Santa Clara County Office of Education
Xavier De La Torre, Ed.D.
County Superintendent of Schools

Informational Bulletin

For Santa Clara County Districts

District Business & Advisory Services

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Bulletin: 13-052

Date: January 31, 2013

To: District Fiscal Directors
Human Resource and Payroll Directors

From: Cathy McKim

Re: Healthcare Reform Guidance[i]

The purpose of this bulletin is to provide information and guidance regarding the Healthcare Reform provisions.

Background

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) enacted comprehensive health insurance reforms designed to ensure Americans have access to quality, affordable health insurance. Implementation of the Affordable Care Act occurs in stages, with many of the reforms and requirements taking effect in 2013 and 2014. Some of the provisions that may impact employers with 50 or more employees include:

The attached document will identify the following major areas of change:

- Employer Shared Responsibility Provisions
- Required Summary of Benefits and Coverage Disclosure Rates
- Medical Loss Ratio Rebates
- W-2 Reporting Requirements
- Limits on Flexible Spending Account Contributions
- Additional Medicare Withholding
- 90-Day Maximum Waiting Period
- Transitional Reinsurance Program Fees
- Workplace Wellness Programs
- Health Insurance Coverage Reporting Requirements
- Tax Treatment for Adult Children
- Over the Counter Drugs
- Excise Tax on High Cost Plans
- HSA Penalty Tax
- Comparative Effectiveness Research Fees
- Indirect Fees
- Administrative Requirements

Please distribute this memo within your District as deemed appropriate.

[i] Presented on January 31, 2013- District Chief Business Officer's Meeting

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HEALTH CARE REFORM GUIDANCE

Presented on January 31, 2013

District Chief Business Officers' Meeting

HIGHLIGHTS

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) enacted comprehensive health insurance reforms designed to ensure Americans have access to quality, affordable health insurance. Implementation of the Affordable Care Act occurs in stages, with many of the reforms and requirements taking effect in 2013 and 2014. Some of the provisions that may impact employers with 50 or more employees include:

Employer Shared Responsibility Provisions

Beginning in 2014, employers with 50 or more full-time (or full-time equivalent) employees that do not offer affordable health insurance may be required to pay an assessment if at least one of their full-time employees is certified to receive a premium tax credit in an individual Marketplace (Attachment 1). The ACA provides that, beginning in 2014, individuals will be eligible for refundable premium tax credits if they:

1. are not eligible for health insurance coverage through an employer or through a government program;
2. are citizens of or lawfully present in the United States and not incarcerated (other than pending final disposition of charges);
3. have modified adjusted gross household incomes (MAGI) between 100 percent and 400 percent of the federal poverty level.

The tax credits will be paid on a monthly basis directly to the qualified health plan (QHP) that an individual enrolls in through the exchange.

A full-time employee is one who is employed an average of at least 30 hours per week. The assessment, known as Employer Shared Responsibility, will offset part of the cost of the Marketplace tax credits. If a business meets the threshold level of 50 full-time or full-time equivalent employees, or is close to it, it's important to understand how these rules may apply and how the payment amounts are calculated. Refer to the attached FAQs from the IRS for more information.

Alternatively, if an employer offers health coverage that is either unaffordable (the premium contribution to receive health coverage from the employer costs the employee more than 9.5% of W-2 income) or inadequate (the coverage has an actuarial value of less than 60%), the employer must pay a monthly Free Rider Penalty of 1/12th x $3,000 x each full-time employee who receives a premium tax credit for Exchange coverage, capped at the penalty amount the employer would have paid for not offering coverage.

Summary of Benefits and Coverage (SBCs) Disclosure Rules

Employers are required to provide employees with a standard "Summary of Benefits and Coverage" form explaining what their plan covers and what it costs. The purpose of the SBC form is to help employees better understand and evaluate their health insurance options. Penalties may be imposed for non-compliance. For more information, refer to Attachment 2 which is a completed Summary of Benefits and Coverage Form from the U.S. Department of Labor.

Medical Loss Ratio Rebates

Under ACA, insurance companies must spend at least 80% of premium dollars on medical care rather than administrative costs. Insurers who do not meet this ratio are required to provide rebates to their policyholders, which is typically an employer who provides a group health plan.

W-2 Reporting of Aggregate Health Care Costs

Beginning January 2013 (applicable to 2012 reporting), most employers must report the aggregate annual cost of employer-provided coverage for each employee on the Form W-2. The new W-2 reporting requirement is informational only and it does not require taxation on any health plan coverage. Reporting is required for most employer-sponsored health coverage, including group medical coverage.

Limits on Flexible Spending Account Contributions

For plan years beginning on or after January 2013, the maximum amount an employee may elect to contribute to health care flexible spending arrangements (FSAs) for any year will be capped at $2500, subject to cost-of-living adjustments. Note that the limit only applies to elective employee contributions and does not extend to employer contributions.

Additional Medicare Withholding on Wages

Beginning January 1, 2013, the ACA increases the employee portion of the Medicare Part A Hospital Insurance (HI) withholdings by .9% (from 1.45% to 2.35%) on employees with incomes of over $200,000 for single filers and $250,000 for married joint filers. It is the employer's obligation to withhold this additional tax for single filers only. The employer portion of the tax will remain unchanged at 1.45%.

90-Day Maximum Waiting Period

Beginning January 1, 2014, individuals who are eligible for employer-provided health coverage will not have to wait more than 90 days to begin coverage. Please refer to the IRS website at http://www.irs.gov/irb/2012-41_IRB/ar08.html for up to date guidance on this topic.

Transitional Reinsurance Program Fees

Section 1341 of the Affordable Care Act establishes a transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. For three years beginning in 2014, health insurance issuers and third party administrators on behalf of group health plans will be required to pay reinsurance fees to state-established Exchange reinsurance entities. The purpose of the fee is to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation.

The U.S. Department of Health and Human Services estimates that the fees for 2014 will be $5.25 a month (or $63 for the year) for each individual covered under a health care plan, with the required fee for the following two years to be somewhat lower. The fee applies to all employer-sponsored plans providing major medical coverage, including retiree programs.

Workplace Wellness Programs

The ACA creates new incentives to promote employer wellness programs and encourage opportunities to support healthier workplaces. Effective January 1, 2014, the maximum reward under a health-contingent wellness program will increase from 20 percent to 30 percent of the cost of health coverage, and the maximum reward for programs designed to prevent or reduce tobacco use will be as much as 50 percent.

Health Insurance Coverage Reporting Requirements

Beginning with health coverage provided on or after January 1, 2014, employers subject to the Employer Shared Responsibility rules must provide the IRS with information about full time employees' coverage under the health plans and the cost of benefits provided. See Attachment 3 for the IRS notice related to this mandate. Likewise, employers that sponsor self-insured plans must submit reports (Attachment 4) detailing information for each covered individual. The first of these reports must be filed in 2015.

Tax Treatment for Adult Children

For plan years beginning on or after *September 23,2010,* health plans that cover children are required to offer coverage to adult children up to age 26. In addition, Health Care Reform extended eligibility for tax-free employer-sponsored health coverage/ reimbursement for adult children until the end of the calendar year in which a child turns age 26. Participants in Health FSAs or HRAs may be reimbursed for medical expenses incurred for these individuals. The rules regarding eligibility for reimbursement of HSA-qualified medical expenses were not changed - only expenses incurred by tax-qualified dependents may be reimbursed on a tax-free basis from an HSA.

Over-the-Counter Drugs

Effective *January 1, 2011,* reimbursements for over-the-counter (OTC) drugs and medicines are permitted only with a medical practitioner's prescription. The IRS's general rule is that Health

FSA debit cards may not be used to purchased drugs or medicines over- the-counter. However, if a pharmacist dispenses a drug or medicine "behind-the-counter" pursuant to a prescription (even if it's a drug that may be purchased over-the-counter),the charge will be coded as a prescription drug, which the card should allow the customer to purchase. In other words, if the purchase "looks" to the debit card like it's an over-the-counter purchase, the card will deny the charge; if the purchase "looks" to the debit card like a prescription, the card should allow the charge.

Excise Tax on High Cost Plans (Cadillac Tax)

Effective *January 1, 2018,* an excise tax will be imposed to the extent the aggregate value of specified employer sponsored health coverage exceeds certain threshold amounts- generally $10,200 for individual coverage and $27,500 for family coverage.

HSA Penalty Tax

Beginning *January* 7, *2011,* withdrawals from HSAs not used for qualified medical expenses are subject to a 20% excise tax, which is an increase from 10% under prior law.

Comparative Effectiveness Research Fee

Plan sponsors of self-funded health plans and insurers of insured health plans must pay a fee to help fund the Patient-Centered Outcomes Research Institute based on the average number of lives covered participating in the plan. Details regarding how and when to pay the fee have not yet been published. The fee is as follows:

- $1 per individual for the first plan year beginning after September 30,2011.
- $2 per plan participant for the 2012 and 2013 plan years.
- Increase to indexed cost of “national health expenditures” for September 30, 2014 through September 30, 2019
- No fees beyond September 30, 2019.

Indirect Fees

Health Care Reform includes three fees that could indirectly raise health plan costs for plan sponsors:

- Prescription Drug Manufacturer Fee - Effective *January 1, 2011,* brand name prescription drug manufacturers must pay an annual fee based on their prescription drug sales. Costs are likely to be passed onto plan sponsors in the form of increased brand name prescription drug costs.
- Medical Device Fee - Effective *January 1, 2012,* medical device manufacturers, producers, or importers must pay an excise tax equal to 2.3% of the sale price on the sale of certain medical devices. Costs are likely to be passed on to plan sponsors in the form of increased medical device costs.

- Health Insurer Fee -Effective *January 1, 2014*, insurance companies must pay an annual fee based on the amount of premiums they receive. Costs are likely to be passed on to plan sponsors in the form of increased premiums.

Administrative Requirements

30-day Open Enrollment

Plans were required to offer a minimum of 30 days for open enrollment for the first plan year beginning on or after September 23, 2010. The purpose was to provide an adequate opportunity to enroll for individuals who were previously excluded from the plan due to the imposition of lifetime limits or age. This was a one-time requirement.

Automatic Enrollment

Plan sponsors with 200 or more full-time employees must automatically enroll their newly eligible full-time employees in employer- sponsored health coverage. In the event employees want different health coverage, they will be able to opt out of the employer's plan. The employer will be required to provide notices to employees regarding the automatic enrollment process. The effective date for this requirement is expected to be established by regulations, which the agencies don't expect to publish before 2014.

W-2 Reporting

Most employers are required to report the aggregate cost of specified employer-sponsored health coverage on employee W-2 Forms beginning with the 2012 calendar year (W-2s generally required to be provided no later than January 2013). Certain small employers (those that file fewer than 250 W-2 Forms for the previous calendar year) are exempt from the new reporting requirement until the IRS publishes additional guidance.

Quality Reporting

Plan sponsors of non-grandfathered plans must report on plan benefits and reimbursement structures that provide certain quality related programs like disease management. Reports must be issued annually to The U.S. Department of Health and Human Services (HHS) and to employees during open enrollment. HHS must develop guidance by March 23, 2013 and is likely to establish the effective date in that guidance.

Coverage and Workforce Reporting

Effective on January 1, 2014, employers with 50 or more full-time employees must submit reports to the IRS with extensive details about the employer's health coverage and the employer's reports to the IRS with extensive details about employer’s health coverage and employer’s workforce. An employer must also provide a written statement to each full-time employee named in the report.

Cadillac Tax Reporting

Effective January 1, 2018, plan sponsors are required to calculate on a per month basis the value of health coverage that each employee selects and, if coverage for any individual exceeds the applicable threshold, to notify the entity required to pay the tax and the IRS. For more information see the summary of the Cadillac Tax in the summary of Plan Sponsorship Provisions.

Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act

December 28, 2012

Basics of the Employer Shared Responsibility Provisions

1. What are the Employer Shared Responsibility provisions?

Starting in 2014, employers employing at least a certain number of employees (generally 50 full-time employees and full-time equivalents, explained more fully below) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). Under these provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges.

To be subject to these Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed on average at least **30** hours per week (so half-time would be 15 hours per week).

2. When do the Employer Shared Responsibility provisions go into effect?

The Employer Shared Responsibility provisions generally go into effect on January 1, 2014. Employers will use information about the employees they employ during 2013 to determine whether they employ enough employees to be subject to these new provisions in 2014. See question 4 for more information on determining whether an employer is subject to the Employer Shared Responsibility provisions.

3. Is more detailed information available about the Employer Shared Responsibility provisions?

Yes. Treasury and the IRS have proposed regulations on the new Employer Shared Responsibility provisions. Comments on the proposed regulations may be submitted by mail, electronically, or hand-delivered, and are due by March 18, 2013.

Which Employers are Subject to the Employer Shared Responsibility provisions?

4. I understand that the employer shared responsibility provisions apply only to employers employing at least a certain number of employees? How does an employer know whether it employs enough employees to be subject to the provisions?

To be subject to the Employer Shared Responsibility provisions, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 (for example, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees). Employers will determine each year, based on their current number of employees, whether they will be considered a large employer for the next year. For example, if an employer has at least 50 full-time employees, (including full-time equivalents) for 2013, it will be considered a large employer for 2014.

Employers average their number of employees across the months in the year to see whether they meet the large employer threshold. The averaging can take account of fluctuations that many employers may experience in their work force across the year. For those employers that may be close to the 50 full-time employee (or equivalents) threshold and need to know what to do for 2014, special transition relief is available to help them count their employees in 2013. See question 19 below for information about this transition relief. The proposed regulations provide additional information about how to determine the average number of employees for a year, including information about how to take account of salaried employees who may not clock their hours and a special rule for seasonal workers.

5. If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?

Yes, consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold. (The rules for combining related employers do not apply for purposes of determining whether an employer owes an

Employer Shared Responsibility payment or the amount of any payment). The proposed regulations provide information on the rules for determining whether companies are related and how they are applied for purposes of the Employer Shared Responsibility provisions.

6. Do the Employer Shared Responsibility provisions apply only to large employers that are for-profit businesses or to other large employers as well?

All employers that employ at least 50 full-time employees or an equivalent combination of full-time and part-time employees are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit and government entity employers.

7. Which employers are not subject to the Employer Shared Responsibility provisions?

Employers who employ fewer than 50 full-time employees (or the equivalent combination of full-time and part-time employees) are not subject to the Employer Shared Responsibility provisions. An employer with at least 50 full-time employees (or equivalents) will not be subject to an Employer Shared Responsibility payment if the employer offers affordable health coverage that provides a minimum level of coverage to its full-time employees.

8. Are companies with employees working outside the United States subject to the Employer Shared Responsibility provisions?

For purposes of determining whether an employer meets the 50 full-time employee (or full-time employees and full-time employee equivalents) threshold, an employer generally will take into account only work performed in the United States. For example, if a foreign employer has a large workforce worldwide, but less than 50 full-time (or equivalent) employees in the United States, the foreign employer generally would not be subject to the Employer Shared Responsibility provisions.

9. Are companies that employ US citizens working abroad subject to the Employer Shared Responsibility provisions?

A company that employs U.S. citizens working abroad generally would be subject to the Employer Shared Responsibility provisions only if the company had at least 50 full-time employees (or the equivalent combination of full-time and part-time employees), determined by taking into account only work performed in the United States. Accordingly, employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer meets the 50 full-time employee (or equivalents) threshold. Furthermore, for employees working abroad the time spent working for the employer outside of the U.S. would not be taken into account for purposes of determining whether the employer owes an Employer Shared Responsibility payment or the amount of any such payment.

Liability for the Employer Shared Responsibility Payment

10. Under what circumstances will an employer owe an Employer Shared Responsibility payment?

In 2014, if an employer meets the 50 full-time employee threshold, the employer generally will be liable for an Employer Shared Responsibility payment only if:

(a) The employer does not offer health coverage or offers coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange;

OR

(b) The employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee (see question 11, below) or did not provide minimum value (see question 12, below).

After 2014, the rule in paragraph (a) applies to employers that do not offer health coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.

11. How does an employer know whether the coverage it offers is affordable?

If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5% of that employee's annual household income, the coverage is not considered affordable for that employee. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement (see question 12, below.)

Because employers generally will not know their employees' household incomes, employers can take advantage of one of the affordability safe harbors set forth in the proposed regulations. Under the safe harbors, an employer can avoid a payment if the cost of the coverage to the employee would not exceed 9.5% of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2, or if the coverage satisfies either of two other design-based affordability safe harbors.

12. How does an employer know whether the coverage it offers provides minimum value?

A minimum value calculator will be made available by the IRS and the Department of Health and Human Services (HHS). The minimum value calculator will work in a similar fashion to the actuarial value calculator that HHS is making available. Employers can input certain information about the

plan, such as deductibles and co-pays, into the calculator and get a determination as to whether the plan provides minimum value by covering at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.

13. If an employer wants to be sure it is offering coverage to all of its full-time employees, how does it know which employees are full-time employees? Does the employer need to offer the coverage to all of its employees because it won't know for certain whether an employee is a full-time employee for a given month until after the month is over and the work has been done?

The proposed regulations provide a method to employers for determining in advance whether or not an employee is to be treated as a full-time employee, based on the hours of service credited to the employee during a previous period. Using this look-back method to measure hours of service, the employer will know the employee's status as a full-time employee at the time the employer would offer coverage. The proposed regulations are consistent with IRS notices that have previously been issued and describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and teachers who have time off between school years.

Calculation of the Employer Shared Responsibility Payment

14. If an employer that does not offer coverage or offers coverage to less than 95% of its employees owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?

In 2014, if an employer employs enough employees to be subject to the Employer Shared Responsibility provisions and does not offer coverage during the calendar year to at least 95% of its full-time employees, it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. (Note that for purposes of this calculation, a full-time employee does not include a full-time equivalent). For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of $2,000. If the employer is related to other employers (see question 5 above), then the 30-employee exclusion is allocated among all the related employers. The payment for the calendar year is the sum of the monthly payments computed for each month for which coverage was not offered. After 2014, these rules apply to employers that do not offer coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.

15. If an employer offers coverage to at least 95% of its employees, and, nevertheless, owes the Employer Shared Responsibility payment, how is the amount of the payment calculated?

For an employer that offers coverage to at least 95% of its full-time employees in 2014, but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 30) multiplied by 1/12 of $2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage). After 2014, these rules apply to employers that offer coverage to at least 95% of full time employees and the dependents of those employees.

Making an Employer Shared Responsibility Payment

16. How will an employer know that it owes an Employer Shared Responsibility payment?

The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after employees' individual tax returns are due for that year claiming premium tax credits and after the due date for employers that meet the 50 full-time employee (plus full-time equivalents) threshold to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

17. How will an employer make an Employer Shared Responsibility payment?

If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file.

Transition Relief

18. I understand that the Employer Shared Responsibility provisions do not go into effect until 2014. However, the health plan that I offer to my employees runs on a fiscal plan year that starts in 2013 and will run into 2014. Do I need to make sure my plan complies with these new requirements in 2013 when the next fiscal plan year starts?

For an employer that as of December 27, 2012, already offers health coverage through a plan that operates on a fiscal year (a fiscal year plan), transition relief is available. First, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014. Second, if (a) the fiscal year plan (including any other fiscal year plans that have the same plan year) was offered to at least one third of the employer's employees (full-time and part-time) at the most recent open season or (b) the fiscal year plan

covered at least one quarter of the employer's employees, then the employer also will not be subject to the Employer Shared Responsibility payment with respect to any of its full-time employees until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. So, for example, if during the most recent open season preceding December 27, 2012, an employer offered coverage under a fiscal year plan with a plan year starting on July 1, 2013 to at least one third of its employees (meeting the threshold for the additional relief), the employer could avoid liability for a payment if, by July 1, 2014, it expanded the plan to offer coverage satisfying the Employer Shared Responsibility provisions to the full-time employees who had not been offered coverage. For purposes of determining whether the plan covers at least one quarter of the employer's employees, an employer may look at any day between October 31, 2012 and December 27, 2012.

19. Is transition relief available to help employers that are close to the 50 full-time employee threshold determine their options for 2014?

Yes. Rather than being required to use the full twelve months of 2013 to measure whether it has 50 full-time employees (or an equivalent number of part-time and full-time employees), an employer may measure using any six-consecutive-month period in 2013. So, for example, an employer could use the period from January 1, 2013, through June 30, 2013, and then have six months to analyze the results, determine whether it needs to offer a plan, and, if so, choose and establish a plan.

Additional Information

20. When can an employee receive a premium tax credit?

Premium tax credits generally are available to help pay for coverage for employees who

- are between 100% and 400% of the federal poverty level and enroll in coverage through an Affordable Insurance Exchange,
- are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and
- are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.

21. If an employer does not employ enough employees to be subject to the Employer Shared Responsibility provisions, does that affect the employer's employees' eligibility for a premium tax credit?

No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer employs enough employees to be subject to the Employer Shared Responsibility provisions.

22. Where can employees get more information about Affordable Insurance Exchanges?

The Department of Health and Human Services is developing the rules for exchanges.

23. The Treasury Department and the IRS have proposed regulations on the Employer Shared Responsibility provisions that are proposed to be effective for months after December 31, 2013. However, there are certain decisions and actions employers may have to take during 2013 to prepare for 2014. May employers rely on the proposed regulations during 2013 for guidance on the Employer Shared Responsibility provisions?

Yes. Taxpayers may rely on the proposed regulations for purposes of compliance with the Employer Shared Responsibility provisions. If the final regulations are more restrictive than the guidance in the proposed regulations, the final regulations will be applied prospectively, and employers will be given sufficient time to come into compliance with the final regulations.

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	——————none——————
	Specialist visit	$50 copay/visit	40% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	——————none——————
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	$10 copay/ prescription (retail and mail order)	40% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	——————none——————
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	——————none——————
	Specialty drugs	50% coinsurance	70% coinsurance	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder outpatient services	$35 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	——————none——————
	Habilitation services	20% coinsurance	40% coinsurance	——————none——————
	Skilled nursing care	20% coinsurance	40% coinsurance	——————none——————
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$35 copay/ visit	Not Covered	Limited to one exam per year
	Glasses	20% coinsurance	Not Covered	Limited to one pair of glasses per year
	Dental check-up	No Charge	Not Covered	Covers up to $50 per year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Your Rights to Continue Coverage:

**** Individual health insurance sample –**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,490
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$30
Coinsurance	$1320
Limits or exclusions	$0
Total	**$2,050**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$800
Copays	$500
Coinsurance	$500
Limits or exclusions	$80
Total	**$1,880**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Attachment 3

Request for Comments on Reporting by Applicable Large Employers on Health Insurance Coverage Under Employer-Sponsored Plans

Notice 2012-33

I. PURPOSE

This notice invites comments on reporting under § 6056 of the Internal Revenue Code for applicable large employers (as defined in § 4980H(c)(2)) that are subject to § 4980H. Section 6056 was enacted by § 1514(a) of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (enacted on March 23, 2010), which was amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152 (enacted on March 30, 2010) (collectively, the Affordable Care Act). Section 6056 requires reporting of certain information on employer-provided health care coverage provided on or after January 1, 2014 and the furnishing of related statements to employees. The first information returns will be filed in 2015. The Internal Revenue Service will use the information that employers report under § 6056 to verify employer-sponsored coverage and to administer the shared employer responsibility provisions under § 4980H(a) and (b). See generally Notice 2011-36, 2011-21 IRB 792, and Notice 2011-73, 2011-40 IRB 74.

The Department of the Treasury and the Service intend to propose regulations implementing the reporting requirements of § 6056. The proposed regulations are expected to include guidance intended to minimize administrative burden and duplicative reporting. To assist in the development of the proposed regulations, this

notice invites comments on issues arising under § 6056, including on possible approaches for coordinating and minimizing duplication between the information required to be reported and furnished by employers under § 6056 and information required to be reported and/or furnished by employers or other persons under other applicable Code provisions. For example, § 6056(d) permits the Secretary of the Treasury to provide, to the maximum extent feasible, that any return or statement required under § 6056 may be provided as part of a return or statement under § 6055 (relating to reporting by entities that provide minimum essential coverage) or § 6051 (relating to reporting by employers on the Form W-2, Wage and Tax Statement), and that an applicable large employer offering coverage of an issuer may agree with the issuer to include information under § 6056 with the return and statement required to be provided by the issuer under § 6055.

II. BACKGROUND

A. Reporting to the Service

Section 6056(a), effective for years beginning after December 31, 2013, directs every applicable large employer (within the meaning of § 4980H(c)(2)) that must meet the shared employer responsibility requirements of § 4980H during a calendar year to file a return with the Service that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the year.

Section 6056(b) generally provides that the return used to satisfy the requirements under § 6056 must:

- Include the name and Employer Identification Number (EIN) of the applicable

large employer;

- Include the date the return is filed;
- Certify whether the applicable large employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in § 5000A(f)(2)) and, if so, certify

  (1) The duration of any waiting period (as defined in § 6056(b)(2)(C)) with respect to such coverage;

  (2) The months during the calendar year when coverage under the plan was available;

  (3) The monthly premium for the lowest cost option in each enrollment category under the plan; and

  (4) The employer's share of the total allowed costs of benefits provided under the plan.
- Report the number of full-time employees for each month of the calendar year;
- Report, for each full-time employee, the name, address, and taxpayer identification number (TIN) of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan; and
- Include such other information as may be required by the Secretary of the Treasury.

B. Reporting to Employees

Section 6056(c) provides that, no later than January 31 following the calendar year referred to in § 6056(a) and (b), the applicable large employer will furnish to each full-time employee whose information is required to be reported to the Service under § 6056(b) a written statement that includes:

- The applicable large employer's name and address;
- The applicable large employer's contact information (including a contact phone number);
- The information relating to coverage provided to that employee (and dependents) that is required to be reported on the § 6056 return.

Section 6056(e) generally permits governmental units or any agency or instrumentality thereof to designate a person to comply with the § 6056 reporting on behalf of the governmental unit, agency or instrumentality.

III. REQUEST FOR COMMENTS

Treasury and the Service anticipate proposing regulations under § 6056, and this notice requests comments on issues arising under § 6056 that would be helpful for the regulations to address, including how to coordinate and minimize duplication between the data employers must report under § 6056 and the data they must report under § 6055 (which provides for annual reporting by employers that sponsor self-insured plans) or other applicable Code or Affordable Care Act provisions. See Notice 2012-32, 2012-20 I.R.B. (May 14, 2012).

Comments must be submitted by June 11, 2012. Comments should be submitted to Internal Revenue Service, CC:PA:LPD:RU (Notice 2012-33), Room 5203, PO Box 7604, Ben Franklin Station, Washington, DC 20224. Submissions may also be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to the Courier's Desk, 1111 Constitution Avenue, NW, Washington, DC 20224, Attn: CC:PA:LPD:RU (Notice 2012-33), Room 5203. Submissions may also be sent electronically via the internet to the following e-mail address: Notice.Comments@irscounsel.treas.gov. Include the notice number (Notice 2012-33) in the subject line.

IV. DRAFTING INFORMATION

The principal author of this notice is R. Lisa Mojiri-Azad of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), though other Treasury Department and Service officials participated in its development. For further information on all other provisions of this notice, contact R. Lisa Mojiri-Azad at (202) 622-6080 (not a toll-free number).

Attachment 4

Request for Comments on Reporting of Health Insurance Coverage

Notice 2012-32

I. PURPOSE

This notice invites comments concerning the reporting requirements under § 6055 of the Internal Revenue Code for health insurance issuers, government agencies, employers that sponsor self-insured plans, and other persons that provide minimum essential coverage to an individual. Section 6055 was added by § 1502(a) of the Patient Protection and Affordable Care Act, Public Law 111-148, which was amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (collectively, the Affordable Care Act). The reporting requirements apply to coverage provided on or after January 1, 2014. The first information returns will be filed in 2015. The Department of the Treasury and the Internal Revenue Service plan to propose regulations implementing the reporting requirements under § 6055. The proposed regulations are expected to include guidance intended to minimize administrative burden and duplicative reporting. To assist in the development of the proposed regulations, this notice invites comments on issues arising under § 6055.

II. BACKGROUND

"Minimum essential coverage" is a term defined to include health insurance coverage offered in the individual market (such as a qualified health plan enrolled in through an Affordable Insurance Exchange (Exchange)), an eligible employer-sponsored plan, or government-sponsored coverage such as Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, or veterans' health care under chapter 17 or 18 of Title 38 U.S.C. Section 5000A(f). Under § 5000A(f)(1)(E), the Department

of Health and Human Services, in coordination with the Treasury Department, may designate other health benefits coverage as minimum essential coverage.

Section 6055(a) requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and other entity that provides minimum essential coverage to file annual returns reporting information for each individual for whom minimum essential coverage is provided. If health insurance coverage is provided by a health insurance issuer and consists of coverage provided through a group health plan of an employer, it is anticipated that the regulations would make the health insurance issuer responsible for the reporting.

Section 6055(b)(1) provides that all information returns reporting minimum essential coverage are to contain (1) the name, address, and taxpayer identification number of the primary insured and each other individual covered under the policy or plan, (2) the dates each individual was covered under minimum essential coverage during the calendar year, (3) in the case of health insurance coverage, whether the coverage is a qualified health plan offered through an Exchange, (4) if the coverage is a qualified health plan offered through an Exchange, the amount (if any) of any advance payment of the premium tax credit under § 1412 of the Affordable Care Act or of any cost-sharing reduction under § 1402 of the Affordable Care Act for each covered individual, and (5) other information that the Secretary requires.

Section 6055(b)(2) provides that information returns for minimum essential coverage provided by a health insurance issuer through an employer's group health plan also include the name, address, and employer identification number of the

employer maintaining the plan, the portion of the premium to be paid by the employer, and any other information that the Secretary may require for administering the tax credit under § 45R (credit for employee health insurance expenses of small employers).

Section 6055(c)(1) directs the entity filing an information return reporting minimum essential coverage to furnish a written statement to each individual listed on the return that shows the information that must be reported to the Service for that individual.

In addition, effective for years beginning after 2013, § 6056 directs every applicable large employer (within the meaning of § 4980H(c)(2)) that is required to meet the shared employer responsibility requirements of § 4980H during a calendar year to file a return with the Service that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the year. The return also is required to include information on the employer's full-time employees, including those who received the coverage and when they received it. Section 6056(d) permits the Secretary to provide, to the maximum extent feasible, that any return or statement required under § 6056 may be provided as part of a return or statement under § 6055 or § 6051 (relating to reporting by employers on the Form W-2, Wage and Tax Statement), and that an applicable large employer offering coverage of an issuer may agree with the issuer to include information under § 6056 with the return and statement provided by the issuer under § 6055. See Notice 2012-33, 2012-20 I.R.B. (May 14, 2012).

III. REQUEST FOR COMMENTS

The Treasury Department and the Service request comments on issues that should be addressed in regulations implementing reporting under § 6055, including but not limited to:

1. How to determine when an individual's coverage begins and ends for purposes of reporting the dates of coverage.

2. How to minimize duplication between the reporting by health insurance issuers and employers under § 6055 and the reporting by Exchanges under § 36B(f)(3).

3. How to coordinate and minimize duplication between the reporting under § 6055, § 6056, and any other applicable Code provision for employers that sponsor self-insured plans, including but not limited to the potential combined reporting referred to in § 6056(d), as described above.

4. When minimum essential coverage is provided through a voluntary employees' beneficiary association or other type of welfare benefit fund, who is required to report under § 6055 and what, if any, special rules should apply.

5. Whether there are any specific concerns that should be taken into account in any of the following circumstances:

a. In the case of electronic information reporting and delivery of statements to individuals and the Service;

b. If a third party administrator has information that is relevant to reporting for a self-insured plan;

c. If an individual is covered under one type of coverage for part of the year and another type of coverage for another part of the year; or

d. When minimum essential coverage is provided under a multiemployer plan.

6. Whether any difficulties exist in identifying the person responsible for administering information reporting for governmental coverage, for example in state-administered programs such as Medicaid.

7. Any additional suggestions for minimizing burden on entities reporting information

under § 6055.

Comments may be submitted in writing on or before June 11, 2012. Comments should be submitted to Internal Revenue Service, CC:PA:LPD:PR (Notice 2012-32), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044, or electronically to Notice.Comments@irscounsel.treas.gov. Please include "Notice 2012-32" in the subject line of any electronic communications. Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (Notice 2012-32), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. All comments will be available for public inspection and copying.

IV. DRAFTING INFORMATION

The principal authors of this notice are Andrew Braden and Frank W. Dunham III of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information, please contact Mr. Braden or Mr. Dunham at (202) 622-4960 (not a toll-free call).