Internal Revenue
bulletin

Bulletin No. 2001–7
February 12, 2001

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. 2001–7, page 541.

Federal rates; adjusted federal rates; adjusted federal long-term rate, and the long-term exempt rate. For purposes of sections 382, 1274, 1288, and other sections of the Code, tables set forth the rates for February 2001.

T.D. 8917, page 538.

Final regulations under section 467 of the Code provide amendments to the section 467 regulations, including the removal of the exception to constant rental accrual for rental agreements involving payments of $2,000,000 or less.

EMPLOYEE PLANS

T.D. 8921, page 532.

Final regulations under section 125 of the Code relate to the tax treatment of cafeteria plans.

T.D. 8931, page 542.

REG–114082–00, page 629.

Temporary and proposed regulations provide interim guidance on the HIPAA requirements for group health plans not to establish any rule of eligibility based on a health factor of any individual and not to charge any individual a greater premium or contribution based on a health factor than any similarly situated individual. T.D. 8931 also contains final regulations for guidance on the HIPAA nondiscrimination requirements. Public comments on the proposed regulations are requested and must be received by April 9, 2001.

REG–114083–00, page 630.

Proposed regulations provide guidance on the limited exception for certain church plans to the HIPAA nondiscrimination requirements for group health plans. Public comments are requested and must be received by April 9, 2001.

REG–114084–00, page 633.

Proposed regulations provide guidance on the exception for *bona fide wellness programs* to the HIPAA nondiscrimination requirements for group health plans. Public comments are requested and must be received by April 9, 2001.

Notice 2001–15, page 589.

Weighted average interest rate update. The weighted average interest rate for January 2001 and the resulting permissable range of interest rates used to calculate current liability for purposes of the full funding limitation of section 412(c)(7) of the Code are set forth.

Rev. Proc. 2001–17, page 589.

Administrative programs; closing agreements. This procedure updates and expands upon the Service's correction programs for retirement programs within the jurisdiction of the Commissioner, Tax Exempt and Government Entities Division. Rev. Proc. 2000–16 modified and superseded. Rev. Proc. 2001–8 modified.

EXEMPT ORGANIZATIONS

Announcement 2001–14, page 648.

This announcement requests comments and suggestions from the public for topics for Exempt Organizations plain-language publications and voluntary compliance programs.

Finding Lists begin on page ii.
Announcements of Disbarments and Suspensions begin on page 649.

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

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are consolidated semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

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

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

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

The Bulletin is divided into four parts as follows:

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

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

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

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

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

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

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

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, page 541.

Section 125.—Cafeteria Plans

26 CFR 1.125–4: Permitted election changes.

T.D. 8921

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Tax Treatment of Cafeteria Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to section 125 cafeteria plans. The final regulations clarify the circumstances under which a cafeteria plan may permit an employee to change his or her cafeteria plan election with respect to accident or health coverage, group-term life insurance coverage, dependent care assistance and adoption assistance during the plan year.

DATES: *Effective Date*: These regulations are effective January 10, 2001.

Applicability Date: See the *Scope of Regulations and Effective Date* portion of this preamble.

FOR FURTHER INFORMATION CONTACT: Christine L. Keller or Janet A. Laufer at (202) 622-6080 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Income Tax Regulations (26 CFR part 1) under section 125 of the Internal Revenue Code (Code). Section 125 generally provides that an employee in a cafeteria plan will not have an amount included in gross income solely because the employee may choose among two or more benefits consisting of cash and qualified benefits. A qualified benefit generally is any benefit that is excludable from gross income under an express provision of the Code, including coverage under an employer-provided accident or health plan under sections 105 and 106, group-term life insurance under section 79, elective contributions under a qualified cash or deferred arrangement within the meaning of section 401(k), dependent care assistance under section 129, and adoption assistance under section 137.[1] Qualified benefits can be provided under a cafeteria plan either through insured arrangements or arrangements that are not insured.

In 1984 and 1989, proposed regulations were published relating to cafeteria plans.[2] In general, the 1984 and 1989 proposed regulations require that, for benefits to be provided on a pre-tax basis under section 125, an employee may make changes during a plan year only in certain circumstances. Specifically, Q&A-8 of §1.125–1 and Q&A–6(b), (c), and (d) of §1.125–2 permit participants to make benefit election changes during a plan year pursuant to changes in cost or coverage, changes in family status, and separation from service.

In 2000, final regulations[3] were issued permitting a participant in a cafeteria plan to change his or her accident or health coverage election during a period of coverage in specific circumstances such as where special enrollment rights arise under section 9801(f) (added to the Code by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(110 Stat. 1936), where eligibility for Medicare or Medicaid is gained or lost, or where a court issues a judgment, decree, or order requiring that an employee's child or foster child who is a dependent receive health coverage. In addition, the final regulations permit an employee to change his or her accident or health coverage election or group-term life insurance election if certain change in status rules are satisfied.

On the same day that the final regulations were issued, proposed regulations[4] were also issued containing change in status rules that apply to other types of qualified benefits (i.e., dependent care assistance and adoption assistance) and describing the circumstances under which changes in the cost or coverage of qualified benefits provide a basis for changes in cafeteria plan elections. The IRS and Treasury received written comments on the proposed regulations and held a public hearing on August 17, 2000. Having considered the comments and the statements made at the hearing, the IRS and Treasury revise the final regulations and adopt the proposed regulations as modified by this Treasury decision. The comments and revisions are discussed below.

Explanation of Provisions

1. *Changes in the March 2000 Final Regulations*

With respect to group-term life insurance and disability coverage, the final regulations issued earlier this year provided flexibility by stating that, in the event of a change in an employee's marital status or a change in the employment status of the employee's spouse or dependent, an employee may elect either to increase such coverage or to decrease such coverage. [5] Commentators recommended that this rule also apply in the case of birth, adoption, placement for adoption, or

---

[1] Section 125(f) provides that the following are not qualified benefits (even though they are generally excludable from gross income under an express provision of the Internal Revenue Code): products advertised, marketed, or offered as long-term care insurance; medical savings accounts under section 106(b); qualified scholarships under section 117; educational assistance programs under section 127; and fringe benefits under section 132.

[2] 49 F.R. 19321 (May 7, 1984) and 54 F.R. 9460 (March 7, 1989), respectively.

[3] T.D. 8878 at 65 F.R. 15548 (March 23, 2000). These final regulations were preceded by temporary regulations issued in 1997. See 62 F.R. 60196 (November 7, 1997) and 62 F.R. 60165 (November 7, 1997).

[4] REG-117162-99 (2000–15 I.R.B. 871 at 65 F.R. 15587) (March 23, 2000).

[5] For example, an employee might seek to increase group-term life insurance due to a marriage (because of the need to provide income to the new spouse in the event that the chief wage-earner dies) or to decrease group-term life insurance due to a marriage (because the new spouse may be a wage-earner who can support the family in the event that the employee dies).

death. The argument was made that in these other situations — because these types of coverage are generally designed to provide income, instead of expense reimbursements — it may be appropriate for the employee to seek to increase or decrease the coverage. In accordance with these recommendations and in the interest of simplicity, the final regulations have been modified to allow participants to increase or decrease these types of coverage for all change of status events. Further, as also suggested by commentators, the final regulations have been modified to expand the rule to apply to coverage to which section 105(c) (which is coverage for permanent loss or loss of use of a member or function of the body) applies.

Commentators requested clarification as to how the election change rules with respect to special enrollment rights under section 9801(f) (enacted under HIPAA) apply to a participant who marries if the group health plan allows the participant to change his or her health coverage election retroactively to the date of the marriage. In response to this comment, language has been added to an example in the final regulations to clarify that an election change can be funded through salary reduction under a cafeteria plan only on a prospective basis, except for the retroactive enrollment right under section 9801(f) that applies in the case of an election made within 30 days of a birth, adoption, or placement for adoption.

With respect to accident or health coverage, the consistency rule in the final regulations requires that any employee who wishes to decrease or cancel coverage because he or she becomes eligible for coverage under a spouse's or dependent's plan due to a marital or employment change in status can do so only if he or she actually obtains coverage under that other plan. Commentators requested clarification as to the type of proof an employer must receive to satisfy this rule, expressing concern that a plan could not implement a change on a timely basis because of a need to obtain proper proof of the other coverage. An example in the final regulations has been revised to make it clear that employers may generally rely on an employee's certification that the employee has or will obtain coverage under the other plan (assuming that the employer has no reason to believe that the employee certification is incorrect).

The final regulations allow a participant to change his or her election if a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody requires that an employee's spouse, former spouse, or other individual provide accident or health coverage for the employee's child or for a foster child who is a dependent of the employee. The final regulations were modified to clarify that the participant can only change his or her election if the spouse, former spouse, or other individual actually provides accident or health coverage for the child.

2. Changes From the March 2000 Proposed Regulations

The final regulations being issued today are generally consistent with the proposed regulations that were issued earlier this year, but include various modifications.

Cost and coverage rules

The proposed regulations included rules allowing election changes in connection with a significant increase in cost or a significant curtailment in coverage, irrespective of whether the plan is insured or not insured. These cost and coverage rules (and the other rules in paragraph (f) of §1.125–4) do not apply with respect to coverage under a health FSA.[6] However, all of the rules in paragraphs (a) through (e) and paragraph (g) of the final regulations under §1.125–4 do apply with respect to coverage under a health FSA. One modification reflected in the final regulations is to clarify that the cost increase rules apply when the amount of an employee's elective contributions under section 125 increases either due to the employee contributing a larger portion of the total cost of the qualified benefits plan (which might occur, for example, if part-time employees pay a larger portion of a plan's cost and the employee switches to part-time status) or due to an increase in the total cost of the qualified benefits plan.

In response to comments, modifications were also made to allow election changes during a period of coverage when there is a significant *decrease* in the cost of a qualified benefits plan or in the cost of a benefits package option under the qualified benefits plan, as well as when there is a significant increase. Under the regulations as modified, if there is a significant decrease in the cost of a qualified benefits plan during the plan year, the final regulations permit a cafeteria plan to allow all employees, even those who have not previously participated in the cafeteria plan, to elect to participate in the qualified benefits plan through the cafeteria plan. Similarly, if there is a significant decrease in the cost of a benefits package option during the plan year, the final regulations permit a cafeteria plan to allow all eligible employees to elect that option (including employees who have elected another option, as well as those who have not previously participated in the cafeteria plan).

Further, in response to comments, modifications were also made to allow midyear election changes when there is a significant improvement in the coverage provided under a benefit package option, as well as when there is a new benefit package option offered under the plan.

Commentators also requested clarification as to whether a cafeteria plan could allow participants to drop coverage in response to a significant change in the cost or coverage of a qualified benefit. The final regulations clarify this issue, and provide that, if there is no other similar coverage, employees may drop coverage (including a change from family to single coverage) in response either to an increase in the cost of a qualified benefit or to a loss of coverage. The regulations also permit an employee to elect similar coverage in response to a significant curtailment in coverage. However, the regulations do not allow an employee to drop coverage altogether if there is a significant curtailment in coverage that does not constitute a loss of coverage. The regulations list the curtailments that are treated as a loss of coverage for this purpose, and include a complete loss of coverage (such as when an HMO ceases to be available in an area where an individual resides, or

[6] A flexible spending arrangement (FSA) is defined in section 106(c)(2). Under section 106(c)(2), an FSA is generally a benefit program under which the maximum reimbursement reasonably available for coverage is less than 500% of the value of the coverage. A health FSA is an accident or health plan that is an FSA.

when an employee or a covered member of the employee's family loses all coverage under a benefit package option by reason of a lifetime or annual limitation). In addition, the final regulations allow a cafeteria plan, in its discretion[7], to treat certain other events as a loss of coverage. These events include a substantial decrease in medical care providers (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decease in the physicians participating in a preferred provider network or an HMO), a reduction in the benefits for a specific type of medical condition or treatment with respect to which the employee or the employee's spouse or dependent is currently in a course of treatment[8], or any other similar fundamental loss of coverage.

For purposes of these rules, a significant curtailment occurs only if there is an overall reduction in coverage provided so as to constitute reduced coverage generally (i.e., a reduction in the fair market value of the coverage). Therefore, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

In response to comments, the rule under the proposed regulations that allowed an employee to change his or her election in response to a change made under a spouse's or dependent's plan has been clarified and broadened. Under the final regulations, the rule applies to coverage available from any employer plan, including any plan of the same employer and any plan of a different employer. In addition, the regulations have been modified to allow an employee to elect to participate in a cafeteria plan if the employee (or the employee's spouse or dependent) loses coverage under a group health plan sponsored by a governmental or educational institution, such as a state program under the State Children Health Insurance Program (SCHIP)[9]. The regulations do not allow a cafeteria plan participant to cease participation in a cafeteria plan if he or she becomes eligible for SCHIP coverage during the year because of a concern that such a rule would violate a fundamental principle of Title XXI of the Social Security Act that SCHIP coverage not supplant existing public or private coverage.

Scope of Regulations and Effective Date

These final regulations address all of the changes in status for which a cafeteria plan may permit election changes, including changes with respect to accident or health coverage, group-term life insurance, dependent care assistance and adoption assistance. In addition, the regulations contain guidance concerning election changes that are permitted because of changes in the cost or coverage of a qualified benefit plan.

Unless specifically noted, these regulations do not override other cafeteria plan requirements such as the rules pertaining to health flexible spending arrangements, and the rules concerning the Family and Medical Leave Act (Public Law 103–3 (107 Stat. 6)) [10].

The changes made by these regulations with respect to the March 2000 final regulations are applicable for cafeteria plan years beginning on or after January 1, 2001, except that the clarification made in paragraph (d)(1)(ii)(B) of these regulations (relating to a spouse, former spouse, or other individual obtaining accident or health coverage for an employee's child in response to a judgment, decree, or order) is applicable for cafeteria plan years beginning on or after January 1, 2002. With respect to the change made in paragraph (d)(1)(ii)(B) of these regulations, taxpayers may, until January 1, 2002, rely on either paragraph (d)(1)(ii)(B) of these regulations or the final regulations published in March 2000 (as §1.125–4(d)(1)(ii)).

The changes made from the March 2000 proposed regulations (including the rules relating to cost or coverage in paragraph (f) of these regulations) are applicable for cafeteria plan years beginning on or after January 1, 2002. With respect to these changes (including the rules relating to cost or coverage in paragraph (f) of these regulations), taxpayers may, until January 1, 2002, rely on either these regulations, the proposed regulations published in March 2000 (under §1.125–4), or the cost or coverage change rules in the 1989 proposed regulations (at § 1.125–2 (Q&A–6(b)).

Special Analyses

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

Drafting Information

The principal authors of these regulations are Christine L. Keller and Janet A. Laufer, Office of Division Counsel/ Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

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

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

---

[7] Such discretion may be exercised on a case by case basis, provided that the exercise of discretion satisfies section 125(c) which prohibits discrimination in favor of highly compensated participants.

[8] Any reduction in coverage that affects a specific individual must not violate the prohibition in section 9802 against discrimination on the basis of health status (and parallel HIPAA provisions in the Employee Retirement Income Security Act of 1974 and the Public Health Service Act). See §§ 54.9802-1 and 54.9802-1T(b)(2).

[9] Added to the Social Security Act by section 4901 of the Balanced Budget Act of 1997, Public Law 105-33 (August 5, 1997).

[10] See §1.125-3, published as a proposed rule at 60 F.R. 66229 (December 21, 1995).

Par. 2. 1.125–4 is amended by:

1. Revising paragraphs (b)(2) *Example 2* (ii).

2. Revising paragraph (c)(1) and adding paragraph (c)(2)(vi).

3. Adding a sentence to the end of paragraph (c)(3)(i).

4. Removing the last sentence in paragraph (c)(3)(iii) and adding a sentence in its place.

5. Adding paragraph (c)(4) *Example 3* (iii).

6. Revising paragraph (c)(4) *Example 4* (ii) and adding paragraph (iii).

7. Adding paragraph (c)(4) *Example 9* and (c)(4) *Example 10.*

8. Revising paragraph (d)(1)(ii).

9. Revising paragraphs (f), (g), (i)(3)and (i)(4).

10. Adding a sentence at the end of paragraph (i)(8), and adding paragraph (i)(9).

11. Revising paragraph (j).

The additions and revisions read as follows:

§1.125–4 Permitted election changes.

* * * * *

(b) * * *

(2) * * *

Example 2. * * *

(ii) *M*'s cafeteria plan may permit *E* to change *E*'s salary reduction election to reflect the change to family coverage under *M*'s accident or health plan because the marriage would result in special enrollment rights under section 9801(f), pursuant to which an election of family coverage under *M*'s accident or health plan would be required to be effective no later than the first day of the first calendar month beginning after the completed request for enrollment is received by the plan. Since no retroactive coverage is required in the event of marriage under section 9801(f), *E*'s salary reduction election may only be changed on a prospective basis. (*E*'s marriage to *F* is also a change in status under paragraph (c) of this section, as illustrated in *Example 1* of paragraph (c)(4) of this section.)

(c) *Changes in status* — (1) *Change in status rule*. A cafeteria plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefits plan (defined in paragraph (i)(8) of this section) to which this paragraph (c) applies and make a new election for the remaining portion of the period (referred to in this section as an election change) if, under the facts and circumstances -

(i) A change in status described in paragraph (c)(2) of this section occurs; and

(ii) The election change satisfies the consistency rule of paragraph (c)(3) of this section.

* * * * *

(2) * * *

(vi) *Adoption assistance*. For purposes of adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

(3) *Consistency rule* — (i) *Application to accident or health coverage and group-term life insurance.* * * * A change in status that affects eligibility under an employer's plan includes a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan.

* * * * *

(iii) *Application of consistency rule.* * * * With respect to group-term life insurance and disability coverage (as defined in paragraph (i)(4) of this section), an election under a cafeteria plan to increase coverage (or an election to decrease coverage) in response to a change in status described in paragraph (c)(2) of this section is deemed to correspond with that change in status as required by paragraph (c)(3)(i) of this section.

(4) * * *

Example 3. * * *

(iii) In addition, under paragraph (f)(4) of this section, if *F* makes an election change to cover *G* under *F*'s employer's plan, then *E* may make a corresponding change to elect employee-only coverage under *P*'s cafeteria plan.

Example 4. * * *

(ii) The transfer is a change in status under paragraph (c)(2)(iii) of this section (relating to a change in worksite), and, under the consistency rule in paragraph (c)(3) of this section, the cafeteria plan may permit *A* to make an election change to elect the indemnity option or HMO #2 or to cancel accident or health coverage.

(iii) The change in work location has no effect on *A*'s eligibility under R's health FSA, so no change in *A*'s health FSA is authorized under this paragraph (c).

* * * * *

Example 9. (i) Employee *A* has one child, *B*. Employee *A*'s employer, *X*, maintains a calendar year cafeteria plan that allows employees to elect coverage under a dependent care FSA. Prior to the beginning of the calendar year, *A* elects salary reduction contributions of $4,000 during the year to fund coverage under the dependent care FSA for up to $4,000 of reimbursements for the year. During the year, *B* reaches the age of 13, and *A* wants to cancel coverage under the dependent care FSA.

(ii) When *B* turns 13, *B* ceases to satisfy the definition of qualifying individual under section 21(b)(1) of the Internal Revenue Code. Accordingly, *B*'s attainment of age 13 is a change in status under paragraph (c)(2)(iv) of this section that affects *A*'s employment-related expenses as defined in section 21(b)(2). Therefore, *A* may make a corresponding change under *X*'s cafeteria plan to cancel coverage under the dependent care FSA.

Example 10. (i) Employer *Y* maintains a calendar year cafeteria plan under which full-time employees may elect coverage under either an indemnity option or an HMO. Employee *C* elects the employee-only indemnity option. During the year, *C* marries *D*. *D* has two children from a previous marriage, and has family group health coverage in a cafeteria plan sponsored by *D*'s employer, *Z*. *C* wishes to change from employee-only indemnity coverage to HMO coverage for the family. *D* wishes to cease coverage in *Z*'s group health plan and certifies to *Z* that *D* will have family coverage under *C*'s plan (and *Z* has no reason to believe the certification is incorrect).

(ii) The marriage is a change in status under paragraph (c)(2)(i) of this section. Under the consistency rule in paragraph (c)(3) of this section, *Y*'s cafeteria plan may permit *C* to change his or her salary reduction contributions to reflect the change from employee-only indemnity to HMO family coverage, and *Z* may permit *D* to revoke coverage under *Z*'s cafeteria plan.

(d) * * * (1) * * *

(ii) Permits the employee to make an election change to cancel coverage for the child if:

(A) The order requires the spouse, former spouse, or other individual to provide coverage for the child; and

(B) That coverage is, in fact, provided.

* * * * *

(f) *Significant cost or coverage changes* — (1) *In general*. Paragraphs (f)(2) through (5) of this section set forth rules for election changes as a result of changes in cost or coverage. This paragraph (f) does not apply to an election change with respect to a health FSA (or on account of a change in cost or coverage under a health FSA).

(2) *Cost changes* - - (i) *Automatic changes*. If the cost of a qualified benefits plan increases (or decreases) during a period of coverage and, under the terms of the plan, employees are required to make a corresponding change in their payments, the cafeteria plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected employees' elective contributions for the plan.

(ii) *Significant cost changes*. If the cost charged to an employee for a benefit package option (as defined in paragraph (i)(2) of this section) significantly increases or significantly decreases during a period of coverage, the cafeteria plan may permit the employee to make a corresponding change in election under the cafeteria plan. Changes that may be made

include commencing participation in the cafeteria plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

(iii) *Application of cost changes*. For purposes of paragraphs (f)(2)(i) and (ii) of this section, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees).

(iv) *Application to dependent care*. This paragraph (f)(2) applies in the case of a dependent care assistance plan only if the cost change is imposed by a dependent care provider who is not a relative of the employee. For this purpose, a relative is an individual who is related as described in section 152(a)(1) through (8), incorporating the rules of section 152(b)(1) and (2).

(3) *Coverage changes* - - (i) *Significant curtailment without loss of coverage*. If an employee (or an employee's spouse or dependent) has a significant curtailment of coverage under a plan during a period of coverage that is not a loss of coverage as described in paragraph (f)(3)(ii) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under an accident or health plan), the cafeteria plan may permit any employee who had been participating in the plan and receiving that coverage to revoke his or her election for that coverage and, in lieu thereof, to elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

(ii) *Significant curtailment with loss of coverage*. If an employee (or the employee's spouse or dependent) has a significant curtailment that is a loss of coverage, the plan may permit that employee to revoke his or her election under the cafeteria plan and, in lieu thereof, to elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (f)(3)(ii), a loss of coverage means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the cafeteria plan may, in its discretion, treat the following as a loss of coverage - -

(A) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the employee or the employee's spouse or dependent is currently in a course of treatment; or

(C) Any other similar fundamental loss of coverage.

(iii) *Addition or improvement of a benefit package option* . If a plan adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, the cafeteria plan may permit eligible employees (whether or not they have previously made an election under the cafeteria plan or have previously elected the benefit package option) to revoke their election under the cafeteria plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option.

(4) *Change in coverage under another employer plan*. A cafeteria plan may permit an employee to make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if - -

(i) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (b) through (g) of this section (disregarding this paragraph (f)(4)); or

(ii) The cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

(5) *Loss of coverage under other group health coverage*. A cafeteria plan may permit an employee to make an election on a prospective basis to add coverage under a cafeteria plan for the employee, spouse, or dependent if the employee, spouse, or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following - -

(i) A State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;

(ii) A medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization

(iii) A State health benefits risk pool; or

(iv) A Foreign government group health plan.

(6) *Examples*. The following examples illustrate the application of this paragraph (f):

Example 1. (i) A calendar year cafeteria plan is maintained pursuant to a collective bargaining agreement for the benefit of Employer *M*'s employ-

ees. The cafeteria plan offers various benefits, including indemnity health insurance and a health FSA. As a result of mid-year negotiations, premiums for the indemnity health insurance are reduced in the middle of the year, insurance co-payments for office visits are reduced under the indemnity plan by an amount which constitutes a significant benefit improvement, and an HMO option is added.

(ii) Under these facts, the reduction in health insurance premiums is a reduction in cost. Accordingly, under paragraph (f)(2)(i) of this section, the cafeteria plan may automatically decrease the amount of salary reduction contributions of affected participants by an amount that corresponds to the premium change. However, the plan may not permit employees to change their health FSA elections to reflect the mid-year change in copayments under the indemnity plan.

(iii) Also, the decrease in co-payments is a significant benefit improvement and the addition of the HMO option is an addition of a benefit package option. Accordingly, under paragraph (f)(3)(ii) of this section, the cafeteria plan may permit eligible employees to make an election change to elect the indemnity plan or the new HMO option. However, the plan may not permit employees to change their health FSA elections to reflect differences in co-payments under the HMO option.

Example 2. (i) Employer *N* sponsors an accident or health plan under which employees may elect either employee-only coverage or family health coverage. The 12-month period of coverage under *N*'s cafeteria plan begins January 1, 2001. *N*'s employee, *A*, is married to *B*. Employee *A* elects employee-only coverage under *N*'s plan. *B*'s employer, *O*, offers health coverage to *O*'s employees under its accident or health plan under which employees may elect either employee-only coverage or family coverage. *O*'s plan has a 12-month period of coverage beginning September 1, 2001. *B* maintains individual coverage under *O*'s plan at the time *A* elects coverage under *N*'s plan, and wants to elect no coverage for the plan year beginning on September 1, 2001, which is the next period of coverage under *O*'s accident or health plan. *A* certifies to *N* that *B* will elect no coverage under *O*'s accident or health plan for the plan year beginning on September 1, 2001 and *N* has no reason to believe that *A*'s certification is incorrect.

(ii) Under paragraph (f)(4)(ii) of this section, *N*'s cafeteria plan may permit *A* to change *A*'s election prospectively to family coverage under that plan effective September 1, 2001.

Example 3. (i) Employer *P* sponsors a calendar year cafeteria plan under which employees may elect either employee-only or family health coverage. Before the beginning of the year, *P*'s employee, *C*, elects family coverage under *P*'s cafeteria plan. *C* also elects coverage under the health FSA for up to $200 of reimbursements for the year to be funded by salary reduction contributions of $200 during the year. *C* is married to *D*, who is employed by Employer *Q*. *Q* does not maintain a cafeteria plan, but does maintain an accident or health plan providing its employees with employee-only coverage. During the calendar year, *Q* adds family coverage as an option under its health plan. *D* elects family coverage under *Q*'s plan, and *C* wants to revoke *C*'s election for health coverage and elect no health coverage under *P*'s cafeteria plan for the remainder of the year.

(ii) *Q*'s addition of family coverage as an option under its health plan constitutes a new coverage option described in paragraph (f)(3)(ii) of this section. Accordingly, pursuant to paragraph (f)(4)(i) of this section, *P*'s cafeteria plan may permit *C* to revoke *C*'s health coverage election if *D* actually elects family health coverage under *Q*'s accident or health plan. Employer *P*'s plan may not permit *C* to change *C*'s health FSA election.

Example 4. (i) Employer *R* maintains a cafeteria plan under which employees may elect accident or health coverage under either an indemnity plan or an HMO. Before the beginning of the year, *R*'s employee, *E* elects coverage under the HMO at a premium cost of $100 per month. During the year, *E* decides to switch to the indemnity plan, which charges a premium of $140 per month.

(ii) *E*'s change from the HMO to indemnity plan is not a change in cost or coverage under this paragraph (f), and none of the other election change rules under paragraphs (b) through (e) of this section apply.

(iii) Although *R*'s health plan may permit *E* to make the change from the HMO to the indemnity plan, *R*'s cafeteria plan may not permit *E* to make an election change to reflect the increased premium. Accordingly, if *E* switches from the HMO to the indemnity plan, *E* may pay the $40 per month additional cost on an after-tax basis.

Example 5. (i) Employee *A* is married to Employee *B* and they have one child, *C*. Employee *A*'s employer, *M*, maintains a calendar year cafeteria plan that allows employees to elect coverage under a dependent care FSA. Child *C* attends *X*'s on site child care center at an annual cost of $3,000. Prior to the beginning of the year, *A* elects salary reduction contributions of $3,000 during the year to fund coverage under the dependent care FSA for up to $3,000 of reimbursements for the year. Employee *A* now wants to revoke *A*'s election of coverage under the dependent care FSA, because A has found a new child care provider.

(ii) The availability of dependent care services from the new child care provider (whether the new provider is a household employee or family member of *A* or *B* or a person who is independent of *A* and *B*) is a significant change in coverage similar to a benefit package option becoming available. Because the FSA is a dependent care FSA rather than a health FSA, the coverage rules of this section apply and *M*'s cafeteria plan may permit *A* to elect to revoke *A*'s previous election of coverage under the dependent care FSA, and make a corresponding new election to reflect the cost of the new child care provider.

Example 6. (i) Employee *D* is married to Employee *E* and they have one child, *F*. Employee *D*'s employer, *N*, maintains a calendar year cafeteria plan that allows employees to elect coverage under a dependent care FSA. Child *F* is cared for by *Y*, *D*'s household employee, who provides child care services five days a week from 9 a.m. to 6 p.m. at an annual cost in excess of $5,000. Prior to the beginning of the year, *D* elects salary reduction contributions of $5,000 during the year to fund coverage under the dependent care FSA for up to $5,000 of reimbursements for the year. During the year, *F* begins school and, as a result, *Y*'s regular hours of work are changed to five days a week from 3 p.m. to 6 p.m. Employee *D* now wants to revoke *D*'s election under the dependent care FSA, and make a new election under the dependent care FSA to an annual cost of $4,000 to reflect a reduced cost of child care due to *Y*'s reduced hours.

(ii) The change in the number of hours of work performed by *Y* is a change in coverage. Thus, *N*'s cafeteria plan may permit *D* to reduce *D*'s previous election under the dependent care FSA to $4,000.

Example 7. (i) Employee *G* is married to Employee *H* and they have one child, *J*. Employee *G*'s employer, *O*, maintains a calendar year cafeteria plan that allows employees to elect coverage under a dependent care FSA. Child *J* is cared for by *Z*, *G*'s household employee, who is not a relative of *G* and who provides child care services at an annual cost of $4,000. Prior to the beginning of the year, *G* elects salary reduction contributions of $4,000 during the year to fund coverage under the dependent care FSA for up to $4,000 of reimbursements for the year. During the year, *G* raises *Z*'s salary. Employee *G* now wants to revoke *G*'s election under the dependent care FSA, and make a new election under the dependent care FSA to an annual amount of $4,500 to reflect the raise.

(ii) The raise in *Z*'s salary is a significant increase in cost under paragraph (f)(2)(ii) of this section, and an increase in election to reflect the raise corresponds with that change in status. Thus, *O*'s cafeteria plan may permit *G* to elect to increase *G*'s election under the dependent care FSA.

Example 8. (i) Employer *P* maintains a calendar year cafeteria plan that allows employees to elect employee-only, employee plus one dependent, or family coverage under an indemnity plan. During the middle of the year, Employer *P* gives its employees the option to select employee-only or family coverage from an HMO plan. *P*'s employee, *J*, who had elected employee plus one dependent coverage under the indemnity plan, decides to switch to family coverage under the HMO plan.

(ii) Employer *P*'s midyear addition of the HMO option is an addition of a benefit package option. Under paragraph (f) of this section, Employee *J* may change his or her salary reduction contributions to reflect the change from indemnity to HMO coverage, and also to reflect the change from employee plus one dependent to family coverage (however, an election of employee-only coverage under the new option would not correspond with the addition of a new option). Employer *P* may not permit *J* to change *J*'s health FSA election.

(g) *Special requirements relating to the Family and Medical Leave Act.* An employee taking leave under the Family and Medical Leave Act (FMLA) (Public Law 103–3 (107 Stat. 6)) may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

* * * * *

(i) * * *

(3) *Dependent.* A dependent means a dependent as defined in section 152, except that, for purposes of accident or health coverage, any child to whom sec-

tion 152(e) applies is treated as a dependent of both parents, and, for purposes of dependent care assistance provided through a cafeteria plan, a dependent means a qualifying individual (as defined in section 21(b)(1)) with respect to the employee.

(4) *Disability coverage*. Disability coverage means coverage under an accident or health plan that provides benefits due to personal injury or sickness, but does not reimburse expenses incurred for medical care (as defined in section 213(d)) of the employee or the employee's spouse and dependents. For purposes of this section, disability coverage includes payments described in section 105(c).

* * * * *

(8) *Qualified benefits plan*. * * * A plan does not fail to be a qualified benefits plan merely because it includes an FSA, assuming that the FSA meets the requirements of section 125 and the regulations thereunder.

(9) *Similar coverage*. Coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide coverage for major medical are considered to be similar coverage. For purposes of this definition, a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA. A plan may treat coverage by another employer, such as a spouse's or dependent's employer, as similar coverage.

(j) *Effective date* — (1) *General rule*. Except as provided in paragraph (j)(2) of this section, this section is applicable for cafeteria plan years beginning on or after January 1, 2001.

(2) *Delayed effective date for certain provisions*. The following provisions are applicable for cafeteria plan years beginning on or after January 1, 2002: paragraph (c) of this section to the extent applicable to qualified benefits other than an accident or health plan or a group-term life insurance plan; paragraph (d)(1)(ii)(B) of this section (relating to a spouse, former spouse, or other individual obtaining accident or health coverage for an employee's child in response to a judgment, decree, or order); paragraph (f) of this section (rules for election changes as a result of cost or coverage changes); and paragraph (i)(9) of this section (defining similar coverage).

1.125–4T [Removed]

Par. 3. Section 1.125–4T is removed.

Robert E. Wenzel,
Deputy Commissioner of Internal Revenue.

Approved December 15, 2000.

Jonathan Talisman,
Acting Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on January 9, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 10, 2001, 66 F.R. 1837)

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, page 541.

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 February 2001. See Rev. Rul. 2001–7, page 541.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, page 541.

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 February 2001. See Rev. Rul. 2001–7, page 541.

---

26 CFR 1.467–2: Rent accrual for section 467 rental agreements without adequate interest.

T.D. 8917

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Section 467 Rental Agreements Involving Payments of $2,000,000 or Less

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations concerning section 467 rental agreements. The regulations provide amendments to the regulations under section 467, including the removal of the exception to constant rental accrual for rental agreements involving payments of $2,000,000 or less. The regulations affect taxpayers that are parties to a section 467 rental agreement.

DATES: *Effective Date*: These regulations are effective January 5, 2001.

Dates of Applicability: For dates of applicability of these regulations, see Effective Dates under SUPPLEMENTARY INFORMATION.

FOR FURTHER INFORMATION CONTACT: Forest Boone, (202) 622-4960 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to 26 CFR Part 1 under section 467 of the Internal Revenue Code (Code). Section 467 was added to the Code by section 92(a) of the Tax Reform Act of 1984 (Public Law 98–369; 98 Stat. 609).

On May 18, 1999, a notice of proposed rulemaking (REG–103694–99, 1999–1, C.B. 49) under section 467 was published in the **Federal Register** (64 F.R. 26924). The notice proposed to amend the section 467 regulations relating to constant rental accrual by treating section 467 rental agreements involving payments of $2,000,000 or less in the same manner as agreements involving payments of more than $2,000,000. Although comments and requests for a public hearing were solicited, no comments were received and no public hearing was requested or held. Accordingly, the amendment to the constant rental accrual rules called for by the proposed regulations is adopted without revision.

In addition, the IRS and Treasury Department have identified three provi-

sions in the section 467 regulations (T.D. 8820, 1999–1 C.B. 1209), published on May 18, 1999, at 64 F.R. 26845, that require clarification. Accordingly, these final regulations also provide clarifying amendments to the section 467 regulations.

Explanation of Provisions

A. *Removal of the $2,000,000 Constant Rental Accrual Exception*

Section 467 includes an anti-abuse rule applicable to certain section 467 rental agreements. Under this rule, a constant rental amount must be taken into account by a lessor and lessee for each rental period during the lease term. The constant rental amount is the amount that, if paid at the end of each rental period, would result in a present value equal to the present value of all amounts payable under the agreement.

Constant rental accrual applies only with respect to leasebacks and long-term agreements that provide for increasing or decreasing rent and only if the Commissioner determines that the agreement is disqualified because tax avoidance is a principal purpose for providing increasing or decreasing rent. In addition, however, the regulations provide that a rental agreement will not be disqualified and, consequently, will not be subject to constant rental accrual unless it requires more than $2,000,000 in rental payments and other consideration.

These final regulations remove the $2,000,000 exception from constant rental accrual for section 467 rental agreements entered into on or after July 19, 1999. Consequently, for section 467 rental agreements entered into on or after July 19, 1999, the Commissioner may determine that the agreement is a disqualified leaseback or long-term agreement subject to constant rental accrual, even if the agreement requires $2,000,000 or less in rental payments and other consideration.

B. *Definition of Lease Term*

Section 1.467–1(h)(6) defines lease term to mean "the period during which the lessee has use of the property subject to the rental agreement, including any option to renew or extend the term of the agreement *other than an option, exercisable by the lessee, as to which it is reasonably expected, as of the agreement date, that the option will not be exercised*." [Emphasis added]. By contrast, the proposed regulations preceding the section 467 final regulations stated that an option period, whether exercisable by the lessor or lessee, is included in the lease term only if it is expected, as of the agreement date, that the option will be exercised. The purpose of the broader rule in the final regulations was to include all lessor option periods in the lease term. The IRS and Treasury Department recognize, however, that the broader rule has caused some uncertainty as to whether a change in the treatment of lessee options, particularly those exercisable at fair market value rental, was also intended. These regulations clarify that a change in the treatment of lessee options was not intended. They provide, in language similar to that of the proposed section 467 regulations, that lessee options are to be included in the lease term only if it is expected, as of the agreement date, that the option will be exercised. For this purpose, a lessee is generally expected to exercise an option if, for example, as of the agreement date the rent for the option period is less than the expected fair market value rental for such period. It should be noted, however, that factors other than the relationship between rent and expected fair market value rental for the option period may be relevant in determining whether it is expected that a lessee option will be exercised. Thus, even in the case of a lessee option exercisable at fair market value rental, it may, on account of such other relevant factors, be expected that the option will be exercised.

C. *When an Amount is Considered Payable*

Section 1.467–1(j)(2)(ii) provides that, for purposes of determining present value and yield under the regulations, an amount is payable on the last day for timely payment (the last day for timely payment rule). The last day for timely payment is the last day such amount may be paid without incurring interest, computed at an arm's-length rate, a substantial penalty, or other substantial detriment (such as giving the lessor the right to terminate the agreement, bring an action to enforce payment, or exercise other similar remedies under the terms of the agreement or applicable law).

The IRS and Treasury Department believe that the last day for timely payment rule, applicable to the computation of present value and yield, should also apply to other cases in which the date on which an amount is payable is relevant for purposes of section 467. Accordingly, the section 467 regulations have been amended to provide that, for purposes of applying all of the section 467 rules, not just those dealing with present value and yield, an amount is payable on the last day for timely payment.

D. *Adequate Interest for Agreements With Both Deferred and Prepaid Rent*

Under the section 467 regulations, the fixed rent for each rental period is the proportional rental amount if the section 467 rental agreement is not a disqualified leaseback or long-term agreement and if the agreement does not provide adequate interest on fixed rent. The regulations set forth rules for determining whether an agreement has adequate interest on fixed rent. These regulations clarify how these rules apply in the case of agreements with both deferred and prepaid rent.

E. *Effective Dates*

The removal of the exception from constant rental accrual for rental agreements involving payments of $2,000,000 or less is applicable for section 467 rental agreements entered into on or after July 19, 1999. The other amendments in these regulations are applicable to rental agreements entered into after March 6, 2001. However, taxpayers may choose to apply these amendments to rental agreements entered into on or before March 6, 2001.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory 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 regulations, and because these regulations do not impose a collection of information on small entities, the Regulatory Flexibility

Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of the regulations is Forest Boone, Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the IRS and Treasury Department participated in the development of the regulations.

*** * * * ***

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

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

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

Par 2. Section 1.467–0 is amended by adding an entry for §1.467–2(b)(3) to read as follows:

§1.467–0 Table of contents.

* * * * *

§1.467–2 Rent accrual for section 467 rental agreements without adequate interest.

* * * * *

(b) * * *

(3) Agreements with both deferred and prepaid rent.

* * * * *

Par 3. Section 1.467–1 is amended by revising paragraphs (h)(6) and (j)(2)(ii) to read as follows:

§1.467–1 Treatment of lessors and lessees generally.

* * * * *

(h) * * *

(6) *Lease term* means the period during which the lessee has use of the property subject to the rental agreement, including any option of the lessor to renew or extend the term of the agreement. An option of the lessee to renew or extend the term of the agreement is included in the lease term only if it is expected, as of the agreement date, that the option will be exercised. For this purpose, a lessee is generally expected to exercise an option if, for example, as of the agreement date the rent for the option period is less than the expected fair market value rental for such period. The lessor's or lessee's determination that an option period is either included in or excluded from the lease term is not binding on the Commissioner. If the lessee (or a related person) agrees that one or both of them will or could be obligated to make payments in the nature of rent (within the meaning of §1.168(i)–2(b)(2)) for a period when another lessee (the substitute lessee) or the lessor will have use of the property subject to the rental agreement, the Commissioner may, in appropriate cases, treat the period when the substitute lessee or lessor will have use of the property as part of the lease term. See §1.467–7(f) for special rules applicable to the lessee, substitute lessee, and lessor. This paragraph (h)(6) applies to section 467 rental agreements entered into after March 6, 2001. However, taxpayers may choose to apply this paragraph (h)(6) to any rental agreement that is described in §1.467–9(a) and is entered into on or before March 6, 2001.

* * * * *

(j) * * *

(2) * * *

(ii) *Time amount is payable*. For purposes of this section and §§1.467–2 through 1.467–9, an amount is payable on the last day for timely payment (that is, the last day such amount may be paid without incurring interest, computed at an arm's-length rate, a substantial penalty, or other substantial detriment (such as giving the lessor the right to terminate the agreement, bring an action to enforce payment, or exercise other similar remedies under the terms of the agreement or applicable law)). This paragraph (j)(2)(ii) applies to section 467 rental agreements entered into after March 6, 2001. However, taxpayers may choose to apply this paragraph (j)(2)(ii) to any rental agreement that is described in §1.467–9(a) and is entered into on or before March 6, 2001.

* * * * *

Par 4. In §1.467–2, paragraph (b)(3) is added to read as follows:

§1.467–2 Rent accrual for section 467 rental agreements without adequate interest.

* * * * *

(b) * * *

(3) *Agreements with both deferred and prepaid rent.* If an agreement has both deferred and prepaid rent, the agreement provides adequate interest under paragraph (b)(1) of this section if the conditions set forth in paragraph (b)(1)(ii)(A) through (D) of this section are met for both the prepaid and the deferred rent. For purposes of this paragraph (b)(3), an agreement will be considered to meet the condition set forth in paragraph (b)(1)(ii)(A) of this section if the agreement provides a single fixed rate of interest on the deferred rent and a single fixed rate of interest on the prepaid rent, even if those rates are not the same. This paragraph (b)(3) applies to section 467 rental agreements entered into after March 6, 2001. However, taxpayers may choose to apply this paragraph (b)(3) to any rental agreement that is described in §1.467–9(a) and is entered into on or before March 6, 2001.

* * * * *

Par 5. In §1.467–3, paragraph (b)(1)(iii) is revised to read as follows:

§1.467–3 Disqualified leasebacks and long-term agreements.

* * * * *

(b) * * * (1) * * *

(iii) For section 467 rental agreements entered into before July 19, 1999, the amount determined with respect to the rental agreement under §1.467–1(c)(4) (relating to the exception for rental agreements involving total payments of $250,000 or less) exceeds $2,000,000.

* * * * *

Robert E. Wenzel,
Deputy Commissioner of Internal Revenue.

Approved December 12, 2000.

Jonathan Talisman,
Acting Assistant Secretary of the Treasury.

(Filed by the Office of the Federal Register on January 4, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 5, 2001, 66 F.R. 1038)

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 February 2001. See Rev. Rul. 2001–7, on this page.

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 February 2001. See Rev. Rul. 2001–7, on this page.

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 February 2001. See Rev. Rul. 2001–7, on this page.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, on this page.

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 February 2001. See Rev. Rul. 2001–7, on this page.

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 February 2001. See Rev. Rul. 2001–7, on this page.

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.)

Federal rates; adjusted federal rates; adjusted federal long-term rate, and the long-term exempt rate. For purposes of sections 382, 1274, 1288, and other sections of the Code, tables set forth the rates for February 2001.

Rev. Rul. 2001-7

This revenue ruling provides various prescribed rates for federal income tax purposes for February 2001 (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)(2) for buildings placed in service during the current month. 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. 2001-7 TABLE 1

Applicable Federal Rates (AFR) for February 2001

	Period for Compounding			
	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-Term				
AFR	5.18%	5.11%	5.08%	5.06%
110% AFR	5.70%	5.62%	5.58%	5.56%
120% AFR	6.22%	6.13%	6.08%	6.05%
130% AFR	6.75%	6.64%	6.59%	6.55%
Mid-Term				
AFR	5.07%	5.01%	4.98%	4.96%
110% AFR	5.59%	5.51%	5.47%	5.45%
120% AFR	6.10%	6.01%	5.97%	5.94%
130% AFR	6.62%	6.51%	6.46%	6.42%
150% AFR	7.66%	7.52%	7.45%	7.40%
175% AFR	8.96%	8.77%	8.68%	8.61%
Long-Term				
AFR	5.48%	5.41%	5.37%	5.35%
110% AFR	6.04%	5.95%	5.91%	5.88%
120% AFR	6.60%	6.49%	6.44%	6.40%
130% AFR	7.15%	7.03%	6.97%	6.93%

REV. RUL. 2001-7 TABLE 2

Adjusted AFR for February 2001

Period for Compounding

	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-term adjusted AFR	3.91%	3.87%	3.85%	3.84%
Mid-term adjusted AFR	4.25%	4.21%	4.19%	4.17%
Long-term adjusted AFR	4.92%	4.86%	4.83%	4.81%

REV. RUL. 2001-7 TABLE 3

Rates Under Section 382 for February 2001

Adjusted federal long-term rate for the current month	4.92%
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.)	5.31%

REV. RUL. 2001-7 TABLE 4

Appropriate Percentages Under Section 42(b)(2) for February 2001

Appropriate percentage for the 70% present value low-income housing credit	8.23%
Appropriate percentage for the 30% present value low-income housing credit	3.53%

REV. RUL. 2001-7 TABLE 5

Rate Under Section 7520 for February 2001

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	6.2%

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

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, page 541.

Section 7520.—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of February 2001. See Rev. Rul. 2001–7, page 541.

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 February 2001. See Rev. Rul. 2001–7, page 541.

Section 9802.—Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

26 CFR 54.9802–1T: Prohibiting disrimination against participants and beneficiaries based on a health factor (temporary)

T.D. 8931

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54

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

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

Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final rules governing the provisions prohibiting discrimination based on a health factor for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DATES: *Effective date*. The interim final rules are effective March 9, 2001.

Applicability dates. For rules describing when this section applies to group health plans and group health insurance issuers, see paragraph (*i*) of these interim regulations.[1]

Comment date. Written comments on these interim regulations are invited and must be received by the Departments on or before April 9, 2001.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic submissions to the Internal Revenue Service (IRS) or Department of Labor) to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to:

CC:M&SP:RU (REG–109707–97)
Room 5226
Internal Revenue Service
POB 7604, Ben Franklin Station
Washington, DC 20044

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

CC:M&SP:RU (REG–109707–97)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW.
Washington, DC 20224

Alternatively, comments may be transmitted electronically via the IRS Internet site at:
http://www.irs.gov/tax_regs/regslist.html.

Comments to the Department of Labor can be addressed to:

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue NW.,
Room C-5331
Washington, DC 20210
Attention: Nondiscrimination Comments

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address. Comments may also be transmitted by e-mail to: *HIPAA702@pwba.dol.gov*.

Comments to HHS can be addressed to:

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-2022-IFC
P.O. Box 26688
Baltimore, MD 21207

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

Room 443-G
Hubert Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

or

Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-1850

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

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-1513, 200 Constitution Avenue, NW., Washington, DC, from 8:30 a.m. to 5:30 p.m.

All submissions to HHS will be open to public inspection and copying in room 309-G of the Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC, from 8:30 a.m. to 5 p.m.

FOR FURTHER INFORMATION CONTACT: Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Amy J. Turner, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-7006; or Ruth A. Bradford, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565.

CUSTOMER SERVICE INFORMATION: Individuals interested in obtaining additional information on HIPAA's nondiscrimination rules may request a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law" by calling the PWBA Toll-Free Publication Hotline at 1-800-998-7542 or may request a copy of the Health Care Financing Administration's new publication entitled "Protecting Your Health Insurance Coverage" by calling (410) 786-1565. Information on HIPAA's nondiscrimination rules and other recent health care laws is also available on the Department of Labor's website (*http://www.dol.gov/dol/pwba*) and the Department of Health and Human Services' website (*http://hipaa.hcfa.gov*).

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code),

[1] Reference in this preamble to a specific paragraph in the interim regulations are to paragraphs in each of the three sets of regulations being published as part of this document. Specifically, references are to paragraphs in 26 CFR 54.9802–1 and 26 CFR 54.9802–1T(see discussion and table in **"C. Format of Regulations"** below), 29 CFR 2590.702, and 45 CFR 146.121.

the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. HIPAA added section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act, which prohibit discrimination in health coverage. Interim final rules implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 F.R. 16894) (April 1997 interim rules). On December 29, 1997, the Departments published a clarification of the April 1997 interim rules as they relate to individuals who were denied coverage before the effective date of HIPAA on the basis of any health factor (62 F.R. 67689).

In the preamble to the April 1997 interim rules, the Departments invited comments on whether additional guidance was needed concerning —

- The extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits;
- The extent to which the statute may permit benefit limitations based on the source of an injury;
- The permissible standards for defining groups of similarly situated individuals;
- Application of the prohibitions on discrimination between groups of similarly situated individuals; and
- The permissible standards for determining bona fide wellness programs.

In the preamble to the April 1997 interim rules, the Departments stated that they intend to issue further regulations on the nondiscrimination rules and that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act before the additional guidance is provided. Accordingly, with the issuance of these interim regulations, the Departments have determined that the period for nonenforcement in cases of good faith compliance ends in accordance with the rules described in paragraph (*i*) of these interim regulations.[2] However, because the interim regulations do not include a discussion of bona fide wellness programs (see proposed regulations REG–114084–00 relating to bona fide wellness programs on page 633 of this Bulletin), the period for good faith compliance continues with respect to those provisions until further guidance is issued.

II. Overview of the Regulations

Section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act (the HIPAA nondiscrimination provisions) establish rules generally prohibiting group health plans and group health insurance issuers from discriminating against individual participants or beneficiaries based on any health factor of such participants or beneficiaries. These interim regulations interpret the HIPAA nondiscrimination provisions. Among other things, the interim regulations —

- Explain the application of these provisions to benefits;
- Clarify the relationship between the HIPAA nondiscrimination provisions and the HIPAA preexisting condition exclusion limitations;
- Explain the application of these provisions to premiums;
- Describe similarly situated individuals;
- Explain the application of these provisions to actively-at-work and nonconfinement clauses; and
- Clarify that more favorable treatment of individuals with medical needs generally is permitted.

Described in REG–114084–00 are proposed standards for defining bona fide wellness programs.

Of course, plans and benefits that are not subject to the HIPAA portability provisions (set forth in Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act) are not subject to the HIPAA nondiscrimination requirements. Accordingly, the following plans and benefits are not subject to the HIPAA nondiscrimination requirements: benefits that qualify under the HIPAA portability provisions as excepted benefits; plans with fewer than two participants who are current employees on the first day of the plan year[3]; and self-funded non-Federal governmental plans that elect, under 45 CFR 146.180, to be exempt from these nondiscrimination requirements. In addition, under a proposed regulation published by the Department of the Treasury and described in REG–114083–00 on page 630 of this Bulletin, certain church plans are treated as not violating the general HIPAA nondiscrimination provisions if the plan requires evidence of good health for the coverage of certain individuals.

Health Factors

The HIPAA nondiscrimination provisions set forth eight health status-related factors. The interim regulations refer to these as "health factors." The eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. These terms are largely overlapping and, in combination, include any factor related to an individual's health.

Evidence of insurability. Several commenters urged that the health factor "evidence of insurability" be interpreted to prohibit plans and issuers from denying coverage to individuals who engage in certain types of activities. Commenters cited language in the conference report that states, "The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities." H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 186 (1996). The interim regulations clarify that evidence of insurability includes participation in activities listed in the conference report. In addition, the interim regulations incorporate the statutory clarification that evidence of insurability includes conditions arising out of acts of domestic violence. See also the discussion below concerning source-of-injury restrictions

[2] See footnote 1.

[3] However, a State may impose the requirements of the HIPAA portability provisions, in whole or in part, on health insurance coverage sold to groups that contain fewer than 2 current employees on the first day of the plan year. *See* sections 2723 and 2791(e) of the PHS Act.

under the heading "Application to Benefits."

Late enrollees and special enrollees. Some commenters asked whether treating late enrollees differently from other enrollees is discrimination based on one or more health factors. HIPAA was designed to encourage individuals to enroll in health coverage when first eligible and to maintain coverage for as long as they continue to be eligible. Permitting plans and issuers to treat late enrollees less favorably than other enrollees is consistent with this objective. The interim regulations clarify that the decision whether to elect health coverage, including the time an individual chooses to enroll, such as late enrollment, is not itself within the scope of any health factor. Thus, the interim regulations permit plans and issuers to treat late enrollees differently from similarly situated individuals who enroll when first eligible.

Although the HIPAA nondiscrimination requirements do not prohibit different treatment of special enrollees, any differential treatment would violate the HIPAA special enrollment requirements. These interim regulations provide a cross-reference to the HIPAA regulations requiring special enrollees to be treated the same as individuals who enroll when first eligible.

Prohibited Discrimination in Rules for Eligibility

These interim regulations provide that group health plans and group health insurance issuers generally may not establish any rule for 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. Under these interim regulations, rules for eligibility include, but are not limited to, rules relating to enrollment, the effective date of coverage, waiting (or affiliation) periods, late and special enrollment, eligibility for benefit packages (including rules for individuals to change their selection among benefit packages), benefits (as described below under the heading "Application to Benefits"), continued eligibility, and terminating coverage of any individual under the plan.

The rules for eligibility apply in tandem with the rules describing similarly situated individuals (described below under the heading "Similarly Situated Individuals") to prevent discrimination in eligibility based on any health factor. Thus, while it is permissible for a plan or issuer to impose waiting periods of different lengths on different groups of similarly situated individuals, a plan or issuer would violate the interim regulations if it imposed a longer waiting period for individuals within the same group of similarly situated individuals based on the higher claims of those individuals (or based on any other adverse health factor of those individuals).

While the interim regulations clarify that late enrollment itself is not within the scope of any health factor, eligibility for late enrollment comes within the scope of rules for eligibility under which discrimination based on one or more health factors is prohibited. The effect of these rules is to permit plans or issuers to treat late enrollees differently from individuals who enroll when first eligible but to prohibit plans and issuers from distinguishing among applicants for late enrollment based on any health factor of the applicant. Thus, a plan could impose an 18-month preexisting condition exclusion on late enrollees while imposing no preexisting condition exclusion on individuals who enroll in the plan when first eligible, but a plan would violate the interim regulations if it conditioned the ability to enroll as a late enrollee on the passing of a physical examination (or on any other health factor of the individual, such as having incurred health claims during a past period below a certain dollar amount).

Application to Benefits

General rules. The extent to which the statutory language prohibits discrimination against individuals in eligibility for particular benefits is subject to a wide range of interpretations. At one extreme, the language could be interpreted as applying only to enrollment and to premiums. Under this interpretation, for example, it would be possible for a plan or issuer to impose a $100 lifetime limit on a particular individual with a history of high health claims (provided that the individual is permitted to enroll in the plan and is charged the same premium as similarly situated individuals), while imposing a $1 million lifetime limit on all other participants in the plan.

At the other extreme, the statutory language could be interpreted to mandate parity in health benefits. This interpretation would prevent plans and issuers from designing benefit packages that control costs and are responsive to employees' preferences for balancing additional benefits with additional costs.

In the preamble to the April 1997 interim rules, the Departments specifically invited comments on whether guidance was needed concerning this issue. The comments received ranged between these two extremes. The approach in these interim regulations takes into account the concerns expressed by commenters, as well as the conference report. Specifically, the conference report states that:

> It is the intent of the conferees that a plan cannot knowingly be designed to exclude individuals and their dependents on the basis of health status. However, generally applicable terms of the plan may have a disparate impact on individual enrollees. For example, a plan may exclude all coverage of a specific condition, or may include a lifetime cap on all benefits, or a lifetime cap on specific benefits. Although individuals with the specific condition would be adversely affected by an exclusion of coverage for that condition . . . such plan characteristics would be permitted as long as they are not directed at individual sick employees or dependents.

H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 186 – 187 (1996).

The interim regulations clarify that they do not require a plan or issuer to provide coverage for any particular benefit to any group of similarly situated individuals. However, benefits provided under a plan or group health insurance coverage must be uniformly available to all similarly situated individuals. 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 or issuer 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 impose annual, lifetime, or other limits on benefits and 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.[4] These interim regulations clarify that whether any plan provision with respect to benefits complies with the interim regulations does not affect whether the provision is permitted under the Americans with Disabilities Act (ADA), or any other law, whether State or federal.[5]

Accordingly, for example, a group health plan may apply a lifetime limit on all benefits provided to each participant covered under the plan. While this limitation on all benefits may adversely impact individuals with serious medical conditions, the limitation is permitted provided that it applies to all similarly situated individuals and is not directed at individual participants or beneficiaries. Similarly, a plan or issuer may establish a specific lifetime limit on the treatment of a particular condition (such as the treatment of temporomandibular joint syndrome (TMJ)) for all similarly situated individuals in the plan. Although individuals with TMJ may be adversely affected by this limitation, because benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and because the limit on benefits for TMJ applies to all similarly situated individuals, the limit is permissible.

Under these interim regulations, plans and issuers therefore have significant flexibility in designing benefits. However, to prevent plans and issuers from restricting benefits based on a specific health factor of an individual under the plan, the interim regulations prohibit benefit restrictions, even if applied uniformly to all similarly situated individuals, from being directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. The interim regulations clarify that a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries. This exception to the general facts and circumstances determination that a change is directed at an individual is necessary to preserve the flexibility of small employers that might otherwise be disproportionately affected and prevented from adopting changes in benefit design. If small employers are unable to modify future benefits to keep health coverage affordable, their alternative may be to eliminate health coverage entirely. At the same time, the exception reflects the common practice of modifying the terms of a plan on an annual basis. Finally, changes in benefit design that are effective earlier than the first day of the next plan year remain subject to a facts and circumstances determination regarding whether the change is directed at individual participants and beneficiaries.

An example illustrates that if an individual files a claim for the treatment of a condition, and shortly thereafter the plan is modified to restrict benefits for the treatment of the condition, effective before the beginning of the next plan year, the restriction would be directed at the individual based on a health factor (absent additional facts to indicate that the change was made independent of the claim) and the plan would violate these interim regulations.

Source-of-injury restrictions. While a person cannot be excluded from a plan for engaging in certain recreational activities (see previous discussion on evidence of insurability under the heading "Health Factors"), benefits for a particular injury can, in some cases, be excluded based on the source of an injury. These plan restrictions are known as source-of-injury restrictions.[6] Under these interim regulations, if a plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not use a source-of-injury restriction to deny benefits otherwise provided for treatment of the injury if it results from an act of domestic violence or a medical condition (including both physical and mental health conditions). An example in the interim regulations clarifies that benefits for injuries generally covered under the plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression. Another example illustrates that a plan can nonetheless exclude benefits for injuries because they were sustained in connection with various recreational activities if the accident did not result from any medical condition (or from domestic violence).

The Relationship Between the HIPAA Nondiscrimination Provisions and the HIPAA Preexisting Condition Exclusion Provisions

Restrictions on benefits based on the fact that a medical condition was present before the first day of coverage discriminate against individuals based on one or more health factors. The statute nonetheless provides that the nondiscrimination provisions are intended to be construed in a manner consistent with the HIPAA provisions specifically allowing the application of preexisting condition exclusions. These latter provisions restrict the ability of a group health plan or group health insurance issuer to apply preexisting condition exclusions, both by restricting the

[4] For special rules that apply to cost-sharing mechanisms that are part of a bona fide wellness program, see the proposed regulations relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.

[5] In this regard, the Equal Employment Opportunity Commission has commented, by letter of July 7, 1997, "Title I of the ADA prohibits disability-based employment discrimination, including discrimination in fringe benefits such as health insurance plans."

[6] A commenter pointed out that this type of restriction is distinct from two other restrictions sometimes referred to as "source-of-injury restrictions" — (1) those based on the geographic location where the injury occurred, and (2) those based on when the injury occurred and whether other coverage was in effect.

circumstances under which an individual's condition is considered preexisting and by limiting the length of the exclusion period. The interim regulations clarify that a preexisting condition exclusion that satisfies the requirements of the HIPAA preexisting condition exclusion provisions is permitted under the HIPAA nondiscrimination requirements if the exclusion applies uniformly to individuals within the same group of similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. A plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at individual participants or beneficiaries.

The examples illustrate that a typical preexisting condition exclusion permitted under the HIPAA preexisting condition exclusion requirements does not violate the HIPAA nondiscrimination requirements even though the exclusion inherently discriminates based on one or more health factors. The examples also illustrate that a plan nonetheless must apply the preexisting condition exclusion to similarly situated individuals in a uniform manner and cannot apply a longer preexisting condition exclusion period based on the submission of claims during the first part of the exclusion period.

Prohibited Discrimination in Premiums or Contributions

Under the interim regulations, a group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan or group health insurance coverage, based on any health factor that relates to that individual or a dependent of that individual. Under the interim regulations, when determining an individual's premium or contribution rate, discounts, rebates, payments in kind, or other premium differential mechanisms are taken into account.[7]

In general, the interim regulations do not restrict the amount that an employer may be quoted or charged by an issuer (or, in the case of a multiemployer plan, by the plan) for coverage of a group of similarly situated individuals. However, the interim regulations prohibit certain billing practices because in many instances they could directly or indirectly result in an individual's being charged more than a similarly situated individual based on a health factor.

Some health insurance issuers that offer health insurance coverage in connection with a group health plan use billing practices with separate individual rates that vary based, in part, on the health factors of the individuals who are eligible to participate in the plan. This practice is generally known as list billing. List billing based on a health factor is prohibited under the interim regulations.

The HIPAA nondiscrimination requirements do not prohibit an issuer from considering all relevant health factors of individuals in order to establish aggregate rates for coverage provided under the group health plan. However, an individual may not be required to pay a higher premium based on any health factor of the individual. Under the interim regulations, an issuer (or a multiemployer plan) may not quote or charge an employer different premium rates on an individual-by-individual basis in a group of similarly situated individuals based on any health factor of the individuals, even if the employer does not pass the different rates through to the individuals. If an issuer wishes to increase rates to cover the additional exposure to expenses that may result from an individual's health factor, the issuer must blend the increase into an overall group rate and then quote or charge a higher per-participant rate. Nonetheless, the prohibition on the practice of list billing based on a health factor does not restrict communications between issuers and plans regarding rate calculations.

Similarly Situated Individuals

The statutory HIPAA nondiscrimination requirements clarify that the general rule prohibiting discrimination in eligibility does not prevent a group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of benefits for "similarly situated individuals" enrolled in the plan or coverage. The statutory rule prohibiting discrimination in charging individuals premiums or contributions prohibits a plan or issuer from requiring any individual, based on any health factor of that individual or a dependent of that individual, to pay a premium or contribution that is greater than the premium or contribution required of a "similarly situated individual." In the preamble to the April 1997 interim rules, the Departments requested comments both on the permissible standards for defining groups of similarly situated individuals and on the application of the prohibitions on discrimination between groups of similarly situated individuals.

Many commenters suggested that discrimination between groups of similarly situated individuals should be permitted, with the caveat that it should not be permissible to define a group based on a health factor. These interim regulations provide that the nondiscrimination rules apply only within a group of similarly situated individuals. Thus, these interim regulations do not prohibit discrimination between or among groups of similarly situated individuals. However, these interim regulations also provide that if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted. This is intended to be a broad anti-abuse standard that applies based on the relevant facts and circumstances of each case.

The permissibility of discrimination between or among groups of similarly situated individuals increases the possibility of abuse in establishing groups of similarly situated individuals. Most commenters addressing this issue focused on the clas-

[7] However, a group health plan or a health insurance issuer offering group health insurance coverage may establish premium or contribution differentials through a bona fide wellness program. (See proposed regulations relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.)

sification of participants and suggested that classifications should be based on work activities and not on a health factor or on activities unrelated to employment. The interim regulations provide generally that participants may be treated as two or more groups of similarly situated individuals if the distinction between or among the groups is based on a bona fide employment-based classification consistent with the employer's usual business practice. The validity of a category as a bona fide employment-based classification is determined based on all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to the anti-abuse standard (described in the preceding paragraph), the interim regulations allow distinctions to be made based on full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations.

Some commenters expressed concern that allowing similarly situated individuals to be determined based on occupation or geographic location would allow plans and issuers to create artificial classifications, ostensibly based on occupation or geographic location, that are actually designed to discriminate based on a health factor of an individual or individuals. These interim regulations permit bona fide classifications based on occupation or geographic location. In this connection, commenters had two principal concerns. First, there was a concern about reclassifications targeting unhealthy individuals. For example, a participant receiving expensive medical treatment might be reclassified to a separate employment category either with reduced health benefits or none at all. The broad anti-abuse standard of these interim regulations is intended, among other things, to prohibit reclassifications directed at individuals such as this.

A second concern that commenters had was that plans and issuers might design health benefits differently for employees in different occupations or geographic locations based, at least in part, on the health factors of these groups of individuals. One example is a plan that offers fewer benefits to employees in one occupation than to employees in another occupation at least in part because of the higher average historical claims of the employees in the first occupation. A second example is a plan that charges employees in one area more than employees in another area at least in part because the cost of medical care is generally higher in the first area. The statute and legislative history appear to allow this practice, and thus these interim regulations do not prohibit the provision of different health benefits for employees in different occupations or geographic locations, based at least in part on the health factors of the group as a whole, if the classifications are not directed at individual participants or beneficiaries based on a health factor of the participants or beneficiaries.

These interim regulations also permit plans and issuers, in certain circumstances, to treat beneficiaries as different groups of similarly situated individuals. Beneficiaries may be treated as a group of similarly situated individuals separate from participants, and different treatment is permitted among beneficiaries based on bona fide employment-based classifications of the participants through whom the beneficiaries are receiving coverage. Thus, if the plan provides different benefits to full-time employees than to part-time employees, then it may also provide different benefits to dependents of full-time employees than to dependents of part-time employees. Similarly, different treatment is permitted based on the beneficiary's relationship to the participant (for example, as a spouse or as a dependent child). Different treatment is also permitted based on the beneficiary's marital status, based on a dependent child's age or student status, or based on any other factor if the factor is not a health factor.

The rules in these interim regulations allowing the different treatment of individuals in different groups of similarly situated individuals are distinct from rules requiring that qualified beneficiaries under a COBRA continuation provision[8] have available the same coverage as similarly situated non-COBRA beneficiaries. Although these interim regulations would not prohibit making benefit packages available to non-COBRA beneficiaries (such as current employees) that are not made available to COBRA qualified beneficiaries (such as former employees), the COBRA continuation provisions prohibit such a difference.

Finally, all of the requirements relating to determining groups of similarly situated individuals are subject to other rules in these interim regulations permitting favorable treatment of individuals with certain adverse health factors (discussed below under the heading "More Favorable Treatment of Individuals with Adverse Health Factors Permitted").

Nonconfinement Provisions

Some group health plans and health insurance issuers refuse to provide benefits to an individual based on the individual's confinement to a hospital or other health care institution at the time coverage otherwise would become effective. Plan provisions like these are often called "nonconfinement clauses." Any reasonable interpretation or application of the statutory HIPAA nondiscrimination provisions prohibits a plan or issuer from imposing a nonconfinement clause.[9] Thus, a plan or issuer may not deny the eligibility of any individual to enroll for benefits or charge any individual a higher premium (or contribution) because the individual, or a dependent of the individual, is confined to a hospital or other health care institution. In addition, some plans and issuers refuse to provide benefits to an individual based on an individual's inability to engage in normal life activities. A plan or issuer generally may not deny the eligibility of any individual to enroll for benefits or charge any individual a higher premium (or contribution) based on any individual's ability to engage in normal life activities. However,

[8] The term *COBRA continuation provision* is defined in 26 CFR 54.9801-2T, 29 CFR 2590.701-2, and 45 CFR 144.103.

[9] For an example illustrating that the imposition of a nonconfinement clause is not a good faith interpretation of the HIPAA nondiscrimination provisions, and the rule requiring that individuals denied enrollment without a good faith interpretation of the law be provided an opportunity to enroll, see the discussion below under the heading "Transitional Rule for Individuals Previously Denied Coverage Based on a Health Factor."

these interim regulations provide an exception that permits plans and issuers to distinguish among employees based on the performance of services. Although in practice nonconfinement clauses generally apply only to dependents, in some cases they apply also to employees. Thus, the interim regulations clarify that a nonconfinement clause would also be impermissible if applied to an employee.

These rules are of particular interest in the case of a group health plan switching coverage from one health insurance issuer to a succeeding health insurance issuer. In such a case, the HIPAA nondiscrimination provisions prohibit the succeeding issuer from denying eligibility to any individual due to confinement to a hospital or other health care institution because such a denial would discriminate in eligibility based on one or more health factors. The obligation of the succeeding issuer to provide coverage to such an individual does not preempt any obligation that the prior issuer may have under other applicable law, including State extension of benefits laws.

Actively-At-Work and Other Service Requirements

Some group health plans and health insurance issuers refuse to provide benefits to an individual if the individual is not actively at work on the day the individual would otherwise become eligible for benefits. Plan provisions like these are often called "actively-at-work clauses." These interim regulations provide that a plan or issuer generally may not impose an "actively-at-work clause." That is, these interim regulations prohibit a plan or issuer from denying the eligibility of any individual to enroll for benefits or charging any individual a higher premium or contribution based on whether an individual is actively at work (including whether an individual is continuously employed). However, an actively-at-work clause is permitted if individuals who are absent from work due to any health factor (for example, individuals taking sick leave) are treated, for purposes of health coverage, as if they are actively at work. Accordingly, plan provisions that delay enrollment until an individual is actively at work on a day following a waiting period (or for a continuous period) are prohibited unless absence from work due to any health factor is considered being actively at work.

These interim regulations also provide an exception for the first day of work to the general prohibition against actively-at-work clauses. Under the exception, a plan or issuer may require an individual to begin work before coverage may become effective.

The interim regulations explain the relationship between the rules governing actively-at-work clauses and the rules describing similarly situated individuals. Under the interim regulations, a plan or issuer is generally permitted to distinguish between groups of similarly situated individuals (provided the distinction is not directed at individual participants or beneficiaries based on a health factor). Examples illustrate that a plan or issuer may condition coverage on an individual's meeting the plan's requirement of working full-time (such as a minimum of 250 hours in a three-month period or 30 hours per week). In addition, a plan or issuer may terminate coverage for former employees while providing coverage to current employees without violating the HIPAA nondiscrimination provisions if the rules describing similarly situated individuals are satisfied, even if the former employee is unable to work due to a health factor. Similarly, a plan or issuer may charge a higher premium to employees no longer performing services than to employees currently performing services without violating the HIPAA nondiscrimination provisions if the rules describing similarly situated individuals are met. An example illustrates that the interim regulations would not, however, permit a plan or issuer to treat individuals on annual or bereavement leave better than individuals on sick leave because groups of similarly situated individuals cannot be established based on any health factor (including the taking of sick leave).

In any case, other federal or State laws, including the COBRA continuation provisions and the Family and Medical Leave Act of 1993 (FMLA), may require individuals to be offered coverage and set limits on the premium or contribution rate.

Bona Fide Wellness Programs

The HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. Thus, there is an exception to the general rule prohibiting discrimination based on a health factor if the reward, such as a premium discount or waiver of a cost-sharing requirement, is based on participation in a program of health promotion or disease prevention. The April 1997 interim rules, these interim regulations, and proposed regulations published elsewhere in this issue of the **Bulletin** refer to programs of health promotion and disease prevention allowed under this exception as "bona fide wellness programs." For a discussion of bona fide wellness programs, see the preamble to proposed regulations published elsewhere in this issue of the **Bulletin**.

More Favorable Treatment of Individuals with Adverse Health Factors Permitted

Many group health plans make certain periods of extended coverage available to employees no longer performing services only if the employee is unable to work due to disability, and many plans make coverage available to dependent children past a certain age only if the child is disabled. Some plans waive or reduce the required employee contribution for coverage if the employee or a member of the employee's immediate family is in a critical medical condition for a prolonged period. Disability and medical condition are listed in the statute as health factors, and several commenters recognized that, under one possible interpretation of the HIPAA nondiscrimination requirements, plan provisions or practices such as these would be impermissible. These commenters asked for guidance clarifying that plan provisions and practices like these would be permissible. Other commenters cited the rule under the COBRA continuation provisions permitting plans to require payment of a higher amount during the disability extension than during other periods of COBRA coverage and asked whether following this COBRA rule is permissible under the HIPAA nondiscrimination requirements.

Eligibility. These interim regulations permit plans and issuers to establish rules for eligibility favoring individuals based on an adverse health factor, such as dis-

ability. Thus, a plan or issuer does not violate the HIPAA nondiscrimination requirements by making extended coverage available to employees no longer providing services only if the employee is unable to work due to disability nor by making coverage available to dependent children past a certain age only if the child is disabled. Examples clarify this rule.

Premiums. These interim regulations also address the circumstances under which differential premiums (or contributions) may be charged to an individual based on an adverse health factor. These interim regulations permit plans and issuers to charge a higher rate in some situations and also a lower rate to individuals based on an adverse health factor, such as disability. A higher rate may be charged only in situations where the individual with the adverse health factor would not have coverage were it not for the adverse health factor. Thus, in a case where a plan or issuer makes extended coverage available to employees no longer performing services only if the employee is unable to work due to disability, the plan could require a higher payment from the employee only while the employee is receiving coverage under that special eligibility provision. However, the plan could not charge a disabled employee a higher rate than nondisabled employees while the disabled employee was still eligible under a generally-applicable eligibility provision, rather than the special extended coverage provision. Accordingly, under the interim regulations, a plan or issuer could charge a higher rate for COBRA coverage during the disability extension than for COBRA coverage outside the disability extension (and the result is the same if the extended coverage for disability is provided pursuant to State law or plan provision rather than pursuant to a COBRA continuation provision).[10]

Although charging a higher rate based on an adverse health factor is limited to the situation in which coverage would not be available but for the adverse health factor, under these interim regulations a plan or issuer is always permitted to charge an individual a lower rate based on an adverse health factor. Thus, even though an employee is receiving coverage under the same eligibility provision as other employees who are required to pay the full employee share of the premium, under the interim regulations it is permissible to waive or reduce the employee share of the premium if the employee or a family member is in critical medical condition for a prolonged period.

No Effect on Other Laws

Compliance with these interim regulations is not determinative of compliance with any other provision of ERISA, or any other State or federal law, including the Americans with Disabilities Act. Therefore, while these interim regulations generally do not impose any new disclosure requirements on plans or issuers, other applicable law continues to apply. For example, under Title I of ERISA, administrators of ERISA-covered group health plans are required to provide participants and beneficiaries with a summary plan description that is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.[11] In addition, some courts have held that fiduciaries of ERISA-covered group health plans are obligated to ensure that plan documents and disclosures are consistent with applicable disclosure requirements and do not serve to mislead or misinform participants and beneficiaries concerning their rights and obligations under the plans in which they participate.[12] Fiduciaries are advised to take steps to ensure that plan disclosures are accurate and are not misleading.

These interim regulations are also not determinative of compliance with the COBRA continuation provisions, or any other State or federal law, such as the Americans with Disabilities Act.

Applicability Date

These interim regulations generally apply for plan years beginning on or after July 1, 2001 (although some provisions apply earlier, as discussed below under the heading "III. Format of Regulations"). As noted above, in the preamble to the April 1997 interim rules the Departments stated that they intended to issue further regulations on the statutory nondiscrimination rules. That preamble also stated that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with the statutory nondiscrimination provisions before the additional guidance was issued. The Departments will not take any enforcement action against a plan or issuer with respect to efforts to comply in good faith with the statutory nondiscrimination provisions before the first plan year beginning on or after July 1, 2001. (See the description of transitional rules immediately below regarding certain interpretations that are not good faith interpretations of the statutory nondiscrimination requirements.) Upon the applicability of these regulations, however, good faith efforts to comply with the statutory provisions addressed by these interim regulations may not be sufficient to avoid adverse enforcement actions by the Departments. Therefore, for plan years beginning on or after July 1, 2001, plans and issuers must comply with the requirements of these regulations in order to avoid adverse enforcement actions. As discussed earlier, under the heading "Background," the period for good faith compliance continues with respect to bona fide wellness programs until further guidance is issued.

Transitional Rules for Individuals Previously Denied Coverage Based on a Health Factor

The April 1997 interim rules clarified that a plan or issuer violates the HIPAA nondiscrimination requirements if it requires an individual to pass a physical examination as a condition for enrollment, even if the condition is imposed only on late enrollees. The HIPAA nondiscrimination requirements apply both to eligibility and continued eligibility of any individual to enroll under a plan. Consequently, once HIPAA became effective with respect to a plan or health insurance issuer, it was a violation of the nondiscrimination requirements to continue to deny an individual eligibility to

[10] This result is consistent with the result under the COBRA continuation provisions. Under those provisions, plans are generally permitted to require payment of up to 102 percent of the applicable premium but are permitted to require payment for coverage of a disabled qualified beneficiary of up to 150 percent of the applicable premium during the disability extension period.

[11] See ERISA section 102, and the Department of Labor's regulations issued thereunder.

[12] See *Varity Corp v. Howe*, 516 U.S. 489, 506 (1996).

enroll if the reason the individual was denied enrollment previously was due to one or more health factors (such as requiring the individual to pass a physical examination).

On December 29, 1997, the Departments issued in the **Federal Register** a clarification of the April 1997 interim rules relating to individuals who were denied coverage due to a health factor before the effective date of HIPAA (62 F.R. 67689). The clarification restates the requirement of the April 1997 interim rules that an individual cannot be denied coverage based on a health factor on or after the effective date of HIPAA. The clarification then states that individuals to whom coverage had not been made available before the effective date of HIPAA based on a health factor and who enrolled when first eligible on or after the effective date of the HIPAA nondiscrimination provisions could not be treated as a late enrollee for purposes of the HIPAA preexisting condition exclusion provisions. Under the clarification, individuals to whom coverage had not been made available include any individual who did not apply for coverage because it was reasonable to believe that the application would have been futile. The rules in the clarification apply whether or not the plan offered late enrollment.

Neither the April 1997 interim rules nor the December 1997 guidance clearly addressed the situation where an individual was denied only late enrollment based on a health factor prior to the effective date of HIPAA and, by the effective date of HIPAA, the plan eliminated late enrollment. For example, prior to HIPAA many plans and issuers allowed individuals to enroll when first eligible without regard to health status, but allowed late enrollees to enroll only if they could pass a physical examination (or present evidence of good health). Upon the effective date of HIPAA, some of these plans and issuers eliminated late enrollment.

Any plan or issuer that permitted these individuals to enroll once the HIPAA nondiscrimination provisions took effect, of course, is in compliance with this provision of the nondiscrimination rules. In contrast, a plan or issuer that continued to deny coverage to these individuals may have done so based on a good faith interpretation of the statute and the Departments' published guidance. For example, a plan or issuer might reasonably have thought that HIPAA did not require it to remedy pre-HIPAA denials of late enrollment based on a health factor for individuals who could have enrolled initially without regard to their health if the plan or issuer eliminated late enrollment by the effective date of HIPAA.

The interim regulations provide transitional rules for situations where coverage was denied to individuals based on one or more health factors, both where the denial was based on a good faith interpretation of the statute or the Departments' published guidance and where it was not. In either event, a safe harbor provides that the Departments will not take any enforcement action with respect to such a denial of coverage if the plan or issuer complies with the transitional rules.

Where the denial was not based on a good faith interpretation, the interim regulations provide that the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001. If the opportunity is presented within the first plan year beginning on or after the effective date of the statutory HIPAA nondiscrimination rules, the enrollment must be effective within that plan year. If this enrollment opportunity is presented after such plan year, the individual must be given an option to have coverage effective either (1) prospectively from the date the plan receives a request for enrollment in connection with the enrollment opportunity or (2) retroactively to the first day of the first plan year beginning on HIPAA's effective date for the plan (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan).

The reason for giving the individual the opportunity to elect retroactive coverage is to make the individual whole; that is, to put the individual in the same financial condition that the individual would have been in had the individual not been denied enrollment. Thus, if the individual elects retroactive coverage, the plan or issuer may require the individual to pay premiums or contributions for the retroactive period (but the plan or issuer cannot charge interest on that amount).

The rule differs for situations where coverage was denied to individuals based on one or more health factors but where the denial was based on a good faith interpretation of the statute or the Departments' prior published guidance. In those situations, these interim regulations require plans and issuers to give the individuals an opportunity to enroll that continues for at least 30 days and with coverage effective not later than July 1, 2001.

In both situations (whether the denial of coverage was or was not based on a good faith interpretation), the interim regulations also clarify that, once enrolled, these individuals cannot be treated as late enrollees. The individual's enrollment date under the plan is the effective date of HIPAA (or, if later, the date the individual would have otherwise been eligible to enroll). In addition, any period between an individual's enrollment date and the effective date of coverage is treated as a waiting period. Thus, for example, with respect to a calendar year plan that is not collectively bargained, an individual who was previously denied late enrollment due to a health factor before the effective date of HIPAA has an enrollment date of January 1, 1998 (HIPAA's effective date for that plan) and a waiting period that begins on that date. Moreover, because any waiting period must begin on the individual's enrollment date, January 1, 1998, and the maximum preexisting exclusion period that can be applied is 12 months, individuals who enroll in the plan on July 1, 2001 cannot be subject to any preexisting condition exclusion period.

Special Transitional Rule for Self-Funded Non-Federal Governmental Plans Exempted under 45 CFR 146.180

The sponsor of a self-funded non-Federal governmental plan may elect under section 2721(b)(2) of the PHS Act and 45 CFR 146.180 to exempt its group health plan from the nondiscrimination requirements of section 2702 of the PHS Act and 45 CFR 146.121. If the plan sponsor subsequently chooses to bring the plan into compliance with these nondiscrimination requirements, the plan must provide notice to that effect to individuals who were denied enrollment based on one or more health factors, and afford those

individuals an opportunity, that continues for at least 30 days, to enroll in the plan. (An individual is considered to have been denied coverage if he or she failed to apply for coverage because, given an exemption election under 45 CFR 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor.) The notice must specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan comes into compliance. The plan may not treat the individual as a late enrollee or a special enrollee. Coverage must be effective no later than the date the exemption election under 45 CFR 146.180 (with regard to these nondiscrimination requirements) no longer applies, or July 1, 2001 (if later) and the plan was acting in accordance with a good faith interpretation of the statutory HIPAA nondiscrimination provisions and guidance published by the Health Care Financing Administration.

III. Format of Regulations

Final and Temporary Treasury Regulations

The Department of the Treasury is issuing a portion of these regulations as final regulations and a portion as temporary and cross-referencing proposed regulations. The April 1997 interim rules were originally issued by Treasury in the form of temporary and cross-referencing proposed regulations. Under section 7805(e)(2) of the Code, however, any temporary regulation issued under the Code expires within three years after the date issued. Treasury is issuing final regulations that restate the rules relating to the HIPAA nondiscrimination requirements from the April 1997 regulations without significant modification. The final regulations apply March 9, 2001. Table 1 identifies which paragraphs of the final regulation issued today correspond to which paragraphs of the April 1997 regulation. New guidance being published today by Treasury is being issued as temporary and cross-referencing proposed regulations. This guidance will apply to group health plans beginning with the first plan year on or after July 1, 2001. (These new temporary regulations will also expire after three years pursuant to section 7805(e) of the Code.)

Table 1
Comparison of Treasury's April 1997 Regulations with Treasury's Final Regulations

April 1997 Regulations	Final Regulation under §9802
§54.9802-1T(a)(1)	§54.9802-1(a)(1),(2); (b)(1)
§54.9802-1T(a)(2)(i)	§54.9802-1(b)(2)(i)(A)
§54.9802-1T(a)(3)	[The corresponding provision is in the new temporary regulations.]
§54.9802-1T(a)(4)	§54.9802-1(b)(1)(iii)
§54.9802-1T(b)(1)	§54.9802-1(c)(1)(i)
§54.9802-1T(b)(2)(i)	§54.9802-1(c)(2)(i)
§54.9802-1T(b)(2)(ii)	§54.9802-1(b)(2)(i); (c)(3)
§54.9802-1T(b)(3)	[The corresponding provision is in the new proposed regulations for wellness programs.]

Interim Final Labor and HHS Regulations

The guidance issued by the Departments of Labor (Labor) and Health and Human Services (HHS) in April 1997 is not subject to a statutory expiration date. Accordingly, the Labor and HHS guidance is being published as interim final regulations. These regulations contain two applicability dates that parallel the two separate applicability dates in the Treasury guidance. Table 2 identifies which paragraphs of the interim final regulation issued today are applicable on March 9, 20001 and which paragraphs take effect on or after July 1, 2001.

Table 2
Applicability Dates for the Interim Final Regulations

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
Health factors	(a)(1)	✓	
Health factors - Evidence of insurability - Conditions arising out of an act of domestic violence	(a)(2)(i)	✓	

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
Health factors - Evidence of insurability - Participation in certain activities	(a)(2)(ii)		✓
Health factors - The decision whether health coverage is elected	(a)(3)		✓
Prohibited discrimination in rules for eligibility - General rule	(b)(1)(i)	✓	
Prohibited discrimination in rules for eligibility - Rules for eligibility described	(b)(1)(ii)		✓
Prohibited discrimination in eligibility - General rule - Example 1	(b)(1)(iii) Example 1	✓	
Prohibited discrimination in eligibility - General rule - Examples 2 through 4	(b)(1)(iii) Examples 2 through 4		✓
Prohibited discrimination in eligibility - Application to benefits - No benefits mandated	(b)(2)(i)(A)	✓	
Prohibited discrimination in eligibility - Application to benefits - Nondiscriminatory benefit restrictions permitted	(b)(2)(i)(B), (C), & (D)		✓
Prohibited discrimination in eligibility - Application to benefits - Certain cost-sharing mechanisms	(b)(2)(ii)	✓	
Prohibited discrimination in eligibility - Application to benefits - Source-of-injury exclusions	(b)(2)(iii)		✓
Prohibited discrimination in eligibility - Application to benefits - Relationship to HIPAA preexisting condition exclusion rules	(b)(3)		✓
Prohibited discrimination in premiums or contributions - General rule	(c)(1)(i)	✓	
Prohibited discrimination in premiums or contributions - Determining an individual's premium rate	(c)(1)(ii)		✓
Prohibited discrimination in premiums or contributions - Group rating on health factors not restricted	(c)(2)(i)	✓	
Prohibited discrimination in premiums or contributions - List billing based on a health factor prohibited	(c)(2)(ii) & (iii)		✓
Prohibited discrimination in premiums or contributions - Exception for bona fide wellness programs	(c)(3)	✓	
Similarly situated individuals	(d)		✓
Nonconfinement and actively-at-work provisions	(e)		✓
Bona fide wellness programs	(f) [Reserved.]		See proposed regulations published elsewhere in this Bulletin.

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
More favorable treatment of individuals with adverse health factors permitted	(g)		✓
No effect on other laws	(h)		✓

IV. Interim Final Regulations with Request for Comments

The principal purpose of these interim final regulations is to provide additional guidance on how to comply with the HIPAA nondiscrimination provisions contained in section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act. Code section 9833, ERISA section 734, and PHS Act section 2792 authorize the Secretaries of the Treasury, Labor, and HHS to issue any interim final rules as the Secretaries deem are appropriate to carry out certain provisions of HIPAA, including the nondiscrimination provisions. As explained below, the Secretaries have determined that these regulations should be issued as interim final rules with requests for comments.

HIPAA was enacted in August of 1996. The Secretaries first issued interim final rules providing guidance on HIPAA's nondiscrimination provisions in April of 1997. In publishing this guidance, the Secretaries relied on the authority granted in section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act, as well as other authority including section 101(g)(4) of HIPAA and section 505 of ERISA. As part of the April 1997 rulemaking, the Secretaries requested comments on whether additional guidance was needed concerning the extent to which the statutory HIPAA nondiscrimination provisions prohibit discrimination against individuals in eligibility for particular benefits; the extent to which the statute may permit benefit limitations based on the source of an injury; the permissible standards for defining groups of similarly situated individuals; the application of the prohibitions on discrimination between groups of similarly situated individuals; and the permissible standards for determining bona fide wellness programs. Numerous comments were received in response to this request.

After evaluating all of the comments, and after speaking with various interested parties in the course of an extensive educational outreach campaign, the Departments have developed these comprehensive regulations. Among other things, the comments reflected the need for more comprehensive guidance on the application of the nondiscrimination provisions. In the period since HIPAA was enacted and the April 1997 regulations were issued, numerous issues have arisen concerning how plans and issuers should apply the nondiscrimination provisions. In addition, the number of comments and the breadth of issues raised demonstrates that these regulations should go into effect on an interim basis pending receipt of further comments. This need to act on an interim basis is also supported by the General Accounting Office's request that the Departments "promptly complete regulations related to HIPAA's non-discrimination provisions" (GAO/HEHS 00-85). Therefore, the Departments have determined that it is appropriate to issue the guidance on an interim final basis, with the exception of the bona fide wellness program provisions.[13] With respect to these last provisions, the Departments would like to better develop the administrative record before any provisions regarding such programs go into effect.

The Secretaries believe that this period of interim effectiveness will provide ample opportunity for the regulated community to comment specifically on this comprehensive guidance, providing a sound basis for developing final rules. The Departments are seeking comments from all those affected by these regulations, and the Departments will consider such comments and will reevaluate these regulations following the comment period in the same way that it would if the regulations had been published in proposed form. Based on such comments and other information obtained through the administration of the nondiscrimination requirements, the Departments will make any necessary modifications to the regulations when they are issued in final form.

[13] See proposed rules relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.

V. Economic Impact and Paperwork Burden

Summary - Department of Labor and Department of Health and Human Services

HIPAA's nondiscrimination provisions generally prohibit group health plans and group health plan issuers from discriminating against individuals in eligibility or premium on the basis of health status factors. The Departments crafted this regulation to secure these protections as intended by Congress in as economically efficient a manner as possible, and believe that the economic benefits of the regulation outweigh its costs.

The primary economic benefits associated with securing HIPAA's nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with health problems. Increased access benefits both newly covered individuals and society at large. It fosters expanded insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. This is especially true for the individuals most affected by HIPAA's nondiscrimination provisions — those with adverse health conditions. Denied insurance, individuals in poorer health are more likely to suffer economic hardship, to forgo badly needed care for financial reasons, and to suffer adverse health outcomes as a result. For them, gaining insurance is more likely to mean gaining economic security, receiving timely, quality care, and living healthier, more productive lives.

Additional economic benefits derive directly from the improved clarity provided by the regulation. The regulation will

reduce uncertainty and costly disputes and promote confidence in health benefits' value, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans.

The Departments estimate that the cost to plans to implement amendments in order to comply with this regulation, revise materials accordingly, and provide notices of opportunities to enroll as required by the regulation will amount to less than $19 million. This is a one-time cost distinguishable from the transfer that will result from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation.

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group health plans to provide coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. Although the Departments are not aware of any published estimates of transfers attributable to HIPAA's statutory nondiscrimination provisions, a rough attempt to gauge the order of magnitude of this transfer suggests that it may amount to more than $400 million annually, which is a small fraction of 1 percent of total expenditures by group plans. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer.

Executive Order 12866 - Department of Labor and Department of Health and Human Services

Under Executive Order 12866, the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the 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.

Pursuant to the terms of the Executive Order, it has been determined that this action raises novel policy issues arising out of legal mandates. In addition, the magnitude of the transfer that arises from the implementation of HIPAA's statutory nondiscrimination provisions is estimated to exceed $100 million. Therefore, this notice is "significant" and subject to OMB review under Sections 3(f)(1) and 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this regulatory action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the interim regulation for purposes of compliance with the Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

1. Statement of Need for Proposed Action

These interim regulations are needed to clarify and interpret the HIPAA nondiscrimination provisions (prohibiting discrimination against individual participants and beneficiaries based on health status) under section 702 of the Employee Retirement Income Security Act of 1974 (ERISA), section 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986. The provisions are needed to ensure that group health plans and group health insurers and issuers do not discriminate against individuals, participants, and beneficiaries based on any health factors with respect to health care coverage and premiums. Additional guidance was required to explain the application of the statute to benefits, clarify the relationship between the HIPAA nondiscrimination provisions and the HIPAA preexisting condition exclusion limitations, explain the applications of these provisions to premiums, describe similarly situated individuals, explain the application of the provisions to actively-at-work and nonconfinement clauses, clarify that more favorable treatment of individuals with medical needs generally is permitted, and describe plans' and issuers' obligations with respect to plan amendments.

2. Costs and Benefits

The primary economic benefits associated with the HIPAA nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with health problems. Expanding access benefits both newly covered individuals and society at large by fostering expanded insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. Additional economic benefits derive directly from the improved clarity provided by the regulation. By clarifying employees' rights and plan sponsors' obligations under HIPAA's nondiscrimination provisions, the regulation will reduce uncertainty and costly disputes and promote confidence in health benefits' value, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans.

The Departments estimate that the cost to plans to implement amendments in order to comply with this regulation, revise materials accordingly, and provide notices of opportunities to enroll as required by the regulation will amount to less than $19 million. This is a one-time cost distinguishable from the transfer that will result from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation.

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group health plans to provide

coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. Although the Departments are not aware of any published estimates of transfers attributable to HIPAA's statutory nondiscrimination provisions, a rough attempt to gauge the order of magnitude of this transfer suggests that it may amount to more than $400 million annually. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer. The Departments note that this transfer is the direct reflection of the intent and beneficial effect of HIPAA's nondiscrimination provisions: increasing access to affordable group health plan coverage for individuals with health problems. They also note that even the full transfer to plans attributable to HIPAA's statutory nondiscrimination provisions probably amounts to a small fraction of 1 percent of total expenditures by these plans.

The Departments believe that the benefits of the regulation outweigh its costs.

A fuller discussion of the Departments assessment of the costs and benefits of this regulation is provided below.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rule making describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations, and governmental jurisdictions.

Because these rules are being issued as interim final rules and not as a notice of proposed rule making, the RFA does not apply and the Departments are not required to either certify that the rule will not have a significant impact on a substantial number of small businesses or conduct a regulatory flexibility analysis. The Departments nonetheless crafted this regulation in careful consideration of its effects on small entities, and have conducted an analysis of the likely impact of the rules on small entities.

For purposes of this discussion, the Departments 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)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. The Departments believe that assessing the impact of this interim final rule on small plans is an appropriate substitute for evaluating the effect on small entities as that term is defined in the RFA.

Small plans in particular will benefit from the regulations' provisions that affirm and clarify the flexibility available to plans under HIPAA's nondiscrimination requirements. Consideration of small plans' needs and circumstances played an important part in the development these provisions. These provisions are discussed in more detail below.

The Departments estimate that plans with 100 or fewer participants will incur costs of $4 million on aggregate to amend their provisions to comply with the regulation and revise their materials accordingly. These costs generally will fall directly to issuers who supply small group insurance products and stop-loss insurers who provide services to small self-insured plans, who will spread those costs across the much larger number of small plans that buy them. These same small plans will incur costs of $10 million to prepare and distribute notices of enrollment opportunities as required by the regulation, the Departments estimate. The total economic cost to small plans to comply with this regulation is estimated to be $14 million. This is a one-time cost distinguishable from the transfer that will result from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group healh plans to provide coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. The Departments note that transfers to small plans attributable to HIPAA's statutory nondiscrimination provisions may amount to approximately $110 million. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer. The Departments note that this transfer is the direct reflection of the intent and beneficial effect of HIPAA's nondiscrimination provisions: increasing access to affordable group health plan coverage for individuals with health problems. They also note that even the full transfer to small plans attributable to HIPAA's statutory nondiscrimination provisions amounts to a small fraction of total expenditures by these plans.

Paperwork Reduction Act - Department of Labor and Department of the Treasury

1. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3506(c)(2)(A). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

Currently, the Pension and Welfare Benefits Administration (PWBA) is soliciting comments concerning the proposed information collection request (ICR) included in the Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market.

The Department has submitted this ICR using emergency review procedures to the Office of Management and Budget (OMB) for its review and clearance in accordance with PRA 95. OMB approval has been requested by March 9, 2001. The Department and OMB are particularly interested in comments that:

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

Comments on the collection of information should be sent to the Office of Information and Regulatory Affairs, **Office of Management and Budget,** Room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Pension and Welfare Benefits Administration. Although comments may be submitted through March 9, 2001, OMB requests that comments be received by February 7, 2001, to ensure their consideration in OMB's review of the request for emergency approval. All comments will be shared among the Departments.

Requests for copies of the ICR may be addressed to: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW, Room N-5647, Washington, D.C., 20210. Telephone: (202) 219-4782; Fax: (202) 219-4745 (these are not toll-free numbers).

2. Department of the Treasury

The collection of information is in 26 CFR 54.9802–1T(*i*)(3)(ii) and (iii). This information is required to be provided so that participants who have been denied group health plan coverage based on a health status factor may be made aware of the opportunity to enroll in the plan. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are mandatory for affected group health plans.

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

Comments on the collection of information should be sent to the **Office of Management and Budget,** Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC, 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224. Comments on the collection of information should be received by February 7, 2001. In light of the request for OMB clearance by March 9, 2001, the early submission of comments is encouraged to ensure their consideration. Comments are specifically requested concerning:

- Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;
- How to enhance the quality, utility, and clarity of the information to be collected;
- How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and
- Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

3. Description of Collection of Information

29 CFR 2590.702(*i*)(3)(ii) and (iii) and 26 CFR 54.9802–1T(*i*)(3)(ii) and (iii) of these interim rules include information collection requests. Paragraphs (*i*)(3)(ii) and (iii) describe the requirement that individuals previously denied coverage under a group health plan be provided with an opportunity to enroll in the plan, and a notice concerning this opportunity. Pursuant to paragraph (*i*)(3)(ii), where coverage denials were not based on a good faith interpretation of section 702 of the ERISA and section 9802 of the Code, notices of the opportunity for individuals previously denied coverage to enroll are required to be provided within 60 days of publication of this interim final rule. Where coverage was denied based on a good faith interpretation of section 702 of ERISA and section 9802 of the Code, the plan or issuer must provide notice of the opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001.

The method of estimating the hour and cost burdens of the information collection request is described in the section of this preamble appearing below entitled *Costs and Benefits of the Regulation*. Generally, the Departments have conservatively estimated that all group health plans that excluded individuals on the basis of health status factors prior to HIPAA's enactment will provide a notice of the opportunity to enroll to all participants. The total burden of providing notices to participants of private employers is divided equally between the Departments of Labor and Treasury.

Paragraph (h), *No effect on other laws*, is not considered to include an information collection request because the provision makes no substantive or material change to the Department of Labor's existing information collection request for the Summary Plan Description and Summary of Material Modifications cur-

rently approved under OMB control number 1210–0039.
Type of Review: New
Agency: Pension and Welfare Benefits Administration, Department of Labor; U.S. Department of the Treasury, Internal Revenue Service
Title: Notice of Opportunity To Enroll
OMB Number: 1210- 0NEW; 1545-0NEW
Affected Public: Individuals or households; Business or other for-profit institutions; Not-for-profit institutions
Total Respondents: 120,000
Frequency of Response: One time
Total Responses: 2.0 million
Estimated Burden Hours: 5,950 (Pension and Welfare Benefits Administration); 5,950 (Internal Revenue Service)
Estimated Annual Costs (Operating and Maintenance): $5.1 million (Pension and Welfare Benefits Administration); $5.1 million (Internal Revenue Serv ice)
Estimated Total Annual Costs: $5.1 million (Pension and Welfare Benefits Administration); $5.1 million (Internal Revenue Service)

Comments submitted in response to the information collection provisions of these Interim Final, final, and temporary rules will be shared among the Departments and summarized and/or included in the request for continuing OMB approval of the information collection request; they will also become a matter of public record.

Paperwork Reduction Act - Department of Health and Human Services

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the OMB for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are, however, requesting an emergency review of this interim final rule with comment period. In compliance with section 3506(c)(2)(A) of the PRA, we are submitting to OMB the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR Part 1320, to ensure compliance with section 2702 of the PHS Act. This section generally prohibits group health plans and group health insurance issuers from discriminating against individual participants or beneficiaries based on any health factor of such participants or beneficiaries. We cannot reasonably comply with normal clearance procedures because public harm is likely to result if the agency cannot enforce the requirements of this section 2702 of the PHS Act in order to ensure that individual participants or beneficiaries are not subject to unfair discrimination.

HCFA is requesting OMB review and approval of this collection 60 working days after the publication of this rule, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below within 30 working days after the publication of this rule.

During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

We are soliciting public comment on each of the issues for the provisions summarized below that contain information collection requirements:

Section 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(h) *No effect on other laws* Although this section generally does not impose new disclosure obligations on plans and issuers, this paragraph (h) states that this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation. Therefore, plan documents (including, for example, group health insurance policies and certificates of insurance) must be amended if they do not accurately reflect the requirements set forth in this section, by the applicability date of this section.

The revisions to the plan documents are intended to eliminate provisions that do not comply with the HIPAA nondiscrimination statute and regulations. In particular, it is anticipated that changes will be required to the majority of actively-at-work provisions and nonconfinement clauses found in plan documents. The modifications are to be made by the applicability date of the regulation and the requirements do not impose any on-going burden. The revisions are anticipated to take 100 hours for state governmental plans and 4,900 hours for local governmental plans. The changes are expected to involve one hour of an attorney's time at a $72 hourly rate. The corresponding plan amendment cost to be performed by service providers who are acting on behalf of the plans, is $32,000 for State governmental plans and $1,311,000 for local governmental plans.

(*i*) *Special transitional rule for self-funded non-Federal governmental plans exempted under 45 CFR 146.180.* Paragraph (4)(i) requires that if coverage has been denied to any individual because the sponsor of a self-funded non-Federal governmental plan has elected under § 146.180 of this part to exempt the plan from the requirements of this section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this section, the plan must: notify the individual that the plan will be coming into compliance with the requirements of this section; afford the individual an opportunity that continues for at least 30 days, specify the effective date of compliance; and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this section (as a matter of administrative convenience; the notice may be disseminated to all employees).

The regulation clarifies that self-funded non-Federal governmental plans are required to give individuals who were previously discriminated against an opportunity to enroll, including notice of an opportunity to enroll. The development of the number of plans that are required to notify individuals were conservatively arrived at by assuming that all plans which have excluded individuals must notify all individuals who are eligible to participate in the plan. Development of the transitional notices are estimated to take 0 hours for State governmental plans and 200 hours for local governmental plans. The corresponding burden for work performed by service providers is anticipated to be $1,000 for State governmental plans and $535,000 for local governmental plans. The Department estimates that the burden to distribute transitional notices will require State governmental plans 800 hours and 1,400 hours for local governmental plans. The corresponding distribution burden performed by service providers is $72,000 for State governmental plans and $158,000 for local governmental plans.

The above costs will be reduced to the extent that State and local governmental plans have elected to opt out of the HIPAA requirements. As of the date of publishing, approximately 600 plans have opted out of the HIPAA statutory and regulatory requirements.

We have submitted a copy of this rule to OMB for its review of the information collection requirements. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

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

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment Management Group,
Division of HCFA Enterprise Standards,
Room C2-26-17,
7500 Security Boulevard,
Baltimore, MD 21244-1850,
Attn: John Burke HCFA-2022,

and

Office of Information and Regulatory Affairs,
Office of Management and Budget,
Room 10235, New Executive Office Building,
Washington, DC 20503,
Attn.: Allison Herron Eydt, HCFA-2022.

Small Business Regulatory Enforcement Fairness Act

This interim final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and is being transmitted to Congress and the Comptroller General for review. The interim final rule is a "major rule," as that term is defined in 5 U.S.C. 804, because it is likely to result in an annual effect on the economy of $100 million or more. As such, this interim final rule is being transmitted to Congress and the Comptroller General for review.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, this interim final rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, nor does it include mandates which may impose an annual burden of $100 million or more on the private sector.

Federalism Statement - Department of Labor and Department of Health and Human Services

Executive Order 13132 (August 4, 1999) 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. Agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these interim final regulations do not have federalism implications, because they do not have substantial 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. This is largely because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal standards in HIPAA prohibiting discrimination based on health factors. Therefore, the regulations are not likely to require substantial additional oversight of States by the Department of Health and Human Services.

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, HIPAA added a new preemption provision to ERISA (as well as to the PHS Act) preserving the applicability of State laws establishing requirements for issuers of group health insurance coverage, except to the extent that these requirements prevent the application of the portability, access, and renewability requirements of HIPAA. The nondiscrimination provisions that are the subject of this rulemaking are included among those requirements.

In enacting these new preemption provisions, Congress indicated its intent to establish a preemption of State insurance requirements only to the extent that those requirements prevent the application of the basic protections set forth in HIPAA. HIPAA's Conference Report states that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). Consequently, under the statute and the Conference Report, State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of" the HIPAA nondiscrimination provisions.

Accordingly, States are given significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law. In many

cases, the federal law imposes minimum requirements which States are free to exceed. Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997, and these regulations do not reduce the discretion given to the States by the statute. It is the Departments' understanding that the vast majority of States have in fact implemented provisions which meet or exceed the minimum requirements of the HIPAA non-discrimination provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. When exercising its responsibility to enforce the provisions of HIPAA, HCFA works cooperatively with the States for the purpose of addressing State concerns and avoiding conflicts with the exercise of State authority.[14] HCFA has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HCFA's procedures address the handling of reports that States may not be enforcing HIPAA's requirements, and the mechanism for allocating enforcement responsibility between the States and HCFA. To date, HCFA has had occasion to enforce the HIPAA non-discrimination provisions in only two States.

Although the Departments conclude that these interim final rules do not have federalism implications, in keeping with the spirit of the Executive Order that agencies closely examine any policies that may have federalism implications or limit the policy making discretion of the States, the Department of Labor and HCFA have engaged in numerous efforts to consult with and work cooperatively with affected State and local officials.

For example, the Departments were aware that some States commented on the way the federal provisions should be interpreted. Therefore, the Departments have sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories, that among other things provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss, and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas, and in-depth consideration of insurance issues by regulators, industry representatives, and consumers. HCFA and Department of Labor staff have attended the quarterly meetings consistently to listen to the concerns of the State Insurance Departments regarding HIPAA issues, including the nondiscrimination provisions. In addition to the general discussions, committee meetings and task groups, the NAIC sponsors the following two standing HIPAA meetings for members during the quarterly conferences:

- HCFA/DOL Meeting on HIPAA Issues (This meeting provides HCFA and Labor the opportunity to provide updates on regulations, bulletins, enforcement actions and outreach efforts regarding HIPAA.)
- The NAIC/HCFA Liaison Meeting (This meeting provides HCFA and the NAIC the opportunity to discuss HIPAA and other health care programs.)

In addition, in developing these interim final regulations, the Departments consulted with the NAIC and requested their assistance to obtain information from the State Insurance Departments. Specifically, we sought and received their input on certain insurance rating practices and late enrollment issues. The Departments employed the States' insights on insurance rating practices in developing the provisions prohibiting "list-billing," and their experience with late enrollment in crafting the regulatory provision clarifying the relationship between the nondiscrimination provisions and late enrollment. Specifically, the regulations clarify that while late enrollment, if offered by a plan, must be available to all similarly situated individuals regardless of any health factor, an individual's status as a late enrollee is not itself within the scope of any health factor.

The Departments also cooperate with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators, and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including HCFA, NAIC and many business and consumer groups. HCFA has sponsored four conferences with the States - the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999 and 2000. Furthermore, both the Department of Labor and HCFA websites offer links to important State websites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

In conclusion, throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress's intent to provide uniform minimum protections to consumers in every State.

Unified Analysis of Costs and Benefits

1. Introduction

HIPAA's nondiscrimination provisions generally prohibit group health plans and group health plan issuers from discriminating against individuals on the basis of health status factors. The primary effect and intent of the provision is to increase access to affordable group health coverage for individuals with health problems. This effect, and the economic costs, benefits, and transfers attendant to it, generally flow directly from the HIPAA's statutory provisions, which are largely self-implementing. However, the statute

[14] This authority applies to insurance issued with respect to group health plans generally, including plans covering employees of church organizations. Thus, this discussion of federalism applies to all group health insurance coverage that is subject to the PHS Act, including those church plans that provide coverage through a health insurance issuer (but not to church plans that do not provide coverage through a health insurance issuer). For additional information relating to the application of these nondiscrimination rules to church plans, see the preamble to regulations being proposed elsewhere in this issue of the Bulletin regarding section 9802(c) of the Code relating to church plans.

alone leaves room for varying interpretations of exactly which practices are prohibited or permitted at the margin. This regulation draws on the Departments' authority to clarify and interpret HIPAA's statutory nondiscrimination provisions in order to secure the protections intended by Congress for plan participants and beneficiaries. The Departments crafted it to satisfy this mandate in as economically efficient a manner as possible, and believe that the economic benefits of the regulation outweigh its costs. The analysis underlying this conclusion takes into account both the effect of the statute and the impact of the discretion exercised in the regulation.

The nondiscrimination provisions of the HIPAA statute and of this regulation generally apply to both group health plans and to issuers of group health plan policies. Economic theory predicts that issuers will pass their costs of compliance back to plans, and that plans may pass some or all of issuers' and their own costs of compliance to participants. This analysis is carried out in light of this prediction.

2. Costs and Benefits of HIPAA's Statutory Nondiscrimination Provisions

As noted above, HIPAA's statutory nondiscrimination provisions are largely self-implementing even in the absence of interpretive guidance. It is the Departments' policy where practicable to evaluate such impacts separately from the impact of discretion exercised in regulation. The Departments provide qualitative assessments of the nature of the costs, benefits, and transfers that are expected to derive from statutory provisions, and provide summaries of any credible, empirical estimates of these effects that are available.

To the Departments' knowledge, there is no publicly available work that quantifies the magnitude or presents the nature of these benefits, costs, and transfers. In its initial scoring of the statute, the Congressional Budget Office did not separately quantify the costs of the nondiscrimination provisions. Therefore, this analysis considers the nature of anticipated costs, benefits, and transfers, and offers a basis for estimating separately the impacts of the statute and regulatory discretion, but does not present a detailed description of any other quantitative analysis of the statute's impact.

HIPAA's statutory nondiscrimination provisions entail new economic costs and benefits, as well as transfers of health care costs among plan sponsors and participants.

The primary statutory economic benefits associated with the HIPAA nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with certain health status-related factors. Expanding access benefits both newly covered individuals and society at large. Individuals without health insurance are less likely to get preventive care and less likely to have a regular source of care.[15] A lack of health insurance generally increases the likelihood that needed medical treatment will be forgone or delayed. Forgoing or delaying care increases the risk of adverse health outcomes. These adverse outcomes in turn spawn higher medical costs which are often shifted to public funding sources (and therefore to taxpayers) or to other payers. They also erode productivity and the quality of life. Improved access to affordable group health coverage for individuals with health problems under HIPAA's nondiscrimination provisions will lead to more insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. This is especially true for the individuals most affected by HIPAA's nondiscrimination provisions — those with adverse health conditions. Denied insurance, individuals in poorer health are more likely to suffer economic hardship, to forgo badly needed care for financial reasons, and to suffer adverse health outcomes as a result. For them, gaining insurance is more likely to mean gaining economic security, receiving timely, quality care, and living healthier, more productive lives.

Plans and issuers will incur economic costs as a result of the law. These are generally limited to administrative costs, such as those incurred to change plan design and pricing structures and update plan materials.

The premiums and claims costs incurred by group health plans to provide coverage to individuals who were previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. As such, these premiums and claims costs are properly characterized as transfers rather than as new economic costs. These transfers shift the burden of health care costs from one party to another without any direct change in aggregate social welfare. For example, as individuals' insurance status changes from insured through an individual policy to insured though an employment based group health plan, health care costs are transferred from these individuals to their employers. Similarly, as individuals' insurance status changes from uninsured to insured through a group health plan, health care costs are transferred from the individuals and public funding sources to employers.

The HIPAA nondiscrimination statutory transfer is likely to be substantial. Annual per-participant group health plan costs average more than $4,000[16], and it is likely that average costs would be higher for individuals who had faced discrimination due to health status factors. Prior to HIPAA's enactment approximately 106,000 employees were denied employment based coverage because of health factors.[17] A simple assessment suggests that the total cost of coverage for such employees could exceed $400 million. However, this potential statutory transfer is small relative to the overall cost of employment-based health coverage. Group health plans will spend about $431 billion this year to cover approximately 77 million participants and their dependents. Transfers under HIPAA's nondiscrimination provision will represent a very small fraction of one percent of total group health plan expenditures.

3. Costs and Benefits of the Regulation

Prohibiting Discrimination — Many of the provisions of this regulation serve to specify more precisely than the statute

[15] Kaiser Family Foundation and *The NewsHour, "NewsHour*/Kaiser Spotlights Misconceptions About the Medically Uninsured: Survey Examines Difficulties Faced by Those Without Health Coverage," News Release, May 16, 2000.

[16] Gabel, Jon R. *Job-based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*. *Health Affairs*. November / December 1999. Volume 18, Number 6.

[17] February 1997 Current Population Survey, Contingent Worker Supplement.

alone exactly what practices are prohibited by HIPAA as unlawful discrimination in eligibility or employee premium among similarly situated employees. For example, under the regulation eligibility generally may not be restricted based on an individuals' participation in risky activities, confinement to an institution or absence from work on enrollment day due to illness, or status as a late enrollee. The regulation provides that various plan features including waiting periods and eligibility for certain benefits constitute rules for eligibility which may not vary across similarly situated employees based on health status factors. It provides that individuals who were previously denied eligibility based on health status factors (or who failed to enroll in anticipation of such denial) must be given an opportunity to enroll. It provides that plans may not reclassify employees based on health status factors in order to create separate groups of similarly situated employees among which discrimination would be permitted.

All of these provisions have the effect of clarifying and ensuring certain participants' right to freedom from discrimination in eligibility and premium amounts, thereby securing their access to affordable group health plan coverage. The costs and benefits attributable to these provisions resemble those attendant to HIPAA's statutory nondiscrimination provisions. Securing participants' access to affordable group coverage provides economic benefits by reducing uninsurance and thereby improving health outcomes. It entails transfers of costs from the employees whose rights are secured (and/or from other parties who would otherwise pay for their health care) to plan sponsors (or to other plan participants if sponsors pass those costs back evenly to them). And it imposes economic costs in the form of administrative burdens to design and implement necessary plan amendments.

The Departments lack any basis on which to distinguish these benefits, costs, and transfers from those of the statute itself. It is unclear how many plans might be engaging in the discriminatory practices targeted for prohibition by these regulatory provisions. Because these provisions operate largely at the margin of the statutory requirements, it is likely that the effects of these provisions will be far smaller than the similar statutory effects. The Departments are confident, however, that by securing employees' access to affordable coverage at the margin, the regulation, like the statute, will yield benefits in excess of costs.

Clarifying Requirements — Additional economic benefits derive directly from the improved clarity provided by the regulation. The regulation provides clarity through both its provisions and its examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's nondiscrimination provisions, the regulation will reduce uncertainty and costly disputes over these rights and obligations. It will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.[18]

Amending Plans — The regulation is expected to entail some new economic costs, in the form of two new administrative burdens, which are distinguishable from those attributable to the statute. First, it is likely that some of the regulation's nondiscrimination provisions will effectively require some plans to amend their terms and revise plan materials. Second, as noted above, the regulation requires that individuals who were previously denied eligibility based on health status factors (or who failed to enroll in anticipation of such denial) must be given an opportunity to enroll. It also requires that plans notify such individuals of their right of enroll. Providing notices under these requirements will entail new administrative costs.

Plans that, prior to HIPAA's effective date, included provisions since prohibited by HIPAA's nondiscrimination requirements, were effectively required by HIPAA to implement conforming amendments and to revise plan materials accordingly. The costs associated with these actions generally are attributable to the HIPAA statute and not to this regulation. However, it is likely that some of the regulation's nondiscrimination provisions will effectively require some plans to amend their terms and revise their materials. For example, the Departments understand that plans commonly require employees to be actively at work on a designated enrollment day in order to qualify for enrollment. It is possible that some plans failed to interpret HIPAA's statutory provisions to prohibit this practice. Such plans will need to amend their terms and materials to provide that employees will not be denied enrollment solely because they were absent due to a health status factor. Such plans will incur administrative costs.

The Departments have no basis for estimating how many plans might need to implement amendments beyond those implemented in response to the HIPAA's statutory nondiscrimination provisions in order to comply with the regulation's corresponding provisions. They adopted conservative assumptions in order to develop an upper bound estimate of the cost to amend plans and materials to conform with the regulation. They assumed that all plans will require at least some amendment to conform with this regulation.

A large majority of fully insured plans do not have unique eligibility and

---

[18] The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (see for example Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," *Tax Policy and Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84 (June 1994), pp. 622-641; Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, Vol. 79, No. 2 (May 1989); Louise Sheiner, "Health Care Costs, Wages, and Aging," Federal Reserve Board of Governors working paper, April 1999; and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, "Pensions and Wages: An Hedonic Price Theory Approach," *International Economic Review*, Vol. 33 No. 1, Feb. 1992.) The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits, they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. The extent to which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers costs and workers willingness to accept wage offsets is minimized.

employee premium provisions but instead choose from a relatively small menu of standardized products offered by issuers. The Departments accordingly assumed that issuers will amend their standardized group insurance products, passing the associated cost back to the plans that buy them. They estimate that a total of approximately 33,000 group insurance products will be so amended, and that the cost of these amendments will be spread across a universe of approximately 2.6 million fully insured plans. The Departments assumed that small self-insured plans (which generally fall outside state regulation of insurance products) choose from a much larger menu of products and that large self-insured plans each have unique eligibility rules will need to be amended independently. This implies a total of approximately 76,000 self-insured plan configurations requiring amendment.

Assuming that each affected group insurance product and self-insured plan configuration would require 1 hour of professional time billed at $72 per hour to design and implement amendments, the aggregate cost to amend plans would be $8 million.

Separate from the cost to design and implement plan amendments is the cost to revise plan materials to reflect the amendments. The Departments note that the cost to revise plan materials can generally be attributed to legal requirements other than the HIPAA statute or this regulation. It is the policy of the Department of Labor to attribute the cost of revising private-sector group health plan materials to its regulation implementing ERISA's Summary Plan Description requirements. Various state laws compel issuers to provide accurate materials, and the Departments believe that State and local governmental plan sponsors and private plan sponsors routinely update plan materials as a matter of either law or compensation and employment policy.

Notifying Employees of Enrollment Opportunities — In estimating the costs associated with the notification requirements, the Departments separately considered the cost of preparing notices and the cost of distributing them.

Based on a 1993 Robert Wood Johnson Foundation survey of employers, the Departments estimate that 128,000 group health plans excluded individuals on the basis of health status factors prior to HIPAA's enactment and will therefore be required by the regulation to prepare and distribute notices. The Departments assumed that preparing the notice will require one hour of time billed at a $72 hourly rate. The cost to develop notices is therefore estimated to be $9 million.

The Departments assumed that plans will distribute notices to all individuals who are eligible for coverage under the plan. It might be necessary to notify individuals who are currently enrolled because such individuals may have dependents for whom eligibility was denied based on a health status factor or may have failed to enroll dependents because they expected that eligibility would be so denied for them. This assumption probably results in an overestimate of the true cost. Some affected plans may already have notified affected individuals of their right to enroll under HIPAA. Others may have historical records of plan enrollment that are sufficiently detailed to allow for the notification of only specific individuals. Based on the 1997 Robert Wood Johnson Foundation survey, the Departments estimate that a total of 2.3 million employees are eligible for coverage under the 128,000 plans that are required to provide notices. The Departments assumed that distributing each notice costs $0.37 for mailing and materials plus 2 minutes of photocopying and mailing billed at a $15 per hour clerical rate for a total per-notice distribution cost of $0.87. The cost to distribute notices is therefore estimated to be $2 million.

The estimated combined cost to prepare and distribute notices therefore amounts to $11 million. The Departments note that this is a one-time cost which will be incurred concurrent with the regulation's applicability date.

The Department's note that the provision of notices will benefit employees who newly learn of opportunities to enroll themselves or their dependents. The result will be fuller realization of HIPAA's intent and employees' associated rights, as well as improved access to affordable group coverage and reduced rates of uninsurance for affected employees.

4. Summary of Cost Estimates

The cost estimates presented here are compiled in the table below. Upper bound cost estimates attributable to the regulation include $8 million to amend plans and revise documents and $11 million to prepare and distribute notices of enrollment opportunities, or a total of $19 million.

Source of cost	$MM	Explanatory notes
Amending plans and revising materials	$8	Upper bound of new economic cost incurred as plans are amended to comply with the regulation. One-time cost.
Notifying employees of enrollment opportunities	$11	Upper bound of new economic cost to prepare and distribute notices. One-time cost.
Prohibiting discrimination	>$400	Transfer attributable to HIPAA's statutory nondiscriminatory provisions. Transfers attributable to the regulation were not estimated but are expected to be a very small fraction of this amount. Ongoing annual level.

5. Assessment of Likelihood of Adverse Secondary Effects

The Departments considered whether employers might reduce or eliminate health insurance benefits for all employees as a result of this regulation. They believe that this is highly unlikely because the regulation affirms and clarifies plan sponsors' flexibility and because its costs will be very small relative to group health plan expenditures.

The regulation affirms plan sponsors' flexibility to design plans and control plan costs in many ways. It affirms and clarifies plans' flexibility under HIPAA to exclude from coverage or limit coverage for certain conditions or services, to require employees to perform services before coverage becomes effective, and to provide different benefits or charge different premiums for employees in different bona fide employment classes. It also clarifies that more favorable treatment of individuals with adverse health factors is permitted, thereby allowing employers to assist employees and their families dealing with disabilities, medical conditions, or other health factors by extending coverage or lowering premiums.

Both the transfer of health insurance costs and the administrative costs generated by this regulation will be very small relative to total group health plan expenditures. The $19 million economic cost estimate attributed to this regulation amounts to a tiny fraction of one percent of the $431 billion that group health plans will spend this year. Even the more than $400 million transfer of cost attributed to HIPAA's statutory nondiscrimination provisions amount to a very small fraction of one percent of that spending. Plan sponsors wishing to do so generally can pass these costs back to participants with small, across the board changes to employee premiums or benefits.

Statutory Authority

The Department of the Treasury final and temporary rules are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 107, 209, 505, 701–703, 711–713, and 731–734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171–1173, 1181, 1182, and 1191–1194), as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436), section 101(g)(4) of HIPAA, and Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

The Department of HHS interim final rule is 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 by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436).

* * * * *

Adoption of Amendments to the Regulations

Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54 — PENSION EXCISE TAXES

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

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

Par. 2. Section 54.9802–1T is removed.

Par. 3. Section 54.9802–1 is added to read as follows:

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

(a) *Health factors*. (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;
(ii) Medical condition (including both physical and mental illnesses);
(iii) Claims experience;
(iv) Receipt of health care;
(v) Medical history;
(vi) Genetic information;
(vii) Evidence of insurability; or
(viii) Disability.

(2) Evidence of insurability includes —

(i) Conditions arising out of acts of domestic violence; and

(ii) **[Reserved]** For further guidance, see §54.9802–1T(a)(2)(ii).

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) 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 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 (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), 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 bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) **[Reserved]** For further guidance, see §54.9802–1T(b)(1)(ii).

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion*. In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. **[Reserved]**

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) **[Reserved]** For further guidance, see §54.9802–1T(b)(2)(i)(B).

(C) **[Reserved]** For further guidance, see §54.9802–1T(b)(2)(i)(C).

(D) **[Reserved]** For further guidance, see §54.9802–1T(b)(2)(i)(D).

(ii) *Cost-sharing mechanisms and wellness programs*. A group health plan with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that

individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions*. **[Reserved]** For further guidance, see §54.9802–1T(b)(2)(iii).

(3) *Relationship to section 9801(a), (b), and (d)*. **[Reserved]** For further guidance, see §54.9802–1T(b)(3).

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(ii) **[Reserved]** For further guidance, see §54.9802–1T(c)(1)(ii).

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section*. Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited*. **[Reserved]** For further guidance, see §54.9802–1T(c)(2)(ii).

(3) *Exception for bona fide wellness programs*. Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals*. **[Reserved]** For further guidance, see §54.9802–1T(d).

(e) *Nonconfinement and actively-at-work provisions*. **[Reserved]** For further guidance, see §54.9802–1T(e).

(f) *Bona fide wellness programs*. **[Reserved]**

(g) *Benign discrimination permitted*. **[Reserved]** For further guidance, see §54.9802–1T(g).

(h) *No effect on other laws*. **[Reserved]** For further guidance, see §54.9802–1T(h).

(*i*) *Effective dates* — (1) *Final rules apply March 9, 2001*. This section applies March 9, 2001.

(2) *Cross-reference to temporary rules applicable for plan years beginning on or after July 1, 2001*. See §54.9802–1T (*i*)(2), which makes the rules of that section applicable for plan years beginning on or after July 1, 2001.

(3) *Cross-reference to temporary transitional rules for individuals previously denied coverage based on a health factor*. See §54.9802–1T(*i*)(3) for transitional rules that apply with respect to individuals previously denied coverage under a group health plan based on a health factor.

Par. 4. Section 54.9802–1T is added to read as follows:

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

(a) *Health factors*. (1) **[Reserved]** For further guidance, see §54.9802–1(a).

(2) Evidence of insurability includes —

(i) **[Reserved]** For further guidance, see §54.9802–1(a)(2)(i).

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under section 9801(f) a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) **[Reserved]** For further guidance, see §54.9802–1(b)(1)(i).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. **[Reserved]** For further guidance, see §54.9802–1(b)(1)(iii), *Example 1*.

Example 2. (i) *Facts*. Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion*. In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts*. Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion*. In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts*. A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion*. See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not

provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) **[Reserved]** For further guidance, see §54.9802–1(b)(2)(i)(A).

(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 may impose annual, lifetime, or other limits on benefits and 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 bona fide 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 any other provision of the Code, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan applies a $500,000 lifetime limit on all benefits 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 $500,000 of benefits are 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 $2 million lifetime limit on all benefits (and no other lifetime limits) 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 $10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion*. Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion*. See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because the rider excluding benefits for the condition that *C* has is directed at *C* even though it applies by its terms to all participants and beneficiaries under the plan.

Example 4. (i) *Facts*. A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2000 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.

Example 5. (i) *Facts*. A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(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.

Example 6. (i) *Facts*. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts*. Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs*. **[Reserved]** For further guidance, see §54.9802–1(b)(2)(ii).

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

Example 1. (i) *Facts*. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the

injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion*. In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts*. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion*. In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to section 9801(a), (b), and (d)*. (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with section 9801(a), (b), and (d);

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with section 9801(a). There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with section 9801(a), (b), and (d) (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts*. A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion*. In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) **[Reserved]** For further guidance, see §54.9802–1(c)(1)(i).

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section*. **[Reserved]** For further guidance, see §54.9802–1(c)(2)(i).

(ii) *List billing based on a health factor prohibited*. However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

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

Example 1. (i) *Facts*. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual *F* had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion*. See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion*. See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs*. **[Reserved]** For further guidance, see §54.9802–1(c)(3).

(d) *Similarly situated individuals*. The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants*. Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of

similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of beneficiaries with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals*. Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

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

Example 1. (i) *Facts*. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's ususal business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 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 dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent 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 dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 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 3. (i) *Facts*. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts*. An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

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 lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion*. Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule*. Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under para-

graphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples*. The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts*. In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion*. See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because Issuer *N* restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts*. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(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.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion*. In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts*. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion*. In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* — (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as annual, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion*. In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on annual leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts*. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual partici-

pants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion*. In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts*. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts*. Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs*. **[Reserved]**

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

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 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion*. In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts*. An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts*. To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion*. In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts*. Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion*. In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws*. Compliance with this section is not determinative of compliance with any other provision of the Code (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(*i*) *Effective dates* — (1) *Final rules apply March 9, 2001*. **[Reserved]** For further guidance, see §54.9802–1(*i*)(1).

(2) *This section applies for plan years beginning on or after July 1, 2001*. Except as provided in paragraph (*i*)(3) of this section, this section applies for plan years beginning on or after July 1, 2001.

Except as provided in paragraph (*i*)(3) of this section, with respect to efforts to comply with section 9802 before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 9802.

(3) *Transitional rules for individuals previously denied coverage based on a health factor*. This paragraph (*i*)(3) provides rules relating to individuals previously denied coverage under a group health plan based on a health factor of the individual. Paragraph (*i*)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (*i*)(3). Paragraph (*i*)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 9802, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (*i*)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (*i*)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (*i*)(3) if the plan has complied with the transitional rules of this paragraph (*i*)(3).

(i) *Denial of coverage clarified*. For purposes of this paragraph (*i*)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law* — (A) *Opportunity to enroll required*. If a plan has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 9802 or any guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(*1*) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 401(c)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(*2*) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(*i*) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(*ii*) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan cannot charge interest on that amount).

(B) *Relation to preexisting condition rules*. For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (*i*)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples*. The rules of this paragraph (*i*)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Employer *X* maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual *F* was hired by Employer *X* before the effective date of section 9802. Before the effective date of section 9802 for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. *F*'s application to enroll when first hired was denied because *F* could not pass a physical examination. Upon the effective date of section 9802 for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives *F* an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion*. In this *Example 1*, the plan complies with the requirements of this paragraph (*i*)(3)(ii).

Example 2. (i) *Facts*. The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual *G* is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed *G* to enroll for coverage.

(ii) *Conclusion*. In this *Example 2*, beginning on the effective date of section 9802 for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 9802 or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give *G* an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at *G*'s option, either retroactively from January 1, 1998 or prospectively from the date *G*'s request for enrollment is received by the plan. If *G* elects coverage to be effective beginning January 1, 1998, the plan can require *G* to pay employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law* — (A) *Opportunity to enroll required*. If a plan has denied coverage to any individual before the first day of the first plan year beginning on or after

July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 9802 or guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules*. For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date under the plan is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

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

Example. (i) *Facts*. Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 9802 (February 1, 1998).

(ii) *Conclusion*. In this *Example*, because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 9802 (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (*i*)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under section 9801 will have expired before July 1, 2001.)

Robert E. Wenzel,
Deputy Commisioner of Internal Revenue.

Approved August 8, 2000.

Jonathan Talisman,
Acting Assistant Secretary of the Treasury.

For the reasons set forth above, 29 CFR Part 2590 is amended as follows:

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

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

Authority: Secs. 107, 209, 505, 701-703, 711–713, and 731–734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171–1173, 1181–1183, and 1191–1194), as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436), section 101(g)(4) of HIPAA, and Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

2. **Section § 2590.702 is revised to read as follows:**

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors*. (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701–2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in § 2590.701–2;

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes —

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 2590.701–6, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (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 (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), 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 bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion*. In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts*. Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion*. In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts*. Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion*. In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts*. A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion*. In this *Example 4*, the issuer's exclusion of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage 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 or issuer 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 impose annual, lifetime, or other limits on benefits and 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 bona fide 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 any other provision of the Act, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan applies a $500,000 lifetime limit on all benefits 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 $500,000 of benefits are 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 $2 million lifetime limit on all benefits (and no other lifetime limits) 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 $10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion*. Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion*. In this *Example 3*, the issuer violates this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) *Facts*. A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is

applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2000 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.

Example 5. (i) *Facts*. A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(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.

Example 6. (i) *Facts*. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts*. Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs*. A group health plan or group health insurance coverage with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

Example 1. (i) *Facts*. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion*. In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts*. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion*. In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to § 2590.701–3*. (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with § 2590.701–3;

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 2590.701–3. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 2590.701–3 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts*. A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion*. In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group

health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section*. Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited*. However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

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

Example 1. (i) *Facts*. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual *F* had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion*. In this *Example 1*, the issuer does not violate the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion*. In this *Example 2*, the issuer violates this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, the issuer would still violate this paragraph (c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs*. Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals*. The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants*. Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals*. Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

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

Example 1. (i) *Facts*. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's ususal business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 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 dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent 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 dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 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 3. (i) *Facts*. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts*. An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

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 lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion*. Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule*. Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples*. The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts*. In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion*. In this *Example 2*, Issuer *N* violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. This section does not affect any obligation Issuer *M* may have under applicable State law to provide any extension of benefits and does not affect any State law governing coordination of benefits.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts*. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(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.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion*. In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts*. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion*. In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* — (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion*. In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts*. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion*. In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts*. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts*. Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs*. [Reserved.]

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

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 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion*. In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts*. An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per

month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion*. In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts*. To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion*. In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts*. Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion*. In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws*. Compliance with this section is not determinative of compliance with any other provision of the Act (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(*i*) *Applicability dates* — (1) *Paragraphs applicable March 9, 2001*. Paragraphs (a)(1), (a)(2)(i), (b)(1)(i), (b)(1)(iii) *Example 1*, (b)(2)(i)(A), (b)(2)(ii), (c)(1)(i), (c)(2)(i), and (c)(3) of this section and this paragraph (*i*)(1) apply to group health plans and health insurance issuers offering group health insurance coverage March 9, 2001.

(2) *Paragraphs applicable for plan years beginning on or after July 1, 2001*. Except as provided in paragraph (*i*)(3) of this section, the provisions of this section not listed in paragraph (*i*)(1) of this section apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2001. Except as provided in paragraph (*i*)(3) of this section, with respect to efforts to comply with section 702 of the Act before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 702 of the Act.

(3) *Transitional rules for individuals previously denied coverage based on a health factor*. This paragraph (*i*)(3) provides rules relating to individuals previously denied coverage under a group health plan or group health insurance coverage based on a health factor of the individual. Paragraph (*i*)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (*i*)(3). Paragraph (*i*)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 702 of the Act, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (*i*)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified*. For purposes of this paragraph (*i*)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law* — (A) *Opportunity to enroll required*. If a plan or issuer has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 702 of the Act or any guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(*1*) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the

plan described in section 101(g)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(*2*) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(*i*) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(*ii*) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan or issuer is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan or issuer may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan or issuer cannot charge interest on that amount).

(B) *Relation to preexisting condition rules*. For purposes of Part 7 of Subtitle B of Title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (*i*)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples*. The rules of this paragraph (*i*)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Employer *X* maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual F was hired by Employer *X* before the effective date of section 702 of the Act. Before the effective date of section 702 of the Act for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. *F*'s application to enroll when first hired was denied because *F* had diabetes and could not pass a physical examination. Upon the effective date of section 702 of the Act for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives *F* an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion*. In this *Example 1*, the plan complies with the requirements of this paragraph (*i*)(3)(ii).

Example 2. (i) *Facts*. The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual *G* is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed *G* to enroll for coverage.

(ii) *Conclusion*. In this *Example 2*, beginning on the effective date of section 702 of the Act for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 702 of the Act or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give *G* an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at *G*'s option, either retroactively from January 1, 1998 or prospectively from the date *G*'s request for enrollment is received by the plan. If *G* elects coverage to be effective beginning January 1, 1998, the plan can require *G* to pay any required employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law* — (A) *Opportunity to enroll required*. If a plan or issuer has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 702 of the Act or guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules*. For purposes of Part 7 of Subtitle B of Title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

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

Example. (i) *Facts*. Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 702 of the Act (February 1, 1998).

(ii) *Conclusion*. In this *Example*, because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 702 (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (*i*)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under § 2590.701–3 will have expired before July 1, 2001.)

3. The heading, paragraph (a)(1), and the first sentence of paragraph (a)(2) of § 2590.736 of Part 2590 are revised to read as follows:

§ 2590.736 Applicability dates.

(a) *General applicability dates* — (1) *Non-collectively bargained plans.* Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section apply with respect to group

health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than in paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). * * *

* * * * *

Signed in Washington, DC, this 28th day of December, 2000.

Leslie B. Kramerich,
Assistant Secretary, Pension and Welfare Benefits Administration
U.S. Department of Labor.

For the reasons set forth above, 45 CFR Part 146 is amended as follows:

PART 146 [AMENDED] — RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

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

Authority: Secs. 2701 through 2763, 2791 and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 as amended by HIPAA (Public Law104–191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 102(c)(4) of HIPAA.

2. **Section § 146.121 is revised to read as follows:**

§ 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in § 144.103;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in 45 CFR 144.103;

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes —

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 146.117, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (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 (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), 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 bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employ-

er maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion.* In this *Example 4*, the issuer's exclusion of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage 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 or issuer 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 impose annual, lifetime, or other limits on benefits and 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 bona fide 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 any other provision of ERISA, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a $500,000 lifetime limit on all benefits 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 $500,000 of benefits are 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 $2 million lifetime limit on all benefits (and no other lifetime limits) 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 $10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* In this *Example 3*, the issuer violates this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) *Facts.* A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2000 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.

Example 5. (i) *Facts.* A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(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.

Example 6. (i) *Facts.* A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan or group health insurance coverage with a

cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

Example 1. (i) *Facts*. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion*. In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts*. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion*. In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to § 146.111*. (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with § 146.111;

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 146.111. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 146.111 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts*. A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion*. In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section*. Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited*. However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

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

Example 1. (i) *Facts*. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual *F* had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion*. In this *Example 1*, the issuer does not violate the provisions of this paragraph

(c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* In this *Example 2*, the issuer violates this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, the issuer would still violate this paragraph (c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals.* Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

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

Example 1. (i) *Facts.* An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's ususal business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 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 dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent 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 dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 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 3. (i) *Facts.* A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

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 lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion*. Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule*. Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples*. The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts*. In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion*. In this *Example 2*, Issuer *N* violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. This section does not affect any obligation Issuer *M* may have under applicable State law to provide any extension of benefits and does not affect any State law governing coordination of benefits.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion*. In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts*. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(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.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion*. In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts*. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion*. In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* — (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan

or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.* [Reserved.]

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

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 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an

adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example,* the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any other provision of the PHS Act (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(*i*) *Applicability dates* — (1) *Paragraphs applicable March 9, 2001.* Paragraphs (a)(1), (a)(2)(i), (b)(1)(i), (b)(1)(iii) *Example 1*, (b)(2)(i)(A), (b)(2)(ii), (c)(1)(i), (c)(2)(i), and (c)(3) of this section and this paragraph (*i*)(1) apply to group health plans and health insurance issuers offering group health insurance coverage March 9, 2001.

(2) *Paragraphs applicable for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (*i*)(3) or (*i*)(4) of this section, the provisions of this section not listed in paragraph (*i*)(1) of this section apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2001. Except as provided in paragraph (*i*)(3) or (*i*)(4) of this section, with respect to efforts to comply with section 2702 of the PHS Act before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against an issuer or plan that has sought to comply in good faith with section 2702 of the PHS Act.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (*i*)(3) provides rules relating to individuals previously denied coverage under a group health plan or group health insurance coverage based on a health factor of the individual. Paragraph (*i*)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (*i*)(3). Paragraph (*i*)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 2702 of the PHS Act or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 2702 of the PHS Act, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (*i*)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 2702 of the PHS Act or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (*i*)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (*i*)(3) if the issuer or plan has complied with the transitional rules of this paragraph (*i*)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (*i*)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law* — (A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 2702 of the PHS Act or any guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(*1*) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 102(c) (3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(*2*) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(*i*) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(*ii*) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan or issuer is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan or issuer may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan or issuer cannot charge interest on that amount).

(B) *Relation to preexisting condition rules*. For purposes of section 2701 of the PHS Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (*i*)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples*. The rules of this paragraph (*i*)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts*. Employer *X* maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual *F* was hired by Employer *X* before the effective date of section 2702 of the PHS Act. Before the effective date of section 2702 of the PHS Act for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. *F*'s application to enroll when first hired was denied because *F* had diabetes and could not pass a physical examination. Upon the effective date of section 2702 of the PHS Act for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives *F* an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion*. In this *Example 1*, the plan complies with the requirements of this paragraph (*i*)(3)(ii).

Example 2. (i) *Facts*. The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual *G* is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed *G* to enroll for coverage.

(ii) *Conclusion*. In this *Example 2*, beginning on the effective date of section 2702 of the PHS Act for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 2702 of the PHS Act or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give *G* an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at *G*'s option, either retroactively from January 1, 1998 or prospectively from the date *G*'s request for enrollment is received by the plan. If *G* elects coverage to be effective beginning January 1, 1998, the plan can require *G* to pay any required employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law* — (A) *Opportunity to enroll required*. If a plan or issuer has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001, based in part on a health factor and that denial was based on a good faith interpretation of section 2702 of the PHS Act or guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules*. For purposes of section 2701 of the PHS Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

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

Example. (i) *Facts*. Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 2702 of the PHS Act (February 1, 1998).

(ii) *Conclusion*. In this *Example*, because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 2702 of the PHS Act (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (*i*)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under § 146.111 will have expired before July 1, 2001.)

(4) *Special transitional rule for self-funded non-Federal governmental plans exempted under 45 CFR 146.180* — (i) If coverage has been denied to any individual because the sponsor of a self-funded non-Federal governmental plan has elected under § 146.180 to exempt the plan from the requirements of this section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this section, the plan —

(A) Must notify the individual that the plan will be coming into compliance with the requirements of this section, specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this section (as a matter of administrative convenience, the notice may be disseminated to all employees);

(B) Must give the individual an opportunity to enroll that continues for at least 30 days;

(C) Must permit coverage to be effective as of the first day of plan coverage for which an exemption election under § 146.180 (with regard to this section) is no longer in effect (or July 1, 2001, if later, and the plan was acting in accordance with a good faith interpretation of section 2702 of the PHS Act and guidance published by HCFA); and

(D) May not treat the individual as a late enrollee or a special enrollee.

(ii) For purposes of this paragraph (*i*)(4), an individual is considered to have been denied coverage if the individual failed to apply for coverage because, given an exemption election under

§ 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor.

(iii) The rules of this paragraph (*i*)(4) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *D* was hired by a non-Federal governmental employer in June 1996. The employer maintains a self-funded group health plan with a plan year beginning on October 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual may enroll effective October 1 of any plan year if the individual can pass a physical examination. The plan sponsor elected under § 146.180 of this part to exempt the plan from the requirements of this section for the plan year beginning October 1, 1997, and renewed the exemption election for the plan year beginning October 1, 1998. That is, the plan sponsor elected to retain the evidence of good health requirement for late enrollees which, absent an exemption election under § 146.180 of this part, would have been in violation of this section as of October 1, 1997. *D* chose not to enroll for coverage when first hired. In February of 1998, *D* was treated for skin cancer but did not apply for coverage under the plan for the plan year beginning October 1, 1998, because *D* assumed *D* could not meet the evidence of good health requirement. With the plan year beginning October 1, 1999, the plan sponsor chose not to renew its exemption election and brought the plan into compliance with this section. However, the terms of the plan, effective October 1, 1999, were amended to permit enrollment only during the initial 30-day period of employment. The plan no longer permits late enrollment under any circumstances, including with respect to current employees not enrolled in the plan. Therefore, *D* was not given another opportunity to enroll in the plan. There is no evidence to suggest that the plan was acting in bad faith in denying *D* coverage under the plan beginning on the effective date of § 146.121 for the plan (October 1, 1999).

(ii) *Conclusion*. In this *Example 1*, because the plan under § 146.180 was previously excluded from the requirements of § 146.121 and thereafter was acting in accordance with a good faith interpretation of § 146.121 and guidance published by HCFA, the failure of the plan to give *D* an opportunity to enroll effective October 1, 1999 was permissible on that date. However, under the transitional rules of this paragraph (*i*)(4), the plan must give *D* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (Additionally, October 1, 1999 is *D*'s enrollment date under the plan and the period between October 1, 1999 and July 1, 2001 is treated as a waiting period. Furthermore, if the plan sponsor has not elected to exempt the plan from limitations on preexisting condition exclusion periods, any preexisting condition exclusion period must be administered in accordance with § 146.111. Accordingly, any preexisting condition exclusion period permitted under § 146.111 will have expired before July 1, 2001.)

Example 2. (i) *Facts*. Individual *E* was hired by a non-Federal governmental employer in February 1995. The employer maintains a self-funded group health plan with a plan year beginning on September 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual may enroll effective September 1 of any plan year if the individual can pass a physical examination. All enrollees are subject to a 12-month preexisting condition exclusion period. The plan sponsor elected under § 146.180 of this part to exempt the plan from the requirements of this section and § 146.111 (limitations on preexisting condition exclusion periods) for the plan year beginning September 1, 1997, and renews the exemption election for the plan years beginning September 1, 1998, September 1, 1999, and September 1, 2000. *E* chose not to enroll for coverage when first hired. In June of 2001, *E* is diagnosed as having multiple sclerosis (MS). With the plan year beginning September 1, 2001, the plan sponsor chooses to bring the plan into compliance with this section, but renews its exemption election with regard to limitations on preexisting condition exclusion periods. The plan affords *E* an opportunity to enroll, without a physical examination, effective September 1, 2001. *E* is subject to a 12-month preexisting condition exclusion period with respect to any treatment *E* receives that is related to *E*'s MS, without regard to any prior creditable coverage *E* may have. Beginning September 1, 2002, the plan will cover treatment of *E*'s MS.

(ii) *Conclusion*. In this *Example 2*, the plan complies with the requirements of this section. (The plan is not required to comply with the requirements of § 146.111 because the plan continues to be exempted from those requirements in accordance with the plan sponsor's election under § 146.180.)

3. The heading, paragraph (a)(1), and the first sentence of paragraph (a)(2) of § 146.125 are revised to read as follows:

§ 146.125 Applicability dates.

(a) *General applicability dates* — (1) *Non-collectively bargained plans*. Part A of title XXVII of the PHS Act and §§146.101 through 146.119, § 146.143, §146.145, 45 CFR part 150, and this section apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans*. Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part A of Title XXVII of the PHS Act and §§ 146.101 through 146.119, § 146.143, § 146.145, 45 CFR part 150, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). *** * ***

*** * * * ***

Dated June 22, 2000.

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

Approved August 29, 2000.

Donna E. Shalala,
Secretary.

(Filed by the Office of the Federal Register on January 5, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 8, 2001, 66 F.R. 1378)

Part III. Administrative, Procedural, and Miscellaneous

Weighted Average Interest Rate Update

Notice 2001–15

Notice 88–73 provides guidelines for determining the weighted average interest rate and the resulting permissible range of interest rates used to calculate current liability for the purpose of the full funding limitation of § 412(c)(7) of the Internal Revenue Code as amended by the Omnibus Budget Reconciliation Act of 1987 and as further amended by the Uruguay Round Agreements Act, Pub. L. 103–465 (GATT).

The average yield on the 30-year Treasury Constant Maturities for December 2000 is 5.49 percent.

The following rates were determined for the plan years beginning in the month shown below.

Month	Year	Weighted Average	90% to 105% Permissible Range	90% to 110% Permissible Range
January	2001	5.91	5.32 to 6.21	5.32 to 6.50

Drafting Information

The principal author of this notice is Todd Newman of the Employee Plans, Tax Exempt and Government Entities Division. For further information regarding this notice, please call Mr. Newman at (202) 283-9702 (not a toll-free number).

26 CFR 601.202: Closing agreements.

Rev. Proc. 2001–17

TABLE OF CONTENTS

PART I. INTRODUCTION TO EMPLOYEE PLANS COMPLIANCE RESOLUTION SYSTEM

SECTION 1. PURPOSE AND OVERVIEW

.01 *Purpose*. This revenue procedure updates the comprehensive system of correction programs for sponsors of retirement plans that are intended to satisfy the requirements of § 401(a), § 403(a), or § 403(b) of the Internal Revenue Code (the "Code"), but that have not met these requirements for a period of time. This system, the Employee Plans Compliance Resolution System ("EPCRS"), permits plan sponsors to correct these failures and thereby continue to provide their employees with retirement benefits on a tax-favored basis. The components of EPCRS are the Self-Correction Program ("SCP"), the Voluntary Correction Program ("VCP"), and the Audit Closing Agreement Program ("Audit CAP").

.02 *General principles underlying EPCRS*. EPCRS is based on the following general principles:

- Sponsors and other administrators of eligible plans should be encouraged to establish administrative practices and procedures that ensure that these plans are operated properly in accordance with the applicable requirements of the Code.
- Sponsors and other administrators of eligible plans should satisfy the applicable plan document requirements of the Code.
- Plan sponsors and other administrators should make voluntary and timely correction of any plan failures, whether involving discrimination in favor of highly compensated employees, plan operations, the terms of the plan document, or adoption of a plan by an ineligible employer. Timely and efficient correction protects participating employees by providing them with their expected retirement benefits, including favorable tax treatment.
- Voluntary compliance is promoted by providing for limited fees for voluntary corrections approved by the Service, thereby reducing employers' uncertainty regarding their potential tax liability and participants' potential tax liability.
- Fees and sanctions should be graduated in a series of steps so that there is always an incentive to correct promptly.
- Sanctions for plan failures identified on audit should be reasonable in light of the nature, extent, and severity of the violation.
- Administration of EPCRS should be consistent and uniform.
- Taxpayers should be able to rely on the availability of EPCRS in taking corrective actions to maintain the tax-favored status of their plans.

.03 *Overview*. EPCRS includes the following basic elements:

- *Self-correction (SCP)*. A plan sponsor that has established compliance practices and procedures may, at any time, correct insignificant Operational Failures without paying any fee or sanction. In

addition, in the case of a Qualified Plan that is the subject of a favorable determination letter from the Service or in the case of a 403(b) Plan, the plan sponsor generally may correct even significant Operational Failures without payment of any fee or sanction.

- *Voluntary correction with Service approval (VCP)*. A plan sponsor, at any time before audit, may pay a limited fee and receive the Service's approval for correction. Under VCP, there are special procedures for certain submissions involving only Operational Fail ures (Voluntary Correction of Operational Failures ("VCO")), and for certain submissions in which limited Operational Failures are being corrected using standardized corrections (Voluntary Correction of Operational Failures Standardized ("VCS")). VCP also includes a special procedure that applies to 403(b) Plans (Voluntary Correction of Tax-sheltered Annuity Failures ("VCT")), a special procedure for anonymous submissions ("Anonymous Submission Procedure"), a special procedure for group submissions (Voluntary Correction of Group Failures ("VCGroup")), and a special procedure that applies to SEPs (Voluntary Correction of SEP Failures ("VCSEPs")).
- *Correction on audit (Audit CAP)*. If a failure (other than a failure corrected through SCP or VCP) is identified on audit, the plan sponsor may correct the failure and pay a sanction. The sanction imposed will bear a reasonable relationship to the nature, extent and severity of the failure, taking into account the extent to which correction occurred before audit.

SECTION 2. EFFECT OF THIS REVENUE PROCEDURE ON PROGRAMS

.01 *Effect on programs*. This revenue procedure modifies and supersedes Rev. Proc. 2000–16, 2000–6 I.R.B. 518, which was the prior consolidated statement of the correction programs under EPCRS. Many of the modifications have been made in response to public comments, and further changes are expected to be made in the future in response to comments previously received. The modifications to Rev. Proc. 2000–16 that are reflected in this revenue procedure include:

- combining the prior programs that allow voluntary correction with Service approval – previously VCR, Walk-In CAP, and TVC — into a single voluntary correction program, called VCP. VCP includes special procedures for certain Operational Failures (VCO and VCS, the successors to VCR and SVP respectively) and for 403(b) Failures (VCT, the successor to TVC), and also includes other new, special procedures described below.
- renaming the previous APRSC program the Self-Correction Program (SCP).
- broadening the submission procedures under VCP to allow certain organizations, such as master and prototype sponsors or third-party administrators, to receive a compliance statement for correcting failures that affect more than one Plan Sponsor (VCGroup).
- revising the submission procedures under VCP to allow Plan Sponsors to submit a request on an anonymous ("John Doe") basis.
- expanding EPCRS to add new procedures specially designed for small employers that sponsor SEPs, permitting small employers to self-correct insignificant SEP failures and making special accommodation for SEP sponsors under EPCRS to take into account special circumstances affecting them.
- extending the duration of the self-correction period under SCP (the former APRSC) for significant operational compliance failures where the Plan Sponsor accepts a transfer of plan assets or effects a plan merger in connection with a corporate merger, acquisition, or other transaction.
- facilitating correction under SCP, VCP, and Audit CAP of previous Qualification Failures by Plan Sponsors that accept transfers of plan assets or effects plan mergers in connection with corporate transactions.
- permitting correction through retroactive amendment where employees are permitted to begin participation before they are eligible (see Example 22 in Appendix B).
- permitting correction through retroactive amendment under SCP and VCO for failures related to permitting hardship withdrawals, providing benefits based on compensation in excess of the section 401(a)(17) limit, and premature participation by otherwise eligible employees.
- permitting correction for employers that were not eligible to sponsor 401(k) plans at the time they adopted the plans.
- clarifying that the ability to self-correct insignificant failures continues to be available under SCP during a plan examination, whether the failure is identified by the Plan Sponsor or by the Service.
- clarifying the reporting requirements applicable to excess distributions from qualified plans and SEPs.
- clarifying how fees are calculated with respect to multiemployer and multiple employer plans.
- clarifying that a failure not disclosed by the Plan Sponsor, but discovered by the Service during the processing of a determination letter submission is subject to the sanction structure of Audit CAP.
- updating the definition of Favorable Letter to take into account GUST (as defined in section 5.01(4)(d)).

.02 *Future enhancements*. (1) It is expected that the EPCRS revenue procedure will continue to be updated on a periodic basis, including, as noted above, further improvements to EPCRS based on comments previously received. In addition, the Service and Treasury continue to invite further comments on how to improve EPCRS. Comments should be sent to:

Internal Revenue Service
Attention: T:EP:RA:VC
1111 Constitution Avenue NW
Washington, D.C. 20224

(2) The Service and Treasury are considering expanding the procedures under EPCRS and are interested in receiving comments regarding, among other things, appropriate correction procedures for failures arising under Simple IRAs (under § 408(p)). Submissions related to Simple IRAs are currently being accepted by the Service on a provisional basis outside of EPCRS.

(3) It is expected that procedural changes may be made in EPCRS during 2001 in connection with the general reorganization of the Service. For example, the address to which comments, submissions, and other correspondence is sent in connection with EPCRS may be changed. Such procedural changes will be announced if and when they are made.

PART II. PROGRAM EFFECT AND ELIGIBILITY

SECTION 3. EFFECT OF EPCRS; RELIANCE

.01 *Effect of EPCRS on Qualified Plans*. For a Qualified Plan, if the eligibility requirements of section 4 are satisfied and the Plan Sponsor corrects a Qualification Failure in accordance with the applicable requirements of SCP in section 7, VCP in sections 10 and 11, or Audit CAP in section 13, the Service will not treat the Qualified Plan as failing to meet § 401(a). Thus, for example, if the Plan Sponsor corrects the failures in accordance with the requirements of this revenue procedure, the plan will be treated as a qualified plan for purposes of applying § 3121(a)(5) (FICA taxes) and § 3306(b)(5) (FUTA taxes).

.02 *Effect of EPCRS on 403(b) Plans*. (1) *Income taxes*. For a 403(b) Plan, if the applicable eligibility requirements of section 4 are satisfied and the Plan Sponsor corrects a failure in accordance with the applicable requirements of SCP in section 7, VCP in sections 10 and 11, or Audit CAP in section 13, the Service will not pursue income inclusion for affected participants, or liability for income tax withholding, on account of the failure. However, the correction of a failure may result in income tax consequences to participants and beneficiaries (for example, participants may be required to include in gross income distributions of Excess Amounts in the year of distribution).

(2) *Excise and employment taxes*. Excise taxes, FICA taxes, and FUTA taxes (and corresponding withholding obligations), if applicable, that result from a failure are not waived merely because the failure has been corrected.

.03 *Effect of EPCRS on SEPs*. For a SEP, if the eligibility requirements of section 4 are satisfied and the Plan Sponsor corrects a failure to satisfy the requirements of § 408(k) in accordance with the applicable requirements of SCP in section 7 (but only if the corresponding Qualification Failure is an insignificant Operational Failure), VCP in sections 10 and 11, or Audit CAP in section 13, the Service will not treat the SEP as failing to meet § 408(k). Thus, for example, if the Plan Sponsor corrects the failures in accordance with the requirements of this revenue procedure, the SEP will be treated as satisfying § 408(k) for purposes of applying § 3121(a)(5) (FICA taxes) and § 3306(b)(5) (FUTA taxes).

.04 *Compliance Statement*. If a Plan Sponsor or Eligible Organization receives a compliance statement under VCP, the compliance statement is binding upon the Service and the Plan Sponsor or Eligible Organization as provided in section 10.08.

.05 *Other taxes and penalties*. See section 6.07 for rules relating to other taxes and penalties.

.06 *Reliance*. Taxpayers may rely on this revenue procedure, including the relief described in sections 3.01, 3.02, and 3.03.

SECTION 4. PROGRAM ELIGIBILITY

.01 *Programs for Qualified Plans and 403(b) Plans*. (1) *SCP*. Qualified Plans and 403(b) Plans are eligible for SCP. SCP is available only for Operational Failures.

(2) *VCP*. Qualified Plans and 403(b) Plans are eligible for VCP. VCP provides general procedures for correction of all Qualification Failures: Operational, Plan Document, Demographic, and Employer Eligibility.

(3) *Audit CAP*. Audit CAP is available for correction of all failures found on examination that have not been corrected in accordance with SCP or VCP.

.02 *Eligibility for other arrangements*. (1) A SEP that is maintained under a Plan Document is eligible for SCP with respect to insignificant failures and is eligible for VCP (under the special VCSEP procedure). A SEP is also eligible for Audit CAP. For purposes of EPCRS, a failure to satisfy § 408(k) is treated like the corresponding Qualification Failure. A failure to satisfy § 408(k) includes a failure to satisfy the 50%-eligible-employees election requirement of § 408(k)(6)(A)(ii) and a failure to satisfy the 25-employee limit of § 408(k)(6)(B).

(2) The Service may extend EPCRS to other arrangements.

.03 *Effect of examination*. If the plan or Plan Sponsor is Under Examination, VCP is not available. However, while the plan or Plan Sponsor is Under Examination, insignificant Operational Failures can be corrected under SCP and, if correction has been substantially completed before the plan or Plan Sponsor is Under Examination, significant Operational Failures can be corrected under SCP.

.04 *Favorable Letter requirement*. VCO and the provisions of SCP relating to significant Operational Failures (see section 9) are available for a Qualified Plan only if the plan is the subject of a Favorable Letter.

.05 *Established practices and procedures*. In order to be eligible for SCP, the Plan Sponsor or administrator of a plan must have established practices and procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with applicable Code requirements. For example, the plan administrator of a Qualified Plan that may be top-heavy under § 416 may include in its plan operating manual a specific annual step to determine whether the plan is top-heavy and, if so, to ensure that the minimum contribution requirements of the top-heavy rules are satisfied. A plan document alone does not constitute evidence of established procedures. In order for a Plan Sponsor or administrator to use SCP, these established procedures must have been in place and routinely followed, and

an Operational Failure must have occurred through an oversight or mistake in applying them, because of an inadequacy in the procedures, or because the failure relates to Transferred Assets and did not occur after the end of the second plan year that begins after the corporate merger, acquisition, or other similar transaction.

.06 *Correction by plan amendment*. (1) *Availability of correction by plan amendment in VCP general procedures*. A Plan Sponsor may use VCP for a Qualified Plan to correct an Operational Failure by a plan amendment to conform the terms of the plan to the plan's prior operations, provided that the amendment complies with the requirements of § 401(a), including the requirements of §§ 401(a)(4), 410(b), and 411(d)(6).

(2) *Certain correction by plan amendment permitted in SCP and VCO*. A Plan Sponsor may use SCP or VCO for a Qualified Plan to correct an Operational Failure by a plan amendment to conform the terms of the plan to the plan's prior operations only to correct Operational Failures listed in section 2.07 of Appendix B. These failures must be corrected in accordance with the correction methods set forth in section 2.07 of Appendix B. The amendment must comply with the requirements of § 401(a), including the requirements of §§ 401(a)(4), 410(b), and 411(d)(6). SCP and VCO are not otherwise available for a Plan Sponsor to correct an Operational Failure by a plan amendment. Thus, if loans were made to participants, but the plan document did not permit loans to be made to participants, the failure cannot be corrected under SCP or VCO by retroactively amending the plan to provide for the loans. However, if a Plan Sponsor corrects an Operational Failure in accordance with SCP or VCO, it may amend the plan to the extent necessary to reflect the corrective action. For example, if the plan failed to satisfy the average deferral percentage ("ADP") test required under § 401(k)(3) and the Plan Sponsor must make qualified nonelective contributions not already provided for under the plan, the plan may be amended to provide for qualified nonelective contributions. The issuance of a compliance statement does not constitute a determination as to the effect of any plan amendment on the qualification of the plan.

.07 *Submission for a determination letter*. In a case in which correction of a Qualification Failure includes correction of a Plan Document Failure or correction of an Operational Failure by plan amendment, as permitted under section 4.06, other than adoption of an amendment designated by the Service as a model amendment or standardized or prototype plan, the amendment must be submitted to the Service for approval using the appropriate application form (i.e., the Form 5300 series or, if permitted, Form 6406) to ensure that the amendment satisfies applicable qualification requirements.

.08 *Availability of correction of Employer Eligibility Failure*. A Plan Sponsor may use VCP general procedures, VCT, and VCSEP to correct an Employer Eligibility Failure. However, under sections 4.01, 4.02, and 10, SCP, VCO, and VCGroup are not available for a Plan Sponsor to correct an Employer Eligibility Failure.

.09 *Egregious failures*. SCP, VCO, VCGroup, and VCSEP are not available to correct failures that are egregious. For example, if an employer has consistently and improperly covered only highly compensated employees or if a contribution to a defined contribution plan for a highly compensated individual is several times greater than the dollar limit set forth in § 415, the failure would be considered egregious. VCP is available to correct egregious failures; however, these failures are subject to the fees described in sections 12.01(4) and 12.05(6).

.10 *Diversion or misuse of plan assets*. SCP, VCP, and Audit CAP are not available to correct failures relating to the diversion or misuse of plan assets.

PART III. DEFINITIONS, CORRECTION PRINCIPLES, AND RULES OF GENERAL APPLICABILITY

SECTION 5. DEFINITIONS

The following definitions apply for purposes of this revenue procedure:

.01 *Definitions for Qualified Plans*. The definitions in this section 5.01 apply to Qualified Plans.

(1) *Qualified Plan*. The term "Qualified Plan" means a plan intended to satisfy the requirements of § 401(a) or § 403(a).

(2) *Qualification Failure*. The term "Qualification Failure" means any failure that adversely affects the qualification of a plan. There are four types of Qualification Failures: (a) Plan Document Failures, (b) Operational Failures, (c) Demographic Failures, and (d) Employer Eligibility Failures.

(a) *Plan Document Failure*. The term "Plan Document Failure" means a plan provision (or the absence of a plan provision) that, on its face, violates the requirements of § 401(a) or § 403(a). Thus, for example, the failure of a plan to be amended to reflect a new qualification requirement within the plan's applicable remedial amendment period under § 401(b) is a Plan Document Failure. For purposes of this revenue procedure, a Plan Document Failure includes any Qualification Failure that is a violation of the requirements of § 401(a) or § 403(a) and that is not an Operational Failure, Demographic Failure, or Employer Eligibility Failure.

(b) *Operational Failure*. The term "Operational Failure" means a Qualification Failure (other than an Employer Eligibility Failure) that arises solely from the failure to follow plan provisions. A failure to follow the terms of the plan providing for the satisfaction of the requirements of § 401(k) and § 401(m) is considered to be an Operational Failure. A plan does not have an Operational Failure to the extent the plan is permitted to be amended retroactively pursuant to § 401(b) or another statutory provision to reflect the plan's operations. However, if within an applicable remedial amendment period under § 401(b), a plan has been properly amended for statutory or regulatory changes and, on or after the later of the date the amendment is effective or is adopted, the amended provisions are not followed, then the plan is considered to have an Operational Failure.

(c) *Demographic Failure*. The term "Demographic Failure" means a failure to satisfy the requirements of § 401(a)(4), § 401(a)(26), or § 410(b) that is not an Operational Failure or an Employer Eligibility Failure. The correction of a Demographic Failure generally requires a corrective amendment to the plan adding more benefits or increasing existing benefits (cf., § 1.401(a)(4)–11(g)).

(d) *Employer Eligibility Failure*. The term "Employer Eligibility Failure" means the adoption of a cash or deferred arrangement (as defined in regulations under § 401(k)) intended to satisfy the requirements of § 401(k) for one or more years between 1987 and 1996 (inclusive) by an employer that was a tax-exempt organization prohibited from adopting a § 401(k) plan during that period. An Employer Eligibility Failure is not a Plan Document, Operational, or Demographic Failure.

(3) *Excess Amount*. The term "Excess Amount" means (a) an Overpayment, (b) an elective deferral or employee after-tax contribution returned to satisfy § 415, (c) an elective deferral in excess of the limitation of § 402(g) that is distributed, (d) an excess contribution or excess aggregate contribution that is distributed to satisfy § 401(k) or § 401(m), (e) an amount contributed on behalf of an employee that is in excess of the employee's benefit provided under a SEP, (f) an excess contribution that is distributed to satisfy § 408(k)(6)(A)(iii), (g) for SEPs, an elective deferral that is distributed to satisfy the limitation of § 401(a)(17), or (h) any similar amount that is required to be distributed in order to maintain plan qualification.

(4) *Favorable Letter*. The term "Favorable Letter" means, in the case of a Qualified Plan, a current favorable determination letter for an individually designed plan (including a volume submitter plan), a current favorable opinion letter for a Plan Sponsor that has adopted a master or prototype plan, or a current favorable notification letter for a Plan Sponsor that has adopted a regional prototype plan. A plan has a current favorable determination letter, opinion letter, or notification letter if either (a), (b), (c), or (d) below is satisfied:

(a) The plan has a favorable determination letter, opinion letter, or notification letter that considers the Tax Reform Act of 1986 ("TRA '86").

(b) The plan is a governmental plan or non-electing church plan described in Rev. Proc. 99–23, 1991–1 C.B. 920, and has a favorable determination, opinion, or notification letter that considers the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), the Deficit Reduction Act of 1984 ("DEFRA"), and the Retirement Equity Act of 1984 ("REA"), and the § 401(b) remedial amendment period for TRA '86 has not yet expired.

(c) The plan is initially adopted or effective after December 7, 1994, and the Plan Sponsor timely submits an application for a determination letter within the plan's remedial amendment period under § 401(b).

(d) The plan is terminated prior to the expiration of the applicable GUST remedial amendment period under § 401(b) and the plan was amended to reflect the provisions of GUST. (GUST is an acronym for the Uruguay Round Agreements Act (GATT), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Small Business Job Protection Act of 1996 (SBJPA), the Taxpayer Relief Act of 1997 (TRA '97), and the Internal Revenue Service Restructuring and Reform Act of 1998 (RRA '98).)

(e) In the case of a SEP, the term "Favorable Letter" means (i) a valid Model Form 5305–SEP or 5305A–SEP adopted by an employer in accordance with the instructions on the applicable Form, (ii) a current favorable opinion letter for a Plan Sponsor that has adopted a prototype SEP which has been amended in accordance with procedures set forth in Rev. Proc. 94–13, 1994–1 C.B. 566, to take into account any applicable changes in the law since the issuance of the opinion letter, or (iii) in the case of an individually designed SEP, a private letter ruling that has been issued for the SEP.

(5) *Maximum Payment Amount*. The term "Maximum Payment Amount" means a monetary amount that is approximately equal to the tax the Service could collect upon plan disqualification and is the sum for the open taxable years of the:

(a) tax on the trust (Form 1041),

(b) additional income tax resulting from the loss of employer deductions for plan contributions (and any interest or penalties applicable to the Plan Sponsor's return), and

(c) additional income tax resulting from income inclusion for participants in the plan (Form 1040).

(6) *Overpayment*. The term "Overpayment" means a distribution to an employee or beneficiary that exceeds the employee's or beneficiary's benefit under the terms of the plan because of a failure to comply with plan terms that implement § 401(a)(17), § 401(m) (but only with respect to the forfeiture of nonvested matching contributions that are excess aggregate contributions), § 411(a)(3)(G), or § 415. An Overpayment does not include a distribution of any Excess Amount described in section 5.01(3)(b) through (h).

(7) *Plan Sponsor*. The term "Plan Sponsor" means the employer that establishes or maintains a qualified retirement plan for its employees.

(8) *Transferred Assets*. The term "Transferred Assets" means plan assets that were received, in connection with a corporate merger, acquisition or other similar employer transaction, by the plan in a transfer (including a merger or consolidation of plan assets) under § 414(l) from a plan sponsored by an employer that was not a member of the same controlled group as the Plan Sponsor. If a transfer of plan assets related to the same employer transaction is accomplished through several transfers, then the date of the transfer is the date of the first transfer.

.02 *Definitions for 403(b) Plans*. The definitions in this section 5.02 apply to 403(b) Plans.

(1) *403(b) Plan*. The term "403(b) Plan" means a plan or program intended to satisfy the requirements of § 403(b).

(2) *403(b) Failure*. A 403(b) Failure is any Operational, Demographic, or Employer Eligibility Failure as defined below.

(a) *Operational Failure*. The term "Operational Failure" means any of the following:

(i) A failure to satisfy the requirements of § 403(b)(12)(A)(ii) (relating to the availability of salary reduction contributions);

(ii) A failure to satisfy the requirements of § 401(m) (as applied to 403(b) Plans pursuant to § 403(b)(12)(A)(i));

(iii) A failure to satisfy the requirements of § 401(a)(17) (as applied to 403(b) Plans pursuant to § 403(b)(12)(A)(i));

(iv) A failure to satisfy the distribution restrictions of § 403(b)(7) or § 403(b)(11);

(v) A failure to satisfy the incidental death benefit rules of § 403(b)(10);

(vi) A failure to pay minimum required distributions under § 403(b)(10);

(vii) A failure to give employees the right to elect a direct rollover under § 403(b)(10), including the failure to give meaningful notice of such right;

(viii) A failure of the annuity contract or custodial agreement to provide participants with a right to elect a direct rollover under §§ 403(b)(10) and 401(a)(31);

(ix) A failure to satisfy the limit on elective deferrals under § 403(b)(1)(E);

(x) A failure of the annuity contract or custodial agreement to provide the limit on elective deferrals under §§ 403(b)(1)(E) and 401(a)(30);

(xi) A failure involving contributions or allocations of Excess Amounts; or

(xii) Any other failure to satisfy applicable requirements under § 403(b) that (A) results in the loss of § 403(b) status for the plan or the loss of § 403(b) status for one or more custodial account(s) or annuity contract(s) under the plan and (B) is not a Demographic Failure, an Employer Eligibility Failure, or a failure related to the purchase of annuity contracts, or contributions to custodial accounts, on behalf of individuals who are not employees of the employer.

(b) *Demographic Failure*. The term "Demographic Failure" means a failure to satisfy the requirements of § 401(a)(4), § 401(a)(26), or § 410(b) (as applied to 403(b) Plans pursuant to § 403(b)(12)(A)(i)).

(c) *Employer Eligibility Failure*. The term "Employer Eligibility Failure" means any of the following:

(i) The adoption of a plan intended to satisfy the requirements of § 403(b) by an employer that is not a tax-exempt organization described in § 501(c)(3) or a public educational organization described in § 170(b)(1)(A)(ii);

(ii) A failure to satisfy the nontransferability requirement of § 401(g);

(iii) A failure to initially establish or maintain a custodial account as required by § 403(b)(7); or

(iv) A failure to purchase (initially or subsequently) either an annuity contract from an insurance company (unless grandfathered under Rev. Rul. 82–102, 1982–1 C.B. 62) or a custodial account from a regulated investment company utilizing a bank or an approved nonbank trustee/custodian.

(3) *Excess Amount*. The term "Excess Amount" means any contributions or allocations that are in excess of the limits under § 415 or § 403(b)(2)(the exclusion allowance limit) for the year.

(4) *Plan Sponsor*. The term "Plan Sponsor" means the employer that offers a 403(b) Plan to its employees.

(5) *Total Sanction Amount*. The term "Total Sanction Amount" means a monetary amount that is approximately equal to the income tax the Service could collect as a result of the failure.

.03 *Under Examination*. (1) The term "Under Examination" means: (a) a plan that is under an Employee Plans examination (that is, an examination of a Form 5500 series or other Employee Plans examination), or (b) a Plan Sponsor that is under an Exempt Organizations examination (that is, an examination of a Form 990 series or other Exempt Organizations examination).

(2) A plan that is under an Employee Plans examination includes any plan for which the Plan Sponsor, or a representative, has received verbal or written notification from Employee Plans of an impending Employee Plans examination, or of an impending referral for an Employee Plans examination, and also includes any plan that has been under an Employee Plans examination and is now in Appeals or in litigation for issues raised in an Employee Plans examination. A plan is considered to be Under Examination if it is aggregated for purposes of satisfying the nondiscrimination requirements of § 401(a)(4), the minimum participation requirements of § 401(a)(26), the minimum coverage requirements of § 410(b), or the requirements of § 403(b)(12), with a plan(s) that is Under Examination. In addition, a plan is considered to be Under Examination with respect to a failure of a qualification requirement (other than those described in the preceding sentence) if the plan is aggregated with another plan for purposes of satisfying that qualification requirement (for example, § 402(g), § 415, or § 416) and that other plan is Under Examination. For example, assume Plan A has a § 415 failure, Plan A is aggregated with Plan B only for purposes of § 415, and Plan B is Under Examination. In this case, Plan A is considered to be Under Examination with respect to the § 415 failure. However, if Plan A has a failure relating to the spousal consent rules under § 417 or the vesting rules of § 411, Plan A is not considered to be Under Examination with respect to the § 417 or § 411 failure. For purposes of this revenue procedure, the term aggregation does not include consideration of benefits provided by various plans for purposes of the average benefits test set forth in § 410(b)(2).

(3) An Employee Plans examination also includes a case in which a Plan Sponsor has submitted a Form 5310 and the Employee Plans agent notifies the Plan Sponsor, or a representative, of possible Qualification Failures, whether or not the Plan Sponsor is officially notified of an "examination." This would include a case where, for example, a Plan Sponsor has applied for a determination letter on plan termination, and an Employee Plans agent notifies the Plan Sponsor that there are partial termination concerns.

(4) A Plan Sponsor that is under an Exempt Organizations examination includes any Plan Sponsor that has received (or whose representative has received) verbal or written notification from Exempt Organizations of an impending Exempt Organizations examination or of an impending referral for an Exempt Organizations examination and also includes any Plan Sponsor that has been under an Exempt Organizations examination and is now in Appeals or in litigation for issues raised in an Exempt Organizations examination.

.04 *SEP*. The term "SEP" means a plan intended to satisfy the requirements of § 408(k). For purposes of this revenue procedure, the term SEP also includes a salary reduction SEP ("SARSEP") described in § 408(k)(6), when applicable.

SECTION 6. CORRECTION PRINCIPLES AND RULES OF GENERAL APPLICABILITY

.01 *Correction principles; rules of general applicability*. The general correction principles in section 6.02 and rules of general applicability in sections 6.03 through 6.10 apply for purposes of this revenue procedure.

.02 *Correction principles*. Generally, a failure is not corrected unless full correction is made with respect to all participants and beneficiaries, and for all taxable

years (whether or not the taxable year is closed). Even if correction is made for a closed taxable year, the tax liability associated with that year will not be redetermined because of the correction. In the case of a Qualified Plan with an Operational Failure, correction is determined taking into account the terms of the plan at the time of the failure. Correction should be accomplished taking into account the following principles:

(1) *Restoration of benefits*. The correction method should restore the plan to the position it would have been in had the failure not occurred, including restoration of current and former participants and beneficiaries to the benefits and rights they would have had if the failure had not occurred.

(2) *Reasonable and appropriate correction*. The correction should be reasonable and appropriate for the failure. Depending on the nature of the failure, there may be more than one reasonable and appropriate correction for the failure. For Qualified Plans, any correction method permitted under Appendix A or Appendix B is deemed to be a reasonable and appropriate method of correcting the related Qualification Failure. Any correction method permitted under Appendix A applicable to a 403(b) Plan is deemed to be a reasonable and appropriate method of correcting the related 403(b) Failure. Whether any other particular correction method is reasonable and appropriate is determined taking into account the applicable facts and circumstances and the following principles:

(a) The correction method should, to the extent possible, resemble one already provided for in the Code, regulations thereunder, or other guidance of general applicability. For example, for Qualified Plans, the defined contribution plan correction methods set forth in § 1.415–6(b)(6) would be the typical means of correcting a failure under § 415. Likewise, the correction method set forth in § 1.402(g)–1(e)(2) would be the typical means of correcting a failure under § 402(g).

(b) The correction method for failures relating to nondiscrimination should provide benefits for nonhighly compensated employees. For example, for Qualified Plans, the correction method set forth in § 1.401(a)(4)–11(g) (rather than methods making use of the special testing provisions set forth in § 1.401(a)(4)–8 or § 1.401(a)(4)–9) would be the typical means of correcting a failure to satisfy nondiscrimination requirements. Similarly, the correction of a failure to satisfy the requirements of § 401(k)(3), § 401(m)(2), or § 401(m)(9) (relating to nondiscrimination), solely by distributing excess amounts to highly compensated employees would not be the typical means of correcting such a failure.

(c) The correction method should keep plan assets in the plan, except to the extent the Code, regulations, or other guidance of general applicability provide for correction by distribution to participants or beneficiaries or return of assets to the employer or Plan Sponsor. For example, if an excess allocation (not in excess of the § 415 limits) made under a Qualified Plan was made for a participant under a plan (other than a cash or deferred arrangement), the excess should be reallocated to other participants or, depending on the facts and circumstances, used to reduce future employer contributions.

(d) The correction method should not violate another applicable specific requirement of § 401(a) or § 403(b) (for example, § 401(a)(4), § 411(d)(6), or § 403(b)(12), as applicable), or § 408(k) for SEPs. If an additional failure is created as a result of the use of a correction method in this revenue procedure, then that failure also must be corrected in conjunction with the use of that correction method and in accordance with the requirements of this revenue procedure.

(3) *Consistency Requirement*. Generally, where more than one correction method is available to correct a type of Operational Failure for a plan year (or where there are alternative ways to apply a correction method), the correction method (or one of the alternative ways to apply the correction method) should be applied consistently in correcting all Operational Failures of that type for that plan year. Similarly, earnings adjustment methods generally should be applied consistently with respect to corrective contributions or allocations for a particular type of Operational Failure for a plan year.

(4) *Principles regarding corrective allocations and corrective distributions*. The following principles apply where an appropriate correction method includes the use of corrective allocations or corrective distributions:

(a) Corrective allocations under a defined contribution plan should be based upon the terms of the plan and other applicable information at the time of the failure (including the compensation that would have been used under the plan for the period with respect to which a corrective allocation is being made) and should be adjusted for earnings (including losses) and forfeitures that would have been allocated to the participant's account if the failure had not occurred. The corrective allocation need not be adjusted for losses. See section 3 of Appendix B for additional information on calculation of earnings for corrective allocations.

(b) A corrective allocation to a participant's account because of a failure to make a required allocation in a prior limitation year will not be considered an annual addition with respect to the participant for the limitation year in which the correction is made, but will be considered an annual addition for the limitation year to which the corrective allocation relates. However, the normal rules of § 404, regarding deductions, apply.

(c) Corrective allocations should come only from employer contributions (including forfeitures if the plan permits their use to reduce employer contributions).

(d) In the case of a defined benefit plan, a corrective distribution for an individual should be increased to take into account the delayed payment, consistent with the plan's actuarial adjustments.

(5) *Special exceptions to full correction*. In general, a failure must be fully corrected. Although the mere fact that correction is inconvenient or burdensome is not enough to relieve a Plan Sponsor of the need to make full correction, full correction may not be required in certain situations because it is unreasonable or not feasible. Even in these situations, the correction method adopted must be one that does not have significant adverse effects on participants and beneficiaries or the plan, and that does not discriminate significantly in favor of highly compensated employees. The exceptions described below specify those situations in which full correction is not required.

(a) *Reasonable estimates*. If it is not possible to make a precise calculation,

or the probable difference between the approximate and the precise restoration of a participant's benefits is insignificant and the administrative cost of determining precise restoration would significantly exceed the probable difference, reasonable estimates may be used in calculating appropriate correction.

(b) *Delivery of very small benefits*. If the total corrective distribution due a participant or beneficiary is $20 or less, the Plan Sponsor is not required to make the corrective distribution if the reasonable direct costs of processing and delivering the distribution to the participant or beneficiary would exceed the amount of the distribution.

(c) *Locating lost participants*. Reasonable actions must be taken to find all current and former participants and beneficiaries to whom additional benefits are due, but who have not been located after a mailing to the last known address. In general, such actions include use of the Internal Revenue Service Letter Forwarding Program (see Rev. Proc. 94–22, 1994–1 C.B. 608) or the Social Security Administration Reporting Service. A plan will not be considered to have failed to correct a failure due to the inability to locate an individual if either of these programs is used; provided that, if the individual is later located, the additional benefits must be provided to the individual at that time.

(6) *Reporting*. Any distributions from the plan should be properly reported.

.03 *Correction of an Employer Eligibility Failure (only available under VCP general procedures, VCT, and VCSEP)*. (1) The permitted correction of an Employer Eligibility Failure is the cessation of all contributions (including salary reduction and after-tax contributions) beginning no later than the date the application under VCP is filed. Pursuant to VCP correction, the assets in such a plan are to remain in the trust, annuity contract, or custodial account and are to be distributed no earlier than the occurrence of one of the applicable distribution events, e.g., for 403(b) Plans, the events described in § 403(b)(7) (to the extent the assets are held in custodial accounts) or § 403(b)(11) (for those assets invested in annuity contracts that would be subject to § 403(b)(11) restrictions if the employer were eligible). A Plan that is corrected through VCP will be treated as subject to all of the requirements and provisions of § 401(a) for a Qualified Plan, § 403(b) for a 403(b) Plan, and § 408(k) for a SEP (including Code provisions relating to rollovers).

(2) Cessation of contributions is not required if continuation of contributions would not be an Employer Eligibility Failure (for example, a tax-exempt employer may maintain a § 401(k) plan after 1996).

(3) Because a plan with an Employer Eligibility Failure will be treated as subject to all of the applicable Code qualification requirements, the Plan Sponsor must also correct all other failures in accordance with this revenue procedure.

.04 *Correction by plan amendment*. In any case in which correction of a Qualified Plan failure includes correction of a Plan Document Failure or correction of an Operational Failure by plan amendment as permitted under section 4.06, other than adoption of a model amendment or a standardized or prototype plan, the amendment must be submitted to the Service for approval under the appropriate application form (i.e., Form 5300 series or Form 6406) to ensure that the amendment satisfies applicable qualification requirements.

.05 *Special rules relating to Excess Amounts*. (1) *Treatment of Excess Amounts under Qualified Plans*. A distribution of an Excess Amount is not eligible for the favorable tax treatment accorded to distributions from Qualified Plans (such as eligibility for rollover under § 402(c)). To the extent that a current or prior distribution was a distribution of an Excess Amount, distribution of that Excess Amount is not an eligible rollover distribution. Thus, for example, if such a distribution was contributed to an individual retirement arrangement ("IRA"), the contribution is not a valid rollover contribution for purposes of determining the amount of excess contributions (within the meaning of § 4973) to the individual's IRA. A distribution of an Excess Amount is generally treated in the manner described in section 3 of Rev. Proc. 92–93, 1992–2 C.B. 505, relating to the corrective disbursement of elective deferrals. The distribution must be reported on Forms 1099–R for the year of distribution with respect to each participant or beneficiary receiving such a distribution. Where an Excess Amount has been distributed the Plan Sponsor must notify the recipient that (a) the Excess Amount was distributed and (b) the Excess Amount was not eligible for favorable tax treatment accorded to distributions from Qualified Plans (and, specifically, was not eligible for tax-free rollover).

(2) *Treatment of Excess Amounts under 403(b) Plans*. (a) *Distribution of Excess Amounts*. Excess Amounts for a year, adjusted for earnings through the date of distribution, must be distributed to affected participants and beneficiaries and are includible in their gross income in the year of distribution. The distribution of Excess Amounts is not an eligible rollover distribution within the meaning of § 403(b)(8). A distribution of Excess Amounts is generally treated in the manner described in section 3 of Rev. Proc. 92–93, 1992–2 C.B. 505, relating to the corrective disbursement of elective deferrals. The distribution must be reported on Forms 1099–R for the year of distribution with respect to each participant or beneficiary receiving such a distribution. In addition, the Plan Sponsor must inform affected participants and beneficiaries that the distribution of Excess Amounts is not eligible for rollover. Excess Amounts distributed pursuant to this subparagraph (2)(a) are not treated as amounts previously excludable under § 403(b)(2)(A)(ii) for purposes of calculating the maximum exclusion allowance for the taxable year of the distribution and for subsequent taxable years.

(b) *Retention of Excess Amounts*. Under VCT and Audit CAP, Excess Amounts will be treated as corrected (even though the Excess Amounts are retained in the 403(b) Plan) if the following requirements are satisfied. Excess Amounts arising from a § 415 failure, adjusted for earnings through the date of correction, must reduce affected participants' applicable § 415 limit for the year following the year of correction (or for the year of correction if the Plan Sponsor so chooses), and subsequent years, until the excess is eliminated. Excess Amounts (whether arising from a § 415 failure or a § 403(b)(2) failure), adjusted for earnings

through the date of correction, must also reduce participants' exclusion allowances by being treated as amounts previously excludable under § 403(b)(2)(A)(ii) beginning with the year following the year of correction (or the year of correction if the Plan Sponsor so chooses). If this correction method is used, it must generally be used for all participants who have Excess Amounts.

.06 *Correction under statute or regulations*. Generally, none of the correction programs are available to correct failures that can be corrected under the Code and related regulations. For example, as a general rule, a Plan Document Failure that is a disqualifying provision for which the remedial amendment period under § 401(b) has not expired can be corrected by operation of the Code through retroactive remedial amendment.

.07 *Matters subject to excise taxes*. (1) Except as provided in paragraph (3) of this subsection, excise taxes and additional taxes, to the extent applicable, are not waived merely because the underlying failure has been corrected or because the taxes result from the correction. Thus, for example, the excise tax on certain excess contributions under § 4979 is not waived under these correction programs.

(2) Except as provided in paragraph (3) of this section, the correction programs are not available for events for which the Code provides tax consequences other than plan disqualification (such as the imposition of an excise tax or additional income tax). For example, funding deficiencies (failures to make the required contributions to a plan subject to § 412), prohibited transactions, and failures to file the Form 5500 cannot be corrected under the correction programs. However, if the event is also an Operational Failure (for example, if the terms of the plan document relating to plan loans to participants were not followed and loans made under the plan did not satisfy § 72(p)(2)), the correction programs will be available to correct the Operational Failure, even though the excise or income taxes generally still will apply.

(3) As part of VCP, if the failure involves the failure to satisfy the minimum required distribution requirements of § 401(a)(9), in appropriate cases, the Service will waive the excise tax under § 4974 applicable to plan participants. The waiver will be included in the compliance statement. The Plan Sponsor, as part of the submission, must request the waiver and in cases where the participant subject to the excise tax is an owner-employee, as defined in § 401(c)(3), or a 10 percent owner of a corporation, the Plan Sponsor must also provide an explanation supporting the request.

.08 *Correction for SEPs*. (1) *Correction for SEPs generally*. Generally, the correction for a SEP is expected to be similar to the correction required for a Qualified Plan with a similar Qualification Failure.

(2) *Special correction for SEPs*. Under VCSEP, in any case in which correction under section 6.08(1) is not feasible for a SEP or in any other case determined by the Service in its discretion (including failures relating to §§ 402(g), 415, and 401(a)(17), failures relating to deferral percentages, discontinuance of contributions to a SARSEP, and retention of overcontributions for cases in which there has been no violation of a statutory limitation), the Service may provide for a different correction. See section 12.07 for a special fee that may apply in such a case.

(3) *Correction of failure to satisfy deferral percentage test*. If the failure involves a violation of the deferral percentage test under § 408(k)(6)(A)(iii) applicable to a SARSEP, there are several methods to correct the failure, similar to the methods used in VCS and VCO. This failure may be corrected in one of the following ways:

(a) The Plan Sponsor may make contributions that are 100% vested to all eligible nonhighly compensated employees (to the extent permitted by § 415) necessary to raise the deferral percentage needed to pass the test. This amount may be calculated as either the same percentage of compensation or the same flat dollar amount (regardless of the terms of the SEP).

(b) The Plan Sponsor may effect distribution of excess contributions, adjusted for earnings through the date of correction, to highly compensated employees to correct the failure. The Plan Sponsor must also contribute to the SEP an amount equal to the total amount distributed. This amount must be allocated to (i) current employees who were nonhighly compensated employees in the year of the failure, (ii) current nonhighly compensated employees who were nonhighly compensated employees in the year of the failure, or (iii) employees (both current and former) who were nonhighly compensated employees in the year of the failure.

(4) *Treatment of undercontributions to a SEP*. (a) *Make-up contributions; earnings*. The Plan Sponsor should correct undercontributions to a SEP by contributing make-up amounts that are fully vested, adjusted for earnings credited from the date of the failure to the date of correction.

(b) *Earnings adjustment methods*. (i) The earnings rate generally is based on the investment results that would have applied to the corrective contribution if the failure had not occurred.

(ii) Insofar as SEP assets are held in IRAs, there is no earnings rate under the SEP as a whole. If the Plan Sponsor is unable to determine what the actual investment results would have been, a reasonable interest rate may be used.

.09 *Confidentiality and disclosure*. Because each correction program relates directly to the enforcement of the Code qualification requirements, the information received or generated by the Service under the program is subject to the confidentiality requirements of § 6103 and is not a written determination within the meaning of § 6110.

.10 *No effect on other law*. Correction under these programs has no effect on the rights of any party under any other law, including Title I of the Employee Retirement Income Security Act of 1974 ("ERISA").

PART IV. SELF-CORRECTION (SCP)

SECTION 7. IN GENERAL

The requirements of this section 7 are satisfied with respect to an Operational Failure if the Plan Sponsor of a Qualified Plan, a 403(b) Plan, or a SEP satisfies the requirements of section 8 (relating to insignificant Operational Failures) or, in the case of a Qualified Plan or a 403(b) Plan, section 9 (relating to significant Operational Failures).

SECTION 8. SELF-CORRECTION OF INSIGNIFICANT OPERATIONAL FAILURES

.01 *Requirements*. The requirements of this section 8 are satisfied with respect to an Operational Failure if the Operational Failure is corrected and, given all the facts and circumstances, the Operational Failure is insignificant. This section 8 is available for correcting an insignificant Operational Failure even if the plan or Plan Sponsor is Under Examination and even if the Operational Failure is discovered by an agent on examination.

.02 *Factors*. The factors to be considered in determining whether or not an Operational Failure under a plan is insignificant include, but are not limited to: (1) whether other failures occurred during the period being examined (for this purpose, a failure is not considered to have occurred more than once merely because more than one participant is affected by the failure); (2) the percentage of plan assets and contributions involved in the failure; (3) the number of years the failure occurred; (4) the number of participants affected relative to the total number of participants in the plan; (5) the number of participants affected as a result of the failure relative to the number of participants who could have been affected by the failure; (6) whether correction was made within a reasonable time after discovery of the failure; and (7) the reason for the failure (for example, data errors such as errors in the transcription of data, the transposition of numbers, or minor arithmetic errors). No single factor is determinative. Additionally, factors (2), (4), and (5) should not be interpreted to exclude small businesses.

.03 *Multiple failures*. In the case of a plan with more than one Operational Failure in a single year, or Operational Failures that occur in more than one year, the Operational Failures are eligible for correction under this section 8 only if all of the Operational Failures are insignificant in the aggregate. Operational Failures that have been corrected under SCP in section 9 and VCP in sections 10 and 11 are not taken into account for purposes of determining if Operational Failures are insignificant in the aggregate.

.04 *Examples*. The following examples illustrate the application of this section 8. It is assumed, in each example, that the eligibility requirements of section 4 relating to SCP have been satisfied and that no Operational Failures occurred other than the Operational Failures identified below.

Example 1: In 1984, Employer X established Plan A, a profit-sharing plan that satisfies the requirements of § 401(a) in form. In 1999, the benefits of 50 of the 250 participants in Plan A were limited by § 415(c). However, when the Service examined Plan A in 2002, it discovered that, during the 1999 limitation year, the annual additions allocated to the accounts of 3 of these employees exceeded the maximum limitations under § 415(c). Employer X contributed $3,500,000 to the plan for the plan year. The amount of the excesses totaled $4,550. Under these facts, because the number of participants affected by the failure relative to the total number of participants who could have been affected by the failure, and the monetary amount of the failure relative to the total employer contribution to the plan for the 1999 plan year, are insignificant, the § 415(c) failure in Plan A that occurred in 1999 would be eligible for correction under this section 8.

Example 2: The facts are the same as in *Example* 1, except that the failure to satisfy § 415 occurred during each of the 1998, 1999, and 2000 limitation years. In addition, the three participants affected by the § 415 failure were not identical each year. The fact that the § 415 failures occurred during more than one limitation year did not cause the failures to be significant; accordingly, the failures are still eligible for correction under this section 8.

Example 3: The facts are the same as in *Example* 1, except that the annual additions of 18 of the 50 employees whose benefits were limited by § 415(c) nevertheless exceeded the maximum limitations under § 415(c) during the 1999 limitation year, and the amount of the excesses ranged from $1,000 to $9,000, and totaled $150,000. Under these facts, taking into account the number of participants affected by the failure relative to the total number of participants who could have been affected by the failure for the 1999 limitation year (and the monetary amount of the failure relative to the total employer contribution), the failure is significant. Accordingly, the § 415(c) failure in Plan A that occurred in 1999 is ineligible for correction under this section 8 as an insignificant failure.

Example 4: Employer J maintains Plan C, a money purchase pension plan established in 1992. The plan document satisfies the requirements of § 401(a) of the Code. The formula under the plan provides for an employer contribution equal to 10% of compensation, as defined in the plan. During its examination of the plan for the 1999 plan year, the Service discovered that the employee responsible for entering data into the employer's computer made minor arithmetic errors in transcribing the compensation data with respect to 6 of the plan's 40 participants, resulting in excess allocations to those 6 participants' accounts. Under these facts, the number of participants affected by the failure relative to the number of participants that could have been affected is insignificant, and the failure is due to minor data errors. Thus, the failure occurring in 1999 would be insignificant and therefore eligible for correction under this section 8.

Example 5: Public School maintains for its 200 employees a salary reduction 403(b) Plan (the "Plan") that satisfies the requirements of § 403(b). The business manager has primary responsibility for administering the Plan, in addition to other administrative functions within Public School. During the 1998 plan year, a former employee should have received an additional minimum required distribution of $278 under § 403(b)(10). Another participant received an impermissible hardship withdrawal of $2,500. Another participant made elective deferrals of $11,000, $1,000 of which was in excess of the § 402(g) limit. Under these facts, even though multiple failures occurred in a single plan year, the failures will be eligible for correction under this section 8 because in the aggregate the failures are insignificant.

SECTION 9. SELF-CORRECTION OF SIGNIFICANT OPERATIONAL FAILURES

.01 *Requirements*. The requirements of this section 9 are satisfied with respect to an Operational Failure (even if significant) if the Operational Failure is corrected and the correction is either completed or substantially completed (in accordance with section 9.04) by the last day of the correction period described in section 9.02.

.02 *Correction period*. (1) *End of correction period*. The last day of the correction period for an Operational Failure is the last day of the second plan year following the plan year for which the failure occurred. However, in the case of a failure to satisfy the requirements of § 401(k)(3), 401(m)(2), or 401(m)(9), the correction period does not end until the last day of the second plan year following the plan year that includes the last day of the additional period for correction permitted under § 401(k)(8) or 401(m)(6). If a 403(b) Plan does not have a plan year, the plan year is deemed to be the calendar year for purposes of this subsection.

(2) *Extension of correction period for Transferred Assets*. In the case of an Operational Failure that relates only to Transferred Assets, the correction period does not end until the last day of the first plan year that begins after the corporate merger, acquisition, or other similar employer transaction between the Plan Sponsor and the sponsor of the transferor plan.

(3) *Effect of examination*. The correction period for an Operational Failure that occurs for any plan year ends, in any event, on the first date the plan or Plan Sponsor is Under Examination for that plan year (determined without regard to

the second sentence of section 9.02). (But see section 9.04 for special rules permitting completion of correction after the end of the correction period.)

.03 *Correction by plan amendment*. In order to complete correction by plan amendment (as permitted under section 4.06) during the correction period, the appropriate application (i.e., the Form 5300 series or Form 6406) must be submitted before the end of the correction period.

.04 *Substantial completion of correction*. Correction of an Operational Failure is substantially completed by the last day of the correction period only if the requirements of either paragraph (1) or (2) are satisfied.

(1) The requirements of this paragraph (1) are satisfied if:

(a) during the correction period, the Plan Sponsor is reasonably prompt in identifying the Operational Failure, formulating a correction method, and initiating correction in a manner that demonstrates a commitment to completing correction of the Operational Failure as expeditiously as practicable, and

(b) within 90 days after the last day of the correction period, the Plan Sponsor completes correction of the Operational Failure.

(2) The requirements of this paragraph (2) are satisfied if:

(a) during the correction period, correction is completed with respect to 85 percent of all participants affected by the Operational Failure, and

(b) thereafter, the Plan Sponsor completes correction of the Operational Failure with respect to the remaining affected participants in a diligent manner.

.05 *Examples*. The following examples illustrate the application of this section 9. Assume that the eligibility requirements of section 4 relating to SCP have been met.

Example 1: Employer Z established a qualified defined contribution plan in 1986 and received a favorable determination letter for TRA '86. During 1999, while doing a self-audit of the operation of the plan for the 1998 plan year, the plan administrator discovered that, despite the practices and procedures established by Employer Z with respect to the plan, several employees eligible to participate in the plan were excluded from participation. The administrator also found that for 1998 Operational Failures occurred because the elective deferrals of additional employees exceeded the § 402(g) limit and Employer Z failed to make the required top-heavy minimum contribution. During the 1999 plan year, the Plan Sponsor made corrective contributions on behalf of the excluded employees, distributed the excess deferrals to the affected participants, and made a top-heavy minimum contribution to all participants entitled to that contribution for the 1999 plan year. Each corrective contribution and distribution was credited with earnings at a rate appropriate for the plan from the date the corrective contribution or distribution should have been made to the date of correction. Under these facts, the Plan Sponsor has corrected the Operational Failures for the 1998 plan year within the correction period and thus satisfied the requirements of this section 9.

Example 2: Employer A established a qualified defined contribution plan, Plan A, in 1990 and received a favorable determination letter for TRA '86. In April 2002, Employer A purchased all of the stock of Employer B, a wholly-owned subsidiary of Employer C. Employees of Employer B participated in a qualified defined contribution plan sponsored by Employer C, Plan C. Following Employer A's review of Plan C, Employer A and Employer C agreed that Plan A would accept a transfer of plan assets attributable to the account balances of the employees of Employer B who had participated in Plan C. As part of this agreement, Employer C represented to Employer A that Plan C is tax qualified. Employers A and C also agreed that such transfer would be in accordance with § 414(l) and § 1.414(l)–1 and addressed issues related to costs associated with the transfer. Following the transaction, the employees of Employer B began participation in Plan A. Effective July 1, 2002, Plan A accepted the transfer of plan assets from Plan C. After the transfer, Employer A determined that all the participants in one division of Employer B had been incorrectly excluded from allocation of the profit sharing contributions for the 1998 and 1999 plan years. During 2003, Employer A made corrective contributions on behalf of the affected participants. The corrective contributions were credited with earnings at a rate appropriate for the plan from the date the corrective contribution should have been made to the date of correction and Employer A otherwise complied with the requirements of SCP. Under these facts, Employer A has, within the correction period, corrected the Operational Failures for the 1998 and 1999 plan years with respect to the assets transferred to Plan A, and thus satisfied the requirements of this section 9.

PART V. VOLUNTARY CORRECTION PROGRAM WITH SERVICE APPROVAL (VCP)

SECTION 10. VCP GENERAL PROCEDURES

.01 *VCP requirements*. The requirements of this section 10 are satisfied with respect to failures submitted in accordance with the requirements of this section 10 if the Plan Sponsor pays the compliance fee required under section 12 and implements the corrective actions and satisfies any other conditions in the compliance statement described in section 10.07.

.02 *Identification of failures*. VCP is not based upon an examination of the plan by the Service. Only the failures raised by the Plan Sponsor or failures identified by the Service in processing the application will be addressed under the program, and only those failures will be covered by the program. The Service will not make any investigation or finding under VCP concerning whether there are failures.

.03 *Effect of VCP submission on examination*. Because VCP does not arise out of an examination, consideration under VCP does not preclude or impede (under § 7605(b) or any administrative provisions adopted by the Service) a subsequent examination of the Plan Sponsor or the plan by the Service with respect to the taxable year (or years) involved with respect to matters that are outside the compliance statement. However, a Plan Sponsor's statements describing failures are made only for purposes of VCP and will not be regarded by the Service as an admission of a failure for purposes of any subsequent examination.

.04 *No concurrent examination activity*. Except in unusual circumstances, a plan that has been properly submitted under VCP will not be examined while the submission is pending. This practice regarding concurrent examinations does not extend to other plans of the Plan Sponsor. Thus, any plan of the Plan Sponsor that is not pending under VCP could be subject to examination.

.05 *Submission of determination letter application for plan amendments*. In any case in which correction of a Qualified Plan failure includes correction of a Plan Document Failure or correction of an Operational Failure by plan amendment as permitted under section 4.06, other than adoption of an amendment designated by the Service as a model amendment or a standardized or prototype plan, the Plan Sponsor should submit a copy of the amendment, the appropriate application form (i.e., Form 5300 series or Form 6406), and the appropriate user fee concurrently and to the same address as the VCP submission.

.06 *Processing of submission*. (1) *Screening of submission*. Upon receipt of a submission under VCP, the Service will review whether the eligibility requirements of section 4 and the submission requirements of section 11 are satisfied.

If the Service determines that a VCP submission is seriously deficient, the Service reserves the right to return the submission, including any compliance fee, without contacting the Plan Sponsor.

(2) *Review of submission.* Once the Service determines that the submission is complete under VCP, the Service will consult with the Plan Sponsor or the Plan Sponsor's representative to discuss the proposed corrections and the plan's administrative procedures.

(3) *Additional information required.* If additional information is required, a Service representative will generally contact the Plan Sponsor or the Plan Sponsor's representative and explain what is needed to complete the submission. The Plan Sponsor will have 21 calendar days from the date of this contact to provide the requested information. If the information is not received within 21 days, the matter will be closed, the compliance fee will not be returned, and the case may be referred to Employee Plans Examinations. Any request for an extension of the 21-day time period must be made in writing within the 21-day time period and must be approved by the Service (by the applicable group manager).

(4) *Additional failures discovered after initial submission.* (a) A Plan Sponsor that discovers additional, unrelated failures after its initial submission may request that such failures be added to its submission. However, the Service retains the discretion to reject the inclusion of such failures if the request is not timely, for example, if the Plan Sponsor makes its request when processing of the submission is substantially complete.

(b) If the Service discovers an unrelated failure while the request is pending, the failure generally will be added to the failures under consideration. However, the Service retains the discretion to determine that a failure is outside the scope of the voluntary request for consideration because it was not voluntarily brought forward by the Plan Sponsor. In this case, if the additional failure is significant, all aspects of the plan may be examined and the rules pertaining to Audit CAP will apply. (See sections 13 and 14.)

(5) *Conference right.* If the Service initially determines that it cannot issue a compliance statement because the parties cannot agree upon correction or a change in administrative procedures, the Plan Sponsor (generally through the Plan Sponsor's representative) will be contacted by the Service representative and offered a conference with the Service. The conference can be held either in person or by telephone, and must be held within 21 calendar days of the date of contact. The Plan Sponsor will have 21 calendar days after the date of the conference to submit additional information in support of the submission. Any request for an extension of the 21-day time period must be made in writing within the 21-day time period and must be approved by the Service (by the applicable group manager). Additional conferences may be held at the discretion of the Service.

(6) *Failure to reach resolution.* If the Service and the Plan Sponsor cannot reach agreement with respect to the submission, all aspects of the plan may be examined, and the Service may refer the submission to Employee Plans Examinations.

(7) *Issuance of compliance statement.* If agreement is reached, the Service will send to the Plan Sponsor an unsigned compliance statement specifying the corrective action required. Within 30 calendar days of the date the compliance statement is sent, a Plan Sponsor must sign the compliance statement and return it and any compliance fee required to be paid at the time that the compliance statement is signed (see sections 11.05 and 11.06 regarding timing of payment of compliance fee). The Service will then issue a signed copy of the compliance statement to the Plan Sponsor. If the Plan Sponsor does not send the Service the signed compliance statement (with the compliance fee) within 30 calendar days, the plan may be referred to Employee Plans Examinations for examination consideration.

(8) *Timing of correction.* The Plan Sponsor must implement the specific corrections and administrative changes set forth in the compliance statement within 150 days of the date of the compliance statement. Any request for an extension of this time period must be made in advance and in writing and must be approved by the Service.

(9) *Modification of compliance statement.* Once the compliance statement has been issued (based on the information provided), the Plan Sponsor cannot request a modification of the compliance terms except by a new request for a compliance statement. However, if the requested modification is minor and is postmarked no later than 30 days after the compliance statement is issued, the compliance fee for the modification will be the lesser of the original compliance fee or $1,250.

(10) *Verification.* Once the compliance statement has been issued, the Service may require verification that the corrections have been made and that any plan administrative procedures required by the statement have been implemented. This verification does not constitute an examination of the books and records of the employer or the plan (within the meaning of § 7605(b)). If the Service determines that the Plan Sponsor did not implement the corrections and procedures within the stated time period, the plan may be referred to Employee Plans Examinations for examination consideration.

.07 *Compliance statement.* (1) *General description of compliance statement.* The compliance statement issued for a VCP submission addresses the failures identified, the terms of correction, including any revision of administrative procedures, and the time period within which proposed corrections must be implemented, including any changes in administrative procedures. The compliance statement also provides that the Service will not treat the plan as failing to satisfy the applicable requirements of the Code on account of the failures described in the compliance statement if the conditions of the compliance statement are satisfied. Where current procedures are inadequate for operating the plan in conformance with the applicable requirements of the Code, the compliance statement will be conditioned upon the implementation of stated administrative procedures. The Service may prescribe appropriate administrative procedures in the compliance statement.

(2) *Compliance statement conditioned upon timely correction.* The compliance statement is conditioned on (i) there being no misstatement or omission of material facts in connection with the submission and (ii) the implementation of the specific corrections and satisfaction of

any other conditions in the compliance statement.

(3) *Authority delegated*. Compliance statements (including any waiver of the excise tax under § 4974) are authorized to be signed by Area Managers reporting to the Director, Employee Plans Examinations, and managers within Employee Plans Rulings and Agreements, under the Tax Exempt and Government Entities Division of the Service.

.08 *Effect of compliance statement on examination*. The compliance statement is binding upon both the Service and the Plan Sponsor or Eligible Organization with respect to the specific tax matters identified therein for the periods specified, but does not preclude or impede an examination of the plan by the Service relating to matters outside the compliance statement, even with respect to the same taxable year or years to which the compliance statement relates.

.09 *Processing of determination letter applications not submitted under VCP*. (1) The Service may process a determination letter application submitted under the determination letter program (including an application requested on Form 5310) concurrently with a VCP submission for the same plan. However, issuance of the determination letter in response to an application made on a Form 5310 will be suspended pending the closure of the VCP submission.

(2) A submission of a plan under the determination letter program does not constitute a submission under VCP. Thus, a Plan Sponsor that discovers a Qualification Failure in its plan must make a separate application under VCP. If the failure is discovered by the Service in connection with a determination letter application, the agent may issue a closing agreement with respect to the failures identified or, if appropriate, refer the case to Employee Plans Examinations. In either case, the fee structure in section 12, applicable to VCP, will not apply. Instead, the fee structure in section 14 relating to Audit CAP will apply. (See sections 13 and 14.)

.10 *Special rules relating to VCO*. (1) Under VCP, Operational Failures in a Qualified Plan may be corrected under the VCO rules in this subsection. VCO is available only if the plan's identified failures are all Operational Failures and only if the plan has a Favorable Letter.

(2) If the plan is not the subject of a Favorable Letter, or if the submission either includes a failure other than an Operational Failure or includes an egregious failure described in section 4.09, the submission will be converted from a submission under VCO to a submission under the VCP general procedures. The compliance fee will be retained and will be applied to the compliance fee required under the VCP general procedures. The Service retains the discretion to determine whether a submission is outside the scope of the special VCO rules even if the identified failures are Operational Failures and the plan has a Favorable Letter. The discretion will be applied only in rare and unusual circumstances.

(3) Reliance on any compliance statement issued for a plan initially adopted or effective after December 7, 1994, other than an adoption of a master or prototype or regional prototype plan, is conditioned upon the plan being timely submitted for a determination letter within the plan's remedial amendment period under § 401(b).

.11 *Special rules relating to VCS*. (1) Under VCO, certain Operational Failures in a Qualified Plan may be corrected under the VCS rules in this subsection. VCS is available only if the plan's only identified Operational Failures are failures addressed in Appendix A or Appendix B of this revenue procedure and the failures are corrected in accordance with an applicable correction method set forth in Appendix A or Appendix B. Appropriate correction must be made for any Qualification Failure that results from the application of a VCS correction.

(2) The correction methods set forth in Appendix A and Appendix B are strictly construed and are the only acceptable correction methods for failures corrected under VCS. If the Plan Sponsor wishes to modify a correction method provided in Appendix A or Appendix B or to propose another method, the Plan Sponsor may not use VCS, but may request a compliance statement under the VCO procedure.

(3) VCS is not available if the Plan Sponsor has identified more than two failures in a single VCS request. If there are one or two failures that can be corrected under VCS and there are other failures that cannot be corrected under VCS, VCS is not available. The Service reserves the right to shift requests for consideration under VCS into VCO if the Plan Sponsor submits a second VCS request with respect to the same plan while the first VCS request is being considered or during the 12 months after the first VCS compliance statement is issued. Both VCS requests may be shifted into VCO if the first VCS request is still being considered.

(4) The Service will review a VCS request within 120 days of the date the submission is received and determined to be complete. If the Service determines that the request is acceptable, the Service will issue a compliance statement on the Plan Sponsor's proposed correction.

.12 *Special rules relating to Anonymous (John Doe) Submission Procedure*. (1) The Service has established an Anonymous Submission Procedure that permits submission of a Qualified or 403(b) Plan under VCP without initially identifying the plan or the Plan Sponsor. Only failures other than those addressed in Appendix A and Appendix B may be submitted under this procedure. A plan is not eligible for the Anonymous Submission Procedure with respect to a failure that was submitted under the Anonymous Submission Procedure within the preceding two years. The requirements of this revenue procedure relating to VCP, including sections 10, 11, and 12, apply to these submissions. However, information identifying the plan or the Plan Sponsor may be redacted. Once the Service and the plan representative reach agreement with respect to the submission, the Service will contact the plan representative in writing indicating the terms of the agreement. The Plan Sponsor will have 21 calendar days from the date of the letter of agreement to identify the plan and Plan Sponsor. If the Plan Sponsor does not submit the identifying material within 21 calendar days of the letter of agreement, the matter will be closed and the compliance fee will not be returned.

(2) Notwithstanding section 10.04, until the plan and Plan Sponsor are identi-

fied to the Service, a submission under this subsection does not preclude or impede an examination of the Plan Sponsor or its plan(s). Thus, a plan submitted under the Anonymous Submission Procedure that comes Under Examination prior to the date the plan and Plan Sponsor identifying materials are received by the Service will no longer be eligible for either the Anonymous Submission Procedure or VCP.

(3) Unless otherwise extended, the Anonymous Submission Procedure will not apply to applications submitted after December 31, 2002.

.13 *Special rules relating to VCT*. A VCP submission for a 403(b) Plan is required to be made under the VCT procedure. A VCT submission is subject to the procedures of sections 10 and 11. A 403(b) Plan is not eligible for VCO or VCS.

.14 *Special rules relating to VCGroup*. (1) *General rules*. An Eligible Organization may submit a VCP request for a Qualified Plan or a 403(b) Plan under the VCGroup procedure under this subsection and may not submit an application under VCO, VCS, VCT, or the Anonymous Submission Procedure. VCGroup applies if (a) the failures are all Operational Failures and the Eligible Organization is an Eligible Organization defined in sections 10.14(2)(b) or (c), or (b) the failures are all Plan Document Failures and the Eligible Organization is a Sponsor as defined in section 10.14(2)(a).

(2) *Eligible Organizations*. For purposes of VCGroup, the term "Eligible Organization" means either (a) a Sponsor (as that term is defined in section 4.09 of Rev. Proc. 2000–20 2000–6 I.R.B. 553) of a master or prototype plan that (i) receives an opinion letter that considers the provisions of GUST, or (ii) has received an opinion letter that considers TRA '86 and has been submitted for a GUST opinion letter by December 31, 2000, (b) an insurance company or other entity that has issued annuity contracts or provides services with respect to assets for 403(b) Plans, or (c) an entity that provides its clients with administrative services with respect to Qualified Plans or 403(b) Plans. An Eligible Organization is not eligible for VCGroup unless the submission includes a failure resulting from a systemic error involving the Eligible Organization that affects at least 20 plans. If, at any time before the Service provides an unsigned compliance statement, the number of plans that have the same failure falls below 20, the Eligible Organization must notify the Service that it is no longer eligible for VCGroup (and the compliance fee will be retained).

(3) *Special VCGroup procedures*. (a) A VCGroup submission is subject to the same procedures as any VCP submission in accordance with sections 10 and 11, except that the Eligible Organization is responsible for performing the procedural obligations imposed on the Plan Sponsor under sections 10 and 11.

(b) When an Eligible Organization under VCGroup receives an unsigned compliance statement on the proposed correction and agrees to the terms of the compliance statement, the Eligible Organization must return to the Service within 120 calendar days not only the signed compliance statement and any additional compliance fee under section 12.06, but also a list containing (i) the employers' tax identification numbers for the Plan Sponsors of the plans to whom the compliance statement may be applicable and (ii) the plans by name, plan number, type of plan, number of plan participants, and trust's tax identification numbers, if applicable, along with (iii) a power of attorney (which may be a limited power of attorney) from each of the Plan Sponsors authorizing the Eligible Organization or its representative to act on the Plan Sponsor's behalf with respect to the items in the compliance statement and (iv) a copy of the most recently filed Form 5500 series return for each plan. Only those plans for which correction is actually made within 240 calendar days of the date of the signed compliance statement (or within such longer period as may be agreed to by the Service at the request of the Eligible Organization) will be covered by that statement.

(c) Notwithstanding section 10.04, until the Eligible Organization provides the Service with the information of section 10.14(3)(b)(i) through (iv) with respect to a Plan Sponsor and its plan(s), a VCGroup submission does not preclude or impede an examination of the Plan Sponsor or its plan(s).

(4) *VCGroup implementation*. The VCGroup procedure is being implemented on a provisional basis, and the Service and Treasury invite comments on the operation of the VCGroup procedure. While the Anonymous Submission Procedure is not available in connection with the VCGroup procedure, Eligible Organizations that are considering filing a VCGroup submission may, of course, discuss the submission with the Service on an anonymous basis before filing the VCGroup submission.

.15 *Special rules relating to VCSEP*. A VCP submission for a SEP is required to be made under the VCSEP procedure. A VCSEP submission is subject to the procedures of sections 10 and 11. A SEP Plan is not eligible for VCO or VCS.

.16 *Multiemployer and multiple employer plans*. (1) In the case of a multiemployer or multiple employer plan, the plan administrator (rather than any contributing or adopting employer) must request consideration of the plan under the programs. The request must be with respect to the plan, rather than a portion of the plan affecting any particular employer.

(2) If a VCP submission for a multiemployer or multiple employer plan has failures that apply to fewer than all of the employers under the plan, the plan administrator may choose to have the compliance fee (in section 12) or sanction (in section 14) calculated separately for each employer based on the assets attributable to that employer, rather than being attributable to the assets of the entire plan. Thus, the plan administrator may choose to apply the provisions of this paragraph where the failure is attributable in whole or in part to data, information, actions, or inactions that are within the control of the employers rather than the multiemployer or multiple employer plan (such as attribution in whole or in part to the failure of a employer to provide the plan administrator with full and complete information).

SECTION 11. APPLICATION PROCEDURES FOR VCP

.01 *General rules*. The requirements of this section 11 are satisfied if the request for a compliance statement from the Service under VCP satisfies the infor-

mational and other requirements of this section 11. In general, a request under VCP consists of a letter from the Plan Sponsor (which may be a letter from the Plan Sponsor's representative) to the Service that contains a description of the failures, a description of the proposed methods of correction, and other procedural items, and includes supporting information and documentation as described below.

.02 *Submission requirements*. The letter from the Plan Sponsor or the Plan Sponsor's representative must contain the following:

(1) A complete description of the failures and the years in which the failures occurred, including closed years (that is, years for which the statutory period has expired).

(2) A description of the administrative procedures in effect at the time the failures occurred.

(3) An explanation of how and why the failures arose.

(4) A detailed description of the method for correcting the failures that the Plan Sponsor has implemented or proposes to implement. Each step of the correction method must be described in narrative form. The description must include the specific information needed to support the suggested correction method. This information includes, for example, the number of employees affected and the expected cost of correction (both of which may be approximated if the exact number cannot be determined at the time of the request), the years involved, and calculations or assumptions the Plan Sponsor used to determine the amounts needed for correction. See section 10.11 for special procedures regarding VCS.

(5) A description of the methodology that will be used to calculate earnings or actuarial adjustments on any corrective contributions or distributions (indicating the computation periods and the basis for determining earnings or actuarial adjustments, in accordance with section 6.02(4)).

(6) Specific calculations for each affected employee or a representative sample of affected employees. The sample calculations must be sufficient to demonstrate each aspect of the correction method proposed. For example, if a Plan Sponsor requests a compliance statement with respect to a failure to satisfy the contribution limits of § 415(c) and proposes a correction method that involves elective contributions (whether matched or unmatched) and matching contributions, the Plan Sponsor must submit calculations illustrating the correction method proposed with respect to each type of contribution. As another example, with respect to a failure to satisfy the ADP test in § 401(k)(3), the Plan Sponsor must submit the ADP test results both before the correction and after the correction.

(7) The method that will be used to locate and notify former employees and beneficiaries, or an affirmative statement that no former employees or beneficiaries were affected by the failures or will be affected by the correction.

(8) A description of the measures that have been or will be implemented to ensure that the same failures will not recur.

(9) A statement that, to the best of the Plan Sponsor's knowledge, neither the plan nor the Plan Sponsor is Under Examination.

(10) If a submission includes a failure that refers to Transferred Assets and occurred prior to the transfer, a description of the transaction (including the dates of the employer change and the plan transfer).

.03 *Submission requirements under special procedures*. The letter from the Plan Sponsor or the Plan Sponsor's representative must also contain the following:

(1) *VCO*. In the case of a VCO submission, a statement (if applicable) that the plan is currently being considered in a determination letter application. If the request for a determination letter is made while a request for consideration under VCO is pending, the Plan Sponsor must update the VCO request to add this information.

(2) *VCS*. In the case of a VCS submission, a statement that it is a VCS request, a description of the applicable correction in accordance with Appendix A or Appendix B, and a statement that the Plan Sponsor proposes to implement (or has implemented) the correction(s).

(3) *VCT*. In the case of a VCT submission, a statement that the Plan Sponsor has contacted all other entities involved with the plan and has been assured of cooperation in implementing the applicable correction, to the extent necessary. For example, if the plan's failure is the failure to satisfy the requirements of § 403(b)(1)(E) on elective deferrals, the Plan Sponsor must, prior to making the VCT application, contact the insurance company or custodian with control over the plan's assets to assure cooperation in effecting a distribution of the excess deferrals and the earnings thereon. An application under VCT must also contain a statement as to the type of employer (e.g., a tax-exempt organization described in § 501(c)(3)) submitting the VCT application.

(4) *Anonymous Submission*. In the case of an Anonymous Submission, a statement that the plan has not used the Anonymous Submission Procedure in the preceding two years with respect to the failures included in the submission.

(5) *VCGroup*. A VCGroup submission must be signed by the Eligible Organization or the Eligible Organization's authorized representative and accompanied by a copy of the relevant portions of the plan document(s).

(6) *VCSEP*. In the case of an VCSEP submission, a statement that it is a VCSEP request, a description of the applicable correction, and a statement that the Plan Sponsor proposes to implement (or has implemented) the correction(s).

.04 *Required documents*. A VCP submission must be accompanied by the following documents:

(1) *Form 5500 or similar information*. (a) *VCP*. In the case of the general procedures under VCP, a copy of the most recently filed Form 5500 series return.

(b) *VCO and VCS*. In the case of a VCO or VCS submission, a copy of the first page and a copy of the page containing employee census information (currently, line 7f of the 1999 Form 5500) and a copy of the page containing the total amount of plan assets (currently, line 31f of the 1999 Form 5500) or the most recently filed Form 5500 series return.

(c) *Anonymous submission*. In the case of a submission under the Anonymous Submission Procedure, the employee census and plan asset information may be redacted and replaced by numbers that are rounded up.

(d) *VCT*. In the case of a VCT submission, if Form 5500 is inapplicable,

the information generally included on the first two pages of Form 5500, including the name and number of the plan, and the employer's Employer Identification Number.

(e) *VCSEP*. In the case of a VCSEP submission, if Form 5500 is inapplicable, the information generally included on the first two pages of Form 5500, including the name and number of the plan, and the employer's Employer Identification Number.

(2) *Plan document*. A copy of the relevant portions of the plan document. For example, in a case involving improper exclusion of eligible employees from a profit-sharing plan with a cash or deferred arrangement, relevant portions of the plan document include the eligibility, allocation, and cash or deferred arrangement provisions of the basic plan document (and the adoption agreement, if applicable), along with applicable definitions in the plan. If the plan is a 403(b) Plan and a plan document is not available, written descriptions of the plan, and sample salary reduction agreements if relevant. In the case of a SEP, submit the entire plan document.

(3) *Determination letter application*. In any case in which correction of a Qualified Plan failure includes correction of a Plan Document Failure or correction of an Operational Failure by plan amendment as permitted under section 4.06, other than adoption of an amendment designated by the Service as a model amendment or a standardized or prototype plan, the Plan Sponsor must submit the amendment, the appropriate application form (i.e., Form 5300 series or Form 6406), and the appropriate user fee.

(4) *Copy of Favorable Letter for VCO, VCS, or VCSEP*. In the case of VCO, VCS, or VCSEP, a copy of the determination letter, opinion letter, or notification letter that considered TRA '86, except:

(a) a governmental plan, or a nonelecting church plan described in Rev. Proc. 99–23 for which the TRA '86 remedial amendment period has not yet expired should submit a copy of the determination, opinion, or notification letter that considered TEFRA, DEFRA, and REA and a statement that explains the reason why the period has not yet expired,

(b) plans initially adopted or effective after December 7, 1994 should submit a statement that the plan will be submitted timely for a determination, opinion, or notification letter within the plan's remedial amendment period under § 401(b), and

(c) in the case of a SEP, a copy of the most recent opinion letter for a prototype SEP, a copy of the current model SEP on Form 5305–SEP or 5305A–SEP, a copy of the private letter ruling issued to an individually designed SEP.

.05 *Date VCP fee due generally*. Except as provided in section 11.06, the VCP fee under section 12 is due at the time the compliance statement is signed by the Plan Sponsor and returned to the Service.

.06 *Fee due earlier for VCO, VCS, Anonymous Submission, VCGroup, and VCSEP*. In the case of a VCO or VCS submission, the appropriate fee described in section 12.02 or 12.03 must be included with the submission. In the case of a submission made under the Anonymous Submission Procedure, VCGroup, or VCSEP, the initial fee described in section 12.04(1), 12.06, or 12.07(1), respectively, must be included with the submission (and any additional fee is due at the time provided in section 11.05).

.07 *Signed submission*. The submission must be signed by the Plan Sponsor or the sponsor's authorized representative.

.08 *Power of attorney requirements*. To sign the submission or to appear before the Service in connection with the submission, the Plan Sponsor's representative must comply with the requirements of section 9.02(11) and (12) of Rev. Proc. 2001–4, 2001–1 I.R.B. 121.

.09 *Penalty of perjury statement*. The following declaration must accompany a request and any factual information or change in the submission at a later time: **"Under penalties of perjury, I declare that I have examined this submission, including accompanying documents, and, to the best of my knowledge and belief, the facts presented in support of this submission are true, correct, and complete."** The declaration must be signed by the Plan Sponsor, not the Plan Sponsor's representative.

.10 *Checklist.* The Service will be able to respond more quickly to a VCP request if the request is carefully prepared and complete. The checklist in Appendix C is designed to assist Plan Sponsors and their representatives in preparing a submission that contains the information and documents required under this revenue procedure. The checklist in Appendix C must be completed, signed, and dated by the Plan Sponsor or the Plan Sponsor's representative, and should be placed on top of the submission. A photocopy of this checklist may be used.

.11 *Designation*. The letter to the Service should be designated "VCP", "VCO", "VCS", "VCT", "VCSEP", or "VCGroup", as appropriate, in the upper right hand corner of the letter. In addition if the submission is an Anonymous Submission, the letter should also be designated "Anonymous Submission Procedure".

.12 *VCP mailing address.* Submissions under VCO (and any VCO submission under the Anonymous Submission Procedure), VCGroup, and VCSEP should be mailed to:

Internal Revenue Service
Attention: T:EP:RA:VC
P.O. Box 27063
McPherson Station
Washington, D.C. 20038

All other VCP submissions should be mailed to:

If the entity is in:	*the application should be sent to*:
Connecticut, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont	Employee Plans VCP Internal Revenue Service 10 Metro Tech Center 625 Fulton Street Brooklyn, NY 11201 Phone (718) 488-2372 FAX (718) 488-2405
Alabama, Delaware, District of Columbia, Florida, Georgia, Indiana, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, any U.S. possession or foreign country	Employee Plans VCP Internal Revenue Service Room 1550 P.O. Box 13163 Baltimore, MD 21203 Phone (410) 962-3499 FAX (410) 962-0882
Arkansas, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin	Employee Plans VCP Internal Revenue Service 230 S. Dearborn MC 4913 Chi Chicago, IL 60604 Phone (312) 886-1277 FAX (312) 886-2386
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming	Employee Plans VCP Internal Revenue Service 2 Cupania Circle Monterey Park, CA 91755-7431 Phone (323) 869-3905 FAX (323) 869-3949

.13 *Maintenance of copies of submissions*. Plan Sponsors and their representatives should maintain copies of all correspondence submitted to the Service with respect to their VCP requests.

SECTION 12. VCP FEES

.01 *VCP general procedure compliance fee*. (1) *Compliance fee chart*. Except as otherwise provided in this section 12, the compliance fee for an application under VCP is determined in accordance with the chart below. The chart contains a graduated range of fees based on the size of the plan and the number of participants. Each range includes a minimum amount, a maximum amount, and a presumptive amount. In each case, the minimum amount is the applicable VCO fee in section 12.02. It is expected that in most instances the compliance fee imposed will be at or near the presumptive amount in each range; however, the fee may be a higher or lower amount within the range, depending on the factors in paragraph (2) below.

VCP GENERAL PROCEDURES COMPLIANCE FEES		
# of participants	Fee range	Presumptive Amount
10 or fewer	VCO fee* to $4,000	$2,000
11 to 50	VCO fee* to $8,000	$4,000
51 to 100	VCO fee* to $12,000	$6,000
101 to 300	VCO fee* to $16,000	$8,000
301 to 1,000	VCO fee* to $30,000	$15,000
Over 1,000	VCO fee* to $70,000	$35,000

* Items marked by asterisk refer to the VCO compliance fee that would apply under section 12.02 if the plan had been submitted under VCO.

(2) *Factors considered*. Except as provided in section 12.01(3) with respect to nonamenders and section 12.01(4) relating to egregious failures, consideration of whether the compliance fee should be equal to, greater than, or less than the presumptive amount will depend on factors relating to the nature, extent, and severity of the failure. These factors include: (a) whether the failure is a failure to satisfy the requirements of § 401(a)(4), § 401(a)(26), or § 410(b), (b) whether the plan has both Operational and Plan Document Failures, (c) the period over which the violation occurred (for example, the time that has elapsed since the end of the applicable remedial amendment period under § 401(b) for a Plan Document Failure), (d) the extent to which the plan has accepted Transferred Assets, and the extent to which the failures relate to the Transferred Assets and occurred before the transfer, and (e) whether the plan has a Favorable Letter.

(3) *VCP fee for nonamenders*. Except in rare and unusual circumstances, the VCP compliance fee for a submission that includes only a Plan Document Failure that is solely a failure to amend the plan timely to comply with required tax law changes is determined in accordance with section 12.01(1), as follows.

(a) UCA or OBRA '93 model amendments only – the fee is the halfway point between the minimum amount and the presumptive amount of the applicable fee range.

(b) TRA '86 - the fee is the presumptive amount of the applicable fee range, and clause (a) does not apply.

(c) TEFRA, DEFRA, or REA – the fee is the halfway point between the presumptive amount and the maximum amount of the applicable fee range, and clauses (a) and (b) do not apply.

(d) ERISA - the fee is the maximum amount of the applicable fee range, and clauses (a), (b), and (c) do not apply.

(4) *Egregious failures*. In cases involving failures that are egregious (as described in section 4.09), (a) the maximum compliance fee applicable to the plan under the chart in 12.01(1) is increased to 40 percent of the Maximum Payment Amount and (b) no presumptive amount applies.

.02 *VCO fee*. (1) *VCO fee generally*. Unless VCS is applicable, the VCO compliance fee depends on the assets of the plan and the number of plan participants.

(a) The fee for a plan with assets of less than $500,000 and no more than 1,000 plan participants is $500.

(b) The fee for a plan with assets of at least $500,000 and no more than 1,000 plan participants is $1,250.

(c) The fee for a plan with more than 1,000 plan participants but fewer than 10,000 plan participants is $5,000.

(d) The fee for a plan with 10,000 or more plan participants is $10,000.

(2) *Rev. Proc. 2001-8 modified*. The VCO, Anonymous Submission Procedure, VCGroup, and VCSEP compliance fee is processed under the user fee program described in Rev. Proc. 2001-8, 2001-1 I.R.B. 239.

.03 *VCS fee*. The VCS compliance fee is $350.

.04 *Fee for Anonymous Submission*. The compliance fee for the Anonymous Submission Procedure is the fee applicable under other provisions of this section 12 (i.e., the fee under section 12.01 for VCP general procedures, the fee under section 12.02 for VCO, or the fee under section 12.05 for VCT).

(1) The initial portion of the fee is the amount determined under section 12.02 (for the VCP general procedures or VCO) or 12.05(2) (for VCT).

(2) The additional fee, if any, is the fee determined under section 12.01 or 12.05, if applicable, reduced by the fee in section 12.04(1).

.05 *VCT Fee*. (1) *VCT compliance fee*. The applicable VCT compliance fee depends on the type of failure and, generally, the number of employees of the employer.

(2) *Fee for Operational Failures*. Subject to section 12.05(3), the compliance fee for submissions that include only Operational Failures is as follows:

(a) The fee for an employer with fewer than 25 employees is $500.

(b) The fee for an employer with at least 25 and no more than 1,000 employees is $1,250.

(c) The fee for an employer with more than 1,000 employees but less than 10,000 is $5,000.

(d) The fee for an employer with 10,000 or more employees is $10,000.

(3) *Fee for certain Excess Amounts*. Subject to section 12.05(6), the compliance fee for Excess Amounts that are corrected pursuant to section 6.05(2)(b) is equal to the sum of (a) the applicable fee described in section 12.05(2), plus (b) two percent of the Excess Amounts, adjusted for earnings through the date of the VCT application, contributed or allocated in the calendar year of the VCT application and in the three calendar years prior thereto. If there is a failure to satisfy both the § 403(b)(2) and § 415 limits with respect to a single employee for a year, the fee will take into account only the larger Excess Amount.

(4) *Fee for Demographic and Eligibility Failures.* (a) Subject to section 12.05(6), the compliance fee for a 403(b) Plan with failures that include any Demographic or Employer Eligibility Failure is determined in accordance with the VCP fee table in section 12.01(1), except that (i) the reference to VCO fees is changed to refer to the VCT compliance fee for Operational Failures in section 12.05(2) above and (ii) the fee is determined with reference to the number of employees rather than participants.

(b) In addition to the types of factors listed in section 12.01(2), factors considered in determining the compliance fee for failures that include any Demographic or Employer Eligibility Failure under VCT include: (i) whether the failures include a Demographic Failure, (ii) whether the 403(b) Plan has a combination of two or more types of failures (Operational, Demographic, and Employer Eligibility); and (iii) the period of time over which the failure occurred.

(5) *Fee for multiple failures.* If correction is requested for multiple failures, the compliance fee is determined in accordance with the table below.

Multiple Operational Failures	Fee described in section 12.05(2)
Multiple Demographic or Eligibility Failures	Fee described in section 12.05(4)
Combination of Operational and Demographic or Eligibility Failures	Fee described in section 12.05(4)
Operational Failure(s) with section 6.05(2)(b) correction of Excess Amounts	Fee described in section 12.05(3)
Demographic or Eligibility Failures and Operational Failures including section 6.05(2)(b) correction of Excess Amounts	Fee described in section 12.05(3), substituting section 12.05(4) fee for section 12.05(2) fee

(6) *Fee for egregious failures.* In cases involving failures that are egregious, the maximum VCT compliance fee applicable to the plan is increased to 40 percent of the Total Sanction Amount and no presumptive amount applies.

.06 *VCGroup fees*. The compliance fee for a VCGroup submission is based on the number of plans to which the compliance statement is applicable. The initial fee is $10,000. In the case of a submission with only corrections under Appendix A or B, an additional fee is due equal to the product of the number of plans in excess of 20 times $125, up to a maximum of $40,000; in any other case, the additional fee is equal to the product of the number of plans in excess of 20 times $250, up to a maximum of $90,000.

.07 *VCSEP fees*. The applicable VCSEP compliance fee is the same as the fee for VCP in section 12.01, subject to the following:

(1) In the case of a SEP with Operational Failures only, the compliance fee is determined in accordance with the VCO fee schedule in section 12.02, except that the fee is determined solely on the basis of the number of plan participants.

(2) In any case in which a SEP correction is not similar to a correction for a similar Qualification Failure (as provided under section 6.08(1)), the Service may impose an additional fee.

.08 *Establishing amount of assets and number of plan participants*. Compliance fees under this section 12 are calculated by the Plan Sponsor using the numbers from the most recently filed Form 5500 series to establish the fee. Thus, with respect to the 1999 Form 5500, the Plan Sponsor would use the number shown on line 7(f) (or the equivalent line on the Form 5500 C/R or EZ) to establish the number of plan participants and would use line 31(f) (or the equivalent line on the Form 5500 C/R or EZ) to establish the amount of plan assets. If the submission involves a plan with Transferred Assets and the Service determines that none of the failures in the submission occurred after the end of the second plan year that begins after the corporate merger, acquisition or other similar employer transaction, the Plan Sponsor may calculate the amount of plan assets and number of plan participants based on the Form 5500 information that would have been filed by the Plan Sponsor for the plan year that includes the employer transaction if the Transferred Assets were maintained as a separate plan. In the case of a SEP not required to file a Form 5500, the Plan Sponsor may use other reasonable information to determine the amount of plan assets and the number of participants.

PART VI. CORRECTION ON AUDIT (AUDIT CAP)

SECTION 13. DESCRIPTION OF AUDIT CAP

.01 *Audit CAP requirements*. If the Service identifies a failure (other than a failure that has been corrected in accordance with SCP or VCP) upon an Employee Plans or Exempt Organizations examination of a Qualified Plan, 403(b) Plan, or SEP, the requirements of this section 13 are satisfied with respect to the failure if the Plan Sponsor corrects the failure, pays a sanction in accordance with section 14, satisfies any additional requirements of section 13.03, and enters into a closing agreement with the Service.

.02 *Payment of sanction*. Payment of the sanction under section 14 generally is required at the time the closing agreement is signed.

.03 *Additional requirements*. Depending on the nature of the failure, the Service will discuss the appropriateness of the plan's existing administrative procedures with the Plan Sponsor. If existing administrative procedures are inadequate for operating the plan in conformance with the applicable requirements of the Code, the closing agreement may be conditioned upon the implementation of stated procedures. In addition, for Qualified Plans, the Plan Sponsor may be required to obtain a Favorable Letter before the closing agreement is signed unless the Service determines that it is unnecessary based on the facts and circumstances (for example, because the plan already has a Favorable Letter and no significant amendments are adopted). If a Favorable Letter is required, the Plan Sponsor is required to pay the applicable user fee for obtaining the letter.

.04 *Failure to reach resolution*. If the Service and the Plan Sponsor cannot reach an agreement with respect to the correction of the failure(s) or the amount of the sanction, the plan will be disqualified or, in the case of a 403(b) Plan or SEP, will not have reliance on this revenue procedure.

.05 *Effect of closing agreement*. A closing agreement constitutes an agreement between the Service and the Plan Sponsor that is binding with respect to the tax matters identified therein for the periods specified.

.06 *Other procedural rules*. The procedural rules for Audit CAP are set forth in Internal Revenue Manual ("IRM") 7.9.2, EPCRS.

SECTION 14. AUDIT CAP SANCTION

.01 *Determination of sanction*. The sanction under Audit CAP is a negotiated

percentage of the Maximum Payment Amount. For 403(b) Plans and SEPs, the sanction is a negotiated percentage of the Total Sanction Amount. Sanctions will not be excessive and will bear a reasonable relationship to the nature, extent, and severity of the failures, based on the factors below.

.02 *Factors considered*. Factors include: (1) the steps taken by the Plan Sponsor to ensure that the plan either had no failures or corrected them through SCP or VCP, including the extent to which correction had progressed before the examination was initiated, (2) the amount of the fee the Plan Sponsor would have paid under section 12 for correcting the failures, (3) the number and type of employees affected by the failure, (4) the number of nonhighly compensated employees who would be adversely affected if the plan were not treated as qualified or as satisfying the requirements of § 403(b) or § 408(k), (5) whether the failure is a failure to satisfy the requirements of § 401(a)(4), § 401(a)(26), or § 410(b), either directly or through § 403(b)(12), (6) the period over which the failure occurred (for example, the time that has elapsed since the end of the applicable remedial amendment period under § 401(b) for a Plan Document Failure), and (7) the reason for the failure (for example, data errors such as errors in transcription of data, the transposition of numbers, or minor arithmetic errors). Factors relating only to Qualified Plans also include: (1) whether the plan is the subject of a Favorable Letter, (2) whether the plan has both Operational and other failures, and (3) the extent to which the plan has accepted Transferred Assets, and the extent to which failures relate to Transferred Assets and occurred before the transfer. Additional factors relating only to 403(b) Plans include: (1) whether the plan has a combination of Operational, Demographic, or Employer Eligibility Failures, (2) the extent to which the failure relates to Excess Amounts, and (3) whether the failure is solely an Employer Eligibility Failure.

.03 *Transferred Assets*. If the examination involves a plan with Transferred Assets and the Service determines that the failures did not occur after the end of the second plan year that begins after the corporate merger, acquisition, or other similar employer transaction occurred, the sanction under Audit CAP will not exceed the sanction that would apply if the Transferred Assets were maintained as a separate plan.

PART VII. EFFECT ON OTHER DOCUMENTS; EFFECTIVE DATE; PAPERWORK REDUCTION ACT

SECTION 15. EFFECT ON OTHER DOCUMENTS

.01 *Revenue procedure 2000–16 modified and superseded*. Rev. Proc. 2000–16 is modified and superseded by this revenue procedure.

.02 *Rev. Proc. 2001–8 modified*. Rev. Proc. 2001–8 is modified as provided in section 12.

SECTION 16. EFFECTIVE DATE

This revenue procedure is generally effective May 1, 2001. In addition, Plan Sponsors and Eligible Organizations are permitted, at their option, to apply the provisions of this revenue procedure on or after January 19, 2001 (the release date of this revenue procedure). Unless a Plan Sponsor or Eligible Organization applies this revenue procedure earlier, this revenue procedure is effective:

(1) with respect to SCP, for failures for which correction is not complete before May 1, 2001.

(2) with respect to VCP, for applications submitted on or after May 1, 2001; and

(3) with respect to Audit CAP, for examinations begun on or after May 1, 2001.

SECTION 17. PAPERWORK REDUCTION ACT

The collection of information contained in this revenue procedure has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1673.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number.

The collection of information in this revenue procedure is in sections 4.06, 6.02(5)(c), 6.05, 10.01, 10.02, 10.05–10.07, 11.02–11.04, 11.07–11.13, 13.01, section 2.01–2.07 of Appendix B, and Appendix C. This information is required to enable the Commissioner, Tax Exempt and Government Entities Division of the Internal Revenue Service to make determinations regarding the issuance of various types of closing agreements and compliance statements. This information will be used to issue closing agreements and compliance statements to allow individual plans to continue to maintain their tax qualified and tax-deferred status. As a result, favorable tax treatment of the benefits of the eligible employees is retained. The likely respondents are individuals, state or local governments, businesses or other for-profit institutions, nonprofit institutions, and small businesses or organizations.

The estimated total annual reporting and/or recordkeeping burden is 56,272 hours.

The estimated annual burden per respondent/recordkeeper varies from .5 to 42.5 hours, depending on individual circumstances, with an estimated average of 113.11 hours. The estimated number of respondents and/or recordkeepers is 4,292.

The estimated frequency of responses is occasional.

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

DRAFTING INFORMATION

The principal authors of this revenue procedure are Maxine Terry and Carlton Watkins of the Tax Exempt and Government Entities Division. For further information concerning this revenue procedure, please contact Employee Plans taxpayer assistance telephone service between 1:30 and 3:30 p.m., Eastern Time, Monday through Thursday at (202) 283-9516/9517. (These telephone numbers are not toll-free numbers.) Ms. Terry and Mr. Watkins may be reached at (202) 283-9888 (also not a toll-free number).

APPENDIX A

OPERATIONAL FAILURES AND CORRECTIONS UNDER VCS

.01 *General rule*. This appendix sets forth Operational Failures relating to Qualified Plans and corrections under VCS in accordance with section 10.11. In each case, the method described corrects the Operational Failure identified in the headings below. Corrective allocations and distributions should reflect earnings and actuarial adjustments in accordance with section 6.02(4). The correction methods in this appendix are acceptable under SCP and VCP (including VCS). Additionally, the correction methods and the earnings adjustment methods in Appendix B are acceptable under SCP and VCP (including VCS but not VCT).

.02 *Failure to properly provide the minimum top-heavy benefit under § 416 of the Code to non-key employees*. In a defined contribution plan, the permitted correction method is to properly contribute and allocate the required top-heavy minimums to the plan in the manner provided for in the plan on behalf of the non-key employees (and any other employees required to receive top-heavy allocations under the plan). In a defined benefit plan, the minimum required benefit must be accrued in the manner provided in the plan.

.03 *Failure to satisfy the ADP test set forth in § 401(k)(3), the ACP test set forth in § 401(m)(2), or the multiple use test of § 401(m)(9)*. The permitted correction method is to make qualified nonelective contributions (QNCs) (as defined in § 1.401(k)–1(g)(13)(ii)) on behalf of the nonhighly compensated employees to the extent necessary to raise the actual deferral percentage or actual contribution percentage of the nonhighly compensated employees to the percentage needed to pass the test or tests. The contributions must be made on behalf of all eligible nonhighly compensated employees (to the extent permitted under § 415) and must either be the same flat dollar amount or the same percentage of compensation. QNCs contributed to satisfy the ADP test need not be matched. Employees who would have been eligible for a matching contribution had they made elective contributions must be counted as eligible employees for the ACP test, and the plan must satisfy the ACP test. Under this VCS correction method, a plan may not be treated as two separate plans, one covering otherwise excludable employees and the other covering all other employees (as permitted in § 1.410(b)–6(b)(3)) in order to reduce the number of employees eligible to receive QNCs. Likewise, under this VCS correction method, the plan may not be restructured into component plans (as permitted in § 1.401(k)–1(h)(3)(iii) for plan years before January 1, 1992) in order to reduce the number of employees eligible to receive QNCs.

.04 *Failure to distribute elective deferrals in excess of the § 402(g) limit (in contravention of § 401(a)(30))*. The permitted correction method is to distribute the excess deferral to the employee and to report the amount as taxable in the year of deferral and in the year distributed. In accordance with § 1.402(g)–1(e)(1)(ii), a distribution to a highly compensated employee is included in the ADP test; a distribution to a nonhighly compensated employee is not included in the ADP test.

.05 *Exclusion of an eligible employee from all contributions or accruals under the plan for one or more plan years*. The permitted correction method is to make a contribution to the plan on behalf of the employees excluded from a defined contribution plan or to provide benefit accruals for the employees excluded from a defined benefit plan. If the employee should have been eligible to make an elective contribution under a cash or deferred arrangement, the employer must make a QNC to the plan on behalf of the employee that is equal to the actual deferral percentage for the employee's group (either highly compensated or nonhighly compensated). If the employee should have been eligible to make employee contributions or for matching contributions (on either elective contributions or employee contributions), the employer must make a QNC to the plan on behalf of the employee that is equal to the actual contribution percentage for the employee's group (either highly compensated or nonhighly compensated). Contributing the actual deferral or contribution percentage for such employees eliminates the need to rerun the ADP or ACP test to account for the previously excluded employees. Under this VCS correction method, a plan may not be treated as two separate plans, one covering otherwise excludable employees and the other covering all other employees (as permitted in § 1.410(b)–6(b)(3)) in order to reduce the amount of QNCs. Likewise, restructuring the plan into component plans under § 1.401(k)–1(h)(3)(iii) is not permitted in order to reduce the amount of QNCs.

.06 *Failure to timely pay the minimum distribution required under § 401(a)(9)*. In a defined contribution plan, the permitted correction method is to distribute the required minimum distributions. The amount to be distributed for each year in which the failure occurred should be determined by dividing the adjusted account balance on the applicable valuation date by the applicable divisor. For this purpose, adjusted account balance means the actual account balance, determined in accordance with § 1.401(a)(9)–1 Q&A F–5 of the proposed regulations, reduced by the amount of the total missed minimum distributions for prior years. In a defined benefit plan, the permitted correction method is to distribute the required minimum distributions, plus an interest payment representing the loss of use of such amounts.

.07 *Failure to obtain participant and/or spousal consent for a distribution subject to the participant and spousal consent rules under §§ 401(a)(11), 411(a)(11) and 417*. The permitted correction method is to give each affected participant a choice between providing informed consent for the distribution actually made or receiving a qualified joint and survivor annuity. In order to use this VCS correction method, the Plan Sponsor must have contacted each affected participant and spouse (to whom the participant was married at the annuity starting date) and received responses from each such individual before requesting consideration under VCS. In the event that participant and/or spousal consent is required but cannot be obtained, the participant must receive a qualified joint and survivor annuity based on the monthly amount that would have been provided under the plan at his or her retirement date. This annuity may be actuarially reduced to take into account distributions already received by the participant. However, the portion of the qualified joint and survivor annuity payable to the spouse upon the death of

the participant may not be actuarially reduced to take into account prior distributions to the participant. Thus, for example, if in accordance with the automatic qualified joint and survivor annuity option under a plan, a married participant who retired would have received a qualified joint and survivor annuity of $600 per month payable for life with $300 per month payable to the spouse upon the participant's death but instead received a single-sum distribution equal to the actuarial present value of the participant's accrued benefit under the plan, then the $600 monthly annuity payable during the participant's lifetime may be actuarially reduced to take the single-sum distribution into account. However, the spouse must be entitled to receive an annuity of $300 per month payable for life beginning at the participant's death.

.08 *Failure to satisfy the § 415 limits in a defined contribution plan.* The permitted correction for failure to limit annual additions (other than elective deferrals and employee contributions) allocated to participants in a defined contribution plan as required in § 415 (even if the excess did not result from the allocation of forfeitures or from a reasonable error in estimating compensation) is to place the excess annual additions into an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used as an employer contribution in the succeeding year(s). While such amounts remain in the unallocated account, the employer is not permitted to make additional contributions to the plan. The permitted VCS correction for failure to limit annual additions that are elective deferrals or employee contributions (even if the excess did not result from a reasonable error in determining the amount of elective deferrals or employee contributions that could be made with respect to an individual under the § 415 limits) is to distribute the elective deferrals or employee contributions using a method similar to that described under § 1.415–6(b)(6)(iv). Elective deferrals and employee contributions that are matched may be returned, provided that the matching contributions relating to such contributions are forfeited (which will also reduce excess annual additions for the affected individuals). The forfeited matching contributions are to be placed into an unallocated account to be used as an employer contribution in succeeding periods.

APPENDIX B

CORRECTION METHODS AND EXAMPLES; EARNINGS ADJUSTMENT METHODS AND EXAMPLES

SECTION 1. PURPOSE, ASSUMPTIONS FOR EXAMPLES AND SECTION REFERENCES

.01 *Purpose*. (1) This appendix sets forth correction methods relating to Operational Failures under Qualified Plans. This appendix also sets forth earnings adjustment methods. The correction methods and earnings adjustment methods described in this appendix are acceptable under SCP and VCP (including VCS, but not VCT).

(2) This appendix does not apply to 403(b) Plans or SEPs. Accordingly, sponsors of 403(b) Plans or SEPs cannot rely on the correction methods and the earnings adjustment methods under this appendix.

.02 *Assumptions for Examples*. Unless otherwise specified, for ease of presentation, the examples assume that:

(1) the plan year and the § 415 limitation year are the calendar year;

(2) the employer maintains a single plan intended to satisfy § 401(a) and has never maintained any other plan;

(3) in a defined contribution plan, the plan provides that forfeitures are used to reduce future employer contributions;

(4) the Qualification Failures are Operational Failures and the eligibility and other requirements for SCP, VCP or Audit CAP, whichever applies, are satisfied; and

(5) there are no Qualification Failures other than the described Operational Failures, and if a corrective action would result in any additional Qualification Failure, appropriate corrective action is taken for that additional Qualification Failure in accordance with EPCRS.

.03 *Section References*. References to section 2 and section 3 are references to the section 2 and 3 in this appendix.

SECTION 2. CORRECTION METHODS AND EXAMPLES

.01 *ADP/ACP Failures.*

(1) Correction Methods. (a) VCS Correction Method. Appendix A, section .03 sets forth the VCS correction method for a failure to satisfy the actual deferral percentage ("ADP"), actual contribution percentage ("ACP"), or multiple use test set forth in §§ 401(k)(3), 401(m)(2), and 401(m)(9), respectively.

(b) One-to-One Correction Method. (i) General. In addition to the VCS correction method, a failure to satisfy the ADP, ACP, or multiple use test may be corrected using the one-to-one correction method set forth in this section 2.01(1)(b). Under the one-to-one correction method, an excess contribution amount is determined and assigned to highly compensated employees as provided in paragraph (1)(b)(ii) below. That excess contribution amount (adjusted for earnings) is either distributed to the highly compensated employees or forfeited from the highly compensated employees' accounts as provided in paragraph (1)(b)(iii) below. That same dollar amount (i.e., the excess contribution amount, adjusted for earnings) is contributed to the plan and allocated to nonhighly compensated employees as provided in paragraph (1)(b)(iv) below.

(ii) Determination of the Excess Contribution Amount. The excess contribution amount for the year is equal to the excess of (A) the sum of the excess contributions (as defined in § 401(k)(8)(B)), the excess aggregate contributions (as defined in § 401(m)(6)(B)), and the amount treated as excess contributions or excess aggregate contributions under the multiple use test pursuant to § 401(m)(9) and § 1.401(m)–2(c) for the year, as assigned to each highly compensated employee in accordance with § 401(k)(8)(C) and (m)(6)(C), over (B) previous corrections that complied with § 401(k)(8), (m)(6), and (m)(9). See Notice 97–2, 1997–1 C.B. 348.

(iii) Distributions and Forfeitures of the Excess Contribution Amount. (A) The portion of the excess contribution amount assigned to a particular highly compensated employee under paragraph (1)(b)(ii) is adjusted for earnings through the date of correction. The amount assigned to a particular highly compensated employee, as adjusted, is distributed or, to the extent the amount

was forfeitable as of the close of the plan year of the failure, is forfeited. If the amount is forfeited, it is used in accordance with the plan provisions relating to forfeitures that were in effect for the year of the failure. If the amount so assigned to a particular highly compensated employee has been previously distributed; the amount is an Excess Amount within the meaning of section 5.01(3) of this revenue procedure. Thus, pursuant to section 6.05 of this revenue procedure, the employer must notify the employee that the Excess Amount was not eligible for favorable tax treatment accorded to distributions from qualified plans (and, specifically, was not eligible for tax-free rollover).

(B) If any matching contributions (adjusted for earnings) are forfeited in accordance with § 411(a)(3)(G), the forfeited amount is used in accordance with the plan provisions relating to forfeitures that were in effect for the year of the failure.

(C) If a payment was made to an employee and that payment is a forfeitable match described in either paragraph (1)(b)(iii)(A) or (B), then it is an Overpayment defined in section 5.01(6) of this revenue procedure that must be corrected (see sections 2.04 and 2.05 below).

(iv) Contribution and Allocation of Equivalent Amount. (A) The employer makes a contribution to the plan that is equal to the aggregate amounts distributed and forfeited under paragraph (1)(b)(iii)(A) (i.e., the excess contribution amount adjusted for earnings, as provided in paragraph (1)(b)(iii)(A), which does not include any matching contributions forfeited in accordance with § 411(a)(3)(G) as provided in paragraph (1)(b)(iii)(B)). The contribution must satisfy the vesting requirements and distribution limitations of § 401(k)(2)(B) and (C).

(B)(*1*) This paragraph (1)(b)(iv)(B)(*1*) applies to a plan that uses the current year testing method described in Notice 98–1, 1998–1 C.B. 327. The contribution made under paragraph (1)(b)(iv)(A) is allocated to the account balances of those individuals who were either (I) the eligible employees for the year of the failure who were not highly compensated employees for that year or (II) the eligible employees for the year of the failure who were not highly compensated employees for that year and who also are not highly compensated employees for the year of correction. Alternatively, the contribution is allocated to account balances of eligible employees described in (I) or (II) of the preceding sentence, except that the allocation is made only to the account balances of those employees who are employees on a date during the year of the correction that is no later than the date of correction. Regardless of which of these four options (described in the two preceding sentences) the employer selects, the contribution is allocated to each such employee either as the same percentage of the employee's compensation for the year of the failure or as the same dollar amount for each employee. (See Examples 1, 2 and 3.) Under the one-to-one correction method, the amount allocated to the account balance of an employee (i.e., the employee's share of the total amount contributed under paragraph (1)(b)(iv)(A)) is not further adjusted for earnings and is treated as an annual addition under § 415 for the year of the failure for the employee for whom it is allocated.

(*2*) This paragraph (1)(b)(iv)(B)(*2*) applies to a plan that uses the prior year testing method described in Notice 98–1. Paragraph (1)(b)(iv)(B)(*1*) is applied by substituting "the year prior to the year of the failure" for "the year of the failure".

(2) Examples.

Example 1:

Employer A maintains a profit-sharing plan with a cash or deferred arrangement that is intended to satisfy § 401(k) ("401(k) plan") using the current year testing method described in Notice 98–1. The plan does not provide for matching contributions or employee after-tax contributions. In 1999, it was discovered that the ADP test for 1997 was not performed correctly. When the ADP test was performed correctly, the test was not satisfied for 1997. For 1997, the ADP for highly compensated employees was 9% and the ADP for nonhighly compensated employees was 4%. Accordingly, the ADP for highly compensated employees exceeded the ADP for nonhighly compensated employees by more than two percentage points (in violation of § 401(k)(3)). (The ADP for nonhighly compensated employees for 1996 also was 4%, so the ADP test for 1997 would not have been satisfied even if the plan had used the prior year testing method described in Notice 98–1.) There were two highly compensated employees eligible under the 401(k) plan during 1997, Employee P and Employee Q. Employee P made elective deferrals of $8,000, which is equal to 10% of Employee P's compensation of $80,000 for 1997. Employee Q made elective deferrals of $9,500, which is equal to 8% of Employee Q's compensation of $118,750 for 1997.

Correction:

On June 30, 1999, Employer A uses the one-to-one correction method to correct the failure to satisfy the ADP test for 1997. Accordingly, Employer A calculates the dollar amount of the excess contributions for the two highly compensated employees in the manner described in § 401(k)(8)(B). The amount of the excess contribution for Employee P is $3,200 (4% of $80,000) and the amount of the excess contribution for Employee Q is $2,375 (2% of $118,750), or a total of $5,575. In accordance with § 401(k)(8)(C), $5,575, the excess contribution amount, is assigned $2,037.50 to Employee P and $3,537.50 to Employee Q. It is determined that the earnings on the assigned amounts through June 30, 1999 are $407 and $707 for Employees P and Q, respectively. The assigned amounts and the earnings are distributed to Employees P and Q. Therefore, Employee P receives $2,444.50 ($2,037.50 + $407) and Employee Q receives $4,244.50 ($3,537.50 + $707). In addition, on the same date, a corrective contribution is made to the 401(k) plan equal to $6,689 (the sum of the $2,444.50 distributed to Employee P and the $4,244.50 distributed to Employee Q). The corrective contribution is allocated to the account balances of eligible nonhighly compensated employees for 1997, pro rata based on their compensation for 1997 (subject to § 415 for 1997).

Example 2:

The facts are the same as in Example 1.

Correction:

The correction is the same as in Example 1, except that the corrective contribution of $6,689 is allocated in an equal dollar amount to the account balances of eligible nonhighly compensated employees for 1997 who are employees on June 30, 1999, and who are nonhighly compensated employees for 1999 (subject to § 415 for 1997).

Example 3:

The facts are the same as in Example 1, except that for 1997 the plan also provides (1) for employee after-tax contributions and (2) for matching contributions equal to 50% of the sum of an employee's elective deferrals and employee after-tax contributions that do not exceed 10% of the employee's compensation. The plan provides that matching contributions are subject to the plan's 5-year graded vesting schedule and that matching contributions are forfeited and used to reduce employer contributions if associated elective deferrals or employee after-tax contributions are distributed to correct an ADP, ACP or multiple use test failure. For 1997, nonhighly compensated employees made employee after-tax contributions and no highly compensated employee made any employee after-tax contributions. Employee P received a matching contribution of $4,000 (50% of $8,000) and Employee Q

received a matching contribution of $4,750 (50% of $9,500). Employees P and Q were 100% vested in 1997. It is determined that, for 1997, the ACP for highly compensated employees was not more than 125% of the ACP for nonhighly compensated employees, so that the ACP and multiple use tests would have been satisfied for 1997 without any corrective action.

Correction:

The same corrective actions are taken as in Example 1. In addition, in accordance with the plan's terms, corrective action is taken to forfeit Employee P's and Employee Q's matching contributions associated with their distributed excess contributions. Employee P's distributed excess contributions and associated matching contributions are $2,037.50 and $1,018.75, respectively. Employee Q's distributed excess contributions and associated matching contributions are $3,537.50 and $1,768.75, respectively. Thus, $1,018.75 is forfeited from Employee P's account and $1,768.75 is forfeited from Employee Q's account. In addition, the earnings on the forfeited amounts are also forfeited. It is determined that the respective earnings on the forfeited amount for Employee P is $150 and for Employee Q is $204. The total amount of the forfeitures of $3,141.50 (Employee P's $1,018.75 + $150 and Employee Q's $1,768.75 + $204) is used to reduce contributions for 1999 and subsequent years.

.02 *Exclusion of Eligible Employees.*

(1) Exclusion of Eligible Employees in a 401(k) or (m) Plan. (a) Correction Method. (i) VCS Correction Method for Full Year Exclusion. Appendix A, section .05 sets forth the VCS correction method for the exclusion of an eligible employee from all contributions under a 401(k) or (m) plan for one or more full plan years. (See Example 4.) In section 2.02(1)(a)(ii) below, the VCS correction method for the exclusion of an eligible employee from all contributions under a 401(k) or (m) plan for a full year is expanded to include correction for the exclusion of an eligible employee from all contributions under a 401(k) or (m) plan for a partial plan year. This correction for a partial year exclusion may be used in conjunction with the correction for a full year exclusion.

(ii) Expansion of VCS Correction Method to Partial Year Exclusion. (A) In General. The correction method in Appendix A, section .05 is expanded to cover an employee who was improperly excluded from making elective deferrals or employee after-tax contributions for a portion of a plan year or from receiving matching contributions (on either elective deferrals or employee after-tax contributions) for a portion of a plan year. In such case, a permitted correction method for the failure is for the employer to satisfy this section 2.02(1)(a)(ii). The employer makes a corrective contribution on behalf of the excluded employee that satisfies the vesting requirements and distribution limitations of § 401(k)(2)(B) and (C).

(B) Elective Deferral Failures. The appropriate corrective contribution for the failure to allow employees to make elective deferrals for a portion of the plan year is equal to the ADP of the employee's group (either highly or nonhighly compensated), determined prior to correction under this section 2.02(1)(a)(ii), multiplied by the employee's plan compensation for the portion of the year during which the employee was improperly excluded. The corrective contribution for the portion of the plan year during which the employee was improperly excluded from being eligible to make elective deferrals is reduced to the extent that (*1*) the sum of that contribution and any elective deferrals actually made by the employee for that year would exceed (*2*) the maximum elective deferrals permitted under the plan for the employee for that plan year (including the § 402(g) limit). The corrective contribution is adjusted for earnings. (See Examples 5 and 6.)

(C) Employee After-tax and Matching Contribution Failures. The appropriate corrective contribution for the failure to allow employees to make employee after-tax contributions or to receive matching contributions because the employee was precluded from making employee after-tax contributions or elective deferrals for a portion of the plan year is equal to the ACP of the employee's group (either highly or nonhighly compensated), determined prior to correction under this section 2.02(1)(a)(ii), multiplied by the employee's plan compensation for the portion of the year during which the employee was improperly excluded. The corrective contribution is reduced to the extent that (*1*) the sum of that contribution and the actual total employee after-tax and matching contributions made by and for the employee for the plan year would exceed (*2*) the sum of the maximum employee after-tax contributions permitted under the plan for the employee for the plan year and the matching contributions that would have been made if the employee had made the maximum matchable contributions permitted under the plan for the employee for that plan year. The corrective contribution is adjusted for earnings.

(D) Use of Prorated Compensation. For purposes of this paragraph (1)(a)(ii), for administrative convenience, in lieu of using the employee's actual plan compensation for the portion of the year during which the employee was improperly excluded, a pro rata portion of the employee's plan compensation that would have been taken into account for the plan year, if the employee had not been improperly excluded, may be used.

(E) Special Rule for Brief Exclusion from Elective Deferrals. An employer is not required to make a corrective contribution with respect to elective deferrals, as provided in section 2.02(1)(a)(ii)(B), (but is required to make a corrective contribution with respect to any employee after-tax and matching contributions, as provided in section 2.02(1)(a)(ii)(C)) for an employee for a plan year if the employee has been provided the opportunity to make elective deferrals under the plan for a period of at least the last 9 months in that plan year and during that period the employee had the opportunity to make elective deferrals in an amount not less than the maximum amount that would have been permitted if no failure had occurred. (See Example 7.)

(b) Examples.

Example 4:

Employer B maintains a 401(k) plan. The plan provides for matching contributions for eligible employees equal to 100% of elective deferrals that do not exceed 3% of an employee's compensation. The plan provides that employees who complete one year of service are eligible to participate in the plan on the next January 1 or July 1 entry date. Twelve employees (8 nonhighly compensated employees and 4 highly compensated employees) who had met the one year eligibility requirement after July 1, 1995, and before January 1, 1996, were inadvertently excluded from participating in the plan beginning on January 1, 1996. These employees were offered the opportunity to begin participating in the plan on January 1, 1997. For 1996, the ADP for the highly compensated employees was 8% and the ADP for the nonhighly compensated employees was 6%. In addition, for 1996, the ACP for the highly compensated employees was 2.5% and the ACP for the nonhighly compensated employees

was 2%. The failure to include the 12 employees was discovered during 1998.

Correction:

Employer B uses the VCS correction method for full year exclusions to correct the failure to include the 12 eligible employees in the plan for the full plan year beginning January 1, 1996. Thus, Employer B makes a corrective contribution (that satisfies the vesting requirements and distribution limitations of § 401(k)(2)(B) and (C)) for each of the excluded employees. The contribution for each of the improperly excluded highly compensated employees is 10.5% (the highly compensated employees' ADP of 8% plus ACP of 2.5%) of the employee's plan compensation for the 1996 plan year (adjusted for earnings). The contribution for each of the improperly excluded nonhighly compensated employees is 8% (the nonhighly compensated employees,' ADP of 6% plus ACP of 2%) of the employee's plan compensation for the 1996 plan year (adjusted for earnings).

Example 5:

Employer C maintains a 401(k) plan. The plan provides for matching contributions for each payroll period that are equal to 100% of an employee's elective deferrals that do not exceed 2% of the eligible employee's plan compensation during the payroll period. The plan does not provide for employee after-tax contributions. The plan provides that employees who complete one year of service are eligible to participate in the plan on the next January 1 or July 1 entry date. A nonhighly compensated employee who met the eligibility requirements and should have entered the plan on January 1, 1996, was not offered the opportunity to participate in the plan. In August of 1996, the error was discovered and Employer C offered the employee an election opportunity as of September 1, 1996. The employee made elective deferrals equal to 4% of the employee's plan compensation for each payroll period from September 1, 1996, through December 31, 1996, (resulting in elective deferrals of $500). The employee's plan compensation for 1996, was $36,000 ($23,500 for the first eight months and $12,500 for the last four months). Employer C made matching contributions equal to $250 for the excluded employee, which is 2% of the employee's plan compensation for each payroll period from September 1, 1996, through December 31, 1996, ($12,500). The ADP for nonhighly compensated employees for 1996 was 3% and the ACP for nonhighly compensated employees for 1996 was 1.8%.

Correction:

Employer C uses the VCS correction method for partial year exclusions to correct the failure to include the eligible employee in the plan. Thus, Employer C makes a corrective contribution (that satisfies the vesting requirements and distribution limitations of § 401(k)(2)(B) and (C)) for the excluded employee. In determining the amount of corrective contributions (both for the elective deferral and for the matching contribution), for administrative convenience, in lieu of using actual plan compensation of $23,500 for the period the employee was excluded, the employee's annual plan compensation is pro rated for the eight-month period that the employee was excluded from participating in the plan. The failure to provide the excluded employee the right to make elective deferrals is corrected by the employer making a corrective contribution on behalf of the employee that is equal to $720 (the 3% ADP percentage for nonhighly compensated employees multiplied by $24,000, which is 8/12ths of the employee's 1996 plan compensation of $36,000), adjusted for earnings. In addition, to correct for the failure to receive the plan's matching contribution, a corrective contribution is made on behalf of the employee that is equal to $432 (the 1.8% ACP for the nonhighly compensated group multiplied by $24,000, which is 8/12ths of the employee's 1996 plan compensation of $36,000), adjusted for earnings. Employer C determines that $682, the sum of the actual matching contribution received by the employee for the plan year ($250) and the corrective contribution to correct the matching contribution failure ($432), does not exceed $720, the maximum matching contribution available to the employee under the plan (2% of $36,000) determined as if the employee had made the maximum matchable contributions. In addition to correcting the failure to include the eligible employee in the plan, Employer C reruns the ADP and ACP tests for 1996 (taking into account the corrective contribution and plan compensation for 1996 for the excluded employee) and determines that the tests were satisfied.

Example 6:

The facts are the same as in Example 5, except that the plan provides for matching contributions that are equal to 100% of an eligible employee's elective deferrals that do not exceed 2% of the employee's plan compensation for the plan year. Accordingly, the actual matching contribution made by Employer C for the excluded employee for the last four months of 1996 is $500 (which is equal to 100% of the $500 of elective deferrals made by the employee for the last four months of 1996).

Correction:

The correction is the same as in Example 5, except that the corrective contribution made for the first 8 months of 1996 to correct the failure to make matching contributions is equal to $220 (adjusted for earnings), instead of the $432 (adjusted for earnings) in Example 5, because the corrective contribution is limited to the maximum matching contributions available under the plan for the employee for the plan year, $720 (2% of $36,000), reduced by the actual matching contributions made for the employee for the plan year, $500.

Example 7:

The facts are the same as in Example 5, except that the error is discovered in March of 1996 and the employee was given the opportunity to make elective deferrals beginning on April 1, 1996. The amount of elective deferrals that the employee was given the opportunity to make during 1996 was not less than the maximum elective deferrals that the employee could have made if the employee had been given the opportunity to make elective deferrals beginning on January 1, 1996. The employee made elective deferrals equal to 4% of the employee's plan compensation for each payroll period from April 1, 1996 through December 31, 1996 of $28,000 (resulting in elective deferrals of $1,120). Employer C made a matching contribution equal to $560, which is 2% of the employee's plan compensation for each payroll period from April 1, 1996 through December 31, 1996 ($28,000). The employee's plan compensation for 1996 was $36,000 ($8,000 for the first three months and $28,000 for the last nine months).

Correction:

Employer C uses the VCS correction method for partial year exclusions to correct the failure to include an eligible employee in the plan. Because the employee was given an opportunity to make elective deferrals to the plan for at least the last 9 months of the plan year (and the amount of the elective deferrals that the employee had the opportunity to make was not less than the maximum elective deferrals that the employee could have made if the employee had been given the opportunity to make elective deferrals beginning on January 1, 1996), under the special rule set forth in section 2.02(1)(a)(ii)(E), Employer C is not required to make a corrective contribution for the failure to allow the employee to make elective deferrals. In determining the amount of corrective contribution with respect to the failure to allow the employee to receive matching contributions, in lieu of using actual plan compensation of $8,000 for the period the employee was excluded, the employee's annual plan compensation is pro rated for the three-month period that the employee was excluded from participating in the plan. Accordingly, a corrective contribution is made on behalf of the employee that is equal to $160, which is the lesser of (i) $162 (a matching contribution of 1.8% of $9,000, which is 3/12ths of the employee's 1996 plan compensation of $36,000), and (ii) $160 (the excess of the maximum matching contribution for the entire plan year, which is equal to 2% of $36,000, or $720, over the matching contributions made after March 31, 1996, $560). The contribution is adjusted for earnings.

(2) Exclusion of Eligible Employees In a Profit-Sharing Plan.

(a) Correction Methods. (i) VCS Correction Method. Appendix A, section .05 sets forth the VCS correction method for correcting the exclusion of an eligible employee. In the case of a defined contribution plan, the VCS correction method is to make a contribution on behalf of the excluded employee. Section 2.02(2)(a)(ii) below clarifies the VCS correction method in the case of a profit-sharing or stock bonus plan that provides for non-

elective contributions (within the meaning of § 1.401(k)–1(g)(10)).

(ii) Clarification of VCS Correction Method for Profit-Sharing Plans. To correct for the exclusion of an eligible employee from nonelective contributions in a profit-sharing or stock bonus plan under the VCS correction method, an allocation amount is determined for each excluded employee on the same basis as the allocation amounts were determined for the other employees under the plan's allocation formula (e.g., the same ratio of allocation to compensation), taking into account all of the employee's relevant factors (e.g., compensation) under that formula for that year. The employer makes a corrective contribution on behalf of the excluded employee that is equal to the allocation amount for the excluded employee. The corrective contribution is adjusted for earnings. If, as a result of excluding an employee, an amount was improperly allocated to the account balance of an eligible employee who shared in the original allocation of the nonelective contribution, no reduction is made to the account balance of the employee who shared in the original allocation on account of the improper allocation. (See Example 8.)

(iii) Reallocation Correction Method. (A) In General. Subject to the limitations set forth in section 2.02(2)(a)(iii)(F) below, in addition to the VCS correction method, the exclusion of an eligible employee for a plan year from a profit-sharing or stock bonus plan that provides for nonelective contributions may be corrected using the reallocation correction method set forth in this section 2.02(2)(a)(iii). Under the reallocation correction method, the account balance of the excluded employee is increased as provided in paragraph (2)(a)(iii)(B) below, the account balances of other employees are reduced as provided in paragraph (2)(a)(iii)(C) below, and the increases and reductions are reconciled, as necessary, as provided in paragraph (2)(a)(iii)(D) below. (See Examples 9 and 10.)

(B) Increase in Account Balance of Excluded Employee. The account balance of the excluded employee is increased by an amount that is equal to the allocation the employee would have received had the employee shared in the allocation of the nonelective contribution. The amount is adjusted for earnings.

(C) Reduction in Account Balances of Other Employees. (*1*) The account balance of each employee who was an eligible employee who shared in the original allocation of the nonelective contribution is reduced by the excess, if any, of (I) the employee's allocation of that contribution over (II) the amount that would have been allocated to that employee had the failure not occurred. This amount is adjusted for earnings taking into account the rules set forth in section 2.02(2)(a)(iii)(C)(*2*) and (*3*) below. The amount after adjustment for earnings is limited in accordance with section 2.02(2)(a)(iii)(C)(*4*) below.

(*2*) This paragraph (2)(a)(iii)(C)(*2*) applies if most of the employees with account balances that are being reduced are nonhighly compensated employees. If there has been an overall gain for the period from the date of the original allocation of the contribution through the date of correction, no adjustment for earnings is required to the amount determined under section 2.02(2)(a)(iii)(C)(*1*) for the employee. If the amount for the employee is being adjusted for earnings and the plan permits investment of account balances in more than one investment fund, for administrative convenience, the reduction to the employee's account balance may be adjusted by the lowest earnings rate of any fund for the period from the date of the original allocation of the contribution through the date of correction.

(*3*) If an employee's account balance is reduced and the original allocation was made to more than one investment fund or there was a subsequent distribution or transfer from the fund receiving the original allocation, then reasonable, consistent assumptions are used to determine the earnings adjustment.

(*4*) The amount determined in section 2.02(2)(a)(iii)(C)(*1*) for an employee after the application of section 2.02(2)(a)(iii)(C)(*2*) and (*3*) may not exceed the account balance of the employee on the date of correction, and the employee is permitted to retain any distribution made prior to the date of correction.

(D) Reconciliation of Increases and Reductions. If the aggregate amount of the increases under section 2.02(2)(a)(iii)(B) exceeds the aggregate amount of the reductions under section 2.02(2)(a)(iii)(C), the employer makes a corrective contribution to the plan for the amount of the excess. If the aggregate amount of the reductions under section 2.02(2)(a)(iii)(C) exceeds the aggregate amount of the increases under section 2.02(2)(a)(iii)(B), then the amount by which each employee's account balance is reduced under section 2.02(2)(a)(iii)(C) is decreased on a pro rata basis.

(E) Reductions Among Multiple Investment Funds. If an employee's account balance is reduced and the employee's account balance is invested in more than one investment fund, then the reduction may be made from the investment funds selected in any reasonable manner.

(F) Limitations on Use of Reallocation Correction Method. If any employee would be permitted to retain any distribution pursuant to section 2.02(2)(a)(iii)(C)(*4*), then the reallocation correction method may not be used unless most of the employees who would be permitted to retain a distribution are nonhighly compensated employees.

(b) Examples.

Example 8:

Employer D maintains a profit-sharing plan that provides for discretionary nonelective employer contributions. The plan provides that the employer's contributions are allocated to account balances in the ratio that each eligible employee's compensation for the plan year bears to the compensation of all eligible employees for the plan year and, therefore, the only relevant factor for determining an allocation is the employee's compensation. The plan provides for self-directed investments among four investment funds and daily valuations of account balances. For the 1997 plan year, Employer D made a contribution to the plan of a fixed dollar amount. However, five employees who met the eligibility requirements were inadvertently excluded from participating in the plan. The contribution resulted in an allocation on behalf of each of the eligible employees, other than the excluded employees, equal to 10% of compensation. Most of the employees who received allocations under the plan for the year of the failure were nonhighly compensated employees. No distributions have been made from the plan since 1997. If the five excluded employees had shared in the original allocation, the allocation made on behalf of each employee would have equaled 9% of compensation. The excluded employees began participating in the plan in the 1998 plan year.

Correction:

Employer D uses the VCS correction method to correct the failure to include the five eligible

employees. Thus, Employer D makes a corrective contribution to the plan. The amount of the corrective contribution on behalf of the five excluded employees for the 1997 plan year is equal to 10% of compensation of each excluded employee, the same allocation that was made for other eligible employees, adjusted for earnings. The excluded employees receive an allocation equal to 10% of compensation (adjusted for earnings) even though, had the excluded employees originally shared in the allocation for the 1997 contribution, their account balances, as well as those of the other eligible employees, would have received an allocation equal to only 9% of compensation.

Example 9:

The facts are the same as in Example 8.

Correction:

Employer D uses the reallocation correction method to correct the failure to include the five eligible employees. Thus, the account balances are adjusted to reflect what would have resulted from the correct allocation of the employer contribution for the 1997 plan year among all eligible employees, including the five excluded employees. The inclusion of the excluded employees in the allocation of that contribution would have resulted in each eligible employee, including each excluded employee, receiving an allocation equal to 9% of compensation. Accordingly, the account balance of each excluded employee is increased by 9% of the employee's 1997 compensation, adjusted for earnings. The account balance of each of the eligible employees other than the excluded employees is reduced by 1% of the employee's 1997 compensation, adjusted for earnings. Employer D determines the adjustment for earnings using the earnings rate of each eligible employee's excess allocation (using reasonable, consistent assumptions). Accordingly, for an employee who shared in the original allocation and directed the investment of the allocation into more than one investment fund or who subsequently transferred a portion of a fund that had been credited with a portion of the 1997 allocation to another fund, reasonable, consistent assumptions are followed to determine the adjustment for earnings. It is determined that the total of the initially determined reductions in account balances exceeds the total of the required increases in account balances. Accordingly, these initially determined reductions are decreased pro rata so that the total of the actual reductions in account balances equals the total of the increases in the account balances, and Employer D does not make any corrective contribution. The reductions from the account balances are made on a pro rata basis among all of the funds in which each employee's account balance is invested.

Example 10:

The facts are the same as in Example 8.

Correction:

The correction is the same as in Example 9, except that, because most of the employees whose account balances are being reduced are nonhighly compensated employees, for administrative convenience, Employer D uses the earnings rate of the fund with the lowest earnings rate for the period of the failure to adjust the reduction to each account balance. It is determined that the aggregate amount (adjusted for earnings) by which the account balances of the excluded employees is increased exceeds the aggregate amount (adjusted for earnings) by which the other employees' account balances are reduced. Accordingly, Employer D makes a contribution to the plan in an amount equal to the excess. The reduction from account balances is made on a pro rata basis among all of the funds in which each employee's account balance is invested.

.03 *Vesting Failures.*

(1) Correction Methods. (a) Contribution Correction Method. A failure in a defined contribution plan to apply the proper vesting percentage to an employee's account balance that results in forfeiture of too large a portion of the employee's account balance may be corrected using the contribution correction method set forth in this paragraph. The employer makes a corrective contribution on behalf of the employee whose account balance was improperly forfeited in an amount equal to the improper forfeiture. The corrective contribution is adjusted for earnings. If, as a result of the improper forfeiture, an amount was improperly allocated to the account balance of another employee, no reduction is made to the account balance of that employee. (See Example 11.)

(b) Reallocation Correction Method. In addition to the contribution correction method, in a defined contribution plan under which forfeitures of account balances are reallocated among the account balances of the other eligible employees in the plan, a failure to apply the proper vesting percentage to an employee's account balance which results in forfeiture of too large a portion of the employee's account balance may be corrected under the reallocation correction method set forth in this paragraph. A corrective reallocation is made in accordance with the reallocation correction method set forth in section 2.02(2)(a)(iii), subject to the limitations set forth in section 2.02(2)(a)(iii)(F). In applying section 2.02(2)(a)(iii)(B), the account balance of the employee who incurred the improper forfeiture is increased by an amount equal to the amount of the improper forfeiture and the amount is adjusted for earnings. In applying section 2.02(2)(a)(iii)(C)(*1*), the account balance of each employee who shared in the allocation of the improper forfeiture is reduced by the amount of the improper forfeiture that was allocated to that employee's account. The earnings adjustments for the account balances that are being reduced are determined in accordance with sections 2.02(2)(a)(iii)(C)(*2*) and (*3*) and the reductions after adjustments for earnings are limited in accordance with section 2.02(2)(a)(iii)(C)(*4*). In accordance with section 2.02(2)(a)(iii)(D), if the aggregate amount of the increases exceeds the aggregate amount of the reductions, the employer makes a corrective contribution to the plan for the amount of the excess. In accordance with section 2.02(2)(a)(iii)(D), if the aggregate amount of the reductions exceeds the aggregate amount of the increases, then the amount by which each employee's account balance is reduced is decreased on a *pro rata* basis. (See Example 12.)

(2) Examples.

Example 11:

Employer E maintains a profit-sharing plan that provides for nonelective contributions. The plan provides for self-directed investments among four investment funds and daily valuation of account balances. The plan provides that forfeitures of account balances are reallocated among the account balances of other eligible employees on the basis of compensation. During the 1997 plan year, Employee R terminated employment with Employer E and elected and received a single-sum distribution of the vested portion of his account balance. No other distributions have been made since 1997. However, an incorrect determination of Employee R's vested percentage was made resulting in Employee R receiving a distribution of less than the amount to which he was entitled under the plan. The remaining portion of Employee R's account balance was forfeited and reallocated (and these reallocations were not affected by the limitations of § 415). Most of the employees who received allocations of the improper forfeiture were nonhighly compensated employees.

Correction:

Employer E uses the contribution correction method to correct the improper forfeiture. Thus, Employer E makes a contribution on behalf of Employee R equal to the incorrectly forfeited amount (adjusted for earnings) and Employee R's account balance is increased accordingly. No reduction is made from the account balances of the employees who received an allocation of the improper forfeiture.

Example 12:

The facts are the same as in Example 11.

Correction:

Employer E uses the reallocation correction method to correct the improper forfeiture. Thus, Employee R's account balance is increased by the amount that was improperly forfeited (adjusted for earnings). The account of each employee who shared in the allocation of the improper forfeiture is reduced by the amount of the improper forfeiture that was allocated to that employee's account (adjusted for earnings). Because most of the employees whose account balances are being reduced are nonhighly compensated employees, for administrative convenience, Employer E uses the earnings rate of the fund with the lowest earnings rate for the period of the failure to adjust the reduction to each account balance. It is determined that the amount (adjusted for earnings) by which the account balance of Employee R is increased exceeds the aggregate amount (adjusted for earnings) by which the other employees' account balances are reduced. Accordingly, Employer E makes a contribution to the plan in an amount equal to the excess. The reduction from the account balances is made on a pro rata basis among all of the funds in which each employee's account balance is invested.

.04 *§ 415 Failures.*

(1) Failures Relating to a § 415(b) Excess.

(a) Correction Methods. (i) Return of Overpayment Correction Method. Overpayments as a result of amounts being paid in excess of the limits of § 415(b) may be corrected using the return of Overpayment correction method set forth in this paragraph (1)(a)(i). The employer takes reasonable steps to have the Overpayment (with appropriate interest) returned by the recipient to the plan and reduces future benefit payments (if any) due to the employee to reflect § 415(b). To the extent the amount returned by the recipient is less than the Overpayment, adjusted for earnings at the plan's earnings rate, then the employer or another person contributes the difference to the plan. In addition, in accordance with section 6.05 of this revenue procedure, the employer must notify the recipient that the Overpayment was not eligible for favorable tax treatment accorded to distributions from qualified plans (and, specifically, was not eligible for tax-free rollover). (See Examples 15 and 16.)

(ii) Adjustment of Future Payments Correction Method. (A) In General. In addition to the return of overpayment correction method, in the case of plan benefits that are being distributed in the form of periodic payments, Overpayments as a result of amounts being paid in excess of the limits in § 415(b) may be corrected by using the adjustment of future payments correction method set forth in this paragraph (1)(a)(ii). Future payments to the recipient are reduced so that they do not exceed the § 415(b) maximum limit and an additional reduction is made to recoup the Overpayment (over a period not longer than the remaining payment period) so that the actuarial present value of the additional reduction is equal to the Overpayment plus interest at the interest rate used by the plan to determine actuarial equivalence. (See Examples 13 and 14.)

(B) Joint and Survivor Annuity Payments. If the employee is receiving payments in the form of a joint and survivor annuity, with the employee's spouse to receive a life annuity upon the employee's death equal to a percentage (e.g., 75%) of the amount being paid to the employee, the reduction of future annuity payments to reflect § 415(b) reduces the amount of benefits payable during the lives of both the employee and spouse, but any reduction to recoup Overpayments made to the employee does not reduce the amount of the spouse's survivor benefit. Thus, the spouse's benefit will be based on the previous specified percentage (e.g., 75%) of the maximum permitted under § 415(b), instead of the reduced annual periodic amount payable to the employee.

(C) Overpayment Not Treated as an Excess Amount. An Overpayment corrected under this adjustment of future payment correction method is not treated as an Excess Amount as defined in section 5.01(3) of this revenue procedure.

(b) Examples.

Example 13:

Employer F maintains a defined benefit plan funded solely through employer contributions. The plan provides that the benefits of employees are limited to the maximum amount permitted under § 415(b), disregarding cost-of-living adjustments under § 415(d) after benefit payments have commenced. At the beginning of the 1998 plan year, Employee S retired and started receiving an annual straight life annuity of $140,000 from the plan. Due to an administrative error, the annual amount received by Employee S for 1998 included an Overpayment of $10,000 (because the § 415(b)(1)(A) limit for 1998 was $130,000). This error was discovered at the beginning of 1999.

Correction:

Employer F uses the adjustment of future payments correction method to correct the failure to satisfy the limit in § 415(b). Future annuity benefit payments to Employee S are reduced so that they do not exceed the § 415(b) maximum limit, and, in addition, Employee S's future benefit payments from the plan are actuarially reduced to recoup the Overpayment. Accordingly, Employee S's future benefit payments from the plan are reduced to $130,000 and further reduced by $1,000 annually for life, beginning in 1999. The annual benefit amount is reduced by $1,000 annually for life because, for Employee S, the actuarial present value of a benefit of $1,000 annually for life commencing in 1999 is equal to the sum of $10,000 and interest at the rate used by the plan to determine actuarial equivalence beginning with the date of the first Overpayment and ending with the date the reduced annuity payment begins. Thus, Employee S's remaining benefit payments are reduced so that Employee S receives $129,000 for 1999, and for each year thereafter.

Example 14:

The facts are the same as in Example 13.

Correction:

Employer F uses the adjustments of future payments correction method to correct the § 415(b) failure, by recouping the entire excess payment made in 1998 from Employee S's remaining benefit payments for 1999. Thus, Employee S's annual annuity benefit for 1999 is reduced to $119,400 to reflect the excess benefit amounts (increased by interest) that were paid from the plan to Employee S during the 1998 plan year. Beginning in 2000, Employee S begins to receive annual benefit payments of $130,000.

Example 15:

The facts are the same as in Example 13, except that the benefit was paid to Employee S in the form of a single-sum distribution in 1998, which exceeded the maximum § 415(b) limits by $110,000.

Correction:

Employer F uses the return of overpayment correction method to correct the § 415(b) failure. Thus, Employer F notifies Employee S of the $110,000 Overpayment and that the Overpayment was not eligible for favorable tax treatment accorded to distributions from qualified plans (and, specifically, was not eligible for tax-free rollover). The notice also informs Employee S that the Overpayment (with interest at the rate used by the plan to calculate the single-sum payment) is owed to the plan. Employer F takes reasonable steps to have the Overpayment (with interest at the rate used by the plan to calculate the single-sum payment) paid to the plan. Employee S pays the $110,000 (plus the requested interest) to the plan. It is determined that the plan's earnings rate for the relevant period was 2 percentage points more than the rate used by the plan to calculate the single-sum payment. Accordingly, Employer F contributes the difference to the plan.

Example 16:

The facts are the same as in Example 15.

Correction:

Employer F uses the return of overpayment correction method to correct the § 415(b) failure. Thus, Employer F notifies Employee S of the $110,000 Overpayment and that the Overpayment was not eligible for favorable tax treatment accorded to distributions from qualified plans (and, specifically, was not eligible for tax-free rollover). The notice also informs Employee S that the Overpayment (with interest at the rate used by the plan to calculate the single-sum payment) is owed to the plan. Employer F takes reasonable steps to have the Overpayment (with interest at the rate used by the plan to calculate the single-sum payment) paid to the plan. As a result of Employer F's recovery efforts, some, but not all, of the Overpayment (with interest) is recovered from Employee S. It is determined that the amount returned by Employee S to the plan is less than the Overpayment adjusted for earnings at the plan's earnings rate. Accordingly, Employer F contributes the difference to the plan.

(2) Failures Relating to a § 415(c) Excess.

(a) Correction Methods. (i) VCS Correction Method. Appendix A, section .08 sets forth the VCS correction method for correcting the failure to satisfy the § 415(c) limits on annual additions.

(ii) Forfeiture Correction Method. In addition to the VCS correction method, the failure to satisfy § 415(c) with respect to a nonhighly compensated employee (A) who in the limitation year of the failure had annual additions consisting of both (I) either elective deferrals or employee after-tax contributions or both and (II) either matching or nonelective contributions or both, (B) for whom the matching and nonelective contributions equal or exceed the portion of the employee's annual addition that exceeds the limits under § 415(c) ("§ 415(c) excess") for the limitation year, and (C) who has terminated with no vested interest in the matching and nonelective contributions (and has not been reemployed at the time of the correction), may be corrected by using the forfeiture correction method set forth in this paragraph. The § 415(c) excess is deemed to consist solely of the matching and nonelective contributions. If the employee's § 415(c) excess (adjusted for earnings) has previously been forfeited, the § 415(c) failure is deemed to be corrected. If the § 415(c) excess (adjusted for earnings) has not been forfeited, that amount is placed in an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s) (or if the amount would have been allocated to other employees who were in the plan for the year of the failure if the failure had not occurred, then that amount is reallocated to the other employees in accordance with the plan's allocation formula). Note that while this correction method will permit more favorable tax treatment of elective deferrals for the employee than the VCS correction method, this correction method could be less favorable to the employee in certain cases, for example, if the employee is subsequently reemployed and becomes vested. (See Examples 17 and 18.)

(iii) Return of Overpayment Correction Method. A failure to satisfy § 415(c) that includes a distribution of the § 415(c) excess attributable to nonelective contributions and matching contributions may be corrected using the return of overpayment correction method set forth in this paragraph. The employer takes reasonable steps to have the Overpayment (i.e., the distribution of the § 415(c) excess adjusted for earnings to the date of the distribution), plus appropriate interest from the date of the distribution to the date of the repayment, returned by the employee to the plan. To the extent the amount returned by the employee is less than the Overpayment adjusted for earnings at the plan's earnings rate, then the employer or another person contributes the difference to the plan. The Overpayment, adjusted for earnings at the plan's earnings rate to the date of the repayment, is to be placed in an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s) (or if the amount would have been allocated to other eligible employees who were in the plan for the year of the failure if the failure had not occurred, then that amount is reallocated to the other eligible employees in accordance with the plan's allocation formula). In addition, the employer must notify the employee that the Overpayment was not eligible for favorable tax treatment accorded to distributions from qualified plans (and, specifically, was not eligible for tax-free rollover).

(b) Examples.

Example 17:

Employer G maintains a 401(k) plan. The plan provides for nonelective employer contributions, elective deferrals, and employee after-tax contributions. The plan provides that the nonelective contributions vest under a 5-year cliff vesting schedule. The plan provides that when an employee terminates employment, the employee's nonvested account balance is forfeited five years after a distribution of the employee's vested account balance and that forfeitures are used to reduce employer contributions. For the 1998 limitation year, the annual additions made on behalf of two nonhighly compensated employees in the plan, Employees T and U, exceeded the limit in § 415(c). For the 1998 limitation year, Employee T had § 415 compensation of $60,000, and, accordingly, a § 415(c)(1)(B) limit of $15,000. Employee T made elective deferrals and employee after-tax contributions. For the 1998 limitation year, Employee U had § 415 compensation of $40,000, and, accordingly, a § 415(c)(1)(B) limit of $10,000. Employee U made elective deferrals. Also, on January 1, 1999, Employee U, who had three years of service with Employer G, terminated his employment and received his entire vested account balance (which consisted of his elective deferrals). The annual additions for Employees T and U consisted of:

	T	U
Nonelective Contributions	$7,500	$4,500
Elective Deferrals	10,000	5,800
After-tax Contributions	500	0
Total Contributions	$18,000	$10,300
§ 415(c) Limit	$15,000	$10,000
§ 415(c) Excess	$3,000	$300

Correction:

Employer G uses the VCS correction method to correct the § 415(c) excess with respect to Employee T (i.e., $3,000). Thus, a distribution of plan assets (and corresponding reduction of the account balance) consisting of $500 (adjusted for earnings) of employee after-tax contributions and $2,500 (adjusted for earnings) of elective deferrals is made to Employee T. Employer G uses the forfeiture correction method to correct the § 415(c) excess with respect to Employee U. Thus, the § 415(c) excess is deemed to consist solely of the nonelective contributions. Accordingly, Employee U's nonvested account balance is reduced by $300 (adjusted for earnings) which is placed in an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s). After correction, it is determined that the ADP and ACP tests for 1998 were satisfied.

Example 18:

Employer H maintains a 401(k) plan. The plan provides for nonelective employer contributions, matching contributions and elective deferrals. The plan provides for matching contributions that are equal to 100% of an employee's elective deferrals that do not exceed 8% of the employee's plan compensation for the plan year. For the 1998 limitation year, Employee V had § 415 compensation of $50,000, and, accordingly, a § 415(c)(1)(B) limit of $12,500. During that limitation year, the annual additions for Employee V totaled $15,000, consisting of $5,000 in elective deferrals, a $4,000 matching contribution (8% of $50,000), and a $6,000 nonelective employer contribution. Thus, the annual additions for Employee V exceeded the § 415(c) limit by $2,500.

Correction:

Employer H uses the VCS correction method to correct the § 415(c) excess with respect to Employee V (i.e., $2,500). Accordingly, $1,000 of the unmatched elective deferrals (adjusted for earnings) are distributed to Employee V. The remaining $1,500 excess is apportioned equally between the elective deferrals and the associated matching employer contributions, so Employee V's account balance is further reduced by distributing to Employee V $750 (adjusted for earnings) of the elective deferrals and forfeiting $750 (adjusted for earnings) of the associated employer matching contributions. The forfeited matching contributions are placed in an unallocated account; similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s). After correction, it is determined that the ADP and ACP tests for 1998 were satisfied.

.05 *Correction of Other Overpayment Failures.*

An Overpayment, other than one described in section 2.04(1) (relating to a § 415(b) excess) or section 2.04(2) (relating to a § 415(c) excess), may be corrected in accordance with this section 2.05. An Overpayment from a defined benefit plan is corrected in accordance with the rules in section 2.04(1). An Overpayment from a defined contribution plan is corrected in accordance with the rules in section 2.04(2)(a)(iii).

.06 *§ 401(a)(17) Failures.*

(1) Reduction of Account Balance Correction Method. The allocation of contributions or forfeitures under a defined contribution plan for a plan year on the basis of compensation in excess of the limit under § 401(a)(17) for the plan year may be corrected using the reduction of account balance correction method set forth in this paragraph. The account balance of an employee who received an allocation on the basis of compensation in excess of the § 401(a)(17) limit is reduced by this improperly allocated amount (adjusted for earnings). If the improperly allocated amount would have been allocated to other employees in the year of the failure if the failure had not occurred, then that amount (adjusted for earnings) is reallocated to those employees in accordance with the plan's allocation formula. If the improperly allocated amount would not have been allocated to other employees absent the failure, that amount (adjusted for earnings) is placed in an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s). For example, if a plan provides for a fixed level of employer contributions for each eligible employee, and the plan provides that forfeitures are used to reduce future employer contributions, the improperly allocated amount (adjusted for earnings) would be used to reduce future employer contributions. (See Example 19.) If a payment was made to an employee and that payment was attributable to an improperly allocated amount, then it is an Overpayment defined in section 5.01(6) of this revenue procedure that must be corrected (see sections 2.04 and 2.05).

(2) Example.

Example 19:

Employer J maintains a money purchase pension plan. Under the plan, an eligible employee is entitled to an employer contribution of 8% of the employee's compensation up to the § 401(a)(17) limit ($160,000 for 1998). During the 1998 plan year, an eligible employee, Employee W, inadvertently was credited with a contribution based on compensation above the § 401(a)(17) limit. Employee W's compensation for 1998 was $220,000. Employee W received a contribution of $17,600 for 1998 (8% of $220,000), rather than the contribution of $12,800 (8% of $160,000) provided by the plan for that year, resulting in an improper allocation of $4,800.

Correction:

The § 401(a)(17) failure is corrected using the reduction of account balance method by reducing Employee W's account balance by $4,800 (adjusted for earnings) and crediting that amount to an unallocated account, similar to the suspense account described in § 1.415–6(b)(6)(iii), to be used to reduce employer contributions in succeeding year(s).

.07 Correction by Amendment Under VCP and SCP.

(1) § 401(a)(17) Failures. (a) Contribution Correction Method. In addition to the reduction of account balance correction method under section 2.06 of this Appendix B, an employer may correct a § 401(a)(17) failure for a plan year under a defined contribution plan under VCP and SCP (in accordance with the requirements of sections 8, 10, and 11) by using the contribution correction method set forth in this paragraph. The employer contributes an additional amount on behalf of each of the other employees (excluding each employee for whom there was a § 401(a)(17) failure) who received an allocation for the year of the failure, amending the plan (as necessary) to provide for the additional allocation. The amount contributed for an employee is equal to the employee's plan compensation for the year of the failure multiplied by a fraction, the numerator of which is the improperly allocated amount made on behalf of the employee with the largest improperly allocated amount, and the denominator of which is the limit under § 401(a)(17) applicable to the year of the failure. The resulting additional amount for each of the other employees is adjusted for earnings. (See Example 20.)

(b) Examples.

Example 20:

The facts are the same as in Example 19.

Correction:

Employer J corrects the failure under VCP using the contribution correction method by (1) amending the plan to increase the contribution percentage for all eligible employees (other than Employee W) for the 1998 plan year and (2) contributing an additional amount (adjusted for earnings) for those employees for that plan year. To determine the increase in the plan's contribution percentage (and the additional amount contributed on behalf of each eligible employee), the improperly allocated amount ($4,800) is divided by the § 401(a)(17) limit for 1998 ($160,000). Accordingly, the plan is amended to increase the contribution percentage by 3 percentage points ($4,800/$160,000) from 8% to 11%. In addition, each eligible employee for the 1998 plan year (other than Employee W) receives an additional contribution of 3% multiplied by that employee's plan compensation for 1998. This additional contribution is adjusted for earnings.

(2) Hardship Distribution Failures. (a) Plan Amendment Correction Method. The Operational Failure of making hardship distributions to employees under a plan that does not provide for hardship distributions may be corrected under VCP and SCP using the plan amendment correction method set forth in this paragraph. The plan is amended retroactively to provide for the hardship distributions that were made available. This paragraph does not apply unless (i) the amendment satisfies § 401(a), and (ii) the plan as amended would have satisfied the qualification requirements of § 401(a) (including the requirements applicable to hardship distributions under § 401(k), if applicable) had the amendment been adopted when hardship distributions were first made available. (See Example 21.)

(b) Example.

Example 21:

Employer K, a for-profit corporation, maintains a 401(k) plan. Although plan provisions in 1998 did not provide for hardship distributions, beginning in 1998 hardship distributions of amounts allowed to be distributed under § 401(k) were made currently and effectively available to all employees (within the meaning of § l.401(a)(4)–4). The standard used to determine hardship satisfied the deemed hardship distribution standards in § 1.401(k)–1(d)(2). Hardship distributions were made to a number of employees during the 1998 and 1999 plan years, creating an Operational Failure. The failure was discovered in 2000.

Correction:

Employer K corrects the failure under VCP by adopting a plan amendment, effective January 1, 1998, to provide a hardship distribution option that satisfies the rules applicable to hardship distributions in § 1.401(k)–1(d)(2). The amendment provides that the hardship distribution option is available to all employees. Thus, the amendment satisfies § 401(a), and the plan as amended in 2000 would have satisfied § 401(a) (including § 1.401(a)(4)–4 and the requirements applicable to hardship distributions under § 401(k)) if the amendment had been adopted in 1998.

(3) Inclusion of Ineligible Employee Failure. (a) Plan Amendment Correction Method. The Operational Failure of including an ineligible employee in the plan who has not completed the plan's minimum age or service requirements may be corrected under VCP and SCP by using the plan amendment correction method set forth in this paragraph. The plan is amended retroactively to change the eligibility provisions to provide for the inclusion of the ineligible employee to reflect the plan's actual operations. This paragraph does not apply unless (i) the amendment satisfies § 401(a) at the time it is adopted, (ii) the amendment would have satisfied § 401(a) had the amendment been adopted at the earlier time when it is effective, and (iii) the employees affected by the amendment are predominantly nonhighly compensated employees.

(b) Example.

Example 22:

Employer L maintains a 401(k) plan applicable to all of its employees who have at least six months of service. The plan is a calendar year plan. The plan provides that Employer L will make matching contributions based upon an employee's salary reduction contributions. In 2001, it is discovered that all four employees who were hired by Employer L in 2000 were permitted to make salary reduction contributions to the plan effective with the first weekly paycheck after they were employed. Three of the four employees are nonhighly compensated. Employer L matched these employees' salary reduction contributions in accordance with the plan's matching contribution formula. Employer L calculates the ADP and ACP tests for 2000 (taking into account the salary reduction and matching contributions that were made for these employees) and determines that the tests were satisfied.

Correction:

Employer L corrects the failure under SCP by adopting a plan amendment, effective for employees hired on or after January 1, 2000, to provide that there is no service eligibility requirement under the plan and submitting the amendment to the Service for a determination letter.

SECTION 3. EARNINGS ADJUSTMENT METHODS AND EXAMPLES

.01 *Earnings Adjustment Methods*. (1) In general. (a) Under section 6.02(4)(a) of this revenue procedure, whenever the appropriate correction method for an Operational Failure in a defined contribution plan includes a corrective contribution or allocation that increases one or more employees' account balances (now or in the future), the contribution or allocation is adjusted for earnings and forfeitures. This section 3 provides earnings adjustment methods (but not forfeiture adjustment methods) that may be used by an employer to adjust a corrective contribution or allocation for earnings in a defined contribution plan. Consequently, these earnings adjustment methods may be used to determine the earnings adjustments for corrective contributions or allocations made under the correction methods in section 2 and under the VCS correction methods in Appendix A. If an earnings adjustment method in this section 3 is used to adjust a corrective contribution or allocation, that adjustment is treated as satisfying the earnings adjustment requirement of section 6.02(4)(a) of this revenue procedure. Other earnings adjustment methods, different from those illustrated in this section 3, may also be appropriate for adjusting corrective contributions or allocations to reflect earnings.

(b) Under the earnings adjustment methods of this section 3, a corrective contribution or allocation that increases an employee's account balance is adjusted to reflect an "earnings amount" that is based on the earnings rate(s) (determined under section 3.01(3)) for the period of the failure (determined under section 3.01(2)). The earnings amount is allocated in accordance with section 3.01(4).

(c) The rule in section 6.02(5)(a) of this revenue procedure permitting reasonable estimates in certain circumstances applies for purposes of this section 3. For this purpose, a determination of earnings made in accordance with the rules of administrative convenience set forth in this section 3 is treated as a precise determination of earnings. Thus, if the probable difference between an approximate determination of earnings and a determination of earnings

under this section 3 is insignificant and the administrative cost of a precise determination would significantly exceed the probable difference, reasonable estimates may be used in calculating the appropriate earnings.

(d) This section 3 does not apply to corrective distributions or corrective reductions in account balances. Thus, for example, while this section 3 applies in increasing the account balance of an improperly excluded employee to correct the exclusion of the employee under the reallocation correction method described in section 2.02(2)(a)(iii)(B), this section 3 does not apply in reducing the account balances of other employees under the reallocation correction method. (See section 2.02(2)(a)(iii)(C) for rules that apply to the earnings adjustments for such reductions.) In addition, this section 3 does not apply in determining earnings adjustments under the one-to-one correction method described in section 2.01(1)(b)(iii).

(2) Period of the Failure. (a) General Rule. For purposes of this section 3, the "period of the failure" is the period from the date that the failure began through the date of correction. For example, in the case of an improper forfeiture of an employee's account balance, the beginning of the period of the failure is the date as of which the account balance was improperly reduced.

(b) Rules for Beginning Date for Exclusion of Eligible Employees from Plan. (i) General Rule. In the case of an exclusion of an eligible employee from a plan contribution, the beginning of the period of the failure is the date on which contributions of the same type (e.g., elective deferrals, matching contributions, or discretionary nonelective employer contributions) were made for other employees for the year of the failure. In the case of an exclusion of an eligible employee from an allocation of a forfeiture, the beginning of the period of the failure is the date on which forfeitures were allocated to other employees for the year of the failure.

(ii) Exclusion from a 401(k) or (m) Plan. For administrative convenience, for purposes of calculating the earnings rate for corrective contributions for a plan year (or the portion of the plan year) during which an employee was improperly excluded from making periodic elective deferrals or employee after-tax contributions, or from receiving periodic matching contributions, the employer may treat the date on which the contributions would have been made as the midpoint of the plan year (or the midpoint of the portion of the plan year) for which the failure occurred. Alternatively, in this case, the employer may treat the date on which the contributions would have been made as the first date of the plan year (or the portion of the plan year) during which an employee was excluded, provided that the earnings rate used is one half of the earnings rate applicable under section 3.01(3) for the plan year (or the portion of the plan year) for which the failure occurred.

(3) Earnings Rate. (a) General Rule. For purposes of this section 3, the earnings rate generally is based on the investment results that would have applied to the corrective contribution or allocation if the failure had not occurred.

(b) Multiple Investment Funds. If a plan permits employees to direct the investment of account balances into more than one investment fund, the earnings rate is based on the rate applicable to the employee's investment choices for the period of the failure. For administrative convenience, if most of the employees for whom the corrective contribution or allocation is made are nonhighly compensated employees, the rate of return of the fund with the highest earnings rate under the plan for the period of the failure may be used to determine the earnings rate for all corrective contributions or allocations. If the employee had not made any applicable investment choices, the earnings rate may be based on the earnings rate under the plan as a whole (i.e., the average of the rates earned by all of the funds in the valuation periods during the period of the failure weighted by the portion of the plan assets invested in the various funds during the period of the failure).

(c) Other Simplifying Assumptions. For administrative convenience, the earnings rate applicable to the corrective contribution or allocation for a valuation period with respect to any investment fund may be assumed to be the actual earnings rate for the plan's investments in that fund during that valuation period. For example, the earnings rate may be determined without regard to any special investment provisions that vary according to the size of the fund. Further, the earnings rate applicable to the corrective contribution or allocation for a portion of a valuation period may be a pro rata portion of the earnings rate for the entire valuation period, unless the application of this rule would result in either a significant understatement or overstatement of the actual earnings during that portion of the valuation period.

(4) Allocation Methods. (a) In General. For purposes of this section 3, the earnings amount generally may be allocated in accordance with any of the methods set forth in this paragraph (4). The methods under paragraph (4)(c), (d), and (e) are intended to be particularly helpful where corrective contributions are made at dates between the plan's valuation dates.

(b) Plan Allocation Method. Under the plan allocation method, the earnings amount is allocated to account balances under the plan in accordance with the plan's method for allocating earnings as if the failure had not occurred. (See Example 23.)

(c) Specific Employee Allocation Method. Under the specific employee allocation method, the entire earnings amount is allocated solely to the account balance of the employee on whose behalf the corrective contribution or allocation is made (regardless of whether the plan's allocation method would have allocated the earnings solely to that employee). In determining the allocation of plan earnings for the valuation period during which the corrective contribution or allocation is made, the corrective contribution or allocation (including the earnings amount) is treated in the same manner as any other contribution under the plan on behalf of the employee during that valuation period. Alternatively, where the plan's allocation method does not allocate plan earnings for a valuation period to a contribution made during that valuation period, plan earnings for the valuation period during which the corrective contribution or allocation is made may be allocated as if that employee's account balance had been increased as of the last day of the prior valuation period by the corrective contribution or allocation, including only that portion of the earnings amount attributable to earnings through the last day of the prior valuation period. The employee's account balance is then

further increased as of the last day of the valuation period during which the corrective contribution or allocation is made by that portion of the earnings amount attributable to earnings after the last day of the prior valuation period. (See Example 24.)

(d) Bifurcated Allocation Method. Under the bifurcated allocation method, the entire earnings amount for the valuation periods ending before the date the corrective contribution or allocation is made is allocated solely to the account balance of the employee on whose behalf the corrective contribution or allocation is made. The earnings amount for the valuation period during which the corrective contribution or allocation is made is allocated in accordance with the plan's method for allocating other earnings for that valuation period in accordance with section 3.01(4)(b). (See Example 25.)

(e) Current Period Allocation Method. Under the current period allocation method, the portion of the earnings amount attributable to the valuation period during which the period of the failure begins ("first partial valuation period") is allocated in the same manner as earnings for the valuation period during which the corrective contribution or allocation is made in accordance section 3.01(4)(b). The earnings for the subsequent full valuation periods ending before the beginning of the valuation period during which the corrective contribution or allocation is made are allocated solely to the employee for whom the required contribution should have been made. The earnings amount for the valuation period during which the corrective contribution or allocation is made ("second partial valuation period") is allocated in accordance with the plan's method for allocating other earnings for that valuation period in accordance with section 3.01(4)(b). (See Example 26.)

.02 Examples.

Example 23:

Employer L maintains a profit-sharing plan that provides only for nonelective contributions. The plan has a single investment fund. Under the plan, assets are valued annually (the last day of the plan year) and earnings for the year are allocated in proportion to account balances as of the last day of the prior year, after reduction for distributions during the current year but without regard to contributions received during the current year (the "prior year account balance"). Plan contributions for 1997 were made on March 31, 1998. On April 20, 2000, Employer L determines that an operational failure occurred for 1997 because Employee X was improperly excluded from the plan. Employer L decides to correct the failure by using the VCS correction method for the exclusion of an eligible employee from nonelective contributions in a profit-sharing plan. Under this method, Employer L determines that this failure is corrected by making a contribution on behalf of Employee X of $5,000 (adjusted for earnings). The earnings rate under the plan for 1998 was +20%. The earnings rate under the plan for 1999 was +10%. On May 15, 2000, when Employer L determines that a contribution to correct for the failure will be made on June 1, 2000, a reasonable estimate of the earnings rate under the plan from January 1, 2000 to June 1, 2000 is +12%.

Earnings Adjustment on the Corrective Contribution:

The $5,000 corrective contribution on behalf of Employee X is adjusted to reflect an earnings amount based on the earnings rates for the period of the failure (March 31, 1998 through June 1, 2000) and the earnings amount is allocated using the plan allocation method. Employer L determines that a pro rata simplifying assumption may be used to determine the earnings rate for the period from March 31, 1998, to December 31, 1998, because that rate does not significantly understate or overstate the actual earnings for that period. Accordingly, Employer L determines that the earnings rate for that period is 15% (9/12 of the plan's 20% earnings rate for the year). Thus, applicable earnings rates under the plan during the period of the failure are:

Time Periods	Earnings Rate
3/31/98 - 12/31/98 (First Partial Valuation Period)	+15%
1/1/99 - 12/31/99	+10%
1/1/00 - 6/1/00 (Second Partial Valuation Period)	+12%

If the $5,000 corrective contribution had been contributed for Employee X on March 31, 1998, (1) earnings for 1998 would have been increased by the amount of the earnings on the additional $5,000 contribution from March 31, 1998, through December 31, 1998, and would have been allocated as 1998 earnings in proportion to the prior year (December 31, 1997) account balances, (2) Employee X's account balance as of December 31, 1998, would have been increased by the additional $5,000 contribution, (3) earnings for 1999 would have been increased by the 1999 earnings on the additional $5,000 contribution (including 1998 earnings thereon) allocated in proportion to the prior year (December 31, 1998) account balances along with other 1999 earnings, and (4) earnings for 2000 would have been increased by the earnings on the additional $5,000 (including 1998 and 1999 earnings thereon) from January 1 to June 1, 2000, and would be allocated in proportion to the prior year (December 31, 1999) account balances along with other 2000 earnings. Accordingly, the $5,000 corrective contribution is adjusted to reflect an earnings amount of $2,084 ($5,000[(1.15)(1.10)(1.12)-1]) and the earnings amount is allocated to the account balances under the plan allocation method as follows:

(a) Each account balance that shared in the allocation of earnings for 1998 is increased, as of December 31, 1998, by its appropriate share of the earnings amount for 1998, $750 ($5,000(.15)).

(b) Employee X's account balance is increased, as of December 31, 1998, by $5,000.

(c) The resulting December 31, 1998 account balances will share in the 1999 earnings, including the $575 for 1999 earnings included in the corrective contribution ($5,750(.10)), to determine the account balances as of December 31, 1999. However, each account balance other than Employee X's account balance has already shared in the 1999 earnings, excluding the $575. Accordingly, Employee X's account balance as of December 31, 1999 will include $500 of the 1999 portion of the earnings amount based on the $5,000 corrective contribution allocated to Employee X's account balance as of December 31, 1998 ($5,000(.10)). Then each account balance that originally shared in the allocation of earnings for 1999 (i.e., excluding the $5,500 additions to Employee X's account balance) is increased by its appropriate share of the remaining 1999 portion of the earnings amount, $75.

(d) The resulting December 31, 1999, account balances (including the $5,500 additions to Employee X's account balance) will share in the 2000 portion of the earnings amount based on the estimated January 1, 2000, to June 1, 2000, earnings included in the corrective contribution equal to $759 ($6,325(.12)). (See Table 1.)

TABLE 1
CALCULATION AND ALLOCATION OF THE
CORRECTIVE AMOUNT ADJUSTED FOR EARNINGS

	Earnings Rate	Amount	Allocated to:
Corrective Contribution		$5,000	Employee X
First Partial Valuation Period Earnings	15%	750[1]	All 12/31/1997 Account Balances[4]
1999 Earnings	10%	575[2]	Employee X ($500)/ All 12/31/1998 Account Balances ($75)[4]
Second Partial Valuation Period Earnings	12%	759[3]	All 12/31/1999 Account Balances (including Employee X's $5,500)[4]
Total Amount Contributed		$7,084	

[1]$5,000 x 15%
[2]$5,750($5,000 +750) x 10%
[3]$6,325($5,000 +750 +575) x 12%
[4] After reduction for distributions during the year for which earning are being determined but without regard to contributions received during the year for which earnings are being determined.

Example 24:

The facts are the same as in Example 23.

Earnings Adjustment on the Corrective Contribution:

The earnings amount on the corrective contribution is the same as in Example 23, but the earnings amount is allocated using the specific employee allocation method. Thus, the entire earnings amount for all periods through June 1, 2000 (i.e., $750 for March 31, 1998 to December 31, 1998, $575 for 1999, and $759 for January 1, 2000 to June 1, 2000) is allocated to Employee X. Accordingly, Employer L makes a contribution on June 1, 2000, to the plan of $7,084 ($5,000(1.15)(1.10)(1.12)). Employee X's account balance as of December 31, 2000, is increased by $7,084. Alternatively, Employee X's account balance as of December 31, 1999, is increased by $6,325 ($5,000(1.15)(1.10)), which shares in the allocation of earnings for 2000, and Employee X's account balance as of December 31, 2000 is increased by the remaining $759. (See Table 2.)

TABLE 2

CALCULATION AND ALLOCATION OF THE
CORRECTIVE AMOUNT ADJUSTED FOR EARNINGS

	Earnings Rate	Amount	Allocated to:
Corrective Contribution		$5,000	Employee X
First Partial Valuation Period Earnings	15%	750[1]	Employee X
1999 Earnings	10%	575[2]	Employee X
Second Partial Valuation Period Earnings	12%	759[3]	Employee X
Total Amount Contributed		$7,084	

[1]$5,000 x 15%

[2]$5,750($5,000 +750) x 10%

[3]$6,325($5,000 +750 +575) x 12%

Example 25:

The facts are the same as in Example 23.

Earnings Adjustment on the Corrective Contribution:

The earnings amount on the corrective contribution is the same as in Example 23, but the earnings amount is allocated using the bifurcated allocation method. Thus, the earnings for the first partial valuation period (March 31, 1998 to December 31, 1998) and the earnings for 1999 are allocated to Employee X. Accordingly, Employer L makes a contribution on June 1, 2000 to the plan of $7,084 ($5,000(1.15)(1.10)(1.12)). Employee X's account balance as of December 31, 1999 is increased by $6,325 ($5,000(1.15)(1.10)); and the December 31, 1999 account balances of employees (including Employee X's increased account balance) will share in estimated January 1, 2000 to June 1, 2000 earnings on the corrective contribution equal to $759 ($6,325(.12)). (See Table 3.)

TABLE 3
CALCULATION AND ALLOCATION OF THE
CORRECTIVE AMOUNT ADJUSTED FOR EARNINGS

	Earnings Rate	Amount	Allocated to:
Corrective Contribution		$5,000	Employee X
First Partial Valuation Period Earnings	15%	750[1]	Employee X
1999 Earnings	10%	575[2]	Employee X
Second Partial Valuation Period	12%	759[3]	12/31/99 Account Balances Earnings (including Employee X's $6,325)[4]
Total Amount Contributed		$7,084	

[1]$5,000 x 15%
[2]$5,750($5,000 +750) x 10%
[3]$6,325($5,000 +750 +575) x 12%
[4] After reduction for distributions during the 2000 year but without regard to contributions received during the 2000 year .

Example 26:

The facts are the same as in Example 23.

Earnings Adjustment on the Corrective Contribution:

The earnings amount on the corrective contribution is the same as in Example 23, but the earnings amount is allocated using the current period allocation method. Thus, the earnings for the first partial valuation period (March 31, 1998 to December 31, 1998) are allocated as 2000 earnings. Accordingly, Employer L makes a contribution on June 1, 2000 to the plan of $7,084 ($5,000 (1.15)(1.10)(1.12)). Employee X's account balance as of December 31, 1999, is increased by the sum of $5,500 ($5,000(1.10)) and the remaining 1999 earnings on the corrective contribution equal to $75 ($5,000(.15)(.10)). Further, both (1) the estimated March 31, 1998 to December 31, 1998 earnings on the corrective contribution equal to $750 ($5,000(.15)) and (2) the estimated January 1, 2000 to June 1, 2000, earnings on the corrective contribution equal to $759 ($6,325(.12)) are treated in the same manner as 2000 earnings by allocating these amounts to the December 31, 2000, account balances of employees in proportion to account balances as of December 31, 1999 (including Employee X's increased account balance). (See Table 4.) Thus, Employee X is allocated the earnings for the full valuation period during the period of the failure.

TABLE 4
CALCULATION AND ALLOCATION OF THE
CORRECTIVE AMOUNT ADJUSTED FOR EARNINGS

	Earnings Rate	Amount	Allocated to:
Corrective Contribution		$5,000	Employee X
First Partial Valuation Period Earnings	15%	750[1]	12/31/99 Account Balances (including Employee X's $ 5,575)[4]
1999 Earnings	10%	575[2]	Employee X
Second Partial Valuation Period Earnings	12%	759[3]	12/31/99 Account Balances (including Employee X's $5,575)[4]
Total Amount Contributed		$7,084	

[1]$5,000 x 15%
[2]$5,750($5,000 +750) x 10%
[3]$6,325($5,000 +750 +575) x 12%
[4] After reduction for distributions during the year for which earnings are being determined but without regard to contributions received during the year for which earnings are being determined.

APPENDIX C

VCP CHECKLIST
IS YOUR SUBMISSION COMPLETE?

INSTRUCTIONS

The Service will be able to respond more quickly to your VCP request if it is carefully prepared and complete. To ensure that your request is in order, use this checklist. Answer each question in the checklist by inserting yes, no, or N/A, as appropriate, in the blank next to the item. *Sign and date the checklist (as taxpayer or authorized representative) and place it on top of your request.* You must submit a completed copy of this checklist with your request.

If a completed checklist is not submitted with your request, substantive consideration of your submission will be deferred until a completed checklist is received.

TAXPAYER'S NAME _____

TAXPAYER'S I.D. NO. _____

PLAN NAME & NO. _____

ATTORNEY/P.O.A. _____

The following items relate to all submissions:

_____ 1. Have you included a complete description of the failure(s) and the years in which the failure(s) occurred (including the years for which the statutory period has expired)? (See section 11.02(1) of Rev. Proc. 2001-17.) (Hereafter, all section references are to Rev. Proc. 2001-17.)

_____ 2. Have you included an explanation of how and why the failure(s) arose, including a description of the administrative procedures for the plan in effect at the time the failure(s) occurred? (See section 11.02(2) and (3).)

_____ 3. Have you included a detailed description of the method for correcting the failure(s) identified in your submission? This description must include, for example, the number of employees affected and the expected cost of correction (both of which may be approximated if the exact number cannot be determined at the time of the request), the years involved, and calculations or assumptions the Plan Sponsor used to determine the amounts needed for correction. In lieu of providing correction calculations with respect to each employee affected by a failure, you may submit calculations with respect to a representative sample of affected employees. However, the representative sample calculations must be sufficient to demonstrate each aspect of the correction method proposed. Note that each step of the correction method must be described in narrative form. (See section 11.02(4).)

_____ 4. Have you described the earnings or interest methodology (indicating computation period and basis for determining earnings or interest rates) that will be used to calculate earnings or interest on any corrective contributions or distributions? (As a general rule, the interest rate (or rates) earned by the plan during the applicable period(s) should be used in determining the earnings for corrective contributions or distributions.) (See section 11.02(5).)

If you inserted "N/A" for item 4, enter explanation:

_____

_____

_____

_____ 5. Have you submitted specific calculations for each affected employee or a representative sample of affected employees? (See section 11.02(6).)

_____ 6. Have you described the method that will be used to locate and notify former employees or, if there are no former employees affected by the failure(s) or the correction(s), provided an affirmative statement to that effect? (See section 11.02(7).)

_____ 7. Have you provided a description of the administrative measures that have been or will be implemented to ensure that the same failure(s) do not recur? (See section 11.02(8).)

_____ 8. Have you included a statement that, to the best of the Plan Sponsor's knowledge, the plan is not currently under an Employee Plans examination? (See section 11.02(9).)

_____ 9. Have you included a statement that, to the best of the Plan Sponsor's knowledge, the Plan Sponsor is not under an Exempt Organizations examination? (See section 11.02(9).)

_____ 10. Have you included a copy of the portions of the plan document (and adoption agreement, if applicable) relevant to the failure(s) and method(s) of correction? (See section 11.04(2).)

_____ 11. Have you included a copy of the plan's most recent Favorable Letter and/or the required applicable document(s)? (See section 11.04(4).)

_____ 12. Have you included the appropriate voluntary compliance fee due with the submission? (See section 11.06.)

_____ 13. Have you included the original signature of the sponsor or the sponsor's authorized representative? (See section 11.07.)

_____ 14. Have you included a Power of Attorney (Form 2848)? Note: representation under VCP is limited to attorneys, certified public accountants, enrolled agents, and enrolled actuaries; unenrolled return preparers are not eligible to act as representatives under VCP. (See section 11.08.)

_____ 15. Have you included a Penalty of Perjury Statement signed (original signature only) and dated by the Plan Sponsor? (See section 11.09.)

_____ 16. Have you designated your submission as a VCP, VCO, VCS, VCT, VCSEP, VCGroup, or Anonymous Submission Procedure, as appropriate? (See section 11.11.)

The following items relate only to submissions under VCO (including VCS):

_____ 17. If the plan is currently being considered in a determination letter application on a Form 5310, have you included a statement to that effect? (See section 11.03(10).)

_____ 18. Have you included a copy of the first page, the page containing employee census information (currently line 7f of the 1999 Form 5500), and the information relating to plan assets (currently line 31f of the 1999 Form 5500) of the most recently filed Form 5500 series return? Note: If a Form 5500 is not applicable, insert N/A and furnish the name of the plan, and the census information required of Form 5500 series filers. (See section 11.04(1)(b).)

_____ 19. Have you proposed a time period of correction that is limited to 150 days (240 days for VCGroup) from the date the compliance statement is issued? (See sections 10.06(8) and 10.14(3)(b).)

The following items relate only to submissions under VCS:

_____ 20. Are each of the failures you have identified eligible for correction under VCS? (See Appendix A and Appendix B.)

_____ 21. Have you identified no more than two VCS failures? (If more than two failures were identified, VCS is not available, but you may make a submission under VCO.) (See section 10.11(3).)

_____ 22. Have you proposed to correct the failure(s) identified in your request using the permitted correction method(s) set forth in Appendix A or Appendix B? (See Appendix A and Appendix B.)

The following items relates only to submissions under the general procedures of VCP:

_____ 24. Have you included a copy of the most recently filed Form 5500? (See section 11.04(1)(b).)

_____ 25. Have you submitted an application for a determination letter? (See section 11.05.)

_____ _____

Signature Date

_____

Title or Authority

_____

Typed or printed name of person signing checklist

Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

HIPAA Nondiscrimination

REG–114082–00

AGENCY: Internal Revenue Service (IRS), Treasury.

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

SUMMARY: In T.D. 8931 on page 542 of this Bulletin, the IRS is issuing temporary and final regulations governing the provisions prohibiting discrimination based on a health factor for group health plans. The IRS is issuing the temporary and final regulations at the same time that the Pension and Welfare Benefits Administration of the U.S. Department of Labor and the Health Care Financing Administration of the U.S. Department of Health and Human Services are issuing substantially similar interim final regulations governing the provisions prohibiting discrimination based on a health factor for group health plans and issuers of health insurance coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers and group health plans relating to the group health plan nondiscrimination requirements. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written comments and requests for a public hearing must be received by April 9, 2001.

ADDRESSES: Send submissions to: CC:M&SP:RU (REG–114082–00), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:M&SP:RU (REG-114082–00), room 5226, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC.

Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at:

http://www.irs.gov/tax_regs/regslist.html.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Russ Weinheimer at 202-622-6080; concerning submissions of comments or requests for a hearing, Sonya Cruse at 202-622-7190 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information referenced in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)).

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

The collections of information are in §54.9802–1T (see the temporary regulations published elsewhere in this issue of the Bulletin). The collections of information are required so that individuals denied enrollment in a group health plan based on one or more health factors will be apprised of their right to enroll in the plan without regard to their health. The likely respondents are business or other for-profit institutions, nonprofit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required of plans that have denied enrollment to individuals based on one or more health factors.

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

Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224. Comments on the collection of information should be received by April 9, 2001. Comments are specifically requested concerning:

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

Background

The temporary regulations published in T.D. 8931 add a new §54.9802–1T to the Miscellaneous Excise Tax Regulations.[1] When these proposed regulations are published as final regulations, they will supplement the final regulations in §54.9802–1 published in T.D. 8931. The proposed, temporary, and final regulations

[1] A previous §54.9802-1T was published in the Federal Register on April 8, 1997. By operation of section 7805(e) of the Internal Revenue Code, the previous §54.9802-1T expired on April 8, 2000. Proposed regulations containing the same text as previous §54.9802-1T were also published on April 8, 1997, and final regulations based on those proposed regulations are being published in the Federal Register as §54.9802-1. The new §54.9802-1T being published in T.D. 8931 consists almost entirely of new guidance not contained in the previous §54.9802-1T.

are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and Human Services (the joint rulemaking).

The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations.

Special Analyses

This regulation is not subject to the Unfunded Mandates Reform Act of 1995 because the regulation is an interpretive regulation. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this regulation. For further information and for analyses relating to the joint rulemaking, see the preamble to the joint rulemaking. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) that are submitted timely to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Russ Weinheimer, Office of the Operating Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), IRS. However, other personnel from the IRS and Treasury Department participated in their development. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and the U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

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

PART 54—PENSION EXCISE TAXES

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

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

Par. 2. Section 54.9802–1 is amended to read as follows:

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

[The text of the proposed amendments to this section is the same as the text of §54.9802–1T published in T.D. 8931].

Robert E. Wenzel,
Deputy Commissioner of Internal Revenue.

(Filed by the Office of the Federal Register on January 5, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 8, 2001, 66 F.R. 1435)

Notice of Proposed Rulemaking

Exception to the HIPAA Nondiscrimination Requirements for Certain Grandfathered Church Plans

REG–114083–00

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations that provide guidance under section 9802(c) of the Internal Revenue Code relating to the exception for certain grandfathered church plans from the nondiscrimination requirements applicable to group health plans under section 9802(a) and (b). Final, temporary, and proposed regulations (T.D. 8931, REG–114082–00, and REG–114084–00) relating to the nondiscrimination requirements under section 9802(a) and (b) are being published on pages 542, 631, and 635 in this issue of the Bulletin. The regulations will generally affect sponsors of and participants in certain self-funded church plans that are group health plans, and the regulations provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: Written or electronic comments and requests for a public hearing must be received by April 9, 2001.

ADDRESSES: Send Submissions to: CC:M&SP:RU (REG–114083–00), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to: CC:M&SP:RU (REG–114083–00), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC. Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at: *http://www.irs.gov/tax_regs/regslist.html.*

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Russ Weinheimer at 202-622-6080; concerning submissions of comments or requests for a hearing, Sonya Cruse at 202-622-7190 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Miscellaneous Excise Tax Regulations (26 CFR part 54) relating to the exception for certain grandfathered church plans from the nondiscrimination requirements applicable to group health plans. The nondiscrimination requirements applicable to group health plans were added to the Internal Revenue Code (Code), in section 9802, by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. HIPAA also added similar nondiscrimination provisions applicable to group health plans and health insurance issuers (such as health insurance companies and health maintenance organizations) under the Employee Retirement

Income Security Act of 1974 (ERISA), administered by the U.S. Department of Labor, and the Public Health Service Act (PHS Act), administered by the U.S. Department of Health and Human Services.

Final and temporary regulations relating to the HIPAA nondiscrimination requirements in paragraphs (a) and (b) of section 9802 of the Code are being published in T.D. 8931 on page 542 of this Bulletin. Those regulations are similar to, and have been developed in coordination with, interim final regulations also being published today by the Departments of Labor and Health and Human Services. Guidance under the HIPAA nondiscrimination requirements is summarized in a joint preamble to the final, interim final, and temporary regulations.

The exception for certain grandfathered church plans was added to section 9802, in a new subsection (c), by section 1532 of the Taxpayer Relief Act of 1997, Public Law 105–34. These proposed regulations would provide guidance for this exception. The guidance is summarized in the explanation below.

Explanation of Provisions

Church plans that are group health plans are generally subject to the Code provisions in Chapter 100 relating to access, portability, and renewability.1 However, under section 9802(c), church plans satisfying certain requirements continuously since July 15, 1997 are not treated as failing to meet the section 9802 prohibitions against discrimination based on any health factor solely because the plan requires evidence of good health for the coverage of certain individuals.

The grandfather rule in section 9802(c) applies to a church plan for a plan year only if, on July 15, 1997 and at all times after that date before the beginning of the plan year, the church plan had provisions satisfying one of two alternative conditions. The first alternative condition is that the plan contain provisions requiring evidence of good health of two sets of individuals, that is, both (1) any employee of an employer with 10 or fewer employees and (2) any self-employed individual. The proposed regulations specify that this condition is not satisfied if the plan requires evidence of good health of only one of these sets of individuals. The proposed regulations also clarify that the plan provision for the first set of individuals must be exactly 10 or fewer. Thus, a plan provision requiring evidence of good health for employees of an employer of fewer than 10, or of greater than 10, employees does not satisfy this condition. For example, a plan provision requiring evidence of good health of any employee of an employer of five or fewer employees does not satisfy this condition.

The second alternative condition is that the plan contain provisions requiring evidence of good health of any individual who enrolls after the first 90 days of initial eligibility. The proposed regulations clarify that the period for these plan provisions must be exactly 90 days. Thus, a plan provision requiring evidence of good health of any individual who enrolls after the first 120 days of initial eligibility does not satisfy this condition.

The grandfather rule in section 9802(c) of the Code is not by its terms limited in its application to self-funded church plans. Section 2702 of the Public Health Service Act (PHS Act) imposes nondiscrimination requirements on health insurance issuers offering group health insurance coverage, and those nondiscrimination requirements are generally similar to the nondiscrimination requirements imposed on group health plans (including church plans) under paragraphs (a) and (b) of section 9802 of the Code. However, section 2702 of the PHS Act does not include an exception for health insurance issuers offering group health insurance coverage to church plans comparable to the exception for church plans in section 9802(c) of the Code. Thus, if a church plan providing benefits through group health insurance coverage were to require evidence of good health of certain individuals as permitted under section 9802(c) of the Code, the requirement of evidence of good health would cause the health insurance issuer providing the coverage to violate the nondiscrimination requirements of the PHS Act. In such a case, the sanctions under the PHS Act would apply to the issuer, but those under the Code would not apply to the church plan. Thus, assuming that group health insurance coverage complies with the nondiscrimination requirements of the PHS Act, the rule in section 9802(c) of the Code is, in effect, available only to church plans that are not funded through group health insurance because only such church plans do not include insurance coverage that is subject to Title XXVII of the PHS Act. Accordingly, the examples in the proposed regulations illustrating situations where section 9802(c) is available are limited to group health plans that are not funded through group health insurance in order to avoid misleading insured church plans about the availability of the grandfather rule in section 9802(c).

Special Analyses

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

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments that are submitted timely (a signed original and eight (8) copies) to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Russ Weinheimer, Office of the Operating Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Proposed Amendments to the Regulations

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

PART 54 — PENSION EXCISE TAXES

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

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

Section 54.9802–2 also issued under 26 U.S.C. 9802. * * *

Par. 2. Section 54.9802–2 is added to read as follows:

§54.9802–2 Special rules for certain church plans.

(a) *Exception for certain church plans*—(1) *Church plans in general.* A church plan described in paragraph (b) of this section is not treated as failing to meet the requirements of section 9802 or §§54.9802–1 and 54.9802–1T solely because the plan requires evidence of good health for coverage of individuals under plan provisions described in paragraph (b)(2) or (3) of this section.

(2) *Health insurance issuers.* See sections 2702 and 2721(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300gg–2 and 300gg–21(b)(1)(B)) and 45 CFR 146.121, which require health insurance issuers providing health insurance coverage under a church plan that is a group health plan to comply with nondiscrimination requirements similar to those that church plans are required to comply with under section 9802 and §§54.9802–1 and 54.9802–1T except that those nondiscrimination requirements do not include an exception for health insurance issuers comparable to the exception for church plans under section 9802(c) and this section.

(b) *Church plans to which this section applies*—(1) *Church plans with certain coverage provisions in effect on July 15, 1997.* This section applies to any church plan (as defined in section 414(e)) for a plan year if, on July 15, 1997 and at all times thereafter before the beginning of the plan year, the plan contains either the provisions described in paragraph (b)(2) of this section or the provisions described in paragraph (b)(3) of this section.

(2) *Plan provisions applicable to individuals employed by employers of 10 or fewer employees and self-employed individuals*—(i) A plan contains the provisions described in this paragraph (b)(2) if it requires evidence of good health of both —

(A) Any employee of an employer of 10 or fewer employees (determined without regard to section 414(e)(3)(C), under which a church or convention or association of churches is treated as the employer); and

(B) Any self-employed individual.

(ii) A plan does not contain the provisions described in this paragraph (b)(2) if the plan contains only one of the provisions described in this paragraph (b)(2). Thus, for example, a plan that requires evidence of good health of any self-employed individual, but not of any employee of an employer with 10 or fewer employees, does not contain the provisions described in this paragraph (b)(2). Moreover, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer of fewer than 10 (or greater than 10) employees. Thus, for example, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer with five or fewer employees.

(3) *Plan provisions applicable to individuals who enroll after the first 90 days of initial eligibility*—(i) A plan contains the provisions described in this paragraph (b)(3) if it requires evidence of good health of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) A plan does not contain the provisions described in this paragraph (b)(3) if it provides for a longer (or shorter) period than 90 days. Thus, for example, a plan requiring evidence of good health of any individual who enrolls after the first 120 days of initial eligibility under the plan does not contain the provisions described in this paragraph (b)(3).

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

Example 1. (i) *Facts.* A church organization maintains two church plans for entities affiliated with the church. One plan is a group health plan that provides health coverage to all employees (including ministers and lay workers) of any affiliated church entity that has more than 10 employees. The other plan is Plan *O*, which is a group health plan that is not funded through insurance coverage and that provides health coverage to any employee (including ministers and lay workers) of any affiliated church entity that has 10 or fewer employees and any self-employed individual affiliated with the church (including a self-employed minister of the church). Plan *O* requires evidence of good health in order for any individual of a church entity that has 10 or fewer employees to be covered and in order for any self-employed individual to be covered. On July 15, 1997, and at all times thereafter before the beginning of the plan year, Plan *O* has contained all the preceding provisions.

(ii) *Conclusion.* In this *Example 1*, because Plan *O* contains the plan provisions described in paragraph (b)(2) of this section and because those provisions were in the plan on July 15, 1997, and at all times thereafter before the beginning of the plan year, Plan *O* will not be treated as failing to meet the requirements of section 9802, §54.9802–1, or §54.9802–1T for the plan year solely because the plan requires evidence of good health for coverage of the individuals described in those plan provisions.

Example 2. (i) *Facts.* A church organization maintains Plan *P*, which is a church plan that is not funded through insurance coverage and that is a group health plan providing health coverage to individuals employed by entities affiliated with the church and self-employed individuals affiliated with the church (such as ministers). On July 15, 1997, and at all times thereafter before the beginning of the plan year, Plan *P* has required evidence of good health for coverage of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) *Conclusion.* In this *Example 2*, because Plan *P* contains the plan provisions described in paragraph (b)(3) of this section and because those provisions were in the plan on July 15, 1997, and at all times thereafter before the beginning of the plan year, Plan *P* will not be treated as failing to meet the requirements of section 9802, §54.9802–1, or §54.9802–1T for the plan year solely because the plan requires evidence of good health for coverage of individuals enrolling after the first 90 days of initial eligibility under the plan.

(d) *Effective date.* **[Reserved]**

Robert E. Wenzel,
Deputy Commissioner of Internal Revenue.

(Filed by the Office of the Federal Register on January 5, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 8, 2001, 66 F.R. 1437)

Notice of Proposed Rulemaking and Request for Comments

Notice of Proposed Rulemaking for Bona Fide Wellness Programs

REG–114084–00

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Notice of proposed rulemaking and request for comments.

SUMMARY: This proposed rule would implement and clarify the term "bona fide wellness program" as it relates to regulations implementing the nondiscrimination provisions of the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act, as added by the Health Insurance Portability and Accountability Act of 1996.

DATES: Written comments on this notice of proposed rulemaking are invited and must be received by the Departments on or before April 9, 2001.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic submissions to the Internal Revenue Service (IRS) or Department of Labor) to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to:

CC:M&SP:RU (REG–114084–00)
Room 5226
Internal Revenue Service
POB 7604, Ben Franklin Station
Washington, DC 20044

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

CC:M&SP:RU (REG–114084–00)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW.
Washington, DC 20224

Alternatively, comments may be transmitted electronically via the IRS Internet site at:

http://www.irs.gov/tax_regs/regslist.html.

Comments to the Department of Labor can be addressed to:

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue NW.,
Room C-5331
Washington, DC 20210

Attention: Wellness Program Comments

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address. Comments may also be transmitted by e-mail to: *Wellness@pwba.dol.gov.*

Comments to HHS can be addressed to:

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-2078-P
P.O. Box 26688
Baltimore, MD 21207

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

Room 443-G
Hubert Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

or

Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-1850

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

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-1513, 200 Constitution Avenue, NW., Washington, DC from 8:30 a.m. to 5:30 p.m.

All submissions to HHS will be open to public inspection and copying in room 309-G of the Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC from 8:30 a.m. to 5 p.m.

FOR FURTHER INFORMATION CONTACT: Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Amy J. Turner, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Ruth A. Bradford, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565.

CUSTOMER SERVICE INFORMATION: Individuals interested in obtaining additional information on HIPAA's nondiscrimination rules may request a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law" by calling the PWBA Toll-Free Publication Hotline at 1-800-998-7542 or may request a copy of the Health Care Financing Administration's new publication entitled "Protecting Your Health Insurance Coverage" by calling (410) 786-1565. Information on HIPAA's nondiscrimination rules and other recent health care laws is also available on the Department of Labor's website (*http://www.dol.gov/dol/pwba*) and the Department of Health and Human Services' website (*http://hipaa.hcfa.gov*).

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. HIPAA added section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act, which prohibit discrimination in health coverage. However, the HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. Interim final rules implementing the HIPAA provisions were first

made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 F.R. 16894) (April 1997 interim rules).

In the preamble to the April 1997 interim rules, the Departments invited comments on whether additional guidance was needed concerning, among other things, the permissible standards for determining bona fide wellness programs. The Departments also stated that they intend to issue further regulations on the nondiscrimination rules and that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act before the additional guidance is provided. The new interim regulations relating to the HIPAA nondiscrimination rules (published in T.D. 8931 on page 542 of this Bulletin**)** do not include provisions relating to bona fide wellness programs. Accordingly, the period for good faith compliance continues with respect to those provisions until further guidance is issued. Compliance with the provisions of these proposed regulations constitutes good faith compliance with the statutory provisions relating to wellness programs.

II. Overview of the Proposed Regulations

The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from charging similarly situated individuals different premiums or contributions based on a health factor. In addition, under the interim regulations in T.D. 8931, cost-sharing mechanisms such as deductibles, copayments, and coinsurance are considered restrictions on benefits. Thus, they are subject to the same rules as are other restrictions on benefits; that is, they 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. However, the HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. Thus, there is an exception to the general rule prohibiting discrimination based on a health factor if the reward, such as a premium discount or waiver of a cost-sharing requirement, is based on participation in a program of health promotion or disease prevention. The April 1997 interim rules, the interim regulations published in T.D. 8931, and these proposed regulations refer to programs of health promotion and disease prevention allowed under this exception as "bona fide wellness programs." In order to prevent the exception to the nondiscrimination requirements for bona fide wellness programs from eviscerating the general rule contained in the HIPAA nondiscrimination provisions, these proposed regulations impose certain requirements on wellness programs providing rewards that would otherwise discriminate based on a health factor.

A wide range of wellness programs exist to promote health and prevent disease. However, many of these programs are not subject to the bona fide wellness program requirements. The requirements for bona fide wellness programs apply only to a wellness program that provides a reward based on the ability of an individual to meet a standard that is related to a health factor, such as a reward conditioned on the outcome of a cholesterol test. Therefore, without having to comply with the requirements for a bona fide wellness program, a wellness program could —

- Provide voluntary testing of enrollees for specific health problems and make recommendations to address health problems identified, if the program did not base any reward on the outcome of the health assessment;
- Encourage preventive care through the waiver of the copayment or deductible requirement for the costs of well-baby visits;
- Reimburse employees for the cost of health club memberships, without regard to any health factors relating to the employees; or
- Reimburse employees for the costs of smoking cessation programs, without regard to whether the employee quits smoking.

A wellness program that provides a reward based on the ability of an individual to meet a standard related to a health factor violates the interim regulations published in T.D. 8931 unless it is a bona fide wellness program. Under these proposed regulations, a wellness program must meet four requirements to be a bona fide wellness program.

First, the total reward that may be given to an individual under the plan for all wellness programs is limited. A reward can be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), or the absence of a surcharge. The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed a specified percentage of the cost of employee-only coverage under the plan. The cost of employee-only coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage.

The proposed regulations specify three alternative percentages: 10, 15, and 20. The Departments welcome comments on the appropriate level for the percentage. Comments will be taken into account in determining the standard for the final regulations.

Several commenters on the April 1997 regulations suggested that the amount of a reward should be permitted if it is actuarially determined based on the costs associated with the health factor measured under the wellness program. However, in some cases, the resulting reward (or penalty) might be so large as to have the effect of denying coverage to certain individuals. The percentage limitation in the proposed regulations is designed to avoid this result. The percentage limitation also avoids the additional administrative costs of a reward based on actuarial cost.

The Departments recognize that there may be some programs that currently offer rewards, individually or in the aggregate, that exceed the specified percentage. However, as noted below in the economic analysis, data is scarce regarding practices of wellness programs. Thus, the Departments specifically request comments on the appropriateness of the specified percentage of the cost of employee-only coverage under a plan as the maximum reward for a bona fide wellness

program, including whether a larger amount should be allowed for wellness programs that include participation by family members (i.e., the specified percentage of the cost of family coverage). Note also that, as stated above, the period for good faith compliance continues with respect to whether wellness programs satisfy the statutory requirements. While compliance with these proposed regulations constitutes good faith compliance with the statutory provisions, it is possible that, based on all the facts and circumstances, a plan's wellness program that provides a reward in excess of the specified range of percentages of the cost of employee-only coverage may also be found to meet the good faith compliance standard.

Under these proposed regulations, the second requirement to be a bona fide wellness program is that the program must be reasonably designed to promote good health or prevent disease for individuals in the program. This requirement prevents a program from being a subterfuge for merely imposing higher costs on individuals based on a health factor by requiring a reasonable connection between the standard required under the program and the promotion of good health and disease prevention. Among other things, a program is not reasonably designed to promote good health or prevent disease unless the program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year. In contrast, a program that imposes a reward or penalty for the duration of the individual's participation in the plan based solely on health factors present when an individual first enrolls in a plan is not reasonably designed to promote health or prevent disease (because, if the individual cannot qualify for the reward by adopting healthier behavior after initial enrollment, the program does not have any connection to improving health).

The third requirement to be a bona fide wellness program under these proposed regulations is that the reward under the program must be available to all similarly situated individuals. The April 1997 interim rules provided that if, under the design of the wellness program, enrollees might not be able to achieve a program standard due to a health factor, the program would not be a bona fide wellness program. These proposed regulations increase flexibility for plans by allowing plans to make individualized adjustments to their wellness programs to address the health factors of the particular individuals for whom it is unreasonably difficult to qualify for the benefits under the program. Specifically, the program must allow any individual for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to satisfy the initial program standard an opportunity to satisfy a reasonable alternative standard. The examples clarify that a reasonable alternative standard must take into account the relevant health factor of the individual who needs the alternative. A program does not need to establish the specific reasonable alternative standard before the program commences. To satisfy this third requirement for being a bona fide wellness program, it is sufficient to determine a reasonable alternative standard once a participant informs the plan that it is unreasonably difficult for the participant due to a medical condition to satisfy the general standard (or that it is medically inadvisable for the participant to attempt to achieve the general standard) under the program.

Many commenters asked how the bona fide wellness program requirements apply to programs that provide a reward for not smoking. An example in the proposed regulations clarifies that if it is unreasonably difficult for an individual to stop smoking due to an addiction to nicotine[1], the individual must be provided a reasonable alternative standard to obtain the reward.

The fourth requirement to be a bona fide wellness program under the proposed regulations is that all plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard. The proposed regulations include model language that can be used to satisfy this requirement; examples also illustrate substantially similar language that would satisfy the requirement.

The proposed regulations contain two clarifications of this fourth requirement. First, plan materials are not required to describe specific reasonable alternative standards. It is sufficient to disclose that some reasonable alternative standard will be made available. Second, any plan materials that describe the general standard would also have to disclose the availability of a reasonable alternative standard. However, if the program is merely mentioned (and does not describe the general standard), disclosure of the availability of a reasonable alternative standard is not required.

III. Economic Impact and Paperwork Burden

Summary - Department of Labor and Department of Health and Human Services

Under the proposed regulation, health plans generally may vary employee premium contributions or benefit levels across similarly situated individuals based on health status factors only in connection with bona fide wellness programs. The regulation establishes four requirements for such bona fide wellness programs. It (1) limits the permissible amount of variation in employee premium or benefit levels; (2) requires that programs be reasonably designed to promote health or prevent disease; (3) requires programs to permit plan participants who for medical reasons would incur unreasonable difficulty to satisfy the programs' initial wellness standards to satisfy reasonable alternative standards instead; and (4) requires certain plan materials to disclose the availability of such alternative standards. The Departments carefully considered the costs and benefits attendant to these requirements. The Departments believe that the benefits of these requirements exceed their costs.

The Departments anticipate that the proposed regulation will result in transfers of cost among plan sponsors and participants and in new economic costs and benefits.

Economic benefits will flow from plan sponsors' efforts to maintain wellness programs' effectiveness where discounts or

[1] Under the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, American Psychiatric Association, 1994 (DSM IV), nicotine addiction is a medical condition. See also Rev. Rul. 99-28, 1999-1 C.B. 1269 (June 21, 1999), citing a report of the Surgeon General stating that scientists in the field of drug addiction agree that nicotine, a substance common to all forms of tobacco, is a powerfully addictive drug.

surcharges are reduced and from plans sponsors' provision of reasonable alternative standards that help improve affected plan participants' health habits and health. The result will be fewer instances where wellness programs merely shift costs to high risk individuals and more instances where they succeed at improving such individuals' health habits and health.

Transfers will arise because the size of some discounts and surcharges will be reduced, and because some plan participants who did not satisfy wellness programs' initial standards will satisfy alternative standards. These transfers are estimated to total between $18 million and $46 million annually. (The latter figure is an upper bound, reflecting the case in which all eligible participants pursue and satisfy alternative standards.)

New economic costs may be incurred if reductions in discounts or surcharges reduce wellness programs' effectiveness, but this effect is expected to be very small because reductions will be small and relatively few plans and participants will be affected. Other new economic costs will be incurred by plan sponsors to make available reasonable alternative standards where required. The Departments were unable to estimate these costs but are confident that these costs in combination with the transfers referenced above will not exceed the estimate of the transfers alone. Affected plan sponsors can satisfy the proposed regulation's third requirement by making available any reasonable standard they choose, including low cost alternatives. It is unlikely that plan sponsors would choose alternative standards whose cost, in combination with costs transferred from participants who satisfy them, would exceed the cost of providing discounts or waiving surcharges for all eligible participants.

Executive Order 12866 - Department of Labor and Department of Health and Human Services

Under Executive Order 12866, the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the 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.

Pursuant to the terms of the Executive Order, it has been determined that this action raises novel policy issues arising out of legal mandates. Therefore, this notice is "significant" and subject to OMB review under Section 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this regulatory action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the interim regulation for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

Statement of Need for Proposed Action

These interim regulations are needed to clarify and interpret the HIPAA nondiscrimination provisions (Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status) under Section 702 of the Employee Retirement Income Security Act of 1974 (ERISA), Section 2702 of the Public Health Service Act, and Section 9802 of the Internal Revenue Code of 1986. The provisions are needed to ensure that group health plans and group health insurers and issuers do not discriminate against individuals, participants, and beneficiaries based on any health factors with respect to health care premiums. Additional guidance was required to define bona fide wellness programs.

Costs and Benefits

The Departments anticipate that the proposed regulation will result in transfers of cost among plans sponsors and participants and in new economic costs and benefits. The economic benefits of the regulation will include a reduction in instances where wellness programs merely shift costs to high risk individuals and an increase in instances where they succeed at improving such individuals' health habits and health. Transfers are estimated to total between $18 million and $46 million annually. The Departments were unable to estimate new economic costs but are confident that these costs in combination with the transfers referenced above will not exceed the estimate of the transfers alone. The Departments believe that the regulation's benefits will exceed its costs. Their unified analysis of the regulation's costs and benefits is detailed later in this preamble.

Regulatory Flexibility Act - Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis (IRFA) at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of analysis under the RFA, PWBA proposes 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)(2) of the Employee Retirement Income Security Act of 1974 (ERISA), which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for exemptions or simplified annual reporting and disclosure for wel-

fare benefit plans. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 C.F.R. §§ 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 covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Thus, PWBA believes that assessing the impact of this proposed rule on small plans is an appropriate substitute for evaluating the effect on small entities. For purposes of their unified IFRA, the Departments adhered to PWBA's proposed definition of small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business which 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 this proposed rule on small entities.

Under this proposed regulation, health plans generally may vary employee premium contributions or benefit levels across similarly situated individuals based on health factors only in connection with bona fide wellness programs. The regulation establishes four requirements for such bona fide wellness programs.

The Departments estimate that 36,000 plans with fewer than 100 participants vary employee premium contributions or benefit levels across similarly situated individuals based on health factors. While this represents just 1 percent of all small plans, the Departments nonetheless believe that it represents a substantial number of small entities. The Departments also note that at least some premium discounts or surcharges may be large. Premium discounts associated with wellness programs are believed to range as high as $560 per affected participant per year. Therefore, the Departments believe that the impact of this regulation on at least some small entities may be significant. Having reached these conclusions, the Departments carried out an IRFA as part of their unified analysis of the costs and benefits of the regulation. The reasoning and assumptions underlying the Departments' unified analysis of the regulation's costs and benefits are detailed later in this preamble.

The regulation's first requirement caps maximum allowable variation in employee premium contribution and benefit levels. The Departments estimate that 9,300 small plans will be affected by the cap. These plans can comply with this requirement by reducing premiums (or increasing benefits) by $1.1 million on aggregate for those participants whose premiums are higher (or whose benefits are lower) due to health factors. This would constitute an ongoing, annual transfer of cost of $1.1 million, or $122 on average per affected plan. The regulation does not limit small plans' flexibility to transfer this cost back evenly to all participants in the form of small premium increases or benefit cuts.

The regulation's second requirement provides that wellness programs must be reasonably designed to promote health or prevent disease. Comments received by the Departments and available literature on employee wellness programs suggest that existing wellness programs generally satisfy this requirement. The requirement therefore is not expected to compel small plans to modify existing wellness programs. It is not expected to entail economic costs nor to prompt transfers.

The third requirement provides that rewards under wellness programs must be available to all similarly situated individuals. In particular, programs must allow individuals for whom it would be unreasonably difficult due to a medical condition to satisfy initial program standards an opportunity to satisfy reasonable alternative standards. The Departments believe that some small plans' wellness programs do not currently satisfy this requirement and will have to be modified.

The Departments estimate that 21,000 small plans' wellness programs include initial standards that may be unreasonably difficult for some participants to meet. These plans are estimated to include 18,000 participants for whom the standard is in fact unreasonably difficult to meet. (Many small plans are very small, having fewer than 10 participants, and many will include no participant for whom the initial standard is unreasonable difficult to meet for a medical reason.) Satisfaction of alternative standards by these participants will result in transfers of cost as they qualify for discounts or escape surcharges. If all of these participants request and then satisfy an alternative standard, the transfer would amount to $5 million annually. If one-half request alternative standards and one-half of those meet them, the transfer would amount to $1 million.

In addition to transfers, small plans will also incur new economic costs to provide alternative standards. However, plans can satisfy this requirement by providing inexpensive alternative standards, and have the flexibility to select whatever reasonable alternative standard is most desirable or cost efficient. Plans not wishing to provide alternative standards also have the option of abolishing health-status based variation in employee premiums. The Departments expect that the economic cost to provide alternatives combined with the associated transfer cost of granting discounts or waiving surcharges will not exceed the transfer cost associated with granting discounts or waiving surcharges for all participants who qualify for an alternative, estimated here at $1 million to $5 million, or about $55 to $221 per affected plan. Plans have the flexibility to transfer some or all of this cost evenly to all participants in the form of small premium increases or benefit cuts.

The fourth requirement provides that plan materials describing wellness plan standards must disclose the availability of reasonable alternative standards. This requirement will affect the 36,000 small plans that apply discounts or surcharges. These plans will incur economic costs to revise affected plan materials. The 5,000 to 18,000 small plan participants who will succeed at satisfying these alternative standards will benefit from these disclosures. The disclosures need not specify what alternatives are available, and the regulation provides model language that can be used to satisfy this requirement. Legal requirements other than this regulation generally require plans and issuers to maintain accurate materials describing plans. Plans and issuers generally update such materials on a regular basis as part of

their normal business practices. This requirement is expected to represent a negligible fraction of the ongoing, normal cost of updating plans' materials. This analysis therefore attributes no cost to this requirement.

Special Analyses — Department of the Treasury

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that this notice of proposed rulemaking does not impose a collection of information on small entities and is not subject to section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5). For these reasons, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply pursuant to 5 U.S.C. section 603(a), which exempts from the Act's requirements certain rules involving the internal revenue laws. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Paperwork Reduction Act

Department of Labor and Department of the Treasury

This Notice of Proposed Rulemaking includes a requirement that if the plan materials describe the standard required to be met in order to qualify for a reward such as a premium discount or waiver of a cost-sharing requirement, they must also disclose the availability of a reasonable alternative standard. However, plan materials are not required to describe specific reasonable alternatives. The proposal also includes examples of disclosures which would satisfy the requirements of the proposed rule.

Plan administrators of group health plans covered under Title I of ERISA are required to make certain disclosures about the terms of a plan and material changes in terms through a Summary Plan Description or Summary of Material Modifications pursuant to sections 101(a) and 102(a) of ERISA. Group health plans and issuers also typically make other informational materials available to participants, either as a result of state and local requirements, or as part of their usual business practices in connection with the offer and promotion of health care coverage to employees.

While this proposal may cause group health plans to modify informational materials pertaining to wellness programs, the Departments conclude that it creates no new information collection requirements, and that the overall impact on existing information collection activities will be negligible. First, as described earlier, it is estimated that the proposed reasonable alternative requirements for bona fide wellness programs will impact a maximum of 22,000 plans and 229,000 participants. These numbers are very small in comparison with the 2.5 million ERISA group health plans that cover 65 million participants, and 175,500 state and local governmental plans that cover 11.5 million participants.

In addition, because model language is provided in the proposal, these modifications are expected to require a minimal amount of effort, such that they fall within the provision of OMB regulations in 5 CFR 1320.3(c)(2). This provision excludes from the definition of collection of information language which is supplied by the Federal government for disclosure purposes.

Finally, the Department of Labor's methodology in accounting for the burden of the Summary Plan Description (SPD) and Summary of Material Modifications (SMM), as currently approved under OMB control number 1210–0039, incorporates an assumption concerning a constant rate of revision in these disclosure materials which is based on plans' actual reporting on the annual report/return (Form 5500) of their rates of modification. This occurrence of SPD revisions is generally more frequent than the minimum time frames described in section 104(b) and related regulations. The annual hour and cost burdens of the SMM/SPD information collection request is currently estimated at 576,000 hours and $97 million. Because the burden of modifying a wellness program's disclosures is expected to be negligible, and readily incorporated in other revisions made to plan materials on an ongoing basis, the methodology used already accounts for this type of change. Therefore, the Department concludes that the modification described in this proposal to the information collection request is neither substantive nor material, and accordingly it attributes no burden to this regulation.

Department of Health and Human Services

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(f) *Bona fide wellness programs* Paragraph (1)(iv) requires the plan or issuer to disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard required under paragraph (f)(1)(iii) of this section. However, in plan materials that merely mention that a program is available, without describing its terms, the disclosure is not required. This requirement will affect the estimated 1,300 nonfederal governmental plans that apply premium discounts or surcharges. The development of the materials is expected to take 100 hours for nonfederal governmental plans. The corresponding burden performed by service providers is estimated to be $38,000.

We have submitted a copy of this rule to OMB for its review of the information collection requirements. These requirements are not effective until they have

been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

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

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment Management Group,
Division of HCFA Enterprise Standards,
Room C2-26-17, 7500 Security Boulevard,
Baltimore, MD 21244-1850,
Attn: John Burke, HCFA-2078-P,

and

Office of Information and Regulatory Affairs,
Office of Management and Budget,
Room 10235, New Executive Office Building,
Washington, DC 20503,
Attn.: Allison Herron Eydt, HCFA-2078-P.

Small Business Regulatory Enforcement Fairness Act

The proposed rule is subject to the 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 Congress and the Comptroller General for review. The rule is not a "major rule" as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, State, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), as well as Executive Order 12875, this proposed rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, nor does it include mandates which may impose an annual burden of $100 million or more on the private sector.

Federalism Statement - Department of Labor and Department of Health and Human Services

Executive Order 13132 (August 4, 1999) 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. 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 do not have federalism implications, because they do not have substantial 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. This is largely because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal standards in HIPAA prohibiting discrimination based on health factors. Therefore, the regulations are not likely to require substantial additional oversight of States by the Department of Health and Human Services.

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, HIPAA added a new preemption provision to ERISA (as well as to the PHS Act) preserving the applicability of State laws establishing requirements for issuers of group health insurance coverage, except to the extent that these requirements prevent the application of the portability, access, and renewability requirements of HIPAA. The nondiscrimination provisions that are the subject of this rulemaking are included among those requirements.

In enacting these new preemption provisions, Congress indicated its intent to establish a preemption of State insurance requirements only to the extent that those requirements prevent the application of the basic protections set forth in HIPAA. HIPAA's Conference Report states that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). Consequently, under the statute and the Conference Report, State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of" the HIPAA nondiscrimination provisions.

Accordingly, States are given significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law. In many cases, the federal law imposes minimum requirements which States are free to exceed. Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997, and these regulations do not reduce the discretion given to the States by the statute. It is the Departments' understanding that the vast majority of States have in fact implemented provisions which meet or exceed the minimum requirements of the HIPAA non-discrimination provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. When exercising its responsibility to enforce the provisions of HIPAA, HCFA works cooperatively with the States for the purpose of addressing State concerns and avoiding conflicts with the exercise of State authority.[2] HCFA has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HCFA's procedures address

[2] This authority applies to insurance issued with respect to group health plans generally, including plans covering employees of church organizations. Thus, this discussion of federalism applies to all group health insurance coverage that is subject to the PHS Act, including those church plans that provide coverage through a health insurance issuer (but not to church plans that do not provide coverage through a health insurance issuer). For additional information relating to the application of these nondiscrimination rules to church plans, see the preamble to regulations being proposed elsewhere in this issue of the Bulletin regarding section 9802(c) of the Code relating to church plans.

the handling of reports that States may not be enforcing HIPAA's requirements, and the mechanism for allocating enforcement responsibility between the States and HCFA. To date, HCFA has had occasion to enforce the HIPAA non-discrimination provisions in only two States.

Although the Departments conclude that these proposed regulations do not have federalism implications, in keeping with the spirit of the Executive Order that agencies closely examine any policies that may have federalism implications or limit the policy making discretion of the States, the Department of Labor and HCFA have engaged in numerous efforts to consult with and work cooperatively with affected State and local officials.

For example, the Departments were aware that some States commented on the way the federal provisions should be interpreted. Therefore, the Departments have sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories, that among other things provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss, and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas, and in-depth consideration of insurance issues by regulators, industry representatives, and consumers. HCFA and Department of Labor staff have attended the quarterly meetings consistently to listen to the concerns of the State Insurance Departments regarding HIPAA issues, including the nondiscrimination provisions. In addition to the general discussions, committee meetings and task groups, the NAIC sponsors the following two standing HIPAA meetings for members during the quarterly conferences:

- HCFA/DOL Meeting on HIPAA Issues (This meeting provides HCFA and Labor the opportunity to provide updates on regulations, bulletins, enforcement actions and outreach efforts regarding HIPAA.)
- The NAIC/HCFA Liaison Meeting (This meeting provides HCFA and the NAIC the opportunity to discuss HIPAA and other health care programs.)

In their comments on the 1997 interim rules, the NAIC suggested that the permissible standards for determining bona fide wellness programs ensure that such programs are not used as a proxy for discrimination based on a health factor. The NAIC also commented that the nondiscrimination provisions of HIPAA "are especially significant in their impact on small groups, and particularly in small groups, where there is a great potential for adverse selection and gaming." One State asked that the Departments' final nondiscrimination provisions be as consumer-protective as possible. Finally, another State described already-existing State regulation of issuers offering wellness programs in that State and asked that standards for bona fide wellness programs be left to the States.

The Departments considered these views very carefully when formulating the wellness program proposal. While allowing plans a great deal of flexibility in determining what kinds of incentives best encourage the plan's own participants and beneficiaries to pursue a healthier lifestyle, the Departments proposal ensures that individuals have an opportunity to qualify for the premium discount or other reward. If an individual is unable to satisfy a wellness program standard due to a health factor, plans are required to make a reasonable alternative standard available to the individual. In addition, the Departments reiterate their position that State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of" the federal law and therefore are saved from preemption. Therefore, these more protective State laws continue to apply for individuals receiving health insurance coverage in connection with a group health plan.

The Departments welcome further comment on these issues from the States in response to this proposal.

The Departments also cooperate with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators, and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including HCFA, NAIC and many business and consumer groups. HCFA has sponsored four conferences with the States - the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999 and 2000. Furthermore, both the Department of Labor and HCFA websites offer links to important State websites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

In conclusion, throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health plans and health insurance issuers, and the rights of those individuals that Congress intended to protect through the enactment of HIPAA.

Unified Analysis of Costs and Benefits - Department of Labor and Department of Health and Human Services

Introduction

Under the proposed regulation, health plans generally may vary employee premium contributions or benefit levels across similarly situated individuals based on health factors only in connection with bona fide wellness programs. The regulation establishes four requirements for such bona fide wellness programs.

A large body of literature, together with comments received by the Departments, demonstrate that well-designed wellness programs can deliver benefits well in excess of their costs. For example, the U.S. Centers for Disease Control and Prevention estimate that implementing proven clinical smoking cessation interventions can save one year of life for each $2,587 invested. In addition to reduced mortality, benefits of effective wellness programs can include reduced absenteeism, improved productivity, and reduced medical costs. The requirements contained in the proposed regulation were crafted to accommodate and not impair such beneficial programs, while combating discrimination in eligibility and premiums for similarly situated individuals as intended by Congress.

Detailed Estimates

Estimation of the economic impacts of the four requirements is difficult because

data on affected plans' current practices are incomplete, and because plans' approaches to compliance with the requirements and the effects of those approaches will vary and cannot be predicted. Nonetheless, the Departments undertook to consider the impacts fully and to develop estimates based on reasonable assumptions.

Based on a 1993 survey of employers by the Robert Wood Johnson Foundation, the Departments estimate that 1.6 percent of large plans and 1.2 percent of small plans currently vary employee premium contributions across similarly situated individuals and will be subject to the four requirements for bona fide wellness programs. This amounts to 32,000 plans covering 1.2 million participants. According to an industry survey by Hewitt Associates, just more than one-third as many plans vary benefit levels across similarly situated individuals as vary premiums. This amounts to 11,000 plans covering 415,000 participants. The Departments separately considered the effect of each of the four requirements on these plans. For purposes of its estimates, the Departments assumed that one-half of the plans in the latter group are also included in the former, thereby estimating that 37,000 plans covering 1.4 million participants will be subject to the four requirements for bona fide wellness programs.

Limit on Dollar Amount — Under the first requirement, any discount or surcharge, whether applicable to employee premiums or benefit levels, must not exceed a specified percentage of the total premium for employee-only coverage under the plan. The proposed regulations specify three alternative percentages: 10, 15, and 20. For purposes of this discussion, the Departments examine the midpoint of the three alternative percentages, 15 percent.

The Departments lack representative data on the magnitude of the discounts and surcharges applied by affected plans today. One leading consultant practicing in this area believes that wellness incentive premium discounts ranged from about $60 to about $480 annually in 1998, averaging about $240 that year. Expressed as a percentage of average total premium for employee-only coverage that year, this amounts to a range of about 3 percent to 23 percent and an average of about 11 percent. This suggests that most affected plans, including some whose discounts are somewhat larger than average, already comply with the first requirement and will not need to reduce the size of the discounts or surcharges they apply. It appears likely, however, that a sizeable minority of plans — perhaps a few thousand plans covering a few hundred thousand participants — will need to reduce the size of their discounts or surcharges in order to comply with the first requirement. The table below summarizes the Departments' assumptions regarding the size of discounts and surcharges at year 2000 levels, expressed in annual amounts.

The Departments considered the potential economic effects of requiring these plans to reduce the size of their discounts or surcharges. These effects are likely to include transfers of costs among plan sponsors and participants, as well as new economic costs and benefits.

Single employee total premium		$2,448
Discount or Surcharge		
low	3%	$70
average	11%	$280
high	23%	$560
Cap on discount or surcharge	15%	$367

Transfers will arise as plans reduce discounts and surcharges. Plan sponsors can exercise substantial control over the size and direction of these transfers. Limiting the size of discounts and surcharges restricts only the differential treatment of participants who satisfy wellness program standards and those who do not. It does not, for example, restrict plans sponsors' flexibility to determine the respective employer and employee shares of base premiums. Possible outcomes include a transfer of costs to plan sponsors from participants who satisfy wellness program standards, from plan sponsors to participants who do not satisfy the standards, from participants who satisfy the standards to those who do not, or some combination of these.

The Departments developed a very rough estimate of the total amount of transfers that might derive from this requirement. The Departments' estimate assumes that (1) all discounts and surcharges take the form of employee premium discounts; (2) discounts are distributed evenly within both the low-to-average range and the average-to-high range, and are distributed across these ranges such that their mean equals the assumed average; and (3) 70 percent of participants qualify for the discount. This implies that just more than one-fourth of plans with discounts or surcharges will be impacted by the cap, and that these plans' current discounts and surcharges exceed the cap by $86 on average. The 9,600 affected plans could satisfy this requirement by reducing premiums for the 106,000 participants who do not qualify by $86 annually, for an aggregate, ongoing annual transfer of approximately $9 million. The Departments solicit comments on their assumptions and estimate, and would welcome information supportive of better estimates.

New economic costs and benefits may arise if changes in the size of discounts or surcharges result in changes in participant behavior.

Net economic welfare might be lost if some wellness programs' effectiveness is eroded, but the magnitude and incidence

of such effects is expected to be negligible. Consider a wellness program that discounts premiums for participants who take part in an exercise program. It is plausible that, at the margin, a few participants who would take part in order to obtain a discount of between $368 and $560 annually will not take part to obtain a discount of $367. This might represent a net loss of economic welfare. This effect is expected to be negligible, however. Based on the assumptions specified above, just 248,000 participants now qualifying for discounts would be affected. Reductions in discounts are likely to average about $86 annually, which amounts to $7 per month or $3 per biweekly pay period. Employee premiums are often deducted from pay pre-tax, so the after tax value of these discounts may be even smaller. Moreover, the proposed regulation caps only discounts and surcharges applied to similarly situated individuals in the context of a group health plans. It does not restrict plan sponsors from employing other motivational tools to encourage participation in wellness programs. According to the Hewitt survey, among 408 employers that offered incentives for participation in wellness programs, 24 percent offered awards or gifts and 62 percent varied life insurance premiums, while just 14 percent varied medical premiums.

On the other hand, net economic welfare likely will be gained in instances where large premium differentials would otherwise have served to discourage enrollment in health plans by employees who did not satisfy wellness program requirements. Consider a plan that provides a very large discount for non-smokers. The very high employee premiums charged to smokers might discourage some from enrolling in the plan at all, and some of these might be uninsured as a result. It seems unlikely that the plan sponsor would respond to the first requirement of the proposed regulation by raising premiums drastically for all non-smokers, driving many out of the plan. Instead, the plan sponsor would reduce premiums for smokers, and more smokers would enroll. This would result in transfers to newly enrolled smokers from the plan sponsor (and possibly from non-smokers if the plan sponsor makes other changes to compensation). But it would also result in net gains in economic welfare from reduced uninsurance.

The Departments believe that the net economic gains from prohibiting discounts and surcharges so large that they could discourage enrollment based on health factors outweigh any net losses that might derive from the negligible reduction of some employees' incentive to participate in wellness programs. Comments are solicited on the magnitude of these and any other effects and on the attendant costs and benefits.

Reasonable Design — Under the second requirement, the program must be reasonably designed to promote health or prevent disease. The Departments believe that a program that is not so designed would not provide economic benefits, but would serve merely to transfer costs from plan sponsors to targeted individuals based on health factors. This requirement therefore is not expected to impose economic costs but might prompt transfers of costs from otherwise targeted individuals to their plans' sponsors (or to other participants in their plans if plan sponsors elect to pass these costs back evenly to all participants). Comments received by the Departments and available literature on employee wellness programs, however, suggest that existing wellness programs generally satisfy this requirement. The requirement therefore is not expected to compel plans to modify existing wellness programs. It is not expected to entail economic costs nor to prompt transfers. The Departments would appreciate comments on this conclusion and information on the types of existing wellness programs (if any) that would not satisfy requirement.

Uniform Availability — The third requirement provides that rewards under the program must be available to all similarly situated individuals. In particular, the program must allow any individual for whom it would be unreasonably difficult due to a medical condition to satisfy the initial program standard an opportunity to satisfy a reasonable alternative standard. Comments received by the Departments and available literature on employee wellness programs suggest that some wellness programs do not currently satisfy this requirement and will have to be modified. Based on the Hewitt survey, the Departments estimate that among employers that provide incentives for employees to participate in wellness programs, 18 percent require employees to achieve a low risk behavior to qualify for the incentive, 79 percent require a pledge of compliance, and 38 percent require participation in a program. (These numbers sum to more than 100 percent because wellness programs may apply more than one criterion.) Depending on the nature of the wellness program, it might be unreasonably difficult due to a medical condition for at least some plan participants to achieve the behavior or to comply with or participate in the program.

The Departments identified three broad types of economic impact that might arise from the third requirement. First, affected plans will incur some economic cost to make available reasonable alternative standards. Second, additional economic costs and benefits may arise depending on the nature of alternatives provided, individuals' use of these alternatives, and any changes in the affected individuals' behavioral and health outcomes. Third, some costs may be transferred from individuals who would fail to satisfy programs' initial standards, but who will satisfy reasonable alternative standards once available (and thereby qualify for associated discounts), to plan sponsors (or to other participants in their plans if plan sponsors elect to pass these costs back evenly to all participants).

The Departments note that some plans that apply different discounts or surcharges to similarly situated individuals and are therefore subject to the requirement may not need to provide alternative standards. The requirement provides that alternative standards need not be specified or provided until a participant for whom it is unreasonably difficult due to a medical condition to satisfy the initial standard seeks such an alternative. Some wellness programs' initial standards may be such that no participant would ever find them unreasonably difficult to satisfy due to a medical condition. The Departments reviewed Hewitt survey data on wellness program standards and criteria. Based on their review they estimate that 20,000 of the 35,000 potentially affected plans have initial wellness program standards that might be unreasonably difficult for some participants to satisfy due to a medical condition. Moreover, because alternatives need not be made available until

they are sought by qualified plan participants, it might be possible for some of these plans to go for years or even indefinitely without needing to make available an alternative standard. This could be particularly likely for small plans. The most common standards for wellness programs pertain to smoking, blood pressure, and cholesterol levels, according to the Hewitt Survey. Based on U.S. Centers for Disease Control and Management data on the incidence of certain health habits and conditions in the general population, the Departments estimate that among companies with 5 employees, about one-fourth probably employ no smokers, and about one-third probably employ no one with high blood pressure or cholesterol. Approximately 96 percent of all plans with potentially difficult initial wellness program standards have fewer than 100 participants.

How many participants might qualify for, seek, and ultimately satisfy alternative standards? The Departments lack sufficient data to estimate these counts with confidence. Rough estimates were developed as follows. The Departments examined the Hewitt survey of wellness program provisions and U.S. Centers for Disease Control and Prevention statistics on the incidence of certain health habits and conditions in the general population in order to discern how wellness programs' initial standards might interact with plan participants' health habits and health status. Based on these data, it appears that as many as 29 percent of participants in plans with discounts or surcharges, or 394,000 individuals, might fail to satisfy wellness programs' initial standards. Of these, approximately 229,000 are in the 22,000 plans which apply standards that might be unreasonably difficult due to a medical condition for some plan participants to satisfy, the Departments estimate. The standards would in fact be unreasonably difficult to satisfy for some subset of these individuals — 148,000 by the Departments' estimate. The Departments lack any basis to estimate how many of these will avail themselves of an alternative standard, or how many that do will succeed in satisfying that standard. To estimate the potential impact of this requirement, the Departments considered two assumptions: an upper bound assumption under which all 148,000 individuals seek and satisfy alternative standards, and an alternative assumption under which one-half (or 74,000) seek an alternative and one-half of those (37,000) satisfy it.

Where plans are required to make available reasonable alternative standards, what direct costs will they incur? The regulation does not prescribe a particular type of alternative standard that must be provided. Instead, it permits plan sponsors flexibility to provide any reasonable alternative. The Departments expect that plans sponsors will select alternatives that entail the minimum net costs (or, stated differently, the maximum net benefits) that are possible. Plan sponsors may select low-cost alternatives, such as requiring an individual for whom it would be unreasonably difficult to quit smoking (and thereby qualify for a non-smoker discount) to attend a smoking cessation program that is available at little or no cost in the community, or to watch educational videos or review educational literature. Plan sponsors presumably will select higher-cost alternatives only if they thereby derive offsetting benefits, such as a higher smoking cessation success rate. The Departments also note that the number of plans with initial wellness program standards that might be unreasonably difficult for some participants to satisfy is probably small (having been estimated at 22,000, or 1 percent of all plans), as is the number of individuals who would take advantage of alternative standards (estimated at between 74,000 and 148,00, or between 0.1 percent and 0.2 percent of all participants).

It seems reasonable to presume that the net cost plan sponsors will incur in the provision of alternatives, including transfers as well as new economic costs and benefits, will not exceed the transfer cost of providing discounts (or waiving surcharges) for all plan participants who qualify for alternatives, which is estimated below at between $9 million and $37 million. It is likely that many plan sponsors will find more cost effective ways to satisfy this requirement, and that the true net cost to them will therefore be much smaller than this. The Departments have no basis for estimating the magnitude of the cost of providing alternative standards or of potential offsetting benefits, however, and therefore solicit comments from the public on this question.

What other economic costs and benefits might arise where alternative standards are made available? A large number of outcomes are possible. Consider a program that provides premium discounts for non-smokers.

It is possible that some individuals who would have quit smoking in order to qualify for a discount will nonetheless find it unreasonably difficult to quit and will obtain the discount while continuing to smoke by satisfying an alternative standard. This would represent a net loss of economic welfare from increased smoking.

On the other hand, consider individuals who, in the context of the initial program, are unable or unwilling to quit smoking. It seems likely that some of these individuals could quit with appropriate assistance, and that some alternative standards provided by plan sponsors will provide such assistance. In such cases, a program which had the effect of shifting premium costs to smokers would be transformed into one that successfully reduced smoking. This would represent a net gain of economic welfare.

Which scenario is more likely? The Departments have no concrete basis for answering this question, and therefore solicit comments on it. However, the Departments note that plan sponsors will have strong motivation to identify and provide alternative standards that have positive net economic effects. They will be disinclined to provide alternatives that undermine their overall wellness program and worsen behavioral and health outcomes, or that make financial rewards available absent meaningful efforts by participants to improve their health habits and health. Instead they will be inclined to provide alternatives that sustain or reinforce plan participants' incentive to improve their health habits and health, and/or that help participants make such improvements. It therefore seems likely that gains in economic welfare from this requirement will equal or outweigh losses. The Departments anticipate that the requirement to provide reasonable alternative standards will reduce instances where wellness programs serve only to

shift costs to higher risk individuals and increase instances where programs succeed at helping high risk individuals improve their health habits and health.

What transfers of costs might derive from the availability of (and participants' satisfaction of) alternative standards? The transfers arising from this requirement may take the form of transfers to participants who satisfy new alternative wellness program standards from plan sponsors, to such participants from other participants, or some combination of these. The Departments estimated potential transfers as follows. Assuming average annual total premiums for employee-only coverage of $2,448,[3] the maximum allowable discount of 15 percent amounts to $367 per year. As noted earlier, discounts under existing wellness programs appear to average about 11 percent (or $280 per year for a plan costing $2,448), ranging from 3 percent ($70) to 23 percent ($560). Reducing all discounts greater than $367 per year to that amount will reduce the average, perhaps to about $251. Assuming that the 37,000 to 148,000 participants who satisfy alternative standards would not have satisfied the wellness programs' initial standards, the transfers attributable to their discounts and hence to this requirement would amount to between $9 million and $37 million. The Departments solicit comments on their assumptions and estimates regarding transfers that may derive from this requirement.

Disclosure of Alternatives' Availability — The fourth requirement provides that plan materials describing wellness plan standards must disclose the availability of reasonable alternative standards. This requirement will affect the 37,000 plans that apply discounts or surcharges. These plans will incur economic costs to revise affected plan materials. The 37,000 to 148,000 participants who will succeed at satisfying these alternative standards will benefit from these disclosures. The disclosures need not specify what alternatives are available, and the regulation provides model language that can be used to satisfy this requirement. The Departments generally account elsewhere for plans' cost of updating such materials to reflect changes in plan provisions as required under various disclosure requirements and as is part of usual business practice. This particular requirement is expected to represent a negligible fraction of the ongoing cost of updating plans' materials, and is not separately accounted for here.

* * * * *

Proposed Amendments to the Regulations

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

PART 54 — PENSION EXCISE TAXES

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

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

Par. 2. Section 54.9802-1 is amended by adding text to paragraph (f) to read as follows:

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

* * * * *

(f) *Bona fide wellness programs* — (1) *Definition*. A wellness program is a bona fide wellness program if it satisfies the requirements of paragraphs (f)(1)(i) through (f)(1)(iv) of this section. However, a wellness program providing a reward that is not contingent on satisfying a standard related to a health factor does not violate this section even if it does not satisfy the requirements of this paragraph (f) for a bona fide wellness program.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed [10/15/20] percent of the cost of employee-only coverage under the plan. For this purpose, the cost of employee-only coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage. A reward can be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), or the absence of a surcharge.

(ii) The program must be reasonably designed to promote good health or prevent disease. For this purpose, a program is not reasonably designed to promote good health or prevent disease unless the program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iii) The reward under the program must be available to all similarly situated individuals. A reward is not available to all similarly situated individuals for a period unless the program allows —

(A) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard for the reward; and

(B) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard for the reward.

(iv) The plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard required under paragraph (f)(1)(iii) of this section. (However, in plan materials that merely mention that a program is available, without describing its terms, this disclosure is not required.) The following language, or substantially similar language, can be used to satisfy this requirement: "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 4, 5, and 6 of paragraph (f)(2) of this section.

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

Example 1. (i) *Facts.* A group health plan offers a wellness program to participants and beneficiaries under which the plan provides memberships to a local fitness center at a discount.

(ii) *Conclusion.* In this *Example 1*, the reward under the program is not contingent on satisfying

[3]Average level based on the Kaiser Family Foundation/Health Research and Education Trust *Survey of Employer-Sponsored Health benefits*, 1999, projected by the Departments to 2000 levels.

any standard that is related to a health factor. Therefore, there is no discrimination based on a health factor under either paragraph (b) or (c) of this section and the requirements for a bona fide wellness program do not apply.

Example 2. (i) *Facts*. An employer sponsors a group health plan. The annual premium for employee-only coverage is $2,400 (of which the employer pays $1,800 per year and the employee pays $600 per year). The plan implements a wellness program that offers a $240 rebate on premiums to program enrollees.

(ii) *Conclusion*. In this *Example 2*, the program satisfies the requirements of paragraph (f)(1)(i) of this section because the reward for the wellness program, $240, does not exceed [10/15/20] percent of the total annual cost of employee-only coverage, [$240/$360/$480]. ($2,400 x [10/15/20]% = [$240/$360/$480].)

Example 3. (i) *Facts*. A group health plan gives an annual premium discount of [10/15/20] percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion*. In this *Example 3*, the program is not a bona fide wellness program. The program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard for obtaining the premium discount. (In addition, plan materials describing the program are required to disclose the availability of the reasonable alternative standard for obtaining the premium discount.) Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 4. (i) *Facts*. Same facts as *Example 3*, except that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count), the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual *D* is unable to achieve a cholesterol count under 200. The plan accommodates *D* by making the discount available to *D*, but only if *D* complies with a low-cholesterol diet.

(ii) *Conclusion*. In this *Example 4*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 5. (i) *Facts*. A group health plan will waive the $250 annual deductible (which is less than [10/15/20] percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard during the year) is given the same discount if the individual satisfies a reasonable alternative standard that is tailored to the individual's situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived, such as a dietary regimen."

(ii) *Conclusion*. In this *Example 5*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 6. (i) *Facts*. In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is [10/15/20] percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual *E* to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates *E* by requiring *E* to participate in a smoking cessation program to avoid the surcharge. *E* can avoid the surcharge for as long as *E* participates in the program, regardless of whether *E* stops smoking (as long as *E* continues to be addicted to nicotine).

(ii) *Conclusion*. In this *Example 6*, the premium surcharge is permissible as a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

* * * * *

Robert E. Wenzel,
Deputy Commissioner of Internal Revenue.

For the reasons set forth above, 29 CFR Part 2590 is proposed to be amended as follows:

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

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

Authority: Secs. 107, 209, 505, 701-703, 711-713, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181-1183, and 1191-1194), as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104-204, 110 Stat. 2935), and WHCRA (Public Law 105-277, 112 Stat. 2681-436), section 101(g)(4) of HIPAA, and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

2. **Section 2590.702 is proposed to be revised by adding text to paragraph (f) to read as follows:**

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

* * * * *

(f) *Bona fide wellness programs* — (1) *Definition*. A wellness program is a bona fide wellness program if it satisfies the requirements of paragraphs (f)(1)(i) through (f)(1)(iv) of this section. However, a wellness program providing a reward that is not contingent on satisfying a standard related to a health factor does not violate this section even if it does not satisfy the requirements of this paragraph (f) for a bona fide wellness program.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed [10/15/20] percent of the cost of employee-only coverage under the plan. For this purpose, the cost of employee-only coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage. A reward can be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), or the absence of a surcharge.

(ii) The program must be reasonably designed to promote good health or prevent disease. For this purpose, a program is not reasonably designed to promote good health or prevent disease unless the program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iii) The reward under the program must be available to all similarly situated individuals. A reward is not available to all similarly situated individuals for a period unless the program allows —

(A) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard for the reward; and

(B) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard for the reward.

(iv) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard required under paragraph (f)(1)(iii) of this section. (However, in plan materials that merely mention that a program is available, without describing its terms, this disclosure is not required.) The following language, or substantially similar language, can be used to satisfy this requirement: "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 4, 5, and 6 of paragraph (f)(2) of this section.

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

Example 1. (i) *Facts.* A group health plan offers a wellness program to participants and beneficiaries under which the plan provides memberships to a local fitness center at a discount.

(ii) *Conclusion*. In this *Example 1*, the reward under the program is not contingent on satisfying any standard that is related to a health factor. Therefore, there is no discrimination based on a health factor under either paragraph (b) or (c) of this section and the requirements for a bona fide wellness program do not apply.

Example 2. (i) *Facts*. An employer sponsors a group health plan. The annual premium for employee-only coverage is $2,400 (of which the employer pays $1,800 per year and the employee pays $600 per year). The plan implements a wellness program that offers a $240 rebate on premiums to program enrollees.

(ii) *Conclusion*. In this *Example 2*, the program satisfies the requirements of paragraph (f)(1)(i) of this section because the reward for the wellness program, $240, does not exceed [10/15/20] percent of the total annual cost of employee-only coverage, [$240/$360/$480]. ($2,400 x [10/15/20]% = [$240/$360/$480].)

Example 3. (i) *Facts*. A group health plan gives an annual premium discount of [10/15/20] percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion*. In this *Example 3*, the program is not a bona fide wellness program. The program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard for obtaining the premium discount. (In addition, plan materials describing the program are required to disclose the availability of the reasonable alternative standard for obtaining the premium discount.) Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 4. (i) *Facts*. Same facts as *Example 3*, except that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count), the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual *D* is unable to achieve a cholesterol count under 200. The plan accommodates *D* by making the discount available to *D*, but only if *D* complies with a low-cholesterol diet.

(ii) *Conclusion*. In this *Example 4*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 5. (i) *Facts*. A group health plan will waive the $250 annual deductible (which is less than [10/15/20] percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard during the year) is given the same discount if the individual satisfies a reasonable alternative standard that is tailored to the individual's situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body

mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived, such as a dietary regimen."

(ii) *Conclusion.* In this *Example 5*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 6. (i) *Facts.* In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is [10/15/20] percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual *E* to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates *E* by requiring *E* to participate in a smoking cessation program to avoid the surcharge. *E* can avoid the surcharge for as long as *E* participates in the program, regardless of whether *E* stops smoking (as long as *E* continues to be addicted to nicotine).

(ii) *Conclusion.* In this *Example 6*, the premium surcharge is permissible as a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

* * * * *

Signed at Washington, DC this 28th day of December 2000.

Leslie B. Kramerich,
Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.

For the reasons set forth above, we propose to amend 45 CFR Part 146 as follows:

PART 146 [AMENDED] — RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

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

Authority: Secs. 2701 through 2763, 2791 and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, 300gg-92 as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104-204, 110 Stat. 2935), and WHCRA (Public Law 105-277, 112 Stat. 2681-436), and section 102(c)(4) of HIPAA.

2. **We propose to revise § 146.121 by adding text to paragraph (f) to read as follows:**

§ 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

* * * * *

(f) *Bona fide wellness programs* — (1) *Definition.* A wellness program is a bona fide wellness program if it satisfies the requirements of paragraphs (f)(1)(i) through (f)(1)(iv) of this section. However, a wellness program providing a reward that is not contingent on satisfying a standard related to a health factor does not violate this section even if it does not satisfy the requirements of this paragraph (f) for a bona fide wellness program.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed [10/15/20] percent of the cost of employee-only coverage under the plan. For this purpose, the cost of employee-only coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage. A reward can be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), or the absence of a surcharge.

(ii) The program must be reasonably designed to promote good health or prevent disease. For this purpose, a program is not reasonably designed to promote good health or prevent disease unless the program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iii) The reward under the program must be available to all similarly situated individuals. A reward is not available to all similarly situated individuals for a period unless the program allows —

(A) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard for the reward; and

(B) A reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard for the reward.

(iv) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard required under paragraph (f)(1)(iii) of this section. (However, in plan materials that merely mention that a program is available, without describing its terms, this disclosure is not required.) The following language, or substantially similar language, can be used to satisfy this requirement: "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 4, 5, and 6 of paragraph (f)(2) of this section.

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

Example 1. (i) *Facts*. A group health plan offers a wellness program to participants and beneficiaries under which the plan provides memberships to a local fitness center at a discount.

(ii) *Conclusion*. In this *Example 1*, the reward under the program is not contingent on satisfying any standard that is related to a health factor. Therefore, there is no discrimination based on a health factor under either paragraph (b) or (c) of this section and the requirements for a bona fide wellness program do not apply.

Example 2. (i) *Facts*. An employer sponsors a group health plan. The annual premium for employee-only coverage is $2,400 (of which the employer pays $1,800 per year and the employee pays $600 per year). The plan implements a wellness program that offers a $240 rebate on premiums to program enrollees.

(ii) *Conclusion*. In this *Example 2*, the program satisfies the requirements of paragraph (f)(1)(i) of this section because the reward for the wellness program, $240, does not exceed [10/15/20] percent of the total annual cost of employee-only coverage, [$240/$360/$480]. ($2,400 x [10/15/20]% = [$240/$360/$480].)

Example 3. (i) *Facts*. A group health plan gives an annual premium discount of [10/15/20] percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion*. In this *Example 3*, the program is not a bona fide wellness program. The program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard for obtaining the premium discount. (In addition, plan materials describing the program are required to disclose the availability of the reasonable alternative standard for obtaining the premium discount.) Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 4. (i) *Facts*. Same facts as *Example 3*, except that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count), the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual *D* is unable to achieve a cholesterol count under 200. The plan accommodates *D* by making the discount available to *D*, but only if *D* complies with a low-cholesterol diet.

(ii) *Conclusion*. In this *Example 4*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 5. (i) *Facts*. A group health plan will waive the $250 annual deductible (which is less than [10/15/20] percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard during the year) is given the same discount if the individual satisfies a reasonable alternative standard that is tailored to the individual's situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived, such as a dietary regimen."

(ii) *Conclusion*. In this *Example 5*, the program is a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 6. (i) *Facts*. In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is [10/15/20] percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual *E* to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates *E* by requiring *E* to participate in a smoking cessation program to avoid the surcharge. *E* can avoid the surcharge for as long as *E* participates in the program, regardless of whether *E* stops smoking (as long as *E* continues to be addicted to nicotine).

(ii) *Conclusion*. In this *Example 6*, the premium surcharge is permissible as a bona fide wellness program because it satisfies the four requirements of this paragraph (f). First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote good health or prevent disease. Third, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fourth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

* * * * *

Dated June 22, 2000.

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

Approved August 29, 2000.

Donna E. Shalala,
Secretary.

(Filed by the Office of the Federal Register on January 5, 2001, 8:45 a.m., and published in the issue of the Federal Register for January 8, 2001, 66 F.R. 1421)

Request for Ideas for Exempt Organizations Plain-Language Publications and Voluntary Compliance Programs

Announcement 2001-14

The Exempt Organizations function of the Tax Exempt and Government Entities Division (TE/GE) is requesting comments

in two areas directly related to its increased emphasis on enhancing voluntary compliance. As part of its reorganization, a new Customer Education and Outreach office has been created within Exempt Organizations. This office will be responsible for coordinating and redesigning the means by which Exempt Organizations interacts with its community. Exempt Organizations, as restructured, also contemplates the establishment of an office of voluntary compliance.

This announcement is to request comments and suggestions relating to areas within the jurisdiction of these two new offices. First, suggestions are being solicited for new initiatives in the areas of outreach and education. In particular, help is solicited on two items: IRS Internet web-page content and plain language publications. It is anticipated that Exempt Organizations will develop a web page for use in communicating with its customers. Suggestions are solicited on how such a web page should be designed and what content should be included. Exempt Organizations also intends to aggressively pursue the issuance of plain language publications for use by its customers. In the past, these publications have been successful in helping to promote compliance. For example, Exempt Organizations has issued plain-language publications on various topics, including the *Gaming Publication for Tax-Exempt Organizations*, Pub. 3079 (4-98), the *Tax Guide for Veterans' Organizations,* Pub. 3386 (6-99), and the *Draft Tax Guide For Churches and Other Religious Organizations*, Pub. 1828 (9-94). Exempt Organizations plans to issue more plain-language publications in the future as part of its increased focus on customer education and outreach.

Second, as its new design indicates, the Exempt Organizations function is planning on establishing voluntary compliance programs. It is anticipated that there may be several programs, some of which are very targeted (e.g., in 1992, Exempt Organizations established a voluntary compliance program to resolve tax exemption issues arising from gross or net revenue stream joint ventures between hospitals and their medical staffs in announcement 92-70, 1992-19 I.R.B. 89.) Other voluntary compliance programs may be much broader. For example, consideration will be given to programs to cover those organizations that came to the Internal Revenue Service as non-filers or to correct previous compliance difficulties.

Exempt Organizations invites interested members of the public to submit written suggestions for topics for plain-language publications, IRS Internet website content, or suggestions for additional voluntary compliance programs. Members of the public are further invited to submit drafts of proposed plain-language publications or proposed voluntary compliance programs if they so desire. All submissions will be available for public inspection and copying in their entirety.

ADDRESS

Members of the public may submit suggestions or drafts by electronic message, by mail, or by hand delivery. Electronic messages may be addressed to **TE/GE-Exempt@irs.gov.* Mail may be addressed to Ms. Virginia Richardson, T:EO, 1111 Constitution Avenue, NW, Washington, D.C. 20224, Attn: 2001-14. Hand delivered items may be addressed to Ms. Virginia Richardson, T:EO, Attn: 2001-14, and delivered, between 8:00 a.m. and 5:00 p.m., to the Courier's Desk, 1111 Constitution Avenue, NW, Washington, D.C. 20224. Exempt Organizations regrets that it will be unable to respond individually to suggestions or drafts.

DRAFTING INFORMATION

The principal author of this announcement is Virginia Richardson of Exempt Organizations. For further information regarding this announcement contact Virginia Richardson at (202) 283-8938 (not a toll-free call).

Announcement of the Consent Voluntary Suspension of Attorneys, Certified Public Accountants, Enrolled Agents, and Enrolled Actuaries From Practice Before the Internal Revenue Service

Under 31 Code of Federal Regulations, Part 10, an attorney, certified public accountant, enrolled agent or enrolled actuary, in order to avoid the institution or conclusion of a proceeding for his disbarment or suspension from practice before the Internal Revenue Service, may offer his consent to suspension from such practice. The Director of Practice, in his discretion, may suspend an attorney, certified public accountant, enrolled agent or enrolled actuary in accordance with the consent offered.

Attorneys, certified public accountants, enrolled agents and enrolled actuaries are prohibited in any Internal Revenue Service matter from directly or indirectly employing, accepting assistance from, being employed by or sharing fees with, any practitioner disbarred or suspended from practice before the Internal Revenue Service.

To enable attorneys, certified public accountants, enrolled agents and enrolled actuaries to identify practitioners under consent suspension from practice before the Internal Revenue Service, the Director of Practice will announce in the Internal Revenue Bulletin the names and addresses of practitioners who have been suspended from such practice, their designation as attorney, certified public accountant, enrolled agent or enrolled actuary, and date or period of suspension. This announcement will appear in the weekly Bulletin at the earliest practicable date after such action and will continue to appear in the weekly Bulletins for five successive weeks or for as many weeks as is practicable for each attorney, certified public accountant, enrolled agent or enrolled actuary so suspended and will be consolidated and published in the Cumulative Bulletin.

The following individuals have been placed under consent suspension from practice before the Internal Revenue Service:

Name	Address	Designation	Date of Suspension
Sinclair, Gerald A.	Hammond, IN	Enrolled Agent	August 16, 2000 to August 15, 2001
Barrett, Norman	Dover, DE	CPA	September 1, 2000 to November 30, 2001
Janus, Stephen E.	Michigan City, IN	CPA	September 20, 2000 to September 19, 2003
McCormack, Frank J.	Castlebury, FL	CPA	September 20, 2000 to September 19, 2003
Serio, Vinson J.	Metairie, LA	Enrolled Agent	October 1, 2000 to September 30, 2003
Baker, Linda L.	West Orange, NJ	CPA	October 20, 2000 to April 19, 2004
Duncanson, Thomas D.	Mankato, MN	CPA	November 7, 2000 to May 6, 2003
West, Keith	Pasadena, CA	Enrolled Agent	November 15, 2000 to May 14, 2001
Overbeck, Marietta	Evansville, IN	CPA	November 15, 2000 to November 14, 2002
Garrison, John L.	Guymon, OK	CPA	November 20, 2000 to November 19, 2002
Aiken, Kim Allen	Olympia, WA	CPA	December 10, 2000 to June 9, 2002
D'Arata, David J.	Buffalo, NY	CPA	January 1, 2001 to June 30, 2003
Gambrel, Thomas R.	Corbin, KY	CPA	January 1, 2001 to December 31, 2004

Announcement of the Expedited Suspension of Attorneys, Certified Public Accountants, Enrolled Agents, and Enrolled Actuaries From Practice Before the Internal Revenue Service

Under title 31 of the Code of Federal Regulations, section 10.76, the Director of Practice is authorized to immediately suspend from practice before the Internal Revenue Service any practitioner who, within five years, from the date the expedited proceeding is instituted, (1) has had a license to practice as an attorney, certified public accountant, or actuary suspended or revoked for cause; or (2) has been convicted of any crime under title 26 of the United States Code or, of a felony under title 18 of the United States Code involving dishonesty or breach of trust.

Attorneys, certified public accountants, enrolled agents, and enrolled actuaries are prohibited in any Internal Revenue Service matter from directly or indirectly employ-

ing, accepting assistance from, being employed by, or sharing fees with, any practitioner disbarred or suspended from practice before the Internal Revenue Service.

To enable attorneys, certified pubic accountants, enrolled agents, and enrolled actuaries to identify practitioners under expedited suspension from practice before the Internal Revenue Service, the Director of Practice will announce in the Internal Revenue Bulletin the names and addresses of practitioners who have been suspended from such practice, their designation as attorney, certified public accountant, enrolled agent, or enrolled actuary, and date or period of suspension. This announcement will appear in the weekly Bulletin at the earliest practicable date after such action and will continue to appear in the weekly Bulletins for five successive weeks or for as many weeks as is practicable for each attorney, certified public accountant, enrolled agent, or enrolled actuary so suspended and will be consolidated and published in the Cumulative Bulletin.

The following individuals have been placed under suspension from practice before the Internal Revenue Service by virtue of the expedited proceeding provisions of the applicable regulations:

Name	Address	Designation	Date of Suspension
Barger, Robert E.	Garden Ridge, TX	Attorney	Indefinite from October 10, 2000
Roberts, Thomas W.	Cincinnati OH	CPA	Indefinite from October 24, 2000

Announcement of the Disbarment and Suspension of Attorneys, Certified Public Accountants, Enrolled Agents, and Enrolled Actuaries From Practice Before the Internal Revenue Service

Under Section 330, Title 31 of the United States Code, the Secretary of the Treasury, after due notice and opportunity for hearing, is authorized to suspend or disbar from practice before the Internal Revenue Service any person who has violated the rules and regulations governing the recognition of attorneys, certified public accountants, enrolled agents or enrolled actuaries to practice before the Internal Revenue Service.

Attorneys, certified public accountants, enrolled agents, and enrolled actuaries are prohibited in any Internal Revenue Service matter from directly or indirectly employing, accepting assistance from, being employed by, or sharing fees with any practitioner disbarred or under suspension from practice before the Internal Revenue Service.

To enable attorneys, certified public accountants, enrolled agents and enrolled actuaries to identify such disbarred or suspended practitioners, the Director of Practice will announce in the Internal Revenue Bulletin the names and addresses of practitioners who have been suspended from such practice, their designation as attorney, certified public accountant, enrolled agent or enrolled actuary, and the date of disbarment or period of suspension. This announcement will appear in the weekly Bulletin for five successive weeks or as long as it is practicable for each attorney, certified public accountant, enrolled agent or enrolled actuary so suspended or disbarred and will be consolidated and published in the Cumulative Bulletin.

After due notice and opportunity for hearing before an administrative law judge, the following individual has been disbarred from futher practice before the Internal Revenue Service:

Name	Address	Designation	Effective Date
Joyner, Joseph	Gary, IN	CPA	November 24, 2000

Definition of Terms

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

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

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

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

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

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

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

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance 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.—Statements of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.

Numerical Finding List[1]

Bulletins 2001–1 through 2001–6

Announcements:

2001–1, 2001–2 I.R.B. *277*
2001–2, 2001–2 I.R.B. *277*
2001–3, 2001–2 I.R.B. *278*
2001–4, 2001–2 I.R.B. *286*
2001–5, 2001–2 I.R.B. *286*
2001–6, 2001–3 I.R.B. *357*
2001–7, 2001–3 I.R.B. *357*
2001–8, 2001–3 I.R.B. *357*
2001–9, 2001–3 I.R.B. *357*
2001–10, 2001–4 I.R.B. *431*
2001–11, 2001–4 I.R.B. *432*
2001–12, 2001–6 I.R.B. *526*

Notices:

2001–1, 2001–2 I.R.B. *261*
2001–2, 2001–2 I.R.B. *265*
2001–3, 2001–2 I.R.B. *267*
2001–4, 2001–2 I.R.B. *267*
2001–5, 2001–3 I.R.B. *327*
2001–6, 2001–3 I.R.B. *327*
2001–7, 2001–4 I.R.B. *374*
2001–8, 2001–4 I.R.B. *374*
2001–9, 2001–4 I.R.B. *375*
2001–10, 2001–5 I.R.B. *459*
2001–11, 2001–5 I.R.B. *464*
2001–12, 2001–3 I.R.B. *328*
2001–13, 2001–6 I.R.B. *514*
2001–14, 2001–6 I.R.B. *516*

Proposed Regulations:

REG–251701–96, 2001–4, I.R.B. *396*
REG–106542–98, 2001–5, I.R.B. *473*
REG–121928–98, 2001–6, I.R.B. *520*
REG–104683–00, 2001–4, I.R.B. *407*
REG–106702–00, 2001–4, I.R.B. *424*
REG–106791–00, 2001–6, I.R.B. *521*
REG–107176–00, 2001–4, I.R.B. *428*
REG–107566–00, 2001–3, I.R.B. *346*
REG–116468–00, 2001–6, I.R.B. *522*
REG–119352–00, 2001–6, I.R.B. *525*

Railroad Retirement Quarterly Rates:

2001–2, I.R.B. *258*

Revenue Procedures:

2001–1, 2001–1 I.R.B. *1*
2001–2, 2001–1 I.R.B. *79*
2001–3, 2001–1 I.R.B. *111*
2001–4, 2001–1 I.R.B. *121*
2001–5, 2001–1 I.R.B. *164*
2001–6, 2001–1 I.R.B. *194*
2001–7, 2001–1 I.R.B. *236*
2001–8, 2001–1 I.R.B. *239*
2001–9, 2001–3 I.R.B. *328*
2001–10, 2001–2 I.R.B. *272*
2001–11, 2001–2 I.R.B. *275*
2001–12, 2001–3 I.R.B. *335*
2001–13, 2001–3 I.R.B. *337*
2001–14, 2001–3 I.R.B. *343*
2001–15, 2001–5 I.R.B. *465*
2001–16, 2001–4 I.R.B. *376*

Revenue Rulings:

2001–2, 2001–2 I.R.B. *255*
2001–3, 2001–3 I.R.B. *319*
2001–4, 2001–3 I.R.B. *295*
2001–5, 2001–5 I.R.B. *451*
2001–6, 2001–6 I.R.B. *491*

Treasury Decisions:

8910, 2001–2 I.R.B. *258*
8911, 2001–3 I.R.B. *321*
8912, 2001–5 I.R.B. *452*
8913, 2001–3 I.R.B. *300*
8915, 2001–4 I.R.B. *359*
8916, 2001–4 I.R.B. *360*
8918, 2001–4 I.R.B. *372*
8919, 2001–6 I.R.B. *505*
8922, 2001–6 I.R.B. *508*
8923, 2001–6 I.R.B. *485*
8924, 2001–6 I.R.B. *489*
8925, 2001–6 I.R.B. *496*
8926, 2001–6 I.R.B. *492*
8930, 2001–5 I.R.B. *433*

[1] A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2000–27 through 2000–52 is in Internal Revenue Bulletin 2001–1, dated January 2, 2001.

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

Bulletins 2001–1 through 2001–6

Announcement:

98–99
Modified by
Ann. 2001–9, 2001–3 I.R.B. *357*

99–79
Superseded by
Ann. 2001–3, 2001–2 I.R.B. *278*

2000–97
Corrected by
Ann. 2001–7, 2001–3 I.R.B. *357*

Cumulative Bulletin:

1998–2
Corrected by
Ann. 2001–5, 2001–2 I.R.B. *286*

Notices:

98–39
Modified by
Notice 2001–9, 2001–4 I.R.B. *375*

98–40
Modified by
Notice 2001–9, 2001–4 I.R.B. *375*

99–53
Modified and superseded by
Notice 2001–7, 2001–4 I.R.B. *374*

2000–21
Superseded by
Notice 2001–1, 2001–2 I.R.B. *261*

2000–22
Modified and superseded by
Notice 2001–8, 2001–4 I.R.B. *374*

2000–43
Extended by
Notice 2001–13, 2001–6 I.R.B. *514*

Proposed Regulations:

REG–116733–98
Withdrawn by
Ann. 2001–11, 2001–4 I.R.B. *432*

Revenue Procedures:

83–87
Superseded by
Rev. Proc. 2001–15, 2001–5 I.R.B. *465*

92–19
Superseded by
Rev. Proc. 2001–15, 2001–5 I.R.B. *465*

96–17
Modified by
Rev. Proc. 2001–9, 2001–3 I.R.B. *328*

99–47
Superseded by
Rev. Proc. 2001–16, 2001–4 I.R.B. *376*

99–49
Modified and amplified by
Rev. Proc. 2001–10, 2001–2 I.R.B. *272*

Revenue Procedures–continued:

2000–1
Superseded by
Rev. Proc. 2001–1, 2001–1 I.R.B. *1*

2000–2
Superseded by
Rev. Proc. 2001–2, 2001–1 I.R.B. *79*

2000–3
Superseded by
Rev. Proc. 2001–3, 2001–1 I.R.B. *111*

2000–4
Superseded by
Rev. Proc. 2001–4, 2001–1 I.R.B. *121*

2000–5
Superseded by
Rev. Proc. 2001–5, 2001–1 I.R.B. *164*

2000–6
Superseded by
Rev. Proc. 2001–6, 2001–1 I.R.B. *194*

2000–7
Superseded by
Rev. Proc. 2001–7, 2001–1 I.R.B. *236*

2000–8
Superseded by
Rev. Proc. 2001–8, 2001–1 I.R.B. *239*

2000–22
Modified and superseded by
Rev. Proc. 2001–10, 2001–2 I.R.B. *272*

2001–13
Clarified by
Notice 2001–12, 2001–3 I.R.B. *328*

Revenue Rulings:

64–328
Modified by
Notice 2001–10, 2001–5 I.R.B. *459*

66–110
Modified by
Notice 2001–10, 2001–5 I.R.B. *459*

Treasury Decisions:

8889
Corrected by
Ann. 2001–14, 2001–2 I.R.B. *286*

[1] A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2000–27 through 2000–52 is in Internal Revenue Bulletin 2001–1, dated January 2, 2001.

United States Government
INFORMATION
PUBLICATIONS ★ PERIODICALS ★ ELECTRONIC PRODUCTS

New Deposit Account?
Check here ❑

Order processing code
* 3333

Publications

Qty.	Stock Number	Title	Price Each	Total Price
	021-066-00005-2	Subject Bibliography listing Cum. Bulletins available thru 1998-2	FREE	FREE
	048-004-02333-4	Cum. Bulletin 1994-2 (July-Dec)	$62	
	048-004-02335-1	Cum. Bulletin 1995-1 (Jan-June)	63	
	048-004-02338-5	Cum. Bulletin 1995-2 (July-Dec)	58	
	048-004-02366-1	Cum. Bulletin 1996-1 (Jan-June)	77	
	048-004-02376-8	Cum. Bulletin 1996-2 (July-Dec)	57	
	048-004-02384-9	Cum. Bulletin 1996-3 (1996 Tax Legislation)	84	
	048-004-02385-7	Cum. Bulletin 1997-1 (Jan-June)	75	
	048-004-02397-1	Cum. Bulletin 1997-2 (July-Dec)	68	
	048-004-02424-1	Cum. Bulletin 1997-3	62	
	048-004-02425-0	Cum. Bulletin 1997-4 Vol. 1	74	
	048-004-02430-6	Cum. Bulletin 1997-4 Vol. 2	76	
	048-004-02405-5	Cum. Bulletin 1998-1 (Jan-June)	86	
	048-004-02422-5	Cum. Bulletin 1998-2 (July-Dec)	70	

Total for Publications

Subscriptions

Qty.	List ID	Title	Price Each	Total Price
	IRB	Internal Revenue Bulletin	$170	
		Optional – Add $50 to open Deposit Account. Also check box in upper right.		
		Total for Subscriptions		
		Total for Publications and Subscriptions		

NOTE: All prices include regular shipping and handling. Subscription prices are subject to change at any time. International customers, please add 25%.

Check method of payment:

❑ Check payable to Superintendent of Documents
❑ Deposit Account ☐☐☐☐☐☐☐☐–☐
❑ VISA ❑ MasterCard ❑ Discover/NOVUS

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐ (expiration date)

Thank you for your order!

Authorizing signature 7/00

Company or personal name (Please type or print)

Additional address/attention line

Street address

City, State, Zip code

Daytime phone with area code

E-mail address

Purchase order number (optional)

Standing Order Service *

To automatically receive future editions of *Internal Revenue Cumulative Bulletins* without having to initiate a new purchase order, sign below for Standing Order Service.

Qty.	Standing Order	Title
	ZIRSC	Internal Revenue Cumulative Bulletins

Authorization

I hereby authorize the Superintendent of Documents to charge my account for Standing Order Service:

(enter account information at right)

❑ VISA ❑ MasterCard ❑ Discover/NOVUS

❑ Superintendent of Documents Deposit Account

Authorizing signature (Standing orders not valid unless signed.)

Please print or type your name.

Daytime phone number (_____) _____

SuDocs Deposit Account

A Deposit Account will enable you to use Standing Order Service to receive subsequent volumes quickly and automatically. For an initial deposit of $50 you can establish your Superintendent of Documents Deposit Account.

❑ **YES!** Open a Deposit Account for me so I can order future publications quickly and easily. I'm enclosing the $50 initial deposit.

Phone orders: (202) 512-1800
Fax orders: (202) 512-2250
Mail orders: Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Online orders: http://bookstore.gpo.gov/irs

DO NOT SEND THIS ORDER FORM TO IRS.

* Standing Order Service

Just sign the authorization above to charge selected items to your existing Deposit Account, VISA, or MasterCard Discover/NOVUS account. Or open a Deposit Account with an initial deposit of $50 or more. Your account will be charged only as each volume is issued and mailed. Sufficient money must be kept in your account to insure that items are shipped. Service begins with the next issue released of each item you select.

You will receive written acknowledgement for each item you choose to receive by Standing Order Service.

If you wish to cancel your Standing Order Service, please notify the Superintendent of Documents in writing (telephone cancellations are accepted but must be followed up with a written cancellation within 10 days).

Important: Please include this completed order form with your payment.

INTERNAL REVENUE BULLETIN

The Introduction at the beginning of this issue describes the purpose and content of this publication. The weekly Internal Revenue Bulletin is sold on a yearly subscription basis by the Superintendent of Documents. Current subscribers are notified by the Superintendent of Documents when their subscriptions must be renewed.

CUMULATIVE BULLETINS

The contents of this weekly Bulletin are consolidated semiannually into a permanent, indexed, Cumulative Bulletin. These are sold on a single copy basis and *are not* included as part of the subscription to the Internal Revenue Bulletin. Subscribers to the weekly Bulletin are notified when copies of the Cumulative Bulletin are available. Certain issues of Cumulative Bulletins are out of print and are not available. Persons desiring available Cumulative Bulletins, which are listed on the reverse, may purchase them from the Superintendent of Documents.

ACCESS THE INTERNAL REVENUE BULLETIN ON THE INTERNET

You may view the Internal Revenue Bulletin on the Internet at www.irs.gov. Select Tax Info for Business at the bottom of the page. Then select Internal Revenue Bulletins.

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.

HOW TO ORDER

Check the publications and/or subscription(s) desired on the reverse, complete the order blank, enclose the proper remittance, detach entire page, and mail to the Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Please allow two to six weeks, plus mailing time, for delivery.

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 e-mail us your suggestions or comments through the IRS Internet Home Page (www.irs.gov) or write to the IRS Bulletin Unit, W:CAR:MP:FP, Washington, DC 20224.

Internal Revenue Service
Washington, DC 20224

Official Business
Penalty for Private Use, $300