

in income to be eligible for relief under this notice, and that inclusion in income occurs in a year subsequent to the year the plan was corrected, the service provider must include the statement with the return for the year of the correction as well as the return for the year of income inclusion.”

H. To provide relief from the employee information reporting requirements upon the correction of an operational failure in the same taxable year as the failure occurs, § IX.A of Notice 2008–113 is modified to read as follows:

“A. Information Required with Respect to Correction of an Operational Failure in the Same Taxable Year as the Failure Occurs

A service recipient described in § IV of this notice must attach to its timely filed (including extensions) original federal income tax return for its taxable year in which the failure occurred a statement entitled “§ 409A Relief under IV of Notice 2008–113” stating that it is relying upon § IV of this notice with respect to a correction of a failure to comply with § 409A and setting out the following information with respect to each such failure:

1. The name and taxpayer identification number of each service provider affected by the failure and whether such service provider is an insider with respect to the service recipient. Where the same or a substantially similar operational failure has occurred with respect to multiple service providers, the information required in § IX.A.2 through 5 may be supplied only once with respect to such operational failure, provided that the identification of each service provider affected by the operational failure in this § IX.A.1 references such information and the amount involved in the operational failure with respect to such service provider.

2. Identification of the nonqualified deferred compensation plan with respect to which such failure occurred.

3. A brief description of the failure and the circumstances under which it occurred, including the amount involved and date on which the failure occurred.

4. A brief description of the steps taken to correct the failure and the date on which such correction was completed.

5. A statement that the operational failure is eligible for the correction under the

terms of this notice, and that the service recipient has taken all actions required, and otherwise met all requirements, for such correction.

In addition, each service recipient relying on the relief provided in § IV of this notice must make reasonable efforts to provide notice to the examining agent upon the commencement of an examination of the service recipient’s federal tax return that the service recipient was relying upon the relief provided under this notice for years covered by the examination.”

IV. EFFECTIVE DATE

Taxpayers may rely on this Notice 2010–80 for the modifications to Notice 2008–113 for taxable years beginning on or after January 1, 2010. Taxpayers may rely on this Notice 2010–80 for the modifications to Notice 2010–6 for taxable years beginning on or after January 1, 2009.

V. EFFECT ON OTHER DOCUMENTS

Notice 2008–113 and Notice 2010–6 are modified as provided in this notice. Except as explicitly provided, this notice does not otherwise affect the guidance provided in Notice 2010–6 and Notice 2008–113.

VI. DRAFTING INFORMATION

The principal author of this notice is Keith Ranta of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), although other Treasury and IRS officials participated in its development. For further information on the provisions of this notice, contact Keith Ranta at (202) 927–9639 (not a toll-free number).

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 insur-

ance 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 de-

termine 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 ex-

pensive 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.

(iii) 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 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.

(ii) 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). ($\$5,000 \div \$7,000 = 71\%$).

(iii) 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 ($\$18,000 \div 4$).

(iv) 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 X (\$4,500) is at least 66% of the self-only composite rate for Plan X (\$6,250). ($\$4,500 \div \$6,250 = 72\%$).

(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, 2010–21 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 I.R.B. 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).

Funding Relief For Multiemployer Defined Benefit Plans Under PRA 2010

Notice 2010–83

I. PURPOSE

This notice provides guidance in the form of questions and answers for sponsors of multiemployer defined benefit plans with respect to the special funding rules under § 431(b)(8), as added by section 211(a)(2) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA 2010), Pub. L. No. 111–192.

II. BACKGROUND

Section 412 contains minimum funding rules that generally apply to pension plans. Section 431 sets forth the funding rules that apply specifically to multiemployer defined benefit plans. Section 432 sets forth additional rules that apply to multiemployer plans in effect on July 16, 2006, that are in endangered or critical status.

Section 431 provides rules for determining, based on charges and credits to the plan's funding standard account, the minimum contribution that must be made to a multiemployer defined benefit plan in order to satisfy the funding requirements under § 412. Under § 431(b)(2)(B)(iii) and (b)(3)(B)(ii), net experience losses and gains are amortized by charges (in the case of losses) and credits (in the case of gains) in equal annual installments over 15 plan years.

Section 431(b)(8), added to the Code by section 211(a)(2) of PRA 2010, provides two special funding rules available to multiemployer plans, a special amortization rule in § 431(b)(8)(A) and a special asset valuation rule in § 431(b)(8)(B).

Section 431(b)(8)(A) provides a special amortization rule for certain net investment losses in the case of a multiemployer plan that meets a solvency test. The special rule applies to the portion of the plan's experience loss or gain for a plan year attributable to net investment losses (if any) incurred in either or both of the first two plan years ending after August 31, 2008 (an eligible loss year). This portion of the experience loss or gain may be treated as an item