Internal Revenue
bulletin

Bulletin No. 2011-42
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HIGHLIGHTS OF THIS ISSUE

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

INCOME TAX

T.D. 9546, page 505.

Final regulations under section 142 of the Code provide the definition of solid waste disposal facilities for purposes of the rules applicable to tax-exempt bonds issued by state and local governments to finance solid waste disposal facilities.

REG–111283–11, page 573.

Proposed regulations describe swaps and similar agreements that fall within the meaning of section 1256(b)(2)(B) of the Code. The proposed regulations also revise the definition of a notional principal contract under regulations section 1.446–3. A public hearing is scheduled for January 19, 2012.

REG–128224–06, page 533.

Proposed regulations under section 67 of the Code provide guidance on which costs incurred by estates or trusts other than grantor trusts (non-grantor trusts) are subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a). A public hearing is scheduled for December 19, 2011.

EMPLOYEE PLANS

REG–140038–10, page 537.

Proposed regulations under section 9815 of the Code implement the disclosure requirements to help plans and individuals better understand their health coverage, as well as other coverage options, regarding the summary of benefits and coverage and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Affordable Care Act.

ESTATE TAX

Notice 2011–82, page 516.

This notice provides guidance under section 2010 of the Code on electing portability of a deceased spousal unused exclusion amount on a Form 706 *(United States Estate (and Generation-Skipping Transfer) Tax Return)*. This notice also announces that the Treasury Department and the Service intend to issue regulations to implement the provisions of section 2010(c) and invites public comments.

Rev. Proc. 2011–48, page 527.

This procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Code and the corresponding regulations. In addition, this procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration.

EXCISE TAX

REG–140038–10, page 537.

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Finding Lists begin on page ii.

Department of the Treasury
Internal Revenue Service

ADMINISTRATIVE

Notice 2011–81, page 513.

Optional special per diem rates. This notice provides the 2011–2012 special *per diem* rates for taxpayers to use in substantiating the amount of ordinary and necessary business expenses incurred while traveling away from home, specifically (1) the special transportation industry rates, (2) the rate for the incidental expenses only deduction, and (3) the rates and list of high-cost localities for the high-low substantiation method.

Notice 2011–82, page 516.

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Rev. Proc. 2011–46, page 518.

Nonaccrual-experience method book safe harbor. This procedure provides a safe harbor method of accounting for taxpayers using the nonaccrual-experience method of accounting under section 448(d)(5) of the Code and regulations section 1.448–2. This procedure also provides procedures for obtaining automatic consent to change to this safe harbor method and to make certain changes within this method. Rev. Proc. 2006–56 modified and amplified.

Rev. Proc. 2011–47, page 520.

Per diem allowances. This procedure provides optional rules for deeming substantiated the amount of certain business expenses of traveling away from home reimbursed to an employee, partner, or volunteer, or deductible by an employee or self-employed individual. Rev. Proc. 2010–39 amplified, modified, and superseded.

Rev. Proc. 2011–48, page 527.

This procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Code and the corresponding regulations. In addition, this procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration.

The IRS Mission

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

Introduction

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

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

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

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

The Bulletin is divided into four parts as follows:

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

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

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

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

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

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

Section 62.—Adjusted Gross Income Defined

26 CFR 1.62–2: Reimbursements and other expense allowance arrangements.

Rules are provided under which a reimbursement or other expense allowance arrangement for the cost of lodging, meal, and incidental expenses, or of meal and incidental expenses only, incurred by an employee, partner, or volunteer while traveling away from home, satisfies the requirements of section 62(c) of the Code for substantiation of the amount of the expenses. See Rev. Proc. 2011-47, page 520.

Section 142.—Exempt Facility Bond

26 CFR 1.142(a)(6)–1: Exempt facility bonds: solid waste disposal facilities.

T.D. 9546

Definition of Solid Waste Disposal Facilities for Tax-Exempt Bond Purposes

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations on the definition of solid waste disposal facilities for purposes of the rules applicable to tax-exempt bonds issued by State and local governments. These regulations provide guidance to State and local governments that issue tax-exempt bonds to finance solid waste disposal facilities and to taxpayers that use those facilities.

DATES: *Effective Date:* These regulations are effective August 19, 2011.

Applicability Date: For dates of applicability, see §1.142(a)(6)–1(i).

FOR FURTHER INFORMATION CONTACT: Timothy Jones, (202) 622–3980 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document amends the Income Tax Regulations (26 CFR part 1) under section 142 of the Internal Revenue Code (Code) to provide final rules for determining whether a facility is a solid waste disposal facility under section 142(a)(6). This document also removes certain existing regulations on this subject. On September 16, 2009, the IRS published a Notice of Proposed Rulemaking (REG–140492–02, 2009–42 I.R.B. 559) in the **Federal Register** (74 FR 47500) (the Proposed Regulations). The Proposed Regulations under proposed §1.142(a)(6)–1 would modify existing regulations under §1.103–8(f)(2) of the Income Tax Regulations and §17.1 of the temporary Income Tax Regulations (together, the Existing Regulations) on this subject. Public comments on the Proposed Regulations were received and a public hearing was held on January 5, 2010.

After consideration of the public comments, the IRS and the Treasury Department adopt the Proposed Regulations, with revisions, as final regulations by this Treasury decision (the Final Regulations). Significant aspects of the public comments and the revisions made in the Final Regulations are discussed in this preamble.

Explanation of Provisions

1. *Introduction.*

In general, interest on State or local bonds is excludable from gross income under section 103(a). Under section 103(b), however, interest on private activity bonds is excludable from gross income under section 103 only if the bond meets the requirements for a qualified bond under section 141(e) and other applicable requirements under section 103. Section 141(e) defines a qualified bond to include an *exempt facility bond* that meets certain requirements. Section 142(a) defines an exempt facility bond to mean any bond that is issued as part of an issue 95 percent or more of the net proceeds of which are to be used to provide an exempt facility specified in section 142(a). Section 142(a)(6) includes a solid waste disposal facility as one specified type of qualified exempt facility.

In general, the Proposed Regulations addressed the requirements for solid waste disposal facilities under section 142(a)(6) for purposes of eligibility for tax-exempt private activity bond financing. The Proposed Regulations provided that a facility qualifies as a solid waste disposal facility if it processes solid waste in a qualified solid waste disposal process, performs preliminary functions, or is a functionally related or subordinate facility. The Proposed Regulations focused on eligible processes to dispose of solid waste, including a final disposal process, an energy conversion process, and a recycling process. The Proposed Regulations also provided a more developed definition of solid waste which focused on used materials and residual materials, with certain specific exclusions. The Proposed Regulations eliminated a "no-value" test from the solid waste definition under §1.103–8(f)(2)(ii)(b) of the Existing Regulations, which provides that material does not qualify as solid waste unless, on the issue date of the tax-exempt bonds used to provide the solid waste disposal facility, the property is useless, unused, unwanted, or discarded solid material that has no market or other value at the place where the property is located (No-Value Test). The Proposed Regulations also proposed various allocation and accounting rules based on existing principles for mixed-input facilities and mixed-use facilities. Overall, the Proposed Regulations implement a policy in favor of recycling through the use of solid waste disposal facilities.

Commentators generally supported the approach taken towards solid waste disposal facilities under the Proposed Regulations. The Final Regulations retain the overall approach of the Proposed Regulations and make certain technical changes in response to public comments, as discussed further in this preamble.

2. *Solid Waste Disposal Facility.*

The Proposed Regulations defined the term *solid waste disposal facility* to mean a facility that processes solid waste in a qualified solid waste disposal process, performs a preliminary function, or is a functionally related and subordinate facility.

The Final Regulations retain this definition of a solid waste disposal facility.

3. *Definition of Solid Waste*.

The Proposed Regulations defined the term *solid waste* to mean garbage, refuse, and other solid material derived from any agricultural, commercial, consumer, or industrial operation or activity, based largely on an existing definition under the Existing Regulations. The Proposed Regulations refined the existing definition to require that solid waste be either *used material* or *residual material*. The Proposed Regulations also eliminated the No-Value Test. Additionally, the Proposed Regulations required that the person who acquires the material must reasonably expect to introduce it into a qualified solid waste disposal process within a reasonable period of time after acquisition.

The Proposed Regulations defined *used material* to mean any material that has been used previously as an agricultural, commercial, consumer, or industrial product or as a component of any such product. The Proposed Regulations defined *residual material* to mean any residual byproduct or excess unused raw material that remains from the production of any agricultural, commercial, consumer, or industrial product, provided that material qualified as residual material only to the extent that it constituted less than five percent (5%) of the total material introduced into the production process and it had a fair market value that is reasonably expected to be lower than that of any product made in that production process.

The Final Regulations generally retain the core definition of solid waste from the Proposed Regulations but modify that definition in certain technical respects. The Final Regulations clarify that material is "solid" only if it is solid at ambient temperature and pressure. The Final Regulations also clarify that solid waste can result from governmental operations or activities. The Final Regulations expand the definition of solid waste to include animal waste.

With respect to the definition of *residual material*, commentators generally supported the analytic standard under the Proposed Regulations, but recommended removing the five percent (5%) size limitation on residual material. Commentators recommended removing this size limit because it unduly restricts the scope of residual material in many circumstances and it arbitrarily treats various industries and activities differently because residual amounts vary widely by industry and activity. The Final Regulations adopt this comment to eliminate the five percent (5%) size limitation on residual material and otherwise generally retain the analytic standard for residual material. The Final Regulations also expand the definition of residual material to include material derived from providing a service in which no product is produced.

Further, for purposes of determining residual material when multiple production processes are operated on the same site, commentators recommended a separate evaluation of each process. Based on reasons associated with scope and administrability, the IRS and the Treasury Department intended to cover only residual material that remains at the end of integrated processes that are functionally interconnected or interdependent, based on all the facts and circumstances. Accordingly, the Final Regulations do not adopt this comment. Instead, the Final Regulations adopt an integrated process standard to limit residual material.

4. *Specific Exclusions from the Definition of Solid Waste*.

In general, the Proposed Regulations excluded from the definition of solid waste the following items: (1) virgin material; (2) solids within liquids and liquid waste; (3) precious metals; (4) hazardous material; and (5) radioactive material. The Final Regulations retain these exclusions with certain technical modifications.

The exclusion for virgin material aimed to distinguish solid waste disposal from manufacturing. The exclusion for certain precious metals aimed to recognize that recovery of these metals generally would take place without regard to a recycling industry. With respect to the exclusions for hazardous and radioactive waste, the statute and legislative history indicate that Congress intended to exclude hazardous waste and radioactive waste from solid waste. The statute treats qualified hazardous waste facilities as eligible exempt facilities under section 142(a)(10) separate and apart from solid waste disposal facilities under section 142(a)(6). In addition, the legislative history provides, in relevant part, that "the conferees wish to clarify that solid waste does not include most hazardous waste (including radioactive waste)." H.Rep. No. 99–841, at II–704 (1986), 1986–3 (Vol. 4) C.B. 704.

Some commentators expressed concern that the introduction of virgin material or precious metals into a final disposal process, such as a landfill (as contrasted with a recycling process), could disqualify a facility from treatment as a qualified solid waste disposal facility. The Final Regulations address this comment favorably and modify the definition of solid waste to allow the introduction of virgin materials and precious metals into a final disposal process. The Final Regulations also add a provision that allows the IRS to identify other excluded precious metals in future public administrative guidance.

Commentators also recommended treating hazardous waste and radioactive waste as solid waste. The Final Regulations generally do not adopt this comment. The IRS and the Treasury Department believe that Congress generally intended to exclude these materials from the definition of solid waste. Recognizing that only certain hazardous waste and radioactive waste are required to be disposed of at regulated facilities, however, the Final Regulations limit the exclusions for these two types of waste to the extent that they are required to be disposed of or contained at a regulated hazardous waste or radioactive waste disposal facility.

5. *Qualified Solid Waste Disposal Process*.

The Proposed Regulations provided for three eligible types of solid waste disposal processes: a final disposal process, an energy conversion process, and a recycling process. To provide flexibility for future innovation, the Proposed Regulations provided that, absent an express restriction in the proposed regulations, a solid waste disposal function may employ any biological, engineering, industrial, or technological method.

The Final Regulations generally retain the eligible types of solid waste disposal processes from the Proposed Regulations, with technical clarifications. The Final Regulations clarify that a final disposal process includes the spreading of solid

waste in an environmentally compliant and safe manner. The Final Regulations also clarify that an energy conversion process ends at the point at which useful energy is first created or incorporated into the form of synthesis gas, heat, hot water, or other useful energy.

6. *First Useful Product Principle*.

The Proposed Regulations provided guidance on the standard for determining the first useful product for purposes of establishing the end point of a solid waste disposal process. The first useful product principle has particular application to recycling. Under the Proposed Regulations, a useful product generally included a product useful for consumption, either as an ultimate end-use product or as an input to some stage of a manufacturing or production process, and that could be sold for such use (taking into account operational constraints on such sales for certain integrated processes), whether or not actually sold.

The Final Regulations generally retain the first useful product standard from the Proposed Regulations. Some commentators recommended that determinations under the first useful product rule take into account geographic location and transportation costs in certain situations. The Final Regulations adopt this comment.

7. *Mixed-Input Facilities*.

The Proposed Regulations provided a mixed-input accounting rule, which treated a facility as a qualified solid waste disposal facility if at least 65 percent of all of the material introduced into such facility in each year consisted of solid waste. This proposed rule recognizes that recycling processes may require supplemental inputs besides solid waste to operate viably. This proposed rule is similar to an existing rule under §1.103–8(f)(2)(ii)(c) of the Existing Regulations. This proposed rule requires annual testing for compliance with the requisite 65 percent solid waste threshold. Several commentators recommended reformulating this 65 percent test to require compliance based on an aggregate testing period measured over the life of the tax-exempt bonds instead of an annual testing period. These commentators expressed concerns about compliance with an annual test during start-up periods and aberrational years for various reasons.

The Final Regulations retain the annual 65 percent test for mixed-input facilities with modifications. In response to the public comments, the Final Regulations provide a special rule that allows a three-year curative period to address the impact of extraordinary events outside the control of the operator of the solid waste disposal facility (such as natural disasters, strikes, major utility disruptions, or governmental interventions). In addition, the Final Regulations provide that the annual testing does not begin until the facility is placed in service within the meaning of the special placed-in-service definition in §1.150–2(c), which focuses on the point at which a facility is operational at substantially its design level.

8. *Certain Other Changes*.

Several commentators recommended removal of the proposed concept of facilities that perform a preliminary function for a qualified solid waste disposal process and removal of the threshold limit on preliminary functions that requires more than 50 percent of the materials that result from preliminary functions to constitute solid waste. The Final Regulations retain the concept of a preliminary function, but remove the 50 percent threshold limit on preliminary functions. The Final Regulations also provide for application of a mixed-use accounting rule to facilities that perform preliminary functions.

One commentator expressed concern that *Example 2* in the Proposed Regulations was confusing, and the Final Regulations remove that example with no substantive inference intended by that removal. The Final Regulations also expand and clarify certain other examples.

Commentators recommended various transition rules for applicability of the Final Regulations to refunding bonds issued prior to the date of publication of the final regulations. The Final Regulations provide a transition rule for current refunding bonds the weighted average maturity of which is no longer than the remaining weighted average maturity of the refunded bonds.

Effective/Applicability Dates

The Final Regulations apply to bonds to which section 142 applies that are sold on or after October 18, 2011. Issuers may apply the Final Regulations to outstanding bonds sold before October 18, 2011. The Final Regulations need not be applied to bonds that are issued in a current refunding to refund bonds to which the Final Regulations do not apply if the weighted average maturity of the refunding bonds is no longer than the remaining weighted average maturity of the refunded bonds.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It 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 are interpretative and 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 Code, the proposed regulations preceding these final regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these final regulations is Timothy L. Jones, Office of Associate Chief Counsel (Financial Institutions and Products). However, other personnel from the IRS and the Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, under the authority of 26 U.S.C. 7805, 26 CFR parts 1 and 17 are 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 * * *

§1.103–8 [Amended]

Par. 2. Section 1.103–8 is amended by removing paragraph (f)(2)(ii) and redesignating paragraph (f)(2)(iii) as (f)(2)(ii).

Par. 3. Section 1.142(a)(6)–1 is added to read as follows:

§1.142(a)(6)–1 Exempt facility bonds: solid waste disposal facilities.

(a) *In general*. This section defines the term solid waste disposal facility for purposes of section 142(a)(6).

(b) *Solid waste disposal facility*. The term *solid waste disposal facility* means a facility to the extent that the facility—

(1) Processes solid waste (as defined in paragraph (c) of this section) in a qualified solid waste disposal process (as defined in paragraph (d) of this section);

(2) Performs a preliminary function (as defined in paragraph (f) of this section); or

(3) Is functionally related and subordinate (within the meaning of §1.103–8(a)(3)) to a facility described in paragraph (b)(1) or (b)(2) of this section.

(c) *Solid waste*—(1) *In general*. Except to the extent excluded under paragraph (c)(2) of this section, for purposes of section 142(a)(6), the term *solid waste* means garbage, refuse, and other solid material derived from any agricultural, commercial, consumer, governmental, or industrial operation or activity if the material meets the requirements of both paragraph (c)(1)(i) and paragraph (c)(1)(ii) of this section. For purposes of this section, material is solid if it is solid at ambient temperature and pressure.

(i) *Used material or residual material*. Material meets the requirements of this paragraph (c)(1)(i) if it is either used material (as defined in paragraph (c)(1)(i)(A)) of this section or residual material (as defined in paragraph(c)(1)(i)(B) of this section).

(A) *Used material*. The term *used material* means any material that is a product of any agricultural, commercial, consumer, governmental, or industrial operation or activity, or a component of any such product or activity, and that has been used previously. Used material also includes animal waste produced by animals from a biological process.

(B) *Residual material*. The term *residual material* means material that meets the requirements of this paragraph (c)(1)(i)(B). The material must be a residual byproduct or excess raw material that results from or remains after the completion of any agricultural, commercial, consumer, governmental, or industrial production process or activity or from the provision of any service. In the case of multiple processes constituting an integrated manufacturing or industrial process, the material must result from or remain after the completion of such integrated process. As of the issue date of the bonds used to finance the solid waste disposal facility, the material must be reasonably expected to have a fair market value that is lower than the value of all of the products made in that production process or lower than the value of the service that produces such residual material.

(ii) *Reasonably expected introduction into a qualified solid waste disposal process*. Material meets the requirements of this paragraph (c)(1)(ii) if it is reasonably expected by the person who generates, purchases, or otherwise acquires it to be introduced within a reasonable time after such generation, purchase or acquisition into a qualified solid waste disposal process described in paragraph (d) of this section.

(2) *Exclusions from solid waste*. The following materials do not constitute solid waste:

(i) *Virgin material*. Except to the extent that virgin material constitutes an input to a final disposal process or residual material, solid waste excludes any virgin material. The term *virgin material* means material that has not been processed into an agricultural, commercial, consumer, governmental, or industrial product, or a component of any such product. Further, for this purpose, material continues to be virgin material after it has been grown, harvested, mined, or otherwise extracted from its naturally occurring location and cleaned, divided into component elements, modified, or enhanced, as long as further processing is required before it becomes an agricultural, commercial, consumer, or industrial product, or a component of any such product.

(ii) *Solids within liquids and liquid waste*. Solid waste excludes any solid or dissolved material in domestic sewage or other significant pollutant in water resources, such as silt, dissolved or suspended solids in industrial waste water effluents, dissolved materials in irrigation return flows or other common water pollutants, and liquid or gaseous waste.

(iii) *Precious metals*. Except to the extent that a precious metal constitutes an input to a final disposal process and/or an unrecoverable trace of the particular precious metal, solid waste excludes gold, silver, ruthenium, rhodium, palladium, osmium, iridium, platinum, gallium, rhenium, and any other precious metal material as may be identified by the Internal Revenue Service in future public administrative guidance.

(iv) *Hazardous material*. Solid waste excludes any hazardous material that must be disposed of at a facility that is subject to final permit requirements under subtitle C of title II of the Solid Waste Disposal Act as in effect on the date of the enactment of the Tax Reform Act of 1986 (which is October 22, 1986). See section 142(h)(1) of the Internal Revenue Code for the definition of qualified hazardous waste facilities.

(v) *Radioactive material*. Solid waste excludes any radioactive material subject to regulation under the Nuclear Regulatory Act (10 CFR §1.1 *et seq.*), as in effect on the issue date of the bonds.

(d) *Qualified solid waste disposal process*. The term *qualified solid waste disposal process* means the processing of solid waste in a final disposal process (as defined in paragraph (d)(1) of this section), an energy conversion process (as defined in paragraph (d)(2) of this section), or a recycling process (as defined in paragraph (d)(3) of this section). Absent an express restriction to the contrary in this section, a qualified solid waste disposal process may employ any biological, engineering, industrial, or technological method.

(1) *Final disposal process*. The term *final disposal process* means the placement of solid waste in a landfill (including, for this purpose, the spreading of solid waste over land in an environmentally compliant and safe manner with no intent to remove such solid waste), the incineration of solid waste without capturing any useful energy, or the containment of solid waste with a reasonable expectation as of the date of issue of the bonds that the containment will continue indefinitely and that the solid waste has no current or future beneficial use.

(2) *Energy conversion process*. The term *energy conversion process* means a thermal, chemical, or other process that is applied to solid waste to create and capture synthesis gas, heat, hot water, steam, or other useful energy. The energy conversion process begins at the point of the first application of such process. The energy conversion process ends at the point at which the useful energy is first created, captured, or incorporated into the form of synthesis gas, heat, hot water, or other useful energy and before any transfer or distribution of such synthesis gas, heat, hot water or other useful energy, regardless of whether such synthesis gas, heat, hot water, or other useful energy constitutes a first useful product within the meaning of paragraph (e) of this section.

(3) *Recycling process*—(i) *In general*. The term *recycling process* means reconstituting, transforming, or otherwise processing solid waste into a useful product. The recycling process begins at the point of the first application of a process to reconstitute or transform the solid waste into a useful product, such as decontamination, melting, re-pulping, shredding, or other processing of the solid waste to accomplish this purpose. The recycling process ends at the point of completion of production of the first useful product from the solid waste.

(ii) *Refurbishment, repair, or similar activities*. The term *recycling process* does not include refurbishment, repair, or similar activities. The term *refurbishment* means the breakdown and reassembly of a product if such activity is done on a product-by-product basis and if the finished product contains more than 30 percent of its original materials or components.

(e) *First useful product*. The term *first useful product* means the first product produced from the processing of solid waste in a solid waste disposal process that is useful for consumption in agricultural, consumer, commercial, governmental, or industrial operation or activity and that could be sold for such use, whether or not actually sold. A useful product includes both a product useful to an individual consumer as an ultimate end-use consumer product and a product useful to an industrial user as a material or input for processing in some stage of a manufacturing or production process to produce a different end-use consumer product. The determination of whether a useful product has been produced may take into account operational constraints that affect the point in production when a useful product reasonably can be extracted or isolated and sold independently. For this purpose, the costs of extracting, isolating, storing, and transporting the product to a market may only be taken into account as operational constraints if the product is not to be used as part of an integrated manufacturing or industrial process in the same location as that in which the product is produced.

(f) *Preliminary function*. A *preliminary function* is a function to collect, separate, sort, store, treat, process, disassemble, or handle solid waste that is preliminary to and directly related to a qualified solid waste disposal process.

(g) *Mixed-use facilities*—(1) *In general*. If a facility is used for both a qualified solid waste disposal function (including a qualified solid waste disposal process or a preliminary function) and a nonqualified function (a mixed-use facility), then the costs of the facility allocable to the qualified solid waste disposal function are determined using any reasonable method, based on all the facts and circumstances. See §1.103–8(a)(1) for allocation rules on amounts properly allocable to an exempt facility. Facilities qualify as functionally related and subordinate to a qualified solid waste disposal function only to the extent that they are functionally related and subordinate to the portion of the mixed-use facility that is used for one or more qualified solid waste disposal functions (including a qualified solid waste disposal process or a preliminary function).

(2) *Mixed inputs*—(i) *In general*. Except as otherwise provided in paragraph (g)(2)(ii) of this section, for each facility (or a portion of a mixed-use facility) performing a qualified solid waste disposal process or a preliminary function, the percentage of the costs of the property used for such process that are allocable to a qualified solid waste disposal process or a preliminary function cannot exceed the average annual percentage of solid waste processed in that qualified solid waste disposal process or that preliminary function while the issue is outstanding. The annual percentage of solid waste processed in that qualified solid waste disposal process or preliminary function for any year is the percentage, by weight or volume, of the total materials processed in that qualified solid waste disposal process or preliminary function that constitute solid waste for that year.

(ii) *Special rule for mixed-input processes if at least 65 percent of the materials processed are solid waste*—(A) *In general*. Except as otherwise provided in paragraph (g)(2)(ii)(B) of this section, for each facility (or a portion of a mixed-use facility) performing a qualified solid waste disposal process or preliminary function, if the annual percentage of solid waste processed in that qualified solid waste disposal process or preliminary function for each year that the issue is outstanding (beginning with the date such facility is placed in service within the meaning of §1.150–2(c)) equals at least 65 percent of the materials processed in that qualified solid waste disposal process or preliminary function, then all of the costs of the property used for such process are treated as allocable to a qualified solid waste disposal process. The annual percentage of solid waste processed in such qualified solid waste disposal process or preliminary function for any year is the percentage, by weight or volume, of the total materials processed in that qualified solid waste disposal process or preliminary function that constitute solid waste for that year.

(B) *Special rule for extraordinary events*. In the case of an extraordinary event that is beyond the control of the operator of a solid waste disposal facility (such as a natural disaster, strike, major utility disruption, or governmental intervention) and that causes a solid waste disposal facility to be unable to meet the 65 percent test under paragraph (g)(2)(ii)(A) of this section for a particular year, the percentage of solid waste processed for that year equals—

(*1*) The sum of the amount of solid waste processed in the solid waste disposal facility for the year affected by the extraordinary event and the amount of solid waste processed in the solid waste disposal facility during the following two years in excess of the amount required to meet the general 65 percent threshold for the facility during each of such two years; divided by

(*2*) The total materials processed in the solid waste disposal facility during the year affected by the extraordinary event. If the resulting measure of solid waste

processed for the year affected by the extraordinary event equals at least 65 percent, then the facility is treated as meeting the requirements of the 65 percent test under paragraph (g)(2)(ii)(A) of this section for such year.

(iii) *Facilities functionally related and subordinate to mixed-input facilities*. Except to the extent that facilities are functionally related and subordinate to a mixed-input facility that meets the 65 percent test under paragraph (g)(2)(ii) of this section, facilities qualify as functionally related and subordinate to a mixed-input facility only to the extent that they are functionally related and subordinate to the qualified portion of the mixed-input facility that is used for one or more qualified solid waste disposal functions (including a qualified solid waste disposal process or a preliminary function).

(h) *Examples*. The following examples illustrate the application of this section:

Example 1. Nonqualified Unused Material—Cloth. Company A takes wool and weaves it into cloth and then sells the cloth to a manufacturer to manufacture clothing. The cloth is material that has not been used previously as a product of or otherwise used in an agricultural, commercial, consumer, governmental, or industrial operation or activity, or as a component of any such product or activity. Accordingly, the cloth is not solid waste.

Example 2. Residual Material—Waste Coal. Company B mines coal. Some of the ore mined is a low quality byproduct of coal mining commonly known as waste coal, which cannot be converted to energy under a normal energy-production process because the BTU content is too low. Waste coal has the lowest fair market value of any product produced in Company B's coal mining process. Waste coal is solid waste because it is residual material within the meaning of paragraph (c)(1)(i)(B) of this section and Company B reasonably expects to introduce the waste coal into a solid waste disposal process.

Example 3. Virgin Material—Logs. Company C cuts down trees and sells the logs to another company, which further processes the logs into lumber. In order to facilitate shipping, Company C cuts the trees into uniform logs. The trees are not solid waste because they are virgin material within the meaning of paragraph (c)(2)(i) of this section that are not being introduced into a final disposal process within the meaning of paragraph (d)(1) of this section. The division of such trees into uniform logs does not change the status of the trees as virgin material.

Example 4. Qualified Solid Waste Disposal Process—Landfill. Company D plans to construct a landfill. The landfill will not be subject to the final permit requirements under subtitle C of title II of the Solid Waste Disposal Act (as in effect on the date of enactment of the Tax Reform Act of 1986). As of the issue date, Company D expects that the landfill will be filled entirely with material that will qualify as solid waste within the meaning of paragraph (c) of this section. Placing solid waste into a landfill is a qualified solid waste disposal process. The landfill is a qualified solid waste disposal facility.

Example 5. Qualified Solid Waste Disposal Process—Recycling Tires. Company E owns a facility that converts used tires into roadbed material. The used tires are used material within the meaning of paragraph (c)(1)(i)(A) of this section that qualifies as solid waste. Between the introduction of the old tires into the roadbed manufacturing process and the completion of the roadbed material, the facility does not create any interim useful products. The process for the manufacturing of the roadbed material from the old tires is a qualified solid waste disposal process as a recycling process and the facility that converts the tires into roadbed material is a qualified solid waste disposal facility. This conclusion would be the same if the recycling process took place at more than one plant.

Example 6. Qualified Solid Waste Disposal Process—Energy Conversion Process. Company F receives solid waste from a municipal garbage collector. Company F burns that solid waste in an incinerator to remove exhaust gas and to produce heat. Company F further processes the heat in a heat exchanger to produce steam. Company F further processes the steam to generate electricity. The energy conversion process ends with the production of steam. The facilities used to burn the solid waste and to capture the steam as useful energy are qualified solid waste disposal facilities because they process solid waste in an energy conversion process. The generating facilities used to process the steam further to generate electricity are not engaged in the energy conversion process and are not qualified solid waste disposal facilities.

Example 7. Nonqualified Refurbishment. Company G purchases used cars and restores them. This restoration process includes disassembly, cleaning, and repairing of the cars. Parts that cannot be repaired are replaced. The restored cars contain at least 30 percent of the original parts. While the cars are used material, the refurbishing process is not a qualified solid waste disposal process. Accordingly, Company G's facility is not a qualified solid waste disposal facility.

Example 8. Qualified Solid Waste Disposal Facility—First Useful Product Rule—Paper Recycling. (i) Company H employs an integrated process to re-pulp discarded magazines, clean the pulp, and produce retail paper towel products. Operational constraints on Company H's process do not allow for reasonable extraction, isolation, and sale of the cleaned paper pulp independently without degradation of the pulp. Company H further processes the paper pulp into large industrial-sized rolls of paper which are approximately 12 feet in diameter. At this point in the process, Company H could either sell such industrial-sized rolls of paper to another company for further processing to produce retail paper products or it could produce those retail products itself. In general, paper pulp is a useful product that is bought and sold on the market as a material for input into manufacturing or production processes. The discarded magazines are used material within the meaning of paragraph (c)(1)(i)(A) of this section. Company H's facility is engaged in a recycling process within the meaning of paragraph (d)(3) of this section to the extent that it repulps and cleans the discarded magazines generally and further to the extent that it produces industrial-sized rolls of paper under the particular circumstances here. Specifically, taking into account the operational constraints on Company H's facility that limit its ability reasonably to extract, isolate, and sell the paper pulp independently, the first useful products within the meaning of paragraph (e) of this section from Company H's recycling process are the industrial-sized rolls of paper. The portion of Company H's facility that processes the discarded magazines and produces industrial-sized rolls of paper is a qualified solid waste disposal facility, and the portion of Company H's facility that further processes the industrial-sized rolls of paper into retail paper towels is not a qualified solid waste facility.

(ii) The facts are the same as in paragraph (i) of this *Example 8*, except that Company H is able reasonably to extract the cleaned paper pulp from the process without degradation of the pulp and to sell the cleaned paper pulp at its dock for a price that exceeds its costs of extracting the pulp from the process. Therefore, the paper pulp is the first useful product within the meaning of paragraph (e) of this section. As a result, the portion of Company H's facility that processes the discarded magazines is a qualified solid waste disposal facility, and the portion of Company H's facility that produces industrial-sized rolls of paper is not a qualified solid waste disposal facility. If, however, the only reasonable way Company H could sell the pulp was to transport the pulp to a distant market, then the costs of storing and transporting the pulp to the market may be taken into account in determining whether the pulp is the first useful product.

Example 9. Preliminary Function—Energy Conversion Process. (i) Company I owns a paper mill. At the mill, logs from nearby timber operations are processed through a machine that removes bark. The stripped logs are used to manufacture paper. The stripped bark has the lowest fair market value of any product produced from the paper mill. The stripped bark falls onto a conveyor belt that transports the bark to a storage bin that is used to store the bark briefly until Company I feeds the bark into a boiler. The conveyor belt and storage bin are used only for these purposes. The boiler is used only to create steam by burning the bark, and the steam is used to generate electricity. The stripped bark is solid waste because it is residual material within the meaning of paragraph (c)(1)(i)(B) of this section and Company I expects to introduce the bark into an energy conversion process within a reasonable period of time. The creation of steam from the stripped bark is an energy conversion process that starts with the incineration of the stripped bark. The energy conversion process is a qualified solid waste disposal process. The conveyor belt performs a collection activity that is preliminary and that is directly related to the solid waste disposal function. The storage bin performs a storage function that is preliminary and that is directly related to the solid waste disposal function. Thus, the conveyor belt and storage bin are solid waste disposal facilities. The bark removal process is not a preliminary function because it is not directly related to the energy conversion process and it does not become so related merely because it results in material that is solid waste.

(ii) The facts are the same as in paragraph (i) of this *Example 9*, except that the stripped bark represents only 55 percent by weight and volume of the materials that are transported by the conveyor belt. The remaining 45 percent of the materials transported by the conveyor belt are not solid waste and these

other materials are sorted from the conveyor belt by a sorting machine immediately before the stripped bark arrives at the storage bin. Fifty-five percent of the costs of the conveyor belt and the sorting machine are allocable to solid waste disposal functions.

Example 10. Preliminary Function—Final Disposal Process. Company J owns a waste transfer station and uses it to collect, sort, and process solid waste. Company J uses its trucks to haul the solid waste to the nearest landfill. At least 65 percent by weight and volume of the material brought to the transfer station is solid waste. The waste transfer station and the trucks perform functions that are preliminary and directly related to the solid waste disposal function of the landfill. Thus, the waste transfer station and the trucks qualify as solid waste disposal facilities.

Example 11. Mixed-Input Facility. Company K owns an incinerator financed by an issue and uses the incinerator exclusively to burn coal and other solid material to create steam. Each year while the issue is outstanding, 40 percent by volume and 45 percent by weight of the solid material that Company K processes in the conversion process is coal. The remainder of the solid material is either used material or residual material within the meaning of paragraph (c)(1)(i) of this section. Sixty percent of the costs of the property used to perform the energy conversion process are allocable to a solid waste disposal function.

(i) *Effective/Applicability Dates*—(1) *In general*. Except as otherwise provided in this paragraph (i), this section applies to bonds to which section 142 applies that are sold on or after October 18, 2011.

(2) *Elective retroactive application*. Issuers may apply this section, in whole, but not in part, to outstanding bonds to which section 142 applies and which were sold before October 18, 2011.

(3) *Certain refunding bonds*. An issuer need not apply this section to bonds that are issued in a current refunding to refund bonds to which this section does not apply if the weighted average maturity of the refunding bonds is no longer than the remaining weighted average maturity of the refunded bonds.

PART 17 [Removed]

Par. 4. Part 17 is removed.

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

Approved August 9, 2011.

Emily S. McMahon,
(Acting) Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on August 18, 2011, 8:45 a.m., and published in the issue of the Federal Register for August 19, 2011, 76 F.R. 51879)

Section 162.—Trade or Business Expenses

26 CFR 1.162–17: Reporting and substantiation of certain business expenses of employees.

Rules are provided for substantiating the amount of a deduction for an expense for meal and incidental expenses, or for incidental expenses only, incurred while traveling away from home. See Rev. Proc. 2011-47, page 520.

Section 274.—Disallowance of Certain Entertainment, Etc., Expenses

26 CFR 1.274–5: Substantiation requirements.

Rules are provided for substantiating the amount of a deduction for an expense for meal and incidental expenses, or for incidental expenses only, incurred while traveling away from home. See Rev. Proc. 2011-47, page 520.

Section 446.—General Rule for Methods of Accounting

This revenue procedure provides a book safe harbor method of accounting for taxpayers using the nonaccrual-experince method of accounting and procedures for obtaining automatic consent to change to the method and to make certain changes within the method. See Rev. Proc. 2011-46, page 518.

Section 481.—Adjustments Required by Changes in Methods of Accounting

This revenue procedure provides procedures for taxpayers using the nonaccrual-experience (NAE) method of accounting to change to a book safe harbor NAE method of accounting. Taxpayer changing to the NAE book safe harbor method must make an adjustment under section 481(a) of the Code, however taxpayers make certain changes within the method using a cut-off. See Rev. Proc. 2011-46, page 518.

Section 2010.—Unified Credit Against Estate Tax

This notice provides guidance under section 2010(c) of the Code on electing portability of a deceased spousal unused exclusion amount on a Form 706 *(United States Estate (and Generation-Skipping Transfer) Tax Return)*. This notice also announces that the Treasury Department and the Internal Revenue Service intend to issue regulations to implement the provisions of section 2010(c) of the Code and invites public comments. See Notice 2011-82, page 516.

Section 2053.—Expenses, Indebtedness, and Taxes

26 CFR 20.2053–1: Deductions for expenses, indebtedness, and taxes; in general

This revenue procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Internal Revenue Code and the corresponding regulations. In addition, this revenue procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this revenue procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration. See Rev. Proc. 2011-48, page 527.

Section 6402.—Authority to Make Credits or Refunds

26 CFR 301.6402–1: Authority to make credits or refunds.

This revenue procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Internal Revenue Code and the corresponding regulations. In addition, this revenue procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this revenue procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration. See Rev. Proc. 2011-48, page 527.

Section 6501.—Limitations on Assessment and Collection

26 CFR 301.6501(a)–1: Period of limitations upon assessment and collection.

This revenue procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Internal Revenue Code and the corresponding regulations. In addition, this revenue procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this revenue procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration. See Rev. Proc. 2011-48, page 527.

Section 6511.—Limitations on Credit or Refund

26 CFR 301.6511(a)–1: Period of limitation on filing claim.

This revenue procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Internal Revenue Code and the corresponding regulations. In addition, this revenue procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this revenue procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration. See Rev. Proc. 2011-48, page 527.

Section 6514.—Credits or Refunds after Period of Limitation

26 CFR 301.6514(a)–1: Credits or refunds after period of limitation.

This revenue procedure instructs taxpayers how to file a protective claim for refund when the estate has a claim or expense not yet deductible under section 2053 of the Internal Revenue Code and the corresponding regulations. In addition, this revenue procedure details the procedures the Service will follow in processing these protective claims for refund. Finally, this revenue procedure instructs taxpayers how to notify the Service that a section 2053 protective claim for refund is ready for consideration. See Rev. Proc. 2011-48, page 527.

Part III. Administrative, Procedural, and Miscellaneous

2011–2012 Special Per Diem Rates

Notice 2011–81

SECTION 1. PURPOSE

This annual notice provides the 2011–2012 special *per diem* rates for taxpayers to use in substantiating the amount of ordinary and necessary business expenses incurred while traveling away from home, specifically (1) the special transportation industry meal and incidental expenses rates (M&IE rates), (2) the rate for the incidental expenses only deduction, and (3) the rates and list of high-cost localities for purposes of the high-low substantiation method.

SECTION 2. BACKGROUND

Rev. Proc. 2011–47, 2011–42 I.R.B. 520, provides rules for using a *per diem* rate to substantiate, under § 274(d) of the Internal Revenue Code and § 1.274–5 of the Income Tax Regulations, the amount of ordinary and necessary business expenses paid or incurred while traveling away from home. Taxpayers using the rates and list of high-cost localities provided in this notice must comply with Rev. Proc. 2011–47.

SECTION 3. SPECIAL M&IE RATES FOR TRANSPORTATION INDUSTRY

The special M&IE rates for taxpayers in the transportation industry are $59 for any locality of travel in the continental United States (CONUS) and $65 for any locality of travel outside the continental United States (OCONUS). See section 4.04 of Rev. Proc. 2011–47.

SECTION 4. RATE FOR INCIDENTAL EXPENSES ONLY DEDUCTION

The rate for any CONUS or OCONUS locality of travel for the incidental expenses only deduction is $5 per day. See section 4.05 of Rev. Proc. 2011–47.

SECTION 5. HIGH-LOW SUBSTANTIATION METHOD

1. *Annual high-low rates*. For purposes of the high-low substantiation method, the *per diem* rates in lieu of the rates described in section 4.01 of Rev. Proc. 2011–47 (the *per diem* substantiation method) are $242 for travel to any high-cost locality and $163 for travel to any other locality within CONUS. The amount of the $242 high rate and $163 low rate that is treated as paid for meals for purposes of § 274(n) is $65 for travel to any high-cost locality and $52 for travel to any other locality within CONUS. See section 5.02 of Rev. Proc. 2011–47. The *per diem* rates in lieu of the rates described in section 4.02 of Rev. Proc. 2011–47 (the meal and incidental expenses only substantiation method) are $65 for travel to any high-cost locality and $52 for travel to any other locality within CONUS.

2. *High-cost localities*. The following localities have a federal *per diem* rate of $202 or more, and are high-cost localities for all of the calendar year or the portion of the calendar year specified in parentheses under the key city name.

Key City	*County or other defined location*
Arizona	
Sedona	City limits of Sedona
(March 1-April 30)	
California	
Monterey	Monterey
Napa	Napa
(October 1-November 30 and April 1-September 30)	
San Diego	San Diego
San Francisco	San Francisco
Santa Barbara	Santa Barbara
Santa Monica	City limits of Santa Monica
Yosemite National Park	Mariposa
(June 1-August 31)	
Colorado	
Aspen	Pitkin
(December 1-March 31 and June 1-August 31)	
Denver/Aurora	Denver, Adams, Arapahoe, and Jefferson
Steamboat Springs	Routt
(December 1-March 31)	
Telluride	San Miguel
(December 1-March 31)	

Key City	*County or other defined location*
Vail (December 1-August 31)	Eagle
District of Columbia	
Washington D.C. (also the cities of Alexandria, Falls Church, and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland) (See also Maryland and Virginia)	
Florida	
Fort Lauderdale (January 1-May 31)	Broward
Fort Walton Beach/De Funiak Springs (June 1-July 31)	Okaloosa and Walton
Key West	Monroe
Miami (December 1-March 31)	Miami-Dade
Naples (January 1-April 30)	Collier
Illinois	
Chicago (October 1-November 30 and April 1-September 30)	Cook and Lake
Louisiana	
New Orleans (October 1-June 30)	Orleans, St. Bernard, Jefferson and Plaquemine Parishes
Maine	
Bar Harbor (July 1-August 31)	Hancock
Maryland	
Baltimore City (October 1-November 30 and March 1-September 30)	Baltimore City
Cambridge/St. Michaels (June 1-August 31)	Dorchester and Talbot
Ocean City (June 1-August 31)	Worcester
Washington, DC Metro Area	Montgomery and Prince George's
Massachusetts	
Boston/Cambridge	Suffolk, City of Cambridge
Falmouth (July 1-August 31)	City limits of Falmouth
Martha's Vineyard (July 1-August 31)	Dukes
Nantucket (June 1-September 30)	Nantucket
New Hampshire	
Conway (July 1-August 31)	Carroll

Key City	*County or other defined location*
New York	
Floral Park/Garden City/Great Neck	Nassau
Glens Falls (July 1-August 31)	Warren
Lake Placid (July 1-August 31)	Essex
Manhattan (includes the boroughs of Manhattan, Brooklyn, the Bronx, Queens and Staten Island)	Bronx, Kings, New York, Queens, Richmond
Saratoga Springs/Schenectady (July 1-August 31)	Saratoga and Schenectady
Tarrytown/White Plains/New Rochelle	Westchester
North Carolina	
Kill Devil (June 1-August 31)	Dare
Pennsylvania	
Philadelphia	Philadelphia
Rhode Island	
Jamestown/Middletown/Newport (October 1-October 31 and May 1-September 30)	Newport
Utah	
Park City (January 1-March 31)	Summit
Virginia	
Washington, DC Metro Area	Cities of Alexandria, Fairfax, and Falls Church; counties of Arlington and Fairfax
Virginia Beach (June 1-August 31)	City of Virginia Beach
Washington	
Seattle	King
Wyoming	Teton and Sublette
Jackson/Pinedale (July 1-August 31)	

3. *Changes in high-cost localities*. The list of high-cost localities in this notice differs from the list of high-cost localities in section 5.03 of Rev. Proc. 2010–39 (changes listed by key cities).

a. No localities have been added to the list of high-cost localities.

b. The portion of the year for which the following are high-cost localities has been changed: Yosemite National Park, California; and Chicago, Illinois.

c. The following localities have been removed from the list of high-cost localities: Phoenix/Scottsdale, Arizona; South Lake Tahoe, California; Silverthorne/Breckenridge, Colorado; Riverhead/Ronkonkoma/Melville, New York; and Stowe, Vermont.

SECTION 6. EFFECTIVE DATE

This notice is effective for *per diem* allowances for lodging, meal and incidental expenses, or for meal and incidental expenses only that are paid to any employee on or after October 1, 2011, for travel away from home on or after October 1, 2011. For purposes of computing the amount allowable as a deduction for travel away from home, this notice is effective for meal and incidental expenses or for incidental expenses only paid or incurred on or after October 1, 2011. See sections 4.06 and 5.04 of Rev. Proc. 2011–47 for transition rules for the last 3 months of calendar year 2011.

DRAFTING INFORMATION

The principal author of this notice is Eric D. Brauer of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this notice, contact Mr. Brauer at (202) 622–4970 (not a toll-free call).

Guidance on Electing Portability of Deceased Spousal Unused Exclusion Amount

Notice 2011–82

PURPOSE

This notice alerts executors of the estates of decedents dying after December 31, 2010, of the need to file a Form 706, *United States Estate (and Generation-Skipping Transfer) Tax Return*, within the time prescribed by law (including extensions) in order to elect to allow the decedent's surviving spouse to take advantage of the deceased spouse's unused exclusion amount, if any, pursuant to section 303(a) of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, P.L. 111–312 (124 Stat. 3302) (TRUIRJCA) and section 2010(c)(5)(A) of the Internal Revenue Code (Code). In particular, for the executor of the estate of a decedent to elect under section 2010(c)(5)(A) (a "portability election") to allow the decedent's surviving spouse to use the decedent's unused exclusion amount, the executor is required to file a Form 706 for the decedent's estate, even if the executor is not otherwise obligated to file a Form 706. This notice also alerts executors of the estates of decedents dying after December 31, 2010, that the estate of such a decedent will be considered to have made a portability election if a Form 706 is timely filed in accordance with the instructions for that form. For those estates filing a Form 706 that choose not to make a portability election, this notice addresses how to avoid making the election. This notice also reminds taxpayers that a portability election can be made only on a Form 706 timely filed by the estate of a decedent dying after December 31, 2010, and any attempt to make a portability election on a Form 706 filed for the estate of a decedent dying on or before December 31, 2010, will be ineffective. Finally, this notice alerts taxpayers that the Treasury Department and the Internal Revenue Service (Service) intend to issue regulations under section 2010(c) of the Code to address issues arising with respect to the portability election, and anticipate that those regulations will be consistent with the provisions of this notice.

BACKGROUND

Sections 302(a)(1) and 303(a) of TRUIRJCA, enacted on December 17, 2010, amended section 2010(c) of the Code. Section 2010(c), as amended, generally allows the surviving spouse of a decedent dying after December 31, 2010, to use the decedent's unused exclusion amount in addition to the surviving spouse's own basic exclusion amount. Thus, sections 302(a)(1) and 303(a) of TRUIRJCA eliminate the need for spouses to retitle property and create trusts solely to take full advantage of each spouse's basic exclusion amount.

Section 2010(c)(1) of the Code provides that the applicable credit amount is the amount of the tentative tax that would be determined under section 2001(c) if the amount with respect to which the tentative tax is to be computed were equal to the applicable exclusion amount. Thus, generally, the applicable credit amount effectively exempts from federal estate and gift tax a person's taxable transfers with a cumulative value not exceeding the applicable exclusion amount.

Under section 2010(c)(2), a person's applicable exclusion amount is the sum of (A) the basic exclusion amount and (B) in the case of a surviving spouse, the deceased spousal unused exclusion amount, if any.

Section 2010(c)(3) sets the basic exclusion amount at $5,000,000 in 2011, to be adjusted annually for inflation after 2011.

Section 2010(c)(4) defines the term "deceased spousal unused exclusion amount" to mean, with respect to the surviving spouse of a decedent dying after December 31, 2010, the lesser of (A) the basic exclusion amount, or (B) the excess of (i) the basic exclusion amount of the last such deceased spouse of such surviving spouse, over (ii) the amount with respect to which the tentative tax is determined under section 2001(b)(1) on the estate of such deceased spouse. The unused exclusion amount of a deceased spouse who died before January 1, 2011, cannot be used by the surviving spouse, regardless of the date of the surviving spouse's death.

Under section 2010(c)(5)(A), a deceased spousal unused exclusion amount may be taken into account by a surviving spouse in determining the surviving spouse's applicable exclusion amount only if the executor of the deceased spouse timely files a Form 706 for the deceased spouse's estate, on which the executor computes the deceased spousal unused exclusion amount and makes a portability election. An election, once made, is irrevocable. However, no election may be made if the Form 706 is filed after the time prescribed by law (including extensions) for filing a Form 706.

Section 6075(a) requires the executor of a decedent's estate filing a tax return to file the Form 706 within 9 months after the date of the decedent's death. Section 6081(a) provides that the Secretary may grant a reasonable extension of time for filing any return; however, generally, no such extension may be for more than 6 months. Section 20.6081–1(b) of the Estate Tax Regulations grants executors of decedents' estates an automatic 6-month extension of time to file the Form 706. Executors currently may request the automatic extension of time to file Form 706 by timely filing Form 4768, *"Application for Extension of Time To File a Return and/or Pay U.S. Estate (and Generation-Skipping Transfer) Taxes."*

Section 2010(c)(5)(B) allows the Secretary to examine a return of the predeceased spouse, even after the time has expired under section 6501 for assessing tax under chapter 11 or 12, to make determinations with respect to the deceased spousal unused exclusion amount, notwithstanding any period of limitation in section 6501.

Section 2010(c)(6) provides that the Secretary shall prescribe regulations as may be necessary or appropriate to implement section 2010(c).

DISCUSSION

The Treasury Department and the Service anticipate that, as a general rule, married couples will want to ensure that the unused basic exclusion amount of the first spouse to die will be available to the surviving spouse and, thus, that the estates of most (if not all) married decedents dying after December 31, 2010, will want to make the portability election. As indicated above, because the election is to be made on a timely-filed Form 706, the Treasury Department and the Service anticipate a significant increase in the number of Forms 706 that will be filed by the estates of decedents dying after

December 31, 2010, and that many of those returns will be filed by the estates of decedents whose gross estates have a value below the applicable exclusion amount.

As a result, the Treasury Department and the Service believe that the procedure for making the portability election on the Form 706 should be as straightforward and uncomplicated as possible to reduce the risk of inadvertently missed elections. To that end, the Treasury Department and the Service have determined that the timely filing of a Form 706, prepared in accordance with the instructions for that form, will constitute the making of a portability election by the estate of a decedent dying after December 31, 2010. Thus, by timely filing a properly-prepared and complete Form 706, an estate will be considered to have made the portability election without the need to make an affirmative statement, check a box, or otherwise affirmatively elect, on the Form 706. Until such time as the IRS revises the Form 706 to expressly contain the computation of the deceased spousal unused exclusion amount, a timely-filed and complete Form 706 that is prepared in accordance with the instructions for that form will be deemed to contain the computation of the deceased spousal unused exclusion amount, thereby satisfying the requirements in section 2010(c)(5)(A) for making an effective election.

The Treasury Department and the Service acknowledge that an estate may not want to make the portability election. Not filing a timely Form 706 will prevent the making of that election. However, if such an estate is obligated to file a Form 706 because the value of the gross estate exceeds the applicable exclusion amount, or files a Form 706 for another reason, the executor must follow the instructions for Form 706 that will describe the necessary steps to avoid making the election.

The Treasury Department and the Service recognize that the due date for filing Form 706 for those decedents dying in the first quarter of 2011 is fast approaching and remind executors of the ability to request an automatic 6-month extension by filing Form 4768 before the due date for filing Form 706. See § 20.6081–1(a) and (b) of the Estate Tax Regulations.

The Treasury Department and the Service intend to issue regulations, pursuant to the specific authority provided in section 2010(c)(6), to address various issues arising with respect to implementation of the provisions of section 2010(c).

GUIDANCE

1. If the executor of the estate of a decedent dying after December 31, 2010, intends to make the portability election to allow the decedent's surviving spouse to use the deceased spousal unused exclusion amount, the executor must file a complete Form 706 within the time prescribed by law (including extensions), regardless of whether or not the gross estate has a value in excess of the exclusion amount or otherwise is obligated to file a Form 706.

2. The estate of a decedent dying after December 31, 2010, will be deemed to make the portability election to allow the decedent's surviving spouse to use the deceased spousal unused exclusion amount by the timely filing of a complete and properly-prepared Form 706. To ensure the correct exclusion amount and tax rates, executors should use the Form 706 issued for the year of the decedent's death. Until such time as the IRS revises the Form 706 to expressly contain the computation of the deceased spousal unused exclusion amount, a complete and properly-prepared Form 706 will be deemed to contain the computation of the deceased spousal unused exclusion amount.

3. The executor of the estate of a decedent dying after December 31, 2010, that timely files a complete Form 706, but that chooses not to make the portability election to allow the decedent's surviving spouse to use the deceased spousal unused exclusion amount, must follow the instructions for Form 706 that will describe the steps the executor must take to notify the Service that the decedent's estate is not making the portability election. If the executor of such an estate chooses not to make the portability election and is not otherwise obligated to file a Form 706, not timely filing a Form 706 will effectively prevent the making of that election.

4. The estate of a decedent dying on or before December 31, 2010, is not entitled to make a portability election. Any attempt to make a portability election on a Form 706 filed for the estate of such a decedent will be ineffective.

5. The Treasury Department and the Service intend to issue regulations to implement the provisions of section 2010(c).

REQUEST FOR COMMENTS

Comments are invited on the following specific issues, which have been identified for consideration in proposed regulations to be issued under section 2010(c):

1. The determination in various circumstances of the deceased spousal unused exclusion amount and the applicable exclusion amount;

2. The order in which exclusions are deemed to be used;

3. The effect of the last predeceasing spouse limitation described in section 2010(c)(4)(B)(i);

4. The scope of the Service's right to examine a return of the first spouse to die without regard to any period of limitation in section 6501; and

5. Any additional issues that should be considered for inclusion in the proposed regulations.

Comments will be considered if submitted in writing by October 31, 2011. All comments will be available for public inspection and copying. Comments may be submitted in one of three ways:

a. By mail to CC:PA:LPD:PR (Notice 2011–82), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
b. Electronically to *Notice.Comments@irscounsel.treas.gov.* Please include "Notice 2011–82" in the subject line of any electronic communications.
c. By hand-delivery Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2011–82), Courier's Desk, Internal Revenue Service, 1111 Constitution Ave., NW, Washington, DC 20224.

EFFECTIVE DATE

This notice is applicable with respect to the estates of decedents dying after December 31, 2010.

DRAFTING INFORMATION

The principal author of this notice is Karlene M. Lesho of the Office of Associate Chief Counsel (Passthroughs

and Special Industries). For further information regarding this notice, contact Karlene M. Lesho at (202) 622–3090 (not a toll-free call).

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26 CFR 601.204: Changes in accounting periods and in methods of accounting.
(Also Part I, §§ 446, 448, 481.)

Rev. Proc. 2011–46

SECTION 1. PURPOSE

This revenue procedure provides a book safe harbor method of accounting for taxpayers using the nonaccrual-experience (NAE) method of accounting under § 448(d)(5) of the Internal Revenue Code and § 1.448–2 of the Income Tax Regulations. This revenue procedure also provides the procedures by which a taxpayer may obtain automatic consent (1) to change to the NAE book safe harbor method, and (2) to make certain changes within the NAE book safe harbor method.

SECTION 2. BACKGROUND

.01 Section 448(d)(5) provides that certain taxpayers may use the NAE method to account for amounts to be received for the performance of services. In general, taxpayers eligible to use a NAE method are not required to accrue any portion of amounts that, based on the taxpayer's experience, will not be collected.

.02 The NAE method is available only to a taxpayer using an accrual method of accounting that either provides services in a field described in § 448(d)(2)(A) (health, law, engineering, architecture, accounting, actuarial science, performing arts, or consulting), or that meets the $5 million annual gross receipts test of § 448(c). The NAE method may not be used for amounts for which the taxpayer charges interest or penalties for failure to timely pay. See § 448(d)(5)(B) and § 1.448–2(c)(1)(ii).

.03 Section 448(d)(5)(C) provides that the Secretary shall provide guidance that permits taxpayers to use computations and formulas that, based on experience, accurately reflect the amount of income that a taxpayer will not collect (the uncollectible amount).

.04 Section 1.448–2(f) describes safe harbor NAE methods that a taxpayer may use to determine the uncollectible amount. Section 1.448–2(b) provides that, except as provided in other published guidance, a taxpayer that wishes to change to a NAE method other than one of the safe harbor methods must request advance consent from the Commissioner.

.05 Rev. Proc. 2011–14, 2011–4 I.R.B. 330, provides procedures for a taxpayer to obtain automatic consent of the Commissioner to change to a method of accounting described in the Appendix to Rev. Proc. 2011–14.

.06 Rev. Proc. 2006–56, 2006–2 C.B. 1169, provides procedures for requesting the consent of the Commissioner to make certain changes to, from, or within a NAE method of accounting and to adopt certain NAE methods.

SECTION 3. SCOPE

This revenue procedure applies to a taxpayer that is eligible to use the NAE method of accounting under § 448(d)(5) and § 1.448–2, and has an applicable financial statement, as defined in section 4.02 of this revenue procedure.

SECTION 4. APPLICATION

.01 *NAE book safe harbor.*

(1) *In general.* A taxpayer within the scope of this revenue procedure may compute its uncollectible amount under the NAE book safe harbor method by multiplying the portion of the year-end allowance for doubtful accounts on the taxpayer's applicable financial statement that is attributable to current year NAE-eligible accounts receivable by 95 percent. A taxpayer using the NAE book safe harbor is generally subject to the rules in § 1.448–2; however, the NAE book safe harbor is not subject to the self-testing requirements of § 1.448–2(e).

(2) *Allowance for doubtful accounts.* For purposes of this revenue procedure, an allowance for doubtful accounts on a taxpayer's applicable financial statement must represent the amount of outstanding accounts receivable the taxpayer anticipates it will not collect. Therefore, an allowance that is computed to maximize the deferral of taxable income under this revenue procedure and does not represent the amount of outstanding accounts receivable the taxpayer anticipates it will not collect in the future does not qualify under this revenue procedure.

(3) *Current year NAE-eligible accounts receivable.* Current year NAE-eligible accounts receivable are accounts receivable described in § 1.448–2(c)(1)(i) that a taxpayer earns during the current taxable year. They do not include accounts receivable for which a taxpayer is prohibited from using the nonaccrual experience method, such as amounts not earned through the performance of services and amounts for which the taxpayer charges interest or penalties for failure to timely pay. See § 1.448–2(c)(1)(ii).

(4) *Computation of NAE-eligible amount.* A taxpayer may use any reasonable method to determine the amount of the taxpayer's applicable financial statement allowance for doubtful accounts that is attributable to current year NAE-eligible accounts receivable. In general, a method will not be considered reasonable if the method fails to consider relevant information that is readily available to the taxpayer that would produce a result that is materially different than the method employed by the taxpayer.

(5) *Periodic system compatibility.* The NAE book safe harbor is a qualifying periodic system of accounting for billings under Notice 88–51, 1988–1 C.B. 535.

.02 *Applicable financial statement.* A taxpayer's applicable financial statement is the taxpayer's financial statement listed in paragraphs (1) through (3) of this section 4.02 that has the highest priority (including priority within paragraph (2)). A taxpayer that does not have a financial statement described in this section 4.02 does not have an applicable financial statement for purposes of this revenue procedure. A taxpayer's financial statement that is properly incorporated into a parent's consolidated applicable financial statement that is described in this section 4.02 will qualify as an applicable financial statement. The financial statements are, in descending priority —

(1) A financial statement required to be filed with the Securities and Exchange Commission (SEC) (the 10-K or the Annual Statement to Shareholders);

(2) A certified audited financial statement that is accompanied by the report of an independent CPA (or in the case of a foreign corporation, by the report of a sim-

ilarly qualified independent professional), that is used for —

(a) Credit purposes,

(b) Reporting to shareholders, or

(c) Any other substantial non-tax purpose; or

(3) A financial statement (other than a tax return) required to be provided to the federal or a state government or any federal or state agency (other than the SEC or the Internal Revenue Service).

.03 *Examples*.

Example 1. Application of NAE book safe harbor. (i) On December 31, 2011, the balance sheet in calendar-year Taxpayer's applicable financial statement includes an allowance for doubtful accounts of $1,300,000. Of this balance, $300,000 represents the amount attributable to current year accounts receivable that Taxpayer anticipates it will not collect in the future.

(ii) Taking into account relevant information that is readily available, Taxpayer makes a reasonable determination that $200,000 of the $300,000 current year addition to the financial statement allowance for doubtful accounts is attributable to its current year NAE-eligible accounts receivable. Taxpayer computes the amount of income that it may exclude under the NAE book safe harbor method by multiplying the $200,000 increment to the financial statement year-end allowance for doubtful accounts attributable to current year NAE-eligible accounts receivable by 95%. Therefore, the amount of income that Taxpayer is not required to accrue for federal income tax purposes under section 448(d)(5) for the taxable year ending December 31, 2011, is $190,000 ($200,000 x 95%).

Example 2. Recoveries. (i) On December 31, 2011, the balance sheet in Taxpayer's applicable financial statement includes an allowance for doubtful accounts of $1,300,000, representing outstanding accounts receivable that Taxpayer anticipates it will not collect in the future. During calendar year 2012, Taxpayer collects $100,000 of accounts receivable that had been included in its allowance for doubtful accounts.

(ii) Taking into account relevant information that is readily available, Taxpayer determines that $60,000 of the $100,000 financial statement recovery from the allowance for doubtful accounts is attributable to recoveries of NAE-eligible accounts receivable, all or a portion of which Taxpayer had properly excluded from income in a prior year under the NAE rules. As required by § 1.448–2(d)(5), Taxpayer must include the recovered amount in income in the taxable year ending December 31, 2012. The amount of additional income that Taxpayer must include under § 1.448–2(d)(5) is equal to the amount of the recovery that Taxpayer previously excluded from income under an NAE method. Thus, if in a prior year Taxpayer excluded 95% of the recovered $60,000 under the NAE book safe harbor method, Taxpayer is required to include $57,000 ($60,000 x 95%) in income in the taxable year ending December 31, 2012.

SECTION 5. CHANGE IN METHOD OF ACCOUNTING

.01 *Change to the NAE book safe harbor*.

(1) *In general.* A change in a taxpayer's method of accounting to the NAE book safe harbor method is a change in method of accounting to which the provisions of §§ 446 and 481 and the regulations thereunder apply. A taxpayer within the scope of this revenue procedure is granted the consent of the Commissioner to change to the NAE book safe harbor method permitted under section 4 of this revenue procedure if the taxpayer complies with the applicable provisions of Rev. Proc. 2006–56 and Rev. Proc. 2011–14 (or any successor).

(2) *Scope limitations.* The scope limitations in section 4.02 of Rev. Proc. 2011–14 (or any successor) do not apply for a taxpayer's first taxable year ending on or after September 28, 2011. However, if, at the time a taxpayer files a Form 3115 for that year with the national office, and the taxpayer's NAE method is an issue under consideration for a taxable year under examination, before an appeals office, or before a federal court, then the audit protection of section 7 of Rev. Proc. 2011–14 (or any successor) does not apply. A taxpayer's NAE method of accounting is an issue under consideration for the taxable years under examination if the taxpayer receives written notification (for example, by examination plan, information document request, or notification of proposed adjustment, or income tax examination changes) from the examining agent(s) specifically citing the treatment of the NAE method of accounting as an issue under consideration.

.02 *Change in applicable financial statements and allowance for doubtful accounts*.

(1) *In general.* A change to a taxpayer's method for determining its allowance for doubtful accounts for its applicable financial statements is a change in method of accounting to which the provisions of § 446 and the regulations thereunder apply. A taxpayer within the scope of this revenue procedure is granted the consent of the Commissioner to change this method if the taxpayer complies with the applicable provisions of Rev. Proc. 2011–14 (or any successor) and this paragraph 5.02. An adjustment to a taxpayer's estimates in determining its allowance for doubtful accounts that does not change the base or formula is not a change in the method of determining the allowance for doubtful accounts under this paragraph 5.02. For example, if a taxpayer estimates that 4% of its receivables are uncollectible in a taxable year, and using the same methodology estimates that 6% of its receivables are uncollectible in the subsequent taxable year, the adjustment to its estimate is not a change in the method of determining the allowance for doubtful accounts.

(2) *Restatement of applicable financial statements*. A taxpayer's restatement of its applicable financial statements does not invalidate the taxpayer's method of accounting or change its uncollectible amount determined under the NAE book safe harbor in earlier taxable years.

(3) *Manner of making change.*

(a) A taxpayer makes a change in method of accounting under this paragraph 5.02 by attaching a statement to its original return for the taxable year of change (or to an amended return if under the limited relief for a late application provided in section 6.02(3)(d) of Rev. Proc. 2011–14, or any successor). The taxpayer is not required to file a copy of the statement with the national office under section 6.02(3)(a) of Rev. Proc. 2011–14 (or any successor). The statement must include the following information:

(i) The taxpayer's name and taxpayer identification number for each applicant;

(ii) The beginning and ending dates of the year of change;

(iii) For each applicant, the type of applicable financial statement (as defined in section 4.02 of this revenue procedure) the taxpayer uses;

(iv) A description of the method the taxpayer uses to determine its allowance for doubtful accounts on its applicable financial statements before and after the change; and

(v) The designated automatic accounting method change number 35.

(b) A change under this paragraph 5.02 is made on a cut-off basis and applies only to accounts receivable earned on or after the first day of the taxable year of change. A taxpayer must continue to apply its former method to accounts receivable earned before the taxable year of change. Accord-

ingly, a § 481(a) adjustment is neither permitted nor required.

(4) *Scope limitations*. The scope limitation in section 4.02(7) of Rev. Proc. 2011–14 (or any successor) does not apply to a change in method of accounting under this section 5.02. A taxpayer that is otherwise ineligible to file an automatic method change because it is under examination (as defined in section 3.08 of Rev. Proc. 2011–14 (or any successor)) for any income tax issue may change its method of accounting under this paragraph 5.02, however, the audit protection provisions of section 7 of Rev. Proc. 2011–14 (or any successor) do not apply.

.03 *Change in method of determining the NAE-eligible amount*.

(1) *In general*. A change in a taxpayer's method for determining the portion of its applicable financial statement allowance for doubtful accounts that is attributable to current year NAE-eligible accounts receivable (as described in section 4.01(4) of this revenue procedure) is a change in method of accounting to which the provisions of § 446 and the regulations thereunder apply. A taxpayer within the scope of this revenue procedure is granted the consent of the Commissioner to change this method if the taxpayer complies with the applicable provisions of Rev. Proc. 2011–14 (or any successor) and this paragraph 5.03.

(2) *Manner of making change*.

(a) A taxpayer makes a change in method of accounting under this paragraph 5.03 by attaching a statement to its original return for the taxable year of change (or to an amended return if under the limited relief for a late application provided in section 6.02(3)(d) of Rev. Proc. 2011–14, or any successor). The taxpayer is not required to file a copy of the statement with the national office under section 6.02(3)(a) of Rev. Proc. 2011–14 (or any successor). The statement must include the following information:

(i) The taxpayer's name and taxpayer identification number for each applicant;

(ii) The beginning and ending dates of the year of change;

(iii) A description of the method the taxpayer uses to determine its NAE-eligible amount before and after the change; and

(iv) The designated automatic accounting method change number 35.

(b) A change under this paragraph 5.03 is made on a cut-off basis and applies only to accounts receivable earned on or after the first day of the taxable year of change. A taxpayer must continue to apply its former method to accounts receivable earned before the taxable year of change. Accordingly, a § 481(a) adjustment is neither permitted nor required.

(3) *Scope limitation*. The scope limitation in section 4.02(7) of Rev. Proc. 2011–14 (or any successor) does not apply to a change in method of accounting under this section 5.03.

SECTION 6. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2006–56 is modified and amplified to include the NAE book safe harbor method in the safe harbors described in paragraphs (1), (7), and (8) of section 3.01 and in section 3.02. Therefore, a taxpayer may change to the NAE book safe harbor method using the provisions of section 14.04 of the APPENDIX of Rev. Proc. 2011–14 (or any successor) if the taxpayer is otherwise eligible to use Rev. Proc. 2011–14.

SECTION 7. EFFECTIVE DATE

This revenue procedure is effective for taxable years ending on or after September 28, 2011.

SECTION 8. DRAFTING INFORMATION

The principal author of this revenue procedure is W. Thomas McElroy, Jr., of the Office of Associate Chief Counsel (Income Tax and Accounting). For further information regarding this revenue procedure, contact Karla M. Meola at (202) 622–4930 (not a toll-free call).

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26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.

(Also: Part I, §§ 62, 162, 267, 274; 1.62–2, 1.162–17, 1.267(a)–1, 1.274–5.)

Rev. Proc. 2011–47

SECTION 1. PURPOSE

This revenue procedure updates Rev. Proc. 2010–39, 2010–42 I.R.B. 459, and provides rules for using a *per diem* rate to substantiate, under section 274(d) of the Internal Revenue Code and section 1.274–5 of the Income Tax Regulations, the amount of ordinary and necessary business expenses paid or incurred while traveling away from home. Taxpayers are not required to use a method described in this revenue procedure. A taxpayer may substantiate actual allowable expenses if the taxpayer maintains adequate records or other sufficient evidence.

This revenue procedure provides rules for using a *per diem* rate to substantiate the amount of an employee's expenses for lodging, meal, and incidental expenses, or for meal and incidental expenses only, that a payor (an employer, its agent, or a third party) reimburses. Employees and self-employed individuals that deduct unreimbursed expenses for travel away from home may use a *per diem* rate for meals and incidental expenses, or incidental expenses only, under this revenue procedure. This revenue procedure does not provide rules for using a *per diem* rate to substantiate the amount of lodging expenses only.

Announcement 2011–42, 2011–32 I.R.B. 138, advised taxpayers that the Internal Revenue Service intends to discontinue the high-low substantiation method. Subsequently a number of taxpayers commented that they use the high-low substantiation method and asked that the Service retain it. Accordingly, this revenue procedure continues to authorize the high-low substantiation method.

Beginning with the rates for 2011–2012, the Service will publish an annual notice that provides the special *per diem* rates for purposes of sections 4.04, 4.05, and 5 of this revenue procedure and the list of high-cost localities for purposes of section 5 of this revenue procedure and will update this revenue procedure only as necessary.

SECTION 2. BACKGROUND AND CHANGES

.01 Section 162(a) allows a deduction for ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business, including expenses for travel away from home. However, under section 262, a taxpayer may not deduct personal travel or living expenses.

.02 Section 274(n) generally limits the amount allowable as a deduction under section 162 for any expense for food, beverages, or entertainment to 50 percent of the otherwise allowable amount. For an individual during, or incident to, a period of duty subject to the hours of service limitations of the Department of Transportation, section 274(n)(3) provides that, for taxable years beginning in 2008 or thereafter, the deductible percentage for these expenses is 80 percent.

.03 To deduct expenses for travel away from home, a taxpayer must substantiate the expenses under section 274(d), which also authorizes the Secretary to prescribe that some or all of the substantiation requirements do not apply to an expense that does not exceed a particular amount.

.04 Section 1.274–5(g) authorizes the Commissioner to prescribe rules under which reimbursement arrangements or *per diem* allowances are regarded (1) as equivalent to substantiation, by adequate records or other sufficient evidence, of the amount of travel expenses for purposes of section 1.274–5(c), and (2) as satisfying the requirements of an adequate accounting to the employer of the amount of travel expenses for purposes of section 1.274–5(f).

.05 For purposes of determining adjusted gross income, section 62(a)(2)(A) allows an employee to deduct business expenses the employee pays or incurs in performing services under a reimbursement or other expense allowance arrangement with a payor.

.06 Section 62(c) provides that an arrangement is not treated as a reimbursement or other expense allowance arrangement for purposes of section 62(a)(2)(A) if it (1) does not require the employee to substantiate the expenses covered by the arrangement to the payor, or (2) allows the employee to retain any amount in excess of the substantiated expenses covered under the arrangement. Section 62(c) further provides, however, that substantiation is not required for the expense to the extent provided in regulations under section 274(d).

.07 Under section 1.62–2(c), a reimbursement or other expense allowance arrangement satisfies the requirements of section 62(c) if it meets the requirements of business connection, substantiation, and returning amounts in excess of expenses. In that case, all amounts paid under the arrangement are treated as paid under an accountable plan and are excluded from income and wages. If an arrangement does not meet one or more of these requirements, all amounts paid under the arrangement are treated as paid under a nonaccountable plan and are included in an employee's gross income, must be reported as wages or compensation on the employee's Form W–2, and are subject to the withholding and payment of employment taxes.

.08 Section 1.62–2(e)(2) provides that the amount of a business expense substantiated under section 1.274–5(g) is treated as substantiated for purposes of section 1.62–2.

.09 Under section 1.62–2(f)(2), the Commissioner may prescribe rules for treating an arrangement providing *per diem* allowances as satisfying the requirement of returning amounts in excess of expenses if the arrangement requires the employee to return amounts that relate to unsubstantiated travel days, even though the arrangement does not require the employee to return the portion of the allowance that relates to substantiated travel days but that exceeds the deemed substantiated amount for those days. The allowance must be reasonably calculated not to exceed the amount of the employee's expenses or anticipated expenses and the employee must be required to return within a reasonable period of time any portion of the allowance that relates to unsubstantiated travel days. Under section 1.62–2(h)(2)(i)(B), the portion of the allowance that relates to substantiated travel days but exceeds the substantiated amount for those days and that the employee is not required to return is subject to withholding and payment of employment taxes. See sections 31.3121(a)–3, 31.3231(e)–1(a)(5), 31.3306(b)–2, and 31.3401(a)–4 of the Employment Tax Regulations.

.10 Under section 1.62–2(h)(2)(i)(B)(4), the Commissioner may prescribe special rules for the timing of withholding and paying employment taxes on *per diem* allowances.

.11 Section 1.274–5(j)(1) authorizes the Commissioner to establish a method allowing a taxpayer to treat a specific amount as paid or incurred for meals while traveling away from home instead of substantiating the actual cost.

.12 Section 1.274–5(j)(3) authorizes the Commissioner to establish a method allowing a taxpayer to treat a specific amount as paid or incurred for incidental expenses while traveling away from home in lieu of substantiating the actual cost.

.13 This revenue procedure includes modifications to Rev. Proc. 2010–39 as follows:

(1) The special *per diem* rates are now published in a separate annual notice. The notice provides (1) the special transportation industry meal and incidental expenses rates (M&IE rates), (2) the rate for the incidental expenses only deduction, and (3) the rates and list of high-cost localities for purposes of the high-low substantiation method. The Service plans to discontinue publishing this revenue procedure annually but will publish modifications as required. This revenue procedure remains in effect until superseded.

(2) Section 3.04 clarifies that partners and volunteers who receive reimbursements from payors may use the methods allowed under this revenue procedure to substantiate their expenses.

(3) Under section 5, taxpayers may now use the high-low substantiation method in lieu of the meal and incidental expenses only *per diem* substantiation method provided in section 4.02 for travel within the continental United States.

(4) Transition rules for the last 3 months of each calendar year are moved from sections 3.02(1)(a) and 4.04(6) to new section 4.06 and from section 5.05 to section 5.04.

SECTION 3. DEFINITIONS

.01 *Per diem allowance*. The term "*per diem* allowance" means a payment under a reimbursement or other expense allowance arrangement that is —

(1) Paid for ordinary and necessary business expenses incurred, or that the payor reasonably anticipates will be incurred, by an employee for lodging, meal, and incidental expenses, or for meal and incidental expenses, for travel away from home performing services as an employee of the employer,

(2) Reasonably calculated not to exceed the amount of the expenses or the anticipated expenses, and

(3) Paid at or below the applicable federal *per diem* rate, a flat rate or stated schedule, or in accordance with any other Service-specified rate or schedule.

.02 *Federal per diem rate and federal M&IE rate*.

(1) *In general*. The federal *per diem* rate is equal to the sum of the applicable federal lodging expense rate and the applicable federal M&IE rate for the day and locality of travel.

(a) *CONUS rates*. The General Services Administration (GSA) publishes the rates for localities in the continental United States (CONUS), as noted in Appendix A to 41 C.F.R. ch. 301. The GSA rates are available on the internet at *www.gsa.gov*.

(b) *OCONUS rates*. The rates for localities outside the continental United States (OCONUS) are established by the Secretary of Defense (rates for non-foreign localities, including Alaska, Hawaii, Puerto Rico, the Northern Mariana Islands, and the possessions of the United States) and by the Secretary of State (rates for foreign localities). These rates are published in the *Per Diem* Supplement to the Standardized Regulations (Government Civilians, Foreign Areas) (updated on a monthly basis) and are available on the internet at *www.defensetravel.dod.mil* and *www.state.gov*.

(2) *Locality of travel*. The term "locality of travel" means the locality where an employee or self-employed individual traveling away from home stops for sleep or rest.

(3) *Incidental expenses*. The term "incidental expenses has the same meaning as in the Federal Travel Regulations, 41 C.F.R. 300–3.1 (fees and tips given to porters, baggage carriers, bellhops, hotel maids, stewards or stewardesses and others on ships, and hotel servants in foreign countries; transportation between places of lodging or business and places where meals are taken, if suitable meals can be obtained at the temporary duty site; and the mailing cost associated with filing travel vouchers and payment of employer-sponsored charge card billings). Future changes to the definition of incidental expenses in the Federal Travel Regulations will be announced in the annual notice providing the special *per diem* rates.

.03 *Flat rate or stated schedule*.

(1) *In general*. Except as provided in section 3.03(2) of this revenue procedure, an allowance is paid at a flat rate or stated schedule if it is provided on a uniform and objective basis for the expenses described in section 3.01(1) of this revenue procedure. The allowance may be paid for the number of days away from home performing services as an employee or on any other basis that is consistently applied and in accordance with reasonable business practice. Thus, for example, an hourly payment to cover meal and incidental expenses paid to a pilot or flight attendant who is traveling away from home performing services as an employee is an allowance paid at a flat rate or stated schedule. Likewise, a payment based on the number of miles traveled (such as cents per mile) to cover meal and incidental expenses paid to an over-the-road truck driver who is traveling away from home performing services as an employee is an allowance paid at a flat rate or stated schedule.

(2) *Limitation*. An allowance that is computed on a basis similar to that used in computing an employee's wages or other compensation (such as the number of hours worked, miles traveled, or pieces produced) does not meet the business connection requirement of section 1.62–2(d), is not a *per diem* allowance, and is not paid at a flat rate or stated schedule, unless, as of December 12, 1989, (a) the allowance was identified by the payor either by making a separate payment or by specifically identifying the amount of the allowance, or (b) an allowance computed on that basis was commonly used in the industry in which the employee performed services. See section 1.62–2(d)(3)(ii).

.04 *Partners and volunteers*. Individuals subject to the rules of Subchapter K (partners) and individuals performing services without remuneration (volunteers) who receive reimbursements from payors may use the methods allowed under this revenue procedure to substantiate their expenses. The rules of sections 3, 4, 5, and 6 (except section 6.06) of this revenue procedure apply to reimbursements from payors to partners or volunteers.

SECTION 4. PER DIEM SUBSTANTIATION METHOD

.01 *Per diem allowance*. If a payor pays a *per diem* allowance in lieu of reimbursing actual lodging, meal, and incidental expenses incurred or to be incurred by an employee for travel away from home, the amount of the expenses that is deemed substantiated for each calendar day is equal to the lesser of the *per diem* allowance for that day or the amount computed at the federal *per diem* rate (see section 3.02 of this revenue procedure) for the locality of travel for that day (or partial day, see section 6.04 of this revenue procedure). See section 4.06(1) of this revenue procedure for transition rules.

.02 *Meal and incidental expenses only per diem allowance*. If a payor pays a *per diem* allowance only for meal and incidental expenses in lieu of reimbursing actual meal and incidental expenses incurred or to be incurred by an employee for travel away from home, the amount of the expenses that is deemed substantiated for each calendar day is equal to the lesser of the *per diem* allowance for that day or the amount computed at the federal M&IE rate for the locality of travel for that day or partial day. A *per diem* allowance is treated as paid for meal and incidental expenses only if (1) the payor pays the employee for actual expenses for lodging based on receipts submitted to the payor, (2) the payor provides the lodging in kind, (3) the payor pays the actual expenses for lodging directly to the provider of the lodging, (4) the payor does not have a reasonable belief that the employee will or did incur lodging expenses, or (5) the allowance is computed on a basis similar to that used in computing an employee's wages or other compensation (such as the number of hours worked, miles traveled, or pieces produced). See section 4.06(1) of this revenue procedure for transition rules.

.03 *Method for meal and incidental expenses only deduction*. Instead of the actual expense amount, employees and self-employed individuals may substantiate the amount of deductible meal expenses by

using an amount computed at the federal M&IE rate for the locality of travel for each calendar day or partial day the employee or self-employed individual is traveling away from home. This amount is deemed substantiated for purposes of section 1.274–5T(b)(2)(i) and (c), provided the employee or self-employed individual substantiates the elements of time, place, and business purpose of the travel for that day or partial day in accordance with those regulations. See section 6.05(1) of this revenue procedure for rules related to the application of the section 274(n) limitation to amounts determined under this section 4.03. See section 4.05 of this revenue procedure for a method for substantiating the deductible amount of incidental expenses that employees or self-employed individuals who do not pay or incur meal expenses may use. See section 4.06(1) of this revenue procedure for transition rules.

.04 *Special rules for the transportation industry*.

(1) *In general*. This section 4.04 applies to (a) a payor that pays a *per diem* allowance only for meal and incidental expenses for travel away from home to an employee in the transportation industry and computes the amount under section 4.02 of this revenue procedure, or (b) an employee or self-employed individual in the transportation industry who computes the deductible amount for meal and incidental expenses for travel away from home under section 4.03 of this revenue procedure.

(2) *Transportation industry defined*. For purposes of this section 4.04, an employee or self-employed individual is in the transportation industry only if the employee's or self-employed individual's work (a) is of the type that directly involves moving people or goods by airplane, barge, bus, ship, train, or truck, and (b) involves regularly traveling away from home and stopping during a single trip at localities with differing federal M&IE rates. For purposes of the preceding sentence, a payor must determine that an employee or a group of employees is in the transportation industry by using a method that is consistently applied and in accordance with reasonable business practice.

(3) *Rates*. A taxpayer described in section 4.04(1) of this revenue procedure may use the CONUS and OCONUS special M&IE rates (published in an annual notice) for the transportation industry. A payor that uses either or both of these special rates for an employee must use the special rate(s) for all amounts deemed substantiated under section 4.02 of this revenue procedure paid to that employee for travel away from home within CONUS and/or OCONUS during the calendar year. Similarly, an employee or self-employed individual who uses either or both of these special rates must use the special rate(s) for all amounts deemed substantiated under section 4.03 of this revenue procedure for travel away from home within CONUS and/or OCONUS during the calendar year. See section 4.06(2) of this revenue procedure for transition rules.

(4) *Periodic rule*. A payor described in section 4.04(1) of this revenue procedure may compute the amount of an employee's expenses that is deemed substantiated under section 4.02 of this revenue procedure periodically (not less frequently than monthly) rather than daily by comparing the total *per diem* allowance paid for the period to the sum of the amounts computed either at the federal M&IE rate(s) for the localities of travel, or at the special rate described in section 4.04(3), for the days or partial days the employee is away from home during the period.

(5) *Examples*.

(a) *Example 1*. Taxpayer, an employee in the transportation industry, travels away from home on business within CONUS for 10 days during a calendar month. A payor pays Taxpayer a *per diem* allowance for meal and incidental expenses only that the payor computes using section 4.04(3) of this revenue procedure. The CONUS special M&IE rate is $59 per day. The amount deemed substantiated under section 4.02 of this revenue procedure is equal to the lesser of the total *per diem* allowance paid for the month or $590 (10 days away from home at $59 per day).

(b) *Example 2*. Taxpayer, a truck driver employee in the transportation industry, is paid a "cents-per-mile" allowance that qualifies as an allowance paid under a flat rate or stated schedule as defined in section 3.03 of this revenue procedure. Taxpayer travels away from home on business for 10 days. Based on the number of miles Taxpayer is expected to drive per day, Taxpayer's employer pays an allowance of $500 for the 10 days of business travel. The CONUS special M&IE rate is $59 per day. Taxpayer actually drives for 8 days, and does not drive for the other 2 days Taxpayer is away from home. Taxpayer is paid under the periodic rule used for transportation industry employers and employees in accordance with section 4.04(4) of this revenue procedure. The amount deemed substantiated is the full $500 because that amount does not exceed $590 (10 days away from home at $59 per day).

.05 *Method for incidental expenses only deduction*. Instead of using actual expenses in computing the amount allowable as a deduction for ordinary and necessary incidental expenses paid or incurred for travel away from home, employees and self-employed individuals who pay or incur incidental expenses but do not pay or incur meal expenses for a calendar day or partial day of travel away from home may use, for each calendar day or partial day the employee or self-employed individual is away from home, an amount that the Service publishes in an annual notice. This amount is deemed substantiated for purposes of section 1.274–5T(b)(2)(i) and (c), provided the employee or self-employed individual substantiates the elements of time, place, and business purpose of the travel for that day or partial day in accordance with those regulations. The method authorized by this section 4.05 may not be used by payors that reimburse expenses under section 4.01, 4.02, or 5.01 of this revenue procedure, or by employees or self-employed individuals who use the method described in section 4.03 of this revenue procedure to substantiate the amount of deductible meal and incidental expenses. See section 6.05(5) of this revenue procedure for rules related to the application of the section 274(n) limitation to amounts determined under this section 4.05.

.06 *Transition rules*.

(1) *In general*. In applying section 4.01, 4.02, or 4.03 of this revenue procedure, taxpayers may continue to use the CONUS rates in effect for the first 9 months of the calendar year, instead of the updated GSA rates, for expenses of all CONUS travel away from home that are paid or incurred during the last 3 months of the calendar year. A taxpayer must use either the rates for the first 9 months of the calendar year or the updated rates for the period October 1 through December 31 of each calendar year consistently.

(2) *Special transportation industry rates*. Under the calendar-year convention provided in section 4.04(3) of this revenue procedure, a taxpayer who uses the federal M&IE rates during the first 9 months of the calendar year to substantiate the amount of an individual's travel expenses under sections 4.02 or 4.03 of this revenue procedure may not use, for that individual, the special transportation

industry rates published in an annual notice until January 1 of the next calendar year. Similarly, a taxpayer who uses the special transportation industry rates during the first 9 months of the calendar year to substantiate the amount of an individual's travel expenses may not use, for that individual, the federal M&IE rates until January 1 of the next calendar year.

SECTION 5. HIGH-LOW SUBSTANTIATION METHOD

.01 *In general*. A payor that pays a *per diem* allowance in lieu of reimbursing actual expenses an employee pays or incurs or will pay or incur for travel away from home may use the high-low substantiation method described in this section 5 in lieu of the *per diem* substantiation method described in section 4.01 of this revenue procedure or the meal and incidental expenses only method described in section 4.02 of this revenue procedure. If a payor uses the high-low substantiation method, the amount of the expenses that is deemed substantiated for each calendar day is equal to the lesser of the actual *per diem* allowance for that day or the amount computed under section 5.02 of this revenue procedure. Employees and self-employed individuals may not use the high-low substantiation method in lieu of the meal and incidental expenses only deduction method described in section 4.03 of this revenue procedure.

.02 *Application of high-low method*. Under the high-low substantiation method, a high rate applies to localities designated as high-cost localities and a low rate applies to every other locality within CONUS (one high rate and one low rate for lodging, meal, and incidental expenses and one high rate and one low rate for meal and incidental expenses only). The high or low rates, as appropriate, apply as if they were the federal *per diem* rate or the federal M&IE rate for the locality of travel. The high and low rates, amounts treated as meal expenses for purposes of § 274(n), and a list of high-cost localities are published in an annual notice.

.03 *Limitation*. A payor that uses the high-low substantiation method for an employee must use that method for all amounts paid to that employee for travel away from home within CONUS during the calendar year. The payor may use any permissible method (actual expenses, the *per diem* substantiation method described in section 4.01 of this revenue procedure, or the meal and incidental expenses only *per diem* substantiation method described in section 4.02 of this revenue procedure) to reimburse that employee for any OCONUS travel away from home.

.04 *Transition rules*. For travel in the last 3 months of a calendar year—

(1) A payor must continue to use the same method (*per diem* method under sections 4.01 or 4.02 of this revenue procedure, or high-low method) for an employee as the payor used during the first 9 months of the calendar year; and

(2) A payor may use either the rates and high-cost localities in effect for the first 9 months of the calendar year or the updated rates and high-cost localities in effect for the last 3 months of the calendar year if the payor uses the same rates and localities consistently for all employees reimbursed under the high-low method.

.05 *Examples*.

(1) *Example 1*. Employer pays a *per diem* allowance for lodging, meal, and incidental expenses to Employee for travel away from home using the high-low substantiation method. Employee travels away from home for 5 full days to City A within CONUS. City A is listed as a high-cost locality. Employer reimburses employee at a rate of $225 per day for each of employee's 5 days of travel. The *per diem* rate for a high-cost locality is $250. The amount deemed substantiated under section 5 of this revenue procedure is $225 per day (the lesser of the *per diem* allowance for each day ($225) or the *per diem* rate for a high-cost locality ($250)).

(2) *Example 2*. Employer pays a *per diem* allowance for meal and incidental expenses only to Employee for travel away from home using the high-low substantiation method. Employee travels away from home to City B (within CONUS) each month of Year 1. For all of Year 1, Employer reimburses Employee at a rate of $50 per day for meal and incidental expenses only. For the first 9 months of Year 1, City B is listed as a high-cost locality. The M&IE rate is $60 for a high-cost locality and $45 for all other localities. For the last 3 months of Year 1, City B is not listed as a high-cost locality, and the M&IE rate for City B is $48. Employer chooses to use the rates and list of high-cost localities in effect during the first 9 months of Year 1 for the last 3 months of Year 1 (instead of the updated rates for the last 3 months of Year 1). If Employer uses the rates and high-cost localities in effect during the first 9 months of Year 1 for the last 3 months of Year 1 consistently for all employees, the amount deemed substantiated for Employee's travel to City B during the last 3 months of Year 1 is $50, the lesser of the M&IE rate for a high-cost locality ($60) or the employee's *per diem* allowance for each day ($50).

SECTION 6. LIMITATIONS AND SPECIAL RULES

.01 *In general*. The federal *per diem* rate and the federal M&IE rate described in section 3.02 of this revenue procedure for the locality of travel apply in the same manner as they apply under the Federal Travel Regulations, 41 C.F.R. Part 301, except as provided in sections 6.02 through 6.04 of this revenue procedure.

.02 *Federal per diem rate*. A receipt for lodging expenses is not required in determining the amount of expenses deemed substantiated at the federal *per diem* rate (including lodging, meal, and incidental expenses in one rate) under section 4.01 or 5.01. See section 7.01 of this revenue procedure for the requirement that an employee substantiate the time, place, and business purpose of the expense.

.03 *Meals provided in kind*. A payor is not required to reduce the federal *per diem* rate or the federal M&IE rate for the locality of travel for meals provided in kind, provided the payor has a reasonable belief that the employee incurred or will incur meal and incidental expenses during each day of travel.

.04 *Proration of the federal per diem or M&IE rate*. Under the Federal Travel Regulations, in determining the federal *per diem* rate or the federal M&IE rate for the locality of travel, the full applicable federal M&IE rate is available for a full day of travel from 12:01 a.m. to 12:00 midnight. A taxpayer must use the method described in section 6.04(1) of this revenue procedure for purposes of determining the amount deemed substantiated for meal and incidental expenses or for incidental expenses only under section 4.03, 4.05, or 5 of this revenue procedure for partial days of travel away from home. For purposes of determining the amount deemed substantiated for a reimbursement for lodging, meal, and incidental expenses under section 4.01, 4.02, or 5 of this revenue procedure for partial days of travel away from home, a payor may use either of the following methods to prorate the federal M&IE rate to determine the federal *per diem* rate or the federal M&IE rate for the partial days of travel:

(1) The rate may be prorated using the method prescribed by the Federal Travel Regulations for meal and incidental expenses for partial days, see 41 C.F.R.

301–11.101, by allocating three-fourths of the applicable rate to each partial day of travel; or

(2) The rate may be prorated using any method that is consistently applied and is consistent with reasonable business practice. For example, if an employee travels away from home from 9 a.m. one day to 5 p.m. the next day, a method of proration that results in an amount equal to two times the federal M&IE rate is consistent with reasonable business practice (even though the Federal Travel Regulations allow only one and a half times the federal M&IE rate).

.05 *Application of the appropriate section 274(n) limitation on meal expenses*. Except as provided in section 6.05(5) of this revenue procedure, all or part of the amount of an expense deemed substantiated under this revenue procedure is subject to the appropriate limitation under section 274(n) (see section 2.02 of this revenue procedure) on the deductibility of food and beverage expenses.

(1) A taxpayer must treat the entire amount computed for meal and incidental expenses under section 4.03 of this revenue procedure as an expense for food and beverages.

(2) If a *per diem* allowance is paid for meal and incidental expenses only, a payor must treat an amount equal to the lesser of the allowance or the federal M&IE rate for the locality of travel for each day or partial day (see section 6.04 of this revenue procedure) as an expense for food and beverages.

(3) If a *per diem* allowance is paid for lodging, meal, and incidental expenses for each calendar day or partial day an employee is away from home at a rate equal to or in excess of the federal *per diem* rate for the locality of travel, a payor must treat an amount equal to the federal M&IE rate for the locality of travel for each calendar day or partial day as an expense for food or beverages.

(4) If a *per diem* allowance is paid for lodging, meal, and incidental expenses for each calendar day or partial day an employee is away from home at a rate less than the federal *per diem* rate for the locality of travel, a payor must:

(a) Treat an amount equal to the federal M&IE rate for the locality of travel for each calendar day or partial day or, if less, the amount of the allowance, as an expense for food or beverages; or

(b) Treat an amount equal to 40 percent of the allowance as an expense for food or beverages.

(5) None of the amount for incidental expenses computed under section 4.05 of this revenue procedure is subject to limitation under section 274(n).

.06 *No double reimbursement or deduction*. If a payor pays a *per diem* allowance in lieu of reimbursing actual lodging, meal, and incidental expenses, or meal and incidental expenses only, under section 4 or 5 of this revenue procedure, and the amount is treated as paid under an accountable plan, any additional payment for those expenses is treated as paid under a nonaccountable plan, is included in an employee's gross income, is reported as wages or other compensation on the employee's Form W–2, and is subject to withholding and payment of employment taxes. Similarly, if an employee or self-employed individual computes the amount allowable as a deduction for meal and incidental expenses for travel away from home under section 4.03 or 4.04 of this revenue procedure, no other deduction is allowed to the employee or self-employed individual for those expenses. For example, an employee receives a *per diem* allowance from a payor for meal and incidental expenses incurred while traveling away from home and the amount is treated as paid under an accountable plan. During that trip, the employee pays for dinner for the employee and two business associates. The payor reimburses as a business entertainment meal expense the meal expense for the employee and the two business associates. Because the payor also pays the employee a *per diem* allowance for meal and incidental expenses, the amount paid for the employee's portion of the business entertainment meal expense is treated as paid under a nonaccountable plan, is reported as wages or other compensation on the employee's Form W–2, and is subject to withholding and payment of employment taxes.

.07 *Related parties*. Sections 4.01 and 5 of this revenue procedure do not apply if a payor and an employee are related within the meaning of section 267(b), but for this purpose the percentage of ownership interest referred to in section 267(b)(2) is 10 percent.

SECTION 7. APPLICATION

.01 An employee satisfies the adequate accounting and substantiation requirements of section 1.274–5(c) and (f)(4) and section 1.274–5T(c) if—

(1) The employee uses this revenue procedure to substantiate to a payor the amount of the employee's travel expenses, and

(2) Within a reasonable period of time, the employee also substantiates to the payor the elements of time, place, and business purpose of the travel in accordance with section 1.274–5T(b)(2) and (c) and section 1.274–5(c) (other than section 1.274–5(c)(2)(iii)(A)).

.02 An arrangement providing *per diem* allowances is treated as satisfying the requirement of section 1.62–2(f)(2) of returning amounts in excess of expenses if an employee is required to return within a reasonable period of time (as defined in section 1.62–2(g)) any portion of the allowance that relates to unsubstantiated travel days, even though the arrangement does not require the employee to return the portion of the allowance that relates to substantiated travel days and that exceeds the amount of the employee's expenses deemed substantiated. For example, a payor provides an employee an advance *per diem* allowance for meal and incidental expenses of $250, based on an anticipated 5 days of business travel at $50 per day to a locality for which the federal M&IE rate is $46, and the employee substantiates 3 full days of business travel. The requirement to return excess amounts is treated as satisfied if the employee is required to return within a reasonable period of time (as defined in section 1.62–2(g)) the portion of the allowance that is attributable to the 2 unsubstantiated days of travel ($100), even though the employee is not required to return the portion of the allowance ($12) that exceeds the amount of the employee's expenses deemed substantiated under section 4.02 of this revenue procedure ($138) for the 3 substantiated days of travel. However, the $12 excess portion of the allowance is treated as paid under a nonaccountable plan as discussed in section 7.04 of this revenue procedure.

.03 An employee is not required to include in gross income the portion of a *per diem* allowance received from a payor that is less than or equal to the amount deemed

substantiated under the rules provided in section 4 or 5 of this revenue procedure if the employee substantiates the business travel expenses covered by the *per diem* allowance in accordance with section 7.01 of this revenue procedure. See section 1.274–5T(f)(2)(i). If the remaining requirements for an accountable plan provided in section 1.62–2 are satisfied, that portion of the allowance is treated as paid under an accountable plan, is not reported as wages or other compensation on the employee's Form W–2, and is exempt from the withholding and payment of employment taxes. See section 1.62–2(c)(2) and (c)(4).

.04 An employee is required to include in gross income only the portion of the *per diem* allowance received from a payor that exceeds the amount deemed substantiated under the rules provided in section 4 or 5 of this revenue procedure if the employee substantiates the business travel expenses covered by the *per diem* allowance in accordance with section 7.01 of this revenue procedure. See section 1.274–5T(f)(2)(ii). In addition, the excess portion of the allowance is treated as paid under a nonaccountable plan, is reported as wages or other compensation on the employee's Form W–2, and is subject to withholding and payment of employment taxes. See section 1.62–2(c)(3)(ii), (c)(5), and (h)(2)(i)(B).

.05 If the amount of the expenses that is deemed substantiated under the rules provided in section 4.01, 4.02, or 5 of this revenue procedure is less than the amount of an employee's business expenses for travel away from home, an employee may claim an itemized deduction for the amount by which the business travel expenses exceed the amount that is deemed substantiated, provided the employee substantiates all the business travel expenses (not just the excess over the federal *per diem* rate), includes on Form 2106, "*Employee Business Expenses*," the deemed substantiated portion of the *per diem* allowance received from the payor, and includes in gross income the portion (if any) of the *per diem* allowance received from the payor that exceeds the amount deemed substantiated. See section 1.274–5T(f)(2)(iii). However, for purposes of claiming this itemized deduction for meal and incidental expenses, substantiation of the amount of the expenses is not required if the employee is claiming a deduction that is equal to or less than the amount computed under section 4.03 of this revenue procedure minus the amount deemed substantiated under sections 4.02 and 7.01 of this revenue procedure. The itemized deduction is subject to the appropriate limitation (see section 2.02 of this revenue procedure) on meal and entertainment expenses in section 274(n) and the 2-percent floor on miscellaneous itemized deductions in section 67.

.06 An employee who pays or incurs meal expenses and does not receive a *per diem* allowance for meal and incidental expenses may deduct an amount computed under section 4.03 of this revenue procedure only as an itemized deduction. This itemized deduction is subject to the appropriate limitation on meal and entertainment expenses in section 274(n) and the 2-percent floor on miscellaneous itemized deductions in section 67.

.07 An employee who does not pay or incur amounts for meal expenses and does not receive a *per diem* allowance for incidental expenses may deduct an amount computed under section 4.05 of this revenue procedure only as an itemized deduction. This itemized deduction is subject to the 2-percent floor on miscellaneous itemized deductions in section 67.

.08 A self-employed individual who pays or incurs meal expenses for a calendar day or partial day of travel away from home may deduct an amount computed under section 4.03 of this revenue procedure in determining adjusted gross income under section 62(a)(1), subject to the appropriate limitation on meal and entertainment expenses in section 274(n).

.09 A self-employed individual who does not pay or incur meal expenses for a calendar day or partial day of travel away from home may deduct an amount computed under section 4.05 of this revenue procedure in determining adjusted gross income under section 62(a)(1).

SECTION 8. WITHHOLDING AND PAYMENT OF EMPLOYMENT TAXES

.01 The portion of a *per diem* allowance, if any, that relates to the days of business travel substantiated and that exceeds the amount deemed substantiated for those days under section 4.01, 4.02, or 5 of this revenue procedure is treated as paid under a nonaccountable plan and is subject to withholding and payment of employment taxes. See section 1.62–2(h)(2)(i)(B).

.02 In the case of a *per diem* allowance paid as a reimbursement, the excess described in section 8.01 of this revenue procedure is subject to withholding and payment of employment taxes in the payroll period in which a payor reimburses the expenses for the days of travel substantiated. See section 1.62–2(h)(2)(i)(B)(2).

.03 In the case of a *per diem* allowance paid as an advance, the excess described in section 8.01 of this revenue procedure is subject to withholding and payment of employment taxes no later than the first payroll period following the payroll period in which the days of travel for which the advance was paid are substantiated. See section 1.62–2(h)(2)(i)(B)(3). If an employee does not substantiate some or all of the days of travel for which the advance was paid within a reasonable period of time or does not return the portion of the allowance that relates to those days within a reasonable period of time, the portion of the allowance that relates to those days is subject to withholding and payment of employment taxes no later than the first payroll period following the end of the reasonable period. See section 1.62–2(h)(2)(i)(A).

.04 In the case of a *per diem* allowance only for meal and incidental expenses for travel away from home paid to an employee in the transportation industry by a payor that uses the rule in section 4.04(4) of this revenue procedure, the excess of the *per diem* allowance paid for the period over the amount deemed substantiated for the period under section 4.02 of this revenue procedure (after applying section 4.04(4) of this revenue procedure), is subject to withholding and payment of employment taxes no later than the first payroll period following the payroll period in which the excess is computed. See section 1.62–2(h)(2)(i)(B)(4).

.05 For example, an employer pays an employee a *per diem* allowance under an arrangement that otherwise meets the requirements of an accountable plan to cover business expenses for meals and lodging for travel away from home at a rate of 120 percent of the federal *per diem* rate for the localities to which the employee travels. The employer does not require the employee to return the 20 percent by which

the reimbursement for those expenses exceeds the federal *per diem* rate. The employee substantiates 6 days of travel away from home: 2 days in a locality where the federal *per diem* rate is $150 and 4 days in a locality where the federal *per diem* rate is $130. The employer reimburses the employee $984 for the 6 days of travel away from home (2 x (120% x $150) + 4 x (120% x $130)), and does not require the employee to return the excess payment of $164 (2 days x $30 ($180-$150) + 4 days x $26 ($156-$130)). For the payroll period in which the employer reimburses the expenses, the employer must withhold and pay employment taxes on $164. See section 8.02 of this revenue procedure.

.06 All payments to an employee under a *per diem* allowance arrangement are treated as paid under a nonaccountable plan if the reimbursement arrangement evidences a pattern of abuse. An arrangement evidences a pattern of abuse if, for example, it has no process to determine when an allowance exceeds the amount that may be deemed substantiated and the arrangement routinely pays allowances in excess of the amount that may be deemed substantiated without requiring actual substantiation or repayment of the excess amount, or treating the excess allowances as wages for employment tax purposes. See section 62(c), section 1.62–2(k), and Rev. Rul. 2006–56, 2006–2 C.B. 874. Thus, these payments are included in the employee's gross income, are reported as wages or other compensation on the employee's Form W–2, and are subject to withholding and payment of employment taxes. See sections 1.62–2(c)(3), (c)(5), and (h)(2).

SECTION 9. EFFECTIVE DATE

This revenue procedure is effective for *per diem* allowances for lodging, meal and incidental expenses, or for meal and incidental expenses only that are paid to an employee on or after October 1, 2011, for travel away from home on or after October 1, 2011. For purposes of computing the amount allowable as a deduction for travel away from home, this revenue procedure is effective for meal and incidental expenses or for incidental expenses only paid or incurred on or after October 1, 2011.

SECTION 10. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2010–39 is modified and amplified and, as modified and amplified, is superseded.

DRAFTING INFORMATION

The principal author of this revenue procedure is Eric D. Brauer of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this revenue procedure, contact Mr. Brauer at (202) 622–4970 (not a toll-free call) or the individual identified in the most recent annual *per diem* notice.

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26 CFR 601.105. Examination of returns and claims for refund, credit or abatement; determination of correct tax liability.
(Also Part I, §§ 2053, 6402; 20.2053–1; 301.6402–2.)

Rev. Proc. 2011–48

SECTION 1. PURPOSE

This revenue procedure provides guidance related to the filing and subsequent resolution of a protective claim for refund of estate tax that is based on a deduction for a claim or expense under section 2053 of the Internal Revenue Code (Code) and the corresponding regulations.

SECTION 2. BACKGROUND

Final regulations (T.D. 9468, 2009–44 I.R.B. 570) under section 2053 of the Code were published in the **Federal Register** on October 20, 2009 (74 FR 53652) to provide guidance in determining the deductible amount of a claim against a decedent's estate under section 2053. The final regulations provide, with certain exceptions, that the amount deductible for a section 2053 claim or expense is limited to the amount actually paid in settlement or satisfaction of that claim or expense (subject to any applicable limitations in § 20.2053–1). For amounts that are not paid or otherwise deductible at the time of filing the *United States Estate (and Generation-Skipping Transfer) Tax Return* (Form 706), § 20.2053–1(d)(5)(i) of the Estate Tax Regulations permits the filing of a protective claim for refund.

Section 20.2053–1(d)(5)(i) provides in part that a protective claim for refund may be filed at any time before the expiration of the period of limitation prescribed in section 6511(a) to preserve the estate's right to claim a refund in the case of a claim or expense that might not be paid or might not otherwise meet the requirements of deductibility under section 2053 and the corresponding regulations until after the expiration of the period of limitation for filing a claim for refund. Such a claim for refund is referred to herein as a "section 2053 protective claim for refund." Section 20.2053–1(d)(5)(i) further provides that a protective claim must identify the outstanding claim or expense that would have been deductible under section 2053(a) or (b) if such item already had been paid, and must describe the reasons and contingencies delaying the actual payment of the claim or expense. When the contingencies delaying actual payment are resolved, § 20.2053–1(d)(5)(i) requires the fiduciary acting on behalf of the estate to notify the Service within a reasonable period that the contingency has been resolved and that the amount deductible under § 20.2053–1 has been established. A deduction will be allowed to the extent the claim or expense that was the subject of the protective claim satisfies the requirements for deductibility under § 2053 and the corresponding regulations, subject to any applicable limitations in § 20.2053–1.

Commentators responding to proposed regulations issued under section 2053 of the Code (published in the **Federal Register** on April 23, 2007 (72 FR 20080)) requested detailed guidance on protective claim for refund procedures. Section 20.2053–1(d)(5)(i) provides that a protective claim for refund shall be made in accordance with guidance that may be provided from time to time by publication in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(*b*)).

SECTION 3. SCOPE

This revenue procedure applies only to section 2053 protective claims for refund. Section 4 of this revenue procedure sets forth procedures for filing a section 2053 protective claim for refund, and Section 5 of this revenue procedure sets forth procedures for notifying the Service that a section 2053 protective claim for refund is

ready for consideration. A taxpayer that files a protective claim for refund and provides notification for consideration to the Service in accordance with the procedures set forth in this revenue procedure will satisfy the generally applicable procedural requirements for claiming a refund as well as the procedural requirements specific to section 2053 for claiming a refund. A taxpayer that chooses not to follow or fails to comply with the procedures set forth in this revenue procedure for a section 2053 protective claim for refund is subject to all of the generally applicable provisions governing claims for refund as well as to the specific section 2053 provisions relating to claims for refund, and will not have the benefit of the limited review described in Notice 2009–84, 2009–44 I.R.B. 592, and section 5.01 of this revenue procedure. See §§ 6402, 6511, and 6514; § 20.2053–1(d)(5).

SECTION 4. PROCEDURE — FILING A SECTION 2053 PROTECTIVE CLAIM FOR REFUND

.01 *Time period for filing a protective claim for refund*. A section 2053 protective claim for refund must be filed before the expiration of the period of limitation prescribed in section 6511(a) for the filing of a claim for refund. Section 6511(a) provides, in relevant part, that a claim for refund shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires later, or if no return was filed by the taxpayer, within 2 years from the time the tax was paid. Only if a protective claim for refund was timely filed may the Internal Revenue Service (Service) refund overpaid estate taxes in those situations where the amount deductible under § 20.2053–1 is not established until after the expiration of the period of limitation. See §§ 6511(b) and 6514(a).

.02 *Generally applicable regulatory requirements for a claim for refund*. Under § 301.6402–2 of the Procedure and Administration Regulations, a claim for refund must set forth, in a written declaration that is executed under penalties of perjury, each ground upon which a refund is claimed and facts sufficient to apprise the Commissioner of the exact basis of the claim. The method under this revenue procedure for satisfying these requirements with respect to a section 2053 protective claim for refund requires that the protective claim for refund identify and describe in detail the claim or expense for which a deduction may be claimed under section 2053 of the Code and otherwise comply with the procedures in this section.

.03 *Who can file a protective claim for refund*. A protective claim for refund must be accompanied by documentary evidence, including certified copies of the letters testamentary, letters of administration, or other similar evidence, to establish the legal authority of a fiduciary or other person to file and pursue a protective claim for refund on behalf of the estate of a decedent. See § 301.6402–2(e) of the Procedure and Administration Regulations. In the estate tax context, proof of legal authority typically is established at the time of filing the *Federal Estate (and Generation-Skipping Transfer) Tax Return* (Form 706). Accordingly, if the fiduciary or other person filing the protective claim for refund on behalf of a decedent's estate is the same fiduciary or other person who filed the decedent's Form 706, the protective claim for refund need only include a statement affirming that the fiduciary or other person filing the protective claim for refund also filed the Form 706 and that such fiduciary or other person is still acting in a representative capacity on behalf of the estate. If the fiduciary or other person filing the protective claim for refund on behalf of a decedent's estate is not the same fiduciary or other person who filed the decedent's Form 706, the protective claim for refund must be accompanied by the necessary documentary evidence establishing proof of legal authority. See section 5.04 of this revenue procedure for guidance on the authority of a transferee or other person to represent the estate in pursuing a section 2053 claim for refund.

.04 *Manner of filing a section 2053 protective claim for refund*.

(1) *Methods of filing*. To be properly filed under this revenue procedure, section 2053 protective claims for refund that are filed for decedents dying on or after January 1, 2012, must be filed using any method described in paragraph (a) or (b). For those section 2053 protective claims for refund filed for decedents dying after October 19, 2009, and before January 1, 2012, the section 2053 protective claims for refund must be filed using the method described in paragraph (b). If a taxpayer has made a filing prior to the issuance of this revenue procedure in an effort to make a protective claim for refund under section 2053, and if the taxpayer has any concern as to whether the prior filing meets the requirements of this revenue procedure, or if the taxpayer wants the benefit of section 4.06 of this revenue procedure, the taxpayer may replace the initial filing with a timely filing in accordance with this section 4.04.

(a) *Schedule PC with Form 706*. A section 2053 protective claim for refund may be filed by attaching one or more completed Schedules PC to the estate's Form 706 at the time of filing that return. Schedule PC is expected to be first available as part of the 2012 Form 706. The Form 706 should indicate that one or more Schedules PC are being filed with the return in order to facilitate the proper processing of Schedule(s) PC, in accordance with the instructions for that schedule.

(b) *Form 843*. A section 2053 protective claim for refund may be filed by filing a Form 843 where the Form 706 for the decedent's estate was previously filed (currently, at the Cincinnati campus), with the notation "Protective Claim for Refund under Section 2053" entered across the top of page 1 of the form. For filing a section 2053 protective claim for refund, the address for the "Cincinnati campus" is: Department of Treasury, Internal Revenue Service Center, 300 Madison Avenue, Stop 823G, Covington, KY 41011, or as otherwise specified in the instructions to the form.

(2) *Separate protective claim for refund for each section 2053 claim or expense*. To be properly filed under this revenue procedure, a separate section 2053 protective claim for refund must be filed as described in section 4.04(1) of this revenue procedure for each claim or expense for which a deduction may be claimed in the future under section 2053 (section 2053 claim or expense). Specifically, a Form 706 may include more than one Schedule PC. In addition, a section 2053 protective claim for refund must not include any claim for refund not based on a deduction under section 2053. Each section 2053 protective claim for refund should indicate whether other protective claims for refund are be-

ing filed or were previously filed and the approximate date on which each was filed.

.05 *Identification of the claim or expense*.

(1) *General rule*. In order for a section 2053 protective claim for refund to be properly filed under this revenue procedure, the outstanding claim or expense that forms the basis of a potential deduction under section 2053 must be clearly identified so that the Service has notice of each claim or expense for which a deduction under section 2053 will be claimed. In addition, as provided in § 20.2053–1(d)(5), proper identification of the claim or expense must include an explanation of the reasons and contingencies delaying the actual payment to be made in satisfaction of the claim or expense. Finally, except as provided in section 4.05(2) of this revenue procedure, claims or expenses related to but separate from a particular section 2053 claim or expense must be separately identified. The use of vague or broad language that does not describe a specific claim or expense that would be deductible under section 2053 does not provide clear identification of a section 2053 claim or expense for purposes of this revenue procedure.

(2) *Related ancillary expenses*. A section 2053 claim or expense that has been adequately identified in a protective claim for refund (in accordance with this section) will be deemed to include, without the need for any further identification, certain related and ancillary expenses relating to resolving, defending, or satisfying the identified claim or expense as well as certain expenses relating to pursuing the claim for refund for the identified claim or expense. For instance, attorneys' fees, court costs, appraisal fees, and accounting fees, may be considered as part of the claim for refund to which it relates, without the need for separate identification of those related administration or litigation expenses. Note, however, that although no separate identification for certain related and ancillary expenses is required under the procedures in this revenue procedure, this procedure shall not be construed to concede that the expenses are deductible under section 2053 in all events. A claim or expense that is the subject of a section 2053 claim for refund must meet the substantive requirements of section 2053 and the corresponding regulations in order to be deductible and the amount of the deduction is subject to any applicable limitations.

(3) *Claims against the estate involving contested matters*. To satisfy the requirements of this section, each section 2053 protective claim for refund involving a contested claim against the estate must notify the Service of the contested matter and the potential liability of the estate. Identification of all of the following facts, as applicable, generally will be sufficient to appropriately identify a claim against the estate involving a contested matter: the name or names of the claimant(s), the basis of the claim or other description of the subject matter of the contested matter, the extent or amount of the liability claimed, and a brief statement reporting the status of the contested matter at the time the protective claim for refund is filed with the Service. For a contested matter that is being litigated, attaching a copy of the relevant pleadings and making reference thereto on the section 2053 protective claim for refund generally will be sufficient to identify appropriately the claim.

(4) *Claims or expenses for which deductions under § 20.2053–1(d)(4) or § 20.2053–4(b) or (c) are claimed on Form 706*. Subject to applicable limitations, an estate may preserve the estate's right to claim a refund based on the amount of any section 2053 claim or expense that is in addition to the amount claimed as a deduction for that claim or expense under § 20.2053–1(d)(4) or § 20.2053–4(b) or (c) on Form 706, if the additional amount might not be paid or might not meet the requirements of § 20.2053–1(d)(4) until after the expiration of the period of limitation prescribed in section 6511(a) for the filing of a claim for refund. To be properly filed under this revenue procedure, a protective claim for refund that is based upon the potential deductibility of such an additional amount must satisfy all of the procedural, identification, and other requirements of this revenue procedure, as applicable. In addition, however, the estate must disclose the amount of the deduction already claimed on Form 706 for the subject claim or expense and must reference the regulatory provision under which the deduction was claimed in order to identify properly the section 2053 claim or expense on a protective claim for refund.

.06 *Period after filing the section 2053 protective claim for refund*.

(1) *Initial processing of section 2053 claim for refund by the Service*. Although the Service generally will not engage in a substantive review of a section 2053 protective claim for refund until the amount of the section 2053 claim or expense has been established, when a section 2053 protective claim for refund is received by the Service, the Service may reject the claim if it appears that one or more preliminary procedural requirements for a valid claim for refund have not been satisfied. For example, the Service may reject a claim that (a) is not timely filed by a fiduciary or other person having legal authority to file a claim for refund on behalf of the estate, (b) does not include a properly executed penalty of perjury statement, or (c) does not adequately describe a claim or expense that, if substantiated at a later time, would support a deduction under section 2053. For those section 2053 protective claims for refund that are not initially rejected by the Service, the Service will acknowledge in written correspondence that the claim has been received. Note, however, that the Service's written acknowledgement that the claim has been received does not constitute a determination that the preliminary procedural requirements for a valid protective claim for refund have been satisfied. Accordingly, upon consideration of the claim once the amount of the section 2053 claim or expense has been established, the Service nevertheless may determine that one or more procedural requirements are not satisfied and the claim for refund then may be denied.

(2) *Contacting the Service when no communication received*. Although a timely-filed section 2053 protective claim for refund will be timely filed even if the Service does not acknowledge its receipt and/or process the protective claim, the fiduciary or other person filing the form on behalf of the estate promptly should contact the Service at (866) 699–4083 (or other appropriate number) to inquire into the Service's receipt and processing of that protective claim for refund if the estate does not receive from the Service the written acknowledgement of receipt described in section 4.06(1) of this revenue procedure within 180 days of filing a section 2053 protective claim for refund on a Schedule PC attached to the Form 706,

or within 60 days of filing a section 2053 protective claim for refund on a Form 843. A certified mail receipt or other evidence of delivery to the Service is not sufficient to ensure and confirm the Service's receipt and processing of the protective claim for purposes of this revenue procedure. See section 4.06(3) of this revenue procedure regarding the possible consequences of not contacting the Service within 30 days after the expiration of these periods.

(3) *Opportunity to cure an inadequately identified section 2053 protective claim for refund*. A section 2053 protective claim for refund must satisfy the timely-filing requirement set forth in section 4.01 of this revenue procedure. The failure of a section 2053 protective claim for refund to satisfy certain other preliminary procedural requirements for a valid claim for refund, including the penalty of perjury statement requirement set forth in section 4.02 of this revenue procedure, may be cured before the expiration of the period of limitation prescribed in section 6511(a). However, the failure of a section 2053 protective claim for refund to satisfy the identification requirement set forth in section 4.05 of this revenue procedure may be cured, as further described below, after the expiration of the period of limitation prescribed in section 6511(a), as long as the section 2053 protective claim for refund as originally filed was timely and properly executed under the penalty of perjury. To cure the section 2053 protective claim for refund, the fiduciary or other person must adequately identify the section 2053 claim or expense in accordance with section 4.05 of this revenue procedure by submitting a corrected (and signed) protective claim for refund before the expiration of the period of limitation prescribed in section 6511(a) or within 45 days after the date of the Service's notice, if any, to the fiduciary or other person of the defect, whichever occurs later. If the Service fails to provide the written acknowledgement of receipt described in section 4.06(1) of this revenue procedure and the fiduciary or other person who filed the section 2053 protective claim for refund fails to contact the Service within 30 days after the applicable time period described in section 4.06(2) of this revenue procedure to confirm the Service's receipt and processing of that section 2053 protective claim for refund, the fiduciary or other person will not have the opportunity to cure the inadequate identification of the section 2053 protective claim for refund after the expiration of the period of limitation prescribed in section 6511(a).

(4) *Effect of section 2053 protective claim for refund on examination of Form 706*. When a fiduciary or other person having authority to file a Form 706 on behalf of an estate also files a section 2053 protective claim for refund on behalf of the estate, generally the Service will not suspend the substantive review and examination of the Form 706 and will not delay issuing a closing letter on the basis that a protective claim for refund has been filed in that estate. Instead, the Form 706 will be processed and examined by the Service in accordance with the regular processing and examination procedures followed for estate tax returns.

SECTION 5. PROCEDURE — NOTIFICATION FOR CONSIDERATION OF A SECTION 2053 PROTECTIVE CLAIM FOR REFUND

.01 *In general*. The Service will refund overpaid estate tax if the Service determines there is an overpayment of tax in connection with a timely-filed section 2053 protective claim for refund, even though the claim or expense that is the subject of the claim for refund does not become deductible under section 2053 until after the expiration of the period of limitation prescribed in section 6511(a) for the filing of a claim for credit or refund. In accordance with Notice 2009–84, 2009–44 I.R.B. 592, in determining whether there is an overpayment of tax based on a timely-filed section 2053 protective claim for refund that becomes ready for consideration after the expiration of the period of limitation on assessment prescribed in section 6501, generally the Service will limit its review of the Form 706 to the deduction under section 2053 that was the subject of the protective claim. When the section 2053 claim or expense that was the subject of the timely-filed section 2053 protective claim for refund meets the requirements for deductibility under § 20.2053–1, a taxpayer must provide a notification to the Service that the claim for refund is ready for consideration as described in section 5.03 of this revenue procedure, and such notification must be executed under penalty of perjury, within the time period described in section 5.02 of this revenue procedure, by the fiduciary or other person having legal authority to file and pursue the claim for refund. The notification generally should describe the relevant facts that support, and provide evidence to substantiate, a deduction under section 2053 and should claim a refund of the overpayment of tax based on the deduction under section 2053 and the resulting recomputation of the estate tax liability.

.02 *Time period for providing notification for consideration of a section 2053 protective claim for refund.*

(1) *General rule*. Under § 20.2053–1(d)(5)(i), a fiduciary or other person having legal authority to pursue the claim for refund must notify the Service within a reasonable period that the reason or contingency delaying the actual payment of the section 2053 claim or expense has been resolved and/or that the amount deductible under § 20.2053–1 has been established. For purposes of this revenue procedure, this requirement is satisfied when the fiduciary or other person having legal authority to pursue the claim for refund on behalf of the estate notifies the Service within 90 days after the date the claim or expense is paid or 90 days after the date on which the amount of the claim or expense becomes certain and is no longer subject to any contingency, whichever occurs later. When the notification to the Service by the fiduciary or other person occurs after the expiration of that 90-day period, the fiduciary or other person should provide an explanation sufficient to establish that there is reasonable cause for the delay. The methods by which a fiduciary or other person having legal authority to file and pursue the claim for refund must notify the Service under this revenue procedure are described in section 5.03 of this revenue procedure.

(2) *Multiple or recurring payments*. For a section 2053 claim or expense involving multiple payments or a series of recurring payments, the payment of which is necessary to claim a deduction based on that claim or expense (such as a contingent obligation described in § 20.2053–4(d)(6)(ii) of the Estate Tax Regulations), the 90-day period described in section 5.02(1) of this revenue proce-

dure will begin with regard to the entire amount of the claim or expense on the date of the last and final payment. Thus, the fiduciary or other person having legal authority to file and pursue the claim for refund may notify the Service within 90 days after the date the liability for the claim or expense is fully satisfied, regardless of the amount of time over which the earlier, partial payments were made. Notwithstanding the preceding sentence, however, the fiduciary or other person having legal authority to file and pursue the claim for refund may notify the Service in accordance with section 5.02(1) of this revenue procedure, but not more often than annually (except in the case of a final payment) of all payments made since the last notification for consideration, if any, in partial satisfaction of a liability for a section 2053 claim or expense, and may thereby claim a partial refund attributable to such payment(s).

.03 *Manner of notifying the Service for consideration of a section 2053 claim for refund.*

(1) *Methods of filing.* To meet the notification requirements under this revenue procedure, whether with regard to the entire claim or expense or to partial payments as made, a notification for consideration of a section 2053 protective claim for refund that is to be filed for a decedent dying on or after January 1, 2012, must be filed using any method described in paragraph (a) or (b). For a notification for consideration of a section 2053 protective claim for refund that is to be filed for a decedent dying after October 19, 2009, and before January 1, 2012, a notification for consideration of a section 2053 protective claim for refund must be filed using the method described in paragraph (b). A notification for consideration of a section 2053 protective claim for refund additionally must meet the applicable requirements in section 5.01 and 5.02 of this revenue procedure.

(a) *Supplemental Form 706.* A notification for consideration of a section 2053 protective claim for refund may be filed by filing, at the same location where the section 2053 protective claim for refund was previously filed, an updated (and signed) Form 706, including each schedule affected by the allowance of the deduction(s) whose amount has been established and including an updated Schedule PC for each section 2053 claim or expense that has become deductible. The notation "Supplemental Information — Notification for Consideration of Section 2053 Protective Claim(s) for Refund filed on [DATE OF PROTECTIVE CLAIM]" must be entered across the top of page 1 of Form 706. In addition, a copy of the originally-filed section 2053 protective claim(s) for refund (filed as described in section 4.04(1) of this revenue procedure) that identifies the section 2053 claims or expenses that now have become deductible must be attached to the Form 706.

(b) *Form 843.* A notification for consideration of a section 2053 protective claim for refund may be filed by filing, at the same location where the section 2053 protective claim for refund was previously filed, one or more updated (and signed) Forms 843 with the notation "Notification for Consideration of Section 2053 Protective Claim for Refund filed on [DATE OF PROTECTIVE CLAIM]" entered across the top of page 1 of the form(s). A copy of the originally-filed section 2053 protective claim(s) for refund (filed as described in section 4.04(1) of this revenue procedure) that identifies the section 2053 claims or expenses that now have become deductible must be attached to the Form(s) 843.

(2) *Separate notifications for consideration for each section 2053 claim or expense.* To be properly filed under this revenue procedure, a separate notification for consideration of a section 2053 protective claim for refund must be filed as described in section 5.03(1) of this revenue procedure for each section 2053 claim or expense for which a section 2053 protective claim for refund was filed. Specifically, an updated Form 706 may include more than one updated Schedule PC. In addition, a notification for consideration of a section 2053 protective claim for refund must not include any claim not based on a deduction under section 2053. Each notification for consideration of a section 2053 protective claim for refund should indicate whether other notifications for consideration are being filed contemporaneously or were previously filed and the approximate date of each such filing.

.04 *Authority of a transferee or other person to represent the estate in pursuit of a claim for refund.* If a fiduciary is no longer acting on behalf of the estate at the time that the amount deductible under § 20.2053–1 is established and the section 2053 protective claim for refund is ready for consideration, one or more persons that are transferees of the probate or nonprobate estate may establish under applicable local law that person's legal authority to pursue the claim for refund on behalf of the estate. For purposes of this provision, any transferee or other person having established legal authority to pursue the claim for refund shall be deemed to have the authority to pursue the claim for refund on behalf of all such transferees or other persons. The transferee or other person must attach to the notification for consideration of a section 2053 protective claim for refund (filed as described in section 5.03 of this revenue procedure) documentary evidence that substantiates that person's assertion of authority to pursue the claim. Depending on applicable local law, the evidence requirement may be satisfied by providing one or more of the following: a certified copy of the final accounting of the estate showing the source of the initial tax payment; relevant testamentary instruments of the decedent such as a will or trust instrument; an affidavit executed under penalties of perjury by the executor or other appropriate party conferring the authority or the right to pursue the refund to one or more transferees or other persons; and such other evidence as may be requested by the Service. The Service will pay the refund of tax to the person or individual who paid the tax, as required by section 6402(a) and subject to regulations under that section.

.05 *Consequences of a section 2053 claim for refund on the marital and charitable deduction.* Because of the application of section 20.2053–1(d)(5)(ii), neither the charitable deduction nor the marital deduction is reduced by the amount of any claim or expense that may be the subject of a section 2053 protective claim for refund until the claim or expense has met the requirements for a deduction under section 2053. The computation of the amount to be refunded under section 2053, as required on Form 843 or a supplemental Form 706, should identify any necessary adjustment to the marital and charitable deductions claimed by the estate, as well as any other arithmetic adjustments that result from the allowance of the deduction.

SECTION 6. EFFECTIVE DATE

This revenue procedure is applicable with respect to protective claims for refund filed on behalf of estates of decedents dying on or after October 20, 2009, the date final regulations (T.D. 9468) under section 2053 were published in the **Federal Register** (74 FR 53652), but only to the extent that the relevant sections of the Code are applicable to the decedent's estate.

SECTION 7. DRAFTING INFORMATION

The principal author of this revenue procedure is Karlene M. Lesho of the Office of Associate Chief Counsel (Passthroughs & Special Industries). For further information regarding this revenue procedure, contact Karlene M. Lesho at (202) 622–3090 (not a toll free call).

Part IV. Items of General Interest

Withdrawal of Notice of Proposed Rulemaking; Notice of Proposed Rulemaking and Notice of Public Hearing

Section 67 Limitations on Estates or Trusts

REG–128224–06

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Withdrawal of notice of proposed rulemaking; notice of proposed rulemaking and notice of public hearing

SUMMARY: This document withdraws the notice of proposed rulemaking (REG–128224–06, 2007–2 C.B. 551 [72 FR 41243]) that was published in the **Federal Register** on July 27, 2007, providing guidance on which costs incurred by estates or trusts other than grantor trusts (non-grantor trusts) are subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a). This document contains proposed regulations that provide guidance on which costs incurred by estates or trusts other than grantor trusts (non-grantor trusts) are subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a). The regulations affect estates and non-grantor trusts. This document also provides notice of a public hearing on these proposed regulations.

DATES: Written and electronic comments must be received by December 7, 2011. Outlines of topics to be discussed at the public hearing scheduled for December 19, 2011 must be received by December 7, 2011.

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG–128224–06), Room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–128224–06), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC, or sent electronically via the Federal eRulemaking Portal at *http://www.regulations.gov/* (IRS REG–128224–06). The public hearing will be held in the IRS Auditorium, Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Jennifer N. Keeney, (202) 622–3060; concerning submissions of comments, the hearing, or to be placed on the building access list to attend the hearing, Richard A. Hurst, (202) 622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed regulations amending 26 CFR Part 1 under section 67 of the Internal Revenue Code (Code) by adding §1.67–4 regarding which costs incurred by an estate or a non-grantor trust are subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a).

Section 67(a) of the Code provides that, for an individual taxpayer, miscellaneous itemized deductions are allowed only to the extent that the aggregate of those deductions exceeds 2 percent of adjusted gross income. Section 67(b) excludes certain itemized deductions from the definition of "miscellaneous itemized deductions." Section 67(e) provides that, for purposes of section 67, the adjusted gross income of an estate or trust shall be computed in the same manner as in the case of an individual. However, section 67(e)(1) provides that the deductions for costs paid or incurred in connection with the administration of the estate or trust that would not have been incurred if the property were not held in such estate or trust shall be treated as allowable in arriving at adjusted gross income. Therefore, deductions described in section 67(e)(1) are not subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a).

A notice of proposed rulemaking (REG–128224–06, 2007–2 C.B. 551) was published in the **Federal Register** (72 FR 41243) on July 27, 2007. The proposed regulations provide that a cost is fully deductible to the extent that the cost is unique to an estate or trust. If a cost is not unique to an estate or trust, such that an individual *could* have incurred the expense, then that cost is subject to the 2-percent floor. For this purpose, the proposed regulations clarify that it is the type of product or service provided to the estate or trust in exchange for the cost, rather than the description of the cost of that product or service, that is tested to determine the uniqueness of the cost. The proposed regulations also address costs subject to the 2-percent floor that are included as part of a comprehensive commission or fee paid to the trustee or executor ("Bundled Fiduciary Fee").

Written comments were received in response to the notice of proposed rulemaking. A public hearing was held on November 14, 2007, at which several commentators offered comments on the notice of proposed rulemaking.

On January 16, 2008, the Supreme Court of the United States issued its decision in *Michael J. Knight, Trustee of the William L. Rudkin Testamentary Trust v. Commissioner*, 552 U.S. 181, 128 S. Ct. 782 (2008), holding that fees paid to an investment advisor by a non-grantor trust or estate generally are subject to the 2-percent floor for miscellaneous itemized deductions under section 67(a). The Court reached this decision on a reading of section 67(e) that differed from that in the proposed regulations. The Court held that the proper reading of the language in section 67(e), which asks whether the expense "would not have been incurred if the property were not held in such trust or estate," requires an inquiry into whether a hypothetical individual who held the same property outside of a trust "customarily" or "commonly" would incur such expenses. Expenses that are "customarily" or "commonly" incurred by individuals are subject to the 2-percent floor.

Following the Supreme Court's decision in *Knight*, the Internal Revenue Service (IRS) and the Treasury Department issued Notice 2008–32, 2008–12 I.R.B. 593 (March 24, 2008) to provide interim guid-

ance on the treatment of Bundled Fiduciary Fees. The notice provided that taxpayers will not be required to determine the portion of a Bundled Fiduciary Fee that is subject to the 2-percent floor under section 67 for any taxable year beginning before January 1, 2008. In the notice, the IRS and the Treasury Department reopened the comment period on the proposed regulations with regard to possible factors on which to base safe harbors for the allocation of a Bundled Fiduciary Fee between costs subject to the 2-percent floor and those exempt from the application of that floor. Written comments were received in response to the notice. The IRS and the Treasury Department subsequently issued Notice 2008–116, 2008–52 I.R.B. 1372 (December 29, 2008) extending the interim guidance provided in Notice 2008–32 to taxable years that begin before January 1, 2009, Notice 2010–32, 2010–16 I.R.B. 594 (April 19, 2010) extending the interim guidance provided in Notice 2008–116 and Notice 2008–32 to taxable years that begin before January 1, 2010, and Notice 2011–37, 2011–20 I.R.B. 785 (May 16, 2011) extending the existing interim guidance to taxable years that begin before the publication of final regulations in the **Federal Register**.

All comments were considered and are available for public inspection. Many of the comments recommended that the proposed regulations be withdrawn and that new proposed regulations be issued to allow the public to comment on the impact of the *Knight* decision on the regulations to be issued under section 67(e). After consideration of all of the comments received since the issuance of the proposed regulations, the proposed regulations published on July 27, 2007, are withdrawn and this document contains new proposed regulations.

Explanation of Provisions

In General

In *Knight*, the Supreme Court held that the deductibility of an expense under section 67(e)(1) depends upon whether the cost is "commonly" or "customarily" incurred when such property is held instead by an individual. In other words, section "67(e)(1) excepts from the 2-percent floor only those costs that it would be *un*common (or unusual, or unlikely) for such a hypothetical individual" holding the same property to incur (emphasis in original). In applying this interpretation of the statute to investment advisory fees incurred by a trust, the Court held that such fees generally are not uncommonly incurred by individual investors and thus are subject to the 2-percent floor. The Court noted, however, that it is conceivable "that a trust may have an unusual investment objective, or may require a specialized balancing of the interests of various parties, such that a reasonable comparison with individual investors would be improper." The Court went on to provide that, "in such a case, the incremental cost of expert advice beyond what would normally be required for the ordinary taxpayer would not be subject to the 2-percent floor." The Court held that the investment advisory fees of the trust in *Knight* properly were subject to the 2-percent floor, and that the trustee did not assert any such unusual facts that would have brought this cost within the exception.

These proposed regulations reflect the reasoning and holding in *Knight* and provide guidance relating to the limited portion of the cost of investment advice that is not subject to the 2-percent floor. To the extent that a portion (if any) of an investment advisory fee exceeds the fee generally charged to an individual investor, and that excess is attributable to an unusual investment objective of the trust or estate or to a specialized balancing of the interests of various parties such that a reasonable comparison with individual investors would be improper, that excess is not subject to the 2-percent floor. Thus, where the costs charged to the trust do not exceed the costs charged to an individual investor, the cost attributable to taking into account the varying interests of current beneficiaries and remaindermen is included in the usual investment advisory fees and is not the type of cost that is excluded from the 2-percent floor under this narrow exception. Individual investors commonly have investment objectives that may require a balance between investing for income and investing for growth and/or a specialized approach for particular assets. Comments are requested on the types of incremental charges, as described in this paragraph, that may be incurred by trusts or estates, as well as a specific description and rationale for any such charges.

Many of the comments received in response to Notice 2008–32 highlighted the legislative intent of the provision imposing the 2-percent floor for miscellaneous itemized deductions. The commentators noted that the intent was to simplify recordkeeping, reduce taxpayer errors, ease administrative burdens for the IRS, and reduce taxpayer errors in distinguishing between nondeductible personal expenditures and deductible miscellaneous itemized deductions. The IRS and the Treasury Department recognize the administrative difficulty of determining whether every type of cost incurred by a trust or estate is the type of cost that would be incurred commonly or customarily by individuals owning the same property. Therefore, the proposed regulations provide simplified rules for the application of section 67(e).

Several commentators questioned the authority of the IRS and the Treasury Department to require the unbundling of fiduciary commissions. However, the *Knight* decision posited just such an unbundling in the case of investment advisory costs rendered for certain services, the cost of which exceeds the costs charged to an individual investor. In determining whether a cost is subject to the 2-percent floor, the relevant cost at issue under section 67(e)(1) should be defined by reference to the products or services that were provided in exchange for that cost, rather than the label that is given to the cost. Therefore, if a fiduciary is performing services that are commonly or customarily performed by an investment advisor retained by an individual investor, then the costs attributable to those services are subject to the 2-percent floor.

Many of the comments received in response to Notice 2008–32 objected to a rule that would require any unbundling of a unitary fee due to the cost and administrative difficulty of implementing a process to track which portions of a single fee are subject to the 2-percent floor. Some commentators anticipated that such a rule would require corporate trustees to invest in expensive software to track and measure the value of the various types of services provided on a trust-by-trust and year-by-year basis.

These proposed regulations do not require the allocation described in the July 2007 proposed regulations. Instead, the

proposed regulations apply section 67(e) as interpreted by the Supreme Court in *Knight,* while also addressing the Government's and taxpayers' interests in reducing the administrative burden of complying with the tax law. The proposed regulations limit the costs that are subject to allocations pursuant to section 67(e) and allow the use of any reasonable method to perform such allocations.

Specifically, the proposed regulations provide that the portion of a bundled fee attributable to investment advice (including any related services that would be provided to any individual investor as part of the investment advisory fee) will be subject to the 2-percent floor. In addition, the proposed regulations provide that, except for the portion so allocated to investment advice, a fiduciary fee not computed on an hourly basis is fully deductible with certain exceptions. The exceptions are payments made to third parties out of the bundled fee that would have been subject to the 2-percent floor if they had been paid directly by the non-grantor trust or estate, and any payments for expenses separately assessed (in addition to the usual or basic fiduciary fee or commission) by the fiduciary or other service provider that are commonly or customarily incurred by an individual owner of such property. An example of such a separately assessed expense subject to the 2-percent floor might be an additional fee charged by the fiduciary for managing rental real estate owned by the non-grantor trust or estate.

The proposed regulations allow the fiduciary and/or return preparer to use any reasonable method to make these allocations. However, the amount of each payment (if any) out of the fiduciary's fee or commission to a third party for expenses subject to the 2-percent floor, and of each separately assessed expense that is commonly or customarily incurred by an individual owner of such property, is readily identifiable without any discretion on the part of the fiduciary. Therefore, the reasonable method standard does not apply to these amounts that are to be deducted from the portion of the bundled fiduciary fee that is not subject to the 2-percent floor.

Comments are requested on the types of methods for making a reasonable allocation, including possible factors on which a reasonable allocation is most likely to be based, and on the related substantiation that will be needed to satisfy the reasonable method standard proposed in these regulations. Specifically, the IRS and the Treasury Department are interested in methods for reasonably estimating the portion of a bundled fee that is attributable to investment advice. For methods based in whole or in part on time devoted to providing investment advice, the IRS and Treasury Department ask for suggestions for alternatives to contemporaneous time records for specific activities that could be used to substantiate the reasonableness of the allocation. The IRS and Treasury Department have considered comments regarding possible numerical or percentage safe harbors in response to Notice 2008–32. Commentators noted that, in many cases, fiduciaries could not rely on safe harbors because their fiduciary duties would require them to make a more accurate estimate so as to not harm the trust or their beneficiaries. In addition, safe harbors could increase complexity by requiring complicated anti-abuse rules. Therefore, comments are requested on methods other than numerical or percentage safe harbors.

Effective Applicability Dates

Notice 2011–37 provides that taxpayers will not be required to determine the portion of a Bundled Fiduciary Fee that is subject to the 2-percent floor under section 67 for taxable years beginning before the date that these regulations are published as final regulations in the **Federal Register**.

Availability of IRS Documents

The IRS notices cited in the preamble are published in the Cumulative Bulletin and are available at *http://www.irs.gov*.

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 regulation 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), 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.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The IRS and the Treasury Department also request comments on the clarity of the proposed rules and how they can be made easier to understand. All comments will be available for public inspection and copying.

A public hearing has been scheduled for December 19, 2011, beginning at 10 a.m. in the IRS Auditorium, Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the Internal Revenue Building lobby more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written or electronic comments by December 7, 2011 and submit an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by December 7, 2011. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the schedule of speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these regulations is Jennifer N. Keeney, Office of the Associate Chief Counsel (Passthroughs

and Special Industries). However, other personnel from the IRS and the Treasury Department participated in their development.

* * * * *

Withdrawal of Notice of Proposed Rulemaking

Accordingly, under the authority of 26 U.S.C. 7805, the notice of proposed rulemaking amending 26 CFR parts 1 and 301 that was published in the **Federal Register** on July 27, 2007, 72 FR 41243 (REG–128224–06), is withdrawn.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.67–4 is added to read as follows:

§1.67–4 Costs paid or incurred by estates or non-grantor trusts.

(a) *In general.* Section 67(e) provides an exception to the 2-percent floor on miscellaneous itemized deductions for costs that are paid or incurred in connection with the administration of an estate or a trust not described in §1.67–2T(g)(1)(i) (a non-grantor trust) and which would not have been incurred if the property were not held in such estate or trust. A cost is subject to the 2-percent floor to the extent that it is included in the definition of miscellaneous itemized deductions under section 67(b), is incurred by an estate or non-grantor trust, and commonly or customarily would be incurred by a hypothetical individual holding the same property.

(b) "*Commonly" or "Customarily" Incurred*—(1) *In general.* In analyzing a cost to determine whether it commonly or customarily would be incurred by a hypothetical individual owning the same property, it is the type of product or service rendered to the estate or non-grantor trust in exchange for the cost, rather than the description of the cost of that product or service, that is determinative. In addition to the types of costs described in paragraphs (b)(2), (3) and (4) of this section, costs that are incurred commonly or customarily by individuals also include expenses that do not depend upon the identity of the payor (in particular, whether the payor is an individual or instead is an estate or trust). Such commonly or customarily incurred costs include, but are not limited to, costs incurred in defense of a claim against the estate, the decedent, or the non-grantor trust that are unrelated to the existence, validity, or administration of the estate or trust.

(2) *Ownership costs.* Ownership costs are costs that are chargeable to or incurred by an owner of property simply by reason of being the owner of the property, such as condominium fees, real estate taxes, insurance premiums, maintenance and lawn services, automobile registration and insurance costs, and partnership costs deemed to be passed through to and reportable by a partner. For purposes of section 67(e), ownership costs are commonly or customarily incurred by a hypothetical individual owner of such property.

(3) *Tax preparation fees.* The application of the 2-percent floor to the cost of preparing tax returns on behalf of the estate, decedent, or non-grantor trust will depend upon the particular tax return. All estate and generation-skipping transfer tax returns, fiduciary income tax returns, and the decedent's final individual income tax returns are not subject to the 2-percent floor. The costs of preparing other individual income tax returns, gift tax returns, and tax returns for a sole proprietorship or a retirement plan, for example, are costs commonly and customarily incurred by individuals and thus are subject to the 2-percent floor.

(4) *Investment advisory fees.* Fees for investment advice (including any related services that would be provided to any individual investor as part of an investment advisory fee) are incurred commonly or customarily by a hypothetical individual investor and therefore are subject to the 2-percent floor. However, certain incremental costs of investment advice beyond the amount that normally would be charged to an individual investor are not subject to the 2-percent floor. For this purpose, such an incremental cost is a special, additional charge added solely because the investment advice is rendered to a trust or estate instead of to an individual, that is attributable to an unusual investment objective or the need for a specialized balancing of the interests of various parties (beyond the usual balancing of the varying interests of current beneficiaries and remaindermen), in each case such that a reasonable comparison with individual investors would be improper.

(c) *Bundled fees*—(1) *In general.* If an estate or a non-grantor trust pays a single fee, commission, or other expense (such as a fiduciary's commission, attorney's fee, or accountant's fee) for both costs that are subject to the 2-percent floor and costs (in more than a *de minimus* amount) that are not, then the single fee, commission, or other expense (bundled fee) must be allocated, for purposes of computing the adjusted gross income of the trust or estate in compliance with section 67(e), between the costs subject to the 2-percent floor and those that are not. Out-of-pocket expenses billed to the trust or estate are treated as separate from the bundled fee.

(2) *Exception.* If a bundled fee is not computed on an hourly basis, only the portion of that fee that is attributable to investment advice is subject to the 2-percent floor; the remaining portion is not subject to that floor. In addition, payments made from the bundled fee to third parties that would have been subject to the 2-percent floor if they had been paid directly by the non-grantor trust or estate are subject to the 2-percent floor, as are any fees or expenses separately assessed by the fiduciary or other payee of the bundled fee (in addition to the usual or basic bundled fee) for services rendered to the trust or estate that are commonly or customarily incurred by an individual.

Example. A corporate trustee charges a percentage of the value of the trust income and corpus as its annual commission. In addition, the trustee bills a separate amount to the trust each year as compensation for leasing and managing the trust's rental real estate. The separate real estate management fee is subject to the 2-percent floor because it is a fee commonly or customarily incurred by an individual owner of rental real estate.

(3) *Reasonable Method.* Any reasonable method may be used to allocate a bundled fee between those costs that are subject to the 2-percent floor and those costs that are not, including without limitation the allocation of a portion of a fiduciary commission that is a bundled fee to investment advice. The reasonable method standard does not apply to

determine the portion of the bundled fee attributable to payments made to third parties for expenses subject to the 2-percent floor or to any other separately assessed expense commonly or customarily incurred by an individual, because those payments and expenses are readily identifiable without any discretion on the part of the fiduciary or return preparer.

(d) *Effective/applicability date*. These regulations apply to taxable years beginning on or after the date that these regulations are published as final regulations in the **Federal Register**.

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

(Filed by the Office of the Federal Register on September 6, 2011, 8:45 a.m., and published in the issue of the Federal Register for September 7, 2011, 76 F.R. 55322)

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

DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Part 147

Notice of Proposed Rulemaking

Summary of Benefits and Coverage and the Uniform Glossary

REG–140038–10

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

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations regarding disclosure of the summary of benefits and coverage and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. This document implements the disclosure requirements to help plans and individuals better understand their health coverage, as well as other coverage options. The templates and instructions to be used in making these disclosures are being issued separately in today's Federal Register.

DATE: *Comment date*. Comments are due on or before October 21, 2011.

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

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

Department of Labor. Comments to the Department of Labor, identified by RIN 1210–AB52, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Email*: *E-OHPSCA2715.EBSA@dol.gov*.
- *Mail or Hand Delivery*: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention*: RIN 1210–AB52.

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

Department of Health and Human Services. In commenting, please refer to file code CMS–9982–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

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

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–9982–P,
P.O. Box 8016,
Baltimore, MD 21244–1850.

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

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

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–9982–P,
Mail Stop C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Room 445-G, Hubert H.
Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201.

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

b. For delivery in Baltimore, MD—

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

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

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

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

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

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

Internal Revenue Service. Comments to the IRS, identified by REG–140038–10, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail*: CC:PA:LPD:PR (REG–140038–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–140038–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224.

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

FOR FURTHER INFORMATION CONTACT: Amy Turner or Heather Raeburn, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Jennifer Libster or Padma Shah, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492–4252.

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

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Pub. L. 111–152, was enacted on March 30, 2010 (these are collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA by section 715). The preemption provisions of ERISA section 731 and PHS Act

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

section 2724[2] (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of part 7 of ERISA and title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of provisions added to the PHS Act by the Affordable Care Act. Accordingly, State laws with stricter health insurance issuer requirements than those imposed by the PHS Act will not be superseded by those provisions. Preemption and State flexibility under PHS Act section 2715 are discussed more fully below under section II.D.

The Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) are taking a phased approach to issuing regulations implementing the revised PHS Act sections 2701 through 2719A and related provisions of the Affordable Care Act. These proposed regulations propose standards for implementing PHS Act section 2715. As discussed more fully below, templates and instructions for meeting the disclosure requirements of PHS Act section 2715 are being issued separately in today's Federal Register.

II. Overview of the Proposed Regulations

A. *Summary of Benefits and Coverage*

1. *In General*

Section 2715 of the PHS Act, added by the Affordable Care Act, directs the Departments to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a summary of benefits and coverage (SBC) that "accurately describes the benefits and coverage under the applicable plan or coverage." The statute directs the Departments, in developing such standards, to "consult with the National Association of Insurance Commissioners" (referred to in this preamble as the "NAIC"), "a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals." The NAIC convened a working group (NAIC working group) comprised of a diverse group of stakeholders. This working group met frequently each month for over one year while developing its recommendations.[3] Throughout the process, NAIC working group draft documents and meeting notes were displayed on the NAIC's website for public review, and several interested parties filed formal comments. In addition to participation from the NAIC working group members, conference calls and in-person meetings were open to other interested parties and individuals and provided an opportunity for non-member feedback. The Departments have received transmittals from the NAIC that include a recommended template for the SBC (with instructions and samples to be used in completing the template) and a recommended uniform glossary.[4]

These regulations generally propose standards for group health plans (and their plan administrators), and health insurance issuers offering group or individual health insurance coverage, that will govern who provides an SBC, who receives an SBC, when the SBC will be provided, and how it will be provided. The Departments invite comment on the standards of the proposed regulations.

In conjunction with these proposed regulations, the Departments are publishing a document today that provides the proposed template for the SBC (with proposed instructions and sample language for completing the template) and the proposed uniform glossary that are identical to the documents that were developed and agreed to by the entire NAIC working group and then voted on and approved by the full NAIC. Instead of proposing possible changes to the NAIC's proposed SBC template and related materials, the document published today incorporates all of the NAIC working group's recommended materials (with the exception of a sample coverage example[5]) and invites public comment. The Departments recognize that changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the disclosures recommended by the NAIC. In addition, the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers.[6]

In general, the Departments have heard concerns about the potential redundancies

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

[3] In developing its recommendations, the NAIC considered the results of various consumer testing sponsored by both insurance industry and consumer associations. Specifically, the draft SBC template, including the coverage examples, and the draft uniform glossary underwent consumer testing to assist in determining adjustments to ensure the final product was consumer friendly. Summaries of this testing are available at: *http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf; http://www.naic.org/documents/committees_b_consumer_information_110603_ahip_bcbsa_consumer_testing.pdf; http://www.naic.org/documents/committees_b_consumer_information_101014_consumers_union.pdf* (a more detailed summary of which is accessible at: *http://prescriptionforchange.org/pdf/CU_Consumer_Testing_Report_Dec_2010.pdf);* and *http://www.naic.org/documents/committees_b_consumer_information_110603_consumers_union_testing.pdf.*

[4] Information on the NAIC working group, including drafts of SBC materials and other supporting documents developed for compliance with PHS Act section 2715, working group membership lists, and meeting minutes, is available at: *http://www.naic.org/committees_b_consumer_information.htm*.

[5] The Appendices do not include a sample coverage example calculation for breast cancer in the individual market that was transmitted by the NAIC. Upon review, it appeared that some of the data in the example might be subject to copyright protection. Moreover, the sample coverage example provided by NAIC was limited to breast cancer in the individual market and did not address the other two coverage examples — maternity coverage and diabetes. Finally, particular coding information and pricing information included in the sample would change annually, which would result in the data included in the sample becoming outdated relatively quickly. Accordingly, HHS is publishing on its website (at http://cciio.cms.gov), the coding and pricing information necessary to perform coverage example calculations for all three coverage examples. HHS will update this information annually.

[6] National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010 Letter to the Secretaries. Available at *http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.*

and additional cost associated with elements of the SBC requirement — including the uniform glossary and the coverage facts labels — particularly for those plans and group health insurance issuers that already provide a Summary Plan Description (SPD) under 29 CFR 2520.104b–2. Comments are solicited on whether the SBC should be allowed to be provided within an SPD if the SBC is intact and prominently displayed at the beginning of the SPD (for example, immediately after a cover page and table of contents), and if the timing requirements for providing the SBC (described in paragraph (a) of the proposed regulations) are satisfied. The Departments also welcome further comments on ways the SBC might be coordinated with other group health plan disclosure materials (*e.g.*, application and open season materials) to communicate effectively with participants and beneficiaries about their coverage and make it easy for them to compare coverage options while also avoiding undue cost or burden on plans and group health insurance issuers.

Consistent with the goals of balancing effective communication and ease of comparison for individuals with minimization of cost and duplication, other sections of this preamble outline and invite comment on potential approaches to major elements of the SBC — the statutorily-required uniform glossary and the coverage examples — in the interest of streamlining standards and making implementation of these components as helpful and user-friendly for individuals, and as workable and efficient as possible.

As discussed below, PHS Act section 2715 generally directs group health plans and health insurance issuers to comply with the SBC requirements beginning on or after March 23, 2012. Comments are requested regarding factors that may affect the feasibility of implementation within this time frame. After the public comment period on these documents, the Departments will finalize the SBC template and instructions. Consistent with PHS Act section 2715(c), the Departments will periodically review and update the documents as appropriate, taking into account public comments.

2. *Providing the SBC*

Paragraph (a) of the proposed regulations implements the general disclosure requirement and sets forth the proposed standards for who provides an SBC, to whom, and when. PHS Act section 2715 generally sets forth that an SBC be provided to applicants, enrollees, and policyholders or certificate holders. PHS Act section 2715(d)(3) places the responsibility to provide an SBC on "(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or (B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of ERISA)."[7] Accordingly, these proposed regulations would interpret PHS Act section 2715 to apply to both group health plans and health insurance issuers offering group or individual health insurance coverage. In addition, consistent with the statute, these proposed regulations would make a plan administrator of a group health plan responsible for providing an SBC. Under the proposed regulations, the SBC would be provided in writing free of charge.

In general, the proposed rules direct that the SBC be provided when a plan or individual is comparing health coverage options. If the information in the SBC changes between the time of application, when the coverage is offered, and when a policy is issued (often the case only for individual market coverage), the proposal would require that an updated SBC be provided. If the information is unchanged, the SBC does not need to be provided again, except upon request. This general approach is explained more fully below.

a. *Provision of the SBC Automatically by an Issuer to a Plan*

Paragraph (a)(1)(i) of the proposed regulations provides that a health insurance issuer offering group health insurance coverage provide the SBC to a group health plan (including, for this purpose, its sponsor) upon an application or request for information by the plan about the health coverage (see section II.A.2.c. of this preamble, below, for a discussion of this proposal). Under this proposal, the SBC must be provided as soon as practicable following the request, but in no event later than seven days following the request. If an SBC is provided upon request for information about health coverage and the plan subsequently applies for health coverage, a second SBC will be provided automatically only if the information in the SBC has changed. If there is a change to the information in the SBC before the coverage is offered, or before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, as applicable). The Departments recognize that often the only change to the SBC is a final premium quote (usually in the individual health insurance market or the small group market). The Departments request comments on whether, in such circumstances, premium information can be provided in another way that is easily understandable and useful to plan sponsors and individuals, other than by sending a new, full SBC.

An issuer also must provide a new SBC if and when the policy, certificate, or contract (for simplicity, referred to collectively as a "policy" in the remainder of this preamble) is renewed or reissued. In the case of renewal or reissuance, if the issuer requires written application materials for renewal (in either paper or electronic form), it must provide the SBC no later than the date the materials are distributed. If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year.

b. *Provision of the SBC Automatically by a Plan or Issuer to Participants and Beneficiaries*

Under paragraph (a)(1)(ii) of the proposed regulations, a group health plan (including the plan administrator), and a health insurance issuer offering group health insurance coverage, must provide

[7] ERISA section 3(16) defines an administrator as: (i) the person specifically designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and plan sponsor cannot be identified, such other person as the Secretary of Labor may by regulation prescribe.

an SBC to a participant or beneficiary[8] with respect to each benefit package offered for which the participant or beneficiary is eligible.[9] The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries. If there is any change to the information required to be in the SBC before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

The plan or issuer must also provide the SBC to special enrollees within seven days of a request for enrollment pursuant to a special enrollment period.[10] Additionally, the plan or issuer must provide a new SBC if and when the coverage is renewed. Specifically, if written application materials are required for renewal (in either paper or electronic form), the SBC must be provided no later than the date the materials are distributed. If renewal is automatic, the proposed rules provide that the SBC must be provided no later than 30 days prior to the first day of coverage in the new plan year.

c. *Provision of the SBC Upon Request*

The regulations propose that a health insurance issuer offering group health insurance coverage provide the SBC to a group health plan (and a plan or issuer must provide the SBC to a participant or beneficiary) upon request, as soon as practicable, but in no event later than seven days following the request. Although PHS Act section 2715 does not specifically reference furnishing SBCs on request, PHS Act section 2715(a) authorizes the Departments to develop standards for providing the SBC to applicants, enrollees, policyholders, and certificate holders. The Departments believe that this provision recognizes that plans and individuals may need or desire the information provided in the SBC at times other than those set forth in the statute to ensure that the plans and individuals have continuous access to coverage and cost information to make informed choices about health coverage.[11] In addition, while the "upon request" provision may result in some additional administrative work for plans and issuers, the Departments have used discretion elsewhere in these proposed regulations to create special rules for avoiding duplication and also propose to reduce burden by facilitating electronic transmittal of the SBC, where appropriate. Accordingly, the Departments have sought to balance providing consumer access to SBCs with minimizing burdens on employers and insurers.

d. *Special Rules to Prevent Unnecessary Duplication With Respect to Group Health Coverage*

The Departments propose, in paragraph (a)(1)(iii), three rules to streamline provision of the SBC and prevent unnecessary duplication with respect to group health plan coverage. First, the requirement to provide an SBC will be considered satisfied for all entities if the SBC is provided by any entity, so long as all timing and content requirements are also satisfied. For example, if a health insurance issuer offering group health insurance coverage provides a complete, timely SBC to the plan's participants and beneficiaries, the plan's requirement to provide the SBC will be satisfied.

Second, if a participant and any beneficiaries are known to reside at the same address, providing a single SBC to that address will satisfy the obligation to provide the SBC for all individuals residing at that address. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC must be provided to the beneficiary at the beneficiary's last known address.

Finally, to further reduce unnecessary duplication with respect to a group health plan that offers multiple benefit packages, in connection with renewal, the plan and issuer only need to automatically provide a new SBC with respect to the benefit package in which a participant or beneficiary is enrolled. SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package for which the participant or beneficiary is eligible, the SBC must be provided as soon as practicable, but in no event later than seven days following the request.

e. *Provision of the SBC by an Issuer Offering Individual Market Coverage*

Under these regulations, the Secretary of HHS sets forth proposed standards applicable to individual health insurance coverage for who provides an SBC, to whom, and when. The intent is to parallel the proposed group market requirements described above, with only those changes necessary to reflect the differences between the two markets. For example, individual policyholders and dependents in the individual market are comparable to group health plan participants and beneficiaries. Accordingly, an issuer offering individual health insurance coverage must provide an SBC as soon as practicable after receiving a request for application or a request for information, but in no event later than seven days after receipt of the request. If an individual later applies for the same policy, a second SBC is required to be provided only if the information in the SBC has changed.

An issuer that makes an offer of coverage must provide an updated SBC only if it has modified the terms of coverage for the

[8] ERISA section 3(7) defines a participant as: any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. ERISA section 3(8) defines a beneficiary as: a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

[9] With respect to insured group health plan coverage, PHS Act section 2715 generally places the obligation to provide an SBC on both a plan and issuer. As discussed below, under section II.A.2.d., "Special Rules to Prevent Unnecessary Duplication With Respect to Group Health Coverage", if either the issuer or the plan provides the SBC, both will have satisfied their obligations. As they do with other notices required of both plans and issuers under Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Code, the Departments expect plans and issuers to make contractual arrangements for sending SBCs. Accordingly, the remainder of this preamble generally refers to requirements for plans or issuers.

[10] Regulations regarding special enrollment can be found at 26 CFR 54.9801–6, 29 CFR 2590.701–6, and 45 CFR 146.117.

[11] Moreover, this provision is consistent with requirements under ERISA section 104(b)(4), which requires ERISA-covered group health plans to provide to participants and beneficiaries, upon request, copies of the instruments under which the plan is established or operated.

individual (including as a result of medical underwriting) that are required to be reflected in the SBC. Similarly, when an individual accepts the offer of coverage, if any terms are modified before the first day of coverage, an updated SBC must again be provided no later than the first day of coverage. A health insurance issuer will provide an SBC annually at renewal, no later than 30 days before the start of the new policy year, reflecting any changes effective for the new policy year.

Finally, similar to the group health coverage rules, for individual health insurance coverage that covers more than one individual (or an application for coverage that is being made for more than one individual), if all those individuals are known to reside at the same address, a single SBC may be provided to that address. This single SBC will satisfy the requirement to provide the SBC for all individuals residing at that address. However, if an individual's last known address is different than the last known address of the individual requesting coverage, the policyholder, or a dependent of either, a separate SBC must be provided to that individual at the individual's last known address.

3. *Content*

PHS Act section 2715(b)(3) generally provides that the SBC must include:

a. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
b. A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
c. The exceptions, reductions, and limitations on coverage;
d. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
e. The renewability and continuation of coverage provisions;
f. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;
g. A statement about whether the plan provides minimum essential coverage as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;
h. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage; and
i. A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

The proposed regulations generally parallel the content elements set forth in the statute. As discussed above, the Departments are issuing a document that proposes to use the NAIC's recommended SBC template and instructions to satisfy the SBC content and appearance requirements of PHS Act section 2715.

A few of the content elements included in the NAIC's recommendations warrant further explanation and discussion. The template developed by the NAIC working group and transmitted to the Departments includes four elements not specified in the statute. Consistent with the Departments' approach of including all of the NAIC's recommended materials, the proposed regulations include these additional recommended elements. The four additional elements are: (1) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; (2) for plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage; (3) an Internet address where an individual may review and obtain the uniform glossary; and (4) premiums (or cost of coverage for self-insured group health plans).

The Departments have included these elements in the proposed regulation consistent with the NAIC's recommendations. PHS Act section 2715(a) requires the Departments to develop regulations for provision of an SBC that accurately describes benefits and coverage, which includes the statutory content elements listed above, but the Departments believe they are not limited to them. The statute also requires the Departments to consult with the NAIC on the development of the standards for the SBC, which includes content. The Departments' proposal includes all of the NAIC's recommendations, including the additional content, and the Departments invite comments on this approach and the four additional SBC content elements. For example, with respect to the requirement to include an Internet address that may be used to obtain a copy of the uniform glossary, the Departments invite comments on whether the SBC also should disclose the option to receive a paper copy of the uniform glossary upon request.

The NAIC instructions provide that the premium generally is the premium as charged by the issuer (which may be evidenced in a rate table attached to the SBC),[12] or the cost of coverage in the case of self-insured plans. The NAIC instructions further provide that, in the case of a group health plan, a participant or beneficiary should consult the employer for information regarding the actual cost of coverage net of any employer subsidy. This raises issues regarding the ability to compare premium or cost information between coverage options. The Departments request comments regarding whether the SBC should include premium or cost information and if so, the extent to which such information should reflect the actual cost to an individual net of any employer contribution, as well as the extent to which the cost information should include costs for different tiers of coverage (for example, self-only, family). The Departments also request comments on how this information can be provided in a way that allows individuals and plan sponsors to make meaningful comparisons about the cost of their coverage options.

With respect to the definitions, the Departments propose to follow an approach

[12] See page 4 of the NAIC Draft Instruction Guide for Group Policies (available at *http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_inst_grp.pdf*).

consistent with the recommendations received from the NAIC.[13] Specifically, PHS Act section 2715(b)(3)(A) requires plans and issuers to include in the SBC "uniform definitions" of common health insurance terms that are consistent with the standards developed under section 2715(g). PHS Act section 2715(g) directs the Departments to "provide for the development of standards for the definitions of terms used in health insurance coverage," including specified insurance-related terms and medical terms, as well as other terms the Departments determine are important to define.

The NAIC working group adopted a two-part approach to the definitions. First, it drafted a consumer-friendly uniform glossary, which includes definitions of health coverage terminology, to be provided in connection with the SBC. The NAIC's uniform glossary provides simple, general, descriptive definitions designed to help consumers understand terms and concepts commonly used in health coverage. For example, "out-of-pocket limit" is defined in the NAIC's uniform glossary as:

> The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 % of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

In these proposed regulations, and as described more fully below under section II.C. of this preamble under the heading "Uniform Glossary", the Departments propose that the NAIC uniform glossary be used to satisfy the requirements of PHS Act 2715(g).

At the same time, these generic glossary definitions, alone, would not necessarily help consumers understand what terms mean under a given plan or policy, nor would they support meaningful comparison of coverage options under PHS Act section 2715(b)(3)(A) because the generic terms used in the glossary are not plan- or policy-specific and would not enable consumers to understand what the terms actually mean in the context of a specific contract. Therefore, in addition to the uniform glossary, the NAIC working group also developed a "Why this Matters" column for the draft SBC template (with instructions for plans and issuers to use in completing the SBC template).[14] The instructions specify how plans and issuers must describe each coverage component in the SBC. For example, the instructions indicate what information must be provided about a plan's out-of-pocket limit on cost sharing, including whether copayments, out-of-network coinsurance, and deductibles are subject to this limit.

In the Departments' proposal, the "Why this Matters" column in the SBC template, together with the instructions for completing this column, constitute the definitions required to be provided under PHS Act section 2715(b)(3)(A). This approach allows plans and issuers flexibility in how they design benefits and coverage features, but proposes that benefits and features be described in a consistent way so that individuals and employers will understand them and appreciate differences from one plan or policy to the next.

With respect to the element of the SBC regarding a statement about whether a plan or coverage provides minimum essential coverage (as defined under section 5000A(f) of the Code) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value requirements (minimum essential coverage statement),[15] because this content is not relevant until other elements of the Affordable Care Act are implemented, this statement is not in the NAIC recommendations. For the same reason, these proposed regulations provide that the minimum essential coverage statement is not required to be in the SBC until the plan or coverage is required to provide an SBC with respect to coverage beginning on or after January 1, 2014.[16]

Starting in 2014, certain individuals who purchase health insurance coverage through the new Affordable Insurance Exchanges ("Exchanges") may be eligible for a premium tax credit to help pay for the cost of that coverage. In general, individuals offered affordable minimum essential coverage under an employer-sponsored plan will not be eligible to receive a premium tax credit. Correctly establishing whether an employer is offering affordable minimum essential coverage is important to individuals, employers, and Exchanges and necessitates the verification of certain information about employer coverage, including the information in the minimum essential coverage statement. The Departments are exploring several reporting options under the Affordable Care Act and other applicable statutory authorities[17] to determine how information about employer-provided coverage can be provided and verified in a manner that limits the burden on individuals, employers, and Exchanges. Because the statutory SBC elements include the information in the minimum essential coverage statement, the Departments invite comments on how employers might provide this information to employees and the Exchanges in a manner that minimizes duplication and burden. The Departments also recognize that some of the plan level information that is required to be provided in the SBC is also required to be provided under section 6056 of the Code (requiring employers to report

[13] National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010 Letter to the Secretaries. Available at *http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.*

[14] National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010, Final Package of Attachments. Available at *http://www.naic.org/documents/committees_b_consumer_information_ppaca_final_materials.pdf.*

[15] PHS Act section 2715(b)(3)(G) provides that this statement must indicate whether the plan or coverage (1) provides minimum essential coverage (as defined under section 5000A(f) of the Code) and (2) ensures that the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs.

[16] The minimum essential coverage and minimum value requirements are part of a larger set of health coverage reforms that take effect on January 1, 2014. The Departments' proposal recognizes this effective date and the need for additional guidance with respect to these requirements and is consistent with the recommendation in the transmittal letter from the NAIC. The NAIC will continue to work to develop a recommendation for this SBC requirement and will submit it to the Departments at a later date.

[17] In addition to section 2715 of the PHS Act, these authorities include, but are not limited to, section 6056 of the Code, as added by section 1514 of the Affordable Care Act (requiring employers to report to the Internal Revenue Service specific information related to employer-sponsored health coverage provided to employees); and section 18B of the Fair Labor Standards Act, as added by section 1512 of the Affordable Care Act (requiring employers to disclose to employees information regarding Exchange coverage options).

to the IRS specific information related to employer-sponsored health coverage provided to employees) and are coordinating their efforts to determine how and whether the same data can be used for multiple purposes. To help develop a simple, efficient system for employers, the Treasury Department and the IRS intend to request comments on employer information reporting required under section 6056 of the Code.

The last SBC content item that merits further discussion is the coverage facts label. The statute requires that an SBC contain a "coverage facts label." For ease of reference, the regulations propose to use "coverage examples," the term recommended by the NAIC, in place of the statutory term. As specified in the statute, the proposed regulations provide that the coverage examples illustrate benefits provided under the plan or coverage for common benefits scenarios, including pregnancy and serious or chronic medical conditions. The coverage example would estimate what proportion of expenses under an illustrative benefits scenario might be covered by a given plan or policy. Consumers then could use this information to compare their share of the costs of care under different plan or coverage options to make an informed purchasing decision.

Under the proposed regulations, consistent with the recommendations of the NAIC working group, a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines available through the National Guideline Clearinghouse. [18]A benefits scenario would include the information needed to simulate how claims would be processed under the scenario to generate an estimate of cost sharing a consumer could expect to pay under the benefit package. The document published contemporaneously with these proposed regulations includes specific instructions and an HHS website with specific information necessary to simulate benefits covered under the plan or policy for specified benefits scenarios.[19]

These proposed regulations provide that the Departments may identify up to six coverage examples that may be required in an SBC. A maximum of six coverage examples was discussed by the NAIC working group, so that consumers may easily read, understand, and compare how benefits are provided for different common medical conditions. In future years, the SBC may include coverage examples in addition to the three proposed now. The Departments propose to limit the number of coverage examples to no more than six to limit the burden on plans and issuers and to ensure that there is adequate space in the SBC to present coverage examples in a manner that is easy to read and useful for individuals. A document published contemporaneously with these proposed regulations adopts a phase-in approach to the coverage examples, and uses the three coverage examples recommended by NAIC for inclusion first - having a baby (normal delivery), treating breast cancer, and managing diabetes.[20]

The Departments invite comments on the proposed coverage examples, whether additional benefits scenarios would be helpful and, if so, what those examples should be. The Departments also invite comments on the benefits and costs associated with developing multiple coverage examples, as well as how multiple coverage examples might promote or hinder the ability to understand and compare terms of coverage. It is anticipated that any additional coverage examples will only be required to be provided prospectively, and that plans and issuers will be provided with adequate time for compliance. Additionally, the Departments invite comments on whether and how to phase in the implementation of the requirement to provide coverage examples. For example, one option would provide that in 2012, coverage examples would only need to be provided for the SBCs with respect to a subset of all benefits packages offered by group health plans or health insurance issuers, with coverage examples required to be provided for all benefits packages in later years. Comments are invited on these issues.

Comments are also requested on whether it would be feasible or desirable to permit plans and issuers to input plan- or policy-specific information into a central Internet portal, such as the Federal health care reform website (*www.healthcare.gov*), that would use the information to generate the coverage examples for each plan or policy. The examples would then be available on the Internet portal for access by individuals. Alternatively, some have suggested that plans and issuers might provide individuals, in a convenient format in the SBC, the several items of plan- or policy-specific information necessary to generate the coverage examples and a reference to the Internet portal, so that individuals could input the information into the Internet portal to generate the coverage examples for the plan or policy. The Departments note that the NAIC considered and rejected the idea of a "cost calculator" or similar tool. The Departments solicit comments on the cost and benefits of these alternatives, including whether such approaches would provide an efficient and effective method for individuals, plans, and issuers to generate or access the coverage examples and how any such approaches could adequately serve individuals who do not have regular access to the Internet (for example, by disclosing in the SBC the option to obtain paper copies of coverage examples generated by the plan or issuer).

4. *Appearance*.

Section 2715 of the PHS Act sets forth the appearance for the SBC. Specifically, the statute provides that the SBC is to be presented in a uniform format utilizing terminology understandable by the average plan enrollee, that does not exceed four pages in length, and does not include print smaller than 12-point font. The proposed regulations, consistent with the NAIC

[18] The National Guideline Clearinghouse, within the Agency for Healthcare Research and Quality (AHRQ), publishes systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances, available at *http://www.guideline.gov/*.

[19] A general instruction guide for completing the coverage examples portion of the SBC, which is identical to that transmitted by the NAIC, is included in the document published today by the Departments. These instructions, together with specific assumptions for coding data and reimbursement rates published today on HHS's website comprise the Departments' instructions for completing the coverage examples portion of the SBC. *See http://cciio.cms.gov. http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_template_blank.xls.* The coding and reimbursement rate assumptions were developed by HHS and are also open for public comment.

[20] *See http://www.naic.org/documents/committees_b_consumer_information_final_coverage_ex.pdf.*

recommendation, interpret the four-page limitation as four double-sided pages.[21] The Departments' view is that this approach will enable group health plans, participants and beneficiaries, and individuals in the individual insurance market to receive enough information to shop for, compare, and make informed decisions regarding various coverage options that may be available to them.[22] The Departments seek comments on this approach.

Consistent with the NAIC recommendations provided to the Departments,[23] under these proposed regulations, a group health plan or a health insurance issuer will provide the SBC as a stand-alone document in the form authorized by the Departments and completed in accordance with the instructions and guidance for completing the SBC that are authorized by the Departments. As noted earlier in this preamble, comments are invited on whether and how the SBC might best be coordinated with the SPD and other group health plan disclosure materials.

5. *Form and Manner*

a. *Group health plan coverage*

To facilitate faster and less burdensome disclosure of the SBC, and consistent with PHS Act section 2715(d)(2), the proposed regulations set forth rules to facilitate electronic transmittal of the SBC, where appropriate. Specifically, an SBC provided by a plan or issuer to a participant or beneficiary may be provided in paper form. Alternatively, for plans and issuers subject to ERISA or the Code, the SBC may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b–1(c) are met.[24] For non-Federal governmental plans, the regulations propose that the SBC may be provided electronically if either the substance of the provisions of the Department of Labor's electronic disclosure rule are met, or if the provisions governing electronic disclosure in the individual health insurance market (described below) are met.

With respect to an SBC provided by an issuer to a plan, the SBC may be provided in paper form or electronically (such as email transmittal or an Internet posting on the issuer's website or on *www.healthcare.gov*). For electronic forms, the format must be readily accessible by the plan; the SBC must be provided in paper form free of charge upon request; and for Internet postings, the plan must be notified by paper or email that the documents are available on the Internet, and given the web address. The Departments invite comments on whether any clarifications are needed with respect to the "readily accessible" standard (for example, whether the requirements for passwords or special software create a sufficient burden that the documents are not "readily accessible"). The Departments also invite comment on whether modifications or adaptations of the SBC are necessary to facilitate or improve electronic disclosure.

b. *Individual health insurance coverage*

With respect to the individual market, the proposed regulations set forth the circumstances in which an issuer offering individual health insurance coverage may provide an SBC in either paper or electronic form. Specifically, under these proposed regulations, unless specified otherwise by an individual, an issuer would be required to provide an SBC (and any subsequent SBC) in paper form if, upon the individual's request for information or request for an application, the individual makes the request in person, by phone or by fax, or by U.S. mail or courier service; or if, when submitting an application, the individual completes the application for coverage by hand, by phone or by fax, or by U.S. mail or courier service. As an alternative, the Departments seek comments on whether it might be appropriate to allow issuers to fulfill an individual's request in electronic form, unless the individual requests a paper form.

Under this proposed rule, an issuer may provide an SBC (and any subsequent SBC) in electronic form (such as through an Internet posting or via electronic mail) if an individual requests information or requests an application for coverage electronically; or, if an individual submits an application for coverage electronically.

To ensure actual receipt of an SBC provided in electronic form, these proposed regulations would set forth certain safeguards for electronic disclosure in the individual market. Under the proposed regulations, an issuer that provides the SBC electronically must:

- Request that an individual acknowledge receipt of the SBC;
- Make the SBC available in an electronic format that is readily usable by the general public;
- If the SBC is posted on the Internet, display the SBC in a location that is prominent and readily accessible to the individual and provide timely notice, in electronic or non-electronic form, to each individual who requests information about, or an application for, coverage, that apprises the individual the SBC is available on the Internet and includes the applicable Internet address;
- Promptly provide a paper copy of the SBC upon request without charge, penalty, or the imposition of any other condition or consequence, and provide the individual with the ability to request a paper copy of the SBC both by using the issuer's Web site (such as by clicking on a clearly identified box to make the request) and by calling a readily available telephone line, the number for which is prominently displayed on the issuer's Web site, policy documents, and other marketing mate-

[21] PHS Act section 2715(b)(1) does not prescribe whether the four pages are four single-sided pages or four double-sided pages. The SBC template transmitted by NAIC exceeded four single-sided pages. After considering the extent of statutorily-required content in PHS Act section 2715(b)(3), as well as the appearance and language requirements of PHS Act sections 2715(b)(1) and (2), the Departments are interpreting four pages to be four double-sided pages, in order to ensure that this information is presented in an understandable and meaningful way.

[22] PHS Act sections 2715(b)(3)(A) and (g)(2) clearly reference consumers comparing coverage and PHS Act section 2715(b)(1) requires a uniform format, to enable shopping and comparing health coverage options.

[23] National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010 Letter to the Secretaries. Available at *http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.*

[24] On April 7, 2011, the Department of Labor published a Request for Information regarding electronic disclosure at 76 FR 19285. In it, the Department of Labor stated that it is reviewing the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by employee benefit plans subject to ERISA. Because these regulations adopt the ERISA electronic disclosure rules by cross-reference, any changes that may be made to 29 CFR 2520.104b–1 in the future would also apply to the SBC.

rials related to the policy and clearly identified as to purpose; and

- Ensure an SBC provided in electronic form is provided in accordance with the appearance, content, and language requirements of this section.

The Departments welcome comments as to whether these or other safeguards are appropriate.

Finally, consistent with the standards for electronic disclosure, these proposed regulations seek to reduce the burden of providing an SBC to individuals shopping for coverage. Specifically, these proposed regulations provide that a health insurance issuer that complies with the requirements set forth at 45 CFR 159.120 (75 FR 24470) for reporting to the Federal health care reform insurance Web portal would be deemed to comply with the requirement to provide the SBC to an individual requesting information about coverage prior to submitting an application. Any SBC furnished at the time of application or subsequently, however, would be required to be provided in a form and manner consistent with the rules described above.

6. *Language*

PHS Act section 2715(b)(2) provides that standards shall ensure that the SBC "is presented in a culturally and linguistically appropriate manner." These proposed regulations provide that, to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules for providing appeals notices in a culturally and linguistically appropriate manner under PHS Act section 2719, and paragraph (e) of its implementing regulations.[25] In general, those rules provide that, in specified counties of the United States, plans and issuers must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages. In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language.[26] The counties in which this must be done are those in which at least ten percent of the population residing in the county is literate only in the same non-English language, as determined in guidance. The Departments welcome comments on whether and how to provide written translations of the SBC in these non-English languages. (Note, nothing in these proposed regulations should be construed as limiting an individual's rights under Federal or State civil rights statutes, such as Title VI of the Civil Rights Act of 1964 (Title VI) which prohibits recipients of Federal financial assistance, including issuers participating in Medicare Advantage, from discriminating on the basis of race, color, or national origin. To ensure non-discrimination on the basis of national origin, recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons. For more information, see, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at *http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html*.)

B. *Notice of Modifications*

Section 2715(d)(4) of the PHS Act directs that a group health plan or health insurance issuer offering group or individual health insurance coverage to provide notice of a material modification if it makes a material modification (as defined under ERISA section 102, 29 U.S.C. 1022) in any of the terms of the plan or coverage involved that is not reflected in the most recently provided SBC. The proposed regulations interpret the statutory reference to the SBC to mean that only a material modification that would affect the content of the SBC would require plans and issuers to provide this notice. In these circumstances, the notice must be provided to enrollees (or, in the individual market, policyholders) no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs other than in connection with a renewal or reissuance of coverage. A material modification, within the meaning of section 102 of ERISA, includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or policy.[27] A material modification could be an enhancement of covered benefits or services or other more generous plan or policy terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing. A material modification could also be a material reduction in covered services or benefits, as defined in 29 CFR 2520.104b–3(d)(3), or more stringent requirements for receipt of benefits. As a result, it also includes changes or modifications that reduce or eliminate benefits, increase premiums and cost-sharing, or impose a new referral requirement.

PHS Act section 2715 and these proposed regulations describe the timing for when a notice of material modification must be provided in situations other than upon renewal at the end of a plan or policy year when a new SBC is provided under the rules of paragraph (a) of the proposed rules. To the extent a plan or policy implements a mid-year change that is a material modification, that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, paragraph (b) of the proposed regulations would require a notice of modifications to be provided 60 days in advance of the effective date of the change. This notice could be satisfied either by a separate notice describing the material modification or by providing an updated SBC reflecting the modification. For ERISA-covered group health plans subject to PHS Act section 2715, this notice is in advance of the timing under the Department of Labor's regulations set forth at 29 CFR 2520.104b–3 that require the provision of a summary of material modification (SMM) (generally not later than 210 days after the close of the plan year in which the modification or change

[25] *See* 75 FR 43330 (July 23, 2010), as amended by 76 FR 37208 (June 24, 2011).

[26] The SBC template, as recommended by the NAIC, does not include this statement; however, these proposed regulations would require that plans and issuers include it.

[27] See DOL Information Letter, Washington Star/Washington-Baltimore Newspaper Guild to Munford Page Hall, II, Baker & McKenzie (February 8, 1985).

was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). In situations where a complete notice is provided in a timely manner under PHS Act section 2715(d)(4), of course, an ERISA-covered plan will also satisfy the requirement to provide an SMM under Part 1 of ERISA. The Departments invite comments on this expedited notice requirement, including whether there are any circumstances where 60-day advance notice might be difficult. The Departments also solicit comments on the format of the notice of modification, particularly for plans and issuers not subject to ERISA.

C. *Uniform Glossary*

Section 2715(g)(2) of the PHS Act directs the Departments to develop standards for definitions for at least the following insurance-related terms: co-insurance, co-payment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network co-payments, out-of-pocket limit, preferred provider, premium, and UCR (usual, customary and reasonable) fees. Section 2715(g)(3) of the PHS Act directs the Departments to develop standards for definitions for at least the following medical terms: durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care. Additionally, the statute directs the Departments to develop standards for such other terms that will help consumers understand and compare the terms of coverage and the extent of medical benefits (including any exceptions and limitations).

The NAIC working group recommended,[28] and the Departments are proposing to adopt for this purpose, inclusion of the following additional terms in the uniform glossary: allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network co-payment, medically necessary, network, out-of-network co-insurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care. The uniform glossary proposed by the Departments is being issued in a document published elsewhere in today's Federal Register.

The Departments invite comments on the uniform glossary, including the content of the definitions and whether there are additional terms that are important to include in the uniform glossary so that individuals and employers may understand and compare the terms of coverage and the extent of medical benefits (or exceptions to those benefits). For example, the Departments are considering whether glossary definitions of any of the following terms would be helpful: claim, external review, maternity care, preexisting condition, preexisting condition exclusion period, or specialty drug. It is anticipated that any additional terms would be included in the uniform glossary prospectively, and that plans and issuers would be provided adequate time for compliance.

The proposed regulations direct a plan or issuer to make the uniform glossary available upon request within seven days. The timing of disclosure is intended to be generally consistent with the proposed requirement, described in section II.A.2.c of this preamble. A plan or issuer may satisfy this disclosure requirement by providing an Internet address where an individual may review and obtain the uniform glossary, as described in section II.A.3 of this preamble. This Internet address may be a place the document can be found on the plan's or issuer's website. It may also be a place the document can be found on the website of either the Department of Labor or HHS. However, a plan or issuer must make a paper copy of the glossary available upon request. Group health plans and health insurance issuers will provide the uniform glossary in the appearance authorized by the Departments, so that the glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee or individual covered under an individual policy.

D. *Preemption*

Section 2715 of the PHS Act is incorporated into ERISA section 715, and Code section 9815, and is subject to the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)). These provisions apply so that the requirements of part 7 of ERISA and part A of title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of part A of title XXVII of the PHS Act. Accordingly, State laws that impose on health insurance issuers requirements that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act. Moreover, PHS Act section 2715(e) provides that the standards developed under PHS Act section 2715(a), "shall preempt any related State standards that require [an SBC] that provides less information to consumers than that required to be provided under this section, as determined by the [Departments]."

Reading these two preemption provisions together, these proposed regulations would not prevent States from imposing separate, additional disclosure requirements on health insurance issuers. The Departments recognize the need to balance States' interest in information disclosure regarding insurance coverage with the primary objective of PHS Act section 2715 (as stated in the section title) of providing for the development and use of a short, uniform explanation of coverage document so that consumers may make apples-to-apples comparisons of plan and coverage options.

E. *Failure to Provide*

PHS Act section 2715(f), incorporated into ERISA section 715 and Code section 9815, provides that a group health plan (in-

[28] National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010 Letter to the Secretaries. Available at *http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.*

cluding its administrator), and a health insurance issuer offering group or individual health insurance coverage, that "willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure." In addition, under PHS Act section 2715(f), a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC. Due to the different enforcement jurisdictions of the Departments, as well as their different underlying enforcement structures, the mechanisms for imposing the new penalty may vary slightly, as discussed below.

1. *Department of HHS*

Enforcement of Part A of Title XXVII of the PHS Act, including section 2715, is generally governed by PHS Act section 2723 and corresponding regulations at 45 C.F.R. 150.101 et seq. Under those provisions, a State has the discretion to enforce the provisions against health insurance issuers in the first instance, and the Secretary of HHS only enforces a provision after the Secretary determines that a State has failed to substantially enforce the provision. If a State enforces a provision such as PHS Act section 2715, it uses its own enforcement mechanisms. If the Secretary enforces, the statute provides for penalties of up to $100 per day for each affected individual.

PHS Act section 2715(f) provides that an entity that willfully fails to provide the information required under PHS Act section 2715 shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee constitutes a separate offense. This penalty can only be imposed by the Secretary.

Paragraph (e) of the regulations proposed by HHS clarifies that States have primary enforcement authority over health insurance issuers for any violations, whether willful or not, using their own remedies. These proposed regulations also clarify that PHS Act section 2715 does not limit the Secretary's authority to impose penalties for willful violations regardless of State enforcement. However, the Secretary intends to use enforcement discretion if the Secretary determines that the State is adequately addressing willful violations.

The Secretary of HHS has direct enforcement authority for violations by non-Federal governmental plans, and will use the appropriate penalty for violations of section 2715, depending on whether the violation is willful. Proposed paragraph (e) of the HHS regulations cross references the enforcement regulations at 45 CFR 150.101 *et seq*., and states that they relate to any failure, regardless of intent, by a health insurance issuer or non-Federal governmental plan, to comply with any requirement of section 2715 of the PHS Act.

2. *Departments of Labor and the Treasury*

The Department of Labor enforces the requirements of part 7 of ERISA and the Department of the Treasury enforces the requirements of chapter 100 of the Code with respect to group health plans maintained by an entity that is not a governmental entity. Generally the enforcement authority under these provisions applies to all nongovernmental group health plans, but the Department of Labor does not enforce the requirements of part 7 of ERISA with respect to church plans.

On April 21, 1999, pursuant to section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191, the Secretaries entered into a memorandum of understanding[29] that, among other things, established a mechanism for coordinating enforcement and avoiding duplication of effort for shared jurisdiction. The memorandum of understanding applies, as appropriate, to health legislation enacted after April 21, 1999 over which at least two of the Departments share jurisdiction, including section 2715 of the PHS Act as incorporated into ERISA and the Code. Therefore, in enforcing PHS Act section 2715, the Departments of Labor and the Treasury will coordinate to avoid duplication in the case of group health plans that are not church plans and that are not maintained by a governmental entity.

a. *Department of Labor*

The Department of Labor will issue separate regulations in the future describing the procedures for assessment of the civil fine provided under PHS Act section 2715(f) as incorporated by section 715 of ERISA. In accordance with ERISA 502(b)(3), 29 U.S.C. 1132(b)(3), the Secretary of Labor is not authorized to assess this fine against a health insurance issuer.

b. *Department of the Treasury*

If a group health plan (other than a plan maintained by a governmental entity) fails to comply with the requirements of chapter 100 of the Code, an excise tax is imposed under section 4980D of the Code. The excise tax is generally $100 per day per individual for each day that the plan fails to comply with chapter 100 with respect to that individual. Numerous rules under section 4980D reduce the amount of the excise tax for failures due to reasonable cause and not to willful neglect. Special rules apply for church plans. Taxpayers subject to the excise tax under section 4980D are required to report the failures under chapter 100 and the amount of the excise tax on IRS Form 8928. See 26 CFR 54.4980D–1, 54.6011–2, and 54.6151–1.

Section 2715(f) of the PHS Act subjects a plan sponsor or designated administrator to a fine of not more than $1,000 for each failure to provide an SBC. Unless and until future guidance provides otherwise, group health plans subject to chapter 100 of the Code should continue to report the excise tax of section 4980D on IRS Form 8928 with respect to failures to comply with PHS Act section 2715. The Secretaries of Labor and the Treasury will coordinate to determine appropriate cases in which the fine of section 2715(f) should be imposed on group health plans that are not maintained by a governmental entity.

F. *Applicability*

PHS Act section 2715 directs that the requirement for group health plans and health insurance issuers to provide an SBC "prior to any enrollment restriction" applies not later than 24 months after the date of enactment (*i.e.*, beginning on or

[29] *See* 64 FR 70164 (December 15, 1999).

after March 23, 2012).[30] As noted earlier, the statute also directs the Departments to consult with the NAIC in developing the SBC standards. The Departments are appreciative of the detailed and valuable work the NAIC and its working group has performed in developing recommended standards and materials, including the NAIC's extensive efforts to involve numerous stakeholder groups in that process for over a year and to provide drafts of its evolving materials to the Departments periodically. Accordingly, as noted, the Departments are appending to the document accompanying these proposed regulations the NAIC's SBC work product for public comment.

The NAIC transmitted its final materials to the Departments on July 29, 2011. In recognition of existing disclosure requirements under 29 CFR 2520.104b–2 for those group health plans that already provide SPDs to participants and concerns raised about providing SBCs by the statutory deadline, comments are solicited on whether and, if so, how practical considerations might affect the timing of implementation. In coordination with the request for comment elsewhere in this preamble on a potential phase-in of the implementation of the requirement to provide coverage examples, comments are invited also on how any potential phase-in of those requirements could or should be coordinated with the timing of the effectiveness of the general SBC standards.

The Departments also request comments on whether any special rules are necessary to accommodate expatriate plans. The Departments note that, in the context of group health plan coverage, section 4(b)(4) of ERISA provides that a plan maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens is exempt from ERISA title I, including ERISA section 715. At the same time, in the Department of HHS's interim final regulations relating to medical loss ratio (MLR) provisions published at 75 FR 74864, a special rule was included for expatriate insurance policies. The Departments invite comments on whether any adjustments are needed under PHS Act section 2715 for expatriate plans and, if so, for what types of coverage.

III. Economic Impact and Paperwork Burden

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a "significant regulatory action" under section 3(f) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As discussed below, the Departments have concluded that these proposed regulations would not have economic impacts of $100 million or more in any one year or otherwise meet the definition of an "economically significant rule" under Executive Order 12866. Nonetheless, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment of the potential benefits and the costs associated with this proposed regulation. The Departments invite comment on this assessment.

1. Current Regulatory Framework

Health plan sponsors and issuers do not currently uniformly disclose information to consumers about benefits and coverage in a simple and consistent way. ERISA-covered group health plan sponsors are required to describe important plan information concerning eligibility, benefits, and participant rights and responsibilities in a summary plan description (SPD). But as these documents have increased in size and complexity — for example, due to the insertion of more legalistic language that is designed to mitigate the employer's risk of litigation — they have become more difficult for participants and beneficiaries to understand.[31] Indeed, a recent analysis of SPDs from 40 employer health plans from across the United States (varying based on geography, firm size, and industry sector) found that, on average, SPDs are generally written at a first year college reading level (with readability ranging from 9th grade reading level to nearly a college graduate reading level).[32] Moreover, the formats of existing SPDs are not standardized; for example, while these documents could be dozens of pages long, there is no requirement that they include an executive summary. Additionally, group health plans not covered by ERISA, such as plans sponsored by State and local governments, are not required to comply with such disclosure requirements.

In the individual market, health insurance issuers are subject to various, diverse State disclosure laws. For example, States like Massachusetts,[33] New York,[34] Rhode Island,[35] Utah[36] and Vermont[37] have established minimum standards for disclosure of health insurance information but even within such States, consumer disclosures vary widely with respect to their re-

[30] Section 2715 is applicable to both grandfathered and non-grandfathered health plans. *See* 26 CFR 54.9815–1251(d), 29 CFR 2590.715–1251(d), and 45 CFR 147.120(d).

[31] ERISA Advisory Council. Report of the Working Group on health and Welfare Benefit Plans' Communication. November 2005. Available at: *http://www.dol.gov/ebsa/publications/AC_1105c_report.html*.

[32] "How Readable Are Summary Plan Descriptions For Health Care Plans?" Employee Benefit Research Institute (EBRI) Notes. October 2006, Vol. 27, No. 10. Available at: *http://www.ebri.org/pdf/notespdf/EBRI_Notes_10–20061.pdf*.

[33] M.G.L.A. 176Q § 5 (2010).

[34] NY Ins. Law § 3217–a (2010).

[35] Office of the Health Insurance Commissioner Regulation 5: Standards for Readability of Health Insurance Forms, State of Rhode Island and Providence Plantations, August 21, 2010.

[36] Utah Code § 31A–22–613.5 (2010).

[37] Division of Health Care Administration, Rule 10.000: Quality Assurance Standards and Consumer Protections for Managed care Plans, State of Vermont, September 20, 1997.

quired content. Additionally, some State disclosure laws are limited to current enrollees, so that individuals shopping for coverage do not receive information about health insurance coverage options. Other State disclosure requirements only extend to managed care organizations, and not to other segments of the market.[38]

2. Need for Regulatory Action

Congress added new PHS Act section 2715 through the Affordable Care Act to ensure that plans and issuers provide benefits and coverage information in a more uniform format that helps consumers to better understand their coverage and better compare coverage options. These proposed regulations are necessary to provide standards for a summary of benefits and coverage and a uniform glossary of terms used in health coverage. This approach is consistent with Executive Order 13563, which directs agencies to "identify and consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public. These approaches include [...] disclosure requirements as well as provision of information to the public in a form that is clear and intelligible."

The patchwork of consumer disclosure requirements makes the process of shopping for coverage an inefficient, difficult, and time-consuming task. Consumers incur significant search costs while trying to locate reliable cost, coverage and benefit data.[39] Such search costs arise, in part, due to a lack of uniform information across the various coverage options, particularly in the individual market but also in some large employer plans. Although not directly comparable, in Medigap, a market with standardized benefits, the average per beneficiary search cost was estimated at $72 —far higher than in other insurance markets, such as auto insurance.[40]

Given this difficulty in obtaining relevant information, consumers may not always make informed purchase decisions that best meet the health and financial needs of themselves, their families, or their employees. Similarly, workers may overestimate or underestimate the value of employer-sponsored health benefits, and thus their total compensation; and health insurance issuers and employers may face less pressure to compete on price, benefits, and quality, leading to inefficiency in the health insurance and labor markets.

Furthermore, research suggests that many consumers do not understand how health insurance works. Oftentimes, health insurance contracts and benefit descriptions are written in technical language that requires a sophisticated level of health insurance literacy many people do not have.[41] One study found that consumers have particular difficulty understanding cost sharing and tend to underestimate their coverage for mental health, substance abuse and prescription drug benefits, while overestimating their coverage for long-term care.[42]

3. Summary of Impacts

Table 1 below depicts an accounting statement summarizing the Departments' assessment of potential benefits, costs, and transfers associated with this regulatory action. The Departments have limited the period covered by the RIA to 2011–2013. Estimates are not provided for subsequent years, because there will be significant changes in the marketplace in 2014 related to the offering of new individual and small group plans through the Affordable Insurance Exchanges, and the wide-ranging scope of these changes makes it difficult to project results for 2014 and beyond.

The direct benefits of these proposed regulations come from improved information, which will enable consumers to better understand the coverage they have and allow consumers choosing coverage to more easily compare coverage options. As a result, consumers may make better coverage decisions, which more closely match their preferences with respect to benefit design, level of financial protection, and cost. The Departments believe that such improvements will result in a more efficient, competitive market. These proposed regulations would also benefit consumers by reducing the time they spend searching for and compiling health plan and coverage information.

Under the proposed regulations, group health plans and health insurance issuers would incur costs to compile and provide the summary of benefits and coverage disclosures (that includes coverage examples (CEs)) and a uniform glossary of health coverage and medical terms. The Departments estimate that the annualized cost may be around $50 million, although there is uncertainty arising from general data limitations and the degree to which economies of scale exist for disclosing this information. The costs estimates employ assumptions that we believe fully capture expected issuer and third-party administrator (TPA) costs, and perhaps overestimate them if, for example, economies of scale are achievable.

The Departments anticipate that the provisions of these proposed regulations will help consumers make better health coverage choices and more easily understand their coverage. In accordance with Executive Orders 12866 and 13563, the Departments believe that the benefits of this regulatory action justify the costs.

[38] For example, New York requires Health Maintenance Organizations to provide to prospective members, as well as policyholders, information on cost-sharing, including out-of-network costs, limitations and exclusions on benefits, prior authorization requirements, and other disclosures such as appeal rights. NY Ins. Law § 3217–a (2010). Utah requires each insurer issuing a health benefit plan to provide all enrollees, prior to enrollment in the health benefit plan, written disclosure of restrictions or limitations on prescription drugs and biologics, coverage limits under the plan, and any limitation or exclusion of coverage. Utah Code § 31A–22–613.5 (2010). Rhode Island requires all health insurance forms to meet minimum readability standards. Office of the Health Insurance Commissioner Regulation 5: Standards for Readability of Health Insurance Forms, State of Rhode Island and Providence Plantations, August 21, 2010.

[39] M. Susan Marquis et al., "Consumer Decision Making in the Individual Health Insurance Market," 25 Health Affairs w.226, w.231-w.232 (May 2006). Available at: *http://content.healthaffairs.org/content/25/3/w226.full.pdf+html*.

[40] Nicole Maestas et al., "Price Variation in Markets with Homogenous Goods: The Case of Medigap," National Bureau of Economic Research (January 2009).

[41] For example, as discussed earlier, the average Summary Plan Description is written at a first-year college reading level. See Employee Benefit Research Institute, October 2006.

[42] D.W. Garnick, A.M. Hendricks, K.E. Thorpe, J.P. Newhouse, K. Donelan and R.J. Blendon. "How well do Americans understand their health coverage?" Health Affairs, 12(3). 1993:204–12. Available at: *http://content.healthaffairs.org/content/12/3/204.full.pdf*.

Table 1. Accounting Table

Benefits:				
Qualitative: Improved information will enable consumers to more easily and efficiently understand and compare coverage, and as a result, make better choices.				
Costs:	Estimate	Year Dollar	Discount Rate Percent	Period Covered
Annualized Monetized ($ millions/year)	$51	2011	7	2011–2013
	$47	2011	3	2011–2013

4. Benefits

In developing these proposed regulations, the Departments carefully considered their potential effects, including costs, benefits, and transfers. Because of data limitations, the Departments did not attempt to quantify expected benefits of these proposed regulations. Nonetheless, the Departments were able to identify several benefits, which are discussed below.

These proposed regulations could generate significant economic and social welfare benefits to consumers. Under these proposed regulations, health insurance issuers and group health plans would provide clear and consistent information to consumers. Uniform disclosure is anticipated to benefit individuals shopping for, or enrolled in, group and individual health insurance coverage and group health plans. The direct benefits of these proposed regulations come from improved information, which will enable consumers to better understand the coverage they have and allow consumers choosing coverage to more easily compare options. As a result, consumers will make better coverage decisions, which more closely match their preferences with respect to benefit design, level of financial protection, and cost. The Departments believe that such improvements will result in a more efficient, competitive market.

These proposed regulations would also benefit consumers by reducing the time they spend searching for and compiling health plan and coverage information. As stated above, consumers in the individual market, as well as consumers in some large employer-sponsored plans, have a number of coverage options and must make a choice using disclosures and tools that vary widely in content and format. A growing body of decision-making research suggests that the abundance and complexity of information can overwhelm consumers and create a significant non-price barrier to coverage.[43] For example, a RAND study of California's individual market found that reducing barriers to information about health insurance products would lead to increases in purchase rates comparable to modest price subsidies.[44] By ensuring consumers have access to readily available, concise, and understandable information about their coverage options, these proposed regulations could reduce consumers' cost of obtaining information and may increase health insurance purchase rates.

Furthermore, greater transparency in pricing and benefits information will allow consumers to make more informed purchasing decisions, resulting in cost-savings for some value-conscious consumers who today pay higher premiums because of imperfect information about benefits.[45] In particular, the use of coverage examples[46] called for by these proposed regulations would better enable consumers to understand how key coverage provisions operate in the context of recognizable health care situations and more meaningfully compare the level of financial protection offered by a plan or coverage, resulting in potential cost-savings.[47,48] The Departments therefore expect that uniform disclosures under these proposed regulations would enable consumers to derive more value from their health coverage and enhance the ability of plan sponsors, particularly small businesses, to purchase products that are appropriate to both their needs and the health and financial needs of their employees.

Finally, these proposed regulations are expected to facilitate consumers' ability to understand their coverage. As stated above, research suggests that consumers do not understand how coverage works or the terminology used in health insurance policies. Consequently, consumers may face unexpected medical expenses if they become seriously ill. They may also become confused by a coverage or payment decision made by their plan or issuer, leading to inefficiency in the operation of em-

[43] Judith H. Hibbard and Ellen Peters, "Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches that Facilitate the Use of Information in Choice," 24 *Annu. Rev. Public Health* 413, 416 (2003).

[44] M. Susan Marquis et al., "Consumer Decision Making in the Individual Health Insurance Market," 25 Health Affairs w.226, w.231-w.232 (May 2006). Available at: *http://content.healthaffairs.org/content/25/3/w226.full.pdf+html*.

[45] A study of California's individual market found that 25 percent of consumers chose products with premiums that were more than 30 percent higher than the median price for an actuarially equivalent product for a similar person. Melinda Beeuwkes Buntin *et al.*,"Trends and Variability In Individual Insurance Products," Health Affairs w3.449, w3.457 (2003), available at *http://content.healthaffairs.org/content/early/2003/09/24/hlthaff.w3.449.citation*.

[46] The NAIC recommends that the term "coverage examples" be used as reference to the statutory term "coverage facts labels," and the Departments concur with this recommendation.

[47] Shoshanna Sofaer *et al.*, "Helping Medicare Beneficiaries Choose Health Insurance: The Illness Episode Approach," 30 The Gerontologist 308–315 (1990).

[48] Michael Schoenbaum *et al.*, "Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis," 38 *Inquiry* 35–48 (Spring 2001).

ployee benefit plans and health insurance coverage. By making it easier for consumers to understand the key features of their coverage, these proposed regulations would enhance consumers' ability to use their coverage. Additionally, the uniform format will make it easier for consumers who change jobs or insurance coverage to see how their new plan or coverage benefits are similar to and different from their previous coverage.

5. Costs

Section 2715 of the PHS Act and these proposed regulations direct group health plans and health insurance issuers to compile and provide a summary of benefits and coverage (SBC) (that includes coverage examples (CEs)) and a uniform glossary of health coverage and medical terms. The Departments have attempted to quantify one-time start-up costs as well as maintenance costs. However, there is uncertainty arising from general data limitations and the degree to which economies of scale can be realized to reduce costs for issuers and TPAs. The costs estimates employ assumptions that we believe more than fully capture expected issuer and third-party administrator costs, and perhaps overestimate them if, for example, economies of scale are achievable. On the basis of such assumptions, the Departments estimate that issuers and TPAs will incur approximately $25 million in costs in 2011, $73 million in costs in 2012, and $58 million in costs in 2013. These costs and the methodology used to estimate them are discussed below, and presented in Tables 2–5 below.

General Assumptions

In order to assess the potential administrative costs relating to these proposed regulations, the Departments consulted with industry experts to gain insight into the tasks and level of resources required. Based on these discussions, the Departments estimate that there will be two categories of principal costs associated with the standards in these proposed regulations: one-time start-up costs and maintenance costs. The one-time start-up costs include costs to develop teams to review the new standards and costs to implement workflow and process changes, particularly the development of information technology (IT) systems interfaces that would generate SBC disclosures through data housed in a number of different systems. The maintenance costs include costs to maintain and update IT systems in compliance with the proposed standards; to produce, review, distribute, and update the SBC disclosures;[49] to produce and distribute notices of modifications, and to provide the glossary in paper form upon request.

With respect to the individual market, issuers are responsible for generating, reviewing, updating, and distributing SBCs. With respect to employer-sponsored coverage, the Departments assume fully-insured plans will rely on health insurance issuers, and self-insured plans will rely on TPAs, to perform these functions. While plans may prepare the SBC disclosures internally, the Departments make this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties such as enrollment and claims processing.[50] Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the purposes of estimating administrative costs.

As discussed in the Medical Loss Ratio (MLR) interim final rule (75 FR 74918), the Departments estimate there are about 440 firms offering comprehensive coverage in the individual, small, or large group markets, and 75 million covered lives therein.[51] The number of covered lives includes individuals in the individual market as well as those in insured group health plans.

With respect to the self-insured market, the Departments estimate there are 77 million individuals in self-insured ERISA-covered plans and approximately 14 million individuals in self-insured non-Federal governmental plans.[52] The Departments note that, according to 2007 Economic Census data, there are 2,243 TPAs providing administrative services for health and/or welfare funds. However, there is some uncertainty as to whether all of those TPAs serve self-insured plans; many issuers, for example, have subsidiary lines of business through administrative services only (ASO) contracts through which they perform third-party administrative functions for self-insured plans.[53] Based on conversations with one national TPA association, the Departments assume that about one-third of the total number of TPAs, or about 748 TPAs, are relevant for purposes of this analysis. However, given the considerable overlap between issuers and TPAs, the Departments recognize there may be fewer affected TPAs, so these estimates should be considered an upper bound of burden estimates. These estimates may be adjusted proportionally in the final regulations based upon additional information about the number of TPAs serving self-insured plans.

Because the SBC disclosures are closely related to disclosures that issuers and TPAs provide today as a part of their normal operations (*e.g.*, information on premiums, covered benefits, and cost sharing), the incremental costs of compiling and providing such readily available information in the proposed, standardized format is estimated to be modest.[54] The per-issuer or -TPA cost will largely be determined by its size (based on annual premium revenues) and current practices-most importantly, whether the issuer

[49] Plans and issuers subject to ERISA or the Code may provide SBCs electronically only if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b–1 are met. Otherwise, by default, plans and issuers must use paper versions of SBCs.

[50] See, for example, the Department of Labor's March 2011 report to Congress on self-insured health plans, available at *http://www.dol.gov/ebsa/pdf/ACAReportToCongress032811.pdf*.

[51] The NAIC data actually indicate 442 issuers and 74,830,101 covered lives. But the Departments have limited these values to only two significant figures given general data uncertainty. For example, the NAIC data do not include issuers regulated by California's Department of Managed Health Care (DMHC) as well as small, single-State issuers that are not required by State regulators to submit NAIC annual financial statements.

[52] U.S. Department of Labor, EBSA calculations using the March 2009 Current Population Survey Annual Social and Economic Supplement and the 2009 Medical Expenditure Panel Survey; see also interim final rule for internal claims and appeals and external review processes (75 FR 43330, 43345).

[53] See, for example, the Department of Labor's March 2011 report to Congress on self-insured health plans, available at *http://www.dol.gov/ebsa/pdf/ACAReportToCongress032811.pdf*.

[54] For example, issuers in the individual and small group markets already report some of the SBC information to HHS for display in the plan finder on the HealthCare.gov website. Issuers have been reporting data to HHS since May 2010 and have refreshed that data on a quarterly basis. These reporting entities have demonstrated that they have the capacity to report information on plan benefit design. See *http://finder.healthcare.gov/*. Further, ERISA-covered plans already report some of the SBC information in summary plan descriptions (SPDs).

or TPA maintains a robust information technology infrastructure, including a plan benefits design database. Moreover, with regard to issuers, administrative costs may be related to the number of markets in which it operates (that is, individual, small group, or large group market); the number of policies it offers; and the number of States and licensed entities through which it offers coverage.

To account for variations among issuers, the Departments classify them by size as small, medium, and large issuers based on 2009 premium revenue for individual, small group, and large group comprehensive coverage.[55] Consistent with the assumptions that were used in the MLR interim final rule, small issuers are defined as those earning up to $50 million in annual premium revenue; medium issuers as those earning between $50 million and $1 billion in annual premium revenue; and large issuers as those earning more than $1 billion in annual premium revenue. Based on these assumptions, the Departments estimate there are 140 small, 230 medium, and 70 large issuers.

To account for variations among TPAs, the Departments applied the proportions of small, medium, and large issuers to the estimated 750 TPAs. The Departments acknowledge that issuers and TPAs are different and may not have the same size variation. Nonetheless, given general data limitations, the Departments have adopted this methodology, and, on its basis, estimate that there are 240 small, 390 medium, and 120 large TPAs. Table 2 below provides a synopsis of the number of issuers and TPAs.

Table 2. Issuer and TPA size classification

	Small	Medium	Large
Issuers	140	230	70
TPAs	240	390	120

Staffing Assumptions

Table 6 below summarizes the Departments' staffing assumptions, including the estimated number of hours for each task for a small, medium, or large issuer/TPA as well as the percentage of time that different professionals devote to each task. The following assumptions are based on the best information available to the Departments at this time. Particularly, the following series of assumptions are based on conversations with industry experts, the Departments' understanding of the regulated community, and previous analysis in the MLR interim final rule. We welcome comments that provide better information or data about any of the following assumptions.

IT Systems and Workflow Process Changes

The Departments estimate that it would take a large issuer/TPA about 960 hours to implement IT systems and workflow process changes, based on discussions with a large issuer. The Departments assume that these IT systems and workflow process changes would be implemented only by IT professionals. Furthermore, the Departments assume that a medium issuer/TPA would need about 75% of large issuer's/TPA's time, and a small issuer would need about 50% of a large issuer's/TPA's time, to implement IT systems and workflow process changes.

The Departments estimate that it would take a large issuer/TPA about 160 hours to develop teams to analyze the new standards in relation to their current workflow processes. The Departments assume such teams would be comprised of IT professionals (45%), benefits/sales professionals (50%), and attorneys (5%). We scale down the burden for medium and small issuers/TPAs by assuming the same relative proportion as above (that is, 75 percent and 50 percent, respectively).

The Departments assume that each issuer/TPA would incur a maintenance cost to maintain IT systems and address changes in regulatory requirements. The Departments assume the maintenance cost would equal 15% of the total one-time burden noted above (for example, the Departments assume it will take a large issuer 15% of 1120 hours, or 168 hours). The Departments further assume that the teams to implement the maintenance tasks would be comprised of IT professionals (55%), benefits/sales professionals (40%), and attorneys (5%).

The Departments assume that the one-time and maintenance costs to implement IT systems changes and to address these regulations would be split between the costs to produce SBCs (50%) and the costs to produce the CEs (50%).

Production and Review of SBCs and CEs

The Departments estimate that each issuer/TPA would need 3 hours to produce, and 1 hour to review, SBCs (not including CEs) for all products. The Departments assume that the 3 hours needed to produce the SBCs would be equally divided between IT professionals and benefits/sales professionals. The Departments assume that the 1 hour needed to review the SBCs would be equally divided between financial managers for benefits/sales professionals and attorneys.

In 2012 and 2013, issuers and TPAs would produce CEs for three benefits scenarios. The Departments estimate it will take each issuer/TPA 90 hours to produce, and 30 hours to review, CEs for all applicable products. The Departments assume that the 90 hours to produce the CEs would be equally divided between IT professionals and benefits/sales professionals. The Departments also assume that the 30 hours to review the CEs would be equally divided between financial managers for benefits/sales professionals and attorneys.

The Departments assume that in 2012 and 2013, respectively, issuers and TPAs

[55] The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business.

would provide, upon request, a paper copy of the uniform glossary to 2.5% and 5% of covered individuals who receive a glossary. The Departments assume that individuals who do not request a paper copy of the glossary will access it electronically using the Internet address provided in the SBC.

For each individual who receives the SBC or uniform glossary in paper form, the Departments estimate that printing and distributing the paper disclosures would take clerical staff about 1 minute (0.02 hours) in the group markets and about 2 minutes (0.03 hours) in the individual market. The Departments assume that the individual market has lower economies of scale and, thus, increased distribution costs.

Labor Cost Assumptions

Table 7 below presents the Departments' hourly labor cost assumptions (stated in 2011 dollars) for each staff category based on BLS data. The Departments use mean hourly wage estimates from the Bureau of Labor Statistics' (BLS) May 2009 National Occupational Employment and Wage Estimates (accessed at *http://www.bls.gov/oes/current/oes_nat.htm#00–0000*) for computer systems analysts (Occupation Code 15–1051), insurance underwriters (Occupation Code 13–2053), financial managers (Occupation Code 23–1011), executive secretaries and administrative assistants (Occupation Code 43–6011), and attorneys (Occupation Code 23–1011) as the basis for estimating labor costs for 2011 through 2013 and adjust the hourly wage rate to include a 33% fringe benefit estimate for private sector employees.[56]

Distribution Assumptions

The Departments make the following assumptions regarding the distribution of the SBC disclosures (including CEs).[57] These assumptions are based on the best information available to the Departments at this time. Particularly, the following series of assumptions are based on conversations with industry experts, the Departments' understanding of the regulated community, and previous analysis in the MLR interim final rule. The distribution assumptions are as follows:

- The SBCs would be limited to one per household for family members located at the same residence. According to one large issuer, there are 2.2 covered lives per family.

- The number of individuals who would receive an SBC before enrolling in the plan or coverage equals 20% of the number of enrollees at any point during the course of a year.[58]

- In 2013, about 2% of covered individuals would receive a notice of modifications.[59] Further, the burden and cost of providing such notices would be proportional to the combined burden and cost of providing the SBCs, including CEs. In 2012, the first year of implementation, the number of notices of modifications would be negligible.

- Electronic distribution will account for 38 percent of all disclosures in the group market and 70 percent of all disclosures in the individual market. The estimate for the group market is based on the methodology used to analyze the cost burden for the DOL claims procedure regulation (OMB Control Number 1210–0053).[60] The estimate for the individual market is based on statistics set forth by the National Telecommunications and Information Administration, which indicate that 30% of Americans do not use the Internet.[61]

- SBC disclosures would be distributed with usual marketing and enrollment materials, thus, costs to mail the documents will be negligible. However, notices of modifications would require mailing and supply costs as follows: $0.44 postage cost per mailing and $0.05 supply cost per mailing.

- Printing costs $0.03 cents per side of a page. Thus, it would cost $0.18 to print a complete SBC (which is six sides of a page based on the length of the NAIC sample completed SBC) and $0.12 cents to print the uniform glossary (which is four sides of a page, based on the length of the NAIC recommended uniform glossary). This cost burden is in addition to the 1 minute or 2 minutes it would take clerical staff to print and distribute the SBC or glossary.

Cost Estimate

The Tables below present costs and burden hours for issuers and TPAs associated the proposed disclosure requirements of PHS Act section 2715. Tables 3–5 contain cost estimates for 2011, 2012, and 2013, derived from the labor hours presented in Table 3 and the hourly rate estimates presented in Table 7, as well as estimates of non-labor costs. Labor hour estimates were developed for each one-time and maintenance task associated with analyzing requirements, developing IT systems, and producing SBCs (that include CEs).

[56] See the Technical Appendix to the MLR interim final rule, available at *http://cciio.cms.gov*.

[57] Although CEs are an integral component of SBCs, the costs associated with CEs are different from the rest of the SBC, and, thus, are separately calculated within this analysis.

[58] Based on this assumption, the Departments estimated that small issuers or TPAs have about 180,000 shoppers in a given year, medium issuers or TPAs have 3,700,000 shoppers in a given year, and large issuers or TPAs have 11,000,000 shoppers in a given year.

[59] ERISA section 104(b) requires ERISA-covered plans to furnish participants and beneficiaries with a Summary of Material Modifications (SMM) no later than 210 days after the end of the plan year in which the material change was adopted. As part of its analysis for the Department of Labor's SPD/SMM regulations (29 CFR 2520.104b–(3)), the Department estimated that about 20 percent of health plans would need to distribute SMM in a given year due to plan amendments. However, almost all of these modification occur between plan years — not during a plan year; therefore, the modifications would be required to be disclosed in a SBC that is distributed upon renewal of coverage. The Departments, thus, expects that only two percent of plans will need to issue an updated SBC mid-year, because mid-year changes that would result in an update to the SBC are very rare. For purposes of simplification, the Departments extend this assumption to the individual market as well.

[60] See the ERISA e-disclosure rule at 29 CFR 2520.104b–1.

[61] U.S. Department of Commerce, National Telecommunications and Information Administration, Digital Nation (February 2010), available at *http://www.ntia.doc.gov/reports/2010/NTIA_internet_use_report_Feb2010.pdf*.

TABLE 3. 2011 Hour Burden, Equivalent Cost, and Cost Burden — 2011 Dollars

	Number of Affected Entities	Hour Burden	Equivalent Cost
SBC Requirements — Issuers — One Time	440	88,000	$4,600,000
SBC Requirements — TPAs — One-Time	750	150,000	$7,800,000
Coverage Example Requirements — Issuers — One Time	440	88,000	$4,600,000
Coverage Example Requirements — TPAs — One-Time	750	150,000	$7,800,000
Total		**240,000**	**$25,000,000**

TABLE 4. 2012 Hour Burden, Equivalent Cost, and Cost Burden — 2011 Dollars

	Number of Affected Entities	Hour Burden	Equivalent Cost	Cost Burden (non-labor)	Number of Disclosures
SBC Requirements — Issuers	440	540,000	$18,000,000	$2,900,000	41,000,000
SBC Requirements — TPAs	750	660,000	$23,000,000	$3,700,000	49,000,000
Coverage Example Requirements — Issuers	440	140,000	$7,600,000	$1,500,000	41,000,000
Coverage Example Requirements — TPAs	750	240,000	$13,000,000	$1,800,000	49,000,000
Glossary Requests — Issuers	440	11,000	$330,000	$370,000	610,000
Glossary Requests — TPAs	750	13,000	$370,000	$470,000	770,000
Subtotal		1,600,000	$62,000,000	$11,000,000	91,000,000
Total 2012 Costs			**$73,000,000**		

TABLE 5. 2013 Hour Burden, Equivalent Cost, and Cost Burden — 2011 Dollars

	Number of Affected Entities	Hour Burden	Equivalent Cost	Cost Burden (non-labor)	Number of Disclosures
SBC Requirements — Issuers	440	480,000	$15,000,000	$2,900,000	41,000,000
SBC Requirements — TPAs	750	560,000	$17,000,000	$3,700,000	49,000,000
Coverage Example Requirements — Issuers	440	79,000	$4,300,000	$1,500,000	41,000,000
Coverage Example Requirements — TPAs	750	130,000	$7,200,000	$1,800,000	49,000,000
Notice of Material Modifications — Issuers	440	10,000	$320,000	$330,000	820,000
Notice of Material Modifications — TPAs	750	12,000	$400,000	$400,000	1,000,000
Glossary Requests — Issuers	440	23,000	$660,000	$700,000	1,200,000
Glossary Requests — TPAs	750	26,000	$750,000	$900,000	1,500,000
Subtotal		1,300,000	$46,000,000	$12,000,000	95,000,000
Total 2013 Costs			**$58,000,000**		

TABLE 6. Estimated Staffing Hours for Small, Medium, and Large Issuers and TPAs

	Percent of Hours by Task	Hours		
STAFFING HOUR ASSUMPTIONS		**Small Issuer/ TPA**	**Medium Issuer/ TPA**	**Large Issuer/ TPA**
IT Development and Workflow Process Change				
One-Time				
Develop Teams / Analyze Requirements (IT, underwriting / sales)		**80**	**120**	**160**
IT Professionals	45%	36	54	72
Benefits / Sales				
Professionals	50%	40	60	80
Attorneys	5%	4	6	8
Implementing Systems Changes (IT and workflow)		**480**	**720**	**960**
IT Professionals	100%	480	720	960

Maintenance				
Updating to Address Changes in Requirements		**84**	**126**	**168**
IT Professionals	55%	46.20	69.30	92.40
Benefits / Sales Professionals	40%	33.60	50.40	67.20
Attorneys	5%	4.20	6.30	8.40
SBC Requirement (maintenance)				
Producing SBCs		**3**	**3**	**3**
IT Professionals	50%	1.5	1.5	1.5
Benefits / Sales Professionals	50%	1.5	1.5	1.5
Internal Review of SBCs		**1**	**1**	**1**
Financial Managers — Benefits / Sales Professionals	50%	0.5	0.5	0.5
Attorneys	50%	0.5	0.5	0.5
Producing and Distributing Paper Version of SBCs (Group Markets)				
Clerical Staff	100%	0.02	0.02	0.02
Producing and Distributing Paper Version of SBCs (Individual Market)				
Clerical Staff	100%	0.03	0.03	0.02
CE Requirement (maintenance)				
Producing 3 CEs		**90**	**90**	**90**
IT Professionals	50%	45	45	45
Benefits / Sales Professionals	50%	45	45	45

Internal Review of 3 CEs		**30**	**30**	**30**
Financial Managers — Benefits / Sales				
Professionals	50%	15	15	15
Attorneys	50%	15	15	15

TABLE 7. Estimated Loaded Hourly Wages for Staff Categories

Staff Category	BLS Code	Loaded Hourly Wage (2011 Dollars)
IT Professionals	Computer Systems Analysts (Occupation Code 15–1051)	$53.26
Financial Professionals — Benefits / Sales	Insurance Underwriters (Occupation Code 13–2053)	$41.94
Financial Manager	Financial Managers (Occupation Code 11–3031)	$75.32
Attorneys	Lawyers (Occupation Code 23–1011)	$85.44
Clerical Staff	Executive Secretaries and Administrative Assistants (Occupation Code 43–6011)	$29.15

6. Regulatory Alternatives

Several provisions in these proposed regulations involved policy choices. A first policy choice involved determining how to minimize the burden of providing the SBC to individuals and employers shopping for health insurance coverage. The Departments recognize it may be difficult for issuers to provide accurate information about the terms of coverage prior to underwriting. Accordingly, the proposed regulations provide that issuers offering health insurance coverage in connection with the individual market that make information for their standard policies available on the Secretary of HHS's Web portal (HealthCare.gov), in compliance with 45 CFR 159.120, will have satisfied the requirement to provide an SBC to individuals who request information about coverage. The Departments believe this approach promotes regulatory efficiency, minimizing the administrative burden on health insurance issuers without lessening the protections under PHS Act section 2715.

A second choice related to whether, in the case of covered individuals residing at the same address, one SBC would satisfy the disclosure requirement with respect to all such individuals, or whether multiple SBCs would be required to be provided. Under the proposed regulations, the Departments allow a plan or issuer to provide a single SBC in circumstances in which a participant and any beneficiaries (or, in the individual market, the primary subscriber and any covered dependents) are known to reside at the same address.

In the group market, the proposed regulations would further limit burden by requiring a plan or issuer to provide, at renewal, a new SBC for only the benefit package in which a participant or beneficiary is enrolled. That is, if the plan offers multiple benefits packages, an SBC is not required for each benefit package offered under the group health plan, which the Departments believe would otherwise create an undue burden during open season. Participants and beneficiaries would be able to receive upon request an SBC for any benefits package for which they are eligible. The Departments believe this balanced approach addresses the needs of plans, issuers, and consumers, at renewal.

A third policy choice related to the interpretation of the PHS Act section 2715(d)(4), which requires notice of any material modification (as defined for purposes of section 102 of ERISA) in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC. The Departments note that a material modification, within the meaning of section 102 of ERISA and its implementing regulations at 29 CFR 2520.104b–3, is broadly defined to include any modification to the coverage offered under the plan or policy, that independently, or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage under the plan or policy. The proposed regulations would interpret this provision as requiring notice only for a material modification that (1) affects the information in the SBC; and (2) occurs other than in connection with

renewal or reissuance of coverage (that is, a mid-plan or -policy year change). This approach is consistent with the language of section 2715(d)(4) and is more narrowly focused on what we interpret to be the purpose of that provision.

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

The Regulatory Flexibility Act (RFA) requires agencies that issue a regulation to analyze options for regulatory relief of small businesses if a proposed rule has a significant impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of ''small entity.'') The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis, HHS determined that there were few if any insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for ''small'' business established by the SBA. Currently, the SBA size threshold is $7 million in annual receipts for both health insurers (North American Industry Classification System, or NAICS, Code 524114) and TPAs (NAICS Code 524292).

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), HHS used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, HHS used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. HHS estimated that there were 28 small entities with less than $7 million in A&H earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business. These 28 small entities represent about 6.4 percent of the approximately 440 health insurers that are accounted for in this RIA. Based on this calculation, the Departments assume that there are an equal percentage of TPAs that are small entities. That is, 48 small entities represent about 6.4 percent of the approximately 750 TPAs that are accounted for in this RIA.

The Departments estimate that issuers and TPAs earning less than $50 million in annual premium revenue, including the 76 small entities mentioned above, would incur costs of approximately $15,000, $26,000, and $15,000 per issuer/TPA in 2011, 2012 and 2013, respectively. Numbers of this magnitude do not approach the amounts necessary to be considered a "significant economic impact" on firms with revenues in the order of millions of dollars. Additionally, as discussed earlier, the Departments believe that these estimates overstate the number of small entities that will be affected by the requirements in this proposed regulation, as well as the relative impact of these requirements on these entities, because the Departments have based their analysis on the affected entities' total A&H earned premiums (rather than their total annual receipts). Accordingly, the Departments have determined and certify that these proposed rules will not have a significant economic impact on a substantial number of small entities, and that a regulatory flexibility analysis is not required.

C. Special Analyses—Department of the Treasury

For purposes of the 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 has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these proposed regulations. It is hereby certified that the collections of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Section 54.9815–2715 of the proposed regulations would require both group health insurance issuers and group health plans to distribute an SBC and notice of any material modifications to the plan that affect the information required in the SBC. Under these proposed regulations, if a health insurance issuer satisfies the obligations to distribute an SBC and a notice of modifications, those obligations are satisfied not just for the issuer but also for the group health plan. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will satisfy these obligations for both the plan and the issuer in almost all cases. For this reason, these information collection requirements will not impose a significant impact on a substantial number of small entities. Pursuant to section 7805(f) of the Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

D. Unfunded Mandates Reform Act—Department of Labor and Department of Health and Human Services

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 states that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a Federal mandate that could result in expenditure in any one year by State, local or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars updated annually for inflation. In 2011, that threshold level is approximately $136 million. These proposed regulations include no mandates on State, local, or Tribal governments. These proposed regulations include directions to produce standardized consumer disclosures that will affect private sector firms (for example, health insurance issuers of-

fering coverage in the individual and group markets, and third-party administrators providing administrative services to group health plans), but we tentatively conclude that these costs will not exceed the $136 million threshold. Thus, we tentatively conclude that these proposed regulations do not impose an unfunded mandate on State, local or Tribal governments or the private sector. Regardless, consistent with policy embodied in UMRA, this notice of proposed rulemaking has been designed to be the least burdensome alternative for State, local and Tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

Section 2715 of the PHS Act directs the Departments, in consultation with the National Association of Insurance Commissioners (NAIC) and a working group comprised of stakeholders, to "develop standards for use by a group health plan and a health insurance issuer in compiling and providing to applicants, enrollees, and policyholders and certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage." Plans and issuers are required to begin providing the disclosure (herein referred to as a "summary of benefits and coverage" or SBC) no later than March 23, 2012.

To implement this provision, collection of information requirements relate to the provision of the following:

- Summary of benefits and coverage.
- Coverage examples (as components of each SBC).
- A uniform glossary of health coverage and medical terms (uniform glossary).
- Notice of modifications.

In developing these collections of information, the Departments have incorporated the documents recommended by the NAIC, including the SBC template (with instructions, samples and a guide for coverage examples calculations to be used in completing the template) and the uniform glossary. These collection instruments were developed over a period of several months and agreed to by the entire NAIC working group and recommended to the Departments by the NAIC.

Currently, the Departments are soliciting public comments for 60 days concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

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

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395–5806 or by e-mail to *oira_submission@omb.eop.gov.* A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–4745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at *reginfo.gov* (*http://www.reginfo.gov/public/do/PRAMain).*

The Departments estimate 858 respondents each year from 2011–2013. This estimate reflects approximately 220 issuers offering comprehensive major medical coverage in the small and large group markets, and approximately 638 third-party administrators (TPAs).[62]

To account for variation in firm size, the Departments estimate a weighted burden on the basis of issuer's 2009 total earned premiums for comprehensive major medical coverage.[63] The Departments define small issuers as those with total earned premiums less than $50 million; medium issuers as those with total earned premiums between $50 million and $999 million; and large issuers as those with total earned premiums of $1 billion or more. Accordingly, the Departments estimate approximately 70 small, 115 medium, and 35 large issuers. Similarly, the Departments estimate approximately 204 small, 332 medium, and 102 large TPAs.

2011 Burden Estimate

While the disclosures in these proposed regulations are not required until March 2012, the Departments estimate a one-time administrative cost of about $36,000,000 across the industry and a total of about 680,000 burden hours to prepare for the provisions of these proposed regulations. This calculation is made assuming issuers and TPAs will need to implement two principal tasks: (1) develop teams to analyze current workflow processes against the new rules and (2) make appropriate changes to IT systems and processes.

With respect to task (1), the Departments estimate about 97,000 burden hours and an equivalent cost of about $4,800,000. The Departments calculate these estimates as follows:[64]

[62] The Departments estimate that there are 440 issuers and 750 TPAs. Because the Department of Labor and the Department of the Treasury share the hour and cost burden for issuers and TPAs with the Department of Health and Human Services, the burden to produce the SBCs including Coverage Examples for group health plans is calculated using half the number of issuers (220) and 85% of the TPAs (638). While the group health plans could prepare their own SBCs including coverage examples, the Departments assume that SBCs including coverage examples would be prepared by service providers, *i.e.*, issuers and TPAs.

[63] The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business

[64] For the purposes of these and other estimates in this section III.E, the Departments again use the assumptions outlined above in section III.A.5.

Task 1: Analyze current workflow and new rules

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	36	$1,900	54	$2,900	72	$3,800
Benefits/Sales Professionals	$41.94	40	$1,700	60	$2,500	80	$3,400
Attorneys	$85.44	4	$340	6	$510	8	$680
Total per issuer/TPA		80	$3,900	120	$5,900	160	$7,900
Total for all issuers/TPAs		22,000	$1,100,000	53,000	$2,600,000	22,000	$1,100,000

With respect to task (2), the Departments estimate about 580,000 burden hours and an equivalent cost of about $31,000,000. The Departments calculate these estimates as follows:

Task 2: IT Changes

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	480	$26,000	720	$38,000	960	$51,000
Total per issuer/TPA		480	$26,000	720	$38,000	960	$51,000
Total for all issuers/TPAs		130,000	$7,100,000	320,000	$17,000,000	130,000	$7,000,000

The Departments assume the total one-time administrative burden will be divided equally between 2011 and 2012. Thus, in 2011, the Departments estimate a one-time administrative cost of about $18,000,000 across the industry and about 340,000 hours. The Departments assume issuers and TPAs will incur no other costs in 2011 related to the proposed collection of information.

2012 Burden Estimate

The estimate hour and cost burden for the collections of information in 2012 are as follows:

- The Departments estimate that there will be about 77,000,000 SBC responses.
- The Departments assume that of the total number of SBC responses, 38% would be sent electronically in the small and large group markets. Accordingly, the Departments estimate that about 29,000,000 SBCs would be electronically distributed, and about 48,000,000 SBCs would be distributed in paper form. The Departments assume there are no costs associated with electronic disclosures; there are costs only with regard to paper disclosures.

Summary of Benefits and Coverage (not including coverage examples) — The estimated hour burden is about 820,000 hours, and the estimated total cost is about $30,000,000. The Departments calculate these estimates as follows:

Task 1: Equivalent Costs for Producing SBCs

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	1.5	$80	1.5	$80	1.5	$80
Benefits/Sales Professionals	$41.94	1.5	$63	1.5	$63	1.5	$63
Financial Managers	$75.32	0.5	$38	0.5	$38	0.5	$38
Attorneys	$85.44	0.5	$43	0.5	$43	0.5	$43
Total per issuer/TPA		4	$220	4	$220	4	$220
Total for all issuers/TPAs		1100	$61,000	1800	$100,000	550	$31,000

Task 2: Equivalent Costs for Distributing SBCs

	Hourly Wage Rate	Hours per SBC	Total Number of SBCs	Total Hours	Total Equivalent Cost
Clerical Staff	$29.15	0.017	48,000,000	820,000	$24,000,000

Task 1: Cost Burden for Printing SBCs

	Cost per SBC	Total SBCs	Total Cost Burden
Printing Costs	$0.12	48,000,000	$5,800,0000

Task 2: Coverage Examples — The estimated hour burden is about 100,000 hours, and the estimated total cost is about $8,700,000. The Departments calculate these estimates as follows:

Task 2: Equivalent Costs for Producing Coverage Examples

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	45	$2,400	45	$2,400	45	$2,400
Benefits/Sales Professionals	$41.94	45	$1,900	45	$1,900	45	$1,900
Financial Managers	$75.32	15	$1,100	15	$1,100	15	$1,100
Attorneys	$85.44	15	$1,300	15	$1,300	15	$1,300
Total per issuer/TPA		120	$6,700	120	$6,700	120	$6,700
Total for all issuers/TPAs		33,000	$1,900,000	53,000	$3,000,000	16,000	$900,000

Task 2: Cost Burden for Printing Coverage Examples

	Printing Cost Per CE	Total CEs Printed	Total Cost Burden
Printing Costs	$0.06	48,000,000	$2,900,0000

Task 3: Glossary Requests — The Departments assume that in 2012, issuers and TPAs will begin responding to glossary requests to covered individuals, and that 2.5% of covered individuals, who receive paper SBCs, will request glossaries. The Departments further estimate that the burden and cost of providing the notices to be 2.5% of the burden and cost of distributing paper SBCs, plus an additional cost burden of $0.49 for each glossary (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2012, the Departments estimate a total cost of about $1,300,000 and 21,000 burden hours associated with about 1,200,000 glossary requests.

Task 4: One-Time Administrative Costs — As mentioned above, the Departments estimate a one-time administrative cost of about $36,000,000 across the industry and a total of about 680,000 burden hours, and assume this burden will be equally divided between 2011 and 2012. Thus, in 2012, the Departments estimate a one-time administrative cost of about $18,000,000 across the industry and about 340,000 burden hours.

The total 2012 burden estimate is about $58,000,000. The total number of burden hours is about 1,300,000.

2013 Burden Estimate

Task 1: Summary of Benefits and Coverage (not including coverage examples) — The number of SBC responses is assumed to remain constant. Thus, in 2013, the Departments again estimate a total cost of about $30,000,000 and about 820,000 burden hours for SBCs (not including coverage examples).

Task 2: Coverage Examples — The Departments again estimate a total cost of about $8,700,000 and 100,000 burden hours for coverage examples.

Task 3: Notices of Modifications — The Departments assume that in 2013, issuers and TPAs would send notices of modifications to covered individuals, and that 2% of covered individuals would receive such notice. The Departments further estimate that the burden and cost of providing the notices to be 2% of the combined burden and cost of the SBCs including the coverage examples, plus an additional cost burden for $0.49 for each paper notice (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2013, the Departments estimate a total cost of about $1,400,000 and 18,000 burden hours associated with about 1,500,000 notices of modification.

Task 4: Glossary Requests — The Departments assume that in 2013, issuers and TPAs will again respond to glossary requests to covered individuals, and that 5% of covered individuals, who receive paper SBCs, will request glossaries. The Departments further estimate that the burden and cost of providing the glossaries to be 5% of the burden and cost of distributing paper SBCs, plus an additional cost burden for $0.49 for each glossary (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2013, the Departments estimate a total cost of about $2,700,000 and 41,000 burden hours associated with 2,400,000 glossary requests.

Task 5: Maintenance Administrative Costs — In 2013, the Departments assume that issuers and TPAs will need to make updates to address changes in standards, and, thus, incur 15% of the one-time administrative burden. Accordingly, the estimated hour burden is about 100,000 hours, and the estimated total cost is about $5,400,000. The Departments calculate these estimates as follows:

Task 2: Equivalent Costs for Producing Coverage Examples

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	46.2	$2,500	69.3	$3,700	92.4	$4,900
Benefits / Sales Professionals	$41.94	33.6	$1,800	50.4	$2,700	67.2	$3,600
Attorneys	$85.44	4.2	$220	6.3	$340	8.4	$450
Total per issuer/TPA		84	$4,500	126	$6,700	168	$8,900
Total for all issuers/TPAs		23,000	$1,200,000	56,000	$3,000,000	23,000	$1,200,000

The total 2013 cost estimate is about $48,000,000.The total number of burden hours is about 1,100,000 hours.

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.

The 2012–2013 paperwork burden estimates are summarized as follows:

Type of Review: New collection.

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

Title: Affordable Care Act Uniform Explanation of Coverage Documents

OMB Number: XXXX–XXX; XXXX–XXXX.

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

Total Respondents: 858.

Total Responses: 80,000,000.

Frequency of Response: On-going.

Estimated Total Annual Burden Hours: 600,000 hours (Employee Benefits Security Administration); 600,000 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: $5,100,000 (Employee Benefits Security Administration); $5,100,000 (Internal Revenue Service).

2. Department of Health and Human Services

The Department estimates 333 respondents each year from 2011–2013. This estimate reflects the approximately 220 issuers offering comprehensive major medical coverage in the individual market and to fully-insured non-federal governmental plans, and 113 TPAs acting as service providers for self-insured non-federal governmental plans.[65]

To account for variation in firm size, the Department estimates a weighted burden on the basis of issuer's 2009 total earned premiums for comprehensive major medical coverage.[66] The Department defines small issuers as those with total earned premiums less than $50 million; medium issuers as those with total earned premiums between $50 million and $999 million; and large issuers as those with total earned premiums of $1 billion or more. Accordingly, the Department estimates approximately 70 small, 115 medium, and 35 large issuers. Similarly, the Department estimates approximately 36 small, 59 medium, and 18 large TPAs.

2011 Burden Estimate

While the disclosures in these proposed regulations are not required until March 2012, the Department estimates a one-time administrative cost of about $14,000,000 across the industry and 270,000 burden hours to prepare for the provisions of these proposed regulations. This calculation is made assuming issuers and TPAs will need to implement two principal tasks: (1) develop teams to analyze current workflow processes against the new standards and (2) make appropriate changes to IT systems and processes.

With respect to task (1), the Department estimates about 38,000 burden hours, and an equivalent cost of about $1,900,000. The Department calculates these estimates as follows:[67]

[65] The Department estimates that there are 440 issuers and 750 TPAs. Because the Department shares the hour and cost burden for issuers with the Department of Labor and the Department of the Treasury, the burden to produce the SBCs including coverage examples for non-federal governmental plans and issuers in the individual market is calculated using half the number of issuers (221) and 15% of TPAs (113). While non-federal governmental plans could prepare their own SBCs including Coverage Examples, the Department assumes that SBCs including coverage examples would be prepared by service providers, *i.e.*, issuers and TPAs.

[66] The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business

[67] For the purposes of these and other estimates in this section III.E, the Departments again use the assumptions outlined above in section III.A.5.

Task 1: Analyze current workflow and new rules

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	36	$1,900	54	$2,900	72	$3,800
Benefits/Sales Professionals	$41.94	40	$1,700	60	$2,500	80	$3,400
Attorneys	$85.44	4	$340	6	$510	8	$680
Total per issuer/TPA		80	$3,900	120	$5,900	160	$7,900
Total for all issuers/TPAs		8,500	$420,000	21,000	$1,000,000	8,500	$450,000

With respect to task (2), the Department estimates 230,000 burden hours, and an equivalent cost of out $12,000,000. The Department calculates these estimates as follows:

Task 2: IT Changes

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	480	$26,000	720	$38,000	960	$51,000
Total per issuer/TPA		480	$26,000	720	$38,000	960	$51,000
Total for all issuers/TPAs		51,000	$2,700,000	125,000	$6,700,000	51,000	$2,700,000

The Department assumes the total one-time administrative burden will be divided equally between 2011 and 2012. Thus, in 2011, the Department estimates a one-time administrative cost of about $7,000,000 across the industry and 135,000 burden hours. The Department assumes issuers and TPAs will incur no other costs in 2011 related to the proposed collection of information.

2012 Burden Estimate

The hour and cost burden for the collections of information are as follows:

- The Department estimates that there will be about 13,000,000 SBC responses in 2012.
- The Department assumes that 38 percent of the SBCs would be sent electronically in the group market, and 70 percent of the SBCs would be sent electronically in the individual market. Accordingly, the Department estimates that about 5,900,000 SBCs would be electronically distributed, and about 7,400,000 SBCs would be distributed in paper form. The Department assumes there are no costs associated with electronic disclosures, and there are costs only with regard to paper disclosures.

Task 1: Summary of benefits and coverage (not including coverage examples) — The estimated hour burden is about 170,000 hours, and the estimated total cost is about $5,900,000. The Department calculates these estimates as follows:

Task 1: Equivalent Costs for Producing SBCs

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	1.5	$80	1.5	$80	1.5	$80
Benefits/Sales Professionals	$41.94	1.5	$63	1.5	$63	1.5	$63
Financial Managers	$75.32	0.5	$38	0.5	$38	0.5	$38
Attorneys	$85.44	0.5	$43	0.5	$43	0.5	$43
Total per issuer/TPA		4	$220	4	$220	4	$220
Total for all issuers/TPAs		420	$24,000	700	$39,000	200	$12,000

Task 1: Equivalent Costs for Distributing SBCs

	Hourly Wage Rate	Hours per SBC	Total Number of SBCs	Total Hours	Total Equivalent Cost
Clerical Staff, Individual Market	$29.15	0.033	2,700,000	89,000	$2,600,000
Clerical, Group Market	$29.15	0.017	4,700,000	80,000	$2,300,000
Total			7,400,000	170,000	$4,900,000

Task 1: Cost Burden for Printing SBCs

	Cost per SBC	Total SBCs	Total Cost Burden
Printing Costs	$0.12	7,400,000	$890,000

Task 2: Coverage Examples — The estimated hour burden is about 40,000 hours, and the estimated total cost is about $2,700,000. The Department calculates these estimates as follows:

Task 2: Equivalent Costs for Producing Coverage Examples

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	45	$2,400	45	$2,400	45	$2,400
Benefits/Sales Professionals	$41.94	45	$1,900	45	$1,900	45	$1,900
Financial Managers	$75.32	15	$1,100	15	$1,100	15	$1,100
Attorneys	$85.44	15	$1,300	15	$1,300	15	$1,300
Total per issuer/TPA		120	$6,700	120	$6,700	120	$6,700
Total for all issuers/TPAs		13,000	$710,000	21,000	$1,200,000	6,400	$350,000

Task 2: Cost Burden for Printing Coverage Examples

	Printing Cost Per CE	Total CEs Printed	Total Cost Burden
Printing Costs	$0.06	7,400,000	$440,000

Task 3: Glossary Requests — The Department assumes that in 2012, issuers and TPAs will begin responding to glossary requests to covered individuals, and that 2.5% of covered individuals, who receive paper SBCs, will request glossaries. The Departments further estimate that the burden and cost of providing the glossaries to be 2.5% of the burden and cost of distributing paper SBCs, plus an additional cost burden of $0.49 for each glossary (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2012, the Department estimates a total cost of about $240,000 and 4,300 burden hours associated with about 190,000 glossary requests.

Task 4: One-Time Administrative Costs: As mentioned above, the Department estimates a one-time administrative cost of about$14,000,000 across the industry and a total of 270,000 burden hours, and assumes this burden will be equally divided between 2011 and 2012. Thus, in 2012, the Department estimates a one-time administrative cost of about $7,000,000 across the industry and 135,000 burden hours.

The total 2012 burden estimate is about $16,000,000. The total number of burden hours is 350,000.

2013 Burden Estimate

Task 1: Summary of benefits and coverage (not including coverage examples) — The number of SBC responses is assumed to remain constant. Thus, in 2013, the Department again estimates a total cost of about $5,900,000 and 170,000 burden hours for SBCs (not including coverage examples).

Task 2: Coverage Examples — In 2013, the Department again estimates a total cost of about $2,700,000 and 40,320 burden hours for coverage examples.

Task 3: Notices of Modifications — The Department assumes that in 2013, issuers will begin sending notices of modifications to covered individuals, and that 2% of covered individuals will receive such notice. The Department further estimates that the burden and cost of providing the notices to be 2% of the combined burden and cost of the SBCs including the coverage examples, plus an additional cost burden for $0.49 for each paper notice (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2013, the Department estimate a total cost of about $300,000 and 4,200 burden hours associated with about 260,000 notices of modification.

Task 4: Glossary Requests — The Department assumes that in 2013, issuers and TPAs will again respond to glossary requests to covered individuals, and that 5% of covered individuals, who receive paper SBCs, will request glossaries. The Department further estimates that the burden and cost of providing the glossaries to be 5% of the burden and cost of distributing paper SBCs, plus an additional cost burden of $0.49 for each glossary (including $0.44 for first-class postage and $0.05 for supply costs). Accordingly, in 2013, the Department estimates a total cost of $470,000 and 8,500 burden hours associated with 370,000 glossary requests.

Task 5: Maintenance Administrative Costs — In 2013, the Department assume that issuers and TPAs will need to make updates to address changes in standards, and, thus, incur 15% of the one-time administrative burden. Accordingly, the estimated hour burden is about 40,000 hours, and the estimated total cost is about $2,000,000. The Departments calculate these estimates as follows:

Task 2: Equivalent Costs for Producing Coverage Examples

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$53.26	46.2	$2,500	69.3	$3,700	92.4	$4,900
Benefits / Sales Professionals	$41.94	33.6	$1,800	50.4	$2,700	67.2	$3,600
Attorneys	$85.44	4.2	$220	6.3	$340	8.4	$450
Total per issuer/TPA		84	$4,500	126	$6,700	168	$8,900
Total for all issuers/TPAs		8,900	$470,000	22,000	$1,100,000	8,900	$470,000

The total 2013 cost estimate is about $11,000,000. The total number of burden hours is about 260,000 hours.

The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.

The 2012–2013 paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agency: Department of Health and Human Services.

Title: Affordable Care Act Uniform Explanation of Coverage Documents

OMB Number: 0938–New.

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

Total Respondents: 333.

Total Responses: 13,000,000.

Frequency of Response: On-going.

Estimated Total Annual Burden Hours: 310,000 hours.

Estimated Total Annual Burden Cost: $1,600,000.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage* or email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office at 410–786–1326.

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

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

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

Attention: CMS Desk Officer, CMS–9982–P

Fax: 202–395–5806; or

E-mail: *OIRA_submission@omb.eop.gov*

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

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have 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 rules have federalism implications, because it would have direct effects on the States, the relationship between national governments and States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers. Under these proposed rules, all group health plans and health insurance issuers offering group or individual health insurance coverage, including self-funded non-federal governmental plans as defined in section 2791 of the PHS Act, would be required to follow uniform standards for compiling and providing a summary of benefits and coverage to consumers. Such Federal standards developed under PHS Act section 2715(a) would preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under PHS Act section 2715(a).

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018). States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. However, under these proposed rules, a State would not be allowed to impose a requirement that modifies the summary of benefits and coverage required to be provided under PHS Act section 2715(a), because it would prevent the application of this proposed rule's uniform disclosure requirement.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected States, including consulting with, and attending conferences of, the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act, including the provisions of section 2715 of the PHS Act. Throughout the process of developing these proposed regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this proposed rule, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached proposed rule in a meaningful and timely manner.

IV. Statutory Authority

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

The Department of Labor proposed regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 3–2010, 75 FR 55354 (September 10, 2010).

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

* * * * *

Sarah Hall Ingram,
Acting Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 15th day of August, 2011.

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

CMS–9982–P

Dated July 28, 2011.

Donald Berwick,
Administrator,
Centers for Medicare &
Medicaid Services.

Dated August 9, 2011.

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

CMS–9982–P

BILLING CODE 4120–01–P

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Chapter I

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

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for Part 54 is amended by adding an entry for

§54.9815–2715 in numerical order to read in part as follows:

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

Section 54.9815–2715 also issued under 26 U.S.C. 9833.

Par. 2. Section 54.9815–2715 is added to read as follows:

§54.9815–2715 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage* — (1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *By a group health insurance issuer to a group health plan* — (A) A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application or request for information about the health coverage as soon as practicable following the request, but in no event later than seven days following the request. If an SBC is provided upon request for information about health coverage and the plan (or its sponsor) subsequently applies for health coverage, a second SBC must be provided under this paragraph (a)(1)(i)(A) only if the information required to be in the SBC has changed.

(B) If there is any change in the information required to be in the SBC before the coverage is offered, or before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the date of the offer (or no later than the first day of coverage, as applicable).

(C) If the issuer renews or reissues the policy, certificate, or contract of insurance (for example, for a succeeding policy year), the issuer must provide a new SBC when the policy, certificate, or contract is renewed or reissued.

(*1*) In the case of renewal or reissuance, if written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date the materials are distributed.

(*2*) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year.

(D) If a group health plan (or its sponsor) requests an SBC from a health insurance issuer offering group health insurance coverage, it must be provided as soon as practicable, but in no event later than seven days following the request for an SBC.

(ii) *By a group health insurance issuer and a group health plan to participants and beneficiaries* — (A) A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section) with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for

enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant or any beneficiaries.

(C) If there is any change to the information required to be in the SBC before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

(D) The plan or issuer must provide the SBC to special enrollees (as described in § 54.9801–6) within seven days of a request for enrollment pursuant to a special enrollment right.

(E) If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the coverage is renewed.

(*1*) If written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date the materials are distributed.

(*2*) If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage under the new plan year.

(F) A plan or issuer must provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request.

(iii) *Special rules to prevent unnecessary duplication with respect to group health coverage* — (A) An entity required to provide an SBC under paragraph (a)(1) of this section with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual.

(B) If a participant and any beneficiaries are known to reside at the same address, and a single SBC is provided to that address, the requirement to provide the SBC is satisfied with respect to all individuals residing at that address. If a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled; SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary are not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request in accordance with the rules of paragraph (a)(1)(ii) of this section, which requires the SBC to be provided as soon as practicable, but in no event later than seven days following the request.

(2) *Content* — (i) *In general*. The SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);

(J) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(K) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;

(L) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section; and

(M) Premiums (or in the case of a self-insured group health plan, cost of coverage).

(ii) *Coverage examples*. The SBC must include coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) that are identified by the Secretary in accordance with the following:

(A) *Number of examples*. The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) *Benefits scenarios*. For purposes of this section, a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines available through the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the types of services, dates of service, applicable billing codes, and allowed charges for each claim in the benefits scenario.

(C) *Demonstration of benefit provided*. To demonstrate benefits provided under the plan or coverage, a plan or issuer simulates how claims would be processed under the scenarios provided by the Secretary to

generate an estimate of cost sharing a consumer could expect to pay under the benefit package. The demonstration of benefits will take into account any cost sharing, excluded benefits, and other limitations on coverage, as described by the Secretary in guidance.

(3) *Appearance*. A group health plan and a health insurance issuer must provide an SBC as a stand-alone document in the form authorized by the Secretary and completed in accordance with the instructions for completing the SBC that are authorized by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(4) *Form* — (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as email or an Internet posting) if the following three conditions are satisfied —

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request, and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a plan or issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically if the requirements of 29 CFR 2520.104b–1 are met.

(5) *Language*. A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of §54.9815–2719T(e) are met as applied to the SBC.

(b) *Notice of modifications*. If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) *Uniform glossary* — (1) *In general*. A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and format requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) *Health-coverage-related terms and medical terms*. The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, for the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance*. A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance authorized in guidance, ensuring that the uniform glossary is presented in a uniform format and utilizes terminology understandable by the average plan enrollee.

(4) *Form and manner*. A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven days of the request. (Under the rules of paragraph (a) of this section, the form authorized in guidance for the SBC will disclose to participants and beneficiaries their rights to request a copy of the uniform glossary.)

(d) *Preemption*. With respect to the standards for providing an SBC required under paragraph (a) of this section, State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) *Failure to provide*. A group health plan or health insurance issuer that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e).

(f) *Applicability date*. This section is applicable beginning March 23, 2012. *See* § 54.9815–1251T(d), providing that this section applies to grandfathered health plans.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

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

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

Par. 4. Section 602.101(b) is amended by adding the following entry in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where Identified and described		Current OMB control No.
* * * * *		
54.9815–2715	.....	1545–
* * * * *		

(Filed by the Office of the Federal Register on August 17, 2011, 11:15 a.m., and published in the issue of the Federal Register for August 22, 2011, 76 F.R. 52446)

Notice of Proposed Rulemaking and Notice of Public Hearing

Swap Exclusion for Section 1256 Contracts

REG–111283–11

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations that describe swaps and similar agreements that fall within the meaning of section 1256(b)(2)(B) of the Internal Revenue Code (Code). This document also contains proposed regulations that revise the definition of a notional principal contract under §1.446–3 of the Income Tax Regulations. This document provides a notice of public hearing on these proposed regulations.

DATES: Written or electronic comments must be received by December 15, 2011. Outlines of topics to be discussed at the public hearing scheduled for January 19, 2012, must be received by December 14, 2011.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–111283–11), room 5203, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington DC 20044. Submissions may be hand delivered Monday through Friday, between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–111283–11), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at *www.regulations.gov/* (IRS-REG–111283–11). The public hearing will be held in the Auditorium, Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, K. Scott Brown (202) 622–7454; concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing, Richard Hurst, (202) 622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Income Tax Regulations (26 CFR 1) under sections 1256 and 446 of the Code. Section 1256(b)(2)(B) was added to the Code by section 1601 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Public Law No. 111–203, §1601, 124 Stat. 1376, 2223 (2010)) (the Dodd-Frank Act). Section 1256(b)(2)(B) provides that certain swaps and similar agreements are not subject to section 1256 of the Code. These proposed regulations provide guidance on the category of swaps and similar agreements that are within the scope of section 1256(b)(2)(B). These proposed regulations also revise the definition and scope of a notional principal contract under §1.446–3 of the Income Tax Regulations.

Explanation of Provisions

A. *Section 1256(b)(2)(B) Language and Legislative History*

Section 1256 provides that contracts classified as section 1256 contracts are marked to market and any gain or loss is generally treated as 60 percent long-term capital gain or loss and 40 percent short-term capital gain or loss. Section 1256(b)(1) defines the term "section 1256 contract" as a regulated futures contract, foreign currency contract, nonequity option, dealer equity option, and dealer securities futures contract. With the exception of a foreign currency contract, a section 1256 contract must be traded on or subject to the rules of a "qualified board or exchange" as defined in section 1256(g)(7).

Section 1601 of the Dodd-Frank Act added section 1256(b)(2)(B), which excludes swaps and similar agreements from the definition of a section 1256 contract. Section 1256(b)(2)(B) provides that the term "section 1256 contract" shall not include—

> any interest rate swap, currency swap, basis swap, interest rate cap, interest rate floor, commodity swap, equity swap, equity index swap, credit default swap, or similar agreement.

Congress enacted section 1256(b)(2)(B) to resolve uncertainty under section 1256 for swap contracts that are traded on regulated exchanges. The specific uncertainty addressed by the enactment of section 1256(b)(2)(B) was described in the Conference Report:

> The title contains a provision to address the recharacterization of income as a result of increased exchange-trading of derivatives contracts by clarifying that section 1256 of the Internal Revenue Code does not apply to certain derivatives contracts transacted on exchanges.

H.R. Conf. Rep. No. 111–517, at 879 (2010). Section 1256(b)(2)(B) contemplates that a swap contract, even if traded on or subject to the rules of a qualified board or exchange, will not be a section 1256 contract.

B. *Scope of Swaps Excluded by Section 1256(b)(2)(B)*

1. *Notional principal contracts and credit default swaps*

Congress incorporated into section 1256(b)(2)(B) a list of swaps that parallels the list of swaps included under the

definition of a notional principal contract in §1.446–3(c) with the addition of credit default swaps. The parallel language suggests that Congress was attempting to harmonize the category of swaps excluded under section 1256(b)(2)(B) with swaps that qualify as notional principal contracts under §1.446–3(c), rather than with the contracts defined as "swaps" under section 721 of the Dodd-Frank Act. Accordingly, §1.1256(b)–1(a) of the proposed regulations provides that a section 1256 contract does not include a contract that qualifies as a notional principal contract as defined in proposed §1.446–3(c). As discussed herein, the proposed regulations under §1.446–3 also expressly provide that a credit default swap is a notional principal contract.

2. *Option on a notional principal contract*

Section 1256(b)(2)(B) raises questions as to whether an option on a notional principal contract that is traded on a qualified board or exchange would constitute a "similar agreement" or would instead be treated as a nonequity option under section 1256(g)(3). Since an option on a notional principal contract is closely connected with the underlying contract, the Treasury Department and the IRS believe that such an option should be treated as a similar agreement within the meaning of section 1256(b)(2)(B). Accordingly, §1.1256(b)–1(a) of the proposed regulations also provides that a section 1256 contract does not include an option on any contract that is a notional principal contract defined in §1.446–3(c) of the proposed regulations.

3. *Ordering rule*

The proposed regulations provide an ordering rule for a contract that trades as a futures contract regulated by the Commodity Futures Trading Commission (CFTC), but that also meets the definition of a notional principal contract. The Treasury Department and the IRS believe that such a contract is not a commodity futures contract of the kind envisioned by Congress when it enacted section 1256. Accordingly, §1.1256(b)–1(a) of the proposed regulations provides that section 1256 does not include any contract, or option on such contract, that is both a section 1256 contract and a notional principal contract as defined in §1.446–3(c) of the proposed regulations.

C. *Definition of Regulated Futures Contract*

Section 1256(g)(1) defines a regulated futures contract as "a contract (A) with respect to which the amount required to be deposited and the amount which may be withdrawn depends on a system of marking to market, and (B) which is traded on or subject to the rules of a qualified board or exchange." The apparent breadth of section 1256(g)(1) has raised questions in the past as to whether a contract other than a futures contract can be a regulated futures contract. The Treasury Department and the IRS have historically limited the scope of a regulated futures contract to those futures contracts that have the characteristics of traditional futures contracts. Under the Dodd-Frank Act, a "designated contract market" may trade both futures contracts and swap contracts, although there will be specific reporting rules for swap contracts. In order to properly limit section 1256 to futures contracts that trade on designated contract markets, §1.1256(b)–1(b) of the proposed regulations provides that a regulated futures contract is a section 1256 contract only if the contract is a futures contract that is not required to be reported as a swap under the Commodity Exchange Act (7 U.S.C. 1) (the CEA). The reporting provisions for swaps under the CEA will not be effective until the CFTC has published final rules implementing such provisions. It is anticipated that swap reporting rules will be in effect before these regulations are finalized. If, however, these proposed income tax regulations are finalized before the swap reporting provisions become effective, the Treasury Department and the IRS will evaluate whether the provisions of §1.1256(b)–1(b) need to be adjusted.

Questions have also been raised as to whether the requirement that a regulated futures contract be "traded on or subject to the rules of" a qualified board or exchange includes off-exchange transactions such as an exchange of a futures contract for a cash commodity, or an exchange of a futures contract for a swap, that are carried out subject to the rules of a CFTC designated contract market. The phrase "traded on or subject to the rules of" appears to have originated under the CEA. Section 4(a) of the CEA provides, in part, that it is unlawful to engage in any transaction in, or in connection with, a commodity futures contract unless such transaction is conducted on or subject to the rules of a board of trade which has been designated as a contract market and such contract is executed or consummated by or through a contract market. Section 5(d) of the CEA, as amended by section 735 of the Dodd-Frank Act, provides that the rules of a designated contract market may authorize, for *bona fide* business purposes, transfer trades or office trades, or an exchange of (i) futures in connection with a cash commodity transaction, (ii) futures for cash commodities, or (iii) futures for swaps. As such, the Treasury Department and the IRS believe that a futures contract that results from one of these transactions is a regulated futures contract under section 1256(g)(1) because the contract is traded subject to the rules of a designated contract market.

D. *Qualified Board or Exchange*

Section 1256(g)(7)(C) provides that a qualified board or exchange includes any other exchange, board of trade, or other market which the Secretary determines has rules adequate to carry out the purposes of section 1256. Section 1.1256(g)–1(a) of the proposed regulations specifies that such determinations are only made through published guidance in the **Federal Register** or in the Internal Revenue Bulletin.

Since section 1256(g)(7) was adopted, the Treasury Department and the IRS have issued determinations for six entities, all of them foreign futures exchanges. See Rev. Rul. 2010–3, 2010–3 I.R.B. 272 (London International Financial Futures and Options Exchange), Rev. Rul. 2009–24, 2009–36 I.R.B. 306 (ICE Futures Canada), Rev. Rul. 2009–4, 2009–5 I.R.B. 408 (Dubai Mercantile Exchange), Rev. Rul. 2007–26, 2007–1 C.B. 970 (ICE Futures), Rev. Rul. 86–7, 1986–1 C.B. 295 (The Mercantile Division of the Montreal Exchange), and Rev. Rul. 85–72, 1985–1 C.B. 286 (International Futures Exchange (Bermuda)). The IRS has followed a two step process for making each of the six qualified board or exchange determinations under section 1256(g)(7). See §601.601(d)(2)(ii)(b).

In the first step, the exchange submitted a private letter ruling to the IRS requesting a determination that the exchange is a qualified board or exchange within the meaning of section 1256(g)(7)(C). Once the IRS determined that the exchange had rules sufficient to carry out the purposes of section 1256, the Treasury Department and the IRS published a revenue ruling announcing that the named exchange was a qualified board or exchange. The revenue rulings apply to commodity futures contracts and futures contract options of the type described under the CEA that are entered into on the named exchange. The revenue ruling does not apply to contracts that are entered into on another exchange that is affiliated with the named exchange.

In determining whether a foreign exchange is a qualified board or exchange under section 1256(g)(7)(C), the Treasury Department and the IRS have looked to whether the exchange received a CFTC "direct access" no-action relief letter permitting the exchange to make its electronic trading and matching system available in the United States, notwithstanding that the exchange was not designated as a contract market pursuant to section 5 of the CEA. Section 738 of the Dodd-Frank Act, however, provides the CFTC with authority to adopt rules and regulations that require registration of a foreign board of trade that provides United States participants direct access to the foreign board of trade's electronic trading system. In formulating these rules and regulations, the CFTC is directed to consider whether comparable supervision and regulation exists in the foreign board of trade's home country. Pursuant to section 738, the CFTC has proposed a registration system to replace the direct access no-action letter process. Under the proposed registration system, a foreign board of trade operating pursuant to an existing direct access no-action relief letter must apply through a limited application process for an "Order of Registration" which will replace the foreign board of trade's existing direct access no-action letter. Many of the proposed requirements for and conditions applied to a foreign board of trade's registration will be based upon those applicable to the foreign board of trade's currently granted direct access no-action relief letter.

The IRS has conditioned a foreign exchange's qualified board or exchange status under section 1256(g)(7)(C) on the exchange continuing to satisfy all CFTC conditions necessary to retain its direct access no-action relief letter. Consequently, if the CFTC adopts the proposed registration system, an exchange that has previously received a qualified board or exchange determination under section 1256(g)(7)(C) must obtain a CFTC Order of Registration in order to maintain its qualified board or exchange status. The IRS will continue to evaluate the CFTC's rules in this regard to determine if any changes to the IRS's section 1256(g)(7)(C) guidance process are warranted.

E. *Definition and Scope of a Notional Principal Contract*

1. *Payments under a notional principal contract*

In 1993, the IRS promulgated §1.446–3(c) which defines a notional principal contract as a financial instrument that provides for the payment of amounts by one party to another at specified intervals calculated by reference to a specified index upon a notional principal amount in exchange for specified consideration or a promise to pay similar amounts. Questions have arisen as to the proper interpretation of this requirement. Sections 1.446–3(c)(1)(i) and (ii) of the proposed regulations expressly provide that a notional principal contract requires one party to make two or more payments to a counterparty. For this purpose, the fixing of an amount is treated as a payment, even if the actual payment reflecting that amount is to be made at a later date. Thus, for example, a contract that provides for a settlement payment referenced to the appreciation or depreciation on a specified number of shares of common stock, adjusted for actual dividends paid during the term of the contract, is treated as a contract with more than one payment with respect to that leg of the contract.

2. *Credit default swaps*

In Notice 2004–52, 2004–2 C.B. 168, the Treasury Department and the IRS described four possible characterizations of a credit default swap. See §601.601(d)(2)(ii)(b). These proposed regulations resolve this uncertainty by adding credit default swaps to the list of swaps categorized as notional principal contracts governed by the rules of §1.446–3.

3. *Weather-related and other non-financial index based swaps*

Since the time that the §1.446–3 regulations were promulgated, markets have developed for contracts based on non-financial indices. Many of these contracts are structured as swaps, and payments are calculated based on indices such as temperature, precipitation, snowfall, or frost. For example, payments made under a weather derivative may be based on heating degree days and cooling degree days. As a technical matter, a weather-related swap currently is not a notional principal contract because a weather index does not qualify as a "specified index" under §1.446–3(c)(2) of the current regulations, which generally require that such index be a financial index.

The Treasury Department and the IRS believe that swaps on non-financial indices should be treated as notional principal contracts. Accordingly, §1.446–3(c)(2)(ii) of the proposed regulations expands a specified index to include non-financial indices that are comprised of any objectively determinable information that is not within the control of any of the parties to the contract and is not unique to one of the parties' circumstances, and that cannot be reasonably expected to front-load or back-load payments accruing under the contract.

4. *Excluded contracts*

Section 1.446–3(c)(1)(ii) currently provides that a contract described in section 1256(b) and a futures contract are not notional principal contracts. In order to remove the circularity that would otherwise exist between excluded contracts under §1.446–3(c)(1)(ii) and proposed §1.1256(b)–1, a contract described in section 1256(b) and a futures contract have been deleted from excluded contracts under proposed §1.446–3(c)(1)(iv).

5. *Conforming Amendments*

The definition of a notional principal contract in §1.446–3(c) of the proposed regulations is intended to be the operative definition for all Federal income tax purposes, except where a different

or more limited definition is specifically prescribed. Thus, the regulations under sections 512, 863, 954, and 988 have been amended to reference the definition of a notional principal contract in §1.446–3(c).

Proposed Effective/Applicability Date

These regulations are proposed to apply to contracts entered into on or after the date the final regulations are published in the **Federal Register.**

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulation does not impose a collection of information on small entitles, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the 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 Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The Treasury Department and IRS invite comments on the clarity of the proposed rules and how they can be made easier to understand. All comments will be available at *www.regulations.gov* or upon request.

A public hearing has been scheduled for January 19, 2012, beginning at 10 a.m. in the Auditorium, Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written or electronic comments by December 15, 2011 and an outline of the topics to be discussed and the time to be devoted to each topic (a signed original and eight (8) copies) by December 14, 2011. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these proposed regulations is K. Scott Brown, Office of the Associate Chief Counsel (Financial Institutions and Products). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.446–3 is amended by:

1. Revising the entries for the table of contents in §1.446–3(a) for paragraphs (c) and (j).

2. Revising paragraphs (c)(1), (c)(2), and (c)(3).

3. Adding and reserving paragraph (c)(5).

4. Adding paragraph (c)(6).

5. Adding two sentences to the end of paragraph (j).

The revisions and additions read as follows:

§1.446–3 Notional principal contracts.

* * * * *

(c) Definitions and scope.

(1) Notional principal contract.

(i) In general.

(ii) Payment defined.

(iii) Included contracts.

(A) Special rule for credit default swaps.

(B) Special rule for nonfunctional currency notional principal contracts.

(iv) Excluded contracts.

(v) Transactions within section 475.

(vi) Transactions within section 988.

(2) Specified index.

(i) Specified financial index.

(ii) Specified non-financial index.

(3) Notional principal amount.

(4) Special definitions.

(i) Related person and party to the contract.

(ii) Objective financial information.

(iii) Dealer in notional principal contracts.

(5) [Reserved]

(6) Examples.

* * * * *

(j) Effective/applicability date.

* * * * *

(c) *Definitions and scope*—(1) *Notional principal contract*—(i) *In general*. A notional principal contract is a financial instrument that requires one party to make two or more payments to the counterparty at specified intervals calculated by reference to a specified index upon a notional principal amount in exchange for specified consideration or a promise to pay similar amounts. An agreement between a taxpayer and a qualified business unit (as defined in section 989(a)) of the taxpayer, or among qualified business units of the same taxpayer, is not a notional principal contract because a taxpayer cannot enter into a contract with itself.

(ii) *Payment defined*. For purposes of paragraph (c)(1)(i) of this section, a payment includes an amount that is fixed on one date and paid or otherwise taken into account on a later date. Thus, for example, a contract that provides for a settlement payment referenced to the appreciation or depreciation on a specified number of shares of common stock, adjusted for actual dividends paid during the term of the contract, is treated as a contract with

more than one payment with respect to that leg of the contract. See *Example 2* of this paragraph (c).

(iii) *Included contracts*. Notional principal contracts governed by this section include contracts commonly referred to as interest rate swaps, currency swaps, basis swaps, interest rate caps, interest rate floors, commodity swaps, equity swaps, equity index swaps, credit default swaps, weather-related swaps, and similar agreements that satisfy the requirements of paragraph (c)(1)(i). A collar is not itself a notional principal contract, but a cap and a floor that comprise a collar may be treated as a single notional principal contract under paragraph (f)(2)(v)(C) of this section. A contract may be a notional principal contract governed by this section even though the term of the contract is subject to termination or extension. Each confirmation under a master agreement to enter into an agreement covered by this section is treated as a separate notional principal contract (or as more than one notional principal contract if the confirmation creates more than one notional principal contract). Notwithstanding the rule under paragraph (c)(3) of this section—

(A) *Special rule for credit default swaps*. A credit default swap contract that permits or requires the delivery of specified debt instruments in satisfaction of one leg of the contract is a notional principal contract if it otherwise satisfies the requirements of paragraph (c)(1)(i) of this section.

(B) *Special rule for nonfunctional currency notional principal contracts*. A notional principal contract that permits or requires the delivery of specified currency in satisfaction of one or both legs of the contract but that otherwise qualifies as a nonfunctional currency notional principal contract under §1.988–1(a)(2)(iii)(B) is a notional principal contract.

(iv) *Excluded contracts*. A forward contract, an option, and a guarantee are not notional principal contracts. An instrument or contract that constitutes indebtedness under general Federal income tax law is not a notional principal contract. An option or forward contract that entitles or obligates a person to enter into a notional principal contract is not a notional principal contract, but payments made under such an option or forward contract may be governed by paragraph (g)(3) of this section.

(v) *Transactions within section 475.* To the extent that the rules provided in paragraphs (e) and (f) of this section are inconsistent with the rules that apply to any notional principal contract that is governed by section 475 and the regulations thereunder, the rules of section 475 and the regulations thereunder govern.

(vi) *Transactions within section 988.* To the extent that the rules provided in this section are inconsistent with the rules that apply to any notional principal contract that is also a section 988 transaction or that is integrated with other property or debt pursuant to section 988(d), the rules of section 988 and the regulations thereunder govern. The rules of §1.446–3(g)(4) are not considered to be inconsistent with the rules of section 988. See §1.988–2(e)(3)(iv).

(2) *Specified index.* A specified index may be either a specified financial index or a specified non-financial index.

(i) *Specified financial index.* A specified financial index is—

(A) A fixed rate, price, or amount;

(B) A fixed rate, price, or amount applicable in one or more specified periods followed by one or more different fixed rates, prices, or amounts applicable in other periods;

(C) An index that is based on objective financial information (as defined in paragraph (c)(4)(ii) of this section); and

(D) An interest rate index that is regularly used in normal lending transactions between a party to the contract and unrelated persons.

(ii) *Specified non-financial index.* A specified non-financial index is any objectively determinable information that—

(A) Is not within the control of any of the parties to the contract and is not unique to one of the parties' circumstances;

(B) Is not financial information; and

(C) Cannot be reasonably expected to front-load or back-load payments accruing under the contract.

(3) *Notional principal amount*. For purposes of this section, a notional principal amount is any specified amount of money or property that, when multiplied by either a specified financial index or a specified non-financial index, measures a party's rights and obligations under the contract, but is not borrowed, loaned, or sold between the parties as part of the contract. The notional principal amount may vary over the term of the contract, provided that it is set in advance or varies based on objective financial information (as defined in paragraph (c)(4)(ii) of this section). If a notional principal contract references a notional principal amount that varies, or that references a different notional principal amount for each party, and a principal purpose for entering into the contract is to avoid the application of the rules in this section, the Commissioner may recharacterize the contract according to its substance, including by separating the contract into a series of notional principal contracts for purposes of applying the rules of this section or by treating the contract, in whole or in part, as a loan.

* * * * *

(5) [Reserved]

(6) *Examples*. The following examples illustrate the application of paragraph (c) of this section.

Example 1. Forward rate agreement. (i) On January 1, 2012, A enters into a contract with unrelated counterparty B under which on December 31, 2013, A will pay or receive from B, as the case may be, an amount determined by subtracting 6% multiplied by a notional amount of $10 million from 3 month LIBOR on December 31, 2013 multiplied by the same notional amount ((3 month LIBOR X $10,000,000) – (6% X $10,000,000)). The contract provides for no other payments.

(ii) Because this contract provides for a single net payment between A and B determined by interest rates in effect on the settlement date of the contract, the contract is not a notional principal contract defined in §1.446–3(c)(1)(i).

Example 2. Equity total return contract with dividend adjustments. (i) On January 1, 2012, A enters into a contract with unrelated counterparty B under which on December 31, 2013, A will receive from B an amount equal to the appreciation (if any) on a notional amount of 1 million shares of XYZ common stock, plus any dividends or other distributions that are paid on 1 million shares of XYZ common stock during the term of the contract. In return, on December 31, 2013 A will pay B an amount equal to any depreciation on 1 million shares of XYZ common stock, and an amount equal to 3 month LIBOR multiplied by the notional value of 1 million shares of XYZ stock on January 1, 2012 compounded over the term of the contract. All payments are netted such that A and B are only liable for the net payment due under the contract on December 31, 2013.

(ii) Because both legs of this contract provide for payments that become fixed during the term of the contract (the dividend payments and the LIBOR-based payments), each leg of the contract is treated as providing for more than one payment. In addition, since the indices referenced in the contract are specified indices described in paragraph (c)(2)(i) of this section, and the 1 million shares of XYZ com-

mon stock are a notional principal amount described in paragraph (c)(3) of this section, the contract is a notional principal contract defined in §1.446–3(c)(1)(i).

* * * * *

(j) *Effective/applicability date.* * * * The rules of paragraph (c) of this section apply to notional principal contracts entered into on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**. Section 1.446–3(c) as contained in 26 CFR part 1 revised April 1, 2011, continues to apply to notional principal contracts entered into before the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 3. Section 1.512(b)–(1) is amended by:

1. Revising paragraph (a)(1).

2. Adding two sentences to the end of paragraph (a)(3).

The revision and addition read as follows:

§1.512(b)–1 Modifications.

* * * * *

(a) *Certain Investment Income*—(1) *In general.* Dividends, interest, payments with respect to securities loans (as defined in section 512(a)(5)), annuities, income from notional principal contracts (as defined in §1.446–3(c)), other substantially similar income from ordinary and routine investments to the extent determined by the Commissioner, and all deductions directly connected with any of the foregoing items of income shall be excluded in computing unrelated business taxable income.

* * * * *

(3) * * * The rules of paragraph (a)(1) of this section apply to notional principal contracts as defined in §1.446–3(c) that are entered into on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**. Section 1.512(b)–1(a)(1) as contained in 26 CFR part 1 revised April 1, 2011, continues to apply to notional principal contracts entered into before the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

* * * * *

Par. 4. Section 1.863–7 is amended by:

1. Revising the third sentence and removing the fourth sentence of paragraph (a)(1).

2. Adding two sentences to the end of paragraph (a)(2).

The revision and addition read as follows:

§1.863–7 Allocation of income attributable to certain notional principal contracts under section 863(a).

(a) *Scope*—(1) *Introduction.* * * * Notional principal contract income is income attributable to a notional principal contract as defined in §1.446–3(c). * * *

(2) * * * The rules of this section apply to notional principal contracts as defined in §1.446–3(c) that are entered into on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**. Section 1.863–7 as contained in 26 CFR part 1 revised April 1, 2011, continues to apply to notional principal contracts entered into before the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

* * * * *

Par. 5. Section 1.954–2 is amended by:

1. Revising paragraph (h)(3)(i).

2. Adding paragraph (h)(3)(iii).

The revision and addition read as follows:

§1.954–2 Foreign personal holding company income.

* * * * *

(3) *Notional principal contracts*—(i) *In general.* Income equivalent to interest includes income from notional principal contracts (as defined in §1.446–3(c)) denominated in the functional currency of the taxpayer (or a qualified business unit of the taxpayer, as defined in section 989(a)), the value of which is determined solely by reference to interest rates or interest rate indices, to the extent that the income from such transactions accrues on or after August 14, 1989.

* * * * *

(iii) *Effective/applicability date.* The rules of paragraph (h)(3) of this section apply to notional principal contracts as defined in §1.446–3(c) that are entered into on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**. Section 1.954–2(h)(3) as contained in 26 CFR part 1 revised April 1, 2011, continues to apply to notional principal contracts entered into before the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

* * * * *

Par. 6. Section 1.988–1 is amended by:

1. Revising paragraph (a)(2)(iii)(B)(*2*).

2. Adding two sentences to the end of paragraph (a)(*2*)(iii)(C).

The revision and addition read as follows:

§1.988–1 Certain definitions and special rules.

(a) * * *

(2) * * *

(iii) * * *

(B) * * *

(*2*) Definition of notional principal contract. Generally, the term "notional principal contract" means a contract defined in §1.446–3(c). However, a "notional principal contract" shall only be considered as described in paragraph (a)(2)(iii)(B)(1) of this section if the underlying property to which the instrument ultimately relates is money (for example, functional currency), nonfunctional currency, or property the value of which is determined by reference to an interest rate. Thus, the term "notional principal contract" includes a currency swap as defined in §1.988–2(e)(2)(ii), but does not include a swap referenced to a commodity or equity index.

(C) * * * The rules of this paragraph (a)(2)(iii) apply to notional principal contracts as defined in §1.446–3(c) that are entered into on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**. Section 1.988–1(a)(2)(iii) as contained in 26 CFR part 1 revised April 1, 2011, continues to apply to notional principal contracts entered into before the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

* * * * *

Par. 7. Section 1.1256(b)–1 is added to read as follows:

§1.1256(b)–1 Section 1256 contract defined.

(a) *General rule*. A section 1256 contract does not include any contract, or option on such contract, that is a notional principal contract as defined in §1.446–3(c). A contract that is defined as both a notional principal contract in §1.446–3(c) and as a section 1256 contract in section 1256(b)(1) is treated as a notional principal contract and not as a section 1256 contract.

(b) *Regulated futures contract*. A regulated futures contract is a section 1256 contract only if the contract is a futures contract—

(1) With respect to which the amount required to be deposited and the amount which may be withdrawn depends on a system of marking to market;

(2) That is traded on or subject to the rules of a qualified board or exchange; and

(3) That is not required to be reported as a swap under the Commodity Exchange Act.

(c) *Effective/applicability date*. The rules of this section apply to contracts entered into on or after the date the final regulations are published in the **Federal Register**.

Par. 8. Section 1.1256(g)–1 is added to read as follows:

§1.1256(g)–1 Qualified board or exchange defined.

(a) *General rule*. A qualified board or exchange means a national securities exchange registered with the Securities Exchange Commission, a domestic board of trade designated as a contract market by the Commodity Futures Trading Commission, or any other exchange, board of trade, or other market for which the Secretary determines in published guidance in the **Federal Register** or in the Internal Revenue Bulletin (see §601.601(d)(2)(ii) of this chapter) that such market has rules adequate to carry out the purposes of section 1256.

(b) *Effective/applicability date*. The rule of this section applies to taxable years ending on or after the date the final regulations are published in the **Federal Register**.

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

(Filed by the Office of the Federal Register on September 15, 2011, 8:45 a.m., and published in the issue of the Federal Register for September 16, 2011, 76 F.R. 57684)

Definition of Terms

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

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

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

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

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

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

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

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D. —Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z —Corporation.

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