Internal Revenue
bulletin

Bulletin No. 2013-14
April 1, 2013

# HIGHLIGHTS OF THIS ISSUE

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

## INCOME TAX

### Notice 2013–15, page 739.

This notice advises State and local housing credit agencies that allocate low-income housing tax credits under section 42 of the Code, and States and other issuers of tax-exempt private activity bonds under section 141, of the population figures to use in calculating: (1) the 2013 calendar year population-based component of the State housing credit ceiling (Credit Ceiling) under section 42(h)(3)(C)(ii); (2) the 2013 calendar year volume cap (Volume Cap) under section 146; and (3) the 2013 volume limit (Volume Limit) under section 142(k)(5).

### Notice 2013–18, page 742.

Notice 2013–18 modifies and supersedes Notice 2000–45, 2000–2 C.B. 256, which provides guidance to taxpayers engaged in the trade or business of farming in determining whether a plant has a preproductive period in excess of 2 years for purposes of section 263A(d) and (e) of the Code. Specifically, Notice 2013–18 removes raspberry, blackberry, and papaya plants from the previously published list of plants having a preproductive period in excess of 2 years. Concurrently with the issuance of Notice 2013–18, the Service and the Treasury Department issued Rev. Proc. 2013–20, which modifies Rev. Proc. 2011–14, 2011–4 I.R.B. 330, to provide procedures for a taxpayer to obtain the automatic consent of the Commissioner under § 446(e) of the Code to change its method of accounting under § 263A for the production of one or more plants removed from the list of plants grown in commercial quantities in the United States having a preproductive period in excess of two years based on the nationwide weighted average preproductive period for such plant. Notice 2000–45 modified and superseded.

### Notice 2013–19, page 743.

This notice provides guidance on whether, for purposes of applying the limitation set forth in the flush language of section 807(d)(1) of the Code (the statutory reserve cap), deficiency reserves are included in the amount taken into account with respect to a life insurance contract in determining statutory reserve under section 807(d)(6).

### Rev. Proc. 2013–20, page 744.

Revenue Procedure 2013–20 modifies Rev. Proc. 2011–14, 2011–4 I.R.B. 330, to provide procedures for a taxpayer to obtain the automatic consent of the Commissioner under section 446(e) of Code to change its method of accounting under section 263A for the production of one or more plants removed from the list of plants grown in commercial quantities in the United States having a preproductive period in excess of two years based on the nationwide weighted average preproductive period for such plant. Concurrently with the issuance of Rev. Proc. 2013–20, the Service and the Treasury Department issued Notice 2013–18, modifying and superseding Notice 2000–45. Notice 2013–18 removes blackberry, raspberry, and papaya plants from the list of plants that produce crops or yields that have a nationwide weighted average preproductive period in excess of 2 years. Rev. Proc. 2011–14 modified.

**(Continued on the next page)**

**Finding Lists begin on page ii.**

Department of the Treasury
Internal Revenue Service

## EXCISE TAX

### REG–118315–12, page 746.

Proposed regulations provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance for United States health risks. This fee was enacted by section 9010 of the Patient Protection and Affordable Care Act. The proposed regulations affect persons engaged in the business of providing health insurance. The proposed regulations provide an explanation of terms, a description of the reporting requirements, the calculation and notification of a preliminary fee, an error correction process, the final fee calculation and notification, the tax treatment of the fee, and instructions regarding how to claim a refund. A public hearing is scheduled for June 21, 2013.

## TAX CONVENTIONS

### Announcement 2013–16, page 738.

The competent authorities of the United States and Norway signed an agreement regarding the United States – Norway income tax treaty. The agreement clarifies, for purposes of paragraph 3 of Article 4A (Offshore Activities), when a resident of one state that operates tugboats and similar vessels in the other state in connection with offshore activities will be exempt from tax in that other state.

## ADMINISTRATIVE

### Notice 2013–16, page 740.

This notice updates the appendix to Notice 2013–1, 2013–3 I.R.B. 281,which lists the Indian tribes who have settled tribal trust cases against the United States. Notice 2012–60 originally was published in I.R.B. 2012–41 (October 9, 2012). Notice 2012–60 was superceded by Notice 2013–1. However, two additional tribes have settled cases against the United States, and we are seeking to publish an updated appendix to Notice 2013–1. Notice 2013–1 Appendix modified and superseded.

### Announcement 2013–19, page 760.

This document contains corrections to final regulations (T.D. 9604, 2012–52 I.R.B. 730) that provides guidance on the excise tax imposed on the sale of certain medical devices, enacted by the Health Care and Education Reconciliation Act of 2010 in conjunction with the Patient Protection and Affordable Care Act.

### Announcement 2013–20, page 761.

This document provides a notice of public hearing on proposed regulations (REG–141066–09, 2013–3 I.R.B. 289) that provide comprehensive guidance for the award program authorized under Code section 7623, as amended. The regulations provide guidance on submitting information regarding underpayments of tax or violations of the internal revenue laws and filing claims for award, as well as on the administrative proceeding applicable to claims for award under section 7623. The regulations also provide guidance on the determination and payment of awards, and provide definitions of key terms used in section 7623. Finally, the regulations confirm that the Director, officers, and employees of the Whistleblower Officer are authorized to disclose return information to the extent necessary to conduct whistleblower administrative proceedings. The public hearing is scheduled for April 10, 2013.

# The IRS Mission

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

# Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

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

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

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

The Bulletin is divided into four parts as follows:

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

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

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

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

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

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

## Section 263A.—Capitalization and Inclusion in Inventory Costs of Certain Expenses

Notice 2013–18 modifies and supersedes Notice 2000–45, 2000–2 C.B. 256, which provides guidance to taxpayers engaged in the trade or business of farming in determining whether a plant has a preproductive period in excess of 2 years for purposes of § 263A(d) and (e) of the Internal Revenue Code. Specifically, Notice 2013–18 removes raspberry, blackberry, and papaya plants from the previously published list of plants having a preproductive period in excess of 2 years. See Notice 2013-18, page 742. Concurrently with the issuance of Notice 2013–18, the Service and the Treasury Department issued Rev. Proc. 2013–20, which modifies Rev. Proc. 2011–14, 2011–4 I.R.B. 330, to provide procedures for a taxpayer to obtain the automatic consent of the Commissioner under § 446(e) of the Internal Revenue Code to change its method of accounting under § 263A for the production of one or more plants removed from the list of plants grown in commercial quantities in the United States having a preproductive period in excess of two years based on the nationwide weighted average preproductive period for such plant. See Rev. Proc. 2013-20, page 744.

# Part II. Treaties and Tax Legislation
## Subpart A.—Tax Conventions and Other Related Items

## U.S. - Norway Agreement Regarding Offshore Activities

## Announcement 2013–16

**The following is a copy of the Competent Authority Agreement entered into by the competent authorities of the United States of America and the Kingdom of Norway** with respect to paragraph 3 of Article 4A (Offshore Activities) of the U.S. – Norway income tax convention. The agreement clarifies, for purposes of paragraph 3 of Article 4A (Offshore Activities), when a resident of a state that operates tugboats and similar vessels in the other state in connection with offshore activities will be exempt from tax in that other state. The agreement lists specific activities that these vessels can undertake and remain exempt from tax. The competent authorities may agree as appropriate to additional activities.

**The text of the Competent Authority Agreement is as follows:**

### COMPETENT AUTHORITY AGREEMENT

The Competent Authorities of the United States and Norway hereby enter into the following mutual agreement ("Agreement"). The Agreement specifies the meaning of profits derived from the transportation by ship or aircraft of supplies or personnel to a location where activities in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources are being carried on in the other Contracting State, or from the operation of tugboats and similar vessels in connection with such activities. The Agreement is entered into under paragraph 2 of Article 27 (Mutual Agreement Procedure) of the Convention Between the United States of America and the Kingdom of Norway for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Property, signed December 3, 1971, and as amended by the Protocol signed September 19, 1980 (the "Treaty").

Paragraph 1 of Article 4A (Offshore Activities) of the Treaty provides that a resident of a Contracting State who carries on activities in the other Contracting State in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources situated in that other Contracting State shall be deemed to be carrying on in respect of those activities a business in that other Contracting State through a permanent establishment or fixed base situated therein.

Paragraph 2 of Article 4A provides an exception to paragraph 1 where the activities are carried on for a period not exceeding 30 days in the aggregate in any 12 month period.

Paragraph 3 of Article 4A of the Treaty provides:

> Notwithstanding the preceding paragraphs, the provisions of Article 6 (Shipping and Air Transport) shall apply to profits derived by a resident of a Contracting State from the transportation by ship or aircraft of supplies or personnel to a location where activities in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources are being carried on in the other Contracting State, or from the operation of tugboats and similar vessels in connection with such activities.

**Section 1**. Solely for the purposes of applying paragraph 3 of Article 4A, the Contracting States understand that profits derived from the following activities will be considered profits derived "from the transportation by ship or aircraft of supplies or personnel to a location where activities in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources are being carried on in the other Contracting State, or from the operation of tugboats and similar vessels in connection with such activities":

a. transportation by ship or aircraft of supplies or personnel to a location where activities in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources are being carried on in the Contracting State;
b. tugboat and towboat services; including helping to move ocean vessels in and out of port and between berths, towing (pushing) barges, and transporting port pilots to ships waiting to enter the ship channel or port;
c. anchor handling;
d. fire-fighting and rescue support; and
e. other activities as may be agreed by the competent authorities.

**Section 2**. The Contracting States further understand that all other profits derived by a resident of a Contracting State from carrying on activities in the other Contracting State in connection with the exploration or exploitation of the seabed and sub-soil and their natural resources carried on in that other Contracting State are not covered by paragraph 3 of Article 4A, including profits derived from the operation of the following:

a. oil production ships;
b. drilling rigs;
c. accommodation platforms;
d. service platforms in stationary position;
e. pipe-laying barges;
f. seismic survey vessels;
g. heavy-lift barges; and
h. other vessels or platforms used in the performance of any activity not described in Section 1 of this competent authority agreement.

Where a multipurpose supply vessel performs both activities covered by Section 1 and activities not covered by Section 1, the part of income that is attributable to Section 1 activities shall be determined on the basis that most correctly reflects the proper character of the income under the facts and circumstances of the particular case including, for example, assets used, expenses incurred, or time spent.

Agreed to by the undersigned Competent Authorities:

Michael Danilack
United States Competent Authority
February 7, 2013

Stig Sollund
Norwegian Competent Authority
February 11, 2013

# Part III. Administrative, Procedural, and Miscellaneous

## 2013 Calendar Year Resident Population Figures

## Notice 2013–15

This notice advises State and local housing credit agencies that allocate low-income housing tax credits under § 42 of the Internal Revenue Code, and States and other issuers of tax-exempt private activity bonds under § 141, of the population figures to use in calculating: (1) the 2013 calendar year population-based component of the State housing credit ceiling (Credit Ceiling) under § 42(h)(3)(C)(ii); (2) the 2013 calendar year volume cap (Volume Cap) under § 146; and (3) the 2013 volume limit (Volume Limit) under § 142(k)(5).

Generally, § 146(j) requires determining the population figures for the population-based component of both the Credit Ceiling and the Volume Cap for any calendar year on the basis of the most recent census estimate of the resident population of a State (or issuing authority) released by the U.S. Census Bureau before the beginning of the calendar year. Similarly, § 142(k)(5) bases the Volume Limit on the State population.

Sections 42(h)(3)(H) and 146(d)(2) require adjusting for inflation the population-based component of the Credit Ceiling and the Volume Cap. The adjustments for the 2013 calendar year are in Rev. Proc. 2012–41, 2012–45 I.R.B. 539. Section 3.03 of Rev. Proc. 2012–41 provides that, for calendar year 2013, the amount for calculating the Credit Ceiling under § 42(h)(3)(C)(ii) is the greater of $2.25 multiplied by the State population, or $2,590,000. Further, section 3.07 of Rev. Proc. 2012–41 provides that the amount for calculating the Volume Cap under § 146(d)(1) for calendar year 2013 is the greater of $95 multiplied by the State population, or $291,875,000.

For the 50 states, the District of Columbia, and Puerto Rico, the population figures for calculating the Credit Ceiling, the Volume Cap, and the Volume Limit for the 2013 calendar year are the resident population estimates released electronically by the U.S. Census Bureau on December 20, 2012, in Press Release CB12–250. For American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands, the population figures for the 2013 calendar year are the 2012 midyear population figures in the U.S. Census Bureau's International Data Base (IDB). The U.S. Census Bureau electronically announced an update of the IDB on June 27, 2012, in Press Release CB12–118.

For convenience, these figures are reprinted below.

*Resident Population Figures*

| | |
|---|---|
| Alabama | 4,822,023 |
| Alaska | 731,449 |
| American Samoa | 54,947 |
| Arizona | 6,553,255 |
| Arkansas | 2,949,131 |
| California | 38,041,430 |
| Colorado | 5,187,582 |
| Connecticut | 3,590,347 |
| Delaware | 917,092 |
| District of Columbia | 632,323 |
| Florida | 19,317,568 |
| Georgia | 9,919,945 |
| Guam | 159,914 |
| Hawaii | 1,392,313 |
| Idaho | 1,595,728 |
| Illinois | 12,875,255 |
| Indiana | 6,537,334 |
| Iowa | 3,074,186 |
| Kansas | 2,885,905 |
| Kentucky | 4,380,415 |
| Louisiana | 4,601,893 |
| Maine | 1,329,192 |
| Maryland | 5,884,563 |
| Massachusetts | 6,646,144 |
| Michigan | 9,883,360 |
| Minnesota | 5,379,139 |
| Mississippi | 2,984,926 |
| Missouri | 6,021,988 |

*Resident Population Figures*

| | |
|---|---|
| Montana | 1,005,141 |
| Nebraska | 1,855,525 |
| Nevada | 2,758,931 |
| New Hampshire | 1,320,718 |
| New Jersey | 8,864,590 |
| New Mexico | 2,085,538 |
| New York | 19,570,261 |
| North Carolina | 9,752,073 |
| North Dakota | 699,628 |
| Northern Mariana Islands | 51,395 |
| Ohio | 11,544,225 |
| Oklahoma | 3,814,820 |
| Oregon | 3,899,353 |
| Pennsylvania | 12,763,536 |
| Puerto Rico | 3,667,084 |
| Rhode Island | 1,050,292 |
| South Carolina | 4,723,723 |
| South Dakota | 833,354 |
| Tennessee | 6,456,243 |
| Texas | 26,059,203 |
| Utah | 2,855,287 |
| Vermont | 626,011 |
| Virginia | 8,185,867 |
| Virgin Islands, U.S. | 105,275 |
| Washington | 6,897,012 |
| West Virginia | 1,855,413 |
| Wisconsin | 5,726,398 |
| Wyoming | 576,412 |

The principal authors of this notice are Julie Hanlon Bolton, Office of the Associate Chief Counsel (Passthroughs and Special Industries), and Timothy L. Jones, Office of the Associate Chief Counsel (Financial Institutions and Products). For further information regarding this notice, please contact Ms. Hanlon Bolton at (202) 622–3040 (not a toll-free call).

## Per Capita Payments from Proceeds of Settlements of Indian Tribal Trust Cases, Updates

## Notice 2013–16

BACKGROUND

Notice 2013–1, 2013–3 IRB 281, provides guidance on the federal tax treatment of *per capita* payments that members of Indian tribes receive from proceeds of certain settlements of tribal trust cases between the United States and those Indian tribes. Additional tribes have settled tribal trust cases against the United States since publication of Notice 2013–1. This notice provides an updated Appendix that reflects the additional settlement agreements.

EFFECT ON OTHER DOCUMENTS

Notice 2013–1 Appendix is modified and superseded.

FURTHER INFORMATION

For further information regarding this notice, please contact Telly Meier at phone number (202) 283–8877 (not a toll-free call).

**Appendix**
**Tribes That Have Entered into Settlement Agreements of Tribal Trust Cases**

1. Assiniboine and Sioux Tribes of the Fort Peck Reservation
2. Bad River Band of Lake Superior Chippewa Indians
3. Blackfeet Tribe of the Blackfeet Indian Reservation
4. Bois Forte Band of Chippewa
5. Cachil Dehe Band of Wintun Indians of the Colusa Rancheria

6. Chippewa Cree Tribe of the Rocky Boy's Reservation
7. Coeur d'Alene Tribe
8. Confederated Salish and Kootenai Tribes
9. Confederated Tribes of Siletz Indians
10. Confederated Tribes of the Colville Reservation
11. Confederated Tribes of the Goshute Reservation
12. Crow Creek Sioux Tribe
13. Eastern Shawnee Tribe of Oklahoma
14. Hualapai Indian Tribe
15. Iowa Tribe of Kansas and Nebraska
16. Kaibab Band of Paiute Indians of Arizona
17. Kickapoo Tribe of Kansas
18. Lac Courte Oreilles Band of Lake Superior Chippewa Indians
19. Lac du Flambeau Band of Lake Superior Chippewa Indians
20. Leech Lake Band of Ojibwe
21. Lower Brule Sioux Tribe
22. Makah Indian Tribe of the Makah Reservation
23. Mescalero Apache Tribe
24. Minnesota Chippewa Tribe
25. Nez Perce Tribe
26. Nooksack Indian Tribe
27. Northern Cheyenne Tribe of Indians
28. Omaha Tribe o Nebraska
29. Passamaquoddy Tribe of Maine
30. Pawnee Nation
31. Prairie Band of Potawatomi Nation
32. Pueblo of Zia
33. Quechan Tribe of the Fort Yuma Reservation
34. Red Cliff Band of Lake Superior Chippewa Indians
35. Rincon Luiseño Band of Indians
36. Rosebud Sioux Tribe
37. Round Valley Indian Tribes
38. Salt River Pima-Maricopa Indian Community
39. Santee Sioux Tribe of Nebraska
40. Sault Ste. Marie Tribe
41. Shoshone-Bannock Tribes of the Fort Hall Reservation
42. Soboba Band of Luiseno Indians
43. Spirit Lake Dakotah Nation
44. Spokane Tribe of Indians
45. Standing Rock Sioux Tribe
46. Stillaguamish Tribe of Indians
47. Summit Lake Paiute Tribe
48. Swinomish Indian Tribal Community
49. Te-Moak Tribe of Western Shoshone Indians
50. Tohono O'odham Nation
51. Tulalip Tribes
52. Tule River Indian Tribe
53. Ute Indian Tribe of the Uintah and Ouray Reservation
54. Ute Mountain Ute Tribe
55. Winnebago Tribe of Nebraska
56. Qawalangin Tribe of Unalaska
57. Tlingit & Haida Tribes of Alaska
58. Northwestern Band of Shoshone Indians
59. Hoopa Valley Tribe
60. Ak-Chin Indian Community
61. Oglala Sioux Tribe
62. Yurok Tribe
63. Cheyenne River Sioux Tribe

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## Update of List of Plants, Grown in Commercial Quantities in the United States, Having a Preproductive Period in Excess of Two Years Based on the Nationwide Weighted Average Preproductive Period for Such Plant.

## Notice 2013–18

PURPOSE

This notice modifies and supersedes Notice 2000–45, 2000–2 C.B. 256, which provides guidance to taxpayers engaged in the trade or business of farming in determining whether a plant has a preproductive period in excess of 2 years for purposes of § 263A(d) and (e) of the Internal Revenue Code.

BACKGROUND

Section 263A requires generally that the direct costs and an allocable share of indirect costs of real or tangible personal property produced by a taxpayer be capitalized. Under § 263A, taxpayers generally are required to capitalize the costs of producing property in a farming business (including animals and plants without regard to the length of their preproductive period).

Sections 263A(d) and (e) set forth special rules for property produced in the trade or business of farming. Under § 263A(d)(1) and § 1.263A–4(a)(2) of the Income Tax Regulations, taxpayers that are not required to use an accrual method by § 447 and are not tax shelters prohibited from using the cash receipts and disbursements method of accounting by § 448(a)(3) ("qualified taxpayers") are not required to capitalize (1) the costs of producing animals in a farming business, or (2) the costs of producing plants with a preproductive period of 2 years or less. In addition, under § 263A(d)(3) and § 1.263A–4(d), a qualified taxpayer may elect to have § 263A not apply to the costs of producing plants in a farming business (other than citrus or almond trees). Thus, unless an election is made to have § 263A not apply in accordance with § 263A(d)(3), qualified taxpayers generally are required to capitalize the costs of producing plants that have a preproductive period in excess of 2 years.

Section 263A(e)(3)(B) and § 1.263A–4(b)(2)(i)(B) provide that, for purposes of determining whether a plant has a preproductive period in excess of 2 years, the preproductive period of plants grown in commercial quantities in the United States must be based on the nationwide weighted average preproductive period for such plants. The legislative history of § 263A explains that Congress expected the Treasury Department to periodically publish a list of the preproductive periods of various plants based on the nationwide weighted averages for such plants. See H.R. Rep. No. 426, 99th Cong., 1st Sess. 628 (1985), 1986–3 (Vol. 2) C.B. 628. A proposed list was included in the preamble of the proposed § 1.263A–4 regulations (REG–208151–91, 1997–2 C.B. 35 [62 Fed. Reg. 44,542]). The Internal Revenue Service (Service) and the Treasury Department received and considered comments on the proposed list in preparing Notice 2000–45.

In Notice 2000–45 the Service and the Treasury Department published a nonexclusive list of plants having a nationwide weighted average preproductive period in excess of 2 years. The Service and the Treasury Department utilized information provided by the United States Department of Agriculture to develop the list published in Notice 2000–45 of plants that have a nationwide weighted average preproductive period in excess of 2 years. At that time, the Department of Agriculture grouped blueberry, blackberry, and raspberry plants into one overall category, called "berries." Blueberry plants made up the largest share of the berries category, and they have a preproductive period greater than 2 years. Since that time, the Department of Agriculture has started tracking blueberry, blackberry, and raspberry plants separately. The Department of Agriculture's current data establishes that blackberry and raspberry plants each have a nationwide weighted average preproductive period of less than 2 years, requiring an update to the list published in Notice 2000–45. The Service and the Treasury Department have also determined that papaya plants should be removed from the list because Department of Agriculture data establishes that papaya plants have a nationwide weighted average preproductive period of less than 2 years.

DISCUSSION

Notice 2000–45 states that the Service and the Treasury Department intend to update, as needed, the list of plants that have a nationwide weighted average preproductive period in excess of 2 years. Based upon information provided by the Department of Agriculture, for the reasons stated above, the Service and the Treasury Department have decided to remove raspberry, blackberry, and papaya plants from its previously published list of plants having a preproductive period in excess of 2 years. In addition, the Service and the Treasury Department have determined that plants producing the following crops or yields continue to have a nationwide weighted average preproductive period in excess of 2 years:

> almonds, apples, apricots, avocados, blueberries, cherries, chestnuts, coffee beans, currants, dates, figs, grapefruit, grapes, guavas, kiwifruit, kumquats, lemons, limes, macadamia nuts, mangoes, nectarines, olives, oranges, peaches, pears, pecans, persimmons, pistachio nuts, plums, pomegranates, prunes, tangelos, tangerines, tangors, and walnuts.

This guidance is not an all-inclusive list of plants that have a nationwide weighted average preproductive period in excess of 2 years. In the case of other plants grown in commercial quantities in the United States, the nationwide weighted average preproductive period must be determined based on available statistical data. § 1.263A–4(b)(2)(i)(B). The Service and the Treasury Department intend to continue to update this guidance periodically as needed.

ACCOUNTING METHOD CHANGES

Concurrently with the issuance of this notice, the Service and the Treasury Department are issuing Revenue Procedure 2013–20 (2013–14 I.R.B. 744). Revenue Procedure 2013–20 modifies Revenue Procedure 2011–14, 2011–4 I.R.B. 330, to provide procedures for a taxpayer to obtain under § 446(e) the automatic consent of the Commissioner (1) to not apply § 263A, pursuant to § 263A(d)(1) and § 1.263A–4(a)(2), to the production of one

or more plants that the Service and the Treasury Department have removed from the list of plants that have a nationwide weighted average preproductive period in excess of 2 years, or (2) to revoke an election pursuant to § 263A(d)(3) and § 1.263A–4(d) to not apply § 263A to the production of a plant or plants that have been removed from the list of plants that have a nationwide weighted average preproductive period in excess of 2 years.

EFFECT ON OTHER DOCUMENTS

Notice 2000–45 is modified and superseded.

DRAFTING INFORMATION

The principal author of this notice is Patrick M. Clinton of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this notice, contact Patrick M. Clinton at (202) 622–4930 (not a toll-free call).

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## Section 807.—Rules for Certain Reserves

*(Also Part I, § 816.)*

## Notice 2013–19

PURPOSE

This notice provides guidance on whether, for purposes of applying the limitation set forth in the flush language of § 807(d)(1) (the statutory reserve cap), deficiency reserves are included in the amount taken into account with respect to a life insurance contract in determining statutory reserves under § 807(d)(6).

BACKGROUND

A life insurance company must pay tax on its life insurance company taxable income, which is defined in § 801(b) to mean life insurance gross income less life insurance deductions. Life insurance gross income is defined in § 803(a) to include net decreases in certain reserves under § 807(a). Life insurance deductions include the general deductions provided in § 805 including, under § 805(a)(2), the net increase in certain reserves under § 807(b). The reserves taken into account under § 807(a) and (b) are described in § 807(c), and include "life insurance reserves (as defined in section 816(b))."

For purposes of determining a life insurance company's decreases or increases in life insurance reserves under § 807, § 807(d)(1) provides that the amount of the life insurance reserve for any contract is the greater of (A) the contract's net surrender value, or (B) the contract's reserve determined under § 807(d)(2) (the Federally prescribed reserve). The flush language of § 807(d)(1) further provides that in no event may the reserve for a contract exceed the amount that would be taken into account with respect to the contract in determining statutory reserves as defined in § 807(d)(6). Section 807(d)(6) generally defines statutory reserves as "the aggregate amount set forth in the annual statement with respect to items described in section 807(c)."

Section 807(d)(2) provides that the Federally prescribed reserve is determined using the tax reserve method applicable to the contract. Section 807(d)(3) defines the applicable tax reserve method and includes an explicit rule in § 807(d)(3)(C) that denies any increase in the Federally prescribed reserve because the net premium (computed on the basis of assumptions required under § 807(d)) exceeds the actual premiums or other consideration charged for the benefit. The reserve that applies because gross premium is less than the net premium is often referred to as a "deficiency reserve."

DISCUSSION

The flush language of § 807(d)(1) limits the reserve for a contract to the amount that would be taken into account with respect to the contract in determining statutory reserves. The term "statutory reserves" is defined in § 807(d)(6) to mean the aggregate amount set forth in the annual statement with respect to items described in § 807(c).

When § 807 was enacted, the term "statutory reserves" for purposes of the statutory reserve cap was defined by cross-reference to former § 809(b)(4)(B)(i), which was the predecessor to § 807(d)(6) and defined statutory reserves identically to § 807(d)(6). After § 807 was enacted as part of the Deficit Reduction Act of 1984, Pub. L. No. 98–369, the Joint Committee of Taxation explained that the statutory reserve cap included deficiency reserves:

> For purposes of determining life insurance company taxable income, the [1984] Act provides that the life insurance reserves for any contract shall be the greater of the net surrender value of the contract or the reserves determined under Federally prescribed rules. In no event will the amount of the tax reserves at any time exceed the amount of statutory reserves, which (given the general definition thereof in new sec. 809(b)(4)(B)(i)) include also any deficiency reserves relating to the liabilities.

Joint Committee on Taxation, General Explanation of the Revenue Provisions of the Tax Reform Act of 1984, at 598.

When later enacting a subsection of a different provision, Congress affirmed the Joint Committee's explanation. Specifically, when Congress enacted § 816(h) in 1986 as a technical correction to the Deficit Reduction Act of 1984, Tax Reform Act of 1986, Pub. L. No. 99–514, § 1821(l), the House report stated that "deficiency reserves are included in statutory reserves for purposes of comparing the tax reserve to statutory reserves in determining the amount of any increase or decrease in the reserves." H.R. Rep. No. 426, 99th Cong., 1st Sess. 956 (1985), 1986–3 C.B. Vol. 2, 956 (House Report). The bill, as ultimately enacted, included § 816(h) from the House bill verbatim.

Moreover, the legislative history of another technical correction to the Deficit Reduction Act of 1984 further demonstrates that both houses of Congress believed the definition of statutory reserves that now appears in § 807(d)(6) includes deficiency reserves. At the same time that § 816(h) was enacted, former § 809(b)(2) was amended to provide that no item could be taken into account more than once in determining the equity base. Both the House Report and the Senate Report noted that former § 809(b)(2) was necessary in part "because deficiency reserves, which are specifically listed in the statute as included in the equity base, could also be included indirectly as part of the excess of statutory policy reserves over tax reserves, which is also specifically included in the equity base." House Report at 948; S. Rep.

No. 313, 99th Cong., 2d Sess. 968 (1986), 1986–3 C.B. Vol. 3 968.

SCOPE AND APPLICATION

For purposes of applying the limitation set forth in the statutory reserve cap in § 807(d)(1), deficiency reserves are included in the amount taken into account with respect to a life insurance contract in determining statutory reserves under § 807(d)(6).

DRAFTING INFORMATION

The principal author of this notice is Sharon Y. Horn of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information, contact Ms. Horn at (202) 622–3970 (not a toll-free call).

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*26 CFR 601.204: Changes in accounting periods and methods of accounting*
*(Also Part I, §§ 263A, 446, 481; 1.263A–4, 1.446–1.)*

## Rev. Proc. 2013–20

SECTION 1. PURPOSE

This revenue procedure modifies Revenue Procedure 2011–14, 2011–4 I.R.B. 330, to provide procedures for a taxpayer to obtain the automatic consent of the Commissioner under § 446(e) of the Internal Revenue Code to change its method of accounting under § 263A for the production of one or more plants removed from the list of plants grown in commercial quantities in the United States having a preproductive period in excess of two years based on the nationwide weighted average preproductive period for such plant.

SECTION 2. BACKGROUND

.01 Section 263A requires generally that the direct costs and an allocable share of indirect costs of real or tangible personal property produced by a taxpayer be capitalized. Under § 263A, taxpayers generally are required to capitalize the costs of producing property in a farming business (including animals and plants without regard to the length of their preproductive period).

.02 Sections 263A(d) and (e) set forth special rules for property produced in the trade or business of farming. Under § 263A(d)(1) and § 1.263A–4(a)(2), taxpayers that are not required by § 447 to use an accrual method of accounting and are not tax shelters prohibited by § 448(a)(3) from using the cash receipts and disbursements method of accounting ("qualified taxpayers") are not required to capitalize (1) the costs of producing animals in a farming business, or (2) the costs of producing plants with a preproductive period of 2 years or less. In addition, under § 263A(d)(3) and § 1.263A–4(d), a qualified taxpayer may elect to have § 263A not apply to the cost of producing plants in a farming business (other than citrus or almond trees). Thus, unless an election is made to have § 263A not apply in accordance with § 263A(d)(3), qualified taxpayers generally are required to capitalize the costs of producing plants that have a preproductive period in excess of 2 years.

.03 Section 263A(e)(3)(B) and § 1.263A–4(b)(2)(i)(B) provide that, for purposes of determining whether a plant has a preproductive period in excess of 2 years, the preproductive period of plants grown in commercial quantities in the United States must be based on the nationwide weighted average preproductive period for such plants. The legislative history of § 263A explains that Congress expected the Treasury Department to periodically publish a list of the preproductive periods of various plants based on the nationwide weighted averages for such plants. See H.R. Rep. No. 426, 99th Cong., 1st Sess. 628 (1985), 1986–3 (Vol. 2) C.B. 628. A proposed list was included in the preamble of the proposed § 1.263A–4 regulations (REG–208151–91, 1997–2 C.B. 35 [62 Fed. Reg. 44542]). The Internal Revenue Service (Service) and Treasury Department received and considered comments on the proposed list in preparing Notice 2000–45.

.04 In Notice 2000–45, 2000–2 C.B. 256, the Service and the Treasury Department published a nonexclusive list of plants having a nationwide weighted average preproductive period in excess of 2 years.

.05. Concurrently with the issuance of this revenue procedure, the Service and the Treasury Department are issuing Notice 2013–18 (2013–14 I.R.B. 742), modifying and superseding Notice 2000–45. Notice 2013–18 removes blackberry, raspberry, and papaya plants from the list of plants that produce crops or yields that have a nationwide weighted average preproductive period in excess of 2 years.

.06 Not applying § 263A to the production of a plant pursuant to § 263A(d)(1) and § 1.263A–4(a)(2) is a method of accounting under § 446. Therefore, a taxpayer that currently applies § 263A to the costs of producing plants with a preproductive period of 2 years or less must obtain the consent of the Commissioner to not apply § 263A to such costs.

.07 The election pursuant to § 263A(d)(3) and § 1.263A–4(d) to not have the rules of § 263A(d) apply to all plants produced in a farming business conducted by the electing taxpayer is a method of accounting under § 446, and once an election is made, it is revocable only with consent of the Commissioner.

.08 Section 1.446–1(e)(3)(ii) authorizes the Commissioner to prescribe administrative procedures setting forth the limitations, terms, and conditions necessary to permit a taxpayer to obtain consent to change a method of accounting. Revenue Procedure 2011–14 provides the procedures by which a taxpayer may obtain automatic consent from the Commissioner to change to a method of accounting described in the APPENDIX of Rev. Proc. 2011–14.

SECTION 3. MODIFICATION TO REV. PROC. 2011–14

Revenue Procedure 2011–14 is modified to add new section 11.08 of the APPENDIX to read as follows:

.08 *Change to not apply § 263A to one or more plants removed from the list of plants that have a preproductive period in excess of 2 years.*

(1) *Description of change*. This change applies to a taxpayer that is not a corporation, partnership, or tax shelter required to use an accrual method of accounting under § 447 or § 448(a)(3), and either (a) wishes to obtain the consent of the Commissioner to not apply § 263A, pursuant to § 263A(d)(1) and § 1.263A–4(a)(2), to the production of one or more plants that the Service and the Treasury Department have removed from the list of plants that have

a nationwide weighted average preproductive period in excess of 2 years, or (b) properly elected, pursuant to § 263A(d)(3) and § 1.263A–4(d), to not apply § 263A to the production of a plant or plants that have been removed from the list of plants that have a nationwide weighted average preproductive period in excess of 2 years, and wishes to revoke its § 263A(d)(3) election with respect to those plants. See Notice 2013–18, or its successor.

(2) *Certain scope limitations temporarily inapplicable*. The scope limitations in sections 4.02(1) through (4) and (7) of this revenue procedure do not apply to a taxpayer that wants to make the change for its first or second taxable year ending after February 15, 2013.

(3) *Audit protection*. If a taxpayer currently does not apply § 263A to its blackberry, raspberry, or papaya plants in a manner that complies with the requirements of § 263A(d)(1) and § 1.263A–4(a)(2), such method of accounting will not be raised as an issue by the Service in a taxable year that ends on or before February 15, 2013. Also, if the use of such a method of accounting by a taxpayer is an issue under consideration (within the meaning of section 3.08 of this revenue procedure) for taxable years in examination, before an Appeals office, or before the U.S. Tax Court in a taxable year that ends on or before February 15, 2013, that issue will not be pursued further by the Service.

(4) *Manner of making change*. A change under this section 11.08 is made with any necessary adjustments under section 481(a). For example, the revocation of an election under section 263A(d)(3) results in a section 481(a) adjustment that must take into account the change in depreciation from the alternative depreciation system to the general depreciation system included within such revocation.

(5) *Designated automatic accounting method change number*. The designated automatic accounting method change number for a change under section 11.08 of this APPENDIX is "181." See section 6.02(4) of this revenue procedure.

(6) *Contact information*. For further information regarding a change under this section, contact Patrick Clinton at 202–622–4950 (not a toll-free call).

## SECTION 4. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2011–14 is modified.

## SECTION 5. EFFECTIVE DATE

This revenue procedure is effective for taxable years ending after February 15, 2013.

## SECTION 6. DRAFTING INFORMATION

The principal author of this revenue procedure is Patrick M. Clinton of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this revenue procedure, contact Patrick M. Clinton at 202–622–4950 (not a toll-free call).

# Part IV. Items of General Interest

## Notice of Proposed Rulemaking and Notice of Public Hearing

## Health Insurance Providers Fee

## REG–118315–12

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations that provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance for United States health risks. This fee is imposed by section 9010 of the Patient Protection and Affordable Care Act, as amended. The regulations affect persons engaged in the business of providing health insurance for United States health risks.

DATES: Written or electronic comments must be received by June 3, 2013. Requests to speak and outlines of topics to be discussed at the public hearing scheduled for June 21, 2013, at 10:00 a.m., must be received by June 3, 2013.

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG–118315–12), Internal Revenue Service, P.O. 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–118315–12), Courier's Desk Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC, or sent electronically via the IRS Internet site via the Federal eRulemaking Portal at *www.regulations.gov* (IRS REG–118315–12). The public hearing will be held in the IRS Auditorium at the Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the substance of the regulation, Charles J. Langley, Jr. at (202) 622–3130; concerning the submission of comments or the public hearing, Oluwafunmilayo (Funmi) Taylor at (202) 622–7180 (not toll-free calls).

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 for review 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 May 3, 2013. Comments are specifically requested concerning:

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

The accuracy of the estimated burden associated with the proposed collection of information;

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 this proposed regulation is in §57.2(e)(2) and requires certain entities to maintain records of consent for a designated entity. This information is necessary to evaluate whether an entity has consented to the designation of another entity to report its net premiums written. The likely respondents are entities in the business of providing health insurance for United States health risks.

Estimated total annual reporting and/or recordkeeping burden: 400 hours.

Estimated average annual burden hours per respondent and/or recordkeeper varies from .25 hours to 1 hour, depending on individual circumstances, with an estimated average of .5 hours.

Estimated number of respondents and/or recordkeepers: 800.

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.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

**Background**

This document proposes to add the Health Insurance Providers Fee Regulations to the Code of Federal Regulations (26 CFR part 57) under section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references in this preamble to section 9010 are references to the ACA. Section 9010 did not amend the Internal Revenue Code (Code) but contains cross-references to specified Code sections. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections in this preamble are references to subtitles, chapters, subchapters, and sections in the Code and related regulations. All references to "fee" in the proposed regulations are references to the fee imposed by section 9010.

Section 9010(a) imposes an annual fee on each covered entity engaged in the business of providing health insurance. The fee is due by the annual date specified by the Secretary of the Treasury or his delegate (Secretary), but in no event later than September 30th of each calendar year in which a fee must be paid (fee year).

Section 9010(c)(1) provides that a covered entity is any entity that provides health insurance for any United States health risk during each fee year. Section 9010(c)(2) excludes the following entities from being covered entities: (A) Any employer to the extent that the employer self-insures its employees' health risks; (B) any governmental entity; (C) any entity (i) that is incorporated as a nonprofit corporation under a State law, (ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h)), and which does not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act; and (D) any entity that is described in section 501(c)(9) (a voluntary employees' beneficiary association (VEBA)) and is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

Section 9010(c)(3)(A) provides a controlled group rule under which all persons treated as a single employer under section 52(a) or (b) or section 414(m) or (o) are treated as a single covered entity. If any entity described in section 9010(c)(2)(C) or (D) (relating to certain nonprofit corporations and non-employer-established VEBAs) is treated as included in a covered entity by reason of the application of section 9010(c)(3)(A), then the net premiums written for health insurance for any United States health risk of that entity are not taken into account.

Section 9010(c)(3)(B) provides that, for purposes of section 9010(c)(3)(A), in applying section 52(a) and (b), section 1563 is applied without regard to section 1563(b)(2)(C). As a result, a foreign entity subject to tax under section 881 can also be part of a controlled group that is treated as a single covered entity under section 9010(c)(3)(A). Section 9010(c)(4) provides that, if more than one person is liable to pay the fee on a single covered entity by reason of the application of the controlled group rule, then all such persons are jointly and severally liable for payment of the fee.

Section 9010 imposes the fee on each covered entity engaged in the business of providing health insurance for United States health risks. Section 9010(h)(3) excludes from health insurance any insurance coverage described in section 9832(c)(1)(A) (accident only or disability only or any combination thereof), any insurance coverage described in section 9832(c)(3) (coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance), any insurance for long-term care, or any Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act). Other than providing for these exclusions, section 9010 does not define health insurance.

Section 9010(d) defines United States health risk to mean a health risk of any individual who is: (1) A United States citizen; (2) a resident of the United States (within the meaning of section 7701(b)(1)(A)); or (3) located in the United States, during the period such individual is so located. Section 9010(h)(2) defines United States for purposes of section 9010 as the 50 States, the District of Columbia, and the possessions of the United States.

Section 9010(b) and (e) provide rules for determining the amount of the annual fee for each covered entity. Under section 9010(e)(1), the aggregate fee amount for all covered entities (referred to as the applicable amount) is $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018. Under section 9010(e)(2), the applicable amount for calendar year 2019 and thereafter is the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)) for the preceding calendar year. Section 9010(b)(1) requires the applicable amount for each year to be allocated, using a specified formula, among covered entities with aggregate net premiums written of over $25 million.

Section 9010(b)(1) provides that the annual fee for each covered entity is calculated by determining the ratio of (1) the covered entity's net premiums written for health insurance for any United States health risk that are taken into account during the preceding calendar year to (2) the aggregate net premiums written for such health insurance of all covered entities that are taken into account during the preceding calendar year. This ratio is then applied to the applicable amount.

Under section 9010(b)(2)(A), the amount of net premiums written that is taken into account for each covered entity per calendar year is 0 percent of net premiums written up to and including $25 million, 50 percent of net premiums written that are more than $25 million but not more than $50 million, and 100 percent of net premiums written that are over $50 million. Additionally, after the application of the dollar thresholds of section 9010(b)(2)(A), section 9010(b)(2)(B) excludes from the amount taken into account 50 percent of the remaining net premiums written for health insurance that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513) of any covered entity qualifying under section 501(c)(3), (4), (26), or (29) and exempt from tax under section 501(a).

Section 9010(b)(3) requires the Secretary to calculate the amount of each covered entity's fee for any calendar year. In calculating the fee, the Secretary must determine each covered entity's net premiums written for United States health risks based on reports submitted to the Secretary by the covered entity and through the use of any other source of information available to the Secretary.

Section 9010(g)(1) requires that, not later than the date determined by the Secretary following the end of the calendar year preceding the fee year, each covered entity must report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written for health insurance for any United States health risk for that preceding calendar year.

Section 9010(g)(2)(A) imposes a penalty on a covered entity for any failure to report the required information by the date prescribed by the Secretary (determined with regard to any extension of time for filing), unless such failure is due to reasonable cause. The penalty is $10,000 plus the lesser of (i) an amount equal to $1,000, multiplied by the number of days during which the failure continues, or (ii) the amount of the fee for which the report was required. Section 9010(g)(2)(B) provides that the failure to report penalty (i) is treated as a penalty for purposes of subtitle F, (ii) must be paid on notice and demand by the Secretary and in the same manner as a tax under the Code, and (iii) is a penalty for which only civil actions for refund under procedures of subtitle F apply.

Section 9010(g)(3)(A) imposes an accuracy-related penalty on a covered entity for any understatement of the covered entity's net premiums written on the required report. Section 9010(g)(3)(B) defines an understatement as the difference between the amount of net premiums written reported by the covered entity and the amount of net premiums written that should have been reported. The penalty is equal to the excess of (i) the amount of the covered entity's fee for the fee year that the Secretary determines should have been paid in the absence of the understatement, over (ii) the amount of the fee that the Secretary determined based on the understatement. Section 9010(g)(3)(C) subjects the accuracy-related penalty to the provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

Section 9010(g)(4) provides that section 6103 (relating to the disclosure of returns and return information) does not apply to any information reported under section 9010(g).

Section 9010(f)(1) treats the fee as an excise tax for purposes of subtitle F to which only civil actions for refund apply. Section 9010(f)(2) treats the fee as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed).

Section 9010(i) directs the Secretary to publish guidance necessary to carry out the purposes of section 9010 and to prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of section 9010, including inappropriate actions taken to qualify as an exempt entity under section 9010(c)(2).

Section 9010(j) provides that section 9010 is effective for calendar years beginning after December 31, 2013.

**Explanation of Provisions**

I. *Overview*

The proposed regulations provide guidance on the annual fee imposed on covered entities engaged in providing health insurance for United States health risks. Generally, each covered entity with aggregate net premiums written over $25 million in the calendar year immediately preceding the fee year (referred to in the proposed regulations as the data year) is liable for the annual fee due by September 30th of each fee year in an amount determined by the IRS under section 9010(b) and the proposed regulations.

II. *Explanation of Terms*

The proposed regulations define numerous terms used in section 9010 and in these regulations, including the following key terms:

A. *Covered Entity*

Section 9010(c)(1) provides that a covered entity is any entity that provides health insurance for any United States health risk during the fee year. The proposed regulations define the term *covered entity* to mean any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) A health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA). Under section 9832(b)(2), the term health insurance issuer generally refers to any insurance company, insurance service, or insurance organization that is subject to State laws that regulate insurance within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA). Under section 9832(b)(3), the term health maintenance organization generally refers to an organization that is recognized or regulated under State or Federal law as a health maintenance organization.

As previously noted, the proposed regulations provide that a covered entity includes a MEWA within the meaning of section 3(40) of ERISA, to the extent that the MEWA is not a fully-insured MEWA, regardless of whether the MEWA is subject to regulation under State insurance law. In the case of a fully-insured MEWA, the MEWA is not a covered entity for purposes of section 9010 because, even though the MEWA receives premiums, it uses those premiums to pay an insurance company to provide the coverage being purchased. In this case, the insurance company is the covered entity because it, and not the MEWA, is providing health insurance. If the MEWA is not fully-insured, however, the MEWA is a covered entity for purposes of section 9010 to the extent that the premiums received by the MEWA are not used to pay an insurance company to provide the coverage being purchased (and are used instead by the MEWA to provide the health insurance itself). For example, if a MEWA received a $10,000 premium payment from a participating employer providing both major medical coverage and separate vision coverage for an individual participant, and the MEWA used $9,000 of that premium payment to pay the premium to cover such individual under a group insurance policy purchased from an insurance company and associated costs, and $1,000 to pay direct reimbursements under the vision plan and associated costs directly, then the MEWA would be treated as a covered entity only with respect to the $1,000 portion of the premium intended to pay the MEWA for providing the vision coverage itself.

The proposed regulations exclude certain other MEWAs from the definition of a covered entity in accordance with one of the exclusions from the MEWA reporting requirements administered by the Department of Labor (DOL). Specifically, the proposed regulations would exclude MEWAs that are exempt from reporting

under 29 CFR 2520.101–2(c)(2)(ii)(B).[1] This section of the DOL regulations generally excludes a MEWA that provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that occurs for a purpose other than to avoid the reporting requirements and does not extend beyond a limited time. This type of MEWA is excluded from the definition of covered entity because it is temporary in nature and exempt from DOL reporting requirements.

The proposed regulations provide that, solely for purposes of section 9010, an Entity Claiming Exception (ECE) is subject to the same regime addressing MEWAs. Therefore, under the proposed regulations, a fully insured ECE is excluded from the definition of covered entity, but a non-fully insured ECE is treated as a covered entity to the extent the ECE is not insured. An ECE is defined in 29 CFR 2520.101–2(b) as an entity that claims it is not a MEWA on the basis that the entity is established or maintained pursuant to one or more agreements that the Secretary of Labor finds to be collective bargaining agreements within the meaning of section 3(40)(A)(i) of ERISA and 29 CFR 2510.3–40.

Currently, in a number of States, entities have been established to make coverage for medical care available to high-risk individuals who may not have access to coverage in the open market. The Treasury Department and the IRS invite comments on the organization and structure of these entities, whether they would be considered covered entities under the general definition, and the extent to which they would qualify for exclusions under the proposed regulations.

B. *Excluded Entities*

1. *Self-Insured Employer*

Section 9010(c)(2)(A) excludes any entity that is a self-insured employer to the extent that such employer self-insures its employees' health risks. The proposed regulations define the term *self-insured employer* to mean an employer that sponsors a self-insured medical reimbursement plan within the meaning of §1.105–11(b)(1)(i) and (ii) of the Income Tax Regulations. This includes an arrangement in which an employer provides self-insured employee health benefits to former employees, such as retired employees, or provides self-insured employee health benefits through an organization described in section 501(c)(9) (a VEBA). The proposed regulations clarify that a self-insured plan may use a third party for administration and bookkeeping functions and still be considered self-insured if there is no shifting of risk to the third party as described in §1.105–11(b)(1)(ii).

2. *Governmental Entities*

Section 9010(c)(2)(B) excludes any governmental entity. The proposed regulations define the term *governmental entity* to mean (1) The United States, (2) any State, (3) the District of Columbia, (4) any possession of the United States, (5) any political subdivision of any of the foregoing (as defined for purposes of section 103), (6) any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)), or (7) any public agency that is created by a State or a political subdivision, organized as a nonprofit under State law, and contracts with the State to administer State Medicaid benefits through local providers or health maintenance organizations. *See* Joint Committee on Taxation, General Explanation of Tax Legislation Enacted by the 111th Congress, JCS–2–11 (March 2011) (JCT General Explanation) at 330.

A State health department or State insurance commission would be included within the meaning of governmental entity under section 9010. The proposed regulations do not include instrumentalities (within the meaning of Rev. Rul. 57–128, 1957–1 C.B. 311, see §601.601(d)(2)(ii)(b)) of a governmental entity in the definition of governmental entity. Instrumentalities that provide health insurance may qualify for other exclusions under section 9010, such as the exclusion for employers that self-insure their employees' health risks (section 9010(c)(2)(A)), the exclusion for certain nonprofit corporations (section 9010(c)(2)(C)), and the partial exclusion for certain high-risk insurance pools described in section 501(c)(26) (section 9010(b)(2)(B)). The Treasury Department and the IRS invite comments on the types of instrumentalities, if any, that would be considered covered entities under the general definition and the extent to which they would qualify for exclusions consistent with the statute.

3. *Certain Nonprofit Corporations*

In accordance with section 9010(c)(2)(C), the proposed regulations exclude any entity that (1) Is incorporated as a nonprofit corporation under State law, (2) meets certain requirements designed to ensure that the net earnings of the entity are not distributed to private parties and that the entity does not engage in political campaign activity or substantial lobbying, and (3) receives more than 80 percent of its gross revenues from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act (which include Medicare, Medicaid, the Children's Health Insurance Plan, and dual eligible plans). An entity is not required to be exempt from tax under section 501(a) to qualify for this exception. However, because the provisions of section 9010(c)(2)(C)(ii) relating to private inurement, lobbying, and political campaign activity are the same as those provisions applicable to organizations described in section 501(c)(3), for purposes of applying these requirements, the proposed regulations adopt the standards set forth under section 501(c)(3) and the regulations thereunder. In accordance with section 9010(c)(2)(C)(ii), the proposed regulations provide that, for an entity that is exempt from tax under section 501(a) and is described in section 501(h)(3), the determination of whether the entity has engaged in substantial lobbying for purposes of section 9010(c)(2)(C)(ii) will be made under section 501(h).

The Treasury Department and the IRS invite comments with respect to how this exclusion is applied.

[1] These final regulations were issued in 2003. In 2011, DOL proposed new regulations under these same sections. The analogous section in the 2011 proposed regulations that describes the MEWAs intended to be excluded from the definition of covered entity is also §2520.101–2(c)(2)(ii)(B) (RIN 1210–AB51). See 76 FR 76222. If and when the DOL finalizes these proposed regulations, the Treasury Department and the IRS intend to apply the new provision (or any analogous provision if modified in the final rule).

4. *Voluntary Employees' Beneficiary Associations (VEBAs)*

In accordance with section 9010(c)(2)(D), the proposed regulations explicitly exclude any VEBA that is established by an entity other than an employer or employers for the purpose of providing health care benefits, such as a union. Also, if a MEWA or ECE provides health benefits through a VEBA, the VEBA is not a covered entity. Furthermore, if an employer or employers provide self-insured employee health benefits through a VEBA, the VEBA is not a covered entity because the exclusion for self-insured employers under section 9010(c)(2)(A) applies. If a VEBA purchases health insurance to cover the beneficiaries of the VEBA, the VEBA is not a covered entity because the issuer providing the health insurance that the VEBA purchases is the covered entity subject to the fee rather than the VEBA. Therefore, the Treasury Department and the IRS are not aware of any VEBAs that would be covered entities under the proposed regulations. The Treasury Department and the IRS invite comments on the types of VEBAs, if any, that do not fall within the exclusions and therefore would be covered entities.

5. *Educational Institutions and Student Health Insurance*

Many educational institutions establish or administer programs that provide students with access to health insurance. In most instances, however, the educational institution uses premiums it receives from students to purchase insurance from a separate, unrelated issuer. This unrelated issuer and not the educational institution will be a covered entity for purposes of section 9010 and it will include the premiums paid by or on behalf of those students for purposes of determining the amount payable under section 9010. The Treasury Department and the IRS invite comments on the circumstances, if any, under which an educational institution might qualify as a covered entity that is subject to the fee and not eligible for an exclusion (for example, a self-insured student health plan).

C. *Controlled Groups*

1. *In General*

The proposed regulations define the term *controlled group* as a group of two or more persons, including at least one person that is a covered entity, that are treated as a single employer under section 52(a), 52(b), 414(m), or 414(o). To clarify how to treat persons that leave or enter a controlled group, the proposed regulations provide that, for purposes of section 9010, a person is treated as a member of the controlled group if it is a member of the group at the end of the day on December 31st of the data year. In accordance with section 9010(c)(3), the proposed regulations treat a controlled group as a single covered entity for purposes of the fee. In determining net premiums written for health insurance for United States health risks of a controlled group, the controlled group generally must take into account the net premiums written for all members for the entire data year.

2. *Designated Entities*

The proposed regulations provide that each controlled group must have a *designated entity*, defined as a person within the controlled group that is designated to act on behalf of the controlled group with regard to the fee. The proposed regulations further provide that if the controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group that filed a consolidated return for Federal income tax purposes, the designated entity is the common parent of the affiliated group identified on the tax return filed for the data year. If the controlled group is not an affiliated group that files a consolidated return for Federal income tax purposes, it may select a person as the designated entity on Form 8963, *Report of Health Insurance Provider Information.* The proposed regulations require only the designated entity to report on behalf of the controlled group. However, the proposed regulations also require each member of a controlled group to maintain a record of its consent to the designated entity selection. The proposed regulations also require the designated entity to maintain a record of all member consents. If the controlled group does not select a person as a designated entity on its Form 8963, the IRS will select a person as a designated entity for the controlled group and advise the designated entity accordingly.

D. *Health Insurance*

1. *In General*

Section 9010 does not define health insurance, providing in section 9010(h)(3) only that health insurance does not include coverage only for accident, or disability income insurance, or any combination thereof as described in section 9832(c)(1)(A); coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance as described in section 9832(c)(3); insurance for long-term care; or Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act). The only definition of health insurance or health insurance coverage in the Code is the definition of health insurance coverage in section 9832(b)(1)(A) for purposes of Chapter 100. The language of section 9832(b)(1)(A) is substantially similar to the only definition of health insurance coverage referenced in the ACA.[2] Accordingly, the proposed regulations define the term *health insurance* by reference to section 9832(b)(1)(A) to mean benefits consisting of medical care (provided directly, through insurance, reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The proposed regulations exclude from the term health insurance all of the excepted benefits listed in section 9832(c) except for section 9832(c)(2)(A) (limited scope dental and vision benefits). In accordance with the explanation provided by the Joint Committee on Taxation, the proposed regulations include limited dental and vision coverage as health insurance for purposes of the fee. *See* JCT General Explanation at 331.

The proposed regulations also provide that, solely for purposes of section 9010, indemnity reinsurance is not health insur-

[2] *See* ACA section 1301(b)(2), referencing section 2791(b) of the Public Health Service Act (PHSA) (42 USC 300gg–91). The definition of health insurance coverage in section 2791(b) of the PHSA is substantially similar to the one provided in section 9832(b)(1)(A) of the Code.

ance. Thus, the fee continues to be imposed on the issuing company. For this purpose, the proposed regulations define the term *indemnity reinsurance* to mean an agreement between two or more insurance companies under which the reinsuring company agrees to accept and to indemnify the issuing company for all or part of the risk of loss under policies specified in the agreement, and the issuing company retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement. No inference is intended as to whether indemnity reinsurance may constitute health insurance for other purposes.

2. *Student Administrative Health Fee Arrangements*

Many educational institutions have arrangements under which the educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the student purchases any available student health insurance coverage). These arrangements are different from premiums and cost-sharing for group health plans and health insurance coverage because all students pay the fee regardless of whether they have student health insurance. Therefore, these arrangements do not constitute health insurance for purposes of section 9010. For a similar conclusion regarding other Federal laws applicable to student health insurance, see Student Health Insurance Coverage, 77 F.R. 16453, 16455–56 (March 21, 2012) (Department of Health and Human Services regulations establishing requirements for student health insurance coverage under the Public Health Service Act and ACA).

3. *Travel Insurance*

The Treasury Department and the IRS are aware that certain travel insurance products may include limited health benefits. However, the term travel insurance does not have a definition for tax purposes and in other contexts has applied to a differing variety of products with different types of coverage, including some products providing only incidental health benefits. To assist in determining which types of travel-related insurance products provide health insurance for purposes of section 9010, the proposed regulations explicitly exclude *travel insurance*, defined as coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed. This definition is a modified version of the National Association of Insurance Commissioners (NAIC) definition of travel insurance.

4. *Retiree-only Health Plans*

The proposed regulations do not provide any special exceptions related to health insurance provided under a plan covering only retired employees. These types of arrangements are not subject to the requirements of Chapter 100 of the Code, not because they do not provide health insurance or because retiree-only coverage is an excepted benefit, but because of an exception in section 9831(a)(2) for group health plans having fewer than two current employees. This exception is not relevant in determining whether the insurance provided is health insurance for purposes of section 9010, which covers issuers of health insurance regardless of whether the insurance is provided under a group health plan. Therefore, health insurance provided under these arrangements is health insurance for purposes of section 9010. However, an employer providing coverage to former employees, such as retired employees, under a self-insured arrangement generally would qualify for the exclusion for self-insured employers. See section II.B.1 of this preamble.

E. *Net Premiums Written*

The fee each year is based on each covered entity's share of net premiums written for health insurance of United States health risks during the data year. Section 9010 does not define net premiums written. The proposed regulations define the term *net premiums written* to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. Because indemnity reinsurance is not considered health insurance for purposes of section 9010, net premiums written does not include premiums written for indemnity reinsurance (and is not reduced by indemnity reinsurance ceded). See section II.D.1 of this preamble. However, net premiums written does include premiums written (and excludes premiums ceded) for assumption reinsurance; that is, reinsurance for which there is a novation and the reinsurer takes over the entire risk pursuant to a new contract. Thus, for covered entities that file the Supplemental Health Care Exhibit (SHCE) with the NAIC, net premiums written for health insurance generally will equal the amount reported on the SHCE as direct premiums written minus MLR rebates with respect to the data year, subject to any applicable exclusions under section 9010 such as exclusions from the term health insurance. This definition of net premiums written for purposes of section 9010 differs from net adjusted premiums reported on the SHCE, which takes into account premiums from ceded and assumed reinsurance. Under current NAIC reporting rules, the amount reported as direct premiums written on the SHCE does not include ceding commissions, and thus there is no need to reduce direct premiums written for ceding commissions in determining net premiums written. However, the SHCE separately accounts for any expected reductions in premiums resulting from MLR rebates with respect to the data year. These amounts are subtracted from direct premiums written in determining net premiums written. The Treasury Department and the IRS invite comments on how to compute MLR rebates with respect to the data year using data reported on the SHCE.

F. *United States Health Risk*

In accordance with section 9010(d), the proposed regulations define the term *United States health risk* to mean the health risk of any individual who is (1) A United States citizen, (2) a resident of the United States (within the meaning of section 7701(b)(1)(A)), or (3) located in the United States, with respect to the period such individual is so located.

For purposes of determining whether an individual is located in the United States, the proposed regulations, in accordance with section 9010(h)(2), define the term *United States* to mean the 50 States, the District of Columbia, and any possession of the United States. The proposed regulations further define the term *located in the United States* to mean present in the United States under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937–1(c)(3)(i) (for presence in a possession of the United States). Subject to certain exceptions, those rules generally treat an individual as present in the United States on any day if the individual is physically present in the United States at any time during such day.

Section 9010(d)(2) refers to "resident of the United States (within the meaning of section 7701(b)(1)(A))." Under section 7701(b), the term United States means the 50 States and the District of Columbia, but it does not include the possessions of the United States. *See* section 7701(a)(9). Therefore, under the proposed regulations, this narrower definition of United States applies for determining who is a "resident of the United States (within the meaning of section 7701(b)(1)(A))." Regardless of the narrower scope of resident of the United States, the Treasury Department and the IRS note that the term United States health risk includes the health risks of individuals in the possessions of the United States since they will either be United States citizens or considered as located in the United States.

Recognizing the unique characteristics of plans covering expatriates, the Treasury Department and the IRS seek specific comments on how the rules proposed in these regulations apply to such plans.

III. *Reporting Requirements, Associated Penalties, and Disclosure*

Section 9010(g)(1) requires each covered entity to report its net premiums written for health insurance for United States health risks during the data year. The proposed regulations require each covered entity, including each controlled group that is treated as a single covered entity, to annually report its net premiums written for health insurance of United States health risks during the data year to the IRS by May 1st of the fee year on Form 8963, *Report of Health Insurance Provider Information,* in accordance with the instructions for the form. A covered entity with net premiums written under the $25 million threshold is not liable for a fee but must still report its net premiums written. The proposed regulations authorize the IRS to provide rules for the manner of reporting (including reporting by designated entities on behalf of controlled groups) in other guidance published in the Internal Revenue Bulletin.

Section 9010(g)(2) imposes a penalty for failing to timely submit a report containing the required information unless the covered entity can show that the failure is due to reasonable cause. Section 9010(g)(3) imposes an accuracy-related penalty for any understatement of a covered entity's net premiums written. The proposed regulations clarify that these penalties are in addition to the fee.

Section 9010(g)(4) provides that section 6103 (relating to the disclosure of returns and return information) does not apply to any information reported by the covered entities under section 9010(g). The Treasury Department and the IRS are considering making available to the public the information reported on Form 8963, *Report of Health Insurance Provider Information*, including the identity of the covered entity and the amount of its net premiums written, at the time the notice of preliminary fee calculation is sent. The Treasury Department and the IRS invite comments on which reported information the IRS should make publicly available.

IV. *Fee Calculation*

Under section 9010 and the proposed regulations, the IRS will calculate a covered entity's fee based on the ratio of the covered entity's net premiums written that are taken into account to the total net premiums written taken into account of all covered entities. For each covered entity, the IRS will not take into account the first $25 million of net premiums written. The IRS will take into account 50 percent of the net premiums written for amounts over $25 million and up to $50 million and 100 percent of the net premiums written over $50 million. Thus, for any covered entity with net premiums written of $50 million or more, the IRS will not take into account the first $37.5 million of net premiums written. Also, because a controlled group is treated as a single covered entity, this reduction applies, in the aggregate, to the net premiums written of the entire controlled group. Additionally, after this reduction, if the covered entity (or any member of a controlled group treated as a single covered entity) is exempt from tax by section 501(a) and is described in section 501(c)(3) (generally, a charity), (4) (generally, a social welfare organization), (26) (generally, a high-risk health insurance pool), or (29) (a consumer operated and oriented plan (CO-OP) health insurance issuer), the IRS will take into account only 50 percent of the remaining net premiums written of that entity (or member) that are attributable to its exempt activities. The proposed regulations further provide that, in the case of a controlled group, the IRS will not take into account any net premiums written of any member that is a nonprofit corporation meeting the requirements of §57.2(b)(2)(iii) of the proposed regulations or a VEBA meeting the requirements of §57.2(b)(2)(iv).

Under the proposed regulations, the IRS will determine net premiums written based on the reports submitted by covered entities and any other source of information available to the IRS. Most covered entities are expected to file the SHCE, which supplements the annual statement filed with the NAIC under applicable State law. For these covered entities, net premiums written for health insurance generally will equal the amount reported on that exhibit as direct premiums written minus MLR rebates with respect to the data year, subject to any applicable exclusions under section 9010 such as exclusions from the term "health insurance." In addition to the SHCE, other sources of information that the IRS may use to determine

net premiums written include the NAIC annual statement, the Accident and Health Policy Experience Exhibit filed with the NAIC, and the MLR Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services. The proposed regulations further provide that the entire amount reported on the SHCE as direct premiums written will be considered to be for United States health risks unless the covered entity can demonstrate otherwise. The Treasury Department and the IRS invite comments on this approach.

V. *Notice of Preliminary Fee Calculation*

The proposed regulations provide that the IRS will send each covered entity a notice of preliminary fee calculation each fee year that will include the covered entity's allocated fee; the covered entity's net premiums written for health insurance of United States health risks; the covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4); the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and a reference to the error correction process set forth in other guidance published in the Internal Revenue Bulletin. The date by which the IRS will send the preliminary fee calculation notice will be specified in other guidance published in the Internal Revenue Bulletin.

VI. *Error Correction Process*

The proposed regulations establish an error correction process that allows a covered entity to submit error correction reports in response to the preliminary fee calculation for the IRS to consider before performing a final fee calculation. The IRS will specify in other guidance published in the Internal Revenue Bulletin the format for error correction report submissions and the date by which a covered entity must submit an error correction report. In the interest of providing finality to the fee calculation process, no additional error correction reports will be accepted after the end of the established error correction period.

VII. *Notification of Final Fee Calculation and Payment*

Section 9010(a) requires the annual fee to be paid by the annual date specified by the Secretary, but in no event later than September 30th of each fee year. The proposed regulations provide that the IRS will send each covered entity its final fee calculation for a fee year no later than August 31st of that fee year, and that the covered entity must pay the fee by September 30th by electronic funds transfer. This notification will include the covered entity's allocated fee, the covered entity's net premiums written for health insurance of United States health risks, the covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4), the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities, and the final determination on the covered entity's error correction report.

Even if a covered entity did not file an error correction report, a covered entity's final fee may differ from a covered entity's preliminary fee because of information discovered about that covered entity through other information sources. In addition, a change in aggregate net premiums written for health insurance of United States health risks can affect each covered entity's fee because each covered entity's fee is a fraction of the aggregate fee collected from all covered entities.

There is no tax return to be filed with the payment of the fee.

VIII. *Tax Treatment of Fee*

Section 9010(f)(1) treats the fee for purposes of subtitle F of the Code (sections 6001 — 7874) as an excise tax to which only civil actions for refund apply. Thus, under the proposed regulations, the fee is treated as an excise tax for purposes of subtitle F to which the deficiency procedures of sections 6211 through 6216 do not apply. The proposed regulations require the IRS to assess the amount of the fee for any fee year within three years of September 30th of that fee year.

Section 9010(f)(2) treats the fee as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed). The Treasury Department and the IRS received comments stating that covered entities may attempt to recover a large portion of the fee from policyholders, either by a corresponding increase in premiums or by separately charging policyholders for a portion of the fee. Some comments requested guidance that recovered fee amounts are excluded from the gross income of covered entities. The income tax treatment of recovered fee amounts is outside the scope of the proposed regulations. However, under section 61(a), gross income means all income from whatever source derived unless a provision of the Code or other law specifically excludes the payment from gross income. No exclusion provision applies to the recovered fee amount. Therefore, the covered entity's gross income includes fees recovered from policyholders, whether or not separately stated on any bill. The Treasury Department and the IRS invite comments on whether the text of the regulations should be revised to clarify that recovered fee amounts are included in a covered entity's gross income.

IX. *Refund Claims*

The proposed regulations require any claim for refund to be filed on Form 843, *Claim for Refund and Request for Abatement*.

**Proposed Effective/Applicability Date**

These regulations are proposed to apply with respect to any fee that is due on or after September 30, 2014.

**Special Analyses**

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that these regulations primarily affect large corporations. Thus, the Treasury Department and the IRS do not expect a sub-

stantial number of small entities to be affected. Therefore, 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 has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

**Comments and Public Hearing**

Before the proposed regulations are adopted as final regulations, consideration will be given to any written (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The Treasury Department and the IRS invite comments on all aspects of the proposed regulations. All comments will be available for public inspection and copying.

A public hearing has been scheduled for June 21, 2013, at 10:00 a.m., in the IRS Auditorium, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit electronic or written comments and submit an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by June 3, 2013. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

**Drafting Information**

The principal author of these regulations is Charles J. Langley, Jr., Office of the Associate Chief Counsel (Passthroughs and Special Industries). However, other personnel from the Treasury Department and the IRS participated in their development.

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**Proposed Amendments to the Regulations**

Accordingly, 26 CFR chapter I is proposed to be amended by adding part 57 to subchapter D to read as follows:

**PART 57 — HEALTH INSURANCE PROVIDERS FEE**

Sec.
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57.2 Explanation of terms.
57.3 Reporting requirements and associated penalties.
57.4 Fee calculation.
57.5 Notice of preliminary fee calculation.
57.6 Error correction process.
57.7 Notification and fee payment.
57.8 Tax treatment of fee.
57.9 Refund claims.
57.10 Effective/applicability date.
57.6302–1 Method of paying the health insurance providers fee.

Authority: 26 U.S.C. 7805; sec. 9010, Pub. L. 111–148 (124 Stat. 119 (2010)).

Section 57.7 also issued under 26 U.S.C. 6302(a).

Section 57.6302–1 also issued under 26 U.S.C. 6302(a).

*§57.0 Table of contents.*

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*§57.6302–1 Method of paying the health insurance providers fee.*

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*§57.1 Overview.*

(a) The regulations in this part 57 are designated "Health Insurance Providers Fee Regulations."

(b) The regulations in this part 57 provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references to section 9010 in these proposed regulations are references to section 9010 of the ACA. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections are references to subtitles, chapters, subchapters and sections in the Internal Revenue Code and the related regulations.

(c) Section 9010(e)(1) sets an applicable fee amount for each year, beginning with 2014, that will be apportioned among covered entities with aggregate net premiums written over $25 million for health insurance for United States health risks. Generally, each covered entity is liable for a fee in each fee year that is based on its net premiums written during the data year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

*§57.2 Explanation of terms.*

(a) *In general.* This section explains the terms used in this part for purposes of the fee.

(b) *Covered entity*—(1) *In general.* Except as provided under paragraph (c)(2) of this section, the term *covered entity* means any entity with net premiums written for health insurance for United States health risks in the fee year if the entity is—

(i) A health insurance issuer within the meaning of section 9832(b)(2), defined in section 9832(b)(2) to include an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a State and that is subject to the respective laws of such jurisdictions that regulate insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA));

(ii) A health maintenance organization within the meaning of section 9832(b)(3), defined in section 9832(b)(3)(A)-(C) to include—

(A) A Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) An organization recognized under State law as a health maintenance organization; or

(C) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization;

(iii) An insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a);

(iv) An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or

(v) A multiple employer welfare arrangement (MEWA), within the meaning of section 3(40) of ERISA, to the extent not fully insured, provided that for this purpose a covered entity does not include a MEWA that is excepted from reporting under 29 CFR 2520.101–2(c)(2)(ii)(B). Solely for purposes of the application of section 9010, an Entity Claiming Exception (defined in 29 CFR 2520.101–2(b)) is treated as a MEWA.

(2) *Exclusions*—(i) *Self-insured employer.* A covered entity does not include any entity that is a self-insured employer to the extent that such entity self-insures its employees' health risks. The term *self-insured employer* means an employer that sponsors a self-insured medical reimbursement plan within the meaning of §1.105–11(b)(1)(i) of this chapter. Self-insured medical reimbursement plans include plans that do not involve shifting risk to an unrelated third party as described in §1.105–11(b)(1)(ii) of this chapter. A self-insured plan may use an insurance company or other third party to provide administrative or bookkeeping functions.

(ii) *Governmental entity.* A covered entity does not include any governmental entity. For this purpose, the term *governmental entity* means—

(A) The United States;

(B) Any State or a political subdivision thereof (as defined for purposes of section 103) including, for example, a State health department or State insurance commission;

(C) Any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)); or

(D) Any public agency that is created by a State or a political subdivision, organized as a nonprofit under State law, and contracts with the State to administer State

Medicaid benefits through local providers or HMOs.

(iii) *Certain nonprofit corporations*. A covered entity does not include any entity—

(A) Which is incorporated as a nonprofit corporation under a State law;

(B) No part of the net earnings of which inures to the benefit of any private shareholder or individual (within the meaning of §§1.501(a)–1(c) and 1.501(c)(3)–1(c)(2) of this chapter);

(C) No substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (within the meaning of §1.501(c)(3)–1(c)(3)(ii) of this chapter) (or which is described in section 501(h)(3) and is not denied exemption under section 501(a) by reason of section 501(h));

(D) Which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office (within the meaning of §1.501(c)(3)–1(c)(3)(iii) of this chapter); and

(E) More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(iv) *Certain voluntary employees' beneficiary associations*. A covered entity does not include any entity that is described in section 501(c)(9) that is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

(3) *State*. Solely for purposes of paragraph (b) of this section, the term *State* means any of the 50 States, the District of Columbia, or any of the possessions of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(c) *Controlled groups*—(1) *In general*. The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o). A controlled group is treated as a single covered entity for purposes of the fee.

(2) *Special rules*. For purposes of paragraph (c)(1) of this section (related to controlled groups)—

(i) A foreign entity subject to tax under section 881 is included within a controlled group under section 52(a) or (b); and

(ii) A person is treated as being a member of the controlled group if it is a member of the group at the end of the day on December 31st of the data year.

(d) *Data year*. The term *data year* means the calendar year immediately before the fee year. Thus, for example, 2013 is the data year for fee year 2014.

(e) *Designated entity*—(1) *In general*. Each controlled group must have a designated entity. The term *designated entity* means the person within the controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to—

(i) Filing Form 8963, *Report of Health Insurance Provider Information*;

(ii) Receiving IRS communications about the fee for the group;

(iii) Filing an error correction report for the group, if applicable, as described in §57.6; and

(iv) Paying the fee for the group to the IRS.

(2) *Selection of designated entity*—(i) *In general*. Except as provided in paragraph (e)(2)(ii) of this section, the controlled group may select its designated entity by filing Form 8963, *Report of Health Insurance Provider Information*, in accordance with the form instructions. The designated entity must state under penalties of perjury that all persons that provide health insurance for United States health risks that are members of the group have consented to the selection of the designated entity. Each member of a controlled group is required to maintain a record of its consent to the controlled group's selection of the designated entity. The designated entity must maintain a record of all member consents. If a controlled group does not select a designated entity, the IRS will select the designated entity.

(ii) *Requirement for affiliated groups; common parent.* If the controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group that files a consolidated return for Federal income tax purposes, the designated entity is the common parent of the affiliated group as identified on the tax return filed for the data year.

(f) *Fee*. The term *fee* means the fee imposed by section 9010 on each covered entity engaged in the business of providing health insurance.

(g) *Fee year*. The term *fee year* means the calendar year in which the fee must be paid to the government.

(h) *Health insurance*—(1) *In general*. Except as provided in paragraph (h)(2) of this section, the term *health insurance* has the same meaning as the term health insurance coverage in section 9832(b)(1)(A), defined to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The term health insurance includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) *Exclusions*. Health insurance does not include—

(i) Coverage only for accident, or disability income insurance, or any combination thereof, within the meaning of section 9832(c)(1)(A);

(ii) Coverage issued as a supplement to liability insurance within the meaning of section 9832(c)(1)(B);

(iii) Liability insurance, including general liability insurance and automobile liability insurance, within the meaning of section 9832(c)(1)(C);

(iv) Workers' compensation or similar insurance within the meaning of section 9832(c)(1)(D);

(v) Automobile medical payment insurance within the meaning of section 9832(c)(1)(E);

(vi) Credit-only insurance within the meaning of section 9832(c)(1)(F);

(vii) Coverage for on-site medical clinics within the meaning of section 9832(c)(1)(G);

(viii) Other insurance coverage that is similar to the insurance coverage in paragraph (h)(2)(i) through (vii) of this section under which benefits for medical care are secondary or incidental to other insurance benefits, within the meaning of section 9832(c)(1)(H), to the extent such insurance coverage is specified in regulations under section 9832(c)(1)(H);

(ix) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section

9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C);

(x) Coverage only for a specified disease or illness within the meaning of section 9832(c)(3)(A);

(xi) Hospital indemnity or other fixed indemnity insurance within the meaning of section 9832(c)(3)(B);

(xii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan, within the meaning of section 9832(c)(4);

(xiii) Student administrative health fee arrangements, as defined in paragraph (h)(3);

(xiv) Travel insurance, as defined in paragraph (h)(4) of this section; or

(xv) Indemnity reinsurance, as defined in paragraph (h)(5)(i) of this section.

(3) *Student administrative health fee arrangement*. For purposes of paragraph (h)(2)(xiii) of this section, the term *student administrative health fee arrangement means an arrangement* under which an educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the student purchases any available student health insurance coverage).

(4) *Travel insurance*. For purposes of paragraph (h)(2)(xiv) of this section, the term *travel insurance* means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

(5) *Reinsurance*—(i) *Indemnity reinsurance*. For purposes of paragraphs (h)(2)(xv) and (k) of this section, the term *indemnity reinsurance* means an agreement between two or more insurance companies under which—

(A) The reinsuring company agrees to accept and to indemnify the issuing company for all or part of the risk of loss under policies specified in the agreement; and

(B) The issuing company retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement.

(ii) *Assumption reinsurance*. For purposes of paragraph (k) of this section, the term *assumption reinsurance* means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(i) *Located in the United States*. The term *located in the United States* means present in the United States (within the meaning of paragraph (m) of this section) under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937–1(c)(3)(i) of this chapter (for presence in a possession of the United States).

(j) *NAIC*. The term *NAIC* means the National Association of Insurance Commissioners.

(k) *Net premiums written*. The term *net premiums written* means premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. Because indemnity reinsurance within the meaning of paragraph (h)(5)(i) of this section is not health insurance under paragraph (h)(1) of this section, net premiums written does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, net premiums written does include premiums written and is reduced by premiums ceded for assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section.

(l) *SHCE*. The term *SHCE* means the Supplemental Health Care Exhibit. The SHCE is a form published by the NAIC that most covered entities are required to file annually under State law.

(m) *United States*. For purposes of paragraph (i) of this section, the term *United States* means the 50 States, the District of Columbia, and any possession of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(n) *United States health risk*. The term *United States health risk* means the health risk of any individual who is—

(1) A United States citizen;

(2) A resident of the United States (within the meaning of section 7701(b)(1)(A)); or

(3) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

*§57.3 Reporting requirements and associated penalties.*

(a) *Reporting requirement*—(1) *In general*. Annually, each covered entity, including each controlled group that is treated as a single covered entity, must report its net premiums written for health insurance of United States health risks during the data year to the IRS by May 1st of the fee year on Form 8963, *Report of Health Insurance Provider Information*, in accordance with the instructions for the form. A covered entity that has net premiums written for health insurance of United States health risks during the data year but does not have any amount taken into account as described in §57.4(a)(4) is still subject to this reporting requirement.

(2) *Manner of reporting*. The IRS may provide rules in guidance published in the Internal Revenue Bulletin for the manner of reporting by a covered entity under this section, including rules for reporting by a designated entity on behalf of a controlled group that is treated as a single covered entity.

(b) *Penalties*—(1) *Failure to report*—(i) *In general*. If any covered entity fails to timely submit a report containing the information required by paragraph (a) of this section, the covered entity is liable for a penalty in the amount described in paragraph (b)(1)(ii) of this section in addition to its fee liability, unless the failure is due to reasonable cause as defined in paragraph (b)(1)(iii) of this section.

(ii) *Amount*. The amount of the penalty for failure to timely submit a report de-

scribed in paragraph (b)(1)(i) of this section is equal to—

(A) $10,000, plus

(B) The lesser of—

(*1*) An amount equal to $1,000, multiplied by the number of days during which such failure continues; or

(*2*) The amount of the covered entity's fee for which the report was required.

(iii) *Reasonable cause*. The penalty for failure to timely submit a report described in paragraph (b)(1)(i) of this section is waived if the failure is due to reasonable cause. A failure will be due to a reasonable cause if the covered entity exercised ordinary business care and prudence and was nevertheless unable to submit the report within the prescribed time. In determining whether the covered entity was unable to timely submit the report described in paragraph (b)(1)(i) of this section despite the exercise of ordinary business care and prudence, the IRS will consider all the facts and circumstances surrounding the failure to submit the report.

(iv) *Treatment of penalty*. The failure to report penalty described in this paragraph (b)(1)—

(A) Is treated as a penalty under subtitle F;

(B) Must be paid on notice and demand by the IRS and in the same manner as a tax under the Internal Revenue Code; and

(C) Is a penalty for which only civil actions for refund under procedures of subtitle F apply.

(2) *Accuracy-related penalty*—(i) *In general*. If any covered entity understates its net premiums written for health insurance of United States health risks in the report required under paragraph (a)(1) of this section, the covered entity is liable for a penalty in the amount described in paragraph (b)(2)(ii) of this section in addition to its fee liability.

(ii) *Amount*. The amount of the accuracy-related penalty described in paragraph (b)(2)(i) of this section is equal to the excess of—

(A) The amount of the covered entity's fee for the fee year that the Secretary determines should have been paid in the absence of any understatement; over

(B) The amount of the covered entity's fee for the fee year that the Secretary determined based on the understatement.

(iii) *Understatement*. An understatement of a covered entity's net premiums written for health insurance of United States health risks is the difference between the amount of net premiums written that the covered entity reported and the amount of net premiums written that the covered entity should have reported.

(iv) *Treatment of penalty*. The accuracy-related penalty is subject to the provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

(3) *Controlled groups*. Each person in a controlled group with an obligation to provide information to the controlled group's designated entity for purposes of the report required to be submitted by the designated entity on behalf of the controlled group is jointly and severally liable for any penalties described in this paragraph (b) for any reporting failures by the designated entity.

*§57.4 Fee calculation.*

(a) *Fee components*—(1) *In general*. For every fee year, the IRS will calculate a covered entity's total fee as described in this section.

(2) *Calculation of net premiums written*. Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account bears to the aggregate net premiums written for health insurance of United States health risks of all covered entities during the data year taken into account.

(3) *Applicable amount*. The applicable amounts for fee years are—

| Fee year | Applicable amount |
|---|---|
| 2014 | $ 8,000,000,000 |
| 2015 | $ 11,300,000,000 |
| 2016 | $ 11,300,000,000 |
| 2017 | $ 13,900,000,000 |
| 2018 | $ 14,300,000,000 |
| 2019 and thereafter | The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)). |

(4) *Net premiums written taken into account*—(i) *In general*. A covered entity's net premiums written for health insurance of United States health risks during any data year are taken into account as follows:

| Covered entity's net premiums written during the data year that are: | Percentage of net premiums written taken into account is: |
|---|---|
| Not more than $25,000,000 | 0 |
| More than $25,000,000 but not more than $50,000,000 | 50 |
| More than $50,000,000 | 100 |

(ii) *Controlled groups*. In the case of a controlled group, paragraph (a)(4)(i) of this section applies to all net premiums written for health insurance of United States health risks during the data year, in the aggregate, of the entire controlled group, except that any net premiums written by any member of the controlled group that is a nonprofit corporation meeting the requirements of §57.2(b)(2)(iii) or a voluntary employees' beneficiary as-

sociation meeting the requirements of §57.2(b)(2)(iv) are not taken into account.

(iii) *Partial reduction for certain exempt activities*. After the application of paragraph (a)(4)(i) of this section, if the covered entity is exempt from Federal income tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29), then only 50 percent of its remaining net premiums written for health insurance of United States health risks that are attributable to its exempt activities (and not to activities of an unrelated trade or business as defined in section 513) during the data year are taken into account.

(b) *Determination of net premiums written*—(1) *In general*. The IRS will determine net premiums written for health insurance of United States health risks based on the reports submitted by the covered entities, together with any other source of information available to the IRS. Other sources of information that the IRS may use to determine net premiums written include the SHCE, which supplements the annual statement filed with the NAIC pursuant to State law, the annual statement itself or the Accident and Health Policy Experience filed with the NAIC, the MLR Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services, or any similar statements filed with the NAIC, with any State government, or with the Federal government pursuant to applicable State or Federal requirements.

(2) *Presumption for United States health risks*. For any covered entity that files the SHCE with the NAIC, the entire amount reported as direct premiums written will be considered to be for United States health risks as described in §57.2(k) (subject to any applicable exclusions for amounts that are not health insurance as described in §57.2(g)(2)) unless the covered entity can demonstrate otherwise.

(c) *Determination of amounts taken into account*. (1) For each fee year and for each covered entity, the IRS will calculate the net premiums written for health insurance of United States health risks taken into account during the data year. The resulting number is the numerator of the ratio described in paragraph (d)(1) of this section.

(2) For each fee year, the IRS will calculate the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities during the data year. The resulting number is the denominator of the ratio described in paragraph (d)(2) of this section.

(d) *Allocated fee calculated*. For each covered entity for each fee year, the IRS will calculate the covered entity's allocated fee by multiplying the applicable amount from paragraph (a)(3) of this section by a fraction—

(1) The numerator of which is the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate net premiums written for health insurance of United States health risks for all covered entities during the data year taken into account (described in paragraph (c)(2) of this section).

*§57.5 Notice of preliminary fee calculation.*

(a) *Content of notice*. Each fee year, the IRS will make a preliminary calculation of the fee for each covered entity as described in §57.4. The IRS will notify each covered entity of its preliminary fee calculation for that fee year. The notification to a covered entity of its preliminary fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) A reference to the error correction procedures specified in guidance published in the Internal Revenue Bulletin.

(b) *Timing of notice*. The IRS will specify in other guidance published in the Internal Revenue Bulletin the date by which it will send each covered entity a notice of its preliminary fee calculation.

*§57.6 Error correction process.*

(a) *In general*. Upon receipt of its preliminary fee calculation, each covered entity will have an opportunity to review this calculation, identify any errors, and submit to the IRS an error correction report.

(b) *Time and manner*. The IRS will specify in other guidance published in the Internal Revenue Bulletin the format for error correction report submissions and the date by which a covered entity must submit an error correction report. The IRS will provide its final determination regarding the covered entity's error correction report no later than the time the IRS provides a covered entity with a final fee calculation.

*§57.7 Notification and fee payment.*

(a) *Content of notice*. Each fee year, the IRS will make a final calculation of the fee for each covered entity as described in §57.4. The IRS will base its final fee calculation on the reports the covered entity provides as adjusted by the error correction process and other sources described in §57.4(b)(1). The notification to a covered entity of its final fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) The final determination on the covered entity's error correction report, if any.

(b) *Timing of notice*. The IRS will send each covered entity a notice of its final fee calculation by August 31st of the fee year.

(c) *Differences in preliminary fee calculation and final calculation*. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the error correction process described in §57.6 or because the IRS discovered additional information relevant to the fee calculation through other information sources as described in §57.4(b)(1). Even if a covered entity did not file an error correction

report described in §57.6, a covered entity's final fee may differ from a covered entity's preliminary fee because of information discovered about that covered entity through other information sources. In addition, a change in aggregate net premiums written for health insurance of United States health risks can affect each covered entity's fee because each covered entity's fee is a fraction of the aggregate fee collected from all covered entities.

(d) *Payment of final fee*. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's EIN as reported on Form 8963, *Report of Health Insurance Provider Information*. The fee must be paid by electronic funds transfer as required by §57.6302–1. There is no tax return to be filed with the payment of the fee.

(e) *Controlled groups*. In the case of a controlled group that is liable for the fee, all members of the controlled group are jointly and severally liable for the fee. Accordingly, if a controlled group's fee is not paid, the IRS may separately assess each member of the controlled group for the full amount of the controlled group's fee.

*§57.8 Tax treatment of fee.*

(a) *Treatment as an excise tax*. The fee is treated as an excise tax for purposes of subtitle F (sections 6001–7874). Thus, references in subtitle F to "taxes imposed by this title," "internal revenue tax," and similar references, are also references to the fee. For example, the fee is assessed (section 6201), collected (sections 6301, 6321, and 6331), enforced (section 7602), subject to examination and summons (section 7602), and subject to confidentiality rules (section 6103), in the same manner as taxes imposed by the Code.

(b) *Deficiency procedures*. The deficiency procedures of sections 6211–6216 do not apply to the fee.

(c) *Limitation on assessment*. The IRS must assess the amount of the fee for any fee year within three years of September 30th of that fee year.

(d) *Application of section 275*. The fee is treated as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed).

*§57.9 Refund claims.*

Any claim for a refund of the fee must be made by the entity that paid the fee to the government and must be made on Form 843, *Claim for Refund and Request for Abatement*, in accordance with the instructions for that form.

*§57.10 Effective/applicability date.*

Sections 57.1 through 57.9 apply to any fee that is due on or after September 30, 2014.

*§57.6302–1 Method of paying the health insurance providers fee.*

(a) *Fee to be paid by electronic funds transfer*. Under the authority of section 6302(a), the fee imposed on covered entities engaged in the business of providing health insurance for United States health risks under section 9010 and §57.4 must be paid by electronic funds transfer as defined in §31.6302–1(h)(4)(i) of this chapter, as if the fee were a depository tax. For the time for paying the fee, see §57.7.

(b) *Effective/Applicability date*. This section applies with respect to any fee that is due on or after September 30, 2014.

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

(Filed by the Office of the Federal Register on March 1, 2013, 8:45 a.m., and published in the issue of the Federal Register for March 4, 2013, 78 F.R. 14034)

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## Taxable Medical Devices; Correction

## Announcement 2013–19

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Correcting Amendment.

SUMMARY: This document contains corrections to final regulations (T.D. 9604, 2012–52 I.R.B. 730) that were published in the **Federal Register** on Friday, December 7, 2012 (77 F.R. 72924). The final regulations provide guidance on the excise tax imposed on the sale of certain medical devices, enacted by the Health Care and Education Reconciliation Act of 2010 in conjunction with the Patient Protection and Affordable Care Act.

DATES: This correction is effective on ***March 12, 2013*** and is applicable after December 31, 2012.

FOR FURTHER INFORMATION CONTACT: Natalie Payne, Michael Beker, or Stephanie Bland, at (202) 622–3130 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

**Background**

The final regulations (T.D. 9604) that are the subject of this correction is under section 4191 of the Internal Revenue Code.

**Need for Correction**

As published, the final regulations (T.D. 9604) contain errors that may prove to be misleading and are in need of clarification.

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**Correction of Publication**

Accordingly, 26 CFR part 48 is corrected by making the following correcting amendments:

**PART 48—MANUFATURERS AND RETAILERS EXCISE TAXES**

Paragraph 1. The authority citation for part 48 continues to read in part as follows:

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

Par. 2. Section 48.4191–2 is amended by revising:

1. The second sentence of paragraph (b)(2).

2. The last sentence of paragraphs (b)(2)(iv) *Example 5*., *Example 6*.,

3. Paragraph (b)(2)(iv) *Example 7*.

4. The last sentence of paragraphs (b)(2)(iv) *Example 8*., *Example 11*., and *Example 13*.

The revisions read as follows:

*§ 48.4191–2 Taxable medical device.*

* * * * *

(b)* * *

(2)* * * A device will be considered to be of a type that is generally purchased by the general public at retail for individual use if it is regularly available for purchase and use by individual consumers who are

not medical professionals, and if the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by a medical professional. * * *

* * * * *

(iv)* * *

*Example 5.* * * * Based on the totality of the facts and circumstances, the mobile x-ray systems are not devices that are of a type that are generally purchased by the general public at retail for individual use.

*Example 6.* * * * Accordingly, the pregnancy test kits are devices that are of a type that are generally purchased by the general public at retail for individual use.

*Example 7.* X manufactures blood glucose monitors, blood glucose test strips, and lancets. X sells the blood glucose monitors, test strips, and lancets to distributors Y and Z, which, in turn, sell the monitors, test strips, and lancets to medical institutions and offices, medical professionals, and retail businesses. The FDA requires manufacturers of blood glucose monitors, test strips, and lancets to list the items as devices with the FDA. The FDA classifies the blood glucose monitors under 21 CFR part 862 (Clinical Chemistry and Clinical Toxicology Devices) and product code NBW. The FDA classifies the test strips under 21 CFR part 862 (Clinical Chemistry and Clinical Toxicology Devices) and product code NBW. The FDA classifies the lancets under 21 CFR part 878 (General and Plastic Surgery Devices) and product code FMK.

The blood glucose monitors and test strips are included in the FDA's online IVD Home Use Lab Tests (Over-the-Counter Tests) database. Therefore, the blood glucose monitors and test strips fall within the safe harbor set forth in paragraph (b)(2)(iii)(A) of this section. Further, the FDA product code name for NBW is "System, Test, Blood Glucose, Over the Counter." Therefore, the blood glucose monitors and test strips also fall within the safe harbor set forth in paragraph (b)(2)(iii)(C) of this section.

In addition, the lancets are supplies necessary for the effective use of DME as described in section 110.3 of chapter 15 of the Medicare Policy Benefit Manual. Therefore, the lancets fall within the safe harbor set forth in paragraph (b)(2)(iii)(D)(*5*) of this section.

Accordingly, the blood glucose monitors, test strips, and lancets are devices that are of a type that are generally purchased by the general public at retail for individual use.

*Example 8.* * * * Accordingly, both the single axis endoskeletal knee shin systems manufactured by X and the prosthetic legs made by Y are devices that are of a type that are generally purchased by the general public at retail for individual use.

* * * * *

*Example 11.* * * * Accordingly, the urinary ileostomy bags are devices that are of a type that are generally purchased by the general public at retail for individual use.

* * * * *

*Example 13.* * * * Based on the totality of the facts and circumstances, the NMRI systems are not devices that are of a type that are generally purchased by the general public at retail for individual use.

* * * * *

Par. 3. Section 48.4216(c)–1 is amended by revising paragraph (e)(1) to read as follows:

*§ 48.4216(c)–1 Computation of tax on leases and installment sales.*

* * * * *

(e) * * *

(1) *General rule*. Payments made on or after January 1, 2013, pursuant to a contract for the lease, installment sale, or sale on credit of a taxable medical device that was entered into on or after March 30, 2010, are subject to tax under section 4191. The provisions of sections 4216(c) and 4217, paragraphs (a), (b), and (c) of this section, and § 48.4217–2 apply.

LaNita VanDyke,
*Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel (Procedure and Administration).*

(Filed by the Office of the Federal Register on March 12, 2013, 8:45 a.m., and published in the issue of the Federal Register for February 13, 2013, 78 F.R. 15877)

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## Awards for Information Relating To Detecting Underpayments of Tax or Violations of the Internal Revenue Laws; Hearing

## Announcement 2013–20

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of public hearing on notice of proposed rulemaking.

SUMMARY: This document provides a notice of public hearing on proposed regulations that provide comprehensive guidance for the award program authorized under Internal Revenue Code section 7623, as amended. The regulations provide guidance on submitting information regarding underpayments of tax or violations of the internal revenue laws and filing claims for award, as well as on the administrative proceedings applicable to claims for award under section 7623. The regulations also provide guidance on the determination and payment of awards, and provide definitions of key terms used in section 7623. Finally, the regulations confirm that the Director, officers, and employees of the Whistleblower Office are authorized to disclose return information to the extent necessary to conduct whistleblower administrative proceedings.

DATES: The public hearing is being held on Wednesday, April 10, 2013, at 10:00 a.m. The IRS must receive outlines of the topics to be discussed at the public hearing by Friday, March 29, 2013.

ADDRESSES: The public hearing is being held in the IRS Auditorium, Internal Revenue Service Building, 1111 Constitution Avenue, NW, Washington, DC 20224. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building.

Send Submissions to CC:PA:LPD:PR (REG–141066–09), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday to CC:PA:LPD:PR (REG–141066–09), Couriers Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224 or sent electronically via the Federal eRulemaking Portal at *www.regulations.gov* (REG–141066–09).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Melissa Jarboe at (202) 622–3620; concerning submissions of comments, the hearing and/or to be placed on the building access list to attend the hearing Oluwafunmilayo Taylor at (202) 622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

The subject of the public hearing is the notice of proposed rulemaking (REG–141066–09, 2013–3 I.R.B. 280) that was published in the **Federal Register** on Tuesday, December 18, 2012 (77 F.R. 74798).

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing that submitted written comments by February 19, 2013, must submit an outline of the

topics to be addressed and the amount of time to be denoted to each topic by Friday, March 29, 2013.

A period of 10 minutes is allotted to each person for presenting oral comments. After the deadline for receiving outlines has passed, the IRS will prepare an agenda containing the schedule of speakers. Copies of the agenda will be made available, free of charge, at the hearing or in the Freedom of Information Reading Room (FOIA RR) (Room 1621) which is located at the 11th and Pennsylvania Avenue, NW, entrance, 1111 Constitution Avenue, NW, Washington, DC 20224.

Because of access restrictions, the IRS will not admit visitors beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this document.

LaNita VanDyke,
*Chief, Publications and Regulations Branch,*
*Legal Processing Division,*
*Associate Chief Counsel*
*(Procedure and Administration).*

# Definition of Terms

*Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:*

*Amplified* describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

*Clarified* is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

*Distinguished* describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

*Modified* is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

*Obsoleted* describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

*Revoked* describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

*Superseded* describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

*Supplemented* is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

*Suspended* is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

# Abbreviations

*The following abbreviations in current use and formerly used will appear in material published in the Bulletin.*

*A*—Individual.
*Acq.*—Acquiescence.
*B*—Individual.
*BE*—Beneficiary.
*BK*—Bank.
*B.T.A.*—Board of Tax Appeals.
*C*—Individual.
*C.B.*—Cumulative Bulletin.
*CFR*—Code of Federal Regulations.
*CI*—City.
*COOP*—Cooperative.
*Ct.D.*—Court Decision.
*CY*—County.
*D*—Decedent.
*DC*—Dummy Corporation.
*DE*—Donee.
*Del. Order*—Delegation Order.
*DISC*—Domestic International Sales Corporation.
*DR*—Donor.
*E*—Estate.
*EE*—Employee.
*E.O.*—Executive Order.
*ER*—Employer.
*ERISA*—Employee Retirement Income Security Act.
*EX*—Executor.
*F*—Fiduciary.
*FC*—Foreign Country.
*FICA*—Federal Insurance Contributions Act.
*FISC*—Foreign International Sales Company.
*FPH*—Foreign Personal Holding Company.
*F.R.*—Federal Register.
*FUTA*—Federal Unemployment Tax Act.
*FX*—Foreign corporation.
*G.C.M.*—Chief Counsel's Memorandum.
*GE*—Grantee.
*GP*—General Partner.
*GR*—Grantor.
*IC*—Insurance Company.
*I.R.B.*—Internal Revenue Bulletin.
*LE*—Lessee.
*LP*—Limited Partner.
*LR*—Lessor.
*M*—Minor.
*Nonacq.*—Nonacquiescence.
*O*—Organization.
*P*—Parent Corporation.
*PHC*—Personal Holding Company.
*PO*—Possession of the U.S.
*PR*—Partner.
*PRS*—Partnership.
*PTE*—Prohibited Transaction Exemption.
*Pub. L.*—Public Law.
*REIT*—Real Estate Investment Trust.
*Rev. Proc.*—Revenue Procedure.
*Rev. Rul.*—Revenue Ruling.
*S*—Subsidiary.
*S.P.R.*—Statement of Procedural Rules.
*Stat.*—Statutes at Large.
*T*—Target Corporation.
*T.C.*—Tax Court.
*T.D.* —Treasury Decision.
*TFE*—Transferee.
*TFR*—Transferor.
*T.I.R.*—Technical Information Release.
*TP*—Taxpayer.
*TR*—Trust.
*TT*—Trustee.
*U.S.C.*—United States Code.
*X*—Corporation.
*Y*—Corporation.
*Z* —Corporation.

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[1] A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2012–27 through 2012–52 is in Internal Revenue Bulletin 2012–52, dated December 27, 2012.

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