Internal Revenue Bulletin: 2016-33

August 15, 2016

REG–103058–16

Notice of Proposed RulemakingInformation Reporting of Catastrophic Health Coverage and Other Issues Under Section 6055

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AGENCY:

Internal Revenue Service (IRS), Treasury.

ACTION:

Notice of proposed rulemaking.

SUMMARY:

This document contains proposed regulations relating to information reporting of minimum essential coverage under section 6055 of the Internal Revenue Code (Code). Health insurance issuers, certain employers, and others that provide minimum essential coverage to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. These proposed regulations affect health insurance issuers, employers, governments, and other persons that provide minimum essential coverage to individuals.

DATES:

Written or electronic comments and requests for a public hearing must be received by October 3, 2016.

ADDRESSES:

Send submissions to: CC:PA:LPD:PR (REG–103058–16), Room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–103058–16), Courier's Desk, Internal Revenue Service, 1111

Constitution Avenue, NW, Washington, DC 20224, or sent electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–103058–16).

FOR FURTHER INFORMATION CONTACT:

Concerning the proposed regulations under section 6055, John B. Lovelace, (202) 317-7006; concerning the proposed regulations under section 6724, Hollie Marx, (202) 317-6844; concerning the submission of comments, Regina Johnson, (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget,** Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service,** Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by October 3, 2016. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the IRS, including whether the information will have practical utility;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collection of information may be minimized, including through the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information in these proposed regulations is in § 1.6055–1. The collection of information will be used to determine whether an individual has minimum essential coverage under section 1501(b) of the Patient Protection and Affordable Care Act (26 U.S.C. 5000A(f)). The collection of information is required to comply with the provisions of section 6055. The likely respondents are health insurers, self-insured employers or other sponsors of self-insured health plans, and governments that provide minimum essential coverage.

The burden for the collection of information contained in these proposed regulations will be reflected in the burden on Form 1095–B, Health Coverage, or another form that the IRS designates, which will request the information in the proposed regulation.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Background

Under section 5000A, individuals must for each month have minimum essential coverage, qualify for a health coverage exemption, or make an individual shared responsibility payment with their income tax returns. Section 6055 provides that all persons who provide minimum essential coverage to an individual must report certain information to the IRS that identifies covered individuals and the period of coverage, and must furnish a statement to the covered individuals containing the same information. The information reported under section 6055 allows individuals to establish, and the IRS to verify, that the individuals were covered by minimum essential coverage for months during the year.

Information returns under section 6055 generally are filed using Form 1095–B. A separate and distinct health coverage-related reporting requirement under section 6056 requires that certain large employers report information on Form 1095–C, Employer-Provided Health Insurance Offer and Coverage. Self-insured employers required to file Form 1095–C use Part III of that form, rather than Form 1095–B, to report information required under section 6055 for individuals enrolled in the self-insured employer-sponsored coverage. These proposed regulations provide guidance under section 6055 only, which relates to Form 1095–B and Form 1095–C, Part III. These proposed regulations do not affect information reporting under section 6056 on Form 1095–C, Parts I and II.

Under section 5000A(f)(1), various types of health plans and programs are minimum essential coverage, including: (1) specified government-sponsored programs such as Medicare Part A, the Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1936 and following sections), the Children's Health Insurance Program under Title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections) (CHIP), the TRICARE program under chapter 55 of Title 10, U.S.C., health care programs for veterans and other individuals under chapter 17 or 18 of Title 38 U.S.C., coverage for Peace Corps volunteers under 22 U.S.C. 2504(e), and coverage under the Nonappropriated Fund Health Benefits Program under section 349 of Public Law 103–337, (2) coverage under an eligible employer-sponsored plan, (3) coverage under a plan in the individual market (such as a qualified health plan offered through an Affordable Insurance Exchange (Exchange, also known as a Marketplace)), (4) coverage under a grandfathered health plan, and (5) other coverage recognized as minimum essential coverage by the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury.

Under section 5000A(f)(3) and § 1.5000A–2(g) of the Income Tax Regulations, coverage that consists solely of excepted benefits described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (42 U.S.C. 300gg–91(c)), and the regulations under that section, is not minimum essential coverage. Section 1.5000A–2(b)(2) lists government-sponsored programs that provide limited benefits and which are not minimum essential coverage.

Under section 5000A(f)(4), an individual who is a bona fide resident of a United States possession for a month is treated as having minimum essential coverage for that month.

Notice 2015–68, 2015–41 I.R.B. 547, provides guidance on various issues under section 6055. In Notice 2015–68, the Treasury Department and the IRS stated that they intend to propose regulations under section 6055 addressing certain of these issues and requested comments. Comments were requested about the application of the reasonable cause rules under section 6724 to section 6055 reporting, in particular as applied to taxpayer identification number (TIN) solicitation and reporting.

Persons Required To Report

Under § 1.6055–1(c)(1)(iii), the executive department or agency of the governmental unit that provides coverage under a government-sponsored program is the reporting entity for government-sponsored minimum essential coverage. Section 1.6055–1(c)(3)(i) specifically provides that the State agency that administers the Medicaid or CHIP program, respectively, must report government-sponsored coverage under section 6055. Notice 2015–68 provides that Medicaid and CHIP agencies in U.S. possessions or territories are not required to report Medicaid and CHIP coverage because an individual eligible for that coverage is generally a bona fide resident of the possession or territory who is deemed to have minimum essential coverage under section 5000A(f)(4) and, therefore, does not require reporting under section 6055 to verify compliance with section 5000A.

In general, under § 1.6055–1(c)(1)(ii) the reporting entity for coverage under a self-insured group health plan is the plan sponsor. Section 1.6055–1(c)(2) provides rules for identifying which entity is the plan sponsor of a self-insured group health plan for purposes of section 6055. For this purpose, the employer is the plan sponsor of a self-insured group health plan established by a single employer (determined without aggregating related entities under section 414). If the plan or arrangement is established or maintained by more than one employer (including a Multiple Employer Welfare Arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA)), and the plan is not a multiemployer plan (as defined in section 3(37) of ERISA), each participating employer is a plan sponsor with respect to that employer's employees. For a self-insured group health plan or arrangement that is a multiemployer plan, the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. For a self-insured group health plan or arrangement maintained solely by an employee organization, the plan sponsor is the employee organization.

The existing regulations at § 1.6055–1(d)(2) provide that no reporting is required for minimum essential coverage that provides benefits in addition or as a supplement to other coverage that is minimum essential coverage if the primary and supplemental coverage have the same plan sponsor or the coverage supplements government-sponsored minimum essential coverage. Notice 2015–68 explained that this rule had proven to be confusing, and, accordingly, the Treasury Department and the IRS intended to propose regulations providing that (1) if an individual is covered by multiple minimum essential coverage plans or programs provided by the same provider, reporting is only required for one of the plans or programs; and (2) reporting generally is not required for an individual's minimum essential coverage to the extent that the individual is eligible for that coverage only if the individual is also covered by other minimum essential coverage for which section 6055 reporting is required.

Information Required To Be Reported

Under section 6055(b) and § 1.6055–1(e)(1), providers of minimum essential coverage must report to the IRS (1) the name, address, and employer identification number (EIN) of the reporting entity required to file the return; (2) the name, address, and TIN, or date of birth if a TIN is not available, of the responsible individual (except that a reporting entity may, but is not required to, report the TIN of a responsible individual not enrolled in the coverage); (3) the name and TIN, or date of birth if a TIN is not available, of each individual who is covered under the policy or program; and (4) the months of coverage for each covered individual.[1] Section 1.6055–1(b)(11) provides that the responsible individual includes a primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on an application who enrolls one or more individuals, including him or herself, in minimum essential coverage.

In addition, under § 1.6055–1(e)(2), for coverage provided by a health insurance issuer through a group health plan, information returns must report (1) the name, address, and EIN of the employer maintaining the plan, and (2) any other information that the Secretary requires for administering the credit under section 45R (relating to the tax credit for employee health insurance expenses of small employers).

A reporting entity that fails to comply with the filing and statement furnishing requirements of section 6055 may be subject to penalties for failure to file timely a correct information return (section 6721) or failure to furnish timely a correct statement (section 6722). See section 6724(d); see also § 1.6055–1(h)(1). These penalties may be waived if the failure is due to reasonable cause and is not due to willful neglect. See section 6724(a). In particular, under § 301.6724–1(a)(2) of the Procedure and Administration Regulations penalties are waived if a reporting entity demonstrates that it acted in a responsible manner and that the failure is due to significant mitigating factors or events beyond the reporting entity's control. For purposes of section 6055 reporting, if the information reported on a return is incomplete or incorrect as a result of a change in circumstances (such as a retroactive change in coverage), a failure to timely file or furnish a corrected document is a failure to file a correct return or furnish a correct statement under sections 6721 and 6722. See § 1.6055–1(h)(2).

In general, under § 301.6724–1(e) a person will be treated as acting in a responsible manner if the person properly solicits a TIN but does not receive it. For this purpose, proper solicitation of a TIN involves an initial solicitation and two subsequent annual solicitations. In general, an initial solicitation is made when the relationship between the reporting entity and the taxpayer is established. If the reporting entity does not receive the TIN, the first annual solicitation is generally required by December 31 of the year in which the relationship with the taxpayer begins (January 31 of the following year if the relationship begins in December). Generally, if the TIN is still not provided, a second annual solicitation is required by December 31 of the following year. Similar rules applying to filers who file or furnish information reports with incorrect TINs are in § 301.6724–1(f).

The preamble to the section 6055 regulations (T.D. 9660, 79 FR 13220) provides short-term relief from reporting penalties for 2015 coverage. Specifically, the IRS will not impose penalties under sections 6721 and 6722 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements. This relief applies to incorrect or incomplete information, including TINs or dates of birth, reported on a return or statement.

Explanation of Provisions and Summary of Comments

1. *Reporting of Catastrophic Plans*

Under § 1.36B–5(a), Exchanges must report to the IRS information relating to qualified health plans in which individuals enroll through the Exchange. Under section 36B(c)(3)(A), the term qualified health plan has the same meaning as defined in section 1301 of the Affordable Care Act except that it does not include a catastrophic plan described in section 1302 of the Affordable Care Act. Thus, Exchanges are not required to report on catastrophic coverage. Section 1.6055–1(d) provides that health insurance issuers need not report on coverage in a qualified health plan in the individual market enrolled in through an Exchange, because that information is generally reported by Exchanges pursuant to § 1.36B–5. Thus, currently neither the Exchanges nor health insurance issuers are responsible for reporting coverage under a catastrophic plan.

Effective administration of section 5000A generally requires reporting of all minimum essential coverage, including catastrophic plans in which individuals enroll through an Exchange. Accordingly, Notice 2015–68 indicated that the Treasury Department and the IRS intended to propose regulations under section 6055 to narrow the relief provided to issuers in § 1.6055–1(d) by requiring issuers of catastrophic plans to report catastrophic plan coverage on Form 1095–B, effective for coverage in 2016 and returns and statements filed and furnished in 2017. Consistent with Notice 2015–68, the proposed regulations include this requirement but, to allow reporting entities sufficient time to implement these reporting requirements, are proposed to be effective for coverage in 2017 and returns and statements filed and furnished in 2018.

Notice 2015–68 indicated that health insurance issuers could voluntarily report on 2015 catastrophic coverage (on returns and statements filed and furnished in 2016) and were encouraged to do so. Notice 2015–68 further provided that an issuer that reports on 2015 catastrophic coverage will not be subject to penalties for these returns. Given the 2017 effective date for reporting of catastrophic coverage provided in these proposed regulations, health insurance issuers similarly may voluntarily report on 2016 catastrophic coverage (on returns and statements filed and furnished in 2017) and are encouraged to do so. An issuer that reports on 2016 catastrophic coverage will not be subject to penalties for these returns.

2. *Reporting of Coverage under Basic Health Programs*

Section 1331 of the Affordable Care Act allows states to establish a Basic Health Program to provide an additional healthcare coverage option to certain individuals not eligible for Medicaid. See 42 CFR Part 600. The Basic Health Program is designated as minimum essential coverage under 42 CFR 600.5.

Section 5000A(f) does not identify the Basic Health Program as a government-sponsored program, but it closely resembles government-sponsored coverage such as Medicaid and CHIP. Accordingly, Notice 2015–68 indicated that the state agency that administers the Basic Health Program is the entity that must report that coverage under section 6055. Consistent with Notice 2015–68, these proposed regulations provide that the State agency administering coverage under the Basic Health Program is required to report that coverage under section 6055.

3. *Truncated TINs*

Section 6055(b) and § 1.6055–1(e) require that health insurance issuers and carriers reporting coverage under insured group health plans report information about the employer sponsoring the plan, including the employer's EIN, to the IRS. Section 6055(c) and § 1.6055–1(g) require that health insurance issuers and carriers reporting information to the IRS furnish a statement to a taxpayer providing information about the filer and the covered individuals. Section 301.6109–4(b)(1) provides that the TIN of a person other than the filer, including an EIN, may be truncated on statements furnished to recipients unless, among other reasons, such truncation is otherwise prohibited by statute or regulations. Thus, under § 1.6055–1(g)(3) of the existing regulations, a recipient's TIN may appear in the form of an IRS truncated taxpayer identification number (TTIN) on a statement furnished to the recipient. These proposed regulations amend the existing regulations to clarify that a TTIN is not an alternative identifying number; rather, it is one of the ways that a TIN may appear, subject to the rules in § 301.6109–4(b)(1).

Existing regulations do not address whether health insurance issuers and carriers are permitted to truncate a sponsoring employer's EIN on statements furnished to taxpayers. Notice 2015–68 advised that the Treasury Department and the IRS intended to propose regulations to clarify that the EIN of the employer sponsoring the plan may be truncated to appear as an IRS TTIN on statements health insurance issuers and carriers furnish to taxpayers. Consistent with Notice 2015–68, the proposed regulations clarify that the EIN of the employer sponsoring the plan may be truncated to appear as an IRS TTIN on statements health insurance issuers and carriers furnish to taxpayers. Section 301.6109–4(b)(2)(ii) prohibits using TTINs if, among other things, a statute specifically requires the use of an EIN. While section 6055(b)(2)(A) requires that the information return filed with the IRS includes the employer's EIN, and section 6055(c)(1)(B) requires that the statement furnished to a taxpayer includes the information required to be shown on the information return with respect to such individual, the statute does not require that the full EIN appear on the statement furnished to taxpayers and the employer's EIN may be truncated to appear in the form of an IRS TTIN.

4. *Plans for Which Reporting is Not Required*

Information reporting under section 6055(a) is generally required of every person who provides minimum essential coverage to an individual during the year. In certain instances where the reporting would be duplicative, the existing regulations allow the person who provides supplemental coverage to forgo information reporting. This supplemental coverage rule in § 1.6055–1(d)(2) was intended to eliminate duplicate reporting of an individual's minimum essential coverage under circumstances when there is reasonable certainty that the provider of the "primary" coverage will report. This rule has proven to be confusing.

The Treasury Department and the IRS indicated in Notice 2015–68 that regulations would be proposed to replace the existing rules. Accordingly, the proposed regulations provide that (1) if an individual is covered by more than one minimum essential coverage plan or program provided by the same reporting entity, reporting is required for only one of the plans or programs; and (2) reporting is not required for an individual's minimum essential coverage to the extent that the individual is eligible for that coverage only if the individual is also covered by other minimum essential coverage for which section 6055 reporting is required. As in Notice 2015–68, the proposed regulations provide that the second rule applies to eligible employer-sponsored coverage only if the supplemental coverage is offered by the

same employer that offered the eligible employer-sponsored coverage for which section 6055 reporting is required. These rules apply month by month and individual by individual.

Thus, under the proposed regulations, applying the first rule, if for a month an individual is enrolled in a self-insured group health plan provided by an employer and also is enrolled in a self-insured health reimbursement arrangement (HRA) provided by the same employer, the reporting entity (the employer) is required to report only one type of coverage for that individual. If an employee is covered under both self-insured arrangements for some months of the year but retires or otherwise drops coverage under the non-HRA group health plan and is covered only under the HRA for other months, the employer must report coverage under the HRA for the months after the employee retires or drops the non-HRA coverage.

Applying the second rule, reporting is not required for minimum essential coverage for a month if that coverage is offered only to individuals who are also covered by other minimum essential coverage, including Medicare, TRICARE, Medicaid, or certain employer-sponsored coverage, for which reporting is required. In these arrangements, the program for which reporting is required represents the primary coverage while the other minimum essential coverage is supplemental to the primary plan.

Under the application of the second rule to eligible employer-sponsored coverage, if an employer offers both an insured group health plan and an HRA for which an employee is eligible if enrolled in the insured group health plan, and an employee enrolls in both, the employer is not required to report the employee's coverage under the HRA. However, if an employee is enrolled in his or her employer's HRA and in a spouse's non-HRA group health plan, the employee's employer is required to report for the HRA, and the employee's spouse's employer (or the health insurance issuer or carrier, if the plan is insured) is required to report for the non-HRA group health plan coverage. The proposed regulations clarify that, for purposes of this rule, an employer is treated as offering minimum essential coverage that is offered by another employer with whom the employer is treated as a single employer under section 414(b), (c), (m), or (o).

Separately, Notice 2015–68 also stated that, because Medicaid and CHIP coverage provided by the governments of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands is generally made available only to individuals who are treated as having minimum essential coverage under section 5000A(f)(4) (and, therefore, do not need section 6055 reporting to verify minimum essential coverage), the Medicaid and CHIP agencies in those U.S. possessions or territories are not required to report that coverage under section 6055. Consistent with that rule, the proposed regulations provide that reporting under section 6055 is not required with respect to Medicaid and CHIP agencies in U.S. possessions or territories.

5. *TIN Solicitation*

Information reporting under section 6055 is subject to the penalty provisions of sections 6721 and 6722 for failure to file timely a correct information return or failure to furnish timely a correct statement to the individual. See § 1.6055–1(h). The penalties may be waived under section 6724(a) if the failure is due to reasonable cause and not due to willful neglect; that is, if a reporting entity demonstrates that it acted in a responsible manner and that the failure is due to significant mitigating factors or events beyond the reporting entity's control. See § 301.6724–1(a)(2). Under § 301.6724–1(e), in cases of a missing TIN, the reporting entity is treated as acting in a responsible manner in soliciting a TIN if the reporting entity makes (1) an initial solicitation when an account is opened or a relationship is established, (2) a first annual solicitation by December 31 of the year the account is opened (or January 31 of the following year if the account is opened in December), and (3) a second annual solicitation by December 31 of the year following the year in which the account is opened. Similar rules apply regarding incorrect TINs under § 301.6724–1(f). The rules in § 301.6724–1(e) and (f) were issued prior to the enactment of section 6055 and apply to most forms of information reporting.

Comments received in response to the first notice of proposed rulemaking (REG–132455–11) under section 6055, published in the **Federal Register** (78 FR 54986) on September 9, 2013, raised concerns about the application of the TIN solicitation rules to section 6055 reporting. Accordingly, Notice 2015–68 provided that, pending the issuance of additional guidance, reporting entities will not be subject to penalties for failure to report a TIN if they comply with the requirements of § 301.6724–1(e) with the following modifications: (1) the initial solicitation is made at an individual's first enrollment or, if already enrolled on September 17, 2015, the next open season, (2) the second solicitation (the first annual solicitation) is made at a reasonable time thereafter, and (3) the third solicitation (the second annual solicitation) is made by December 31 of the year following the initial solicitation. Notice 2015–68 also requested comments on the application of the reasonable cause rules under section 6724 to section 6055 reporting.

In response to the request for comments in Notice 2015–68, one commenter requested that the proposed regulations include detailed rules tailored to TIN solicitation for information returns required by section 6055. This commenter expressed concern that, because the current rules were designed primarily to apply to financial relationships, they are

difficult to apply to section 6055 reporting, particularly the rules for demonstrating that the filer acted in a responsible manner as described in § 301.6724–1(e) and (f). The Treasury Department and the IRS agree with the commenter that some modification to the rules in § 301.6724–1(e) is warranted to account for the differences between information reporting under section 6055 and information reporting under other provisions of the Code. Accordingly, the Treasury Department and the IRS propose regulations to provide specific TIN solicitation rules for section 6055 reporting. Until final regulations are released, reporting entities may rely on these proposed rules and Notice 2015–68. The preamble below also includes some additional transition rules that apply to reporting entities in certain situations.

Section 301.6724–1(e)(1)(i) provides that an initial TIN solicitation must occur when an account (which includes accounts, relationships, and other transactions) is opened. Section 301.6724–1(e) does not define the term "opened" for this purpose. Commenters requested clarification as to how the term "opened" should be interpreted for purposes of reporting under section 6055. In the context of financial accounts, an account is generally considered opened on the first day it is available for use by its owner. In most cases, this would be shortly after the application to open that account is received, and this day would be no earlier than the day the application was received. Health coverage does not work in the same way. In some cases, the first effective date of health coverage is before the day the application was received, making it impractical to solicit TINs before the coverage takes effect. In other cases, the effective date of coverage may be months after the day the application was received. To account for this different timing, the proposed regulations provide that, for purposes of section 6055 reporting, an account is considered "opened" on the date the filer receives a substantially complete application for new coverage or to add an individual to existing coverage. Accordingly, health coverage providers may generally satisfy the requirement for the initial solicitation by requesting enrollees' TINs as part of the application for coverage.

To address differences in the way financial accounts and health coverage are opened, the proposed regulations also change the timing of the first annual solicitation (the second solicitation overall) with respect to missing TINs. Under § 301.6724–1(e)(1)(ii), a first annual solicitation must be made by December 31 of the year the account is opened (or by January 31 of the following calendar year if the account is opened in December). The timing of the first annual solicitation is dictated by the need to have accurate reporting of information to taxpayers and the IRS in preparation for the filing of an income tax return. Accounts, relationships, and other transactions may be opened or begun throughout the year, and may remain active indefinitely. It is beneficial to the IRS, filers, and taxpayers in the context of accounts, relationships, and other transactions to have a single deadline for the first annual solicitation at the end of the calendar year (or January if the account is opened in December).

By contrast, health coverage is generally offered on an annual basis. While individuals may, depending on their circumstances, enroll in coverage at any point during the year, many covered individuals enroll in coverage during the open enrollment period, which is in advance of the beginning of the coverage year. The most common coverage year is the calendar year and many individuals enroll late each year for coverage the following year. For such individuals, requiring the first annual solicitation (the second solicitation overall) by December 31 of the year in which the application is received is earlier than is necessary (because reporting is not due until more than a year later) and coincides with the end of a plan year, which is already the busiest time of year for coverage providers. To address these considerations, the proposed regulations require that the first annual solicitation be made no later than seventy-five days after the date on which the account was "opened" (i.e., the day the filer received the substantially complete application for coverage), or, if the coverage is retroactive, no later than the seventy-fifth day after the determination of retroactive coverage is made. The deadline for the second annual solicitation (third solicitation overall) remains December 31 of the year following the year the account is opened as required by § 301.6724–1(e)(1)(iii).

As noted above, taxpayers may rely on these proposed regulations and on Notice 2015–68 until final regulations are published. To provide additional relief and ensure that the requirements for the first annual and second annual solicitations may be satisfied with respect to individuals already enrolled in coverage, an additional rule is provided. Under this rule, if an individual was enrolled in coverage on any day before July 29, 2016, the account is considered opened on July 29, 2016. Accordingly, reporting entities have satisfied the requirement for the initial solicitation with respect to already enrolled individuals so long as they requested enrollee TINs either as part of the application for coverage or at any other point before July 29, 2016. The deadlines for the first and second annual solicitations are set by reference to the date the account is opened. Thus, the rule above that treats all accounts for individuals currently enrolled in coverage for which a TIN has not been provided as opened on July 29, 2016, provides additional time for the annual solicitations as well. Specifically, consistent with Notice 2015–68, the first annual solicitation should be made at a reasonable time after July 29, 2016. For this purpose, a reporting entity that makes the first annual solicitation within 75 days of the initial solicitation will be treated as having made the second solicitation within a reasonable time. Reporting entities that have not made the initial solicitation before July 29, 2016 should comply with the first annual solicitation requirement by making a solicitation within a reasonable time of July 29, 2016. Notice 2015–68 also provided that a reporting entity is deemed to have satisfied the initial, first annual, and second annual solicitations for an individual whose coverage was terminated prior to September 17, 2015, and taxpayers may continue to rely on this rule as well.

Section 301.6724–1(e)(1)(v) provides that the initial and first annual solicitations relate to failures on returns filed for the year in which the account is opened (meaning that showing reasonable cause with respect to the year the account is opened generally requires making the initial and first annual solicitations in the year the account is opened). Because these proposed regulations provide that an account is considered opened for section 6055 purposes when a substantially complete application for that account is received, an account would, in some cases, be considered open in a year prior to the year for which coverage is actually effective and for which reporting is required. This would occur, for example, when a reporting entity receives an application during open enrollment for coverage effective as of the first day of the next coverage year. To ensure that reporting entities that make the initial solicitation and first annual solicitation are eligible for relief for the first year for which reporting is required, the proposed regulations provide that, for purposes of reporting under section 6055, the initial and first annual solicitations relate to failures on returns required to be filed for the year that includes the day that is the first effective date of coverage for a covered individual. Similarly, § 301.6724–1(e)(1)(v) provides that the second annual solicitation relates to failures on returns filed for the year immediately following the year in which the account is opened and succeeding calendar years (meaning that showing reasonable cause with respect to years after the account is opened generally requires making the second annual solicitation during the year following the year the account is opened). As with the initial and first annual solicitations, the existing rule under § 301.6724–1(e)(1)(v) could provide relief for the wrong year when combined with the proposed definition of account opening under section 6055. Accordingly, the proposed regulations provide that the second annual solicitation relates to failures on returns filed for the year immediately following the year to which the first annual solicitation relates, and succeeding calendar years.

In contrast to missing TINs, the Treasury Department and the IRS do not recognize a similar need to modify the existing first annual solicitation rules for incorrect TINs in § 301.6724–1(f)(1)(ii). As with many other types of information reports, information reports of health coverage are generally filed after the end of the tax year, and thus, it is only after the tax year that a filer would generally receive notice of an incorrect TIN. Because the end of the tax year typically corresponds with the end of the coverage year, there is no reason to distinguish the timing of the correction of incorrect TINs for health coverage from all other types of accounts for which information reporting is required. Consequently, the proposed regulations do not alter the rules for incorrect TINs in § 301.6724–1(f)(1)(ii) and (iii) as applied to information reporting under section 6055. However, as with the rules regarding missing TINs under § 301.6724–1(e)(1)(ii), the rules regarding incorrect TINs in § 301.6724–1(f)(1)(i) make reference to the time an account is "opened." Accordingly, the proposed regulations, which provides that for purposes of section 6055 reporting an account is considered "opened" at the time the filer receives an application for new coverage or to add an individual to existing coverage, also applies for purposes of the initial solicitation for incorrect TINs in § 301.6724–1(f)(1)(i).[2]

a. *Application of the TIN Solicitation Rules to "Responsible Individuals" and "Covered Individuals"*

A commenter requested clarification that the initial and annual solicitations of § 301.6724–1(e)(1)(i) and (ii) need be made only to the responsible individual for all individuals covered under a single policy. The commenter further suggested that TIN solicitations made to a responsible individual be treated as TIN solicitations made to all individuals named on the responsible individual's policy.

Under § 1.6055–1(e)(1)(ii) and (iii), filers must report the TIN of each covered individual (who, under § 301.6721–1(g)(5), are also "payees"), and § 1.6055–1(g)(1) requires that the TIN of each covered individual be shown on statements furnished to the responsible individual. Current § 1.6055–1(g)(1) provides that, for purposes of the penalties under section 6722, the furnishing of a statement to the responsible individual is treated as the furnishing of a statement to a covered individual. This rule is intended to allow reporting entities to satisfy the section 6722 requirements for all covered individuals by furnishing the required statement only to the responsible individual. The Treasury Department and the IRS also intend for a similar rule to apply to the TIN solicitation rules under the section 6724 regulations. To clarify that this is how these rules apply, the proposed regulations expressly provide that TIN solicitations (both initial and annual) made to the responsible individual for a policy or plan are treated as TIN solicitations of every covered individual on the policy or plan for purposes of § 301.6724–1(e)(1) and (f)(1). The filer does not need to make separate solicitations from the responsible individual for each covered individual nor does it need to separately solicit the TINs of each covered individual by contacting each covered individual directly. However, we decline to adopt the commenter's suggestion that a TIN solicitation made to a responsible individual be treated as a TIN solicitation made to all individuals named on that responsible individual's policy at any time, including those individuals added to a policy after the TIN solicitations. When a new individual is added to a policy, the coverage provider establishes a relationship with that individual. The individual is new to the filer, and it is the filer's responsibility to solicit that individual's TIN. Accordingly, to qualify for the penalty waiver, filers must solicit TINs for each individual added to a policy under the procedures outlined in § 301.6724–1(e)(1)(i) and (f)(1)(i); however, any other individual for whom the filer already has a TIN or already has solicited a TIN the prescribed amount of times need not be solicited again regardless of what changes take place during the filer's coverage of that individual.

b. *Different Forms of TIN Solicitations*

A commenter to Notice 2015–68 requested that the provision of renewal applications to enrollees be permitted to satisfy the annual solicitation requirement for purposes of § 301.6724–1(e)(1)(ii) and (iii) and (f)(1)(ii) and (iii) if those renewal applications request TINs from covered individuals. Under current law, TIN requests may be made in a number of different formats. The provision of a renewal application that requests TINs for all covered individuals satisfies the annual solicitation provisions of § 301.6724–1(e)(1)(ii) and (iii) and (f)(1)(ii) and (iii) if it is sent by the deadline for those annual solicitations. Thus, no changes to the regulations are necessary for renewal applications to satisfy the annual solicitation requirement.

The same commenter requested that the requirement in § 301.6724–1(e)(2)(i)(B) to provide the responsible individual with a Form W–9 should be eliminated. The commenter was concerned that this requirement imposes burdens on responsible individuals that make it less likely that they will respond to a TIN solicitation. Section 301.6724–1(e)(2)(i)(B) requires that an annual solicitation include a "Form W–9 or an acceptable substitute . . ." Thus, the existing regulations do not require that Form W–9 be sent. Filers are allowed to request TINs on an acceptable substitute for Form W–9, which includes a renewal application or other request for a TIN. Thus, this comment is not adopted.

This commenter also requested that the requirement in § 301.6724–1(e)(2)(i)(C) that annual solicitations include a return envelope be eliminated, and, if not eliminated, that clarification be provided as to how this requirement applies to multiple TINs. Existing regulations include this requirement because individuals are more likely to comply with a TIN solicitation if that solicitation includes a return envelope. We see no reason that the requirement to include a return envelope, which exists for other information reporting provisions, should be removed for reporting under section 6055. Thus, the proposed regulations do not adopt this comment. However, filers may request more than one TIN at the same time and do not need to send separate envelopes with each request. For example, on a renewal application requesting the TINs for all covered individuals, filers need only provide one return envelope for that application or request.

c. *Solicitations by Employers*

A commenter requested that employers be permitted to make TIN solicitations on behalf of filers. The commenter offered that employers are frequently in a better position than coverage providers to request TINs from the employers' employees and the employees' dependents, and, for practical reasons, it would make sense to allow employers to step in the shoes of the coverage provider for purposes of making the solicitations under § 301.6724–1(e)(1) and (f)(1).

Under existing regulations, actions taken by employers may satisfy the requirement for making an initial or annual TIN solicitation. Employers may, for example, provide their employees with applications for health coverage. If these applications request that the applicants provide TINs for all individuals to be covered, the coverage provider has made an initial solicitation for these individuals' TINs.

The commenter further requested that a filer that arranges to have an employer take on responsibility for the TIN solicitations be treated as having met the penalty waiver requirements of § 301.6724–1(e)(1) and (f)(1). Under existing regulations, qualifying for a penalty waiver requires that the solicitations actually be made. To avoid creating a less stringent standard in cases where an employer is acting on the filer's behalf, the proposed regulations do not adopt the commenter's proposal.

d. *Electronic TIN Solicitations*

A commenter requested that filers be permitted to make annual TIN solicitations by electronic means if the responsible individual has consented to the receipt of information concerning his or her coverage in the same electronic format in which the annual solicitation is made. IRS Publication 1586, Reasonable Cause Regulations and Requirements for Missing and Incorrect Name/TINs (including instructions for reading CD/DVDs), provides that filers may establish an electronic system for payees (including covered individuals) to receive and respond to TIN solicitations, provided certain listed requirements are met. IRS Publication 1586 can be found at *www.irs.gov/forms-pubs*. Because filers are already able to solicit TINs electronically, it is unnecessary to address the commenter's recommendation for electronic TIN solicitations with these proposed regulations.

Proposed Effective/Applicability Date

These regulations are generally proposed to apply for taxable years ending after December 31, 2015, and may be relied on for calendar years ending after December 31, 2013.

The only exception is the rules in section 1 of this preamble relating to reporting of coverage under catastrophic plans. Those rules are proposed to apply for calendar years beginning after December 31, 2016. Health insurance issuers may voluntarily report on 2015 and 2016 catastrophic coverage (on returns and statements filed and furnished in 2016 and 2017 respectively). An issuer that reports on 2015 and/or 2016 catastrophic coverage will not be subject to penalties for these returns.

In addition, until these the proposed regulations are finalized, taxpayers may continue to rely on the rules provided in Notice 2015–68.

Special Analyses

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required.

It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations.

It is hereby certified that these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the information collection required under these regulations is imposed under section 6055. Consistent with the statute, the proposed regulations require a person that provides minimum essential coverage to an individual to file a return with the IRS reporting certain information and to furnish a statement to the responsible individual who enrolled an individual or family in the coverage. These regulations primarily provide the method of filing and furnishing returns and statements under section 6055. Moreover, the proposed regulations attempt to minimize the burden associated with this collection of information by limiting reporting to the information that the IRS will use to verify minimum essential coverage and administer tax credits.

Based on these facts, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

Pursuant to section 7805(f), this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Statement of Availability of IRS Documents

IRS Revenue Procedures, Revenue Rulings notices, notices and other guidance cited in this preamble are published in the Internal Revenue Bulletin (or Cumulative Bulletin) and are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, or by visiting the IRS website at *http://www.irs.gov*.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in this preamble under the “Addresses” heading. The Treasury Department and the IRS request comments on all aspects of the proposed rules. All comments will be available for public inspection at *www.regulations.gov* or upon request. A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register.**

Drafting Information

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

*** * * * ***

Proposed Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 301 are proposed to be amended as follows:

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.6055–1 is amended by:

1. Adding paragraphs (b)(13) and (14).

2. Redesignating paragraph (c)(1)(iv) as (c)(1)(v) and adding a new paragraph (c)(1)(iv).

3. Revising paragraphs (d)(1) and (2).

4. Redesignating paragraph (d)(3) as (d)(5) and adding a new paragraph (d)(3).

5. Adding paragraphs (d)(4) and (6).

6. Revising paragraph (g)(3).

7. Revising paragraph (h)(1).

8. Adding paragraph (h)(3).

9. Revising paragraph (j).

The revisions and additions read as follows:

§ 1.6055–1 Information reporting for minimum essential coverage.

* * * * *

(b) * * *

(13) *Catastrophic plan*. The term catastrophic plan has the same meaning as in section 1302(e) of the Affordable Care Act (42 U.S.C. 18022(e)).

(14) *Basic health program*. The term basic health program means a basic health program established under section 1331 of the Affordable Care Act (42 U.S.C. 18051).

(c) * * *

(1) * * *

(iv) The state agency that administers a Basic Health Program;

* * * * *

(d) *Reporting not required*—(1) *Qualified health plans*. Except for coverage under a catastrophic plan, a health insurance issuer is not required to file a return or furnish a report under this section for coverage in a qualified health plan in the individual market enrolled in through an Exchange.

(2) *Duplicative coverage*. If an individual is covered for a month by more than one minimum essential coverage plan or program provided by the same reporting entity, reporting is required for only one of the plans or programs for that month.

(3) *Supplemental coverage*. Reporting is not required for minimum essential coverage of an individual for a month if that individual is eligible for that coverage only if enrolled in other minimum essential coverage for which section 6055 reporting is required and is not waived under this paragraph (d)(3). This paragraph (d)(3) applies with respect to eligible employer-sponsored coverage only if the supplemental coverage is offered by the same employer that offered the eligible employer-sponsored coverage for which reporting is required. For this purpose, an employer is treated as offering minimum essential coverage offered by any other person that is a member of a controlled group of entities under section 414(b) or (c), an affiliated service group under section 414(m), or an entity in an arrangement described under section 414(o) of which the employer is also a member.

(4) *Certain coverage provided by Territories and Possessions*. The agencies that administer Medicaid and the Children's Health Insurance Program in American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands are not required to report that coverage under section 6055.

* * * * *

(6) *Examples*. The following examples illustrate the rules of this paragraph (d).

Example 1. Upon being hired, Taxpayer A enrolls in a self-insured major medical group health plan and a health reimbursement arrangement (HRA), both offered by A's employer, V. Both the group health plan and the HRA are minimum essential coverage, and V is the reporting entity for both. Because V is the reporting entity for both the self-insured major medical group health plan and the HRA, under paragraph (d)(2) of this section V must report under paragraph (a) of this section for either its self-insured major medical group health plan or its HRA for A for the months in which A is enrolled in both plans.

Example 2. Taxpayer B is enrolled in an insured employer-sponsored group health plan offered by B's employer, W. B is also covered by an HRA offered by W. Under the terms of the HRA, B is eligible for the HRA because B is enrolled in W's insured employer-sponsored group health plan. W's insured employer-sponsored group health plan is minimum essential coverage and, under paragraphs (a) and (c)(1)(i) of this section, the issuer of the insured employer-sponsored group health plan must report coverage under the plan. Therefore, for the months in which B is enrolled in both plans, under paragraph (d)(3) of this section, W does not need to report the HRA for B because the issuer is required to report on coverage for B in the insured employer-sponsored group health plan offered by W for those months.

Example 3. Taxpayer C enrolls in a Medicare Savings Program administered by X, a state Medicaid agency, which provides financial assistance with Medicare Part A premiums. Only individuals enrolled in Medicare Part A are offered coverage in this Medicare Savings Program. Medicare Part A is government-sponsored minimum essential coverage and, under paragraphs (a) and (c)(1)(iii) of this section, Medicare must report coverage under the program. Therefore, under paragraph (d)(3) of this section, X does not need to report under paragraph (a) of this section for C's coverage under the Medicare Savings Program.

Example 4. Taxpayer E obtains a Medicare supplemental insurance (Medigap) policy that provides financial assistance with costs not covered by Medicare Part A from Z, a health insurance issuer. Only individuals enrolled in Medicare Part A are offered coverage under this Medigap policy. Medicare Part A is minimum essential coverage and, under paragraphs (a) and (c)(1)(iii) of this section, Medicare is required to report E's coverage under Medicare Part A. Therefore, under paragraph (d)(3) of this section, Z does not need to report E's coverage under the Medigap policy.

Example 5. Taxpayer F is covered by an HRA offered by F's employer, P. F is also enrolled in a non-HRA group health plan that is self-insured and sponsored by F's spouse's employer, Q. P and Q are not treated as one employer under section 414(b), (c), (m), or (o). Under the terms of the HRA, F is eligible for the HRA only because F is enrolled in a non-HRA group health plan, which in this case is the group health plan offered by Q. However, because the HRA and the non-HRA group health plan are offered by different employers, paragraph (d)(3) of this section does not apply. Accordingly, under paragraphs (a) and (c)(2)(i)(A) of this section, P must report F's enrollment in the HRA, and Q must report F's (and F's spouse's) enrollment in the non-HRA group health plan.

* * * * *

(g) * * *

(3) *Form of the statement*. A statement required under this paragraph (g) may be

made either by furnishing to the responsible individual a copy of the return filed with the Internal Revenue Service or on a substitute statement. A substitute statement must include the information required to be shown on the return filed with the Internal Revenue Service and must comply with requirements in published guidance (see § 601.601(d)(2) of this chapter) relating to substitute statements. An individual's identifying number may be truncated to appear in the form of an IRS truncated taxpayer identification number (TTIN) on the statement furnished to the responsible individual. The identifying number of the employer may also be truncated to appear in the form of a TTIN on the statement furnished to the responsible individual. For provisions relating to the use of TTINs, see § 301.6109–4 of this chapter (Procedure and Administration Regulations).

* * * * *

(h) * * *(1) *In general*. For provisions relating to the penalty for failure to file timely a correct information return required under section 6055, see section 6721 and the regulations under that section. For provisions relating to the penalty for failure to furnish timely a correct statement to responsible individuals required under section 6055, see section 6722 and the regulations under that section. See section 6724, and the regulations thereunder, and

paragraph (h)(3) of this section for provisions relating to the waiver of penalties if a failure to file or furnish timely or accurately is due to reasonable cause and not due to willful neglect.

* * * * *

(3) *Application of section 6724 waiver of penalties to section 6055 reporting*—(i) *In general*. Paragraphs (e) and (f) of § 301.6724–1 of this chapter, as modified by this paragraph (h)(3), apply to reasonable cause waivers of penalties under sections 6721 and 6722 for failure to file timely or accurate information returns or to furnish individual statements required to be filed or furnished under section 6055.

(ii) *Account opened*. For purposes of section 6055 reporting and the solicitation rules contained in paragraphs (i), (ii), (iii), and (v) of § 301.6724–1(e)(1) of this chapter and paragraph (i) of § 301.6724–1(f)(1) of this chapter, an account is considered opened at the time the reporting entity receives a substantially complete application for coverage (including an application to add an individual to existing coverage) from or on behalf of an individual for whom the reporting entity does not already provide coverage.

(iii) *First annual solicitation deadline for missing TINs*. In lieu of the deadline for the first annual solicitation contained in paragraph (ii) of § 301.6724–1(e)(1) of this chapter, the first annual solicitation must be made on or before the seventy-fifth day after the date on which an account is opened (or, in the case of retroactive coverage, the seventy-fifth day after the determination of retroactive coverage is made). The period from the date on which the reporting entity receives an application for coverage to the last day on which the first annual solicitation may be made is the first annual solicitation period.

(iv) *Failures to which a solicitation relates*—(A) *Missing TIN*. For purposes of reporting under section 6055 and the solicitation rules contained in paragraph (1) of § 301.6724–1(e) of this chapter, the initial and first annual solicitations relate to failures on returns required to be filed for the year which includes the first effective date of coverage for a covered individual. The second annual solicitation relates to failures on returns filed for the year immediately following the year to which the first annual solicitation relates and for succeeding calendar years.

(B) *Incorrect TIN*. For purposes of reporting under section 6055 and the solicitation rules contained in paragraph (i) of § 301.6724–1(f)(1) of this chapter, the initial solicitation relates to failures on returns required to be filed for the year which includes the first effective date of coverage for a covered individual.

(v) *Solicitations made to responsible individual*. For purposes of reporting under section 6055 and the solicitation rules contained in § 301.6724–1(e) and (f) of this chapter, an initial or annual solicitation made to the responsible individual is treated as a solicitation made to a covered individual.

* * * * *

(j) *Applicability date*—(1) Except as provided in paragraphs (j)(2) and (3) of this section, this section applies for calendar years ending after December 31, 2014.

(2) Paragraphs (b)(14), (c)(1)(v), (d)(2) through (6), and (g)(3) of this section apply to calendar years ending after December 31, 2015. Paragraphs (d)(2), (d)(3), and (g)(3) of § 1.6055–1 as contained in 26 CFR part 1 edition revision as of April 1, 2016, apply to calendar years ending after December 31, 2014 and beginning before January 1, 2016.

(3) Paragraphs (b)(13) and (d)(1) of this section apply to calendar years beginning after December 31, 2016. Paragraph (d)(1) of § 1.6055–1 as contained in 26 CFR part 1 edition revised as of April 1, 2016, applies to calendar years ending after December 31, 2015 and beginning before January 1, 2017.

PART 301 — PROCEDURE AND ADMINISTRATION

Par. 3. The authority for part 301 continues to read in part as follows:

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

Par. 4. Section 301.6724–1 is amended by adding a sentence to the end of paragraph (e)(1)(vi)(A) to read as follows:

§ 301.6724–1 Reasonable cause.

* * * * *

(e) * * *

(1) * * *

(vi) *Exceptions and limitations*. (A)* * * See § 1.6055–1(h)(3) of this chapter, which provides rules on the time, form, and manner in which a TIN must be provided for information returns required to be filed and individual statements required to be furnished under section 6055.

* * * * *

John Dalrymple, *Deputy Commissioner for Services and Enforcement.*emphasis>

Note

(Filed by the Office of the Federal Register on July 29, 2016, 11:15 a.m., and published in the issue of the Federal Register for August 2, 2016, 81 F.R. 50671)

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[1] The Affordable Care Act also added section 6056, which requires that applicable large employers file and furnish statements containing information related to offers of coverage, if any, made to each full-time employee. To complete these statements properly, employers must have each employee's TIN. In accordance with the requirements of a different Code section (section 3402(f)(2)(A)), employers should have already sought each employee's TIN in advance of the deadline for filing and furnishing statements required under section 6056. Therefore, the TIN solicitation rules in these proposed regulations *only apply* to information reporting under section 6055 (which in the case of an applicable large employer providing coverage under a self-insured plan, includes information reporting on Form 1095–C, Part III).

[2] A filer of the information return required under § 1.6055–1 may receive an error message from the IRS indicating that a TIN and name provided on the return do not match IRS records. An error message is neither a Notice 972CG, Notice of Proposed Civil Penalty, nor a requirement that the filer must solicit a TIN in response to the error message.