

## **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**

#### **Rev. Rul. 2012-13, page 878.**

**Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate.** For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for May 2012.

#### **REG-141268-11, page 896.**

Proposed regulations under section 312 of the Code provide guidance clarifying the allocation of earnings and profits in tax-free transfers from one corporation to another.

### **EMPLOYEE PLANS**

#### **REG-136008-11, page 881.**

Proposed regulations under sections 4375 through 4377 of the Code provide guidance on determining which health insurance policies and self-insured health plans are subject to fees for the Patient-Centered Outcome Research Trust Fund, and also on the requirements for calculating, reporting, and paying the fees.

### **EXEMPT ORGANIZATIONS**

#### **Announcement 2012-22, page 899.**

The IRS has revoked its determination that Big Hope, Inc., of Elon, NC; Freedom Debt Management, Inc., of Boca Raton, FL; Lost Cherokee of Arkansas & Missouri, Inc., of Conway, AR; Marlowe Education Foundation, Inc., of Idaho Falls, ID; Richard E. Feldhake Support Foundation Trust of Phoenix, AZ; and Successful Dreams Equestrian Center of Fitchburg, MA,

qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Code.

### **EXCISE TAX**

#### **REG-136008-11, page 881.**

Proposed regulations under sections 4375 through 4377 of the Code provide guidance on determining which health insurance policies and self-insured health plans are subject to fees for the Patient-Centered Outcome Research Trust Fund, and also on the requirements for calculating, reporting, and paying the fees.

### **TAX CONVENTIONS**

#### **Announcement 2012-21, page 898.**

This document provides a copy of the Competent Authority Agreement entered into on March 19, 2012, by the Competent Authorities of the United States and Germany, regarding the eligibility of certain pension arrangements for benefits under Article 10(3)(b) of the U.S.-Germany income tax treaty.

Finding Lists begin on page ii.



# The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and en-

force 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 and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

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.

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

## Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rates is set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

## Section 1274.—Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)

**Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate.** For purposes of

sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for May 2012.

## Rev. Rul. 2012-13

This revenue ruling provides various prescribed rates for federal income tax purposes for May 2012 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2012-13 TABLE 1  
Applicable Federal Rates (AFR) for May 2012

|                   | <i>Period for Compounding</i> |                   |                  |                |
|-------------------|-------------------------------|-------------------|------------------|----------------|
|                   | <i>Annual</i>                 | <i>Semiannual</i> | <i>Quarterly</i> | <i>Monthly</i> |
| <i>Short-term</i> |                               |                   |                  |                |
| AFR               | .28%                          | .28%              | .28%             | .28%           |
| 110% AFR          | .31%                          | .31%              | .31%             | .31%           |
| 120% AFR          | .34%                          | .34%              | .34%             | .34%           |
| 130% AFR          | .36%                          | .36%              | .36%             | .36%           |
| <i>Mid-term</i>   |                               |                   |                  |                |
| AFR               | 1.30%                         | 1.30%             | 1.30%            | 1.30%          |
| 110% AFR          | 1.44%                         | 1.43%             | 1.43%            | 1.43%          |
| 120% AFR          | 1.57%                         | 1.56%             | 1.56%            | 1.55%          |
| 130% AFR          | 1.70%                         | 1.69%             | 1.69%            | 1.68%          |
| 150% AFR          | 1.96%                         | 1.95%             | 1.95%            | 1.94%          |
| 175% AFR          | 2.29%                         | 2.28%             | 2.27%            | 2.27%          |
| <i>Long-term</i>  |                               |                   |                  |                |
| AFR               | 2.89%                         | 2.87%             | 2.86%            | 2.85%          |
| 110% AFR          | 3.18%                         | 3.16%             | 3.15%            | 3.14%          |
| 120% AFR          | 3.47%                         | 3.44%             | 3.43%            | 3.42%          |
| 130% AFR          | 3.76%                         | 3.73%             | 3.71%            | 3.70%          |

REV. RUL. 2012-13 TABLE 2

Adjusted AFR for May 2012

|                         | <i>Period for Compounding</i> |                   |                  |                |
|-------------------------|-------------------------------|-------------------|------------------|----------------|
|                         | <i>Annual</i>                 | <i>Semiannual</i> | <i>Quarterly</i> | <i>Monthly</i> |
| Short-term adjusted AFR | .27%                          | .27%              | .27%             | .27%           |
| Mid-term adjusted AFR   | 1.30%                         | 1.30%             | 1.30%            | 1.30%          |
| Long-term adjusted AFR  | 3.26%                         | 3.23%             | 3.22%            | 3.21%          |

REV. RUL. 2012-13 TABLE 3

Rates Under Section 382 for May 2012

|  |       |
|--|-------|
| Adjusted federal long-term rate for the current month  | 3.26% |
| Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.) | 3.26% |

REV. RUL. 2012-13 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for May 2012

Note: Under Section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%.

|  |       |
|--|-------|
| Appropriate percentage for the 70% present value low-income housing credit | 7.48% |
| Appropriate percentage for the 30% present value low-income housing credit | 3.21% |

REV. RUL. 2012-13 TABLE 5  
Rate Under Section 7520 for May 2012

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years,  
or a remainder or reversionary interest 1.6%

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**Section 1288.—Treatment  
of Original Issue Discount  
on Tax-Exempt Obligations**

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

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**Section 7520.—Valuation  
Tables**

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

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**Section 7872.—Treatment  
of Loans With Below-Market  
Interest Rates**

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2012. See Rev. Rul. 2012-13, page 878.

# Part IV. Items of General Interest

## Notice of Proposed Rulemaking and Notice of Public Hearing

### Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund

#### REG-136008-11

AGENCY: Internal Revenue Service (IRS), Treasury.

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

SUMMARY: This document contains proposed regulations that implement and provide guidance on the fees imposed by the Patient Protection and Affordable Care Act on issuers of certain health insurance policies and plan sponsors of certain self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund. These proposed regulations affect the issuers and plan sponsors that are directed to pay those fees. This document also contains a request for comments and provides notice of public hearing on these proposed regulations.

DATES: Written or electronic comments must be received by July 16, 2012. Requests to speak and outlines of topics to be discussed at the public hearing scheduled for Wednesday, August 8, 2012, at 10:00 a.m., must be received by July 30, 2012.

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG-136008-11), Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-136008-11), Courier's Desk Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC, or sent electronically via the IRS Internet site via the Federal eRulemaking Portal at [www.regulations.gov](http://www.regulations.gov) (IRS

REG-136008-11). 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 proposed regulations, Rebecca L. Baxter at (202) 622-3970 (regarding health insurance policies) or R. Lisa Mojiri-Azad at (202) 622-6080 (regarding self-insured health arrangements); concerning the submission of comments or the public hearing, Oluwafunmilayo (Funmi) Taylor at (202) 622-7180 (not toll-free numbers).

#### SUPPLEMENTARY INFORMATION:

##### Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:M:S, Washington, DC 20224. Comments on the collection of information should be received by July 16, 2012. Comments are specifically requested concerning:

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

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

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

Estimates of capital or start-up costs and costs of operation, maintenance, and

purchase of services to provide information.

The collections of information in these proposed regulations are in §46.4375-1(c)(2)(v) (use of National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit to calculate the fee under section 4375); §46.4375-1(c)(2)(vi) (use of certain state forms to calculate the fee under section 4375); §46.4376-1(b)(2)(G) (identification or designation of a plan sponsor under the governing plan document for certain applicable self-insured health plans); and §46.4376-1(c)(2)(v) (use of the Form 5500, "Annual Return/Report of Employee Benefit Plan," to calculate the fee under section 4376).

The collections of information under §46.4375-1(c)(2)(v), §46.4375-1(c)(2)(vi), and §46.4376-1(c)(2)(v) are intended to lower the burden on issuers and plan sponsors of calculating the average number of lives covered for the applicable policy year or plan year. The burden for the collection of information contained in these provisions will be reflected in the burden on the Form 720 "Quarterly Federal Excise Tax Return" after it is revised to include the reporting and payment of the fee imposed by sections 4375 and 4376.

The collection of information contained in §46.4376-1(b)(2)(G) is necessary to provide certain entities that establish or maintain an applicable self-insured health plan the flexibility to designate the person that will be responsible for reporting and paying the fee imposed by section 4376. The likely respondents are employers, employee organizations, or persons that establish or maintain an applicable self-insured health plan and are entitled to make an election under §46.4376-1(b)(2)(G).

Estimated number of respondents is 10,000.

Estimated average annual burden per respondent is 5 minutes.

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 contains proposed amendments to 26 CFR part 40 (Excise Tax Procedural Regulations) and 26 CFR part 46 (relating to excise taxes imposed on policies issued by foreign insurers and obligations not in registered form) to implement the requirements under sections 4375 through 4377 of the Internal Revenue Code (Code). Sections 4375 and 4376 of the Code impose fees on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans, and section 4377 contains special rules that apply to these issuers and plan sponsors with respect to these fees. Sections 4375, 4376, and 4377 were added to the Code by section 6301 of the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111–148 (124 Stat. 119 (2010)).

The Affordable Care Act includes provisions that promote research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of medical treatments, services, procedures, drugs, and other strategies or items that treat, manage, diagnose, or prevent illness or injury. One such provision relates to the establishment of the private, nonprofit corporation, the Patient-Centered Outcomes Research Institute (the “Institute”). The Institute will assist, through research, patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. The statute specifically prohibits the Secretary of Health and Human Services (HHS) from using the evidence or findings of the research conducted in determining coverage, reimbursement, or incentive programs unless it is through an iterative and transparent process which includes public comment and considers the effect on subpopulations. Nothing under this provision allows the Secretary of HHS to deny coverage of items or services solely on the basis of comparative

clinical effectiveness research. The statute provides that the Institute will not develop a dollars-per-quality-life-year estimate as a threshold to establish effective or recommended care. Section 6301 of the Affordable Care Act amended the Code by adding new section 9511 to establish the Patient-Centered Outcomes Research Trust Fund (the “Trust Fund”), which is the funding source for the Institute. Section 6301 of the Affordable Care Act also added new Code sections 4375, 4376, and 4377 to provide a funding source for the Trust Fund that is to be financed, in part, by fees to be paid by issuers of specified health insurance policies and sponsors of applicable self-insured health plans.

## Statutory Provisions

Section 4375(a) imposes a fee on an issuer of a specified health insurance policy for each policy year ending on or after October 1, 2012, and before October 1, 2019. Under section 4375(a), the fee is two dollars (one dollar in the case of policy years ending before October 1, 2013) multiplied by the average number of lives covered under the policy. Under section 4375(d), for policy years ending on or after October 1, 2014, the fee is increased based on increases in the projected *per capita* amount of National Health Expenditures. Section 4375(b) provides that the fee imposed by section 4375(a) shall be paid by the issuer of the policy.

Section 4375(c) defines *specified health insurance policy* as any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States. Section 4375(c)(2) excludes from a specified health insurance policy any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c). Section 4375(c)(3) provides that a specified health insurance policy includes any prepaid health coverage arrangement described in section 4375(c)(3)(B). An arrangement is described in section 4375(c)(3)(B) if, under the arrangement, fixed payments or premiums are received as consideration for a person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how the coverage is provided or arranged to be provided.

Section 4376 imposes a fee on a plan sponsor of an applicable self-insured health plan for each plan year ending on or after October 1, 2012, and before October 1, 2019. Under section 4376(a), the fee is two dollars (one dollar for plan years ending before October 1, 2013) multiplied by the average number of lives covered under the plan for the plan year. Under section 4376(d), for plan years ending on or after October 1, 2014, the fee is increased based on increases in the projected *per capita* amount of National Health Expenditures. Section 4376(b)(1) provides that the fee imposed by section 4376(a) shall be paid by the plan sponsor.

Section 4376(b)(2) defines *plan sponsor* as the employer in the case of a plan established or maintained by a single employer, or the employee organization in the case of a plan established or maintained by an employee organization. Section 4376(b)(2) also provides that, in the case of (1) a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, (2) a multiple employer welfare arrangement, or (3) a voluntary employees’ beneficiary association described in section 501(c)(9), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. Section 4376(b)(2) further provides that in the case of a plan established or maintained by a rural electric cooperative (as defined in section 3(40)(B)(iv) of the Employee Retirement Income Security Act of 1974 (ERISA)) or rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA), the plan sponsor is the cooperative or association that established or maintained the plan.

Section 4376(c) defines *applicable self-insured health plan* as any plan for providing accident or health coverage if any portion of the coverage is provided other than through an insurance policy, and the plan is established or maintained: (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a voluntary em-

employees' beneficiary association described in section 501(c)(9), (5) by any organization described in section 501(c)(6), or (6) if not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of ERISA), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

Section 4377 includes definitions and special rules that apply for purposes of sections 4375 and 4376. Section 4377(a)(1) defines *accident and health coverage* as any coverage that, if provided by an insurance policy, would cause the policy to be a specified health insurance policy (as defined in section 4375(c)).

Section 4377(b)(1)(B) provides that "[n]otwithstanding any other law or rule of law, governmental entities shall not be exempt from" the fee imposed by sections 4375 and 4376 unless the policy or plan is an exempt governmental program. Section 4377(b)(3) defines *exempt governmental program* as (1) any insurance program established under title XVIII of the Social Security Act (42 U.S.C. 1395 *et. seq.*) (Medicare), (2) the medical assistance program established by title XIX (42 U.S.C. 1396 *et. seq.*) (Medicaid) or title XXI of the Social Security Act (42 U.S.C. 1397aa *et. seq.*) (Children's Health Insurance Program), (3) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and (4) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act, 25 U.S.C. 1603). Under these special rules, a governmental entity (including a federally recognized Indian tribal government) that is the plan sponsor of an applicable self-insured health plan that does not meet the definition of an exempt governmental program must pay the fee imposed by section 4376.

Section 4377(c) provides that the fees imposed by sections 4375 and 4376 are treated as taxes for purposes of subtitle F of the Code.

### Notice 2011-35

On June 8, 2011, the IRS released Notice 2011-35, 2011-25 I.R.B. 879, which requested comments on how the fees imposed under sections 4375 and 4376 should be calculated and paid, including possible rules and safe harbors. The Treasury Department and the IRS received numerous comments in response to Notice 2011-35 and have considered all comments in drafting these proposed regulations. The relevant portions of Notice 2011-35 and comments are discussed in more detail in this preamble. See §601.601(d)(2).

### Explanation of Provisions

#### *Specified Health Insurance Policies Subject to the Fee under Section 4375*

The fee under section 4375 is imposed on the issuer of a specified health insurance policy. Under the proposed regulations, the fee must be calculated using the applicable dollar amount in effect for the policy year (for example, \$1 for policy years ending on or after October 1, 2012, and before October 1, 2013) and one of the permitted methods for determining the average number of lives covered under the policy during the policy year.

The term *specified health insurance policy* includes only accident and health insurance policies that are issued with respect to an individual residing in the United States. The proposed regulations clarify that for purposes of this fee, "an individual residing in the United States" means an individual who has a place of abode in the United States. The United States, for this purpose, includes American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and any other possession of the United States.

Commentators requested a bright-line rule for determining whether an individual covered by a policy is residing in the United States. Many commentators suggested that issuers should be able to rely on the address on file for the primary insured to determine whether individuals covered by the policy are residing in the United States. The Treasury Department and the IRS recognize that the address on file for the primary insured may be the only information the insurer has with respect to the

residence of the individuals covered under the policy, and also that the address on file is likely the place of abode for most, if not all, of the covered individuals. Accordingly, the proposed regulations provide that if the address on file with the issuer or plan sponsor for the primary insured is outside of the United States, the issuer or plan sponsor may treat the primary insured and the primary insured's spouse, dependents, or other beneficiaries covered under the policy as having the same place of abode and not residing in the United States. For this purpose, the term "primary insured" refers to the individual eligible for coverage other than due to his or her status as a spouse, dependent, or other beneficiary of another insured individual (for example, in the case of a group health plan for employees, the individual eligible for coverage due to his or her status as an employee).

Several commentators also suggested that expatriate policies not be considered specified health insurance policies for purposes of the fee because the policies are issued principally to cover employees who do not reside in the United States. Commentators argued that expatriate policies are predominantly group health insurance policies sold to employers for a unique subset of their employees, the substantial majority of whom are living outside the United States while working for the employer. According to these commentators, only a small minority of the individuals covered under these expatriate policies may be foreign nationals working for the employer in the United States. For these reasons, the proposed regulations provide that the term "specified health insurance policy" does not include any group policy issued to an employer if the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the United States.

Commentators requested that the regulations provide that stop loss and indemnity reinsurance policies not be considered specified health insurance policies. Commentators argued that stop loss and indemnity reinsurance policies are not providing coverage for lives covered; rather, these types of policies are intended to limit the original obligor's financial exposure. Section 4375 imposes a fee based on the average number of lives covered. Be-



cause stop loss and indemnity reinsurance policies generally do not provide coverage based upon the number of lives covered, the proposed regulations provide that for purposes of section 4375, these policies are not specified health insurance policies subject to the fee under section 4375. No inference is intended as to whether stop loss or indemnity reinsurance policies may constitute health insurance policies for other purposes.

Commentators raised questions about the description of prepaid health coverage arrangements in section 4375(c)(3)(B) and requested that the regulations clarify which types of arrangements are covered by that section. One commentator suggested that the language in section 4375(c)(3)(B) is intended to describe health maintenance organizations and similar arrangements, noting that the definition of “health insurance,” which was added to ERISA, the Public Health Service Act, and the Code by the Health Insurance Portability and Accountability Act of 1996, Public Law 104–191 (110 Stat. 1936 (1996)), was specifically drafted to include health maintenance organizations and similar arrangements. The Treasury Department and the IRS agree that the language in section 4375(c)(3)(B) describes health maintenance organizations and similar organizations; therefore, the proposed regulations clarify that the description in section 4375(c)(3)(B) covers any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract.

#### *Self-insured Health Plans and Plan Sponsors Subject to the Fee under Section 4376*

The fee under section 4376 is imposed on the plan sponsor of an applicable self-insured health plan. Under the statute and these proposed regulations, the fee must be calculated using the applicable dollar amount in effect for the plan year (for example, \$1 for plan years ending on or after October 1, 2012, and before

October 1, 2013) and one of the permitted methods for determining the average number of lives covered under the plan during the plan year.

These proposed regulations provide that an applicable self-insured health plan is a plan that is established or maintained by a plan sponsor for the benefit of employees, former employees, members, former members, or other eligible individuals to provide accident and health coverage (within the meaning of §46.4377–1(a)(1) of these proposed regulations), any portion of which is provided other than through an insurance policy and that meets certain other conditions. The proposed regulations provide that an applicable self-insured health plan does not include an exempt governmental program (as defined in section 4377(c)(3)) but does include a plan that is established or maintained solely for the benefit of former employees (commonly referred to as a retiree-only plan).<sup>1</sup> A self-insured health plan that does not provide coverage described in section 4376(c) is not an applicable self-insured health plan. For example, a self-insured group health plan of a Federally recognized Indian tribal government that provides coverage only to tribal members that are not employees of the Indian tribal government would not be an applicable self-insured health plan, unless it otherwise falls within one of the statutory definitions of an applicable self-insured health plan (for example, the plan is established or maintained by a section 501(c)(6) organization).

Notice 2011–35, 2011–25 I.R.B. 879 invited comments on the type or types of health flexible spending arrangements (as described in section 106(c)(2)) (health FSAs) and health reimbursement arrangements (as described in Notice 2002–45, 2002–2 C.B. 93, (HRAs) that would be excluded from the definition of an applicable self-insured health plan because they provide the kind of coverage that, if provided by an insurance policy, would not cause the policy to be treated as a specified health insurance policy, as defined in

section 4375(c). Health FSAs and HRAs are both self-insured health plans.<sup>2</sup> See §601.601(d)(2).

Commentators generally requested that all health FSAs and HRAs be excluded from the definition of applicable self-insured health plan under section 4376. Commentators also suggested that because the majority of health FSAs or HRAs are provided in connection with a major medical plan, they should be excluded from the fee imposed by section 4376 to avoid the fee from being imposed twice with respect to the same individual. Some of the commentators also observed that there would be challenges arising from the possibility that an employer may lack information on the number of dependents whose medical expenses are eligible for reimbursement from an employee’s health FSA or HRA.

Some commentators requested that if HRAs were not excluded from the definition of applicable self-insured health plan, the guidance limit the fee under section 4376 to HRAs that are not offered in connection with a major medical plan or permit treatment of an HRA that is offered in connection with a major medical plan as a single applicable self-insured health plan to avoid the fee applying twice with respect to individuals covered by a major medical plan and a related HRA.

The proposed regulations do not exclude all health FSAs and HRAs from the definition of an applicable self-insured health plan under section 4376. In response to comments, however, these proposed regulations provide that multiple self-insured arrangements established and maintained by the same plan sponsor and with the same plan year are subject to a single fee. Accordingly, an HRA is not subject to a separate fee under section 4376 if the HRA is integrated with another applicable self-insured health plan that provides major medical coverage, provided that the HRA and the other plan are established or maintained by the same plan sponsor. However, section 4375 imposes a separate fee on the issuer of a specified health insurance policy. Con-

<sup>1</sup> Sections 4375 and 4376 may apply to a retiree-only plan because, although section 9832 excludes group health plans that have less than two participants who are current employees (such as retiree-only plans) from the requirements of chapter 100 (which includes a number of requirements added by the Affordable Care Act), this exclusion does not apply to sections 4375 and 4376 because these sections are in chapter 34. In addition, section 4376(c)(2)(A) indicates explicitly that an applicable self-insured health plan includes a plan established or maintained by one or more employers for the benefit of their employees or former employees.

<sup>2</sup> Archer Medical Savings Accounts (Archer MSAs) under section 220(d) and Health Savings Accounts (HSAs) under section 223(d) are tax-favored trusts for the purpose of paying the qualified medical expenses of the account beneficiary. Archer MSAs and HSAs are generally neither health insurance policies nor self-insured health plans and thus are not subject to the taxes under sections 4375 and 4376.

sistent with the statutory structure which separates the fee with respect to health insurance policies from the fee with respect to self-insured plans, the proposed regulations provide that an HRA that is integrated with an insured group health plan is treated as an “applicable self-insured health plan” the plan sponsor of which is subject to the fee under section 4376, while the issuer of the group insurance policy for the insured group health plan is subject to the fee under section 4375, even though the HRA and the insured group health plan are maintained by the same plan sponsor.

These proposed regulations reflect the special rule in section 4375(c)(2), which is carried over to self-insured arrangements through the definition of “accident and health coverage” in section 4377(a)(1), that a specified health insurance policy does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c). The proposed regulations provide that a health FSA that satisfies the requirements of an excepted benefit under section 9832(c) is excluded from the definition of an “applicable self-insured health plan” and therefore is not subject to the fee imposed by section 4376. (See §54.9831-1(c)(3)(v), relating to additional rules on health FSAs that are excepted benefits.) A health FSA that does not satisfy the requirements to be treated as an excepted benefit is an applicable self-insured health plan subject to the fee imposed by section 4376 (and, for purposes of the rules in the preceding paragraph, is treated the same as an integrated HRA).

In addition, to address the concerns raised about the availability of information on the lives covered under an HRA or health FSA, the proposed regulations contain a special rule permitting the plan sponsor to assume one covered life for each employee with an HRA and for each employee with a health FSA that is not an excepted benefit.

Commentators also requested that an employee assistance program (EAP) or wellness arrangement be exempt from the fee. Commentators argued that generally, under an EAP or wellness arrangement, benefits for medical care are secondary or incidental to non-medical benefits. In response, these proposed regulations exclude from the definition of applicable

self-insured health plan an EAP, disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment.

For each type of applicable self-insured health plan identified in section 4376(c), the plan sponsor is the person responsible for the payment of the fee. Section 4376(b)(2) provides that in the case of a plan established or maintained by a single employer, the plan sponsor is the employer, and in the case of a plan established or maintained by a single employee organization, the plan sponsor is the employee organization. Section 4376 does not contain rules that would treat related entities as a single entity. Accordingly, for example, under these proposed regulations, a plan that is maintained by multiple related employers is not a plan that is established or maintained by a single employer, but, for section 4376 purposes, is considered a plan that is established or maintained by two or more employers.

In the case of a plan maintained by two or more employers, the proposed regulations provide that the plan sponsor is the person identified as the plan sponsor by the terms of the document under which the plan is operated, or the employer designated as the plan sponsor for purposes of section 4376 by the terms of the document under which the plan is operated (provided that such designation is made, and that employer has consented to the designation, by no later than the due date of the return under section 4376 for that plan year is required to be filed, after which date such designation for that plan year may not be changed or revoked, and provided further that an employer may be designated as the plan sponsor only if that employer is one of the employers maintaining the plan). In the absence of the identification or designation of a plan sponsor by the terms of the document under which the plan is operated, the proposed regulations provide that the plan sponsor is each employer that maintains the plan (with respect to employees of that employer). Because the plan sponsor may be designated on or before the due date for filing the Form 720, “*Quarterly Federal Excise Tax Return*,” for the plan year, and under these proposed regulations the first potential due date for filing the Form 720 is July 31, 2013, this rule provides related employers that pro-

vide coverage for their employees under a single plan ample time to designate a plan sponsor if the employers wish to consolidate the filing and the payment of the fee under section 4376. In the absence of designation of a plan sponsor in the governing plan document, the proposed regulations provide that the plan sponsor is each employer that maintains the plan (with respect to employees of that employer), and therefore each employer would be required to file its own Form 720, reflecting the section 4376 fee applicable to that employer as a plan sponsor with respect to its employees.

As discussed in Notice 2011-35 and earlier in the section of this preamble entitled “Statutory Provisions,” section 4377(b) provides that the fee imposed by section 4376 applies to a governmental entity that establishes or maintains an applicable self-insured health plan (other than a plan that qualifies as an exempt governmental program) for its employees. These proposed regulations provide that a governmental entity that establishes or maintains an applicable self-insured health plan for its current or former employees is the plan sponsor for purposes of the fee imposed by section 4376. Thus, these proposed regulations require that a governmental entity (including a Federally recognized Indian tribal government) that establishes or maintains an applicable self-insured health plan (other than a plan that qualifies as an exempt governmental program) must calculate, report, and pay the fee under section 4376 in accordance with the guidance in these proposed regulations.

Several commentators requested that the guidance clarify that, in the case of an applicable self-insured health plan that is established or maintained by a board of trustees, plan assets (for example, amounts held in a trust) or the employer contributions to the plan could be used to pay the fee under section 4376. Because the use of plan assets to pay the fee under section 4376 may have implications under various state and Federal laws (including, for example, ERISA’s fiduciary provisions), the question of what the permissible sources of funds are for paying the fee under section 4376 is an issue that is outside the scope of these proposed regulations. The Treasury Department and the IRS have consulted the Department of Labor

concerning comments on the appropriate sources to pay the fee under section 4376. The Department of Labor has advised the Treasury Department and the IRS that it is considering permissible funding sources for these fee payments by plan sponsors that are subject to ERISA's fiduciary provisions.

#### *Calculation of the Fee Under Section 4375*

The fee imposed on an issuer of a specified health insurance policy under section 4375 is based on the average number of lives covered under the policy. Notice 2011-35 invited comments on reasonable methods an issuer may use to determine the average number of lives covered under a policy. Notice 2011-35 also invited comments on whether guidance should provide a safe harbor for issuers that are required to file the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (Exhibit). In particular, the Treasury Department and the IRS outlined a potential safe harbor based on the number of lives reported on the most recently filed Exhibit or based on the average of the covered lives reported on the most recently filed Exhibit and the immediately preceding Exhibit.

Commentators generally favored a safe harbor that allows issuers to calculate the average number of lives covered under the policy based on data reported on the Exhibit but expressed concerns with exclusive reliance upon covered lives data on the Exhibit. According to the instructions to the Exhibit, the term "covered lives" means the total number of lives insured, including dependents, at any time during the reporting period, which means the Exhibit captures all lives covered without regard to how long the coverage lasted. Several commentators recommended that the regulations allow issuers to use member months data reported in the Exhibit. The Exhibit defines the term "member months," as the sum of the number of lives covered on a single day in every month. Commentators argued that dividing the member months data by 12 (the number of months in a reporting period) is a more accurate measure of the average number of lives covered because it better reflects that some individuals may only be insured for part of the year.

Commentators noted that some entities are not required to file the Exhibit, but must provide comparable forms to their applicable state regulators. Commentators recommended that the proposed regulations permit issuers to use information included in any other report filed with a state government.

Some commentators suggested that the regulations allow issuers to determine the average number of lives covered by counting the actual number of lives covered during the policy year. Other commentators requested that the regulations allow the use of any reasonable formula or other method to determine the average number of lives covered, including a formula or method that historically has been used by the issuer for other business purposes.

The proposed regulations provide issuers the choice of using any of four alternative methods to determine the average number of lives covered under policies that it issues for purposes of the fee imposed by section 4375. First, an issuer may determine the average number of lives covered under a policy for a policy year by calculating the sum of lives covered for each day of the policy year and dividing that sum by the number of days in the policy year (the actual count method). Second, an issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered on one date in each quarter of the policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made (the snapshot method). Third, as an alternative to determining the average number of lives covered under each individual policy for its respective policy year, an issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the "member months" reported on the Exhibit divided by 12 (the member months method). Fourth, an issuer that is not required to file the Exhibit may determine the average number of lives covered under all of its policies in effect for a calendar year using data in any form that is equivalent to the Exhibit that is filed with the state of domicile if the state form reports lives covered in the same manner as member months is reported on the Exhibit (the state form method). For this purpose, an equivalent form includes only a form that

reports all the lives covered under the policy (including, for example, spouses, dependents, and other beneficiaries, as applicable).

The proposed regulations direct an issuer to apply a single method in determining the average number of lives covered under the policy for the year. In addition, issuers must use the same method of counting lives for all policies reported on a single return. Issuers using the actual count or snapshot method may change to the snapshot or actual count method from one policy year to the next. For example, an issuer with a policy that has a policy year that ends on June 30, Policy A, may determine lives covered under Policy A for July 1, 2013 to June 30, 2014, using the actual count method if the issuer uses the actual count method for all policies for which a liability will be reported on the Form 720, "Quarterly Federal Excise Tax Return," due by July 31, 2015 (the due date for the return that will include the July 2013 to June 2014 policy year for Policy A, as discussed in the section of this preamble entitled "Application of Excise Tax Procedural Rules (Filing of Returns and Payment of Fees)"). The issuer may change its method for determining lives covered under Policy A to the snapshot method for the July 1, 2014, to June 30, 2015 policy year, provided that the snapshot method is used for all policies for which a liability will be reported on the return due by July 31, 2016 (the due date for the return that will include the July 2014 to June 2015 policy year for Policy A).

While the actual count and snapshot methods count lives covered on a policy-by-policy basis for each policy having a policy year that ends in the reporting period (which is based on the calendar year), the member months and state form methods count all lives covered during the calendar year for all policies in effect during the calendar year irrespective of when actual policy years end. For example, for a policy with a policy year that ends on June 30, member months will include lives covered under that policy from January 1 to December 31 and aggregate those lives covered with all other lives covered for the calendar year under all policies in effect during the calendar year. To convert the lives covered from the member months to the total lives covered under a particular

policy for a policy year is administratively burdensome. Accordingly, the proposed regulations provide that an issuer using the member months or state form method must use that method for all policies for all years for which the fee applies. The Treasury Department and the IRS solicit comments on whether there should be an exception to this rule for issuers of calendar-year only policies who want to switch from the member months or state form method to the actual count or snapshot method and, if so, how to address the transition in methods for the 2012 and 2019 calendar years.

Commentators noted that for 2012 and 2019 a partial year adjustment will be needed because the member months data, which uses the calendar year for all policies, will include in the member months for 2012 and 2019 lives covered under policies with a policy year that ends before October 1, 2012, or after September 30, 2019, which are policies to which the fee under section 4375 does not apply. The Treasury Department and the IRS also understand that the data reported on state forms is generally also based on the calendar year. To adjust for 2012 and 2019, the proposed regulations adopt a *pro rata* approach for calculating the average number of lives covered using the member months method or the state form method for 2012 and 2019. For example, the member months number for 2012 is divided by 12 and the resulting number is multiplied by one-quarter to arrive at the average number of lives covered for October through December 2012. The proposed regulations further treat the amount calculated under this *pro rata* approach as the average number of lives covered for policies with policy years that end on or after October 1, 2012, and before January 1, 2013. Similar rules are provided for 2019.

The Treasury Department and the IRS understand that these proposed regulations are being issued after the beginning of some policy years to which the fee under section 4375 will apply. Because issuers that do not use the member months method or state form method may not have started counting lives covered for policy years that end on or after October 1, 2012, but that began before May 14, 2012, issuers using the actual count method may be-

gin counting lives covered under a policy as of May 14, 2012, rather than the first day of the policy year, and divide by the appropriate number of days remaining in the policy year. Similarly, for policy years that end on or after October 1, 2012, but that began before May 14, 2012, issuers using the snapshot method may use counts from quarters beginning on or after May 14, 2012, to determine the average number of lives covered under the policy. The Treasury Department and the IRS intend for these rules to facilitate compliance for the initial policy years covered by section 4375. Comments are requested as to whether any additional transition rules under section 4375 are needed for this purpose.

#### *Calculation of the Fee Under Section 4376*

The fee imposed on a plan sponsor of an applicable self-insured health plan under section 4376 is based on the average number of lives covered under the plan. Notice 2011-35 invited comments on reasonable methods that could reduce administrative burdens on plan sponsors that must compute the average number of lives covered under an applicable self-insured health plan. Notice 2011-35 also invited comments on safe harbors that would permit a plan sponsor to determine the average number of covered lives under the plan using a formula based on the number of participants and one or more additional factors that account for the number of dependents without requiring that every actual dependent covered under the plan be counted.

Commentators generally favored using reasonable simplifying methods and safe harbors to determine the average number of lives covered under the plan. Some commentators suggested that the guidance permit the use of snapshot data to determine the number of lives taken into account for calculating the average number of lives covered during the plan year. Commentators also suggested that plan sponsors be permitted to determine the average number of lives covered during the year based on information reported on the plan's Form 5500, "Annual Return/Report of Employee Benefit Plan."

Commentators generally recognized that a method that is based on Form 5500 reporting will have limited application because the requirement to file a Form 5500 does not apply to all plan sponsors that are subject to the fee under section 4376. These commentators also noted that the Form 5500 does not include information on the number of lives (participants and dependents) covered under the plan during the plan year, but rather includes information only on the number of participants on the first day and last day of the plan year. Accordingly, the information reported on the Form 5500 would need to be converted to a number that accurately represents the average number of covered lives under the plan for the plan year.

To make it easier for plan sponsors to determine the average number of lives covered under the plan for the plan year, these proposed regulations provide plan sponsors a choice to use any of three alternative methods. First, a plan sponsor may determine the average number of lives covered under the plan for the plan year by calculating the sum of the lives covered for each day of the plan year and dividing that sum by the number of days in the plan year (the actual count method). Second, a plan sponsor may determine the average number of lives covered under the plan for the plan year by adding the totals of lives covered on one date in each quarter, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made (the snapshot method). For this purpose, the number of lives covered on a date may be determined as equal to either the sum of the actual number of lives covered on the dates (the snapshot count method) or the sum of (1) the number of participants with self-only coverage on that date, plus (2) the product of the number of participants with coverage other than self-only coverage on the date and 2.35 (the snapshot factor method).<sup>3</sup> The Treasury Department and the IRS request comments on additional sources of data that could be used to calculate a more accurate conversion factor.

Third, a plan sponsor may determine the average number of lives covered under the plan for the plan year based on a for-

<sup>3</sup> The 2.35 dependency factor reflects that all participants with coverage other than self-only have coverage for themselves and some number of dependents. The Treasury Department and the IRS developed the factor, and other similar factors used in the regulations, in consultation with Treasury Department economists and in consultation with plan sponsors regarding the procedures they currently use for estimating the number of covered individuals.

mula that includes the number of participants actually reported on the Form 5500 for the applicable self-insured health plan for the plan year (the Form 5500 method). For a plan providing only self-only coverage, under the Form 5500 method the plan sponsor may treat the average number of covered lives under the plan for a plan year as the sum of the total participants at the beginning and the end of the plan year, in each case as reported on the Form 5500, divided by two.

For plans providing coverage that is not limited to the self-only coverage, the Form 5500 does not identify whether the coverage is self-only or family (or some other non-self-only coverage). Therefore, the number of participants reported on the Form 5500 generally is converted to covered lives by multiplying the number of participants on each date by a factor of 2.0. (This factor is lower than the 2.35 factor used in the snapshot factor method because this factor takes into account participants with self-only coverage that covers one life, as well as participants with other coverage that covers two or more lives.) Accordingly, under the Form 5500 method for plans that provide coverage not limited to self-only coverage, a plan sponsor may simply add the number of participants reported for the beginning of the plan year to the number reported for the end of the plan year to determine the average number of covered lives for the plan year. The Treasury Department and the IRS request comments on additional sources of data that could be used to calculate a more accurate conversion factor.

The proposed regulations direct a plan sponsor to apply a single method in determining the average number of lives covered under the plan for the entire plan year. However, a plan sponsor is not required to use the same method from one plan year to the next.

The Treasury Department and the IRS understand that these proposed regulations are being issued after the beginning of some plan years to which the fee under section 4376 will apply. Therefore, these proposed regulations include a special rule for the fee under section 4376 applicable for a plan year that ends on or after October 1, 2012, and began before July 11, 2012. Because self-insured plans generally are not required to complete the Exhibit or determine the number

of covered lives for other regulatory purposes, under this special rule, a plan sponsor may use any reasonable method to determine the average number of lives covered under the plan for purposes of calculating the fee under section 4376 for those plan years. For more information about the return filing requirements and payment of the fees, see the section in this preamble entitled “Application of Excise Tax Procedural Rules (Filing of Returns and Payment of Fees).”

#### *Application of Subtitle F*

In accordance with section 4377(c), references in subtitle F (section 6001–7874) to “taxes imposed by this title,” “internal revenue tax,” and similar references apply to the fees imposed by sections 4375 and 4376. For example, the fees imposed by sections 4375 and 4376 are assessed pursuant to section 6201, collected pursuant to sections 6301, 6321, and 6331, enforced pursuant to section 7602, subject to examination and summons pursuant to section 7602, and subject to confidentiality rules pursuant to section 6103, in the same manner as other taxes imposed by the Code.

Sections 4375 and 4376 are in chapter 34 of the Code (Taxes on Certain Insurance Policies). The deficiency procedures of sections 6211–6216 apply only to income, estate, and gift taxes imposed by subtitle A (Income Taxes) and B (Estate and Gift Taxes) and the excise taxes imposed by chapters 41–44. Because sections 4375 and 4376 are in chapter 34, the deficiency procedures do not apply to the fee. Thus, the IRS may assess and collect the fees using the procedures in subtitle F without regard to the restrictions on assessment in section 6213 (relating to petitions to the Tax Court).

#### *Application of Excise Tax Procedural Rules (Filing of Returns and Payment of Fees)*

The Excise Tax Procedural Regulations in 26 CFR part 40 contain rules for depositing, paying, and return filing for a number of excise taxes, including the excise taxes in chapter 34.

Under existing rules for chapter 34 excise taxes, taxpayers pay and report these taxes quarterly on Form 720, “*Quarterly Federal Excise Tax Return*,” by the last day of the first calendar month following the

calendar quarter for which it is filed. The proposed regulations amend this rule so that issuers and plan sponsors will report and pay the section 4375 and 4376 fees only once a year on Form 720, which will be due by July 31 of each year. A person that files a Form 720 only to report liability imposed by section 4375 or 4376 is not required to file a Form 720 at other times during the year. A return will generally cover policy years (section 4375) and plan years (section 4376) that end during the preceding calendar year, or in the case of an issuer that determines the average number of lives covered for purposes of section 4375 using the member months method or the state form method, the return is for all policies in effect during the previous calendar year. The instructions for Form 720 inform filers how and when to file and pay. These instructions require that the filer (the issuer or plan sponsor, as applicable) have an Employer Identification Number (EIN) to use in filing the Form 720.

Most excise taxes reported on Form 720 are required to be deposited semimonthly. However, these proposed regulations do not require semimonthly deposits of the fee imposed by section 4375 or 4376; rather, full payment of the fee is due annually by the July 31 due date of Form 720.

Any claim for a refund of the section 4375 or 4376 fees must be filed on Form 8849, “*Claim for Refund of Excise Taxes*,” or Form 720X, “*Amended Quarterly Federal Excise Tax Return*,” in accordance with the instructions for those forms.

These proposed regulations do not impose any specific recordkeeping requirements for calculating the fees under sections 4375 and 4376. However, see the instructions for Form 720 for general information on recordkeeping requirements.

The IRS will revise the current Form 720 to reflect these fees.

#### *Electronic Filing of Returns*

Form 720 may be filed electronically. For more information on e-file, see [www.irs.gov/efile](http://www.irs.gov/efile). Although electronic filing of the Form 720, “*Quarterly Federal Excise Tax Return*,” is not required, the IRS encourages taxpayers to file the Form 720 electronically. Electronic filing of Form 720 is quick and easy, and it will allow the IRS to provide expedited and improved service and reliability to

taxpayers while reducing processing time and errors. Forms 720 can be submitted on-line. A taxpayer wishing to file the Form 720 electronically must submit it through an approved transmitter software developer. The IRS has posted on its website contact information for all approved Form 720 e-file transmitters at <http://www.irs.gov/efile/lists/0,,id=176152,00.html>. To electronically file the Form 720, taxpayers will incur the cost of the provider's required service fee for online submission.

### *Third-Party Reporting and Payments*

Notice 2011-35 requested comments on the ability of third parties to act on behalf of a plan sponsor in complying with the requirements of the fee under section 4376. A number of commentators suggested that guidance should permit third parties to act on behalf of a plan sponsor in reporting and paying the fee. Most of these commentators requested that the Treasury Department and the IRS establish a special reporting and filing regime for third parties that is different than the regime for plan sponsors. Although the IRS has established limited third-party reporting and payment regimes in certain instances (see for example, Rev. Proc. 2007-38, 2007-1 C.B. 1442), the IRS does not intend to adopt such a program for the fee under section 4375 or the fee under section 4376 because the benefits of such a program would be outweighed by the administrative burdens, particularly given the limited period over which the fee will apply. See §601.601(d)(2).

### **Proposed Effective Date**

These regulations are proposed to apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019. Issuers and plan sponsors may rely on these proposed regulations for guidance pending the issuance of final regulations. Final regulations will be effective as of the date these proposed regulations are published in the **Federal Register**. If and to the extent future guidance is more restrictive than the guidance in these proposed regulations, the future guidance will be applied without retroactive effect.

### **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 13653. Therefore, a regulatory assessment is not required. It is hereby certified that these proposed regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that small businesses generally do not have self-insured health plans and that these regulations will therefore primarily affect large corporations. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. The Treasury Department and the IRS specifically solicit comments from any party, particularly affected small entities, on the accuracy of this certification. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comments on its impact on small business.

### **Comments and Public Hearing**

Before these proposed regulations are adopted as final regulations, consideration will be given to any written or electronic comments that are submitted timely to the IRS. The Treasury Department and the IRS request comments on all aspects of the proposed rules. All comments will be available for public inspection and copying.

A public hearing has been scheduled for August 8, 2012, beginning at 10:00 a.m. in room the auditorium of the Internal Revenue Building, 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 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 written or electronic comments and an outline of the topics to be discussed and the time to be devoted to each topic by July 30, 2012. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the 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 authors of these regulations are Rebecca L. Baxter, Office of Associate Chief Counsel (Financial Institutions & Products), and R. Lisa Mojiri-Azad, Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the Treasury Department and the IRS participated in their development.

\* \* \* \* \*

### **Proposed Amendments to the Regulations**

Accordingly, 26 CFR parts 40 and 46 are proposed to be amended as follows:

#### **PART 40—EXCISE TAX PROCEDURAL REGULATIONS**

Paragraph 1. The authority citation for part 40 continues to read in part as follows:

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

Par. 2. Section 40.0-1 is amended as follows:

1. Paragraph (a) is amended by removing from the third sentence the language "chapter 34 to taxes imposed on policies issued by foreign insurers" and adding "chapter 34 to taxes imposed on certain insurance policies" in its place, and adding a new sentence after the third sentence to read as follows:

#### *§40.0-1 Introduction*

(a) \* \* \* References in this part to "taxes" also include references to the fees imposed by sections 4375 and 4376. \* \* \*

Par. 3. Section 40.6011(a)-1 is amended by:

1. In paragraph (a)(2)(i), first sentence, the language “paragraph (b) of this section” is removed and the language “paragraphs (b) and (c) of this section” is added in its place.

2. Paragraph (c) is added.

The addition reads as follows:

*§40.6011(a)–1 Returns.*

\* \* \* \* \*

(c) *Fees on health insurance policies and self-insured health plans—(1) In general.* A return that reports liability imposed by section 4375 or 4376 is a return for policies or plans with policy or plan years ending in the previous calendar year, or for issuers that determine the average number of lives covered under a policy for purposes of section 4375 using the member months method under §46.4375–1(c)(2)(v) or the state form method under §46.4375–1(c)(2)(vi), the return is for all policies in effect during the previous calendar year. The second sentence of paragraph (a)(2)(i) of this section (relating to filing quarterly returns regardless of whether liability is incurred) does not apply to a person that files a Form 720, “Quarterly Federal Excise Tax Return,” only to report liability imposed by section 4375 or 4376.

(2) *Effective/applicability date.* This paragraph (c) is applicable on April 17, 2012. This paragraph (c) applies to returns that report liability imposed by section 4375 or 4376 for all policies and plans to which section 4375 or 4376 applies.

Par. 4. Section 40.6071(a)–1 is amended as follows:

1. Paragraph (c) is revised.

2. Paragraph (d) is added.

The revision and addition read as follows:

*§40.6071(a)–1 Time for filing returns.*

\* \* \* \* \*

(c) *Fees on health insurance policies and self-insured health plans.* A return that reports liability for the fee imposed by section 4375 must be filed by July 31 of the calendar year immediately following the last day of the policy year. For issuers that determine the average number of lives covered under the policy for section 4375 using the member months method under §46.4375–1(c)(2)(v) or the state

form method under §46.4375–1(c)(2)(vi), the return must be filed by July 31 of the immediately following calendar year. A return that reports liability for the fee imposed by section 4376 for a plan year must be filed by July 31 of the calendar year immediately following the last day of the plan year. Thus, for example, a return that reports liability for the fee imposed by section 4375 for the year ending on December 31, 2012, must be filed by July 31, 2013. As another example, a return that reports liability for the fee imposed by section 4376 for the plan year ending on January 31, 2013, must be filed by July 31, 2014.

(d) *Effective/applicability date.* Paragraph (c) of this section is applicable on April 17, 2012. Paragraphs (a) and (b) of this section apply to returns for calendar quarters beginning on or after October 1, 2001, and paragraph (c) of this section applies to returns that report liability imposed by section 4375 or 4376 for all policies and plans to which section 4375 or 4376 applies.

**§40.6091–1 [Amended]**

Par. 5. Section 40.6091–1(a) is amended by removing the language “paragraph (b) of this section, quarterly returns” and by adding the language “paragraphs (b) and (c) of this section, returns” in its place.

Par. 6. Section 40.6302(c)–1 is amended by revising the section heading and paragraph (e)(1)(iv) to read as follows:

*§40.6302(c)–1 Use of Government depositaries.*

\* \* \* \* \*

(e) \* \* \*

(1) \* \* \*

(iv) Sections 4375 and 4376 (relating to fees on health insurance policies and self-insured health plans).

\* \* \* \* \*

**PART 46—EXCISE TAX ON CERTAIN INSURANCE POLICIES AND OBLIGATIONS NOT IN REGISTERED FORM**

Par. 7. The authority citation for part 46 continues to read in part as follows:

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

Par. 8. In part 46, the heading is revised to read as set forth above.

**§46.0–1 [Amended]**

Par. 9. In §46.0–1, first sentence, the language “policies issued by foreign insurers” is removed and the language “certain insurance policies” is added in its place.

**§46.0–2 [Removed]**

Par. 10. Section 46.0–2 is removed.

Par. 11. In Part 46, subpart C is redesignated as subpart D and a new subpart C is added to read as follows:

**Subpart C—Fees on insured and self-insured health plans**

*§46.4375–1 Fee on Issuers of Specified Health Insurance Policies.*

(a) *In general.* An issuer of a specified health insurance policy is liable for a fee imposed by section 4375 for policy years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides definitions that apply for purposes of section 4375 and this section. Paragraph (c) of this section provides rules for calculating the fee under section 4375. Paragraph (d) of this section provides the effective/applicability date. For rules relating to filing the required return and paying the fee, see §§40.6011(a)–1 and 40.6151(a)–1.

(b) *Definitions.* The following definitions apply for purposes of section 4375 and this section. See also §46.4377–1 for additional definitions.

(1) *Specified health insurance policy—(i) In general.* Except as provided in paragraph (b)(1)(ii) of this section and §46.4377–1, *specified health insurance policy* means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States (as defined in §46.4377–1(a)(2)), including certain prepaid health coverage arrangements as described in paragraph (b)(2) of this section.

(ii) *Exceptions.* The term *specified health insurance policy* does not include—

(A) Any insurance policy if substantially all of its coverage is of excepted benefits described in section 9832(c);

(B) Any group policy issued to an employer where the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the United States (see §46.4377-1(a)(3)); or

(C) Any stop loss or indemnity reinsurance policy.

(iii) *Stop loss policy.* For purposes of paragraph (b)(1)(ii) of this section, *stop loss policy* means an insurance policy in which—

(A) The insurer that issues the policy to a person establishing or maintaining a self-insured health plan becomes liable for all, or an agreed upon portion of, losses that person incurs in covering the applicable lives in excess of a specified amount; and

(B) The person establishing or maintaining the self-insured health plan retains its liability to, and its contractual relationship with, the applicable lives covered.

(iv) *Indemnity reinsurance policy.* For purposes of paragraph (b)(1)(ii), *indemnity reinsurance policy* 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 applicable lives covered.

(2) *Prepaid health coverage arrangement.* The term *prepaid health coverage arrangement* means an arrangement under which fixed payments or premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to individuals residing in the United States, regardless of how such coverage is provided or arranged to be provided. For example, any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract is a specified health insurance policy.

(c) *Calculation of fee—(1) In general.* The amount of the fee for a policy for a policy year is equal to the product of the average number of lives covered under the policy for the policy year (determined in accordance with paragraphs (c)(2) and (c)(3) of this section) and the applicable dollar amount (determined in accordance

with paragraph (c)(4) of this section). For purposes of computing the fee under this paragraph (c), in the case of an issuer that determines the average number of lives covered for all policies in effect during a calendar year using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section, the applicable dollar amount with respect to such issuer's policies for such calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year (determined in accordance with paragraph (c)(4) of this section), except that the applicable dollar amount with respect to such an issuer's policies for calendar year 2019 shall be the applicable dollar amount for policy years ending on September 30, 2019. For more information, see the examples in paragraphs (c)(2)(iii)(B), (c)(2)(iv)(B), (c)(2)(v)(B), and (c)(2)(vi)(B) of this section.

(2) *Determination of the average number of lives covered under a policy—(i) In general.* To determine the average number of lives covered under a specified health insurance policy during a policy year, an issuer must use one of the following methods—

(A) The actual count method (described in paragraph (c)(2)(iii) of this section);

(B) The snapshot method (described in paragraph (c)(2)(iv) of this section);

(C) The member months method (described in paragraph (c)(2)(v) of this section); or

(D) The state form method (described in paragraph (c)(2)(vi) of this section).

(ii) *Consistency requirements.* An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, "*Quarterly Federal Excise Tax Return*," for a particular year, the issuer must use the same method of computing lives covered. An issuer that determines the average number of lives covered by using the actual count method described in paragraph (c)(2)(iii) of this section or the snapshot method described in paragraph (c)(2)(iv) of this section may change its method of computing the average lives covered to the snapshot method or actual count method, provided that the issuer uses the same method for computing the aver-

age lives covered for all policies for which a liability is reported on the Form 720 for that year. For example, an issuer with a policy having a policy year that ends on June 30, Policy A, may determine the average number of lives covered under Policy A for July 1, 2013, to June 30, 2014, using the actual count method if the issuer uses the actual count method for all policies for which a liability will be reported on the Form 720 due by July 31, 2015 (the due date for return that will include the liability for the July 2013 to June 2014 policy year for Policy A). The issuer may change its method for determining the average number of lives covered under Policy A to the snapshot method for the July 1, 2014, to June 30, 2015, policy year, provided that the snapshot method is used for all policies for which a liability will be reported on the Form 720 due by July 31, 2016 (the due date for return that will include the liability for the July 2014 to June 2015 policy year for Policy A). An issuer that determines the average number of lives covered by using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section must use the same method for calculating lives covered for all policy years for which the fee applies.

(iii) *Actual count method—(A) Calculation method.* An issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered for each day of the policy year and dividing that total by the number of days in the policy year.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iii)(A) of this section:

*Example.* Insurance Company A issues three policies that are in effect during 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company A must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company A chooses to use the actual count method under paragraph (c)(2)(iii)(A) of this section to determine average lives covered for policies having a policy year that ends in 2014. Insurance Company A calculates the sum of lives covered under Policy A for each day of the policy year ending November 30, 2014, as 3,285,000. The average number of lives covered under Policy A for the policy year ending November 30, 2014,



is 3,285,000 divided by 365, or 9,000. Insurance Company A calculates the sum of lives covered under Policy B for each day of the policy year ending February 28, 2014, as 547,500. The average number of lives covered under Policy B for the policy year ending on February 28, 2014, is 547,500 divided by 365, or 1,500. Insurance Company A calculates the sum of lives covered under Policy C for each day of the policy year ending December 31, 2014, as 4,380,000. The average number of lives covered under Policy C for the policy year ending December 31, 2014, is 4,380,000 divided by 365, or 12,000. To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company A must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the average number of lives covered for that policy. Insurance Company A then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(iv) *Snapshot method*—(A) *Calculation method*. An issuer may determine the average number of lives covered under a policy for a policy year by adding the totals of lives covered on one date in each quarter of the policy year, or more dates if an equal number of dates is used for each quarter, and dividing that total by the number of dates on which a count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, or the first day of each month).

(B) *Example*. The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iv)(A) of this section:

*Example*. Insurance Company B issues three policies that are in effect during 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Company A must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company B chooses to determine its average lives covered using the snapshot method for all policies that have a policy year that ends in 2014 and chooses to count lives covered on the first day of each quarter of the policy years. On December 1, 2013, Policy A covers 8,900 lives covered, on March 1, 2014, 9,100 lives covered, on June 1, 2014, 9,050 lives covered, and on September 1, 2014, 9,050 lives covered. Insurance Company B treats the average number of lives covered under Policy A for the policy year ending November 30, 2014, as 36,100 (8,900 + 9,100 + 9,050 + 9,050) divided by 4, or 9,025. On March 1, 2013, Policy B covers 1,500 lives covered, on June 1, 2013, 1,350 lives covered, on September 1, 2013, 1,400 lives covered, and on December 1, 2013, 1,550 lives covered. Insurance Company B treats the average number of lives

covered under Policy B for the policy year ending February 28, 2014, as 5,800 (1,500 + 1,350 + 1,400 + 1,550) divided by 4, or 1,450. On January 1, 2014, Policy C covers 12,500 lives covered, on April 1, 2014, 12,250 lives covered, on July 1, 2014, 12,000 lives covered, and on October 1, 2014, 11,250 lives covered. Insurance Company B treats the average number of lives covered under Policy C for the policy year ending December 31, 2014, as 47,750 (12,500 + 12,250 + 12,000 + 11,250) divided by 4, or 12,000. To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company B must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the number of average lives covered for that policy. Insurance Company B then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(v) *Member months method*—(A) *Calculation method*. An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12.

(B) *Example*. The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

*Example*. Insurance Company C chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the member months method of paragraph (c)(2)(v)(A) of this section. Insurance Company C reports 12,000,000 as its member months on the NAIC Supplemental Health Care Exhibit filed for calendar year 2013. Under the member months method, Insurance Company C calculates the average number of lives covered for all its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company C multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(vi) *State form method*—(A) *Calculation method*. An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state of domicile and a method similar to that described in para-

graph (c)(2)(v) of this section, if the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

(B) *Example*. The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(vi)(A) of this section:

*Example*. Insurance Company D is not required to file the NAIC Supplemental Health Care Exhibit, but files a form with its state of domicile. Insurance Company D chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the state form method of paragraph (c)(2)(vi)(A) of this section. The state form reports the number of lives covered in the same manner as member months is reported on the NAIC Supplemental Health Care Exhibit. For calendar year 2013, Insurance Company D reports 12,000,000 as its equivalent member months on the state form. Under the state form method, Insurance Company D calculates the average number of lives covered for all of its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (equivalent member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company D multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(3) *Special rules for the first year and the last year the fee is in effect*—(i) *Calculation of the average number of lives covered under the policy for the first year the fee is in effect*. For issuers that determine the average number of lives covered using data reported on the 2012 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2012 calendar year, the average number of lives covered under all policies in effect for the 2012 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by 1/4. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the actual count method under paragraph (c)(2)(iii) of this section may calculate the average number of lives covered using data from the period beginning May 14, 2012, through the end of the policy year. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers

that determine the average number of lives covered using the snapshot method under paragraph (c)(2)(iv) of this section may calculate the average number of lives covered using dates from the quarters remaining in the policy year starting on or after May 14, 2012. If an abbreviated year is used, the issuer will divide the number of lives covered by the number of days from May 14, 2012, through the end of the policy year (for the actual count method) or the number of days on which a count was made (for the snapshot method).

(ii) *Calculation of the average number of lives covered under the policy for the last year the fee is in effect.* For issuers that determine the average number of lives covered using data reported on the 2019 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2019 calendar year, the average number of lives covered for all policies in effect during the 2019 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by 3/4. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after January 1, 2019, and before October 1, 2019.

(iii) *Example.* The following examples illustrate the principles of paragraph (c)(3) of this section:

*Example 1.* Insurance Company E issues Group Health Insurance Policy C, which has a policy year that ends on November 30, 2012. Insurance Company E determines the average number of lives covered under a policy by using the actual count method. Under that method, for that policy year, Insurance Company E calculates the sum of lives covered under Policy C for each day between May 14, 2012, and November 30, 2012 as 10,000. The average number of lives covered under Policy C for that policy year is 10,000 divided by the number of days from May 14, 2012 through November 30, 2012. Alternatively, Insurance Company E could have counted the number of lives covered for the entire policy year and divided the sum by 365.

*Example 2.* Insurance Company F reports 12,000,000 as its member months on its NAIC Supplemental Health Care Exhibit filed for calendar year 2012. Under the member months method, Insurance Company F calculates the average number of lives covered for 2012 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), and then multiplying the result (1,000,000) by 1/4, which equals 250,000. Accordingly, the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013, is 250,000.

(4) *Applicable dollar amount.* For policy years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is \$1. For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is \$2. For any policy years ending in any fiscal year beginning on or after October 1, 2014, the applicable dollar amount is the sum of—

(i) The applicable dollar amount for the policy year ending in the previous fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for the policy year ending in the previous fiscal year; and

(B) The percentage increase in the projected *per capita* amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the fiscal year.

(d) *Effective/applicability date.* This section is effective on April 17, 2012. This section applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019.

#### *§46.4376–1 Fee on sponsors of self-insured health plans.*

(a) *In general.* A plan sponsor of an applicable self-insured health plan is liable for a fee imposed by section 4376 for plans with plan years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides the definitions that apply for purposes of section 4376 and this section. Paragraph (c) of this section provides the requirements for calculating the fee imposed by section 4376. Paragraph (d) of this section provides the effective/applicability date. For rules relating to filing the required return and paying the fee, see §§40.6011(a)–1 and 40.6151(a)–1.

(b) *Definitions.* The following definitions apply for purposes of section 4376 and this section. See §46.4377–1 for additional definitions.

(1) *Applicable self-insured health plan*—(i) *In general.* Except as provided in paragraph (b)(1)(ii) of this section and §46.4377–1, *applicable self-insured health plan* means a plan that provides for accident or health coverage (within the

meaning of §46.4377–1(a)) if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained—

(A) By one or more employers for the benefit of their employees or former employees;

(B) By one or more employee organizations for the benefit of their members or former members;

(C) Jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees;

(D) By a voluntary employees' beneficiary association, as described in section 501(c)(9);

(E) By an organization described in section 501(c)(6); or

(F) By a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA)), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural cooperative association (as defined in section 3(40)(B)(v) of ERISA).

(ii) *Exceptions.* The term *applicable self-insured health plan* does not include any of the following:

(A) A plan that provides benefits substantially all of which are excepted benefits, as defined in section 9832(c). For example, a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) that satisfies the requirements to be treated as an excepted benefit under section 9832(c) (see also §54.9831–1(c)(3)(v)) is not an applicable self-insured health plan. A health FSA that is not treated as an excepted benefit under section 9832(c) is an applicable self-insured health plan.

(B) An employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

(iii) *Multiple self-insured arrangements established or maintained by the same plan sponsor.* For purposes of section 4376, two or more arrangements established or maintained by the same plan sponsor that provides for accident and health coverage (within the meaning of §46.4377–1(a)) other than through an insurance policy and that have the same plan year may be treated as a sin-

gle applicable self-insured health plan for purposes of calculating the fee imposed by section 4376. For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits, and a separate self-insured arrangement with the same plan year providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan. Similarly, if a plan sponsor provides a Health Reimbursement Arrangement (HRA) that is integrated with another applicable self-insured health plan that provides major medical coverage, the HRA and the major medical plan may be treated as one applicable self-insured health plan.

(2) *Plan sponsor*—(i) *In general.* The term *plan sponsor* means —

(A) The employer, in the case of an applicable self-insured health plan established or maintained by a single employer;

(B) The employee organization, in the case of an applicable self-insured health plan established or maintained by an employee organization;

(C) The joint board of trustees, in the case of a multiemployer plan (as defined in section 414(f));

(D) The committee, in the case of a multiple employer welfare arrangement;

(E) The cooperative or association that establishes or maintains an applicable self-insured health plan established or maintained by a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA) or rural cooperative association (as defined in section 3(40)(B)(v) of ERISA);

(F) The trustee, in the case of an applicable self-insured health plan established or maintained by a voluntary employees' beneficiary association (meaning that the voluntary employees' beneficiary association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person); or

(G) In the case of an applicable self-insured health plan the plan sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, the person identified by the terms of the document under which the plan is operated as the plan sponsor, or the person designated by terms of the document under which the plan is

operated as the plan sponsor for section 4376 purposes, provided that designation is made, and that person has consented to the designation, by no later than the date by which the return paying the fee under section 4376 for that plan year is required to be filed, after which date that designation for that plan year may not be changed or revoked, and provided further that a person may be designated as the plan sponsor only if the person is one of the persons maintaining the plan (for example, one of the employers that is maintaining the plan with one or more other employers or employee organizations).

(H) In the case of an applicable self-insured health plan the sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, and for which no identification or designation of a plan sponsor has been made pursuant to paragraph (b)(2)(i)(G) of this section, each employer that maintains the plan (with respect to employees of that employer), each employee organization that maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative or association that maintains the plan, meaning that each plan sponsor must file a separate Form 720, "Quarterly Federal Excise Tax Return," reflecting its separate liability under section 4376.

(ii) *Example.* The following examples illustrate the principles of paragraph (b)(2) of this section:

*Example 1.* Employer XYZ is a holding company with no employees that owns all the issued and outstanding shares of Employer X, Employer Y, and Employer Z. Employer X, Employer Y, and Employer Z have established the XYZ Group Health Plan to provide accident and health coverage, provided other than through an insurance policy, for the benefit of their employees. The XYZ Group Health Plan has a calendar year plan year. In addition, there is no plan sponsor identified or designated in the plan document. As a self-insured health plan for employees of two or more employers, the XYZ Group Health Plan is an applicable self-insured health plan under section 4376(c)(2)(A) and paragraph (b)(1)(i)(A) of this section. However, a plan sponsor is not identified or designated in the governing plan document. Accordingly, the plan sponsor for purposes of section 4376 is identified under paragraph (b)(2)(i)(H) of this section as Employer X, Employer Y, and Employer Z, each with respect to its own employees covered under the plan. Accordingly, Employer X, Employer Y, and Employer Z each must file a Form 720 reflecting their separate liabilities under section 4376, calculated based upon lives covered that are employees of that employer, or spouses, dependents, or other beneficiaries of employees of that employer and the applicable dollar amount in effect for the plan year.

*Example 2.* The same facts as *Example 1*, except that the governing plan document designates Employer X as the plan sponsor of the XYZ Group Health Plan for purposes of the fee under section 4376. Accordingly, the plan sponsor for purposes of section 4376 is identified under paragraph (b)(2)(i)(G) of this section as Employer X. Employer X must file a Form 720 reflecting liabilities under section 4376, calculated based upon lives covered that are employees of Employer X, Employer Y, or Employer Z, or spouses, dependents, or other beneficiaries of employees of those employers and the applicable dollar amount in effect for the plan year.

(c) *Calculation of fee*—(1) *In general.* The amount of the fee for a plan year is equal to the product of the average number of lives covered under the plan for the plan year (determined in accordance with paragraph (c)(2) of this section) and the applicable dollar amount (determined in accordance with paragraph (c)(3) of this section). For more information, see the examples in paragraphs (c)(2)(iii)(B), (c)(2)(iv)(D), and (c)(2)(v)(B) of this section.

(2) *Determination of the average number of covered lives under the plan*—(i) *In general.* To determine the average number of lives covered under an applicable self-insured health plan during a plan year, a plan sponsor must use one of the following—

(A) The actual count method (described in paragraph (c)(2)(iii) of this section);

(B) The snapshot dates method (described in paragraph (c)(2)(iv) of this section); or

(C) The Form 5500 method (described in paragraph (c)(2)(v) of this section).

(ii) *Consistency within plan year.* A plan sponsor must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. However, a plan sponsor may use a different method from one plan year to the next.

(iii) *Actual count method*—(A) *Calculation method.* A plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered for each day of the plan year and dividing that total by the number of days in the plan year.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iii)(A) of this section:

*Example.* Employer A is the plan sponsor of the Employer A Self-Insured Health Plan, which has a calendar year plan year. Employer A calculates the sum of covered lives under the plan for

each day of the plan year ending December 31, 2013 as 3,285,000. The average number of covered lives under the plan for the plan year ending December 31, 2013 is 3,285,000 divided by 365, or 9,000. To calculate the section 4376 fee for the plan under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer A must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

(iv) *Snapshot methods—(A) In general.* A plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter, and dividing that total by the number of dates on which a count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.). For purposes of this paragraph (c)(2)(iv), the number of lives covered on a designated date may be determined using either the snapshot factor method described in paragraph (c)(2)(iv)(B) of this section or the snapshot count method described in paragraph (c)(2)(iv)(C) of this section.

(B) *Snapshot factor method.* Under the snapshot factor method, the number of lives covered on a date is equal to the sum of the number of participants with self-only coverage on that date, plus the product of the number of participants with coverage other than self-only coverage on the date and 2.35.

(C) *Snapshot count method.* Under the snapshot count method, the number of lives covered on a date equals the actual number of lives covered on the designated date.

(D) *Examples.* The following examples illustrate the principles of paragraphs (c)(1) and (c)(2)(iv) of this section:

*Example 1.* Employer B is the plan sponsor of the Employer B Self-Insured Health Plan, which has a calendar year plan year. Employer B has designated the first day of each quarter of the plan year as the date that Employer B counts the covered lives under the Employer B Self-Insured Health Plan. On January 1, 2013, Employer B Self-Insured Health Plan covers 2,000 covered lives, on April 1, 2013, 2,100 covered lives, on July 1, 2013, 2,050 covered lives, and on October 1, 2013, 2,050 covered lives. Under the snapshot count method, Employer B must determine the average number of covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as  $8,200 (2,000 + 2,100 + 2,050 + 2,050)$  divided by 4, or 2,050. To

calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

*Example 2.* Same facts as *Example 1*, except Employer B determines the number of covered lives not covered by self-only coverage based on the number of participants with coverage other than self-only multiplied by 2.35 (the factor set forth in (c)(2)(iv) of this section). On January 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 1, 2013 and October 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees. Under the snapshot factor method, Employer B must determine the average number of covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as  $9,988 [(600+(800 \times 2.35)) + (608 + (800 \times 2.35)) + (610 + (809 \times 2.35)) + (610 + (809 \times 2.35))]$  divided by 4, or 2,497. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

(v) *Form 5500 method—(A) Calculation method.* A plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of reportable participants for the Form 5500, “Annual Return/Report of Employee Benefit Plan,” that is filed for the applicable self-insured health plan for that plan year. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering only self-only coverage equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the applicable self-insured health plan, divided by 2. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the applicable self-insured health plan.

(B) *Examples.* The following examples illustrate the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

*Example 1.* Employer C is the plan sponsor of the Employer C Self-Insured Health Plan, which has a fiscal year plan year ending on July 31, 2013 and offers only self-only coverage. Employer C files a Form 5500 for the Employer C Self-Insured Health Plan for the plan year ending July 31, 2013 reflecting 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the plan year. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of covered lives for the plan year ending July 31, 2013 as equal to the sum of 4,000 and 4,200 or 8,200, divided by 2, or 4,100. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

*Example 2.* Same facts as *Example 1*, except that the Employer C Self-Insured Health plan offers self-only coverage and family coverage. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of covered lives for the plan year ending July 31, 2013 as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

(vi) *Special rule for health FSAs and HRAs.* For purposes of this section, if a plan sponsor does not maintain an applicable self-insured health plan other than a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) or a health reimbursement arrangement (as described in Notice 2002-45, 2002-2 C.B. 93) (HRA), the plan sponsor may treat each participant’s health FSA or HRA as covering a single covered life (and therefore the plan sponsor is not required to include as covered lives any spouse, dependent, or other beneficiary of the individual participant in the health FSA or HRA, as applicable). If a health FSA or HRA that is an applicable self-insured health plan has the same plan sponsor as another applicable self-insured health plan other than a health FSA or HRA, the two arrangements may be treated as a single plan under paragraph (b)(1)(iii) of this section. However, the special counting rule in this paragraph applies only for purposes of the health FSA or HRA and, therefore, applies only for purposes of the participants in the health FSA or HRA that do not participate in the other applicable self-insured health plan. (The participants in the health FSA or HRA that participate in the other ap-

plicable self-insured health plan will be counted in accordance with the method applied for counting lives under that other plan as described in paragraph (b)(2)(i) of this section.) See §601.601(d)(2).

(vii) *Special rule for the first year the fee is in effect.* Notwithstanding paragraph (c)(2)(i) of this section, for plan years beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

(3) *Applicable dollar amount.* For plan years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is \$1. For plan years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is \$2. For any plan year ending in any fiscal year beginning on or after October 1, 2014, the applicable dollar amount is equal to the sum of—

(i) The applicable dollar amount for plan years ending in the previous fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for plan years ending in the previous fiscal year; and

(B) The percentage increase in the projected *per capita* amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the fiscal year.

(d) *Effective/applicability date.* This section is effective on April 17, 2012. This section applies for plan years that end on or after October 1, 2012, and before October 1, 2019.

#### §46.4377-1 Definitions and special rules.

(a) *Definitions.* The following definitions apply for purposes of sections 4375 and 4376 and §§46.4375-1 and 46.4376-1.

(1) *Accident and health coverage.* The term *accident and health coverage* means any coverage that, if provided by an insurance policy, would cause such policy to be a specified health policy (as defined in section 4375(c)).

(2) *Individual residing in the United States*—(i) The term *individual residing in*

*the United States* means an individual with a place of abode in the United States.

(ii) *Determination of place of abode.* For purposes of paragraph (a)(2) of this section, an issuer or a plan sponsor may rely on the most recent address on file with the issuer or plan sponsor and may treat the primary insured and the primary insured's spouse, dependents, or other beneficiaries covered by the policy, as having the same place of abode. For this purpose, the primary insured is the individual covered by the policy other than due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual.

(3) *United States.* The term *United States* includes American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and any other possession of the United States.

(4) *Fiscal year.* The term *fiscal year* means the year beginning on October 1 and ending on the following September 30.

(b) *Treatment of exempt governmental programs*—(1) *In general.* The fees imposed by sections 4375 and 4376 do not apply to any covered life under an exempt governmental program as defined in paragraph (b)(2) of this section.

(2) *Exempt governmental program.* For purposes of this section, *exempt governmental program* means any—

(i) Insurance program established under title XVIII of the Social Security Act;

(ii) Medical assistance program established by title XIX or XXI of the Social Security Act;

(iii) Program established by Federal law for providing medical care (other than through insurance policies) to individuals (or their spouses and dependents) by reason of such individuals being (or having been) members of the Armed Forces of the United States; and

(iv) Program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

(c) *Effective/applicability date.* This section is effective on April 17, 2012. This section applies to all policies and plans to which section 4375 or 4376 applies.

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

(Filed by the Office of the Federal Register on April 12, 2012, 4:15 p.m., and published in the issue of the Federal Register for April 17, 2012, 77 F.R. 22691)

## Notice of Proposed Rulemaking

### Allocation of Earnings and Profits in Tax-Free Transfers from One Corporation to Another

#### REG-141268-11

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations under section 312 of the Internal Revenue Code (Code). The proposed regulations clarify the regulations under section 312 regarding the allocation of earnings and profits in tax-free transfers from one corporation to another. The proposed regulations affect corporations involved in these transfers and their shareholders.

DATES: Written or electronic comments and requests for a public hearing must be received by July 16, 2012.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-141268-11), Room 5203, 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-141268-11), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC. Submissions may also be sent electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (IRS REG-141268-11).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Stephanie D. Floyd at (202) 622-7930 or Isaac W. Zimbalist at (202) 622-7550 (not toll-free numbers); concerning submissions of comments and/or requests for a public hearing, Oluwafunmilayo (Fummi) Taylor, at 202-622-7180.

SUPPLEMENTARY INFORMATION:

**Background and Explanation of Provisions**

This document contains proposed amendments to 26 CFR part 1 concerning the allocation of earnings and profits in tax-free transfers from one corporation to another. The IRS has historically interpreted the regulations under section 312 as providing that the earnings and profits of the transferor corporation do not move to the transferee in whole or in part other than in a transfer described in section 381 or, to the extent provided under §1.312–10, in a divisive reorganization. Furthermore, the IRS has interpreted the regulations to provide that in a corporate reorganization described in section 381, the acquiring corporation, as defined in §1.381(a)–1(b)(2), succeeds to the full earnings and profits account of the transferor corporation. Thus, the earnings and profits account is not divided if the acquiring corporation in an acquisitive asset reorganization subsequently transfers target assets to one or more controlled subsidiaries. Practitioners have suggested that this result may be unclear under current law. See §1.381(c)(2)–1(d) (providing that where part of the acquired assets is transferred to one or more controlled corporations, or all of the acquired assets are transferred to two or more controlled corporations, the allocation of earnings and profits is made without regard to section 381); §1.312–11(a) (providing for proper adjustment and allocation of earnings and profits with respect to asset transfers in connection with reorganizations, and cross-referencing the section 381 regulations for specific rules).

Consistent with the longstanding administrative position, the proposed regulations clarify that, except as provided in §1.312–10, if property is transferred from one corporation to another and no gain or loss is recognized, no allocation of the earnings and profits of the transferor is made to the transferee unless the transfer is described in section 381(a). The proposed regulations further clarify that, in a transfer described in section 381(a), only the acquiring corporation, as defined in §1.381(a)–1(b)(2), succeeds to the earnings and profits of the distributor or trans-

feror corporation (within the meaning of §1.381(a)–1(a)).

The IRS and Treasury Department believe the proposed rule is appropriate because earnings and profits measures the capacity of a corporation to pay dividends to its shareholders and the corporation that has an interest, directly or indirectly, in all of the target’s assets has the dividend-paying capacity that is most comparable to that of the target. Further, the IRS and Treasury Department believe the rules for the allocation of earnings and profits should conform to the rules for the allocation of other tax attributes under section 381.

**Special Analyses**

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these proposed regulations, and because these regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, these regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

**Comments and Requests for Public Hearing**

Before these 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. All comments will be available for public inspection and copying. A public hearing will be scheduled if requested in writing by any person that timely submits written or electronic comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

**Drafting Information**

The principal author of these proposed regulations is Stephanie D. Floyd of the Office of Associate Chief Counsel

(Corporate). Other personnel from the IRS and Treasury Department participated in their development.

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**Proposed Amendments to the Regulations**

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

**PART 1—INCOME TAXES**

Paragraph 1. The authority citation for part 1 continues to read, in part, as follows:  
Authority: 26 U.S.C. 7805 \* \* \*

Par. 2. Section 1.312–11 is amended by revising paragraph (a) and adding paragraph (e) to read as follows:

*§1.312–11 Effect on earnings and profits of certain other tax-free exchanges, tax-free distributions, and tax-free transfers from one corporation to another.*

(a) In a transfer described in section 381(a), the acquiring corporation, as defined in §1.381(a)–1(b)(2), and only that corporation, succeeds to the earnings and profits of the distributor or transferor corporation (within the meaning of §1.381(a)–1(a)). Except as provided in §1.312–10, in all other cases in which property is transferred from one corporation to another and no gain or loss is recognized (or is recognized only to the extent of the property received other than that permitted to be received without the recognition of gain), no allocation of the earnings and profits of the transferor is made to the transferee.

\* \* \* \* \*

(e) *Effective/Applicability date.* Paragraph (a) of this section applies to transactions occurring on or after the date of publication of the Treasury decision adopting this rule as a final regulation in the **Federal Register**.

**§1.381(c)(2)–1(d) [Removed]**

Par. 3. Section 1.381(c)(2)–1(d) is removed.

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

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## **U.S.-Germany Agreement on Pensions Announcement 2012–21**

The following is a copy of the Competent Authority Agreement (“the Agreement”) entered into on March 19, 2012, by the Competent Authorities of the United States and Germany, regarding the eligibility of certain pension arrangements for benefits under Article 10(3)(b) of the Convention Between the United States of America and Germany for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital and to Certain Other Taxes, together with a related Protocol signed on August 29, 1989, and amended by the Protocol signed on June 1, 2006.

The text of the Agreement is as follows:

### **COMPETENT AUTHORITY AGREEMENT**

The Competent Authorities of the Federal Republic of Germany and the United States of America hereby enter into the following agreement (the “Agreement”) regarding the eligibility of certain pension arrangements for benefits under paragraph 3(b) of Article 10 (Dividends) of the Convention Between the United States of America and Germany for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital and to Certain Other Taxes, together with a related Protocol signed on August 29, 1989, and amended by the Protocol signed on June 1, 2006 (the “Treaty”). The Agreement is entered into under paragraph 3 of Article 25 (Mutual Agreement Procedure) of the Treaty.

It is understood that for purposes of the Agreement, the term “Article” refers to an Article of the Treaty.

Article 10(3)(b) provides that dividends shall not be taxed in the Contracting State of which the company paying the dividends is a resident if the beneficial owner of the dividends is a pension fund that is a resident of the other Contracting State, provided that such dividends are not derived from the carrying on of a business, directly or indirectly, by such pension fund.

Article 10(11) provides that for purposes of Article 10, the term “pension fund” means any person that: (a) is established under the laws of a Contracting State; (b) is established and maintained in that Contracting State primarily to administer or provide pensions or other similar remuneration, including social security payments, disability pensions and widow’s pensions or to earn income for the benefit of one or more of such persons; and (c) is either, in the case of the United States, exempt from tax in the United States with respect to the activities described in subparagraph (b) or, in the case of Germany, a plan the contributions to which are eligible for preferential treatment under the Income Tax Act.

Paragraph 8(b) of the Protocol to the Treaty, as amended by the Protocol signed on June 1, 2006, provides that in the case of Germany, it is understood that Article 10(3)(b) applies to the person treated as the owner of the assets of the pension fund under section 39 of the Fiscal Code, provided the dividends may only be used for providing retirement benefits through such fund.

In order to provide certainty for taxpayers, the competent authorities of Germany and the United States clarify the treatment of a contractual trust arrangement (CTA) established by an employer to hold assets set aside to fund the employer’s simple employer sponsored pension plan (SESP). Provided that the SESP meets all of the requirements set out in section 6a of the German Income Tax Act and that the assets of the CTA are treated as owned by the employer under section 39 of the German Fiscal Code, then dividends derived by the CTA are eligible for benefits under Article 10(3)(b), if all other requirements of the Treaty are satisfied. In such a case, the employer that establishes the CTA shall make the claim for benefits under Article 10(3)(b).

The competent authorities of Germany and the United States also clarify that the term “pension fund” within the meaning of Article 10(11) includes the following entities and that dividends derived by such entities are eligible for benefits under Article 10(3)(b), as if the entity is the beneficial owner of the dividends, if all other requirements of the Treaty are satisfied:

1. A special German investment fund to which the provisions of the German Investment Act (Investmentgesetz) apply, provided such fund is established exclusively to hold the assets of one or more of the following:
  - a. A pension fund within the meaning of Article 10(11) that is established in Germany, or
  - b. A CTA established by an employer to hold assets set aside to fund the employer's SESP provided the assets of the CTA are treated as owned by the employer under section 39 of the Fiscal Code.
2. A group trust described in IRS Revenue Ruling 81-100, as modified by IRS Revenue Rulings 2004-67 and 2011-1, provided that all of its participants are pension funds within the meaning of Article 10 (11) that are established in the United States.
3. A common trust fund (within the meaning of Internal Revenue Code section 584) provided that all of its participants are pension funds within the meaning of Article 10(11) that are established in the United States.

In the case of an entity described in paragraph 1), the investment management company (Kapitalanlagegesellschaft) shall make the claim for benefits under Article 10(3)(b) on behalf of the investment fund. In the case of entities described in paragraphs 2) or 3), the trustee of the group trust or common trust fund, as the case may be, shall make the claim for benefits under Article 10(3)(b) on behalf of the group trust or common trust fund.

Agreed to by the undersigned competent authorities:

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Michael Danilack  
U.S. Competent Authority

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[NAME]  
German Competent Authority

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**Deletions From Cumulative  
List of Organizations  
Contributions to Which  
are Deductible Under Section  
170 of the Code**

**Announcement 2012-22**

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the Service will not disallow deductions for contributions made to a listed organization on or before the date of announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the Service is not precluded from disallowing a deduction for any contributions made after an or-

ganization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, contributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on May 7, 2012, and would end on the date the court first determines that the organization is not described in section 170(c)(2) as more particularly set forth in section 7428(c)(1). For individual contributors, the maximum deduction protected is \$1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in

whole or in part, for the acts or omissions of the organization that were the basis for revocation.

Big Hope, Inc.  
Elon, NC

Freedom Debt Management, Inc.  
Boca Raton, FL

Lost Cherokee of Arkansas & Missouri, Inc.  
Conway, AR

Marlowe Education Foundation, Inc.  
Idaho Falls, ID

Richard E. Feldhake Support Foundation Trust  
Phoenix, AZ

Successful Dreams Equestrian Center  
Fitchburg, MA



# 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.

## Numerical Finding List<sup>1</sup>

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### Announcements:

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<sup>1</sup> A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2011–27 through 2011–52 is in Internal Revenue Bulletin 2011–52, dated December 27, 2011.

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<sup>1</sup> A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2011–27 through 2011–52 is in Internal Revenue Bulletin 2011–52, dated December 27, 2011.

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