts that must be included in income by lessees of passenger automobiles first leased by the taxpayer during calendar year 2014, including a separate table of inclusion amounts for lessees of trucks and vans. The tables detailing these depreciation limitations and lessee inclusion amounts reflect the automobile price inflation adjustments required by § 280F(d)(7) of the Internal Revenue Code.

SECTION 2. BACKGROUND

.01 For owners of passenger automobiles, § 280F(a) imposes dollar limitations on the depreciation deduction for the year the taxpayer places the passenger automobile in service and for each succeeding year. For passenger automobiles placed in service after 1988, § 280F(d)(7) requires the Internal Revenue Service to increase the amounts allowable as depreciation deductions by a price inflation adjustment amount. The method of calculating this price inflation amount for trucks and vans placed in service in or after calendar year 2003 uses a different CPI "automobile component" (the "new trucks" component) than that used in the price inflation amount calculation for other passenger automobiles (the "new cars" component), resulting in somewhat higher depreciation deductions for trucks and vans. This change reflects the higher rate of price inflation for trucks and vans since 1988.

.02 Section 280F(c) requires a reduction in the deduction allowed to the lessee of a leased passenger automobile. The reduction must be substantially equivalent to the limitations on the depreciation deductions imposed on owners of passenger automobiles. Under § 1.280F–7(a) of the Income Tax Regulations, this reduction requires a lessee to include in gross income an amount determined by applying a formula to the amount obtained from a table. One table applies to lessees of trucks and vans and another table applies to all other passenger automobiles. Each table shows inclusion amounts for a range of fair market values for each taxable year after the passenger automobile is first leased.

SECTION 3. SCOPE

.01 The limitations on depreciation deductions in section 4.01(2) of this revenue procedure apply to passenger automobiles (other than leased passenger automobiles) that are placed in service by the taxpayer in calendar year 2014, and continue to apply for each taxable year that the passenger automobile remains in service.

.02 The tables in section 4.02 of this revenue procedure apply to leased passenger automobiles for which the lease term begins during calendar year 2014. Lessees of these passenger automobiles must use these tables to determine the inclusion amount for each taxable year during which the passenger automobile is leased. See Rev. Proc. 2009–24, 2009–17 I.R.B. 885, for passenger automobiles first leased during calendar year 2009; Rev. Proc. 2010–18, 2010–09 I.R.B. 427, as amplified and modified by section 4.03 of Rev. Proc. 2011–21, 2011–12 I.R.B. 560, for passenger automobiles first leased during calendar year 2010; Rev. Proc. 2011–21, for passenger automobiles first leased during calendar year 2011; Rev. Proc. 2012–23, 2012–14 I.R.B. 712, for passenger automobiles first leased during calendar year 2012, and Rev. Proc. 2013–21, 2013–12 I.R.B. 660, for passenger automobiles first leased during calendar year 2013.

SECTION 4. APPLICATION

.01 *Limitations on Depreciation Deductions for Certain Automobiles*.

(1) *Amount of the inflation adjustment*.

(a) *Passenger automobiles (other than trucks or vans)*. Under § 280F(d)(7)(B)(i), the automobile price inflation adjustment for any calendar year is the percentage (if any) by which the CPI automobile component for October of the preceding calendar year exceeds the CPI automobile component for October 1987. Section 280F(d)(7)(B)(ii) defines the term "CPI automobile component" as the automobile component of the Consumer Price Index for all Urban Consumers published by the Department of Labor. The new car component of the CPI was 115.2 for October 1987 and 144.169 for October 2013. The October 2013 index exceeded the October 1987 index by 28.969. Therefore, the automobile price inflation adjustment for 2014 for passenger automobiles (other than trucks and vans) is 25.1 percent (28.969/115.2 x 100%). The dollar limitations in § 280F(a) are multiplied by a factor of 0.251, and the resulting increases, after rounding to the nearest $100, are added to the 1988 limitations to give the depreciation limitations applicable to passenger automobiles (other than trucks and vans) for calendar year 2014. This adjustment applies to all passenger automobiles (other than trucks and vans) that are first placed in service in calendar year 2014.

(b) *Trucks and vans*. To determine the dollar limitations for trucks and vans first placed in service during calendar year 2014, the Service uses the new truck component of the CPI instead of the new car component. The new truck component of the CPI was 112.4 for October 1987 and 151.877 for October 2013. The October 2013 index exceeded the October 1987 index by 39.477. Therefore, the automobile price inflation adjustment for 2014 for trucks and vans is 35.1 percent (39.477/112.4 x 100%). The dollar limitations in § 280F(a) are multiplied by a factor of 0.351, and the resulting increases, after rounding to the nearest $100, are added to the 1988 limitations to give the depreciation limitations for trucks and vans. This adjustment applies to all trucks and vans that are first placed in service in calendar year 2014.

(2) *Amount of the limitation*. Tables 1 and 2 contain the dollar amount of the

depreciation limitation for each taxable year for passenger automobiles a taxpayer places in service in calendar year 2014. Use Table 1 for a passenger automobile (other than a truck or van), and Table 2 for a truck or van, placed in service in calendar year 2014.

REV. PROC. 2014–21 TABLE 1

DEPRECIATION LIMITATIONS FOR PASSENGER AUTOMOBILES (THAT ARE NOT TRUCKS OR VANS) PLACED IN SERVICE IN CALENDAR YEAR 2014

Tax Year	*Amount*
1st Tax Year	$ 3,160
2nd Tax Year	$ 5,100
3rd Tax Year	$ 3,050
Each Succeeding Year	$ 1,875

REV. PROC. 2014–21 TABLE 2

DEPRECIATION LIMITATIONS FOR TRUCKS AND VANS PLACED IN SERVICE IN CALENDAR YEAR 2014

Tax Year	*Amount*
1st Tax Year	$ 3,460
2nd Tax Year	$ 5,500
3rd Tax Year	$ 3,350
Each Succeeding Year	$ 1,975

.02 *Inclusions in Income of Lessees of Passenger Automobiles.*

A taxpayer must follow the procedures in § 1.280F–7(a) for determining the inclusion amounts for passenger automobiles first leased in calendar year 2014. In applying these procedures, lessees of passenger automobiles other than trucks and vans should use Table 3 of this revenue procedure, while lessees of trucks and vans should use Table 4 of this revenue procedure.

REV. PROC. 2014–21 TABLE 3

DOLLAR AMOUNTS FOR PASSENGER AUTOMOBILES (THAT ARE NOT TRUCKS OR VANS) WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Passenger Automobile		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
$18,500	$19,000	3	5	8	10	11
19,000	19,500	3	6	10	11	13
19,500	20,000	3	8	11	13	14
20,000	20,500	4	8	13	14	17
20,500	21,000	4	9	14	17	18
21,000	21,500	5	10	15	18	21
21,500	22,000	5	11	17	20	22
22,000	23,000	6	13	18	23	25
23,000	24,000	7	14	22	26	29
24,000	25,000	8	16	25	29	33
25,000	26,000	8	19	27	32	38
26,000	27,000	9	20	31	35	42

REV. PROC. 2014–21 TABLE 3

DOLLAR AMOUNTS FOR PASSENGER AUTOMOBILES (THAT ARE NOT TRUCKS OR VANS) WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Passenger Automobile		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
27,000	28,000	10	22	33	40	45
28,000	29,000	11	24	36	43	49
29,000	30,000	12	26	39	46	53
30,000	31,000	13	28	41	50	57
31,000	32,000	14	30	44	53	61
32,000	33,000	14	32	47	56	65
33,000	34,000	15	34	50	59	69
34,000	35,000	16	36	52	64	72
35,000	36,000	17	38	55	67	76
36,000	37,000	18	39	59	70	80
37,000	38,000	19	41	61	74	84
38,000	39,000	20	43	64	77	88
39,000	40,000	21	45	67	80	92
40,000	41,000	21	47	70	84	96
41,000	42,000	22	49	73	87	100
42,000	43,000	23	51	75	91	104
43,000	44,000	24	53	78	94	108
44,000	45,000	25	55	81	97	112
45,000	46,000	26	56	84	101	116
46,000	47,000	27	58	87	104	120
47,000	48,000	28	60	90	107	124
48,000	49,000	28	62	93	111	127
49,000	50,000	29	64	96	114	131
50,000	51,000	30	66	98	118	135
51,000	52,000	31	68	101	121	139
52,000	53,000	32	70	104	124	143
53,000	54,000	33	72	106	128	147
54,000	55,000	34	74	109	131	151
55,000	56,000	34	76	112	135	155
56,000	57,000	35	78	115	138	159
57,000	58,000	36	80	118	141	163
58,000	59,000	37	81	121	145	167
59,000	60,000	38	83	124	148	171
60,000	62,000	39	86	128	153	177
62,000	64,000	41	90	134	159	185
64,000	66,000	43	94	139	167	192
66,000	68,000	44	98	145	173	201
68,000	70,000	46	102	150	180	209
70,000	72,000	48	105	156	188	216
72,000	74,000	50	109	162	194	224
74,000	76,000	51	113	168	200	232
76,000	78,000	53	117	173	208	239

REV. PROC. 2014–21 TABLE 3

DOLLAR AMOUNTS FOR PASSENGER AUTOMOBILES (THAT ARE NOT TRUCKS OR VANS)
WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Passenger Automobile		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
78,000	80,000	55	120	179	215	247
80,000	85,000	58	127	189	226	261
85,000	90,000	62	137	203	243	281
90,000	95,000	67	146	217	260	301
95,000	100,000	71	156	231	277	320
100,000	110,000	77	170	253	303	349
110,000	120,000	86	189	281	337	389
120,000	130,000	95	208	310	370	428
130,000	140,000	103	228	337	405	467
140,000	150,000	112	247	366	438	507
150,000	160,000	121	266	394	473	545
160,000	170,000	130	284	423	507	585
170,000	180,000	138	304	451	541	624
180,000	190,000	147	323	479	575	663
190,000	200,000	156	342	507	609	703
200,000	210,000	164	361	536	643	742
210,000	220,000	173	380	565	676	781
220,000	230,000	182	399	593	710	821
230,000	240,000	190	418	622	744	860
240,000	and over	199	437	650	778	899

REV. PROC. 2014–21 TABLE 4

DOLLAR AMOUNTS FOR TRUCKS AND VANS
WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Truck or Van		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
$19,000	$19,500	2	4	5	7	8
19,500	20,000	2	5	7	8	10
20,000	20,500	3	6	8	10	12
20,500	21,000	3	7	10	11	14
21,000	21,500	3	8	11	14	15
21,500	22,000	4	9	12	15	18
22,000	23,000	5	10	15	17	21
23,000	24,000	5	12	18	21	24
24,000	25,000	6	14	20	25	28
25,000	26,000	7	16	23	28	32
26,000	27,000	8	18	26	31	36
27,000	28,000	9	20	28	35	40
28,000	29,000	10	21	32	38	44

REV. PROC. 2014–21 TABLE 4

DOLLAR AMOUNTS FOR TRUCKS AND VANS
WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Truck or Van		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
29,000	30,000	11	23	35	41	48
30,000	31,000	11	26	37	45	52
31,000	32,000	12	27	41	48	56
32,000	33,000	13	29	43	52	60
33,000	34,000	14	31	46	55	64
34,000	35,000	15	33	49	58	68
35,000	36,000	16	35	51	62	72
36,000	37,000	17	37	54	65	76
37,000	38,000	18	38	58	69	79
38,000	39,000	18	41	60	72	83
39,000	40,000	19	43	63	75	87
40,000	41,000	20	44	66	79	91
41,000	42,000	21	46	69	82	95
42,000	43,000	22	48	72	85	99
43,000	44,000	23	50	74	89	103
44,000	45,000	24	52	77	93	106
45,000	46,000	24	54	80	96	111
46,000	47,000	25	56	83	99	115
47,000	48,000	26	58	86	102	119
48,000	49,000	27	60	88	106	123
49,000	50,000	28	62	91	109	127
50,000	51,000	29	63	95	113	130
51,000	52,000	30	65	97	117	134
52,000	53,000	31	67	100	120	138
53,000	54,000	31	69	103	123	142
54,000	55,000	32	71	106	126	146
55,000	56,000	33	73	108	130	150
56,000	57,000	34	75	111	133	154
57,000	58,000	35	77	114	137	157
58,000	59,000	36	79	116	141	161
59,000	60,000	37	80	120	144	165
60,000	62,000	38	84	123	149	172
62,000	64,000	40	87	130	155	180
64,000	66,000	41	91	136	162	187
66,000	68,000	43	95	141	169	195
68,000	70,000	45	99	146	176	203
70,000	72,000	47	102	153	182	211
72,000	74,000	48	107	158	189	219
74,000	76,000	50	110	164	196	227
76,000	78,000	52	114	169	203	235
78,000	80,000	54	118	175	209	243

REV. PROC. 2014–21 TABLE 4

DOLLAR AMOUNTS FOR TRUCKS AND VANS
WITH A LEASE TERM BEGINNING IN CALENDAR YEAR 2014

Fair Market Value of Truck or Van		Tax Year During Lease				
Over	Not Over	1st	2nd	3rd	4th	5th & later
80,000	85,000	57	124	185	222	256
85,000	90,000	61	134	199	239	276
90,000	95,000	65	144	213	256	295
95,000	100,000	70	153	227	273	315
100,000	110,000	76	168	248	298	345
110,000	120,000	85	187	277	332	383
120,000	130,000	93	206	305	366	423
130,000	140,000	102	225	334	400	462
140,000	150,000	111	244	362	434	501
150,000	160,000	120	263	390	468	541
160,000	170,000	128	282	419	502	580
170,000	180,000	137	301	447	536	619
180,000	190,000	146	320	475	571	658
190,000	200,000	154	339	504	604	698
200,000	210,000	163	358	532	639	736
210,000	220,000	172	377	561	672	776
220,000	230,000	180	397	589	706	815
230,000	240,000	189	416	617	740	854
240,000	and over	198	435	645	774	894

SECTION 5. EFFECTIVE DATE

This revenue procedure applies to passenger automobiles that a taxpayer first places in service or first leases during calendar year 2014.

SECTION 6. DRAFTING INFORMATION

The principal author of this revenue procedure is Bernard P. Harvey of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this revenue procedure, contact Mr. Harvey at (202) 317-7005 (not a toll-free Number).

Rev. Proc. 2014–22

26 CFR 601.602: Tax Forms and instructions. (Also part I, section 6033; 1.6033–2)

Revenue Procedure 79–6, 1979–1 C.B. 485, provided for the use of certain United States Department of Labor forms in place of certain portions of the Form 990, Return of Organization Exempt from Income Tax. The Internal Revenue Service determined that the use of these Department of Labor forms is no longer appropriate, and the Form 990 and Instructions were revised for tax years beginning in 2008 to no longer permit their use. Requiring uniform filing of financial data of all exempt organizations improves transparency by making it easier for the public and the IRS to compare the financial data of organizations. In addition, requiring organizations that must e-file to provide financial information electronically, rather than in a separate attachment, improves tax administration. Accordingly, Revenue Procedure 79–6 is hereby revoked.

Drafting Information

The principal author of this revenue procedure is Melinda Williams of the Exempt Organizations, Tax Exempt and Government Entities Division. For further information regarding this ruling, contact Ms. Williams at 202-317-8532 (not a toll free Number).

Part IV. Items of General Interest

Proposed rules.

Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act

REG–122706–12

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rules.

SUMMARY: These proposed regulations would clarify the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation set forth in section 2708 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (Affordable Care Act), as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code.

DATES: Written comments on this notice of proposed rulemaking are invited and must be received by April 25, 2014.

ADDRESSES: Written comments may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the other Departments and will also 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 may be posted on the Internet 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.

Comments, identified by "Ninety-day waiting period limitation," may be submitted by one of the following methods:

Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.

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: Ninety-day waiting period limitation.

Comments received will be posted without change to *www.regulations.gov* and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue NW., Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-6846; or Cam Moultrie Clemmons, Centers for Medicare & Medicaid Services, 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 (*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 (*www.cciio.cms.gov/*) and information on health reform can be found at *www.HealthCare.gov*.

SUPPLEMENTARY INFORMATION:

I. **Background**

The Patient Protection and Affordable Care Act, Pub. L. 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Pub. L. 111–152, was enacted on March 30, 2010. (They are collectively known as the "Affordable Care Act".) The Affordable Care Act reorganizes, amends, and adds 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.[27] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

PHS Act section 2708, as added by the Affordable Care Act and incorporated into ERISA and the Code, provides that a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in PHS Act section 2704(b)(4)) that exceeds 90 days. PHS Act section 2704(b)(4), ERISA section 701(b)(4), and Code section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan. In 2004 regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) portability provisions (2004 HIPAA regulations), the Departments of Labor, Health and Human Services (HHS), and the Treasury (the

[27]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.

Departments[28]) defined a waiting period to mean the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.[29] PHS Act section 2708 does not require an employer to offer coverage to any particular individual or class of individuals, including part-time employees. PHS Act section 2708 merely prevents an otherwise eligible individual from being required to wait more than 90 days before coverage becomes effective. PHS Act section 2708 applies to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after January 1, 2014.

On February 9, 2012, the Departments issued guidance[30] outlining various approaches under consideration with respect to both the 90-day waiting period limitation and the employer shared responsibility provisions under Code section 4980H (February 2012 guidance) and requested public comment. On August 31, 2012, following their review of the comments on the February 2012 guidance, the Departments provided temporary guidance,[31] to remain in effect at least through the end of 2014, regarding the 90-day waiting period limitation, and described the approach they intended to propose in future rulemaking (August 2012 guidance). After consideration of all of the comments received in response to the February 2012 guidance and August 2012 guidance, the Departments issued proposed regulations on March 21, 2013 (78 FR 17313).

Under the proposed regulations, a group health plan, and a health insurance issuer offering group health insurance coverage may not apply any waiting period that exceeds 90 days. The regulations proposed to define "waiting period" as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms). After consideration of comments on the proposed regulations, the Departments are publishing final regulations elsewhere in this issue of the **Bulletin**. These proposed regulations address orientation periods under the 90-day waiting period limitation of PHS Act section 2708 and solicit comment before promulgation of final regulations on this discrete issue.

II. Overview of the Proposed Regulations

A. *Orientation periods*

Final regulations published elsewhere in this edition of the **Bulletin** set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, the final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). Under the final regulations, after an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.[32]

The final regulations do not specify the facts and circumstances under which an employment-based orientation period would not be considered "reasonable and bona fide." These proposed regulations would provide that one month is the maximum allowed length of any reasonable and bona fide employment-based orientation period. During an orientation period, the Departments envision that an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. Under these proposed regulations, one month would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30. If a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition would not be considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period did not exceed one month and the maximum 90-day waiting period would begin on the first day after the orientation period.

B. *Comment invitation and reliance*

The Departments invite comments on these proposed regulations. The Departments will consider compliance with these proposed regulations to constitute compliance with PHS Act section 2708 at least through the end of 2014. To the extent

[28]Note, however, that in the Economic Analysis and Paperwork Burden section of this preamble, in sections under headings listing only two of the three Departments, the term "Departments" generally refers only to the two Departments listed in the heading.

[29]26 CFR 54.9801–3(a)(3)(iii), 29 CFR 2590.701–3(a)(3)(iii), and 45 CFR 146.111(a)(3)(iii).

[30]Department of Labor Technical Release 2012–01, IRS Notice 2012–17, and HHS FAQs issued February 9, 2012.

[31]Department of Labor Technical Release 2012–02, IRS Notice 2012–59, and HHS FAQs issued August 31, 2012.

[32]The final regulations also note that a plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend of holiday.

final regulations or other guidance with respect to the application of the 90-day waiting period limitation to orientation periods is more restrictive on plans and issuers, the final regulations or other guidance will not be effective prior to January 1, 2015, and will provide plans and issuers a reasonable time period to comply.

III. Economic Impact and Paperwork Burden

A. *Executive Order 12866 and 13563 – Department of Labor and Department of Health and Human Services*

Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing and streamlining rules, and of promoting flexibility. It also requires federal agencies to develop a plan under which the agencies will periodically review their existing significant regulations to make the agencies' regulatory programs more effective or less burdensome in achieving their regulatory objectives.

Under Executive Order 12866, a regulatory action deemed "significant" is subject to the requirements of the Executive Order and 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, 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 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.

These proposed regulations are not economically significant within the meaning of section 3(f)(1) of the Executive Order. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these proposed regulations, and the Departments[33] have provided the following assessment of their impact.

1. *Summary*

As stated earlier in this preamble, these proposed regulations address reasonable and bona fide employment-based orientation periods under the 90-day waiting period limitation of PHS Act section 2708. The Departments have crafted these proposed regulations to secure the protections intended by Congress in an economically efficient manner. The Departments lack sufficient data to quantify the regulations' economic cost or benefits. The proposed regulations implementing PHS Act section 2708[34] provided a qualitative discussion of economic impacts of proposed limits on waiting periods and requested detailed comments and data that would allow for quantification of the costs, benefits, and transfers. Comments were received expressing concern about the cost to employers that currently have waiting periods longer than 90 days, and explaining that they would have to change their practices and often have to provide coverage sooner than the 90-day waiting period limitation. No comments provided additional data that would help in estimating the economic impacts of the proposed regulations. The Departments request comments that would allow them to quantify the impacts of these proposed regulations on the discrete issue of orientation periods.

2. *Estimated Number of Affected Entities*

The Departments estimate that 4.1 million new employees receive group health insurance coverage through private sector employers and 1.0 million new employees receive group health insurance coverage through public sector employers annually.[35] The 2013 Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits Annual Survey (the "2013 Kaiser Survey") finds that 30 percent of covered workers were subject to waiting periods of three months or more.[36] The Departments do not have any data, and therefore invite public comment, on the number of employees subject to orientation periods, as described earlier in this preamble.

2. *Benefits*

The final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). These proposed regulations would provide that one month is the maximum allowed length of any reasonable and bona fide employment-based orientation period. During an orientation period, the Departments envision that an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. If a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition would not be considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period did not exceed one month and the maximum 90-day waiting period would begin on the first day after the orientation period.

[33]In section III of this preamble, some subsections have a heading listing one or two of the three Departments. In those subsections, the term "Departments" generally refers only to the Departments listed in the heading.

[34]78 FR 17313 (March 21, 2013).

[35]This estimate is based upon internal Department of Labor calculations derived from the 2009 Medical Expenditure Panel Survey.

[36]*See e.g.*, Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2013 Annual Survey* (2013) available at *http://ehbs.kff.org/pdf/2013/8345.pdf*

3. *Costs*

These proposed regulations could extend the time between an employee beginning work and obtaining health care coverage relative to the time before the issuance of the final regulations and these proposed regulations. If employees delay health care treatment until the expiration of the orientation period and waiting period, detrimental health effects can result, especially for employees and their dependents requiring higher levels of health care, such as older Americans, pregnant women, young children, and those with chronic conditions. This could lead to lower work productivity and missed school days. Low-wage workers also are vulnerable, because they have less income to spend out-of-pocket to cover medical expenses. The Departments anticipate that these proposed regulations could lead to these effects, although the overall cost may be limited because few employees are likely to be affected and it is anticipated that conditioning eligibility on an employee's having completed an orientation period will not result in most employees facing a full additional month between being hired and obtaining coverage.

4. *Transfers*

The possible transfers associated with these proposed regulations would arise from employers beginning to pay their portion of premiums or contributions later than they did before the issuance of the final regulations and these proposed regulations. Recipients of the transfer would be employers who implement an orientation period in addition to the 90-day waiting period, thus delaying having to pay premiums. The source of the transfers would be covered employees who, after these proposed regulations become applicable, will have to wait longer between being employed and obtaining health coverage, during which they must forgo health coverage, purchase COBRA continuation coverage, or obtain an individual health insurance policy – all of which are options that could lead to higher out-of-pocket costs for employees to cover their healthcare expenditures.

The Departments believe that under these proposed regulations only a small number of employers would further delay offering coverage to their employees because a relatively small fraction of workers have an orientation period in addition to a waiting periods that runs for 90 days.

B. *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) applies to most Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.). Unless an agency certifies that such a rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of analysis under the RFA, the Departments propose to continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(3) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for welfare benefit plans that cover fewer than 100 participants.[37]

Further, while some large employers may have small plans, in general, small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these proposed regulations on small plans is an appropriate substitute for evaluating the effect on small entities.

The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments therefore request comments on the appropriateness of the size standard used in evaluating the impact of these proposed regulations on small entities.

The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments lack data to focus only on the impacts on small business. However, the Departments believe that the proposed regulations include flexibility that would minimize the transfers in health insurance premiums that would occur due to the orientation period.

The Departments hereby certify that these proposed regulations will not have a significant economic impact on a substantial number of small entities. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that would allow the Departments to assess the impacts specifically on small plans or suggest alternative rules that accomplish the stated purpose of PHS Act section 2708 and minimize the impact on small entities.

C. *Special Analyses—Department of the Treasury*

For purposes of the Department of the Treasury, it has been determined that this proposed rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. 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 these proposed regulations, and, because these proposed regulations do not impose a collection of information requirement on small entities, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to Code section 7805(f), this proposed rule has been submitted to the Small Business Administration for comment on its impact on small business.

[37]Under ERISA section 104(a)(2), the Secretary may also provide exemptions or simplified reporting and disclosure requirements for pension plans. Pursuant to the authority of ERISA section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46, and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans, that cover fewer than 100 participants and satisfy certain other requirements.

D. *Congressional Review Act*

These proposed 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, if finalized, will be transmitted to the Congress and the Comptroller General for review.

E. *Unfunded Mandates Reform Act*

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, these proposed regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or by the private sector, of $100 million or more adjusted for inflation.

F. *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 proposed 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. In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating 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 consumer protective than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and therefore are unlikely to be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997 (62 FR 16904), and December 30, 2004 (69 FR 78720), and these proposed regulations would clarify and implement the statute's minimum standards and would not significantly reduce the discretion given the States by the statute.

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.

Throughout the process of developing these proposed 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.

IV. Statutory Authority

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

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Public Law 111–148, 124 Stat. 119, as amended by Public Law 111–152, 124 Stat. 1029; Secretary of Labor's Order 3–2010, 75 FR 55354 (September 10, 2010).

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

* * * * *

John Dalrymple
Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this *12th* day of *February*, 2014.

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

Dated: *February 11, 2014*

Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services.

Dated: *February 14, 2014*

Kathleen Sebelius
Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY
Internal Revenue Service

Accordingly, 26 CFR Part 54, as amended by the final rule titled, Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act, published elsewhere in this issue of **Bulletin**, is proposed to be further 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. * * *

Section 54.9815–2708 is also issued under 26 U.S.C. 9833.

*** * * * ***

Par. 2. Section 54.9815–2708 is amended by adding paragraph (c)(3)(iii) and a new Example 11 in paragraph (f) to read as follows:

§ 54.9815–2708 Prohibition on waiting periods that exceed 90 days.

*** * * * ***

(c) * * *

(3) * * *

(iii) *Limitation on orientation periods.* To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

*** * * * ***

(f) * * *

Example 11. (i) *Facts.* Employee *H* begins working full time for Employer *Z* on October 16. *Z* sponsors a group health plan, under which full time employees are eligible for coverage after they have successfully completed a one-month orientation period. *H* completes the orientation period on November 15.

(ii) *Conclusion.* In this *Example 11*, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for *H* must begin no later than February 14, which is the 91st day after *H* completes the orientation period. (If the orientation period was more than one month, it would be considered to be considered a subterfuge for the passage of time and designed to avoid compliance with the 90-day waiting period limitation. Accordingly it would violate the rules of this section.)

* * * * *

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.

Numerical Finding List[1]

Bulletins 2014–1 through 2014–11

Announcements

2014-1, 2014-2 I.R.B. *393*
2014-2, 2014-4 I.R.B. *448*
2014-4, 2014-7 I.R.B. *523*
2014-05, 2014-6 I.R.B. *507*
2014-06, 2014-6 I.R.B. *508*
2014-07, 2014-6 I.R.B. *508*
2014-08, 2014-6 I.R.B. *508*
2014-09, 2014-6 I.R.B. *508*
2014-10, 2014-6 I.R.B. *508*
2014-11, 2014-6 I.R.B. *508*
2014-12, 2014-6 I.R.B. *509*
2014-13, 2014-10 I.R.B. *620*

Notices

2014-1, 2014-2 I.R.B. *270*
2014-2, 2014-3 I.R.B. *407*
2014-3, 2014-3 I.R.B. *408*
2014-4, 2014-2 I.R.B. *274*
2014-5, 2014-2 I.R.B. *276*
2014-6, 2014-2 I.R.B. *279*
2014-7, 2014-4 I.R.B. *445*
2014-8, 2014-5 I.R.B. *452*
2014-9, 2014-5 I.R.B. *455*
2014-10, 2014-9 I.R.B. *605*
2014-12, 2014-9 I.R.B. *606*
2014-13, 2014-10 I.R.B. *616*

Proposed Regulations

REG-154890-03, 2014-6 I.R.B. *504*
REG-159420-04, 2014-2 I.R.B. *374*
REG-144468-05, 2014-6 I.R.B. *474*
REG-119305-11, 2014-8 I.R.B. *524*
REG-140974-11, 2014-3 I.R.B. *438*
REG-121534-12, 2014-6 I.R.B. *473*
REG-122706-12, 2014-11 I.R.B. *647*
REG-136984-12, 2014-2 I.R.B. *378*
REG-113350-13, 2014-3 I.R.B. *440*
REG-141036-13, 2014-7 I.R.B. *516*
REG-143172-13, 2014-2 I.R.B. *383*

Revenue Procedures

2014-1, 2014-1 I.R.B. *1*
2014-2, 2014-1 I.R.B. *90*
2014-3, 2014-1 I.R.B. *111*
2014-4, 2014-1 I.R.B. *125*
2014-5, 2014-1 I.R.B. *169*
2014-6, 2014-1 I.R.B. *198*
2014-7, 2014-1 I.R.B. *238*
2014-8, 2014-1 I.R.B. *242*
2014-9, 2014-2 I.R.B. *281*
2014-10, 2014-2 I.R.B. *293*
2014-11, 2014-3 I.R.B. *411*

Revenue Procedures—Continued

2014-12, 2014-3 I.R.B. *415*
2014-13, 2014-3 I.R.B. *419*
2014-14, 2014-2 I.R.B. *295*
2014-15, 2014-5 I.R.B. *456*
2014-16, 2014-9 I.R.B. *606*
2014-18, 2014-7 I.R.B. *513*
2014-19, 2014-10 I.R.B. *619*
2014-20, 2014-9 I.R.B. *614*
2014-21, 2014-11 I.R.B. *641*
2014-22, 2014-11 I.R.B. *646*

Revenue Rulings

2014-1, 2014-2 I.R.B. *263*
2014-2, 2014-2 I.R.B. *255*
2014-3, 2014-2 I.R.B. *259*
2014-4, 2014-5 I.R.B. *449*
2014-6, 2014-7 I.R.B. *510*
2014-8, 2014-11 I.R.B. *624*

Treasury Decisions

9649, 2014-2 I.R.B. *265*
9650, 2014-3 I.R.B. *394*
9651, 2014-4 I.R.B. *441*
9653, 2014-6 I.R.B. *460*
9654, 2014-6 I.R.B. *461*
9655, 2014-9 I.R.B. *541*
9656, 2014-11 I.R.B. *626*

[1]A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2013–27 through 2013–52 is in Internal Revenue Bulletin 2013–52, dated December 23, 2013.

Finding List of Current Actions on Previously Published Items[1]

Bulletins 2014–1 through 2014–11

Announcements:

2007-44
Modified by
Ann. 2014-4, 2014-7 I.R.B. *523*

2011-49
Modified by
Ann. 2014-4, 2014-7 I.R.B. *523*

Notices:

2006-109
Modified by
Notice 2014-4, 2014-2 I.R.B. *274*

2009-78
Superseded by
T.D. 9654 2014-6 I.R.B. *461*

2013-17
Amplified by
Notice 2014-1, 2014-2 I.R.B. *270*

Revenue Procedures:

2003-49
Modified and superseded by
Rev. Proc. 2014-14, 2014-2 I.R.B. *295*

2011-14
Modified by
Rev. Proc. 2014-16, 2014-9 I.R.B. *606*

2011-14
Clarified by
Rev. Proc. 2014-16, 2014-9 I.R.B. *606*

2011-44
Modified and Superseded by
Rev. Proc. 2014-11, 2014-3 I.R.B. *411*

2011-49
Modified by
Rev. Proc. 2014-6, 2014-1 I.R.B. *198*

2012-19
Modified by
Rev. Proc. 2014-16, 2014-9 I.R.B. *606*

2012-19
Superseded by
Rev. Proc. 2014-16, 2014-9 I.R.B. *606*

2013-1
Superseded by
Rev. Proc. 2014-1, 2014-1 I.R.B. *1*

Revenue Procedures—Continued:

2013-2
Superseded by
Rev. Proc. 2014-2, 2014-1 I.R.B. *90*

2013-3
Superseded by
Rev. Proc. 2014-3, 2014-1 I.R.B. *111*

2013-4
Superseded by
Rev. Proc. 2014-4, 2014-1 I.R.B. *125*

2013-5
Superseded by
Rev. Proc. 2014-5, 2014-1 I.R.B. *169*

2013-6
Superseded by
Rev. Proc. 2014-6, 2014-1 I.R.B. *198*

2013-7
Superseded by
Rev. Proc. 2014-7, 2014-1 I.R.B. *238*

2013-8
Superseded by
Rev. Proc. 2014-8, 2014-1 I.R.B. *242*

2013-9
Superseded by
Rev. Proc. 2014-9, 2014-2 I.R.B. *281*

2013-10
Superseded by
Rev. Proc. 2014-10, 2014-2 I.R.B. *293*

2013-32
Superseded in part by
Rev. Proc. 2014-1, 2014-1 I.R.B. *1*, and
Rev. Proc. 2014-3, 2014-1 I.R.B. *111*

2014-1
Amplified by
Rev. Proc. 2014-18, 2014-7 I.R.B. *513*

2014-3
Amplified by
Rev. Proc. 2014-18, 2014-7 I.R.B. *513*

2014-4
Modified by
Rev. Proc. 2014-19, 2014-10 I.R.B. *619*

Proposed Regulations:

209054-87
A portion withdrawn by
REG-113350-13 2014-3 I.R.B. *440*

[1]A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2013–27 through 2013–52 is in Internal Revenue Bulletin 2013–52, dated December 23, 2013.

INDEX

Internal Revenue Bulletins 2014–1 through 2014–11

The abbreviation and number in parenthesis following the index entry refer to the specific item; numbers in roman and italic type following the parentheses refer to the Internal Revenue Bulletin in which the item may be found and the page number on which it appears.

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

ADMINISTRATIVE

EMPLOYEE PLANS

EMPLOYEE PLANS—Cont.

EMPLOYMENT TAX

ESTATE TAX

EXCISE TAX

EXEMPT ORGANIZATIONS

EXEMPT ORGANIZATIONS—Cont.

INCOME TAX

INCOME TAX—Cont.

Internal Revenue Service
Washington, DC 20224

Official Business
Penalty for Private Use, $300

INTERNAL REVENUE BULLETIN

The Introduction at the beginning of this issue describes the purpose and content of this publication. The weekly Internal Revenue Bulletins are available at *www.irs.gov/irb/*.

CUMULATIVE BULLETINS

The contents of the weekly Bulletins were consolidated semiannually into permanent, indexed, Cumulative Bulletins through the 2008–2 edition.

INTERNAL REVENUE BULLETINS ON CD-ROM

Internal Revenue Bulletins are available annually as part of Publication 1796 (Tax Products CD-ROM). The CD-ROM can be purchased from National Technical Information Service (NTIS) on the Internet at *www.irs.gov/cdorders* (discount for online orders) or by calling 1-877-233-6767. The first release is available in mid-December and the final release is available in late January.

We Welcome Comments About the Internal Revenue Bulletin

If you have comments concerning the format or production of the Internal Revenue Bulletin or suggestions for improving it, we would be pleased to hear from you. You can email us your suggestions or comments through the IRS Internet Home Page (*www.irs.gov*) or write to the IRS Bulletin Unit, SE:W:CAR:MP:P:SPA, Washington, DC 20224.