

U.S. Department of Labor

Employee Benefits Security Administration
200 Constitution Ave. N.W
Washington D.C. 20210



DOL TECHNICAL RELEASE 2012-02

DATE: AUGUST 31, 2012

SUBJECT: GUIDANCE ON 90-DAY WAITING PERIOD LIMITATION UNDER PUBLIC HEALTH SERVICE ACT § 2708

I. INTRODUCTION

The Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) are working together to develop coordinated regulations and other administrative guidance to assist stakeholders with implementation of the Patient Protection and Affordable Care Act (Affordable Care Act). This Technical Release, which is being issued in substantially identical form by the other two Departments, provides temporary guidance regarding the 90-day waiting period limitation in Public Health Service Act (PHS Act) section 2708.¹ The guidance will remain in effect at least through the end of 2014. In addition, the Treasury Department, including the Internal Revenue Service (IRS), is concurrently issuing a notice providing administrative guidance on the shared responsibility of employers under section 4980H of the Internal Revenue Code (Code). See IRS Notice 2012-58. That guidance has been coordinated with the Departments of Labor and HHS and with the guidance contained in this Technical Release.

II. BACKGROUND

PHS Act section 2708 provides that, for plan years beginning on or after January 1, 2014, a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days.² PHS Act section 2704(b)(4), ERISA section 701(b)(4), and Code section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan. In 2004 regulations, the Departments defined a waiting period to mean the

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 (Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, PHS Act section 2708 is subject to shared interpretive jurisdiction by the Departments.

² PHS Act section 2708 applies to both grandfathered and non-grandfathered plans. See section 1251(a)(4)(A)(i) of the Affordable Care Act.

period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.³

PHS Act section 2708 does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees. PHS Act section 2708 merely prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective.

The Departments invited comments on the 90-day waiting period limitation, in addition to requesting comments on the employer shared responsibility provisions of Code section 4980H, in IRS Notice 2011-36.⁴ Subsequent guidance outlined various approaches under consideration with respect to both the 90-day waiting period limitation and the employer shared responsibility provisions.⁵ Specifically, the guidance outlined an approach under which employers would be permitted, under certain circumstances, to use an eligibility condition requiring an employee to complete a specified number of cumulative hours of service in order to be eligible for the coverage under the plan. Comments were invited on this and other aspects of the guidance, including how rules relating to the potential look-back/stability period safe harbor method for determining the full-time status of employees under Code section 4980H should be coordinated with the 90-day waiting period limitation of PHS Act section 2708.

III. GUIDANCE

This section provides temporary guidance on what the Departments will consider as compliance with PHS Act section 2708, and this guidance will remain in effect at least through the end of 2014. Regulations or other guidance on these issues applicable for periods after 2014 will provide adequate time to comply with any additional or modified requirements.

A. WAITING PERIOD DEFINED

A group health plan and a health insurance issuer offering group coverage may not use a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

Consistent with PHS Act section 2708, eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

Furthermore, if, under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period

³ 26 CFR 54.9801-3(a)(3)(iii), 29 CFR 2590.701-3(a)(3)(iii), 45 CFR 146.111(a)(3)(iii).

⁴ See www.irs.gov/file_source/pub_irs-drop_n-11-36.pdf.

⁵ Department of Labor Technical Release 2012-01, IRS Notice 2012-17, and HHS FAQs issued February 9, 2012.

limitation is considered satisfied. Accordingly, a plan or issuer will not be considered to have violated PHS Act section 2708 merely because employees take additional time to elect coverage.

B. APPLICATION TO VARIABLE HOUR EMPLOYEES WHERE A SPECIFIED NUMBER OF HOURS OF SERVICE PER PERIOD IS A PLAN ELIGIBILITY CONDITION

If a group health plan conditions eligibility on an employee regularly working a specified number of hours per period (or working full time), and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period that is consistent with the timeframe permitted for such determinations under Code section 4980H.⁶ An employer may use a measurement period that is consistent with section 4980H, whether or not it is an applicable large employer subject to section 4980H. Except where a waiting period that exceeds 90 days is imposed after a measurement period, the time period for determining whether such an employee meets the plan's eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date, plus if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

IV. EXAMPLES

Examples set forth below illustrate how the "designed to avoid compliance with the 90-day waiting period limitation" standard applies to various plan eligibility conditions at least through the end of 2014. Comments are invited on additional examples (if any) that would be helpful to include in future regulations or other guidance.

Example 1. (i) Facts. Employer *W*'s group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date. Employee *A* is hired and starts on October 31, which is the first day of the payroll period. On November 2, *A* completes and files all the forms necessary to enroll in the plan. *A*'s coverage under the plan becomes effective on November 14, which is the first day of the first payroll period after *A* completes the enrollment forms.

(ii) Conclusion. In this Example 1, under the terms of *W*'s plan, coverage may become effective as early as October 31, depending on when *A* completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective is dependent solely on the length of time taken by *A* to complete the enrollment materials. Therefore, under the terms of the plan, *A* may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with PHS Act section 2708.

⁶ IRS Notice 2012-58 provides guidance regarding the measurement period that may be used under Code section 4980H. That guidance provides a safe harbor method under which an applicable large employer may use a measurement period of up to 12 months to determine whether certain types of new employees are full-time employees, without being subject to an assessable payment under Code section 4980H for that period with respect to such employees.

Example 2. (i) Facts. Employer *X*'s group health plan limits eligibility for coverage to full-time employees. Coverage becomes effective on the first day of the calendar month following the date the employee becomes eligible. Employee *B* begins working full time for Employer *X* on April 11. Prior to this date, *B* worked part time for *X*. *B* enrolls in the plan and coverage is effective May 1.

(ii) Conclusion. In this Example 2, the period from April 11 through April 30 is a waiting period. The period while *B* was working part time is not part of the waiting period because *B* was not in a class of employees eligible for coverage under the terms of the plan while working part time, and full-time versus part-time status is a bona fide employment-based condition that is not considered to be designed to avoid compliance with the 90-day waiting period limitation.

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

(ii) Conclusion. In this Example 3, the measurement period is not considered to be designed to avoid compliance with the 90-day waiting period limitation (and is, therefore, permissible) because the plan may use a reasonable period of time to determine whether a variable-hour employee is full time under PHS Act section 2708 if the period of time is consistent with the timeframe permitted for such determinations under Code section 4980H. In such circumstances, the time period for determining whether an employee is full time will not be considered to avoid the 90-day waiting period limitation if coverage can become effective no later than 13 months from *C*'s start date, plus the time remaining until the first day of the next calendar month.

Example 4. (i) Facts. Employee *D* begins working 25 hours per week for Employer *Z* on January 3 and is considered a part-time employee for purposes of *Z*'s group health plans. *Z* sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. *D* satisfies the plan's cumulative hours of service condition on December 15.

(ii) Conclusion. In this Example 4, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for *D* under the plan must begin no later than the 91st day after *D* works 1,200 hours. (If the plan's cumulative hours of service requirement

were more than 1,200 hours, the Departments would consider the requirement to be designed to avoid compliance with the 90-day waiting period limitation.)

V. RELIANCE

Employers, plans and issuers may rely on the compliance guidance in this notice at least through the end of 2014. An employee or related individual is not eligible for minimum essential coverage under the plan (and therefore may be eligible for a premium tax credit or cost-sharing reduction) during any period when coverage is not offered, including any measurement period or administrative period prior to when coverage takes effect. Thus, all employees, whether full-time, part-time, or variable, who are not offered the opportunity to enroll in health insurance by their employer will be eligible to receive premium tax credits and cost-sharing reductions for Exchange coverage if they meet other conditions for receipt of these credits.

VI. REQUEST FOR COMMENTS

Comments are requested by September 30, 2012. *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 as received, and can be retrieved by most Internet search engines. Comments may be submitted anonymously. Comments will be shared among the Departments.

Comments may be sent electronically to: e-ohpsca-er.ebsa@dol.gov. Alternatively, comments may be sent via mail or hand delivery to: 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.

VII. FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this Technical Release and are publishing substantively identical issuances. Questions concerning the information contained herein may be directed to the Internal Revenue Service at 202-622-6080; the Department of Labor's Office of Health Plan Standards and Compliance Assistance at 202-693-8335; or the Department of HHS at 410-786-1565 or phig@cms.hhs.gov. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov and www.dol.gov/ebsa/healthreform.

Methods for Employer Contributions to SHOP

Two types of reference plan premiums in IRS

Notice:

1. Composite premium (same for each member)
2. Premium that varies by age of member

In both cases, the small business can define its contribution as a percentage of the premium for the reference plan.

Methods for Employer Contributions to SHOP

1. Does employer want each employee to contribute the same amount toward the reference plan; or
2. Does employer want employee's contribution to vary by age?
 - Option 2 results in lower premium contributions for younger individuals and higher premium contributions for older individuals who are also more likely to incur higher out-of-pocket costs.

Option 1

- Employer selects a reference plan, but sets the employee's contribution so that all employees pay the same dollar amount. This dollar amount cannot be more than 50% of the employer-calculated composite rate. The employer contribution is the difference between the premium and the fixed dollar amount of the employee's contribution. If the employee selects an alternate plan, the employee pays the differential premium cost.

Option 1

Employee	John	Angie
Age	35	55
Reference Plan (RP) Premium	\$300	\$600
RP Average Premium (Employer calculated composite rate)	\$450	\$450
Employee Contribution %	50%	50%
Employee Contribution for RP	\$225	\$225
Employer Contribution (\$)	\$75	\$375
Alternate Plan (AP) Premium	\$320	\$650
Employee Contribution for AP	\$245	\$275

Option 2

Employer pays a fixed percentage of a reference plan and employees can enroll in reference plan or use the employer contribution and select other plans. Employer's percentage of contribution is the same for all employees, although the dollar amount of the employer's contribution will vary by age of employee.

Option 2

Employee	Bill	Mary
Age	35	55
Reference Plan (RP) Premium	\$300	\$600
Employer Contribution (%)	50%	50%
Employer Contribution	\$150	\$300
Employee Contribution for RP	\$150	\$300
Alternate Plan Premium (AP)	\$320	\$650
Employee Contribution for AP	\$170	\$350

- A flat dollar contribution for all employees is not permissible based on Age Discrimination in Employment law.
- “Safe harbor” provisions: Employers offering more than one plan and using a reference plan can satisfy uniformity requirements if the self-only composite rate for RP is at least 66 % of the self-only composite rate of each non-reference plan.

environment, including the identification of reinsurance eligible claims by State. The reports would indicate whether HHS accepted or rejected submitted files and data, and errors detected by HHS. Issuers would need to provide corrected files and data to address errors identified in HHS-provided reports for those files and data to be eligible for identification during reinsurance processing. Timeframes for the processing and reporting of these reports, including receipt of corrected files or discrepancy resolution, will be provided in future guidance.

H. Small Business Health Options Program

1. Employee Choice in the Federally-Facilitated SHOP (FF-SHOP)

Employee choice is a central SHOP concept, and facilitating employee choice at a single level of coverage selected by the employer – bronze, silver, gold, or platinum – is a required SHOP function.⁴⁴ In addition, the SHOP may also allow a qualified employer to make QHPs available to employees by other methods.⁴⁵ For the FF-SHOP, we continue to consider whether to allow a qualified employer to offer its employees only a single QHP. We note that, once an employer has selected a single QHP and decided on a contribution toward that QHP, the employer can then offer employees a choice of all the other plans at the same metal level at no additional cost to the employer. Since adding employee choice would have no adverse financial impact on the employer, we propose that Federally-facilitated SHOPs will not offer a single QHP option to employers but will focus instead on the innovative features of a SHOP: a simpler employer experience and enhanced employee choice. In FF-SHOPs, we propose that employers will choose a level of coverage (bronze, silver, gold, or platinum) and a contribution, and employees can then choose any QHP at that level.

⁴⁴ §155.705(b)(2).

⁴⁵ §155.705(b)(3).

In addition to this choice within single level of coverage, many employers expressed support for employer and employee choice across metal levels both in comments to the Exchange Establishment NPRM and in stakeholder discussions. Issuers, however, have expressed concern about the potential risk segmentation that may result. In comments submitted to HHS in connection with the Exchange Final Rule,⁴⁶ issuers urged that employee choice be limited to a single level of coverage selected by the employer based on the potential for risk segmentation with a greater degree of employee choice. There was general agreement among these commenters that the degree of risk segmentation is small if employee choice is limited to a single metal level of coverage, particularly given the presence of risk adjustment, and increases as employee choice is extended across metal levels of coverage. Many commenters suggested that the risk segmentation associated with broad choice across all metal levels may adversely affect premiums.

Some issuers expressed openness to allowing the employee to “buy up” to certain plans at the next higher level of coverage, thereby offering employees a broader range of health plans. Therefore, we seek comment on adding an additional employer option in the FF-SHOP that would allow a qualified employer to make available to employees all QHPs at the level of coverage selected by the employer plus any QHPs at the next higher level of coverage that a QHP issuer agrees to make available under this option. QHP issuers could decide whether or not to make available QHPs at the next higher level of coverage above the level of coverage selected by the employer.

We note that concerns about risk selection will be mitigated both by the risk adjustment program which addresses risk selection directly and by consumer tools

⁴⁶ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-9989), 77 FR 18310 (Mar. 27, 2012).

showing expected “total costs” of coverage (premium, deductibles, copayments and coinsurance) that help consumers compare the cost of a high premium/low cost sharing plan with a low premium/high cost sharing plan. Nonetheless, particularly in the early years of implementation, the FF-SHOP in each State will need to balance the fundamental goal of enhancing employer and employee choice against concerns about potential risk selection to achieve the broadest issuer participation, the best range of plan design choices, and the most effective competition in the small group market. Therefore, we seek comment on a transitional policy in which a Federally-facilitated SHOP would allow or direct employers to choose a single QHP from those offered through the SHOP.

2. Methods for Employer Contributions in the FF-SHOP

Employers may elect a variety of ways to contribute toward health coverage that are consistent with Federal law. Because employees in the FF-SHOP will be choosing their own coverage and will need to know the net cost to them after the employer’s contribution, the employer will need to choose a contribution method before employees select their qualified health plans. To facilitate this, each SHOP would offer “safe harbor” methods of contributing toward the employee coverage – methods that reflect a meaningful employer choice and that conform to existing Federal law. The safe harbor methods described below are not the only allowable methods of contribution, but are those that will be available initially to qualified employers participating in FF-SHOPs.

Under this proposed rule at § 155.705(b)(11), FF-SHOPs would base the employer contribution methods on the cost of a reference plan chosen by the qualified employer. This reference plan approach is one of the methods described in section III.G. of IRS Notice 2010-82 regarding allowable ways an employer may contribute to the employees’ premiums and qualify for the small business premium tax credit prior to

2014.⁴⁷ We note that the IRS plans to issue additional guidance applicable to plan years beginning after 2013.

The IRS Notice describes two types of reference plan premiums – one in which the premium for the reference plan is a composite premium that is the same for each member and a second in which the premium for the reference plan varies with the age of the covered individual (or other permissible rating factor). In both cases, the small business can define its contribution toward a member's coverage as a percentage of the premium for the reference plan.

Except in States that prohibit employee contributions that vary by age or require issuers to quote only composite premiums, the qualified employer would be asked the following question: "Do you want each employee to contribute the same amount toward the reference plan premium, or do you want the employer's contribution to vary with age within the allowed limits?"^{48, 49} This option to charge younger employees lower premiums for a given coverage may help attract younger individuals into the risk pool and may help employer groups meet any minimum participation rates. On the other hand, this option also results in higher premium contributions by older employees who are also more likely to incur higher out-of-pocket costs.⁵⁰

⁴⁷ IRS Notice 2010-82, section III.G. describes employer contribution methods using a reference plan with a variety of different rating methods: per member rating (referred to in the Notice as "list billing"), composite rating (referred to as "composite billing"), and the hybrid method (referred to as an "employer-computed composite rate"). Although prepared as guidance regarding employer contributions eligible for the small business premium tax credit and applicable only through 2013, it provides a clear description of "safe harbor" methods that will be used in the FF-SHOP.

⁴⁸ Thus, the ratio of the employee contribution made by the oldest adult and the youngest adult toward the reference plan cannot exceed 3:1 before any tobacco use factor is applied.

⁴⁹ Because tobacco use information from employees will not be available when estimating total premiums for the group and average premiums per employee, tobacco use will always be a surcharge applied to an employee's or dependent's premium. See the proposed Health Insurance Market Rules (77 Fed. Reg. at 70595-70597) and the Incentives for Nondiscriminatory Wellness Programs in Group Health Plans Proposed Rule (77 Fed. Reg. 70620) for further discussion of the tobacco use surcharge and wellness programs.

⁵⁰ See 29 CFR 1625.10 for a description of the ways in which employee contributions toward premiums may vary according to employee age without constituting impermissible age discrimination.

If the qualified employer decides that the employee's contribution should vary by age, then the employer contribution would be based on the reference plan, and the remaining employee contribution for the employee's plan would not be affected by other employees' decisions about participation. Once the employees have chosen their plans, the qualified employer would approve the final application and the FF-SHOP would enroll the employees in their chosen health plans.

If the qualified employer decides that each employee pays the same amount for the reference plan coverage, regardless of age, the composite premium for the reference plan, and the employer contribution based on that plan, may change based on which employees choose to participate, just as composite premiums may need to be re-quoted by the issuer today. Operationally, once the employee choices have been made, the composite premium for the reference plan would be recalculated, and the employer and employees notified of any changes.

We welcome comments on this approach.

3. Linking Issuer Participation in an FFE to Participation in an FF-SHOP

Consistent with the goal of ensuring choice of affordable insurance plans, in this proposed rule, we propose standards that we believe will help ensure that qualified employers and qualified employees enrolling through a FF-SHOP are offered a robust set of QHP choices in a competitive small group marketplace. We believe that a competitive marketplace offering qualified individuals, qualified employers, and qualified employees a choice of issuers and QHPs is a central goal of the Affordable Care Act, and that the SHOP can provide an effective way for small employers to offer their employees a choice of issuers and QHPs. We propose in §156.200(g) to leverage issuers' participation in an FFE to ensure participation in the FF-SHOP, provided that no issuer would be required to begin offering small group market products as a result of this provision.

32. Section 155.705 is amended by revising paragraph (b)(3) and by adding new paragraphs (b)(10)(i), (b)(10)(ii), (b)(11)(i) and (b)(11)(ii) to read as follows:

§155.705 Functions of a SHOP.

* * * * *

(b) * * *

(3) (i) SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(ii) A Federally-facilitated SHOP will only permit a qualified employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section.

* * * * *

(10) * * *

(i) Subject to sections 2702 and 2703 of the Public Health Service Act, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as Medicare, Medicaid, or TRICARE.

(ii) Notwithstanding paragraph (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum

participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) * * *

~~(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage.~~

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) The employer will select a level of coverage as described in paragraph (b)(2) and (b)(3) of this section.

(B) The employer will select a QHP within that level of coverage to serve as a reference plan on which contributions will be based.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

(D) An employer may establish, to the extent allowed by Federal and State law, different percentages for different employee categories.

(E) Either State law or the employer may require that a Federally-facilitated SHOP base contributions on a calculated composite premium for the reference plan for employees, for adult dependents, and for dependents below age 21.

(F) The resulting contribution amounts for each employee's coverage may then be applied toward the QHP selected by the employee.

33. Section 155.1030 is added to read as follows:

Part III - Administrative, Procedural, and Miscellaneous

Section 45R – Tax Credit for Employee Health Insurance Expenses of Small Employers

Notice 2010-82

I. PURPOSE AND BACKGROUND

Section 45R of the Internal Revenue Code (Code) offers a tax credit to certain small employers that provide health insurance coverage to their employees. The credit is available for taxable years beginning after December 31, 2009. Both taxable employers and employers that are organizations described in § 501(c) and exempt from tax under § 501(a) (tax-exempt employers) may be eligible for the § 45R credit. Employers that satisfy the requirements for the credit are referred to in this notice as “eligible small employers.”

Notice 2010-44, 2010-22 I.R.B. 717, provides guidance on § 45R as in effect for taxable years beginning before January 1, 2014, including transition relief for taxable years beginning in 2010 with respect to the requirements for a qualifying arrangement under § 45R. This notice expands on the guidance provided in Notice 2010-44 and provides guidance on additional issues relating to the small employer tax credit.

II. ISSUES RELATING TO EMPLOYER’S ELIGIBILITY FOR THE CREDIT

To be an eligible small employer: (1) the employer must have fewer than 25 full-time equivalent employees (FTEs) for the taxable year; (2) the average annual wages of its employees for the year must be less than \$50,000 per FTE; and (3) the employer must maintain a “qualifying arrangement.” In general, a qualifying arrangement is an arrangement under which the employer pays premiums for each employee enrolled in

health insurance coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage.

A. Tax-Exempt Employers Not Described in § 501(c) and Exempt Under § 501(a)

Section 45R(f)(1) provides that the credit is available to a tax-exempt eligible small employer, defined in § 45R(f)(2) as "any organization described in § 501(c) which is exempt from taxation under § 501(a)." Tax-exempt organizations that are not both described in § 501(c) and exempt from taxation under § 501(a) are not eligible to claim the credit. However, a § 521 farmers cooperative that is subject to tax under § 1381 is eligible to claim the credit as a taxable employer, if it otherwise meets the definition of an eligible small employer.

B. Employers Not Engaged in a Trade or Business

The statute does not require that, in order for an employer to be an eligible small employer, the employees of the employer must be performing services in a trade or business. Thus, an employer that otherwise meets the requirements for the credit under § 45R for a taxable year beginning before January 1, 2014 does not fail to be an eligible small employer merely because the employees of the employer are not performing services in a trade or business. For example, a household employer that otherwise satisfies the requirements of § 45R is eligible for the credit.

C. Employers Located Outside the United States

For taxable years 2010 through 2013, an eligible small employer's credit is based on premiums paid for health insurance coverage offered by a health insurance issuer, as described in § 9832(b)(1). Section 9832(b)(2) requires that an insurer be licensed to engage in the business of insurance in a State and that the insurer is subject to State

law regulating insurance. For purposes of § 9832(b)(2) and § 45R, "State" is defined in § 7701(a)(10), and means the 50 States plus the District of Columbia. Therefore, an eligible small employer located outside the United States (including an employer located in a U.S. territory), which has income effectively connected with the conduct of a trade or business in the United States, may claim the § 45R credit only if it pays premiums for an employee's health insurance coverage that is issued in and regulated by one of the 50 States or the District of Columbia. Similarly, a tax-exempt eligible small employer located outside the United States (including an employer located in a U.S. territory) would also be required to pay premiums for an employee's health insurance coverage that is issued in and regulated by one of the 50 States or the District of Columbia in order to obtain the refundable credit described in § 45R(f).

III. OTHER ISSUES RELATING TO ELIGIBILITY FOR THE CREDIT

A. Determining Employees Taken Into Account - Spouses

Employees who perform services for the employer during the taxable year are taken into account in determining the employer's FTEs, average wages, and premiums paid, with certain individuals excluded and with employees of certain related employers included. See section II.B of Notice 2010-44. Sole proprietors, partners in a partnership, shareholders owning more than two percent of the stock in an S corporation, and any owners of more than five percent of other businesses are not taken into account as employees for purposes of the credit. Family members of these owners and partners are also not taken into account as employees.

The definition of "family members" for purposes of § 45R does not specifically refer to spouses. However, spouses of certain business owners are excluded from

being taken into account as employees by operation of the ownership attribution rules in the Code. Therefore, the following individuals also are not taken into account as employees for purposes of § 45R: (1) the employee-spouse of a shareholder owning more than two percent of the stock of an S corporation; (2) the employee-spouse of an owner of more than five percent of a business; (3) the employee-spouse of a partner owning more than a five percent interest in a partnership; and (4) the employee-spouse of a sole proprietor. See §§ 45R(e)(1)(A); 1372(b), 318, 416(i)(1)(B)(i).

B. Determining Employees Taken Into Account – Leased Employees and Others

Leased employees (as defined in § 414(n)) are counted in computing an employer's FTEs and average annual wages. See § 45R(e)(1)(B). However, no provision of § 45R supports attributing to the service recipient the leasing organization's payment of premiums. Therefore, premiums for health insurance coverage paid by a leasing organization for a leased employee are not taken into account by the service recipient in computing the service recipient's § 45R credit.

Unless specifically excluded, all employees of the employer during the year for which the credit is being claimed are taken into account in computing an employer's FTEs and annual average wages under § 45R, including, for example, former employees who terminated employment during the year for which the credit is being claimed, employees covered under a collective bargaining agreement, and employees who do not enroll in their employer's health insurance plan (whether or not they are covered under another health insurance plan).

A minister performing services in the exercise of his or her ministry is treated as self-employed for Social Security and Medicare tax purposes. See §§ 1402(c)(2)(D)

and 3121(b)(8)(A). However, for other tax purposes, including § 45R, whether a minister is an employee or self-employed is determined under the common law test for determining worker status. If, under the common law test, a minister is self-employed, the minister is not taken into account in determining an employer's FTEs and premiums paid because § 45R(e)(A)(i) excludes a self-employed individual from the term "employee" for purposes of the credit. If, under the common law test, the minister is an employee, the minister is taken into account in determining an employer's FTEs and premiums paid by the employer for the minister's health insurance coverage can be taken into account in computing the credit, subject to limitations on the credit. (Note that, under § 45R(f)(1)(B), a tax-exempt employer's § 45R credit cannot exceed the total of the tax-exempt eligible small employer's income tax and Medicare tax withholding and its Medicare tax liability for the year). Because compensation of a minister performing services in the exercise of his or her ministry is not subject to Social Security or Medicare tax under the Federal Insurance Contributions Act (FICA), a minister has no wages as defined under § 3121(a) for purposes of computing an employer's average annual wages.

C. Determining Average Annual Wages, Number of Hours Worked, and Number of FTEs

All wages (as defined under § 3121(a) but without regard to the wage base limitation under § 3121(a)) paid (including overtime pay) are taken into account in computing an employer's average annual wages. Thus, for example, if an employee works more than 2,080 hours in a year, all wages paid to the employee, including

wages for the hours in excess of 2,080, are taken into account in computing the employer's average annual wages.

Notice 2010-44 provides three methods that employers are permitted to use for calculating employees' hours of service for the taxable year: (1) counting actual hours worked; (2) using a days-worked equivalency; or (3) using a weeks-worked equivalency. Employers need not use the same method for all employees, but may apply different methods for different classifications of employees, if the classifications are reasonable and consistently applied. For example, an employer may use the actual hours worked method for all hourly employees and the weeks-worked equivalency method for all salaried employees. In addition, employers may change the method for calculating employees' hours of service for each taxable year.

As explained in Notice 2010-44, the number of an employer's FTEs is determined by dividing the total hours of service (but not more than 2,080 hours of service for any employee) by 2,080 hours. See § 45R(d)(2). The result, if not a whole number, is then rounded to the next lowest whole number. However, if, after dividing the total hours of service by 2,080, the resulting number is less than one, the employer rounds up to one FTE.

D. HSAs and Self-Insured Plans, including HRAs and FSAs, are not Qualifying Arrangements

An employer's premium payments are not taken into account for purposes of the § 45R credit unless they are paid for health insurance coverage under a qualifying arrangement. A qualifying arrangement is an arrangement under which the employer pays premiums for each employee enrolled in health insurance coverage offered by the

employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage. Under § 45R(g)(2)(B), for years prior to 2014, health insurance coverage for purposes of the credit is defined in § 9832(b)(1). Among the requirements of § 9832(b)(1) is that the coverage be offered by a health insurance issuer. A health insurance issuer is defined in § 9832(b)(2) as an entity licensed to engage in the business of insurance in a State and which is subject to State law regulating insurance. See § 9832(b)(1) and section II.G of Notice 2010-44. Thus, an employer's self-insured plan is not health insurance coverage for purposes of the credit and any employer contribution to such coverage is not a qualifying arrangement for purposes of § 45R.

Because Health Reimbursement Arrangements (HRAs) and health Flexible Spending Arrangements (health FSAs) are self-insured plans, these arrangements are not health insurance coverage. Health Savings Accounts (HSAs) (defined in § 223(d)(1)) are also not health insurance coverage. Thus, employer contributions to HRAs, health FSAs, or HSAs are not taken into account for purposes of the § 45R credit.

E. Multiemployer Health and Welfare Plans Providing Health Insurance Coverage

For purposes of the § 45R credit, contributions by an employer to a multiemployer plan that are used to pay premiums for health insurance coverage for employees covered by the multiemployer plan are treated as payment of health insurance premiums by the employer. Moreover, if 100 percent of the cost of coverage under the multiemployer plan is paid from nonelective employer contributions, and not by employees, each employer in the multiemployer plan is considered to be contributing

a uniform percentage of 100 percent of the premium on behalf of each employee covered by the plan. Accordingly, an employer that is otherwise an eligible small employer and that contributes to a multiemployer plan that provides for insured health care coverage does not fail to satisfy the requirements for the § 45R credit merely because the insurance premiums are paid by the plan and not directly paid by the employer. In addition, the employer does not fail to be considered to be contributing a uniform percentage of the premium for each employee if 100 percent of the cost of coverage for all employees covered by the plan is paid through employer nonelective contributions. However, self-insured health coverage provided through a multiemployer plan is not health insurance coverage provided under a qualifying arrangement under § 45R.

Multiemployer plans may provide welfare-type benefits in addition to health insurance, such as life insurance or short- or long-term disability benefits. Only the employer contributions to the multiemployer plan that are used to purchase health insurance for an employee are permitted to be taken into account in determining premium payments by the employer under § 45R. Thus, if amounts are contributed to a multiemployer plan for health insurance coverage and also for other benefits, the employer must allocate contributions among the benefits provided, and only the amount allocable to health insurance premiums applies in calculating the § 45R credit. An employer contributing to a multiemployer plan is permitted to rely on information provided by the plan to determine the amount of its contribution that is used to purchase health insurance.

F. Qualifying Arrangements – Church Welfare Benefit Plans

As noted above, for taxable years beginning prior to 2014, health insurance coverage for purposes of the credit means benefits consisting of medical care offered by a health insurance issuer, which is an entity licensed to engage in the business of insurance in a State, and which is subject to State law regulating insurance. See §§ 9832(b)(1) and 9832(b)(2). The Church Plan Parity and Entanglement Prevention Act of 1999 (CPPEPA), Pub. L. No. 106-244, clarifies the status of church welfare benefit plans providing medical benefits in the context of State insurance laws. Section 2(d) of CPPEPA provides that “[n]otwithstanding any other provision of this section, for purposes of enforcing provisions of State insurance laws that apply to a church plan that is a welfare plan, the church plan shall be subject to State enforcement as if the church plan were an insurer licensed by the State.” Thus, under § 2(d) of CPPEPA, a church welfare benefit plan is subject to State insurance law enforcement as if it were licensed as an insurance company. Section 2(e) of the CPPEPA provides that § 2 generally shall not be construed as recharacterizing the status, or modifying or affecting the rights, of any plan participant or beneficiary.

Pursuant to this notice, because a church welfare benefit plan is subject to State insurance law enforcement as if it were licensed under State law, it will be treated as satisfying the requirements for health insurance coverage for purposes of the § 45R credit. Therefore, for these purposes, an arrangement under which a small church employer pays premiums for employees who receive medical care provided through a church welfare benefit plan may be a qualifying arrangement and a small church employer paying for employees’ medical coverage under such a plan may be a tax-

exempt eligible small employer. This treatment of church plan coverage as health insurance coverage applies solely for purposes of § 45R, which applies to the tax treatment of the employer but does not affect the rights of plan participants and beneficiaries.

G. Uniformity Requirement

To receive the tax credit, an eligible small employer must pay a uniform percentage (not less than 50 percent) of the premium for each employee enrolled in health insurance coverage offered by the employer. See § 45R(d)(4). Section V of Notice 2010-44 provides transition relief in applying the uniformity requirement for taxable years beginning in 2010. This section provides rules for applying the uniformity requirement in taxable years beginning after December 31, 2009 and prior to 2014. For taxable years beginning in 2010, an employer may satisfy the uniformity requirement either by meeting the requirements of this section or by meeting the requirements of Section V of Notice 2010-44.

1. Terminology Used in this Notice

For purposes of this notice:

(a) Each benefits package is considered a separate health insurance plan. For example, an employer offers a single health insurance plan if the employer makes only one benefits package available to its employees.

(b) A health insurer that charges a uniform premium for each of the employer's employees or that charges a single aggregate premium for the group of covered employees that the employer may then divide by the number of covered employees to determine the uniform premium is referred to as using "composite billing."

(c) A health insurer that lists a separate premium for each employee based on the age of the employee or other factors is referred to as using "list billing."

(d) A "tier" of coverage is coverage under a benefits package that varies only by the number of individuals covered. For example, self-only coverage, self plus one coverage, and family coverage would constitute three separate tiers of coverage.

(e) The "employer-computed composite rate" for a tier of coverage is the average rate determined by adding the premiums for that tier of coverage for all employees eligible to participate in the employer's health insurance plan (whether or not they actually receive coverage under the plan or under that tier of coverage) and dividing by the total number of such eligible employees.

2. Employers Offering One Plan. An employer that offers a single health insurance plan will satisfy the uniformity requirement of section 45R if it satisfies the requirements of this subsection G.2. An employer whose health insurer uses composite billing must satisfy the requirements of paragraph (a) of this subsection G.2 with respect to self-only coverage under the plan. An employer whose health insurer uses list billing must satisfy the requirements of paragraph (c) of this subsection G.2 with respect to self-only coverage under the plan. If an employer offers a more expensive tier of coverage than single coverage, it must also satisfy paragraph (b) of this subsection G.2 with respect to each such more expensive tier if its insurer uses composite billing and paragraph (d) of this subsection G.2 if its insurer uses list billing.

(a).Employers offering one plan - Self-only coverage – composite billing. An employer satisfies the requirements of this paragraph (a) if it pays the same amount

toward the premium for each employee receiving self-only coverage under the plan, so long as that amount is equal to at least 50 percent of the self-only premium.

(b) Employers offering one plan -other tiers of coverage – composite billing. If an employer offers a tier of coverage that is more expensive than self-only coverage, the employer satisfies the requirements of this paragraph (b) if it pays an amount for each employee enrolled in that more expensive tier of coverage that is the same for all employees and that is no less than the amount that the employer would have contributed toward self-only coverage for that employee. Alternatively, an employer that offers a tier of coverage that is more expensive than self-only coverage may satisfy the requirements of this paragraph (b) by meeting the requirements of paragraph (a) of this subsection G.2 for each tier of coverage that it offers.

(c) Employers offering one plan -self-only coverage – list billing. An employer satisfies the requirements of this paragraph (c) if the employer either: (i) pays toward the premium an amount equal to a uniform percentage (not less than 50 percent) of the premium charged for each employee or (ii) converts the individual premiums for self-only coverage into an employer-computed composite rate for self-only coverage, and, if an employee contribution is required, each employee who receives coverage under the plan pays a uniform amount toward the self-only premium that is no more than 50 percent of the employer-computed composite rate for self-only coverage.

(d) Employers offering one plan -other tiers of coverage – list billing. If an employer offers a tier of coverage that is more expensive than self-only coverage, the employer satisfies the requirements of this paragraph (d) by paying toward the premium for each employee covered under that tier of coverage an amount equal to the

amount that the employer would have contributed with respect to that employee for self-only coverage, calculated either based upon the actual premium that would have been charged by the insurer for that employee for self-only coverage or based upon the employer-computed composite rate for self-only coverage. Alternatively, an employer that offers a tier of coverage that is more expensive than self-only coverage may satisfy the requirements of this paragraph (d) by meeting the requirements of paragraph (b) of this subsection G.2 for each tier of coverage that it offers and substituting the employer-computed composite rate for that tier of coverage for the employer-computed composite rate for self-only coverage.

3. **Employers Offering More than One Plan.** If an employer offers more than one health insurance plan (i.e., more than one benefit package), the employer may satisfy the uniformity requirement in either of two ways:

(a) The employer's payments toward the premium with respect to each plan for which the employer is claiming the credit satisfy subsection G.2 on a plan-by-plan basis. The amounts or percentages of premium paid by the employer for each plan need not be identical, so long as the payments with respect to each plan satisfy subsection G.2, or

(b) If the requirements of subsection G.4 are satisfied, the employer may designate a "reference plan" and make employer contributions in accordance with the following requirements:

(i) The employer determines a level of employer contributions for each employee such that, if all eligible employees enrolled in the reference plan, the contributions would satisfy subsection G.2.

(ii) The employer allows each employee to apply the amount determined under (i) of this paragraph (b) either toward the reference plan or toward the cost of coverage under any of the other available plans.

4. Anti-abuse rule for employers offering more than one plan and using reference plan. The requirements of this subsection G.4 are satisfied if the self-only composite rate for the reference plan is at least 66 percent of the self-only composite rate for each non-reference plan with respect to which the employer claims the credit. For purposes of this paragraph, the self-only composite rate is, in the case of a plan with composite billing, the rate actually charged by the health insurance issuer for self-only coverage, and, in the case of a plan with list billing, the employer-computed composite rate for self-only coverage.

Example 1. (i) In 2011, Employer offers one health insurance plan, Plan A. The premiums for Plan A are \$5,000 per year for self-only coverage, and \$10,000 for family coverage. Employees can elect self-only or family coverage under Plan A.

(ii) Employer pays \$3,000 (60% of the premium) toward self-only coverage under Plan A and \$6,000 (60% of the premium) toward family coverage under Plan A.

(iii) Employer's contributions of 60% of the premium for each tier of coverage satisfy the uniformity requirement in § 45R(d)(4).

Example 2. (i) Same facts as Example 1, except that Employer pays \$3,000 (60% of the premium) for each employee electing self-only coverage under Plan A and pays \$3,000 (30% of the premium) for each employee electing family coverage under Plan A.

(ii) Employer's contributions of 60% of the premium toward self-only coverage and the same dollar amount toward the premium for family coverage satisfy the uniformity requirement in § 45R(d)(4).

Example 3. (i) In 2011, Employer offers two health insurance plans, Plan A and Plan B, both of which use composite billing. The premiums for Plan A are \$5,000 per year for self-only coverage and \$10,000 for family coverage. The premiums for Plan B are \$7,000 per year for self-only coverage and \$13,000 for family coverage. Employees can elect self-only or family coverage under either Plan A or Plan B.

(ii) Employer pays \$3,000 (60% of the premium) for each employee electing self-only coverage under Plan A, \$3,000 (30% of the premium) for each employee electing family coverage under Plan A, \$3,500 (50% of the premium) for each employee electing self-only coverage under Plan B, and \$3,500 (27% of the premium) for each employee electing family coverage under Plan B.

(ii) Employer's contributions of 60% of the premiums for self-only coverage and the same dollar amounts toward the premium for family coverage under Plan A, and of 50% of the premium for self-only of coverage and the same dollar amount toward the premium for family coverage under Plan B, satisfy the uniformity rule on a plan-by-plan basis; therefore the employer's contributions to both plans satisfy the uniformity requirement in § 45R(d)(4).

Example 4. (i) Same facts as Example 3, except that Employer designates Plan A as the reference plan. Employer pays \$2,500 (50% of the premium) for each employee electing self-only coverage under Plan A and pays \$2,500 of the premium for each employee electing family coverage under Plan A or either self-only or family coverage under Plan B.

(iii) The self-only composite rate for Plan A (\$5,000) is greater than 66% of the self-only composite rate for Plan B (\$7,000). ($\$5,000 \div \$7,000 = 71\%$).

(iv) Employer's contribution of \$2,500 toward the premium of each employee enrolled under Plan A or Plan B satisfies the uniformity requirement in § 45R(d)(4).

Example 5. (i) Same facts as Example 4, except that the self-only composite rate for Plan B is \$8,000.

(ii) The self-only composite rate for Plan A (\$5,000) is less than 66% of the self-only composite rate for Plan B (\$8,000). ($\$5,000 \div \$8,000 = 63\%$). Accordingly, Employer may not designate Plan A as the reference plan. The Employer's contribution of \$2,500 toward the premium of each employee enrolled under Plan B fails to satisfy the uniformity requirement in § 45R(d)(4) and the Employer is not eligible for a credit with respect to the premiums paid for Plan B. However, the Employer's contribution of \$2,500 toward the premium of each employee enrolled under Plan A satisfies the uniformity requirement in § 45R(d)(4) and, accordingly, if the other requirements of section 45R are satisfied, the Employer may receive a credit with respect to its contributions to Plan A.

Example 6. (i) For the 2011 taxable year, Employer receives a list billing premium quote from Health Insurance Issuer W for health insurance coverage for each of Employer's four employees.

(ii) For Employee L, age 20, the self-only premium is \$3,000 per year, and the family premium is \$8,000. For Employees M, N and O, each age, 40, the self-only premium is \$5,000 per year and the family premium is \$10,000.

(iii) The total self-only premium for the four employees is \$18,000 ($\$3,000 + (3 \times 5,000)$). Employer calculates a employer-computed composite self-only rate of \$4,500 ($\$18,000 \div 4$).

(iii) Employer offers to make contributions such that each employee would need to pay \$2,000 of the premium for self-only coverage. Under this arrangement, Employer would contribute \$1,000 toward self-only coverage for L and \$3,000 toward self-only coverage for M, N, and O. In the event an employee elects family coverage, Employer would make the same contribution (\$1,000 for L or \$3,000 for M, N, or O) toward the family premium.

(v) Employer satisfies the uniformity requirement in § 45R(d)(4), because it offers and makes contributions based on an employer-calculated composite self-only rate such that, to receive self-only coverage, each employee must pay a uniform amount which is not more than 50 percent of the composite rate, and it allows employees to use the same employer contributions toward family coverage.

Example 7. (i) Same facts as Example 6, except that Employer calculates a employer-computed composite family rate of \$9,500 ($(\$8,000 + (3 \times 10,000)) \div 4$) and requires each employee to pay \$4,000 of the premium for family coverage.

(ii) Employer satisfies the uniformity requirement in § 45R(d)(4), because it offers and makes contributions based on a calculated self-only and family rate such that, to receive either self-only or family coverage, each employee must pay a uniform amount which is not more than 50 percent of the composite rate for coverage of that tier.

Example 8. (i) Same facts as Example 6, except that Employer also receives a list billing premium quote from Health Insurance Issuer X for health insurance coverage for each of Employer's four employees, in addition to the list billing premium quote from Health Insurance Issuer W.

(ii) Health Insurance Issuer X's quote for Employee L, age 20, is \$4,000 per year for self-only coverage or \$12,000 per year for family coverage. For Employees M, N and O, each age 40, the premium is \$7,000 per year for self-only coverage or \$15,000 per year for family coverage.

(iii) The total self-only premium under Plan X is \$25,000 ($\$4,000 + (3 \times 7,000)$). The employer-computed composite self-only rate is \$6,250 ($\$25,000 \div 4$).

(iv) Employer designates Health Insurance Issuer W's health care coverage as the reference plan.

(v) Employer offers to make contributions based on the employer-calculated composite premium for the reference plan (Plan W) such that each employee has to contribute \$2,000 to receive self-only coverage through Plan W. Under this arrangement, Employer would contribute \$1,000 toward self-only coverage for L and \$3,000 toward self-only coverage for M, N, and O. In the event an employee elects family coverage through Plan W or either self-only or family coverage through Plan X, Employer would make the same contribution (\$1,000 for L or \$3,000 for M, N, or O) toward that coverage.

(vi) The self-only composite rate for Plan W (\$5,000) is at least 66% of the self-only composite rate for Plan X (\$6,250). ($\$5,000 \div \$6,250 = 80\%$).

(vii) Employer satisfies the uniformity requirement in § 45R(d)(4), because it offers and makes contributions based on the employer-calculated composite self-only premium for the Plan W reference plan such that, in order to receive self-only coverage, each employee must pay a uniform amount which is not more than 50 percent of the self-only composite premium of the reference plan; it allows employees to use the same employer contributions toward family coverage in the reference plan or coverage through another plans; and the self-only composite rate for the reference plan is at least 66% of the self-only composite rate for the non-reference plan.

Section 45R does not impose a coverage requirement (although, other provisions of the Code, such as § 105(h), may impose coverage requirements on the health plan).

IV. ISSUES RELATING TO CALCULATING THE CREDIT

A. Small Group Market - Employees in Multiple States

Under § 45R(b)(2), the credit is limited by the average premium for the small group market in the State (or area within the State) in which the employee enrolls for coverage. See Rev. Rul. 2010-13, 2010-13 I.R.B. 691, for average State premiums for the taxable year beginning after December 31, 2009. If an employer has employees in multiple States, the employer applies the average premium for the small group market in the State (or area within the State) separately for each employee using the average State premium for the State in which the employee works.

B. Application of Average Premium Cap

Under § 45R(b)(2) and 45R(g)(2)(c), the amount of an employer's premium payments that are taken into account in calculating the credit is limited to the premium payments the employer would have made under the same arrangement if the average premium for the small group market in the State (or an area within the State) in which the employer offers coverage were substituted for the actual premium. See Notice 2010-44 for additional detail. Rev. Rul. 2010-13, 2010-21 IRB 691 lists the applicable average premium for self-only and family plans in the small group market in each State for the 2010 taxable year. For purposes of this calculation, the cap that is used for each employee (be it self-only or family) depends on the coverage the employee takes. This is not affected by whether the employer's contribution for that employee is determined with reference to the self-only plan, or whether an employer satisfies the uniformity requirement in § 45R(d)(4) by paying an amount equal to at least 50 percent of the premium for self-only coverage.

Example 9. (i) In 2011, Employer offers one health insurance plan, Plan X. The premiums for Plan X are \$4,000 per year for self-only coverage, and \$6,000 for family coverage.

(ii) Employer pays 50% of the premiums (\$2,000) for each employee electing self-only coverage and pays \$2,000 for each employee electing family coverage.

(iii) \$2,000 is 50% of the premium for self-only coverage and 33% of the premium for family coverage.

(iv) For employees electing self-only coverage, the limitation to the average State premium for the small group market is 50% of the premium for self-only coverage, and for employees electing family coverage, the limitation to the average State premium for the small group market is 33% of the premium for family coverage.

C. Taxpayers With Fiscal Taxable Years

Section 45R is effective for taxable years beginning after December 31, 2009. If a taxpayer is a calendar year taxpayer, the § 45R credit first applies for the taxable year beginning on January 1, 2010 and ending on December 31, 2010. If the taxpayer is a fiscal year taxpayer with a taxable year beginning, for example, on July 1, 2010, the § 45R credit first applies for the taxable year beginning on July 1, 2010 and ending on June 30, 2011.

EFFECT ON OTHER DOCUMENTS

Notice 2010-44, 2010-22 I.R.B. 717, is amplified.

EFFECTIVE DATE

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

DRAFTING INFORMATION

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