Internal Revenue
bulletin

Bulletin No. 2014–33
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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

REG–104579–13, page 370.

These proposed regulations provide further guidance on the premium tax credit. In particular, the regulations allow certain victims of domestic abuse or spousal abandonment to claim the premium tax credit while filing a return using the Married Filing Separately filing status. In addition, the proposed regulations provide special allocation rules for reconciling advance credit payments, address the indexing in future years of certain amounts used to compute the credit, and describe the coordination between the credit and the deduction under section 162(l) for health insurance costs of self-employed individuals. Comments and requests for a public hearing must be received by October 27, 2014.

REG–107012–14, page 371.

These proposed regulations provide a permissible method of accounting for gains and losses on shares in certain money market funds. They also clarify that an exception to certain information reporting requirements applies to sales of shares in these money market funds. Written or electronic comments must be received by October 27, 2014.

Rev. Proc. 2014–37, page 363.

This Revenue Procedure provides the methodology to determine the applicable percentage table in § 36B(b)(3)(A) of the Internal Revenue Code used to calculate an individual's premium assistance credit amount for taxable years beginning after calendar year 2014. It also provides the methodology to determine the required contribution percentage in § 36B(c)(2)(C)(i)(II) used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage for purposes of § 36B for plan years beginning after calendar year 2014. Additionally, Revenue Procedure 2014–37 reproduces the required contribution percentage, as determined under guidance issued by the Department of Health and Human Services, used to determine whether an individual is eligible for an exemption from the individual shared responsibility payment because of a lack of affordable minimum essential coverage under § 5000A(e)(1)(A) for plan years beginning after calendar year 2014.

Rev. Proc. 2014–41, page 364.

Rev. Proc. 2014–41 provides calculation methods a taxpayer may use to resolve the interrelationship between the section 162(l) deduction and the premium tax credit under section 36B. It provides an iterative calculation and alternative calculation taxpayers may use, as well as examples demonstrating the calculations.

Rev. Proc. 2014–46, page 367.

This Revenue Procedure provides the 2014 monthly national average premium for qualified health plans that have a bronze level of coverage for taxpayers to use in determining their maximum individual shared responsibility payment under § 5000A(c)(1)(B) of the Internal Revenue Code and § 1.5000A–4 of the Income Tax Regulations. The revenue procedure also provides an explanation of the methodology used to determine the monthly national average premium amount.

T.D. 9681, page 340.

These final regulations provide guidance regarding the deductibility of start-up expenditures and organizational expenses for partnerships following a termination of a partnership under section 708(b)(1)(B). Specifically, these final regulations provide that the new partnership is required to continue to amortize those expenditures using the same amortization period adopted by the terminating partnership These final regulations affect partnerships that undergo section 708(b)(1)(B) terminations and their partners.

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Finding Lists begin on page ii.
Index for July through August begins on page iv.

Department of the Treasury
Internal Revenue Service

T.D. 9682, page 342.

This document contains final regulations relating to basis of indebtedness of S corporations to their shareholders. These regulations provide that S corporation shareholders increase their basis of indebtedness of the S corporation to the shareholder only if the indebtedness is bona fide. The final regulations affect shareholders of S corporations.

T.D. 9683, page 330.

These temporary and final regulations provide further guidance on the premium tax credit. In particular, the regulations allow certain victims of domestic abuse or spousal abandonment to claim the premium tax credit while filing a return using the Married Filing Separately filing status. In addition, the regulations provide special allocation rules for reconciling advance credit payments, address the indexing in future years of certain amounts used to compute the credit, and describe the coordination between the credit and the deduction under section 162(l) for health insurance costs of self-employed individuals.

EXCISE TAX

REG–123286–14, page 377.

These proposed regulations modify the definition of controlled group for purposes of the branded prescription drug fee. These proposed regulations affect persons engaged in the business of manufacturing or importing certain branded prescription drugs. Comments and requests for a public hearing must be received by October 27, 2014.

T.D. 9684, page 345.

This document contains final regulations that provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescriptions drugs. This document also withdraws the Branded Prescription Drug Fee temporary regulations and contains new temporary regulations regarding the definition of controlled group that apply January 1, 2015.

The IRS Mission

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

Introduction

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

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

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

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

The Bulletin is divided into four parts as follows:

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

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

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

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

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

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

Section 36.—Refundable Credit for Coverage under a Qualified Health Plan

26 CFR 1.36B–2: Premium Assistance Amount.

TD 9683

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Rules Regarding the Health Insurance Premium Tax Credit

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final and temporary regulations.

SUMMARY: This document contains final and temporary regulations relating to the health insurance premium tax credit enacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act of 2011 and the 3% Withholding Repeal and Job Creation Act. These regulations affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals. The text of the temporary regulations in this document also serves as the text of proposed regulations set forth in a notice of proposed rulemaking (REG–104579–13) on this subject in the Proposed Rules section in this issue of the **Bulletin**.

DATES: *Effective Date*: These regulations are effective on July 28, 2014.

Applicability Date: For applicability dates, see §§ 1.36B–2T(d), 1.36B–3T(m), 1.36B–4T(c), and 1.162(l)–1T(c).

FOR FURTHER INFORMATION CONTACT: Arvind Ravichandran or Shareen Pflanz, (202) 317-4718 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains final and temporary regulations that amend the Income Tax Regulations (26 CFR part 1) under section 36B relating to the premium tax credit and under section 162(l) relating to the deduction for health insurance costs for self-employed individuals. Section 36B was enacted by the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act). Section 36B provides a refundable premium tax credit to help individuals and families afford health insurance purchased through an Exchange.

To be eligible for a premium tax credit under section 36B, an individual must be an applicable taxpayer. Section 36B(c)(1) provides that an applicable taxpayer is a taxpayer (1) with household income for the taxable year between 100 percent and 400 percent of the federal poverty line for the taxpayer's family size, (2) who may not be claimed as a dependent by another taxpayer, and (3) who files a joint return if married (within the meaning of section 7703).

Section 7703(b) allows certain married individuals to be considered not married for purposes of the Internal Revenue Code. Under section 7703(b), a married taxpayer who lives apart from the taxpayer's spouse for the last six months of the taxable year is considered unmarried if he or she files a separate return, maintains as the taxpayer's home a household that is also the principal place of abode of a dependent child for more than half the year, and furnishes over half the cost of the household during the taxable year.

Section 36B(b)(2) provides that a taxpayer's premium tax credit is the lesser of the premiums for the plan or plans in which the taxpayer and the taxpayer's family enroll or the excess of the premiums for the second lowest cost silver plan covering the taxpayer's family (the benchmark plan) over the taxpayer's contribution amount. A taxpayer's contribution amount is the product of the taxpayer's household income and an applicable percentage that increases as the taxpayer's household income increases. Under section 1412 of the Affordable Care Act, eligible taxpayers may receive advance payments of the premium tax credit (advance credit payments). Section 36B(f) provides that taxpayers must reconcile any differences between the taxpayer's advance credit payments for a taxable year and the taxpayer's premium tax credit for the year. If the taxpayer's advance credit payments exceed the allowed premium tax credit, the taxpayer owes the excess as a tax liability, subject to a repayment limitation in section 36B(f)(2)(B).

Under section 162(l), a taxpayer who is an employee within the meaning of section 401(c)(1)—generally, a self-employed individual—is allowed a deduction for all or a portion of the taxpayer's premiums paid during the taxable year for health insurance for the taxpayer, the taxpayer's spouse, the taxpayer's dependents, and any child of the taxpayer under the age of 27. The deduction allowed under section 162(l) is limited to the taxpayer's earned income from the trade or business with respect to which the health insurance plan is established. In addition, section 280C(g) provides that no deduction is allowed under section 162(l) for the portion of premiums for a qualified health plan equal to the amount of the premium tax credit determined under section 36B(a) with respect to those premiums.

Explanation of Provisions

1. *Circumstances in which a Married Taxpayer May Claim a Premium Tax Credit on a Separate Return*

Final regulations under section 36B (TD 9590) were published on May 23, 2012 (77 FR 30377). The final regulations

provide that married taxpayers must file a joint return to claim the premium tax credit. However, the preamble to those regulations provided that Treasury and the IRS would propose additional regulations addressing domestic abuse, abandonment, or similar circumstances that create obstacles to filing a joint return. The preamble also requested comments on how to structure a rule to address these situations.

Several comments were received urging that such a rule be provided. Commenters suggested that the rule draw on the existing regime for innocent spouse relief. Commenters also suggested that relief should be allowed for up to three years.

Notice 2014–23, 2014–16 IRB. 942 (March 26, 2014), allows married victims of domestic abuse to claim a premium tax credit without filing a joint return in 2014. Under Notice 2014–23, for calendar year 2014, a married taxpayer will satisfy the joint filing requirement of section 36B(c)(1)(C) if the taxpayer files a 2014 tax return using a filing status of married filing separately and the taxpayer (i) is living apart from the individual's spouse at the time the taxpayer files his or her tax return, (ii) is unable to file a joint return because the taxpayer is a victim of domestic abuse, and (iii) indicates on his or her 2014 income tax return in accordance with the relevant instructions that the taxpayer meets the criteria under (i) and (ii). Notice 2014–23 also provides that the IRS and Treasury intend to propose regulations incorporating this rule.

Accordingly, the temporary regulations incorporate the rule in Notice 2014–23 for 2014 and subsequent taxable years to provide relief from the joint filing requirement for victims of domestic abuse. The temporary regulations also provide relief to victims of spousal abandonment. Consistent with the comments received, taxpayers may not qualify for relief from the joint filing requirement for a period that exceeds three consecutive years.

The temporary regulations define domestic abuse using a definition that is closely based on the definition of spousal abuse in Rev. Proc. 2013–34, 2013– 2 CB 397, for innocent spouse relief. In particular, domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently and that all facts and circumstances are considered in determining whether an individual is abused. A taxpayer qualifies as a victim of spousal abandonment for a taxable year if the taxpayer is abandoned by his or her spouse and, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence. It is expected that the instructions for the tax form taxpayers will use to compute the premium tax credit will provide further guidance on claiming this relief, including that a taxpayer must certify that the taxpayer meets the criteria for the relief.

On March 31, 2014, the Department of Health and Human Services (HHS) issued guidance on the application of Notice 2014–23 to advance credit payments and cost-sharing reductions. In accordance with the temporary regulations included here, it is anticipated HHS will extend its guidance beyond 2014 and to include victims of spousal abandonment.

Comments are requested on the appropriateness of the relief provided in the temporary regulations, and the appropriateness of the scope of relief, including the circumstances that would make a taxpayer eligible for relief.

2. *Indexing*

To compute the premium tax credit, a taxpayer determines his or her contribution amount by multiplying an applicable percentage by the taxpayer's household income. The taxpayer uses the percentage table in section 36B(b)(3)(A)(i) to compute his or her applicable percentage. Section 36B(b)(3)(A)(ii) provides that, beginning in 2015, the percentages in the table are adjusted to reflect the excess of the rate of premium growth over the rate of income growth for the preceding calendar year. Similarly, section 36B(c)(2)(C)(iv) provides that the affordability percentage provided in section 36B(c)(2)(C)(i)(II) is updated in the same manner for plan years beginning in calendar years after 2014. The affordability percentage is used to determine whether an employer's offer of coverage to an employee is affordable to the employee. Under section 36B(c)(2)(C)(i), a taxpayer who is not offered affordable employer coverage may be eligible for a premium tax credit.

Section 36B(b)(3)(A)(ii) does not specify what measures should be used for premium growth and income growth. The temporary regulations provide that premium growth and income growth will be determined in accordance with further published guidance, see § 601.601(d)(2) of this chapter. Rev. Proc. 2014–37, which is being released simultaneously with these temporary regulations, provides further details on the measures to be used for premium growth and income growth. In particular, consistent with the factors used by HHS to define premium growth in indexing the required contribution percentage in section 5000A, Rev. Proc. 2014–37 provides that premium growth for the preceding calendar year is the projected per enrollee spending for employer-sponsored private health insurance for the preceding calendar year, divided by the projected per enrollee spending for employer-sponsored private health insurance for the calendar year two years prior. Income growth for the preceding calendar year will be the projected GDP per capita for the preceding calendar year divided by the projected GDP per capita for the calendar year two years prior. Projected per enrollee spending for employer-sponsored private health insurance and projected GDP per capita are published by the Office of the Actuary at the Centers for Medicare and Medicaid Services.

Section 36B(b)(3)(A)(ii) also does not make clear what it means to adjust the applicable percentages to "reflect the excess" of one rate "over" the other. Rates of growth are commonly compared by taking their ratio. In addition, the applicable percentages in section 36B(b)(3)(A)(i) and the affordability percentage in section 36B(c)(2)(C)(i)(II) represent shares of income that a taxpayer is expected to spend on health care premiums. The indexing of these measures in section 36B(b)(3)(A)(ii) appears designed to adjust these fractions to reflect changes in the observed share of overall income that is spent on health care premiums. Preserving this relationship requires that the applicable percentages be adjusted based on the ratio of the rate of premium growth to the rate of income growth. Accordingly, the temporary regulations provide that, for taxable years

beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to income growth for the preceding calendar year.

In addition, the temporary regulations provide that adjustments may be made to reflect updates to the data used to compute this ratio for the 2014 calendar year or to reflect updates to data sources used to compute the ratio of premium growth to income growth. Such an adjustment may be necessary to avoid error propagation when making updates. In particular, in computing this ratio for a given calendar year, the computations rely on projected data for the prior year and the 2013 calendar year. To the extent that the final data for the prior calendar year prove different from the projected data, the projected data used in later years will automatically adjust for those differences. However, if the final data for the 2013 calendar year proves different from the projected data, projected data in later years will not adjust for these differences, so an additional adjustment will be needed. Similarly, if alternative data sources are used to compute the ratio in later years, an additional adjustment may be needed to avoid error that could result from transitioning from the prior data sources to the new ones. These adjustments will be made as part of the procedure by which the applicable percentages and affordability percentage are updated by the ratio of premium growth to income growth and will apply prospectively only. For example, if data for the 2013 calendar year data is finalized in early 2016, the additional adjustment will be made in determining the applicable percentages and affordability percentage in effect for the 2017 calendar year.

With respect to the affordability percentage, the final regulations under section 36B inadvertently refer to taxable years rather than plan years beginning after 2014. Consistent with the language in section 36B(c)(2)(C)(iv), the temporary regulations provide that, for plan years beginning in a calendar year after 2014, the affordability percentage will be adjusted by the same method used to adjust the applicable percentages.

The indexing methodology provided for in the temporary regulations is based on the same data sources as the methodology adopted by HHS for adjusting the required contribution percentage in section 5000A, which is used to determine eligibility for an exemption from the shared responsibility payment, and it will result in adjustments to the applicable percentages and affordability percentage that are consistent with the adjustments made by HHS to the required contribution percentage in section 5000A. *See* 79 Fed. Reg. 30240 (May 27, 2014).

Comments are requested on the methodology for indexing. In particular, comments are requested on whether this approach properly captures the rate of premium growth relative to the rate of income growth and whether alternative indices or data sources should be used.

3. *Allocations for Reconciliation of Advance Credit Payments and the Premium Tax Credit*

The final regulations under section 36B provide that a taxpayer must reconcile all advance credit payments for coverage of any member of the taxpayer's family. A taxpayer's family includes the taxpayer, the taxpayer's spouse and the taxpayer's dependents. The final regulations, however, do not address how a taxpayer computes the premium tax credit and reconciles advance credit payments for coverage of a family member if the family member was enrolled in a qualified health plan by another taxpayer, especially in situations in which the family member is enrolled with others who are not in the taxpayer's family. For example, suppose Adult 1 enrolls herself and her three children in a qualified health plan and, based on a good faith assertion that she will claim the children as dependents, is approved for advance credit payments for coverage of the family. One of the children (Child), however, is not claimed by Adult 1 and instead is properly claimed by Adult 2 as a dependent for the taxable year. In this circumstance, the final regulations neither address how much of the premium for the plan purchased by Adult 1 each taxpayer should take into account in determining his or her premium tax credit, nor the amount of advance credit payments for Adult 1's plan that Adult 2 must reconcile for Child's coverage. In addition, the final regulations under section 36B require Adult 1 and Adult 2 to determine their adjusted monthly premium for the applicable benchmark plan (benchmark plan premium) in this circumstance using the rules that apply to taxpayers who do not have family members enrolled by another taxpayer.

The temporary regulations provide rules to address how taxpayers determine their premium tax credit and reconcile advance credit payments in cases in which an individual is enrolled by one taxpayer but another taxpayer claims a personal exemption deduction for the individual. In particular, the temporary regulations provide that if a taxpayer (the enrolling taxpayer) enrolls an individual in a qualified health plan, but another taxpayer (the claiming taxpayer) claims a personal exemption deduction for the enrollee (the shifting enrollee), then for purposes of computing each taxpayer's premium tax credit and reconciling any advance credit payments, the premiums and any advance credit payments for the plan in which the shifting enrollee was enrolled are allocated between the enrolling taxpayer and the claiming taxpayer using an allocation percentage. In addition, the temporary regulations provide an alternate calculation that is used to determine each taxpayer's benchmark plan premium when advance credit payments are allocated, using the same allocation percentage.

The enrolling taxpayer and claiming taxpayer may generally agree on any allocation percentage between zero and one hundred percent. For instance, Adult 1 and Adult 2 may determine that the premium attributable to Child is 20 percent of the total premium for Adult 1's family plan, and agree on an allocation percentage of 20 percent. If the claiming taxpayer and enrolling taxpayer do not agree on a percentage, the allocation percentage is equal to the number of shifting enrollees divided by the total number of individuals enrolled by the enrolling taxpayer in the same qualified health plan as the shifting enrollees. In the example above, if Adult 1 and Adult 2 did not agree on an allocation percentage, the allocation percentage would be 25 percent (one, the number of shifting enrollees, divided by four, the total number of individuals enrolled by Adult 1 in the same plan as the shifting enrollee).

In computing the premium tax credit, the claiming taxpayer is allocated a portion of the premiums for the plan in which the enrollee was enrolled equal to the premiums times the allocation percentage. The enrolling taxpayer is allocated the remainder of the premiums. Similarly, in reconciling advance credit payments, the claiming taxpayer is allocated a portion of the advance credit payments for the plan in which the shifting enrollee was enrolled equal to the advance credit payments times the allocation percentage. The enrolling taxpayer is allocated the remainder of these amounts. Advance credit payments are allocated to the claiming taxpayer only if advance credit payments are made for coverage of the shifting enrollee.

Finally, if advance credit payments are allocated under the rules above, the taxpayers, in computing their premium tax credit, must use an alternative calculation to determine their benchmark plan premium. The benchmark plan premium is generally the premium an issuer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each member of the coverage family. Under the alternative calculation, each taxpayer will first determine the allocable portion of the enrolling taxpayer's benchmark plan premium (allocable portion). The allocable portion is equal to the product of (1) the allocation percentage and (2) the benchmark plan premium for the enrolling taxpayer's coverage family had the enrolling taxpayer claimed a personal exemption deduction for the shifting enrollee or enrollees for the taxable year. If the enrolling taxpayer's coverage family is enrolled in more than one qualified health plan, the allocable portion is determined as if the enrolling taxpayer's coverage family includes only the family members who enrolled in the same plan as the shifting enrollee or enrollees. The benchmark plan premium for the claiming taxpayer is equal to this allocable portion plus the benchmark plan premium for the claiming taxpayer's coverage family excluding the shifting enrollee or enrollees. The enrolling taxpayer's benchmark plan premium is equal to the benchmark plan premium for the enrolling taxpayer's coverage family had the enrolling taxpayer claimed a personal exemption deduction for the shifting enrollee or enrollees, minus the allocable portion.

4. *Reconciliation for Divorced and Separated Taxpayers*

The temporary regulations clarify how taxpayers who legally separate or divorce allocate the benchmark plan premium, the premium for the plan in which the taxpayers or their dependents enroll, and the advance credit payments to compute their respective premium tax credit and excess advance credit payments. The final section 36B regulations provide that if just one of the taxpayers is enrolled in the qualified health plan for the married months, all of the items are allocated to that taxpayer, even if the taxpayer's former spouse had one or more dependents also enrolled in the same plan. The temporary regulations expand the circumstances in which the items are allocated between the former spouses to include dependent situations and limit the instances in which all of the items are allocated to just one of the spouses.

Under the temporary regulations, taxpayers who are married (within the meaning of section 7703) to each other during a taxable year but are not married to each other on the last day of the taxable year, and who are enrolled in the same qualified health plan, must allocate the benchmark plan premium, the premium for the plan in which the taxpayers and their dependents enroll, and the advance credit payments for the period the taxpayers are married during the taxable year. In addition, these items must be allocated for periods in which just one of the former spouses is enrolled if one or more dependents of the other former spouse is also enrolled in the plan. The taxpayers may allocate these items to each former spouse in any proportion but must allocate all items in the same proportion. If the taxpayers do not agree on an allocation that is reported to the IRS in accordance with the relevant forms and instructions, 50 percent of each item is allocated to each taxpayer. If a plan covers for a time period only one of the taxpayers and no dependents, only one of the taxpayers and one or more dependents of that same taxpayer, or only one or more dependents of just one of the taxpayers, then the benchmark plan premium, the premium for the plan in which the taxpayers or their dependents enroll, and the advance credit payments for that period are allocated entirely to that taxpayer.

5. *Reconciliation for Married Taxpayers Who File Separately*

The temporary regulations also amend the reconciliation rules for taxpayers who are married and file separate returns. The final regulations under section 36B provide that a married taxpayer who receives advance credit payments and files an income tax return as married filing separately has received excess advance payments. Under the temporary regulations, a taxpayer who uses a filing status of married filing separately may be allowed a premium tax credit if the taxpayer is a victim of spousal abuse or abandonment. Consequently, in these limited circumstances, a married taxpayer who receives advance credit payments and uses a married filing separately filing status will not have excess advance payments by reason of his or her filing status. The temporary regulations also clarify the manner in which taxpayers reconcile advance credit payments in situations in which the taxpayers indicate that they are married when applying for advance credit payments, but one or both file their tax return using the head of household filing status. Taxpayers who qualify to use the head of household filing status may be eligible for a premium tax credit. In particular, the temporary regulations provide that, in such cases, 50 percent of the advance credit payments for a period of coverage in a qualified health plan are allocated to each taxpayer. However, all of the advance credit payments are allocated to only one of the taxpayers for a period in which a qualified health plan covers only that taxpayer, only that taxpayer and one or more dependents of that taxpayer, or only one or more dependents of that taxpayer. Premiums for the plan in which the taxpayers or their dependents are enrolled are allocated in the same manner whether or not the taxpayers receive advance credit payments. These rules result in the advance credit payments and premiums being allocated in the same proportion to the two taxpayers.

6. *Deduction for Health Insurance Costs of Self-employed Individuals*

Under section 162(l), a taxpayer who is an employee within the meaning of section 401(c)(1) (generally, a self-employed individual) is allowed a deduction for all or a portion of the taxpayer's premiums paid during the taxable year for health insurance for the taxpayer, the taxpayer's spouse, the taxpayer's dependents, and any child of the taxpayer under the age of 27. The section 162(l) deduction is allowed in computing adjusted gross income. The deduction allowed under section 162(l) may not exceed the taxpayer's earned income from the trade or business with respect to which the health insurance plan is established. In addition, section 280C(g) provides that no deduction is allowed under section 162(l) for the portion of premiums for a qualified health plan equal to the amount of the premium tax credit determined under section 36B(a) with respect to those premiums.

The temporary regulations provide rules for the interaction between the section 162(l) deduction and both the premium tax credit and the limitation on additional tax under section 36B(f)(2)(B). The temporary regulations provide that a taxpayer is allowed a deduction under section 162(l) for specified premiums not to exceed the lesser of (1) the specified premiums less the premium tax credit attributable to the specified premiums; and (2) the sum of the specified premiums not paid through advance credit payments and the additional tax imposed (if any) under section 36B(f)(2)(A) with respect to the specified premiums after applying the limitation in section 36B(f)(2)(B). Specified premiums means premiums for a specified qualified health plan or plans for which the taxpayer may otherwise claim a deduction under section 162(l). A specified qualified health plan is a qualified health plan, as defined in § 1.36B–1(c), covering the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer (enrolled family member) for a month that is a coverage month within the meaning of § 1.36B–3(c) for the enrolled family member. If a specified qualified health plan covers one or more individuals other than enrolled family members, the specified premiums include only the portion of the premiums for the specified qualified health plan that is allocable to the enrolled family members under rules similar to § 1.36B–3(h), which provides rules for determining the amount under § 1.36B–3(d)(1) when two families are enrolled in the same qualified health plan.

Although a taxpayer's section 162(l) deduction is limited under section 280C(g) only to the extent of the taxpayer's premium tax credit, some taxpayers with advance payments in excess of their premium tax credit will not have to repay the entire excess because of the limitation on additional tax in section 36B(f)(2)(B). Because the taxpayer does not bear the cost of any portion of the premium that is paid through advance credit payments and that is not subject to repayment due to the limitations, any such amount is treated as an amount of premium tax credit for purposes of section 280C(g).

As a computational matter, the premium tax credit and the limitation on additional tax bear a circular relationship to the section 162(l) deduction that may create challenges for taxpayers. Specifically, the amount of the section 162(l) deduction affects a taxpayer's adjusted gross income, which affects both the premium tax credit and the limitation on additional tax. Conversely, both the premium tax credit and the limitation on additional tax affect the amount a taxpayer spends on health insurance premiums, which in turn affects the taxpayer's section 162(l) deduction.

A taxpayer may resolve the circularity between the section 162(l) deduction and the premium tax credit by taking any position that satisfies the requirements of section 36B, section 162(l) and other applicable tax law and the regulations issued under those sections, including the temporary regulations in this rulemaking.

To address the circularity between the section 162(l) deduction and the limitation on additional tax under section 36B(f)(2)(B) (limitation amount), the temporary regulations provide rules for determining which limitation amount, if any, a taxpayer may use. Taxpayers make this determination before calculating their section 162(l) deduction and premium tax credit. To determine the limitation amount, a taxpayer tests his or her eligibility for each of the limitation amounts that may apply, starting with the lowest, until the taxpayer either determines that he or she qualifies for one of the limitation amounts or exhausts them without qualifying for one. For each limitation amount, the taxpayer qualifies to use that limitation amount if the taxpayer's household income as a percentage of the Federal poverty line, determined by using a section 162(l) deduction equal to the sum of (1) specified premiums, as defined above, not paid through advance credit payments, (2) the limitation amount, and (3) premiums other than specified premiums for which the taxpayer may claim a section 162(l) deduction, is equal to or less than the maximum household income as a percentage of the Federal poverty line for which that limitation amount is available. For example, if a taxpayer's 2014 household income, using a section 162(l) deduction equal to the sum of the specified premiums not paid through advance credit payments and the $600 limitation amount, is less than 200 percent of the Federal poverty line, the taxpayer uses the $600 limitation amount in determining additional tax under section 36B(f)(2)(B). If a taxpayer is unable to qualify for any limitation amount under this rule, the limitation on additional tax under section 36B(f)(2)(B) does not apply to the taxpayer.

A taxpayer who deducts specified premiums under section 162(l) must use the limitation amount determined under this rule notwithstanding that household income as a percentage of the Federal poverty line would, but for this rule, result in a different limitation amount. After a taxpayer determines his or her limitation amount, if any, under this rule, the taxpayer then determines the section 162(l) deduction and premium tax credit under the other rules described above, except using the limitation amount determined under these rules when necessary. These rules apply only for purposes of determining the limitation amount; they do not affect eligibility for the premium tax credit. Thus, it is possible that a taxpayer with household income under 400 percent of the Federal poverty line for the taxpayer's family size may properly claim a premium tax credit but not qualify for a limitation on additional tax.

The temporary regulations further provide that Treasury and IRS may issue additional published guidance to address

potential complexities arising from the interaction of the section 36B premium tax credit and the section 162(l) deduction.

To provide additional assistance to taxpayers with addressing the circularity between the section 162(l) deduction and the premium tax credit, Rev. Proc. 2014–41 provides calculation methods that a taxpayer may use to determine amounts of the section 162(l) deduction and the premium tax credit. The IRS and Treasury request comments on other methods for simplifying these calculations.

Effective/Applicability Date

For applicability dates, see §§ 1.36B–2T(d), 1.36B–3T(m), 1.36B–4T(c), and 1.162(l)–1T(c). The applicability of these regulations expires on or before July 24, 2017**.**

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. For the applicability of the Regulatory Flexibility Act (5 U.S.C. chapter 6) please refer to the cross-reference notice of proposed rulemaking published elsewhere in this issue of the **Bulletin**. Pursuant to section 7805(f), these regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Drafting Information

The principal authors of these regulations are Arvind Ravichandran, Shareen Pflanz and Steve Toomey of the Office of the Associate Chief Counsel (Income Tax & Accounting). However, other personnel from the IRS and the Treasury Department participated in their development.

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Amendments to the Regulations

Accordingly, 26 CFR part 1 is 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 1.36B–2 is amended by:

1. Revising paragraphs (b)(2) and (c)(3)(v)(C).
2. Adding paragraph (d).

The revisions and additions read as follows:

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(b) * * *

(2) [Reserved]. For further guidance, see § 1.36B–2T(b)(2).

* * * * *

(c) * * *

(3) * * *

(v) * * *

(C) [Reserved]. For further guidance, see § 1.36B–2T(c)(3)(v)(C).

* * * * *

(d) [Reserved]. For further guidance, see § 1.36B–2T(d).

Par. 3. Section 1.36B–2T is added to read as follows:

§ 1.36B–2T Eligibility for premium tax credit (temporary).

(a) through (b)(1) [Reserved]. For further guidance, see § 1.36B–2(a) through (b)(1).

(2) *Married taxpayers must file joint return*—(i) *In general*. Except as provided in paragraph (b)(2)(ii) of this section, a taxpayer who is married (within the meaning of section 7703) at the close of the taxable year is an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(ii) *Victims of domestic abuse and abandonment*. Except as provided in paragraph (b)(2)(v) of this section, a married taxpayer satisfies the joint filing requirement of paragraph (b)(2)(i) of this section if the taxpayer files a tax return using a filing status of married filing separately and the taxpayer—

(A) Is living apart from the taxpayer's spouse at the time the taxpayer files the tax return;

(B) Is unable to file a joint return because the taxpayer is a victim of domestic abuse, as described in paragraph (b)(2)(iii) of this section, or spousal abandonment, as described in paragraph (b)(2)(iv) of this section; and

(C) Certifies on the return, in accordance with the relevant instructions, that the taxpayer meets the criteria of this paragraph (b)(2)(ii).

(iii) *Domestic abuse*. For purposes of paragraph (b)(2)(ii) of this section, domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(iv) *Abandonment*. For purposes of paragraph (b)(2)(ii) of this section, a taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

(v) *Three-year rule*. Paragraph (b)(2)(ii) of this section does not apply if the taxpayer met the requirements of paragraph (b)(2)(ii) of this section for each of the three preceding taxable years.

(b)(3) through (c)(3)(v)(B) [Reserved]. For further guidance, see § 1.36B–2(b)(3) through (c)(3)(v)(B).

(C) *Required contribution percentage*. The required contribution percentage is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under published guidance, see § 601.601(d)(2) of this chapter. In addition, the percentage

may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(c)(3)(v)(D) through (c)(4) [Reserved]. For further guidance, see § 1.36B–2(c)(3)(v)(D) through (c)(4).

(d) *Effective/applicability date*. Paragraphs (b)(2) and (c)(3)(v)(C) of this section apply to taxable years beginning after December 31, 2013.

(e) *Expiration date*. Paragraphs (b)(2) and (c)(3)(v)(C) of this section expire on July 24, 2017.

Par. 4. Section 1.36B–3 is amended by:

1. Revising paragraph (g)(1).
2. Adding paragraph (m).

The revisions and additions read as follows:

§ 1.36B–3 Computing the premium assistance credit amount.

* * * * *

(g) * * *

(1) [Reserved]. For further guidance, see § 1.36B–3T(g)(1).

* * * * *

(m) [Reserved]. For further guidance, see § 1.36B–3T(m).

Par. 5. Section 1.36B–3T is added to read as follows:

§ 1.36B–3T Computing the premium assistance credit amount (temporary).

(a) through (f) [Reserved]. For further guidance, see § 1.36B–3(a) through (f).

(g) *Applicable percentage*—(1) *In general***.** The applicable percentage multiplied by a taxpayer's household income determines the taxpayer's annual required share of premiums for the benchmark plan. The required share is divided by 12 and this monthly amount is subtracted from the adjusted monthly premium for the applicable benchmark plan when computing the premium assistance amount. The applicable percentage is computed by first determining the percentage that the taxpayer's household income bears to the Federal poverty line for the taxpayer's family size. The resulting Federal poverty line percentage is then compared to the income categories described in the table in paragraph (g)(2) of this section (or successor tables). An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For taxable years beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined in accordance with published guidance, see § 601.601(d)(2) of this chapter. In addition, the applicable percentages in the table may be adjusted for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(g)(2) through (l) [Reserved]. For further guidance, see § 1.36B–3(g)(2) through (l).

(m) *Effective/applicability date*. Paragraph (g)(1) of this section applies to taxable years beginning after December 31, 2013.

(n) *Expiration date*. Paragraph (g)(1) of this section expires on July 24, 2017.

Par. 6. Section 1.36B–4 is amended by:

1. Revising paragraph (a)(1)(ii).
2. Adding paragraph (a)(3)(iii).
3. In paragraph (a)(4), revising *Example 4* and adding *Examples 10*, *11*, *12*, *13*, and *14*.
4. Revising paragraphs (b)(3) and (b)(4).
5. Removing paragraph (b)(5).
6. Redesignating paragraph (b)(6) as paragraph (b)(5), and revising *Example 9*, and adding *Example 10* to newly redesignated paragraph (b)(5).
7. Adding paragraph (c).

The revisions and additions read as follows:

§ 1.36B–4 Reconciling the premium tax credit with advance credit payments.

(a) * * * (1) * * *

(ii) [Reserved]. For further guidance, see § 1.36B–4T(a)(1)(ii).

* * * * *

(3) * * *

(iii) [Reserved]. For further guidance, see § 1.36B–4T(a)(3)(iii).

(4) * * *

Example 4. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 4*.

* * * * *

Example 10. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 10*.

Example 11. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 11*.

Example 12. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 12*.

Example 13. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 13*.

Example 14. [Reserved]. For further guidance, see § 1.36B–4T(a)(4), *Example 14*.

(b) * * *

(3) [Reserved]. For further guidance, see § 1.36B–4T(b)(3).

(4) [Reserved]. For further guidance, see § 1.36B–4T(b)(4).

(5) * * *

Example 9. [Reserved]. For further guidance, see § 1.36B–4T(b)(5), *Example 9*.

Example 10. [Reserved]. For further guidance, see § 1.36B–4T(b)(5), *Example 10*.

* * * * *

(c) [Reserved]. For further guidance, see § 1.36B–4T(c).

Par. 7. Section 1.36B–4T is added to read as follows:

§ 1.36B–4T Reconciling the premium tax credit with advance credit payments (temporary).

(a)(1)(i) [Reserved]. For further guidance, see § 1.36B–4(a)(1)(i).

(ii) *Allocation rules and responsibility for advance credit payments*—(A) *In general*. A taxpayer must reconcile all advance credit payments for coverage of any member of the taxpayer's family.

(B) *Individuals enrolled by a taxpayer and claimed as a personal exemption deduction by another taxpayer*—(*1*) *In general*. If a taxpayer (the enrolling taxpayer) enrolls an individual in a qualified health plan and another taxpayer (the claiming taxpayer) claims a personal exemption deduction for the individual (the shifting enrollee), then for purposes of computing each taxpayer's premium tax credit and reconciling any advance credit payments, the premiums and advance credit payments for the plan in which the shifting enrollee was enrolled are allocated under this paragraph (a)(1)(ii)(B) according to the allocation percentage described in

paragraph (a)(1)(ii)(B)(*2*) of this section. If advance credit payments are allocated under paragraph (a)(1)(ii)(B)(*4*) of this section, the claiming taxpayer and enrolling taxpayer must use this same allocation percentage to calculate their § 1.36B–3(d)(2) adjusted monthly premiums for the applicable benchmark plan (benchmark plan premiums). This paragraph (a)(1)(ii)(B) does not apply to amounts allocated under § 1.36B–3(h) (qualified health plan covering more than one family) or if the shifting enrollee or enrollees are the only individuals enrolled in the qualified health plan. For purposes of this paragraph (a)(1)(ii)(B)(*1*), a taxpayer who is expected at enrollment in a qualified health plan to be the taxpayer filing an income tax return for the year of coverage with respect to an individual enrolling in the plan has enrolled that individual.

(*2*) *Allocation percentage*. The enrolling taxpayer and claiming taxpayer may agree on any allocation percentage between zero and one hundred percent. If the enrolling taxpayer and claiming taxpayer do not agree on an allocation percentage, the percentage is equal to the number of shifting enrollees claimed as a personal exemption deduction by the claiming taxpayer divided by the number of individuals enrolled by the enrolling taxpayer in the same qualified health plan as the shifting enrollee.

(*3*) *Allocating premiums*. In computing the premium tax credit, the claiming taxpayer is allocated a portion of the premiums for the plan in which the shifting enrollee was enrolled equal to the premiums for the plan times the allocation percentage. The enrolling taxpayer is allocated the remainder of the premiums not allocated to one or more claiming taxpayers.

(*4*) *Allocating advance credit payments*. In reconciling any advance credit payments, the claiming taxpayer is allocated a portion of the advance credit payments for the plan in which the shifting enrollee was enrolled equal to the enrolling taxpayer's advance credit payments for the plan times the allocation percentage. The enrolling taxpayer is allocated the remainder of the advance credit payments not allocated to one or more claiming taxpayers. This paragraph (a)(1)(ii)(B)(*4*) only applies in situations in which advance credit payments are made for coverage of a shifting enrollee.

(*5*) *Premiums for the applicable benchmark plan*. If paragraph (a)(1)(ii)(B)(*4*) of this section applies, the claiming taxpayer's benchmark plan premium is the sum of the benchmark plan premium for the claiming taxpayer's coverage family, excluding the shifting enrollee or enrollees, and the allocable portion. The allocable portion for purposes of this paragraph (a)(1)(ii)(B)(*5*) is the product of the benchmark plan premium for the enrolling taxpayer's coverage family if the shifting enrollee was a member of the enrolling taxpayer's coverage family and the allocation percentage. If the enrolling taxpayer's coverage family is enrolled in more than one qualified health plan, the allocable portion is determined as if the enrolling taxpayer's coverage family includes only the coverage family members who enrolled in the same plan as the shifting enrollee or enrollees. The enrolling taxpayer's benchmark plan premium is the benchmark plan premium for the enrolling taxpayer's coverage family had the shifting enrollee or enrollees remained a part of the enrolling taxpayer's coverage family, minus the allocable portion.

(C) *Responsibility for advance credit payments for an individual for whom no personal exemption deduction is claimed*. If advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attested to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the advance credit payment eligibility determination for coverage of the individual must reconcile the advance credit payments.

(a)(1)(iii) through (a)(3)(ii) [Reserved]. For further guidance, see § 1.36B–4(a)(1)(iii) through (a)(3)(ii).

(iii) *Limitation on additional tax for taxpayers who claim a section 162(l) deduction for a qualified health plan*—(A) *In general*. A taxpayer who receives advance credit payments and deducts premiums for a qualified health plan under section 162(l) must use paragraphs (a)(3)(iii)(B) and (C) of this section to determine the limitation on additional tax in this paragraph (a)(3) (limitation amount). Taxpayers must make this determination before calculating their section 162(l) deduction and premium tax credit. For additional rules for taxpayers who may claim a deduction under section 162(l) for a qualified health plan for which advance credit payments are made, see § 1.162(l)–1T.

(B) *Determining the limitation amount*. A taxpayer described in paragraph (a)(3)(iii)(A) of this section must use the limitation amount for which the taxpayer qualifies under the requirements of paragraph (a)(3)(iii)(C) of this section. The limitation amount determined under this paragraph (a)(3)(iii) replaces the limitation amount that would otherwise be determined under the additional tax limitation table in paragraph (a)(3)(ii) of this section. In applying paragraph (a)(3)(iii)(C) of this section, a taxpayer must first determine whether he or she qualifies for the limitation amount applicable to taxpayers with household income of less than 200 percent of the Federal poverty line for the taxpayer's family size. If the taxpayer is unable to meet the requirements of paragraph (a)(3)(iii)(C) of this section for that limitation amount, the taxpayer must next determine whether he or she qualifies for the limitation applicable to taxpayers with household income of less than 300 percent of the Federal poverty line for the taxpayer's family size. If the taxpayer is unable to meet the requirements of paragraph (a)(3)(iii)(C) of this section for taxpayers with household income of less than 300 percent of the Federal poverty line for the taxpayer's family size, the taxpayer must next determine whether he or she qualifies for the limitation applicable to taxpayers with household income of less than 400 percent of the Federal poverty line for the taxpayer's family size. If the taxpayer is unable to meet the requirements of paragraph (a)(3)(iii)(C) of this section for any limitation amount, the limitation on additional tax under section 36B(f)(2)(B) does not apply to the taxpayer.

(C) *Requirements*. A taxpayer meets the requirements of this paragraph (a)(3)(iii)(C) for a limitation amount if the taxpayer's household income as a percentage of the Federal poverty line is less than or equal to the maximum household income as a percentage of the Federal poverty line for which that limitation is available. Household income for this purpose

is determined by using a section 162(l) deduction equal to the sum of the specified premiums for the plan not paid through advance credit payments and the limitation amount in addition to any deduction allowable under section 162(l) for premiums other than specified premiums. For purposes of this paragraph (a)(3)(iii)(C), specified premiums not paid through advance credit payments means specified premiums, as defined in § 1.162(l)–1T(a)(2), minus advance credit payments made with respect to the specified premiums.

(D) *Examples*. For examples illustrating the rules of this paragraph (a)(3)(iii), see *Examples 13* and *14* of paragraph (a)(4) of this section.

(a)(4), *Example 1*, through *Example 3* [Reserved]. For further guidance, see § 1.36B–4(a)(4), *Example 1* through *Example 3*.

Example 4. Family size decreases. (i) Taxpayers B and C are married and have two children, K and L (ages 17 and 20), whom they claim as dependents in 2013. The Exchange for their rating area projects their 2014 household income to be $63,388 (275 percent of the Federal poverty line for a family of four, applicable percentage 8.78). B and C enroll in a qualified health plan for 2014 that covers the four family members. The annual premium for the applicable benchmark plan is $14,100. B's and C's advance credit payments for 2014 are $8,535, computed as follows: benchmark plan premium of $14,100 less contribution amount of $5,565 (projected household income of $63,388 × .0878) = $8,535.

(ii) In 2014, B and C do not claim L as their dependent (and no taxpayer claims a personal exemption deduction for L). Consequently, B's and C's family size for 2014 is three, their household income of $63,388 is 332 percent of the Federal poverty line for a family of three (applicable percentage 9.5), and the annual premium for their applicable benchmark plan is $12,000. Their premium tax credit for 2014 is $5,978 ($12,000 benchmark plan premium less $6,022 contribution amount (household income of $63,388 × .095)). Because B's and C's advance credit payments for 2014 are $8,535 and their 2014 credit is $5,978, B and C have excess advance payments of $2,557. B's and C's additional tax liability for 2014 under paragraph (a)(1) of this section, however, is limited to $2,500 under paragraph (a)(3) of this section.

Example 5 through *Example 9* [Reserved]. For further guidance, see 1.36B–4(a)(4), *Example 5* through *Example 9*.

Example 10. Allocation percentage, agreement on allocation. (i) Taxpayers G and H are divorced and have two children, J and K. G enrolls herself and J and K in a qualified health plan for 2014. The premium for the plan in which G enrolls is $13,000. The Exchange in G's rating area approves advance credit payments for G based on a family size of three, an annual benchmark plan premium of $12,000 and projected 2014 household income of $58,590 (300 percent of the Federal poverty line for a family of three, applicable percentage 9.5). G's advance credit payments for 2014 are $6,434 ($12,000 benchmark plan premium less $5,566 contribution amount (household income of $58,590 × .095)). G's actual household income for 2014 is $58,900.

(ii) K lives with H for more than half of 2014 and H claims K as a dependent for 2014. G and H agree to an allocation percentage, as described in paragraph (a)(1)(ii)(B)(*2*) of this section, of 20 percent. Under the agreement, H is allocated 20 percent of the items to be allocated and G is allocated the remainder of those items.

(iii) If H is eligible for a premium tax credit, H takes into account $2,600 of the premiums for the plan in which K was enrolled ($13,000 × .20) and $2,400 of G's benchmark plan premium ($12,000 × .20). In addition, H is responsible for reconciling $1,287 ($6,434 × .20) of the advance credit payments for K's coverage.

(iv) G's family size for 2014 includes only G and J and G's household income of $58,900 is 380 percent of the Federal poverty line for a family of two (applicable percentage 9.5). G's benchmark plan premium for 2014 is $9,600 (the benchmark premium for the plan covering G, J and K ($12,000), minus the amount allocated to H ($2,400). Consequently, G's premium tax credit is $4,004 (G's benchmark plan premium of $9,600 minus G's contribution amount of $5,596 ($58,900 × .095)). G has an excess advance payment of $1,143 (the excess of the advance credit payments of $5,147 ($6,434 – $1,287 allocated to H) over the premium tax credit of $4,004).

Example 11. Allocation percentage, no agreement on allocation. (i) The facts are the same as in *Example 10*, except that G and H do not agree on an allocation percentage. Under paragraph (a)(1)(ii)(B)(*2*) of this section, the allocation percentage is 33 percent, computed as follows: the number of shifting enrollees, 1 (K), divided by the number of individuals enrolled by the enrolling taxpayer on the same qualified health plan as the shifting enrollee, 3 (G,J, and K). Thus, H is allocated 33 percent of the items to be allocated and G is allocated the remainder of those items.

(ii) If H is eligible for a premium tax credit, H takes into account $4,290 of the premiums for the plan in which K was enrolled ($13,000 × .33). H, in computing H's benchmark plan premium must include $3,960 of G's benchmark plan premium ($12,000 × .33). In addition, H is responsible for reconciling $2,123 ($6,434 × .33) of the advance credit payments for K's coverage.

(iii) G's benchmark plan premium for 2014 is $8,040 (the benchmark premium for the plan covering G, J, and K ($12,000), minus the amount allocated to H ($3,960). Consequently, G's premium tax credit is $2,444 (G's benchmark plan premium of $8,040 minus G's contribution amount of $5,596 ($58,900 × .095)). G has an excess advance credit payment of $1,867 (the excess of the advance credit payments of $4,311 ($6,434 − $2,123 allocated to H) over the premium tax credit of $2,444).

Example 12. Allocations for an emancipated child. Spouses L and M enroll in a qualified health plan with their child, N. L and M attest that they will claim N as a dependent and advance credit payments are made for the coverage of all three family members. However, N files his own return and claims a personal exemption deduction for himself for the taxable year. Under paragraph (a)(1)(ii)(B)(*1*) of this section, L and M are enrolling taxpayers, N is a claiming taxpayer and all are subject to the allocation rules in paragraph (a)(1)(ii)(B) of this section.

Example 13. Taxpayer with advance credit payments allowed a section 162(l) deduction but not a limitation on additional tax. (i) In 2014, B, B's spouse, and their two dependents enroll in the applicable second lowest cost silver plan with an annual premium of $14,000. B's advance credit payments attributable to the premiums are $8,000. B is self-employed for all of 2014 and derives $75,000 of earnings from B's trade or business. B's household income without including a deduction under section 162(l) for specified premiums is $103,700. The Federal poverty line for a family the size of B's family is $23,550.

(ii) Because B received advance credit payments and deducts premiums for a qualified health plan under section 162(l), B must determine whether B is allowed a limitation on additional tax under paragraph (a)(3)(iii) of this section. B begins by testing eligibility for the $600 limitation amount for taxpayers with household income at less than 200 percent of the Federal poverty line for the taxpayer's family size. B determines household income as a percentage of the Federal poverty line by taking a section 162(l) deduction equal to the sum of the amount of premiums not paid through advance credit payments, $6,000 ($14,000 − $8,000), and the limitation amount, $600. The result is $97,100 ($103,700 − $6,600) or 412 percent of the Federal poverty line for B's family size. Since 412 percent is not less than 200 percent, B may not use a $600 limitation amount.

(iii) B performs the same calculation for the $1,500 ($103,700 − $7,500 = $96,200 or 408 percent of the Federal poverty line) and $2,500 limitation amounts ($103,700 − $8,500 = $95,200 or 404 percent of the Federal poverty line), the amounts for taxpayers with household income of less than 300 percent or 400 percent, respectively, of the Federal poverty line for the taxpayer's family size, and determines that B may not use either of those limitation amounts. Because B does not meet the requirements of paragraph (a)(3)(iii) of this section for any of the limitation amounts in section 36B(f)(2)(B), B is not eligible for the limitation on additional tax for excess advance credit payments.

(iv) Although B may not claim a limitation on additional tax for excess advance credit payments, B may still be eligible for a premium tax credit. B would determine eligibility for the premium tax credit and the amounts of the premium tax credit and the section 162(l) deduction using other rules, including the regulations under section 36B and section 162(l), applying no limitation on additional tax.

Example 14. Taxpayer with advance credit payments allowed a section 162(l) deduction and a limitation on additional tax. (i) Same facts as Example 13, except that B's household income without

including a deduction under section 162(l) for specified premiums is $78,802.

(ii) Because B received advance credit payments and deducts premiums for a qualified health plan under section 162(l), B must determine whether B is allowed a limitation on additional tax under paragraph (a)(3)(iii) of this section. B first determines that B does not meet the requirements of paragraph (a)(3)(iii)(C) of this section for using the $600 or $1,500 limitation amounts, the amounts for taxpayers with household income of less than 200 percent or 300 percent, respectively, of the Federal poverty line for the taxpayer's family size. That is because B's household income as a percentage of the Federal poverty line, determined by using a section 162(l) deduction for premiums for the qualified health plan equal to the sum of the premiums for the plan not paid through advance credit payments and the limitation amount, is more than the maximum household income as a percentage of the Federal poverty line for which that limitation is available (using the $600 limitation, B's household income would be $72,202 ($78,802 – ($6,000 + $600)), which is 307 percent of the Federal poverty line for B's family size; and using the $1,500 limitation, B's household income would be $71,302 ($78,802 – ($6,000 + $1,500)), which is 303 percent of the Federal poverty line for B's family size).

(iii) However, B meets the requirements of paragraph (a)(3)(iii)(C) of this section using the $2,500 limitation amount for taxpayers with household income of less than 400 percent of the Federal poverty line for the taxpayer's family size. This is because B's household income as a percentage of the Federal poverty line by taking a section 162(l) deduction equal to the sum of the amount of premiums not paid through advance credit payments, $6,000, and the limitation amount, $2,500, is $70,302 (299 percent of the Federal poverty line), which is below 400 percent of the Federal poverty line for B's family size, and is less than the maximum amount for which that limitation is available. Thus, B uses a limitation amount of $2,500 in computing B's additional tax on excess advance credit payments.

(iv) B may then determine the amount of the premium tax credit and section 162(l) deduction using the rules under section 36B and section 162(l), applying the $2,500 limitation amount determined above.

(b)(1) through (b)(2) [Reserved]. For further guidance, see § 1.36B–4(b)(1) through (b)(2).

(3) *Taxpayers not married to each other at the end of the taxable year*. Taxpayers who are married (within the meaning of section 7703) to each other during a taxable year but legally separate under a decree of divorce or of separate maintenance during the taxable year, and who are enrolled in the same qualified health plan at any time during the taxable year must allocate the benchmark plan premium, the premium for the plan in which the taxpayers enroll, and the advance credit payments for the period the taxpayers are married during the taxable year. Taxpayers must also allocate these items if one of the taxpayers has a dependent enrolled in the same plan as the taxpayer's former spouse or enrolled in the same plan as a dependent of the taxpayer's former spouse. The taxpayers may allocate these items to each former spouse in any proportion but must allocate all items in the same proportion. If the taxpayers do not agree on an allocation that is reported to the IRS in accordance with the relevant forms and instructions, 50 percent of the premium for the applicable benchmark plan, the premium for the plan in which the taxpayers enroll, and the advance credit payments for the married period are allocated to each taxpayer. If for a period a plan covers only one of the taxpayers and no dependents, only one of the taxpayers and one or more dependents of that same taxpayer, or only one or more dependents of one of the taxpayers, then the benchmark plan premium, the premium for the plan in which the taxpayers enroll, and the advance credit payments for that period are allocated entirely to that taxpayer.

(4) *Taxpayers filing returns as married filing separately or head of household*—(i) *Allocation of advance credit payments*. Except as provided in § 1.36B–2(b)(2)(ii), the premium tax credit is allowed to married (within the meaning of section 7703) taxpayers only if they file joint returns. See § 1.36B–2(b)(2)(i). Taxpayers who receive advance credit payments as married taxpayers and do not file a joint return must allocate the advance credit payments for coverage under a qualified health plan equally to each taxpayer for any period the plan covers and advance credit payments are made for both taxpayers, only one of the taxpayers and one or more dependents of the other taxpayer, or one or more dependents of both taxpayers. If for a period a plan covers or advance credit payments are made for only one of the taxpayers and no dependents, only one of the taxpayers and one or more dependents of that same taxpayer, or only one or more dependents of one of the taxpayers, the advance credit payments for that period are allocated entirely to that taxpayer. If one or both of the taxpayers is an applicable taxpayer eligible for a premium tax credit for the taxable year, the premium tax credit is computed by allocating the premiums for the plan in which the taxpayers or their family members enroll under paragraph (b)(4)(ii) of this section. The repayment limitation described in paragraph (a)(3) of this section applies to each taxpayer based on the household income and family size reported on that taxpayer's return. This paragraph (b)(4) also applies to taxpayers who receive advance credit payments as married taxpayers and file a tax return using the head of household filing status.

(ii) *Allocation of premiums*. If taxpayers who are married within the meaning of section 7703, without regard to section 7703(b), do not file a joint return, 50 percent of the premiums for a period of coverage in a qualified health plan are allocated to each taxpayer. However, all of the premiums are allocated to only one of the taxpayers for a period in which a qualified health plan covers only that taxpayer, only that taxpayer and one or more dependents of that taxpayer, or only one or more dependents of that taxpayer.

(b)(5), *Example 1* through *Example 8* [Reserved]. For further guidance, see § 1.36B–4(b)(5), *Example 1* through *Example 8*.

Example 9. (i) The facts are the same as in *Example 8*, except that X and Y live apart for over 6 months of the year and X properly files an income tax return as head of household. Under section 7703(b), X is treated as unmarried and therefore is not required to file a joint return. If X otherwise qualifies as an applicable taxpayer, X may claim the premium tax credit based on the household income and family size X reports on the return. Y is not an applicable taxpayer and is not eligible to claim the premium tax credit.

(ii) X must reconcile the amount of credit with advance credit payments under paragraph (a) of this section. The premium for the applicable benchmark plan covering X and his two dependents is $9,800. X's premium tax credit is computed as follows: $9,800 benchmark plan premium minus X's contribution amount of $5,700 ($60,000 × .095) equals $4,100.

(iii) Under paragraph (b)(4) of this section, half of the advance payments ($6,880/2 = $3,440) is allocated to X and half is allocated to Y. Thus, X is entitled to $660 additional premium tax credit ($4,100 − $3,440). Y has $3,440 excess advance payments, which is limited to $600 under paragraph (a)(3) of this section.

Example 10. (i) A is married to B at the close of 2014 and they have no dependents. A and B are enrolled in a qualified health plan for 2014 with an annual premium of $10,000 and advance credit payments of $6,500. A is not eligible for minimum essential coverage (other than coverage described in

section 5000A(f)(1)(C)) for any month in 2014. A is a victim of domestic abuse as described in § 1.36B–2(b)(2)(iii). At the time A files her tax return for 2014, A is unable to file a joint return with B for 2014 because of the domestic abuse. A certifies on her 2014 return, in accordance with relevant instructions, that she is living apart from B and is unable to file a joint return because of domestic abuse. Thus, under § 1.36B–2(b)(2)(ii), A satisfies the joint return filing requirement in section 36B(c)(1)(C) for 2014.

(ii) A's family size for 2014 for purposes of computing the premium tax credit is one and A is the only member of her coverage family. Thus, A's benchmark plan for all months of 2014 is the second lowest cost silver plan offered by the Exchange for A's rating area that covers A. A's household income includes only A's modified adjusted gross income. Under paragraph (b)(4)(ii) of this section, A takes into account $5,000 ($10,000 × .50) of the premiums for the plan in which she was enrolled in determining her premium tax credit. Further, A must reconcile $3,250 ($6,500 × .50) of the advance credit payments for her coverage under paragraph (b)(4)(i) of this section.

(c) *Effective/applicability date*. Paragraphs (a)(1)(ii), (a)(3)(iii), (a)(4), *Examples 4*, *10*, *11*, *12*, *13*, and *14*, (b)(3), (b)(4), and (b)(5), *Examples 9* and *10* apply to taxable years beginning after December 31, 2013.

(d) *Expiration date*. Paragraphs (a)(1)(ii), (a)(3)(iii), (a)(4), *Examples 4*, *10*, *11*, *12*, *13*, and *14*, (b)(3), (b)(4), and (b)(5), *Examples 9* and *10* expire on July 24, 2017.

Par. 8. Section 1.162(l)–1T is added to read as follows:

§ 1.162(l)–1T Deduction for health insurance costs of self-employed individuals (temporary).

(a) *Coordination of section 162(l) deduction for taxpayers subject to section 36B*—(1) *In general*. A taxpayer is allowed a deduction under section 162(l) for specified premiums, as defined in paragraph (a)(2) of this section, not to exceed an amount equal to the lesser of—

(i) The specified premiums less the premium tax credit attributable to the specified premiums; and

(ii) The sum of the specified premiums not paid through advance credit payments, as described in paragraph (a)(3) of this section, and the additional tax (if any) imposed under section 36B(f)(2)(A) and § 1.36B–4(a)(1) with respect to the specified premiums after application of the limitation on additional tax in section 36B(f)(2)(B) and § 1.36B–4(a)(3).

(2) *Specified premiums*. For purposes of paragraph (a)(1) of this section, specified premiums means premiums for a specified qualified health plan or plans for which the taxpayer may otherwise claim a deduction under section 162(l). For purposes of this paragraph (a)(2), a specified qualified health plan is a qualified health plan, as defined in § 1.36B–1(c), covering the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer (enrolled family member) for a month that is a coverage month within the meaning of § 1.36B–3(c) for the enrolled family member. If a specified qualified health plan covers individuals other than enrolled family members, the specified premiums include only the portion of the premiums for the specified qualified health plan that is allocable to the enrolled family members under rules similar to § 1.36B–3(h), which provides rules for determining the amount under § 1.36B–3(d)(1) when two families are enrolled in the same qualified health plan.

(3) *Specified premiums not paid through advance credit payments*. For purposes of paragraph (a)(1)(ii) of this section, specified premiums not paid through advance credit payments equal the amount of the specified premiums minus the advance credit payments attributable to the specified premiums.

(b) *Additional guidance*. The Secretary may provide by publication in the **Federal Register** or in the Internal Revenue Bulletin (see § 601.601(d)(2) of this chapter) additional guidance on coordinating the deduction allowed under section 162(l) and the credit provided under section 36B.

(c) *Effective/applicability date*. This section applies for taxable years beginning after December 31, 2013.

(d) *Expiration date*. This section expires on July 24, 2017.

John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved July 22, 2014.

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on July 25, 2014, 8:45 a.m., and published in the issue of the Federal Register for July 28, 2014, 79 F.R. 43622)

Section 708.—Continuation of Partnership

26 CFR 1.708–1: Deductibility of start-up expenditures and organizational expenses for partnerships

TD 9681

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Partnerships; Start-up Expenditures; Organization and Syndication Fees

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final Regulations.

SUMMARY: This document contains final regulations concerning the deductibility of start-up expenditures and organizational expenses for partnerships. The final regulations provide guidance regarding the deductibility of start-up expenditures and organizational expenses for partnerships following a termination of a partnership under section 708(b)(1)(B). These final regulations affect partnerships that undergo section 708(b)(1)(B) terminations and their partners.

DATE: *Effective Date*: These regulations are effective on July 23, 2014.

FOR FURTHER INFORMATION CONTACT: Rachel S. Smith, (202) 317-6852 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains final amendments to the Income Tax Regulations (26 CFR part 1) under section 708(b) of the Internal Revenue Code (Code). On December 9, 2013, proposed regulations (REG–126285–12, 78 FR 73753) were published in the Federal Register. The proposed regulations were intended to eliminate uncertainty regarding whether a partnership is entitled to immediately deduct any unamortized start-up and organizational expenses upon its technical termination. Specifically, the proposed regulations provided that the new partner-

ship was required to continue to amortize those expenditures using the same amortization period adopted by the terminating partnership. No written or electronic comments were received in response to the notice of proposed rulemaking. No requests for a public hearing were received, and accordingly, no hearing was held.

Explanation of Provisions

The Treasury decision adopts the proposed regulations with one minor change for clarity. Specifically, in § 1.708–1(b)(6)(i), "using the same amortization period adopted by the terminating partnership" has been changed to "over the remaining portion of the amortization period adopted by the terminating partnership" to make clear that the amortization period does not restart. No substantive change is intended.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, 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, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small businesses. No comments were received.

Drafting Information

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

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is 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 1.195–2 is added to read as follows:

§ 1.195–2 Technical termination of a partnership.

(a) *In general.* If a partnership that has elected to amortize start-up expenditures under section 195(b) and § 1.195–1 terminates in a transaction (or a series of transactions) described in section 708(b)(1)(B) or § 1.708–1(b)(2), the termination shall not be treated as resulting in a disposition of the partnership's trade or business for purposes of section 195(b)(2). See § 1.708–1(b)(6) for rules concerning the treatment of these start-up expenditures by the new partnership.

(b) *Effective/applicability date.* This section applies to a technical termination of a partnership under section 708(b)(1)(B) that occurs on or after December 9, 2013.

Par. 3. Section 1.708–1 is amended by adding paragraph (b)(6) to read as follows:

§ 1.708–1 Continuation of partnership.

* * * * *

(b) * * *

(6) *Treatment of certain start-up or organizational expenses following a technical termination*—(i) *In general.* If a partnership that has elected to amortize start-up expenditures under section 195(b) or organizational expenses under section 709(b)(1) terminates in a transaction (or a series of transactions) described in section 708(b)(1)(B) or paragraph (b)(2) of this section, the new partnership must continue to amortize those expenditures over the remaining portion of the amortization period adopted by the terminating partnership. See section 195 and § 1.195–1 for rules concerning the amortization of start-up expenditures and section 709 and § 1.709–1 for rules concerning the amortization of organizational expenses.

(ii) *Effective/applicability date.* This paragraph (b)(6) applies to a technical termination of a partnership under section 708(b)(1)(B) that occurs on or after December 9, 2013.

Par. 4. Section 1.709–1 is amended by:

1. Redesignating paragraph (b)(3) as (b)(3)(i).
2. Adding a heading to newly designated paragraph (b)(3)(i).
3. Adding paragraph (b)(3)(ii).
4. Adding a sentence at the end of paragraph (b)(5).

The additions read as follows:

§ 1.709–1 Treatment of organization and syndication costs.

* * * * *

(b) * * *

(3) *Liquidation of partnership*—(i) *In general.* * * *

(ii) *Technical termination of a partnership.* If a partnership that has elected to amortize organizational costs under section 709(b) terminates in a transaction (or a series of transactions) described in section 708(b)(1)(B) or § 1.708–1(b)(2), the termination shall not be treated as resulting in a liquidation of the partnership for purposes of section 709(b)(2). See § 1.708–1(b)(6) for rules concerning the treatment of these organizational costs by the new partnership.

(5) * * * Paragraph (b)(3)(ii) of this section applies to a technical termination of a partnership under section 708(b)(1)(B) that occurs on or after December 9, 2013.

John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved May 29, 2014.

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on July 22, 2014, 8:45 a.m., and published in the issue of the Federal Register for July 23, 2014, 79 F.R. 42680)

Section 1366.—Pass-thru of Items to Shareholders

26 CFR 1.1366.2: Indebtedness between an S corporation and its shareholder.

TD 9682

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Basis of Indebtedness of S Corporations to their Shareholders

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to basis of indebtedness of S corporations to their shareholders. These final regulations provide that S corporation shareholders increase their basis of indebtedness of the S corporation to the shareholder only if the indebtedness is bona fide, which is determined under general Federal tax principles and depends upon all of the facts and circumstances. These final regulations affect shareholders of S corporations.

DATES: *Effective Date*: These final regulations are effective July 23, 2014.

Applicability Date: These final regulations apply to indebtedness between an S corporation and its shareholder resulting from any transaction occurring on or after July 23, 2014.

FOR FURTHER INFORMATION CONTACT: Caroline E. Hay, (202) 317-5279 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations contain amendments to the Income Tax Regulations (26 CFR part 1) under section 1366 of the Internal Revenue Code (Code). On June 12, 2012, the Treasury Department and the IRS published in the **Federal Register** (77 FR 34884) a notice of proposed rulemaking (REG–134042–07) (the proposed regulations) relating to when shareholders have basis in indebtedness that the S corporation owes to the shareholder (basis of indebtedness). The proposed regulations provide that basis of indebtedness of the S corporation to the shareholder means the shareholder's adjusted basis in any bona fide indebtedness of the S corporation that runs directly to the shareholder. No requests to speak at the scheduled public hearing were received and the hearing was canceled. Comments responding to the notice of proposed rulemaking were received. After consideration of all the comments, the proposed regulations are adopted without substantive change by this Treasury decision, except for changes to the effective/applicability date of the regulations and minor clarifying revisions. The comments, which are available at www.regulations.gov or upon request, are discussed in this preamble.

Summary of Comments

1. *Actual Economic Outlay*

Courts developed the actual economic outlay standard, which requires that shareholders be made "poorer in a material sense" to increase their bases of indebtedness. Some courts concluded that an S corporation shareholder was not poorer in a material sense if the shareholder borrowed funds from a related entity and then lent those funds to his S corporation. See, for example, *Oren v. Commissioner*, 357 F.3d 854 (8th Cir. 2004), aff'g, T.C. Memo. 2002–172. Instead of applying the actual economic outlay standard, the proposed regulations provided that shareholders receive basis of indebtedness if it is bona fide indebtedness of the S corporation to the shareholder.

One commentator suggested that language be added to the regulations providing that actual economic outlay is no longer the standard used to determine whether a shareholder obtains basis of indebtedness. After considering this comment, the Treasury Department and the IRS believe that the proposed regulations clearly articulate the standard for determining basis of indebtedness of an S corporation to its shareholder, and further discussion of the actual economic outlay test in the regulations is unnecessary. Accordingly, the final regulations adopt the rule in the proposed regulations without change.

With respect to guarantees, however, the final regulations retain the economic outlay standard by adopting the rule in the proposed regulations that S corporation shareholders may increase their basis of indebtedness only to the extent they actually perform under a guarantee. The final regulations make some minor changes to clarify the treatment of guarantees, including changing the heading to reiterate that the rule for guarantees is distinguished from the general rule adopting a bona fide indebtedness standard and moving the guarantee example after the examples illustrating the general rule consistent with the order of the regulations.

2. *Regulation Examples and "Circular Flow of Funds"*

One commentator requested a change to the fact pattern presented in proposed regulations §1.1366–2(a)(2)(iii), *Example 4*. In *Example 4*, a loan that originally was made by S1 to S2, two related S corporations wholly-owned by the same shareholder, is restructured to be a loan from the shareholder. The restructuring involved S1 distributing the debt to the shareholder and S2 being relieved of its liability to S1 so that S2 is only liable to the shareholder on the debt. The commentator recommended that *Example 4* not require that S2 be relieved of its liability to S1. As stated in the proposed regulations and finalized in these regulations, whether indebtedness is bona fide indebtedness to a shareholder is determined under general Federal tax principles and depends upon all of the facts and circumstances. Whether S2 is relieved of the original liability is an appropriate fact to consider in determining whether the transaction is a restructuring of a debt that results in a bona fide debt that runs directly from S2 to the shareholder. See, for example, Rev. Rul. 75–144 (1975–1 CB 277) (holding that a shareholder increases the shareholder's basis of indebtedness when the shareholder, who had guaranteed a liability of his S corporation, executed his own promissory note in full satisfaction of the S corporation's note to the bank, the bank relieved the S corporation of its liability, and the S corporation became

obligated to the shareholder under the doctrine of subrogation). See also *Gilday v. Commissioner*, T.C. Memo. 1982–242 (holding that shareholders increased their bases of indebtedness when the shareholders gave a bank their notes, the bank canceled the S corporation's note to the bank, and the facts indicated that the S corporation became indebted to the shareholders, regardless of whether subrogation occurred under state law). Accordingly, this comment is not adopted.

This commentator also requested that an example be added to the regulations addressing a "circular flow of funds." The commentator described a circular flow of funds as including a restructuring of a loan originally made by an S corporation owned by the shareholder to another S corporation owned by that shareholder (for purposes of this discussion, S1 and S2, respectively). This loan is restructured by one of two alternative methods: (i) S1 lends money to the shareholder, the shareholder lends that money to S2, and S2 uses that money to repay S1; or (ii) S2 repays S1, S1 lends money to the shareholder, and the shareholder lends that money back to S2.

The Treasury Department and the IRS recognize that there are numerous ways, including certain circular cash flows, in which an S corporation can become indebted to its shareholder. The proposed regulations included *Example 4* as an example of a loan originating between two related entities that is restructured to be from the S corporation to the shareholder to show that the debt need not originate between the S corporation and its shareholder, provided that the resulting debt running between the S corporation and the shareholder is bona fide. The Treasury Department and the IRS are aware, however, of cases involving circular flow of funds that do not result in bona fide indebtedness. See, for example, *Oren v. Commissioner*, 357 F.3d at 859 (purported loans, although meeting all the proper formalities, lacked substance); *Kerzner v. Commissioner*, T.C. Memo. 2009–76, at *5 (transaction lacked substance because money wound up right where it started and shareholder was merely a conduit through which the money flowed). Whether a restructuring results in bona fide indebtedness depends on the facts and circumstances. Because the Treasury Department and the IRS believe that the examples in the proposed regulations adequately illustrate that a restructuring of a debt that did not originate between the shareholder and the S corporation may result in basis of indebtedness as long as the resulting debt is bona fide, these final regulations do not contain additional examples.

Another commentator requested that an example be added to the regulations concerning a fact pattern in which bona fide indebtedness is present, but the shareholder has zero basis in that indebtedness. The commentator concluded that the shareholder would have zero basis of indebtedness in the shareholder's S corporation because the shareholder's basis in the debt is zero. The Treasury Department and the IRS believe that the regulations are clear that shareholders only increase their basis of indebtedness to the extent of the shareholder's adjusted basis (as defined in § 1.1011–1 and as specifically provided in section 1367(b)(2)) in that bona fide indebtedness of the S corporation that runs directly to the shareholder. If the shareholder's basis in the indebtedness is zero, then the shareholder's basis of indebtedness is increased by zero. As such, an additional example illustrating a zero basis of indebtedness has not been added to the final regulations.

3. *Section 1366(d)(1)(A) and Stock Basis*

The preamble to the proposed regulations requested comments regarding the basis treatment when an S corporation shareholder or a partner contributes the shareholder's or partner's own note to an S corporation or a partnership. An S corporation shareholder does not increase his basis in the stock of his S corporation under section 1366(d)(1)(A) from a contribution of his own note. See Rev. Rul. 81–187 (1981–2 CB 167) (holding that a shareholder who (i) merely executed and transferred the shareholder's demand note to the shareholder's wholly owned S corporation, and (ii) made no payment on the note until the following year had a zero basis in the note until the following year when the shareholder made a payment on the note). The preamble to the proposed regulations described as one potential model § 1.704–1(b)(2)(iv)(d)(*2*), which provides that a partner's capital account is increased with respect to non-readily tradable partner notes only (i) when there is a taxable disposition of such note by the partnership, or (ii) when the partner makes principal payments on such note. One commentator recommended consideration of, and consistency with, § 1.166–9(c) (regarding contributions of debt to capital). Another commentator noted that courts have applied the "actual economic outlay" standard to determine when shareholders increase their bases in their S corporation stock. See, for example, *Maguire v. Commissioner*, T.C. Memo. 2012–160. This commentator requested that the final regulations provide that actual economic outlay does not apply to determinations of a shareholder's stock basis under section 1366(d)(1)(A). To expedite finalization of the proposed regulations, the scope of these final regulations is limited to basis of indebtedness. The Treasury Department and the IRS continue to study issues relating to stock basis and may address these issues in future guidance.

4. *Potential Abuses from Shareholders Claiming Indebtedness Basis*

One commentator stressed that, because S corporations are passthrough entities, allowing shareholders to claim S corporation losses if they have basis of indebtedness could allow shareholders to claim losses that are not bona fide. This commentator recommended that the IRS require that shareholders provide information to the IRS that all claimed S corporation losses are bona fide. The proposed regulations, however, do not affect the normal substantiation rules for the validity of claimed losses. See sections 6001 and 6037. See also *INDOPCO, Inc. v. Commissioner*, 503 U.S. 79, 84 (1992) (providing that "an income tax deduction is a matter of legislative grace and that the burden of clearly showing the right to the claimed deduction is on the taxpayer" (quoting *Interstate Transit Lines v. Commissioner*, 319 U.S. 590, 593 (1943))). Accordingly, this comment is beyond the scope of these final regulations.

5. *Effective and Applicability Date*

Commentators also suggested that the Treasury Department and the IRS should permit retroactive application of the regulations. These commentators suggest that, pursuant to section 7805(b)(7), final regulations should allow taxpayers to elect to apply the rules in the regulations retroactively.

The proposed regulations provided that these regulations apply to transactions entered into on or after the regulations are published as final in the **Federal Register**. Upon further consideration of the applicability date, the Treasury Department and the IRS believe that allowing taxpayers to rely on these regulations will provide greater certainty for determining when shareholders have basis of indebtedness. As such, taxpayers may rely on these regulations with respect to indebtedness between an S corporation and its shareholder that resulted from any transaction that occurred in a year for which the period of limitations on the assessment of tax has not expired before July 23, 2014.

Special Analyses

It has been determined that these final regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. 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, the notice of proposed rulemaking that preceded these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

Availability of IRS Documents

The IRS revenue rulings cited in this preamble are published in the Internal Revenue Cumulative Bulletin and are available from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

Drafting Information

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

*** * * * ***

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is 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 1.108–7 is amended by:

1. Removing the language "§ 1.1366–2(a)(5)" in paragraph (d)(2)(iii) and adding "§ 1.1366–2(a)(6)" in its place.

2. Adding two sentences to the end of paragraph (f)(2).

The addition reads as follows:

§ 1.108–7 Reduction of attributes.

* * * * *

(f) * * *

(2) * * * Paragraph (d)(2)(iii) of this section applies on and after July 23, 2014. For rules that apply before that date, see 26 CFR part 1 (revised as of April 1, 2014).

Par. 3. Section 1.1366–0 is amended:

1. By redesignating the entries in the table of contents for § 1.1366–2(a)(2), (a)(3), (a)(4), (a)(5), and (a)(6) as § 1.1366–2 (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7), respectively, and adding new entries for § 1.1366–2 (a)(2) and (a)(2)(i) through (iii).

2. By revising the heading in the table of contents for § 1.1366–5.

The additions and revisions read as follows:

§ 1.1366–0 Table of contents.

* * * * *

§ 1.1366–2 Limitations on deduction of passthrough items of an S corporation to its shareholders.

(a) * * *

(2) Basis of indebtedness.

(i) In general.

(ii) Special rule for guarantees.

(iii) Examples.

* * * * *

§ 1.1366–5 Effective/applicability date.

Par. 4. Section 1.1366–2 is amended by:

1. Removing the language "(a)(3)(i)" in paragraph (a)(1)(i), and adding the language "(a)(4)(i)" in its place.

2. Removing the language "paragraph (a)(3)(ii)" in paragraph (a)(1)(ii), and adding the language "paragraphs (a)(2) and (a)(4)(ii)" in its place.

3. Redesignating paragraphs (a)(2), (a)(3), (a)(4), (a)(5), and (a)(6) as paragraphs (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7) respectively, and adding a new paragraph (a)(2).

4. Removing the language "(a)(3)(i) and (ii)" in newly designated paragraph (a)(3), and adding the language "(a)(4)(i) and (ii)" in its place.

5. Removing the language "paragraphs (a)(1)(i) and (2)" in newly designated paragraph (a)(4)(i), and adding the language "paragraphs (a)(1)(i) and (3)" in its place.

6. Removing the language "paragraphs (a)(1)(ii) and (2)" in newly designated paragraph (a)(4)(ii), and adding the language "paragraphs (a)(1)(ii) and (3)" in its place.

7. Removing the language "(a)(3)(i)" and "(a)(3)(ii)" in newly designated paragraph (a)(5), and adding the language "(a)(4)(i)" and "(a)(4)(ii)", respectively, in their place.

8. Removing the language "(a)(5)(ii)" in newly designated paragraphs (a)(6)(i) and (a)(6)(iii), and adding the language "(a)(6)(ii)" in its place.

9. Removing the language "(a)(4)" in newly designated paragraph (a)(6)(ii), and adding the language "(a)(5)" in its place.

10. Removing the language "paragraphs (a)(1)(i) and (2)" in newly designated paragraph (a)(7), and adding the

language "paragraphs (a)(1)(i) and (3)" in its place.

The additions read as follows:

§ 1.1366–2 Limitations on deduction of passthrough items of an S corporation to its shareholders.

(a) * * *

(2) *Basis of indebtedness*—(i) *In general*. The term *basis of any indebtedness of the S corporation to the shareholder* means the shareholder's adjusted basis (as defined in § 1.1011–1 and as specifically provided in section 1367(b)(2)) in any bona fide indebtedness of the S corporation that runs directly to the shareholder. Whether indebtedness is bona fide indebtedness to a shareholder is determined under general Federal tax principles and depends upon all of the facts and circumstances.

(ii) *Special rule for guarantees*. A shareholder does not obtain basis of indebtedness in the S corporation merely by guaranteeing a loan or acting as a surety, accommodation party, or in any similar capacity relating to a loan. When a shareholder makes a payment on bona fide indebtedness of the S corporation for which the shareholder has acted as guarantor or in a similar capacity, then the shareholder may increase the shareholder's basis of indebtedness to the extent of that payment.

(iii) *Examples*. The following examples illustrate the provisions of paragraph (a)(2)(i) and (ii) of this section:

Example 1. Shareholder loan transaction. A is the sole shareholder of S, an S corporation. S received a loan from A. Whether the loan from A to S constitutes bona fide indebtedness from S to A is determined under general Federal tax principles and depends upon all of the facts and circumstances. See paragraph (a)(2)(i) of this section. If the loan constitutes bona fide indebtedness from S to A, A's loan to S increases A's basis of indebtedness under paragraph (a)(2)(i) of this section. The result is the same if A made the loan to S through an entity that is disregarded as an entity separate from A under § 301.7701–3 of this chapter.

Example 2. Back-to-back loan transaction. A is the sole shareholder of two S corporations, S1 and S2. S1 loaned $200,000 to A. A then loaned $200,000 to S2. Whether the loan from A to S2 constitutes bona fide indebtedness from S2 to A is determined under general Federal tax principles and depends upon all of the facts and circumstances. See paragraph (a)(2)(i) of this section. If A's loan to S2 constitutes bona fide indebtedness from S2 to A, A's back-to-back loan increases A's basis of indebtedness in S2 under paragraph (a)(2)(i) of this section.

Example 3. Loan restructuring through distributions. A is the sole shareholder of two S corporations, S1 and S2. In May 2014, S1 made a loan to S2. In December 2014, S1 assigned its creditor position in the note to A by making a distribution to A of the note. Under local law, after S1 distributed the note to A, S2 was relieved of its liability to S1 and was directly liable to A. Whether S2 is indebted to A rather than S1 is determined under general Federal tax principles and depends upon all of the facts and circumstances. See paragraph (a)(2)(i) of this section. If the note constitutes bona fide indebtedness from S2 to A, the note increases A's basis of indebtedness in S2 under paragraph (a)(2)(i) of this section.

Example 4. Guarantee. A is a shareholder of S, an S corporation. In 2014, S received a loan from Bank. Bank required A's guarantee as a condition of making the loan to S. Beginning in 2015, S could no longer make payments on the loan and A made payments directly to Bank from A's personal funds until the loan obligation was satisfied. For each payment A made on the note, A obtains basis of indebtedness under paragraph (a)(2)(ii) of this section. Thus, A's basis of indebtedness is increased during 2015 under paragraph (a)(2)(ii) of this section to the extent of A's payments to Bank pursuant to the guarantee agreement.

* * * * *

Par. 5. Section 1.1366–5 is revised to read as follows:

§ 1.1366–5 Effective/applicability date.

(a) Sections 1.1366–1, 1.1366–2(a)(1), and 1.1366–2(b) through 1.1366–4 apply to taxable years of an S corporation beginning on or after August 18, 1998.

(b) Section 1.1366–2(a)(2) applies to indebtedness between an S corporation and its shareholder resulting from any transaction occurring on or after July 23, 2014. In addition, S corporations and their shareholders may rely on § 1.1366–2(a)(2) with respect to indebtedness between an S corporation and its shareholder that resulted from any transaction that occurred in a year for which the period of limitations on the assessment of tax has not expired before July 23, 2014.

(c) Sections 1.1366–2(a)(3) through (7), and this section apply on and after July 23, 2014. For rules that apply before that date, see 26 CFR part 1 (revised as of April 1, 2014).

§ 1.1367–1 [Amended]

Par. 6. Section 1.1367–1(h) *Example 5*(iii) is amended by removing the language "§ 1.1366–2(a)(2)" in the third and fourth sentences and adding the language "§ 1.1366–2(a)(3)" in its place.

Par. 7. Section 1.1367–3 is amended by adding two sentences to the end of the paragraph to read as follows:

§ 1.1367–3 Effective/applicability date.

* * * Section 1.1367–1(h), *Example 5*(iii) applies on and after July 23, 2014**.** The rules that apply before July 23, 2014 are contained in § 1.1367–3 in effect prior to July 23, 2014 (see 26 CFR part 1 revised as of April 1, 2014).

John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved May 27, 2014.

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on July 22, 2014, 8:45 a.m., and published in the issue of the Federal Register for July 23, 2014, 79 F.R. 42675)

Section 9008.—Imposition of Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers

2 26 CFR Part 5:1 Branded Prescription Drug Fee

TD 9684

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Parts 51 and 602

Branded Prescription Drug Fee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations, temporary regulations, and removal of temporary regulations.

SUMMARY: This document contains final regulations that provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs. This fee was enacted by section 9008 of the Patient Protection and Affordable Care Act, as amended by section 1404 of the Health Care and Education Reconciliation Act of 2010. This document also withdraws the Branded Prescription Drug Fee temporary regulations and contains new temporary regulations regarding the definition of controlled group that apply beginning on January 1, 2015. The final regulations and the new temporary regulations affect persons engaged in the business of manufacturing or importing certain branded prescription drugs. The text of the temporary regulations in this document also serves as the text of proposed regulations set forth in a notice of proposed rulemaking (REG–123286–14) on this subject in the Proposed Rules section in this issue of the **Bulletin**.

DATES: *Effective Date*: These regulations are effective on July 28, 2014.

Applicability Date: For dates of applicability, see §§ 51.11, 51.11T, and 51.6302–1(b).

FOR FURTHER INFORMATION CONTACT: Celia Gabrysh at (202) 317-6855 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these regulations has been reviewed and approved by the Office of Management and Budget under control number 1545-2209. The collection of information in these final regulations is in §§ 51.2(f)(2) and 51.7. Section 51.2(f)(2) requires consents to be maintained, in the case of a controlled group that is not an affiliated group, by the designated entity and each member of the controlled group. Section § 51.7 requires a covered entity that chooses to dispute its preliminary fee calculation to provide certain information.

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

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 section 6103 of the Internal Revenue Code.

Background

This document contains final regulations that provide guidance under section 9008 of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 1404 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively the ACA). All references in this preamble to section 9008 are references to section 9008 of the ACA. Section 9008 did not amend the Internal Revenue Code (Code) but cross-references specified Code sections.

On November 29, 2010, the IRS released Notice 2010–71, 2010–50 IRB 822, which proposed an approach to implementing the section 9008 fee and requested comments on the proposed approach. The proposed approach included an opportunity to report certain information to the IRS relevant to the fee calculation and provided that the IRS would provide each covered entity with notice of a preliminary fee calculation. This notice was modified and superseded by Notice 2011–9, 2011–6 IRB 459, which was released on January 14, 2011.

On August 18, 2011, the **Federal Register** published temporary regulations relating to the fee on branded prescription drugs (TD 9544, 76 FR 51245). The **Federal Register** also published on the same day a notice of proposed rulemaking (REG–112805–10, 76 FR 51310) cross-referencing the temporary regulations (the proposed regulations).

In response to the proposed regulations, the Department of the Treasury (Treasury Department) and the IRS received a variety of comments from the public. All written comments are available at *www.regulations.gov* or upon request. The Treasury Department and the IRS held a public hearing on November 9, 2012. After considering the public comments and the hearing testimony, the final regulations adopted by this Treasury decision are generally consistent with the proposed regulations and also reflect certain minor changes as described in this preamble. The corresponding temporary regulations are removed. The final regulations and the new temporary regulations are discussed in this preamble.

All references to section 505 are references to section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)). Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections in this preamble are references to subtitles, chapters, subchapters, and sections in the Code and related regulations. All references to "fee" in the final regulations are references to the fee imposed by section 9008 of the ACA.

Effect on Other Documents

The following publications are obsolete as of July 28, 2014:

Notice 2010–71, 2010–51 IRB 822, and Notice 2011–9, 2011–6 IRB 459.

Explanation of Provisions and Summary of Comments

Definitions

Manufacturer or importer

Section 9008(d)(1) defines covered entity as any manufacturer or importer with gross receipts from branded prescription drug sales. Section 9008(e) defines branded prescription drug sales to mean sales of branded prescription drugs to any specified government programs or pursuant to coverage under such programs. These programs are the Medicare Part B program, the Medicare Part D program, the Medicaid program, any program under which branded prescription drugs are procured by the Department of Veterans Affairs, any program under which branded prescription drugs are procured by the Department of Defense, and the TRICARE retail pharmacy program (collectively, the Programs).

The temporary regulations defined a manufacturer or importer of a branded prescription drug as the person identified

in the Labeler Code of the National Drug Code (NDC). The NDC is a unique identifier that is assigned to all drug products approved by the Food and Drug Administration (FDA), including a branded prescription drug. The Labeler Code is the first five numeric characters of the NDC or the first six numeric characters when the available five-character code combinations are exhausted.

Commenters asked the IRS to allocate drug sales to an entity other than the person identified in the Labeler Code of a drug's NDC when a covered entity transfers a drug to another covered entity during the sales year or engages in a transaction, such as a reorganization or a bankruptcy, that results in a different entity selling the drug. The final regulations do not adopt this request. A rule that uses the Labeler Code to identify the manufacturer or importer of a branded prescription drug provides certainty for both covered entities and the IRS. The FDA maintains a database that is available on the FDA website with information about each NDC, including its Labeler Code, which is assigned by the FDA. The IRS refers to this database to identify the person in the NDC's Labeler Code. The IRS encourages covered entities to review and update their NDC data with the FDA to reflect changes in the manufacturer or importer of a branded prescription drug.

Covered Entity and Adjustment Amount

To be a covered entity, a manufacturer or importer must have gross receipts from branded prescription drug sales. Section 9008(b)(1) requires the IRS to calculate each covered entity's fee each fee year using sales data from the preceding calendar year. Pursuant to section 9008(g), the Centers for Medicare and Medicaid Services of the Department of Health and Human Services (CMS), the Department of Veterans Affairs (VA), and the Department of Defense (DOD) (collectively, the Agencies) provide sales data to the IRS. For purposes of calculating the fee, the temporary regulations used the second calendar year preceding the fee year as the sales year. This rule is necessary because CMS cannot complete its data processing within the necessary time frame. The temporary regulations further provided that, because the use of the second preceding year as the sales year, rather than the immediately preceding year, may affect the amount of the fee paid by a covered entity, the annual fee due in every year after 2011 will include an adjustment amount. This amount will be added (or subtracted), as appropriate, to (or from) the fee otherwise payable by the covered entity in the fee year in which the adjustment is calculated. Because CMS cannot complete its data processing any earlier, the final regulations adopt this approach.

A commenter asserted that, under the temporary regulations, a former covered entity may not be eligible for an adjustment amount if the entity does not have any sales in subsequent years and is, therefore, no longer a covered entity. According to the commenter, if a covered entity owes a fee in 2013 based on 2011 sales, but has no sales in 2012 or later years, then that entity would not qualify as a covered entity in 2014 because the temporary regulations do not provide a mechanism for the entity to receive an adjustment amount for 2013. The commenter suggested that if an adjustment amount results in a net credit to the covered entity's fee, the IRS should treat the adjustment amount as an overpayment. The final regulations do not adopt this suggestion. However, the final regulations clarify that an entity is treated as a covered entity for any year in which the entity has branded prescription drug sales and for any year for which those sales must be taken into account in calculating the fee and determining the adjustment amount. Therefore, an entity's status as a covered entity begins in the first year it has branded prescription drug sales to the Programs even though the fee does not take those sales immediately into account, and continues until all sales for that entity have been taken into account for both fee calculation and adjustment amount purposes.

For example, assume that an entity had sales in 2011 with no sales in earlier or later years. The entity is a covered entity beginning in 2011. The entity is not liable for a fee in 2011 or 2012 since those fee years are based on 2009 and 2010 sales, respectively. In 2013, the entity is liable for the fee based on its 2011 sales. Furthermore, the entity is liable for the adjustment amount for the difference between the 2012 fee for the entity computed using 2010 sales, which is $0, and what the 2012 fee would have been using 2011 sales. Even though the entity does not have any sales in 2012 or later years, it will continue to be a covered entity in 2014 because its 2011 sales must be taken into account for purposes of determining the adjustment amount relating to the 2013 fee that applies to the 2014 fee year. The entity will not be a covered entity after 2014 because its 2011 sales will not be taken into account after 2014. The final regulations include this example.

Controlled Group

In accordance with the statute, the temporary regulations provided that a covered entity includes a controlled group. The temporary regulations defined the term *controlled group* to mean a group of at least two covered entities that are treated as a single employer under section 52(a), 52(b), 414(m), or 414(o). Under the final regulations, this definition applies through December 31, 2014. Therefore, this definition applies for purposes of determining who is in the controlled group through the 2016 fee year because the fee for the 2016 fee year is based upon data from the 2014 sales year. In this Treasury decision, the Treasury Department and the IRS are also issuing new temporary regulations (the 2014 temporary regulations), that define the term *controlled group* to mean a group of two or more persons, including at least one person that is a covered entity, that are treated as a single employer under section 52(a), 52(b), 414(m) or 414(o). This new definition applies beginning on January 1, 2015. Therefore, this definition applies for purposes of determining who is in the controlled group beginning with the 2017 fee year because the fee for the 2017 fee year is based upon data from the 2015 sales year. The broader definition of controlled group in the 2014 temporary regulations is supported by the statutory language and is consistent with how controlled group rules with similar statutory language are applied, including how controlled group is defined in § 57.2(c)(1)

for purposes of the health insurance providers fee under ACA section 9010. The Treasury Department and the IRS expect that the broader definition in the 2014 temporary regulations will primarily impact joint and several liability for the fee and will not otherwise affect the administration of the fee. The final regulations include conforming changes to the provision for joint and several liability to clarify that joint and several liability applies to all members of the controlled group under either definition of controlled group, whichever applies.

Designated Entity

The temporary regulations required each controlled group that files a Form 8947, "Report of Branded Prescription Drug Information," to have a designated entity. A designated entity is the person within the controlled group that acts on behalf of the controlled group with regard to the fee. The temporary regulations further provided that if the controlled group, without regard to foreign corporations included under section 9008(d)(2)(B), is also an affiliated group that files a consolidated return for federal income tax purposes, the designated entity is the common parent of the affiliated group identified on the tax return filed for the sales year. If the controlled group is not an affiliated group that files a consolidated return, the temporary regulations allowed the controlled group to select its designated entity. However, if the controlled group did not select a designated entity, the IRS would select a member of the controlled group as the designated entity.

The final regulations modify the temporary regulations to better coordinate with the consolidated return regulations. Specifically, the final regulations provide that the designated entity of a controlled group, without regard to foreign corporations included under section 9008(d)(2)(B), that is a consolidated group (within the meaning of § 1.1502–1(h)) is the agent for the group (within the meaning of § 1.1502–77).

The temporary regulations required the designated entity to state under penalties of perjury that all the covered entities that are members of the controlled group have consented to the selection of the designated entity. The final regulations adopt this requirement and further require each member of the controlled group to maintain a record of its consent. The final regulations also require the designated entity to maintain a record of all of the members' consents. Under the final regulations, this consent requirement does not apply to a controlled group that is a consolidated group (within the meaning of § 1.1502–1(h)). If a controlled group that is not a consolidated group does not select a designated entity, the final regulations provide that the IRS will select a designated entity and all covered entities in the controlled group will be deemed to have consented to the IRS's selection of a designated entity.

Orphan Drug Sales

Section 9008(e)(3) provides that the term branded prescription drug sales does not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C. Section 9008(e)(3) also provides that this exclusion does not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the FDA for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed. In accordance with the statute, the temporary regulations generally defined the term *orphan drug* to mean any branded prescription drug for which any person claimed a section 45C credit and that credit was allowed for any taxable year. The temporary regulations further provided that an orphan drug does not include any drug for which there has been a final assessment or court order disallowing the full section 45C credit taken for the drug. Additionally, in accordance with the statute, the temporary regulations provided that an orphan drug does not include any drug for any sales year after the calendar year in which the FDA approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed, regardless of whether a section 45C credit was allowed for the drug before, in the same year as, or after this FDA approval.

Commenters requested that the final regulations treat a drug as an orphan drug if the section 45C credit was "allowable"; that is, the section 45C credit could have been claimed, but was not actually claimed. Another commenter requested that the final regulations extend orphan drug treatment to any drug for which the section 45C credit was allowable but for which a research tax credit under section 41 was claimed with respect to a taxable year ending on or before December 31, 2010. Several commenters also reasoned that the statutory exception for orphan drugs should be extended to any drug that has been designated by the FDA as an orphan drug. Commenters also requested that the final regulations extend the orphan drug exclusion to drug sales for therapies that have only been approved to treat orphan diseases, and to all products that are FDA-approved for marketing solely for rare diseases and conditions. The final regulations do not adopt these suggestions because the plain language of section 9008(e)(3) requires that the drug be an orphan drug for which the section 45C credit was actually allowed rather than merely allowable. The terms "allowed" and "allowable" have separate and distinct meanings throughout the Code. For example, under section 1016(a)(2), a taxpayer may adjust basis to the extent the amount was "allowed" as a deduction in computing taxable income but not less than the amount "allowable."[1] In addition, the overwhelming weight of authority under the case law interprets the term "allowed" in the Code to require the taxpayer to have actually taken the amount into account

[1]Likewise, under section 1250(b)(3), if a taxpayer can establish that the amount "allowed" as a deduction was less than the amount "allowable," then the amount taken into account for purposes of a depreciation adjustment is the amount "allowed." *See* also section 36B(c)(1)(D) and section 42(j)(5)(A)(i).

for tax purposes.[2] The FDA's mere classification of a drug as an orphan drug is not a determining factor because the plain language of section 9008(e)(3) applies the exclusion only to sales of drugs for which a section 45C credit was in fact allowed.

Commenters also requested that orphan drug status be given to a drug for which a section 45C credit was allowed, even though the drug had been subsequently approved by the FDA for marketing for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. The final regulations do not adopt this suggestion because the plain language of section 9008(e)(3) indicates that if a drug is ever approved for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed, whether before, in the same year as, or after a section 45C credit was allowed for the drug, sales of that drug are not considered sales of an orphan drug beginning in the following sales year. However, a drug will retain its orphan drug status if the drug subsequently receives approval only for another indication for a rare disease or condition for which a section 45C credit was allowed.

Pre-1984 Generic Drugs

Section 9008(e)(2)(A) defines the term branded prescription drug to include any prescription drug the application for which was submitted to the FDA under section 505(b). The final regulations track the statutory language in defining the term branded prescription drug. Neither the statute nor the final regulations specifically refer to or address the treatment of generic drugs.

On September 24, 1984, Congress enacted the Drug Price Competition and Patent Restoration Act of 1984, Public Law 98–417 (1984) (the 1984 Act). The 1984 Act added section 505(j) to provide an expedited approval process for generic drugs. Because an applicant submits an application for approval of a generic drug after the 1984 Act under section 505(j) rather than section 505(b), such a drug is not a branded prescription drug for purposes of the branded prescription drug fee.

It has come to our attention that, before the 1984 Act, an applicant submitted an application for approval of any prescription drug under section 505(b), and no separate statutory process existed for approval of a generic drug. The Treasury Department and the IRS request comments on whether a special rule is appropriate regarding the treatment of generic drugs for which applications were submitted under section 505(b) prior to the 1984 Act, including comments on how to distinguish generic drugs for which applications were submitted under section 505(b) prior to the 1984 Act from other prescription drugs for which applications were submitted under section 505(b) prior to the 1984 Act in a manner that is both administrable and consistent with section 9008. Any special rule regarding the treatment of these generic drugs would be prospective only.

Comments with regard to this issue should be submitted in writing and can be mailed to the Office of Associate Chief Counsel (Passthroughs and Special Industries), Re: REG–112805–10, CC;PSI:B7, Room 5314, 1111 Constitution Avenue, NW, Washington, DC 20224. All comments received will be available for public inspection at *http://www.regulations.gov* (IRS REG–112805–10).

Information Requested From Covered Entities

The temporary regulations gave each covered entity the opportunity to provide information relevant to the determination of the fee by annually submitting Form 8947, including information regarding rebates. Commenters asked that CMS include all rebate data in its reports to the IRS, rather than have the IRS collect rebate data from the covered entities on Form 8947. CMS now includes rebate data for Medicare and federal Medicaid in its reports. Therefore, the final regulations eliminate the provision for separate reporting of Medicare and federal Medicaid rebates by covered entities and Form 8947 no longer requests information on these rebates. However, CMS does not include Medicaid state supplemental rebate data. Until CMS can include Medicaid state supplemental rebate data in its reports to the IRS, covered entities will continue to have the opportunity to submit this rebate data on Form 8947. Therefore, the final regulations retain the provision that permits separate reporting of Medicaid state supplemental rebate data by covered entities.

A commenter asked whether to include state-only pharmaceutical program rebates on Form 8947 as Medicaid Drug Rebates. According to CMS, state-only pharmaceutical programs are not part of the Medicaid Drug Rebate Program or the federal Medicaid program. Therefore, the final regulations specify that the Medicaid Drug Rebate Program's calculated branded prescription drug fee does not include state-only pharmaceutical sales or rebates. Accordingly, a covered entity may not report on its Form 8947 or error report a rebate paid by the covered entity in connection with a state-only pharmaceutical program.

A commenter asked that the final regulations provide that a covered entity may submit an incomplete Form 8947. The final regulations do not adopt this suggestion. Submission of Form 8947 is voluntary. A covered entity that chooses to file Form 8947, however, must state, under penalties of perjury, that to the best of the filer's knowledge and belief, the information provided on Form 8947 is true, correct, and complete. As in the past, a covered entity may correct and supplement information it submitted on Form 8947, if necessary, by submitting one or more error reports as part of the dispute resolution process.

Information Provided by the Agencies

Section 9008(g) requires each Program to calculate and provide sales data based on the methodologies described in section 9008(g). Section 9008(b)(3) requires the IRS to use the data provided by the Programs to calculate the fee. In accordance with the statute, the temporary regulations required the Agencies to provide data to the IRS on branded prescription drug sales that occurred during the sales year by Pro-

[2] *See Virginian Hotel Corporation of Lynchburg v. Helvering*, 319 U.S. 523, 526 (1943); *Flood v. United States*, 33 F.3d 1174, 1178 n.5 (9th Cir. 1994); *Lenz v. Commissioner*, 101 T.C. 260, 265 (1993); *Hightower v. Commissioner*, T.C. Memo 1982–559.

gram and NDC. The temporary regulations also set forth the methodologies used by the Agencies for calculating the sales amounts for each Program.

Commenters raised questions about the descriptions in the temporary regulations of the methodologies used by the Agencies, asked that these descriptions be clarified, suggested alternative methods of calculating Program sales data, and requested additional data. In response to these comments, the final regulations adopt certain suggestions to include revised descriptions of the data and computations the Agencies use to calculate branded prescription drug sales as described in the following sections for each Program. In addition, this preamble provides further background on the methodologies used by the Agencies as described in the following sections for each Program. Because the Agencies have the responsibility to compute and report the data described in the statute, the Treasury Department and the IRS coordinated extensively with the Agencies in preparing the additional background information in the preamble and the revised descriptions in the final regulations.

Medicare Part D

The temporary regulations provided that, to determine branded prescription drug sales amounts for Medicare Part D, CMS will aggregate the ingredient cost reported in the "Ingredient Cost Paid" field and the units reported in the "Quantity Dispensed" field of the Prescription Drug Event (PDE) records at the NDC level for each sales year. Section 9008(g)(1)(A) requires Medicare Part D sales amounts to be reduced by "any per-unit rebate, discount, or other price concession provided by the covered entity."

Commenters asked that the final regulations clarify how CMS determines these net sales amounts. The final regulations adopt this suggestion. The final regulations clarify that CMS will aggregate the "Ingredient Cost Paid" field on the PDE records at the NDC level, reduced by discounts, rebates, and other price concessions provided by the covered entity. To obtain this information, CMS uses two main data sources to determine net sales amounts: the PDE records and the Detailed Direct and Indirect Remuneration (DIR) Report. CMS obtains information for these two data sources from Medicare Part D sponsors.

The final regulations specifically define "discounts, rebates, and other price concessions provided by the covered entity" to include, in part, DIR. DIR is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person) that serve to decrease the costs incurred by the Medicare Part D sponsor (whether directly or indirectly) for the Medicare Part D drug. See 42 CFR 423.308. Thus, DIR includes discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, and coupons. DIR also includes goods in kind, free or reduced-price services, grants, legal judgment amounts, settlement amounts from lawsuits or other legal action, and other price concessions or similar benefits. However, DIR does not include price concessions that CMS does not consider to directly or indirectly impact drug costs incurred by the Medicare Part D sponsor.

The final regulations further provide that DIR includes both DIR reported on the PDE records at the point of sale and DIR reported on the Detailed DIR Report. The temporary regulations provided that, if CMS does not have Medicare Part D rebate information for a sales year, then the IRS will reduce the branded prescription drug sales reported for Medicare Part D by rebates reported by covered entities on Form 8947. This procedure was necessary for fee year 2011 because CMS did not have the information necessary to report Medicare Part D sales data net of DIR. To provide this data to the IRS at the individual drug level as the statute requires, CMS began to collect DIR at the NDC level from Medicare Part D sponsors for use in the 2012 fee year, which Medicare Part D sponsors report to CMS on the Detailed DIR Report. Medicare Part D sponsors also report DIR on the PDE records at the point of sale, though these amounts tend to be nominal. Therefore, since fee year 2012, CMS has been reporting its Medicare Part D sales data to the IRS net of all DIR by deducting from the Ingredient Cost both DIR reported on the PDE records at the point of sale and DIR reported on the Detailed DIR Report. The final regulations reflect this approach. As stated earlier in this preamble, the final regulations also eliminate the provision for separate reporting of Medicare Part D rebates by covered entities on Form 8947.

A commenter requested that the final regulations clarify the treatment of coverage gap discount amounts. The final regulations adopt this suggestion effective for fee years beginning in 2014. The Medicare Part D coverage gap, also known as the "donut hole," is a gap in prescription drug coverage that is being closed due to the Affordable Care Act. Part of closing the coverage gap is the Coverage Gap Discount Program described in section 1860D–14A of the Social Security Act, which requires a 50-percent manufacturer-paid discount on covered brand-name drugs in certain instances. For fee years 2012 and 2013, CMS did not deduct coverage gap discount amounts from the Ingredient Cost. This comment, however, prompted CMS to recharacterize coverage gap discount amounts as a type of rebate, discount, or other price concession for purposes of the fee calculation. Therefore, beginning with the final fee calculation for fee year 2014, CMS will report Medicare Part D sales data to the IRS that is net of coverage gap discount amounts. The final regulations reflect this change.

The final regulations also remove the reference to the "Quantity Dispensed" field of the PDE records. This field has no impact on sales because CMS totals the ingredient cost at the NDC level and determines DIR reported on the PDE records at the point of sale and DIR reported on the Detailed DIR Report at the NDC level. Thus, the unit of reference used by CMS is consistently at the NDC level.

Commenters suggested that the final regulations require CMS to exclude sales in Puerto Rico in determining sales amounts for Medicare Part D. The final regulations do not adopt this suggestion. Section 9008(g) requires each Agency to report to the IRS the total branded prescription drug sales for each covered entity for each Program. Section 9008 does not provide any exclusion for sales in Puerto Rico or any other territory. When calculating its branded prescription drug sales data for Medicare Part D, CMS includes sales, DIR reported on the PDE

records at the point of sale, and DIR reported on the Detailed DIR Report for all sales in the United States and its territories, including the Commonwealth of Puerto Rico.

Medicare Part B

The temporary regulations provided that CMS will determine branded prescription drug sales under Medicare Part B using two data sources. First, CMS will use the data reported by manufacturers pursuant to section 1847A(c) of the Social Security Act (42 U.S.C. 1395w–3a(c)) to calculate the annual weighted average sales price (ASP) for each Healthcare Common Procedure Coding System code (HCPCS code) for the sales year. Second, CMS will use the Medicare Part B National Summary Data File located at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/PartBNationalSummaryDataFile.html* to obtain the number of allowed billing units per HCPCS code for claims incurred during the sales year. The temporary regulations further provided separate detailed methods for CMS to use this data to determine Medicare Part B sales amounts depending on whether (1) the HCPCS code consists solely and exclusively of branded prescription drugs manufactured by a single entity, (2) the HCPCS code consists of a mixture of branded prescription drugs made by different manufacturers and/or a mixture of branded prescription and generic drugs, or (3) CMS is unable to establish a reliable proportion of sales attributable to each NDC assigned to the HCPCS code.

Under the third method in the temporary regulations, if CMS is unable to establish a reliable proportion of sales attributable to each NDC assigned to the HCPCS code, CMS will calculate Medicare Part B sales by using Medicare Part D utilization percentages. A commenter requested that CMS develop a more accurate backup method. The final regulations do not adopt this suggestion. In CMS's view, the existing backup method is sufficiently reliable. Additionally, CMS did not anticipate frequent use of this approach and has not needed to use the backup method for any fee calculation to date. The final regulations do, however, include a more detailed explanation of how CMS uses HCPCS codes as well as an example.

Commenters also expressed concern about whether Medicare Part B is capturing complete data on what are sometimes referred to as non-separately payable drugs. Non-separately payable drugs may not be directly correlated with a single specific HCPCS code. Some non-separately payable drugs are associated with more than one HCPCS code or are bundled with services, such as dialysis. CMS recognizes this concern and makes extensive effort to gather as complete a data set as possible. CMS will continue to work with the data available to capture non-separately payable drugs.

Medicaid

The temporary regulations provided that CMS will determine branded prescription drug sales as the per-unit Average Manufacturer Price (AMP) less the Unit Rebate Amount (URA) that CMS calculates based on manufacturer-reported pricing data multiplied by the number of units reported billed by the states to manufacturers. Specifically, the temporary regulations provided that for any covered entity identified in the first five (or six) digits of an NDC during any of the four quarters of a sales year, CMS uses the following methodology to derive the branded prescription sales amounts that account for third-party payers:

Step 1. Report total dollars per NDC for AMP minus URA, multiplied by the units reported by a state or states;

Step 2. Determine the percentage of the total amount reimbursed that is the Medicaid amount of that reimbursement; and

Step 3. Multiply the percentage of the Medicaid amount of that reimbursement by the dollar figure from step 1 (AMP minus URA, multiplied by units) to get the new adjusted sales dollar totals.

The final regulations clarify that CMS will determine branded prescription drug sales as the per-unit AMP less the URA that CMS calculates based on manufacturer-reported pricing data multiplied by the number of units reported as paid by the states rather than as billed by the states.

Commenters requested that the final regulations require Medicaid to use the per-unit ingredient cost paid to pharmacies by the states as provided in section 9008(g)(3) instead of AMP in computing total branded prescription drug sales. The final regulations do not adopt this suggestion. Medicaid does not have the ability to use the per-unit ingredient cost paid to pharmacies by the states because Medicaid systems are not designed to track drug sales data in this manner or obtain this type of detailed information from the states. Instead, Medicaid systems track drug sales data using AMP. AMP is the best alternative that Medicaid systems permit and serves as a reasonable proxy for the per-unit ingredient cost paid to pharmacies by the states.

The temporary regulations provided that Medicaid branded prescription drug sales data will be based on the data reported to CMS during the sales year by covered entities and the states for drugs paid for by the states in the Medicaid Drug Rebate Program during the sales year. The final regulations clarify that the sales data is based on the data that covered entities report for the sales year rather than the data that covered entities report during the sales year because some reporting for a sales year may occur after that year ends.

Commenters requested that the final regulations clarify the meaning of the phrase "drugs paid for by the states in the Medicaid Drug Rebate Program" and whether it includes units paid for under managed care organization plans. In response to this request, the final regulations specify that "drugs paid for by the states in the Medicaid Drug Rebate Program" includes all branded prescription drug units for which the states bill rebates to covered entities under the Medicaid Drug Rebate Program. This program includes, but is not limited to, units paid for under various health care plans such as fee for service, managed care organizations, and drugs administered in a non-retail setting such as drugs administered in a physician's office, clinic, hospital or other setting. Under the Medicaid Drug Rebate Program, states provide the required utilization data. States report separate totals for each NDC for both fee-for-service and managed care organization utilization

data. Also, as stated earlier in this preamble, the final regulations specify that the Medicaid Drug Rebate Program's calculated branded prescription drug fee does not include state-only pharmaceutical program sales or rebates.

Commenters asked how a covered entity can ensure that a state has updated its Medicaid data files to accurately reflect state rebates. This issue is beyond the scope of these regulations. However, since 2011, in the context of the dispute resolution process, CMS, IRS, and covered entities have devoted extensive resources to resolving discrepancies between a state's reported rebate data that CMS uses to compute Medicaid's branded prescription drug sales data for the IRS and the rebate data that covered entities receive from that state. To resolve these discrepancies on a timely basis, CMS has established a reconciliation process. To maximize the effectiveness of this reconciliation process, however, a covered entity must use the CMS reconciliation process in a timeframe that allows discrepancies to be resolved before CMS computes the branded prescription sales data that it sends the IRS for purposes of computing a covered entity's preliminary fee calculation. A covered entity's timely use of the CMS reconciliation process will help minimize, if not eliminate, the errors related to CMS's Medicaid data that a covered entity would otherwise include in its error report. The web address for this resource is *http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Branded-Prescription-Drug.html*. This CMS Medicaid Branded Prescription Drug Fee program webpage also has additional information regarding Medicaid sales data. Covered entities may e-mail questions to CMS Medicaid regarding the data used in this program at *MedicaidBPD@cms.hhs.gov* with "BPD" in the e-mail subject line.

Department of Veterans Affairs

The temporary regulations provided that VA will provide, by NDC, the total amount paid (net of refunds and rebates, when they are associated with a specific NDC) for each branded prescription drug procured by VA for its beneficiaries during the sales year. For this purpose, a drug is procured on the invoice (billing) date. The temporary regulations further provided that the basis of this information will be national procurement data reported during the sales year by VA's Pharmaceutical Prime Vendor to the VA Pharmacy Benefits Management Service and National Acquisition Center.

A commenter requested that the final regulations require that the amount of the IFF and CRF be excluded from VA sales either by requiring VA to exclude these amounts from its sales data or by allowing a covered entity to report these amounts on its Form 8947. The final regulations do not adopt this suggestion. According to VA, these amounts are part of the total price VA pays to its Pharmaceutical Prime Vendor and are properly included in the sales amount.

A commenter requested that the final regulations confirm that VA sales data does not include DOD, Coast Guard, Indian Health, or other purchases made under the Federal Supply Schedule. VA does not include in its sales data purchases made by other agencies. Because the methodology in the regulations is already limited to purchases made by VA, the final regulations do not need further clarification.

Department of Defense

The temporary regulations provided that, for DOD programs other than TRICARE, DOD will provide, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates or refunds) for each branded prescription drug procured by DOD during the sales year. For this purpose, a drug is procured based upon the date it was ordered.

A commenter requested that the final regulations require that the amount of the Industrial Funding Fee (IFF) and the Cost Recovery Fee (CRF) be excluded from DOD sales, either by requiring DOD to exclude these fees from its sales data or by allowing a covered entity to report these fees on its Form 8947. The IFF and CRF are administrative fees that are added to the cost of purchasing under the Federal Supply Schedule and National Contract Service. The final regulations do not adopt this suggestion. According to DOD, these fee amounts are part of the total price DOD pays to procure a drug and are properly included in the sales amount.

TRICARE

The temporary regulations provided that DOD will provide, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates or refunds) for each branded prescription drug procured by DOD through the TRICARE retail pharmacy program (TRICARE) during the sales year. For TRICARE, a drug is procured based upon the date it was dispensed. The amount paid is based on the submitted ingredient cost paid, aggregated by NDC, for eligible TRICARE claims submitted during the program year, minus any refunds or rebates for the corresponding claims.

Commenters expressed concern that TRICARE's drug sales overlap with DOD and VA and asked that the final regulations address this perceived overlap. The final regulations do not adopt this suggestion. No overlap exists because TRICARE only reports sales from its retail pharmacy network, which is distinct from sales reported by DOD and VA. TRICARE, DOD, and VA separately maintain and report their own drug sales data.

Section 51.4T(f) described the TRICARE and DOD methodologies for calculating sales data. Section 51.4(f) continues to describe the DOD methodology. A new subsection, § 51.4(g), describes the TRICARE methodology.

Fee Calculation Including Adjustment

As stated earlier in this preamble, because the use of the second preceding year as the sales year, rather than the immediately preceding year, may affect the amount of the fee paid by a covered entity, the temporary regulations provided that the annual fee due in every year after 2011 will include an adjustment amount. This adjustment amount will be added (or subtracted), as appropriate, to (or from) the fee otherwise payable by the covered entity in the fee year in which the adjustment is calculated.

A commenter asked that the final regulations provide for a separate dispute resolution process for the adjustment amount after the final fee calculation because errors reported in the dispute resolution process may not be resolved in time to be reflected in the final fee calculation. The final regulations do not adopt this suggestion. The adjustment amount is part of the preliminary fee calculation. Therefore, each covered entity has an opportunity to raise disputes regarding the adjustment amount during the existing dispute resolution process. Moreover, an adjustment to one covered entity's final fee calculation would necessitate a recalculation of each covered entity's prior final fee calculation because the fee is an allocated fee. The final regulations clarify that the IRS will not make adjustments to a final fee calculation.

Because the amount of the fee under the temporary regulations was based on sales from the second preceding year, commenters suggested that the final regulations allow a covered entity to reduce its fee liability in the same year that the covered entity experiences an event that would significantly reduce its sales to the Programs and make corresponding adjustments in future years. Such events may include a drug recall, a loss of patent exclusivity, or bankruptcy. The final regulations do not adopt this suggestion. The statute requires the IRS to determine each covered entity's branded prescription drug sales on the basis of reports submitted by the Agencies and to uniformly apply the fee determination rules to each covered entity's sales data. The methodology adopted in the final regulations ensures that the applicable fee amount is appropriately apportioned among the covered entities.

In accordance with section 9008(f)(1), the temporary regulations treated the fee as an excise tax for purposes of subtitle F. A commenter suggested that the final regulations provide for interest payments for adjustment amounts that are credited to a covered entity. The final regulations do not adopt this suggestion. Instead, the final regulations clarify that an adjustment amount itself is neither an overpayment nor an underpayment, but rather a component of the current year's fee. Thus, for purposes of section 6601, any increase in the current year's fee resulting from any adjustment amount, along with the remainder of the fee, is treated as due on the due date for the current year's fee. Conversely, for purposes of section 6611, any adjustment amount that decreases the current year's fee is treated as a payment towards the current fee amount made on the due date of the current fee year.

Commenters asked that the final regulations clarify whether a covered entity must file Form 843, "Claim for Refund and Request for Abatement," to request that the IRS calculate an adjustment amount when a covered entity anticipates that it is entitled to a positive adjustment amount. As stated earlier in this preamble, a positive adjustment amount is not an overpayment. Accordingly, in response to this comment, the final regulations clarify that a covered entity does not file Form 843 to obtain an adjustment amount. The IRS automatically calculates adjustment amounts. Additionally, the final regulations clarify that if a covered entity's adjustment amount reduces the fee below zero and results in an amount due to the covered entity for the fee year, the IRS will automatically pay this amount due to the covered entity.

Another commenter suggested that the final regulations clarify whether the period of limitations on filing a claim set forth in section 6511 applies to the adjustment amount. Under the final regulations, section 6511 applies to the fee, but not separately to the adjustment amount, because the adjustment amount is merely a component of the fee. For purposes of section 6511, any adjustment amount that decreases the current year's fee is treated as a payment towards the current fee amount made on the due date of the current fee year.

Notification and Payment of Fee

The temporary regulations provided that, no later than August 31st of each fee year, the IRS will send each covered entity its final fee calculation for that fee year. Several commenters suggested that the IRS send the final fee notice in an electronic format. The final regulations do not adopt this suggestion because it is outside the scope of these regulations. However, the final regulations do not prohibit the IRS from using an electronic format for the final fee notice. Moreover, at the time these comments were submitted, the IRS was already sending a covered entity's sales data with its preliminary fee notice on a separate CD-ROM in Microsoft Excel format to each covered entity that timely requested it. After receiving these comments, the IRS began also sending a covered entity's sales data with its final notice on a separate CD-ROM in Microsoft Excel format if the entity had made a timely request for the CD-ROM to be sent with its preliminary fee notice. More information about the manner for notifying covered entities of their preliminary and final fee calculations is contained in Notice 2014–42.

In accordance with section 9008(a)(2), the temporary regulations provided that each covered entity must pay its final fee by September 30th of the fee year. A commenter suggested that the final regulations clarify whether section 7503 applies to the deadline for fee payment. Section 7503 provides that if the last day for performing an act required under the authority of the internal revenue laws falls on a Saturday, Sunday, or a legal holiday, the performance of the act is timely if the act is performed on the next succeeding day that is not a Saturday, Sunday, or a legal holiday. The final regulations do not provide a special rule because section 9008(f)(1) and the final regulations treat the fee as an excise tax for purposes of subtitle F. Therefore, section 7503 applies to the deadline for fee payment.

Dispute Resolution Process

The temporary regulations provided for a dispute resolution process that allows a covered entity to submit error reports in response to the preliminary fee calculation for the IRS to consider before performing the final fee calculation. The temporary regulations described the information that covered entities must submit. The final regulations adopt these provisions with the following minor changes that will allow the IRS to more accurately process a covered entity's disputes.

The temporary regulations required that a Form 2848, "Power of Attorney and Declaration of Representative" must be

filed with an error report. The final regulations clarify that a Form 2848 is required only when the representative is not an employee of the covered entity who is authorized under section 6103 or designated on Form 8947 to discuss the information reported on Form 8947.

The temporary regulations required the name, telephone number, and e-mail address (if available) of one or more employees or representatives with whom errors may be discussed. The final regulations also require a fax number.

For Program errors, the temporary regulations required a covered entity to submit a separate error report for each Program with the asserted errors. For non-Program errors, the temporary regulations required a covered entity to submit one error report with all of the non-Program errors. To streamline the error reporting process, the final regulations require a covered entity to combine both Program and non-Program errors on a single error report, with each asserted error on a separate line.

Availability of IRS Documents.

The IRS notices, the revenue procedure, and the temporary regulations cited in this preamble are published in the Internal Revenue Bulletin and are available at *www.irs.gov*. The temporary regulations are also available in the Code of Federal Regulations.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information in these final regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the only collection burden imposed by these regulations is the requirement to maintain a record of consent to the selection of a designated entity, and this collection burden applies only to designated entities of controlled groups, which tend to be large corporations, and their members. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f), the notice of proposed rulemaking was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

Drafting Information

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

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Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 51 and 602 are amended as follows:

PART 51—BRANDED PRESCRIPTION DRUG FEE

Paragraph 1. The authority citation for part 51 continues to read as follows:

Authority: 26 U.S.C. 7805; sec. 9008, Public Law 111–347 (124 Stat. 119).

Section 51.8 also issued under 26 U.S.C. 6302(a).

Section 51.6302–1 also issued under 26 U.S.C. 6302(a).

Par. 2. Section 51.1 is added to read as follows:

§ 51.1 Overview.

(a) The regulations in this part 51 are designated "Branded Prescription Drug Fee Regulations."

(b) The regulations in this part 51 provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs by section 9008 of the Patient Protection and Affordable Care Act (ACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 1404 of the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law 111–152 (124 Stat. 1029 (2010)). All references in these regulations to section 9008 are references to section 9008 of the ACA, as amended by section 1404 of HCERA. Unless otherwise indicated, all other section references are to sections in the Internal Revenue Code. All references to "fee" in these regulations are references to the fee imposed by section 9008.

(c) Section 9008(b)(4) sets an applicable fee amount for each year, beginning with 2011, that will be apportioned among covered entities with aggregate branded prescription drug sales of over $5 million to government programs or pursuant to coverage under such programs. Generally, each covered entity is liable for a fee in each fee year that is based on its sales of branded prescription drugs in the sales year that corresponds to the fee year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

§ 51.1T [Removed]

Par. 3. Section 51.1T is removed.

Par. 4. Section 51.2T is revised to read as follows:

§ 51.2T Explanation of terms (temporary).

(a) through (e)(2) [Reserved]. For further guidance see § 51.2(a) through (e)(2).

(3) *Controlled Group*. The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(e)(4) through (m) [Reserved]. For further guidance see § 51.2(e)(4) through (m).

Par. 5. Section 51.2 is added to read as follows:

§ 51.2 Explanation of terms.

(a) *In general*. This section explains the terms used in this part for purposes of the fee imposed by section 9008 on branded prescription drugs.

(b) *Agencies*. The term *Agencies* means—

(1) The Centers for Medicare and Medicaid Services of the Department of Health and Human Services (CMS);

(2) The Department of Veterans Affairs (VA); and

(3) The Department of Defense (DOD).

(c) *Branded prescription drug*—(1) *In general*. The term *branded prescription drug* means—

(i) Any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) (FFDCA); or

(ii) Any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(2) *Prescription drug*. The term *prescription drug* means any drug that is subject to section 503(b) of the FFDCA.

(d) *Branded prescription drug sales*. The term *branded prescription drug sales* means sales of branded prescription drugs to any government program or pursuant to coverage under any such government program. However, the term does not include sales of orphan drugs.

(e) *Covered entity*—(1) *In general*. The term *covered entity* means any manufacturer or importer with gross receipts from branded prescription drug sales including—

(i) A single-person covered entity; or

(ii) A controlled group.

(2) *Single-person covered entity*. The term *single-person covered entity* means a covered entity that is not affiliated with a controlled group.

(3) *Controlled group*— (i) *On or before December 31, 2014*. The term *controlled group* means a group of at least two covered entities that are treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(ii) *After December 31, 2014*. For guidance regarding the definition of controlled group after December 31, 2014, see § 51.2T(e)(3).

(4) *Special rules for controlled groups*. For purposes of paragraph (e)(3) of this section (related to controlled groups)—

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

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

(5) *Covered entity status*—(i) *Rule*. An entity's status as a covered entity begins in the first fee year in which the entity has branded prescription drug sales and continues each subsequent fee year until there are no remaining branded prescription drug sales for that entity to be taken into account as described in § 51.5(c) or used to calculate the adjustment amount described in § 51.5(e).

(ii) *Example*. The following example illustrates the rule of paragraph (e)(5)(i) of this section:

(A) *Facts*. Entity A is a manufacturer with gross receipts of more than $5 million from branded prescription drugs sales in 2011. Entity A does not have any gross receipts from branded prescription drug sales before or after 2011.

(B) *Analysis*. Entity A is a covered entity beginning in 2011 because it had gross receipts from branded prescription drug sales in 2011. For the 2011 fee year, Entity A does not owe a fee because the 2011 fee is based on sales data from the 2009 sales year. For the 2012 fee year, Entity A does not owe a fee because the 2012 fee is based on sales data from the 2010 sales year. Entity A continues to be a covered entity for the 2012 fee year because its branded prescription drug sales from the 2011 sales year have not yet been taken into account as described in § 51.5(c) and used to calculate the adjustment amount described in § 51.5(e). For the 2013 fee year, Entity A continues to be a covered entity because a portion of its branded prescription drug sales from the 2011 sales year are taken into account as described in § 51.5(c) for purposes of computing the 2013 fee. For the 2013 fee year, Entity A is also liable for the adjustment amount described in § 51.5(e) for the difference between its 2012 fee computed using sales data from the 2010 sales year, which is $0, and what the 2012 fee would have been using sales data from the 2011 sales year. For the 2014 fee year, Entity A continues to be a covered entity because a portion of its branded prescription drug sales for the 2011 sales year are used to calculate the adjustment amount described in § 51.5(e). Therefore, for the 2014 fee year, Entity A will receive an adjustment amount for the difference between its 2013 fee computed using sales data from the 2011 sales year, and what the 2013 fee would have been using sales data from the 2012 sales year, which is $0. After the 2014 fee year, there are no remaining branded prescription drug sales to be taken into account as described in § 51.5(c) or used to calculate the adjustment amount described in § 51.5(e) for Entity A. Accordingly, Entity A is not a covered entity after the 2014 fee year.

(f) *Designated entity*—(1) *In general*. The term *designated entity* means the person within a controlled group that is designated to act for the controlled group regarding the fee by—

(i) Filing Form 8947, "Report of Branded Prescription Drug Information";

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

(iii) Filing an error report for the group, if applicable, as described in § 51.7; and

(iv) Paying the fee to the government.

(2) *Selection of designated entity*—(i) *Controlled group selection of a designated entity*. Except as provided in paragraph (f)(2)(ii) of this section, the controlled group may select a person as the designated entity by filing Form 8947 in accordance with the form instructions. The designated entity must state under penalties of perjury that all members of the controlled group have consented to the selection of the designated entity. The designated entity must maintain a record of all member consents. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity.

(ii) *Requirement for affiliated groups; agent for the group*. If the controlled group, without regard to foreign corporations included under section 9008(d)(2)(B), is also an affiliated group whose common parent files a consolidated return for federal income tax purposes, the designated entity is the agent for the group (within the meaning of § 1.1502–77 of this title).

(iii) *IRS selection of a designated entity*. Except as provided in paragraph (f)(2)(ii) of this section, if a controlled group does not select a designated entity as provided in paragraph (f)(2)(i) of this section, the IRS will select a member of the controlled group as the designated entity for the controlled group. If the IRS selects the designated entity, then all members of that controlled group will be deemed to have consented to the IRS's selection of the designated entity.

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

(h) *Government programs*. The term *government programs* (collectively "Programs"), means—

(1) The Medicare Part B program;

(2) The Medicare Part D program;

(3) The Medicaid program;

(4) Any program under which branded prescription drugs are procured by the Department of Veterans Affairs;

(5) Any program under which branded prescription drugs are procured by the Department of Defense; and

(6) The TRICARE retail pharmacy program.

(i) *Manufacturer or importer*. The term *manufacturer or importer* means the person identified in the Labeler Code of the National Drug Code (NDC) for a branded prescription drug.

(j) *NDC*. The term *NDC* means the National Drug Code. The NDC is a unique identifier that is assigned to all drug products approved by the Food and Drug Administration (FDA), including a branded prescription drug. The Labeler Code is the first five numeric characters of the NDC or the first six numeric characters when the available five-character code combinations are exhausted.

(k) *Orphan drugs*—(1) *In general*. Except as provided in paragraph (k)(2) of this section, the term *orphan drug* means any branded prescription drug for which any person claimed a section 45C credit and that credit was allowed for any taxable year.

(2) *Exclusions*. The term *orphan drug* does not include—

(i) Any drug for which there has been a final assessment or court order disallowing the full section 45C credit taken for the drug; or

(ii) Any drug for any sales year after the calendar year in which the FDA approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed, regardless of whether a section 45C credit was allowed for the drug before, in the same year as, or after this FDA designation.

(3) *FDA marketing approval for treatment of another rare disease or condition*. If a drug has prior FDA marketing approval for the treatment of a rare disease or condition for which a section 45C credit was allowed, and the FDA subsequently gives the drug marketing approval for the treatment of another rare disease or condition for which another section 45C credit was also allowed, the drug retains its status as an orphan drug provided the FDA has never approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed.

(4) *Examples*. The following examples illustrate the rules of this paragraph (k):

Example 1: Allowance of section 45C credit and later FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition. (i) *Facts*. Drug A is a branded prescription drug that was not on the market before 2011. In 2011, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug A. There was no final IRS assessment or court order that disallowed the full credit for Drug A. In 2012, the FDA approved Drug A for marketing for an indication other than the treatment of the rare disease or condition for which the section 45C credit was allowed and this indication was not for another rare disease or condition for which a section 45C was allowed.

(ii) *Analysis*. In 2011 and 2012, Drug A is an orphan drug because: first, it was a branded prescription drug for which a person claimed a section 45C credit and for which that credit was allowed for a taxable year; second, there was not a final assessment or court order disallowing the full credit taken for the drug; and third, before 2012, the FDA did not approve the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. However, Drug A is not an orphan drug for the 2013 sales year or later sales years because in 2012 the FDA approved Drug A for marketing for an indication other than the treatment of the rare disease or condition for which the section 45C credit was allowed and this indication was not for treatment of another rare disease or condition for which a section 45C credit was allowed.

Example 2: FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition and later allowance of section 45C credit. (i) *Facts*. Drug B is a branded prescription drug that was not on the market before 2011. In 2011, FDA approved Drug B for marketing for the treatment of a rare disease or condition and also approved Drug B for marketing for an indication other than the treatment of a rare disease or condition. In 2012, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug B. There was no final IRS assessment or court order that disallowed the full credit for Drug B.

(ii) *Analysis*. In 2011, Drug B is not an orphan drug because no section 45C credit was allowed and because the FDA approved Drug B for an indication other than the treatment of a rare disease or condition. In 2012, although the covered entity was allowed a section 45C credit for its qualified clinical testing expenses related to Drug B and there was no final IRS assessment or court order that disallowed the full credit, Drug B still is not an orphan drug because the FDA had approved the drug in 2011 for marketing for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed in 2012. Thus, Drug B is not an orphan drug for the 2012 sales year or later sales years.

Example 3: Allowance of section 45C credit and subsequent allowance of section 45C credit with no intervening FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. (i) *Facts*. Drug C is a branded prescription drug that was not on the market before 2010. In 2010, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug C. In 2012, a covered entity claimed an additional section 45C credit for its qualified clinical testing expenses related to Drug C for marketing for the treatment of a rare disease or condition different than the one for which the section 45C credit was claimed in 2010. There was no final IRS assessment or court order that disallowed the full credit for Drug C in 2010 or 2012. The FDA has not approved Drug C for an indication other than the treatment of a rare disease or condition for which a section 45C was allowed.

(ii) *Analysis*. In 2010 and 2011, Drug C is an orphan drug because: first, it was a branded prescription drug for which a person claimed a section 45C credit and for which that credit was allowed for a taxable year; second, there was not a final assessment or court order disallowing the full credit taken for the drug; and third, FDA had not approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. In 2012, Drug C retains its orphan drug status because another section 45C credit was allowed and the FDA did not approve Drug C for marketing for any indication other than the treatment of another rare disease or condition for which a section 45C credit was allowed. Thus, Drug C is an orphan drug for the 2013 sales year.

(l) *Sales taken into account*. The term *sales taken into account* means branded prescription drug sales after application of the percentage adjustment table in section 9008(b)(2) (relating to annual sales less than $400,000,001). See § 51.5(a)(3).

(m) *Sales year*. The term *sales year* means the second calendar year preceding the fee year. Thus, for example, for the fee year of 2014, the sales year is 2012.

Par. 6. Section 51.3 is added to read as follows:

§ 51.3 Information requested from covered entities.

(a) *In general*. Annually, each covered entity may submit a completed Form 8947, "Report of Branded Prescription Drug Information," in accordance with the instructions for the form. Generally, the form solicits information from covered entities on NDCs, orphan drugs, desig-

nated entities, rebates, and other information specified by the form or its instructions.

(b) *Due date*. Form 8947 must be filed by the date prescribed in guidance in the Internal Revenue Bulletin.

§ 51.3T [Removed]

Par. 7. Section 51.3T is removed.

Par. 8. Section 51.4 is added to read as follows:

§ 51.4 Information provided by the Agencies.

(a) *In general*. For each sales year, the IRS will compile a list of branded prescription drugs by NDC using the data submitted on Forms 8947 and in error reports submitted as part of the dispute resolution process (described in § 51.7) and, after applying appropriate due diligence, will provide this list to the Agencies. The Agencies will provide data to the IRS on branded prescription drug sales that occurred during the sales year by Program and NDC. The Agencies will provide data for use in preparing the preliminary fee calculation (described in §§ 51.5 and 51.6) and may revise or supplement that data following review of error reports submitted as part of the dispute resolution process. The calculation methodology for calculating the sales amounts for each Program, including any reasonable estimation techniques and assumptions that the Agencies expect to use, is described in this section.

(b) *Medicare Part D*—(1) *In general*. CMS will determine branded prescription drug sales under Medicare Part D by aggregating the ingredient cost reported in the "Ingredient Cost Paid" field on the Prescription Drug Event (PDE) records at the NDC level, reduced by discounts, rebates, and other price concessions provided by the covered entity, for each sales year. CMS will only include PDE data that Part D sponsors have submitted by the PDE submission deadline (within 6 months after the end of the sales year) and that CMS has approved for inclusion in the Part D payment reconciliation.

(2) *Discounts, rebates, and other price concessions*—(i) *In general*. For purposes of paragraph (b)(1) of this section, the term *discounts, rebates, and other price concessions* means:

(A) Any direct and indirect remuneration (DIR) (within the meaning of paragraph (b)(2)(B) of this section), which includes any DIR reported on the PDE records at the point of sale and any DIR reported on a Detailed DIR Report (within the meaning of paragraph (b)(2)(C) of this section); and

(B) Any coverage gap discount amount (within the meaning of paragraph (b)(2)(D) of this section).

(ii) *Direct and indirect remuneration*. For purposes of paragraph (b)(2)(A)(i) of this section, the term *direct and indirect remuneration* (DIR) has the same meaning as found in the definition of *actually paid* in 42 CFR 423.308.

(iii) *Detailed DIR Report*. For purposes of paragraph (b)(2)(A)(i) of this section, the term *Detailed DIR Report* means the report containing any DIR (within the meaning of paragraph (b)(2)(B) of this section) that is collected yearly from Part D sponsors at the NDC level.

(iv) *Coverage gap discount amount*. For purposes of paragraph (b)(2)(A)(ii) of this section, the term *coverage gap discount amount* means a 50-percent manufacturer-paid discount on certain drugs under the Coverage Gap Discount Program described in section 1860D–14A of the Social Security Act.

(c) *Medicare Part B*—(1) *In general*. CMS will determine branded prescription drug sales under Medicare Part B using the following two data sources:

(i) CMS will use data reported by manufacturers pursuant to section 1847A(c) of the Social Security Act to calculate the annual weighted average sales price (ASP) for each Healthcare Common Procedure Coding System (HCPCS) code for the sales year.

(ii) CMS will use the Medicare Part B National Summary Data File located at *http://www.cms.gov/NonIdentifiableDataFiles/03_PartBNationalSummaryDataFile.asp* to obtain the number of allowed billing units per HCPCS code for claims incurred during the sales year.

(2) *Calculation*—(i) *In general*. Using the data described in paragraph (c)(1) of this section, CMS will determine branded prescription drugs sales under Medicare Part B as described in paragraphs (c)(3), (4), and (5) of this section. CMS reports sales amounts per HCPCS billing code, not per NDC. Therefore, a covered entity's total Part B sales amounts for all NDCs in a given HCPCS billing code appears under only one NDC in each HCPCS billing code and the covered entity's remaining NDCs in the HCPCS billing code are listed with a sales amount of zero.

(ii) *Example of a Part B sales report*:

HCPCS	NDC	Part B amount
J9876	12345-6789-01	$789,000
	12345-6789-02	0
	12345-6789-03	0
	12345-6800-80	0
	12345-6800-90	0

(3) *HCPCS code; single entity*. For each HCPCS code consisting solely and exclusively of branded prescription drugs (as identified by their respective NDCs) manufactured by a single entity, CMS will multiply the annual weighted ASP by the total number of allowed billing units paid during the sales year to determine the total sales for all NDCs associated with the HCPCS code attributed to Medicare Part B.

(4) *HCPCS code; multiple manufacturers and/or multiple drugs*—(i) *Step one*. For each HCPCS code consisting of a mixture of branded prescription drugs made by different manufacturers and/or a mixture of branded prescription and generic drugs, CMS will determine—

(A) The annual weighted ASP for the HCPCS code;

(B) The total number of allowed billing units paid by Medicare Part B for each HCPCS code during the sales year;

(C) The names of the entities engaged in manufacturing each NDC assigned to the HCPCS code; and

(D) Those entities (if any) identified in paragraph (c)(4)(C) of this section that are manufacturing branded prescription drugs assigned to the HCPCS code.

(ii) *Step two*. Using the information from paragraph (c)(4)(i) of this section, CMS will then do the following:

(A) Calculate the proportion of sales, expressed as a percentage, attributed to each NDC assigned to the HCPCS code by determining the percentage of total sales reported to CMS by each manufacturer of NDC(s) that are assigned to the HCPCS code. For example, if HCPCS code JXXXX contains three drugs with a total of $310,000 sales reported by manufacturers to CMS for the sales year, and $100,000 was reported for Drug A, $200,000 was reported for Drug B, and $10,000 was reported for Drug C, the proportion of sales attributed to each NDC will be 32.26 percent for Drug A, 64.52 percent for Drug B, and 3.22 percent for Drug C; and

(B) For each NDC, multiply the product of the annual weighted ASP and the total allowed billing units paid by Medicare Part B for the HCPCS code by the proportion of sales calculated in paragraph (c)(4)(ii)(A) of this section to determine the sales reportable to the IRS (that is, percentage × (annual weighted ASP × allowed units) = total sales reported to IRS for the NDC). The sales for each manufacturer's NDCs assigned to a HCPCS code are summed and the total sales for each manufacturer's NDCs in a HCPCS code will be reported to the IRS.

(5) *HCPCS code; unable to establish a reliable proportion of sales.* If CMS is unable to establish a reliable proportion of sales attributable to each NDC assigned to the HCPCS code using the method described in paragraph (c)(4)(ii)(A) of this section, CMS will use Medicare Part D utilization percentages in lieu of the proportion of sales determined under paragraph (c)(4)(ii)(A) of this section to perform the calculation described in paragraph (c)(4)(ii)(B) of this section.

(d) *Medicaid*. (1) CMS will determine the branded prescription drug sales for Medicaid as the per-unit Average Manufacturer Price (AMP) less the Unit Rebate Amounts (URA) that CMS calculates based on manufacturer-reported pricing data multiplied by the number of units reported billed by states to manufacturers. This data will be based on the data reported to CMS for the sales year by covered entities and the states for drugs paid for by the states in the Medicaid Drug Rebate Program for the sales year. The data will include all branded prescription drug units for which the states bill rebates to covered entities under the Medicaid Drug Rebate Program. This program includes, but is not limited to, units paid for under various health care plans such as fee for service, managed care organizations, and drugs administered in a non-retail setting such as drugs administered in a physician's office, clinic, hospital or other setting. The Medicaid Drug Rebate Program's calculated branded prescription drug fee does not include state-only pharmaceutical program sales or rebates.

(2) For any covered entity identified in the first five (or six) digits of an NDC during any of the four quarters of a sales year, CMS will use the following methodology to derive the sales figures that account for third-party payers, such as Medicare Part B:

(i) Report total dollars per NDC for AMP minus URA multiplied by the units reported by a state or states.

(ii) Determine the percentage of the total amount reimbursed that is the Medicaid amount of that reimbursement. For example, if the total amount reimbursed is $100,000, and the Medicaid amount reimbursed is $20,000, then the percentage is 20 percent.

(iii) Multiply the percentage of the Medicaid amount of that reimbursement (in the example in paragraph (d)(2)(ii) of this section, 20 percent) by the dollar figure derived from paragraph (d)(2)(i) of this section (AMP minus URA multiplied by units) to get the new adjusted sales dollar totals.

(e) *Department of Veterans Affairs*. VA will determine branded prescription drug sales to VA by providing, by NDC, the total amount paid (net of refunds and rebates, when they are associated with a specific NDC) for each branded prescription drug procured by VA for its beneficiaries during the sales year. For this purpose, a drug is procured on the invoice (billing) date. The basis of this information will be national procurement data reported during the sales year by VA's Pharmaceutical Prime Vendor to the VA Pharmacy Benefits Management Service and National Acquisition Center. VA sales data includes the Industrial Funding Fee and the Cost Recovery Fee because these amounts are part of the price VA pays to its Pharmaceutical Prime Vendor to procure a drug.

(f) *Department of Defense*. DOD will determine branded prescription drug sales to DOD (for DOD programs other than the TRICARE retail pharmacy program) by providing, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates and or refunds) for each branded prescription drug procured by DOD (for DOD programs other than the TRICARE retail pharmacy program) during the sales year. For DOD programs other than the TRICARE retail pharmacy program, a drug is procured based upon the date it was ordered. DOD includes the Industrial Funding Fee and the Cost Recovery Fee in its drug sales data because these amounts are part of the price DOD pays to procure a drug.

(g) *TRICARE*. DOD will determine branded prescription drug sales to DOD for the TRICARE retail pharmacy program by providing, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates or refunds) for each branded prescription drug procured by DOD through the TRICARE retail pharmacy program during the sales year. For the TRICARE retail pharmacy program, a drug is procured based upon the date it was dispensed. The amount paid is based on the submitted ingredient cost paid, aggregated by NDC, for eligible TRICARE retail pharmacy claims submitted during the program year, minus any refunds or rebates for the corresponding claims.

§ 51.4T [Removed]

Par. 9. Section 51.4T is removed.

Par. 10. Section 51.5 is added to read as follows:

§ 51.5 Fee calculation.

(a) *Fee components*—(1) *In general*. For every fee year, the IRS will calculate a covered entity's total fee as described in this section. The IRS will determine a covered entity's total fee by applying, if applicable, the adjustment amount described in paragraph (e) of this section to the entity's allocated fee described in paragraph (d) of this section.

(2) *Calculation of branded prescription drug sales*. Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's branded prescription drug sales taken into account during the sales year bears to the aggregate branded prescription drug sales of all covered entities taken into account during the sales year.

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

Fee year	Applicable amount
2011	$2,500,000,000
2012	$2,800,000,000
2013	$2,800,000,000
2014	$3,000,000,000
2015	$3,000,000,000
2016	$3,000,000,000
2017	$4,000,000,000
2018	$4,100,000,000
2019 and thereafter	$2,800,000,000

(4) *Sales taken into account*. A covered entity's branded prescription drug sales taken into account during any calendar year are as follows:

Covered entity's branded prescription drug sales during the calendar year that are:	Percentage of branded prescription drug sales taken into account is
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000	10 percent
More than $125,000,000 but not more than $225,000,000	40 percent
More than $225,000,000 but not more than $400,000,000	75 percent
More than $400,000,000	100 percent

(b) *Determination of branded prescription drug sales*. The IRS will compile each covered entity's branded prescription drug sales for each Program by NDC. Each NDC will be attributed to the covered entity identified in the Labeler Code as of the end of the day on December 31st of the sales year. For a covered entity that is a controlled group, this includes all NDCs in which a member of the covered entity is identified. For this purpose, the IRS may revise the list of NDCs as a result of information received in the dispute resolution process, and the data the IRS uses to produce the final fee calculation will include any revisions provided by the Agencies at the completion of the dispute resolution process. Each covered entity's branded prescription drug sales will be reduced by its Medicaid state supplemental rebate amounts in the following manner. If CMS has Medicaid state supplemental rebate information for a sales year, CMS will report to the IRS branded prescription drug sales for Medicaid net of Medicaid state supplemental rebates. If CMS does not have complete Medicaid state supplemental rebate information for a sales year, the IRS will reduce the branded prescription drug sales that CMS reported for Medicaid by Medicaid state supplemental rebates reported by the covered entities on Form 8947.

(c) *Determination of sales taken into account*. (1) For each sales year and for each covered entity, the IRS will calculate sales taken into account. The resulting number is the numerator of the ratio described in paragraph (d)(1) of this section.

(2) For each sales year, the IRS will calculate the aggregate branded prescription drug sales taken into account for all covered entities. The resulting number is the denominator of the ratio described in paragraph (d)(2) of this section.

(d) *Allocated fee calculation*. For each covered entity for each fee year, the IRS will calculate the entity's allocated fee by multiplying the applicable amount from paragraph (a)(2) of this section by a fraction—

(1) The numerator of which is the covered entity's branded prescription drug sales taken into account during the sales year (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate branded prescription drug sales taken into account for all covered entities during the same year (described in paragraph (c)(2) of this section).

(e) *Adjustment amount*—(1) *In general*. In addition to the allocated fee computed under paragraph (d) of this section, the IRS will also automatically calculate for each covered entity an adjustment amount. An adjustment amount reflects the difference between the allocated fee determined for the covered entity in the immediately preceding fee year, using data from the second calendar year preceding that fee year, and what the allocated fee would have been for that entity for the immediately preceding fee year using data from the calendar year immediately preceding that fee year. For example, for 2014, the adjustment amount for a covered entity will be the difference between the entity's 2013 allocated fee, using 2011 data, and what the 2013 allocated fee would have been using 2012 data. Although the adjustment reflects a revision of the prior year's fee based on data from the year immediately preceding the prior fee year, the adjustment is only taken into account by adding it to or subtracting it from the allocated fee computed under paragraph (d) of this section for the current fee year to arrive at the total fee for the current fee year. An adjustment amount is treated as a component of the current year's fee. For purposes of section 6601, any increase in the allocated fee computed under paragraph (d) of this section for the current fee year resulting from any adjustment amount, along with the remainder of the fee, is treated as a fee liability due on the due date for the current year's fee. For purposes of sections 6511 and 6611, any adjustment amount that decreases the allocated fee computed under paragraph (d) of this section for the current fee year is treated as a payment towards the current fee liability made on the due date of the current fee year.

(2) *Amounts paid to a covered entity because of an adjustment amount*. If a covered entity's adjustment amount reduces the fee computed under paragraph (d) of this section below zero and results in an amount due to the covered entity for the fee year, the IRS will pay this amount due to the covered entity. A covered entity does not file Form 843, Claim for Refund and Request for Abatement, to receive this amount owed to a covered entity.

§ 51.5T [Removed]

Par. 11. Section 51.5T is removed.

Par. 12 Section 51.6 is added to read as follows:

§ 51.6 Notice of preliminary fee calculation.

(a) *Content of notice.* For each sales year, the IRS will make a preliminary calculation of the fee for each covered entity as described in § 51.5. The IRS will notify each covered entity of its preliminary fee calculation for that sales year. The notification to a covered entity of its preliminary fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's branded prescription drug sales, by NDC, by Program;

(3) The covered entity's branded prescription drug sales taken into account after application of § 51.5(a)(4);

(4) The aggregate branded prescription drug sales taken into account for all covered entities;

(5) The covered entity's adjustment amount calculated as described in § 51.5(e); and

(6) A reference to the fee dispute resolution procedures set forth in guidance published in the Internal Revenue Bulletin.

(b) *Time of notice*. The IRS will send each covered entity notice of its preliminary fee calculation by the date prescribed in guidance published in the Internal Revenue Bulletin.

§ 51.6T [Removed]

Par. 13. Section 51.6T is removed.

Par. 14. Section 51.7 is added to read as follows:

§ 51.7 Dispute resolution process.

(a) *In general*. Upon receipt of its preliminary fee calculation, each covered entity will have an opportunity to dispute this calculation by submitting to the IRS an error report as described in this section. The IRS will provide its final determination with respect to error reports no later than the time the IRS provides a covered entity with a final fee calculation.

(b) *Error report information*. To assert that there have been one or more errors in the drug sales data reported by a Program, the mathematical calculation of the fee, the rebate data, the listing of an NDC for an orphan drug, or any other error, a covered entity must submit an error report with each asserted error reported on a separate line. The report must include the following information—

(1) Entity name, address, and Employer Identification Number (EIN) as previously reported on the Form 8947;

(2) The name, telephone number, fax number, and e-mail address (if available) of one or more employees or representatives of the entity with whom the IRS may discuss the claimed errors. If the representative is not an employee of the covered entity who is authorized under section 6103 or designated on Form 8947 to discuss the information reported on Form 8947 with the IRS, a Form 2848, "*Power of Attorney and Declaration of Representative*," must be filed with the error report;

(3) For an error in the drug sales data reported by a Program, the name of the Program that reported the data, the NDC, the specific amount of sales data disputed, the proposed corrected amount, an explanation of why the Agency should use the proposed corrected data instead, and documentation of any Program drug sales data or other information used to establish the existence of any errors.

(4) For a mathematical calculation error, the specific calculation element(s) that the entity disputes and its proposed corrected calculation;

(5) For a rebate data error, the NDC for the drug to which it relates; a discussion of whether the data used in the preliminary fee calculation matches previously reported Form 8947 data on rebates; and, if the data used in the preliminary fee calculation does match the Form 8947 data, an explanation of why the Form 8947 data was erroneous and why the IRS should use the proposed corrected data instead;

(6) For the listing of an NDC for an orphan drug, the name and NDC of the orphan drug; a discussion of whether the data used in the preliminary fee calcula-

tion matches previously reported Form 8947 data on orphan drugs; and, if the data used in the preliminary fee calculation does match the Form 8947 data, an explanation of why the Form 8947 data was erroneous and why the IRS should use the proposed corrected data instead;

(7) For any other asserted error, an explanation of the nature of the error, how the error affects the fee calculation, an explanation of how the entity established that an error occurred, the proposed correction to the error, and an explanation of why the IRS or Agency should use the proposed corrected data instead;

(8) If an entity is using data to establish the existence of an error and that data was not reported on Form 8947 or contained in the notification of the preliminary fee calculation, a description of what the data is, how the entity acquired the data, and who maintains it; and

(9) Documentation of any rebate and orphan drug data, or other information used to establish the existence of any errors.

(c) *Form, manner, and timing of submission*. Each covered entity must submit its error report(s) in the form and manner that is prescribed in guidance published in the Internal Revenue Bulletin. This guidance will also prescribe the date by which each covered entity must submit its report(s).

(d) *Finality*. A covered entity must assert any basis for contesting its preliminary fee calculation during the dispute resolution period. In the interest of providing finality to the fee calculation process, the IRS will not accept an error report after the end of the dispute resolution period or alter the final fee calculation on the basis of information provided after the end of the dispute resolution period.

§ 51.7T [Removed]

Par. 15. Section 51.7T is removed.

Par. 16. Section 51.8 is added to read as follows:

§ 51.8 Notification and payment of fee.

(a) *Notification of final fee calculation*. No later than August 31st of each fee year, the IRS will send each covered entity its final fee calculation for that year. In any fee year, the IRS will base its final fee calculation on data provided to it by the Agencies as adjusted pursuant to the dispute resolution process. The notification to a covered entity of its final fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's adjustment amount calculated as described in § 51.5;

(3) The covered entity's branded prescription drug sales, by NDC, by Program;

(4) The covered entity's branded prescription drug sales taken into account after application of § 51.5(a)(4);

(5) The aggregate branded prescription drug sales taken into account for all covered entities; and

(6) The final determination with respect to error reports.

(b) *Differences in preliminary fee calculation and final fee calculation*. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the dispute resolution process described in § 51.7. Even if a covered entity did not file an error report described in § 51.7, a covered entity's final fee may differ from a covered entity's preliminary fee because of a change in data reported by the Agencies after resolution of error reports, including a change in the aggregate prescription drug sales figure. A change in aggregate prescription drug sales data can affect each covered entity's fee because each covered entity's fee is a fraction of the aggregate fee collected from all covered entities. A covered entity's final fee may also differ from its preliminary fee calculation because the data used in the preliminary fee calculation may have contained inaccurate branded prescription drug sales information that was corrected or updated at the conclusion of the dispute resolution process.

(c) *Payment of final fee*. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's EIN as reported on Form 8947. The fee must be paid by electronic funds transfer as required by § 51.6302–1. There is no tax return to be filed for the fee.

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

§ 51.8T [Removed]

Par. 17. Section 51.8T is removed.

Par. 18. Section 51.9 is added to read as follows:

§ 51.9 Tax treatment of fee.

(a) *Treatment as an excise tax*. The fee imposed by section 9008 is treated as an excise tax for purposes of subtitle F of the Internal Revenue Code (Code) (sections 6001–7874). Thus, references in subtitle F to "taxes imposed by this title," "internal revenue tax," and similar references, are also references to the fee imposed by section 9008. For example, the fee imposed by section 9008 is assessed (section 6201), collected (sections 6301, 6321, and 6331), enforced (section 7402 and 7403), subject to examination and summons (section 7602), and subject to confidentiality rules (section 6103) in the same manner as taxes imposed by the Code.

(b) *Deficiency procedures*. The deficiency procedures of sections 6211–6216 do not apply to the fee imposed by section 9008.

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

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

§ 51.9T [Removed]

Par. 19. Section 51.9T is removed.

Par. 20. Section 51.10 is added to read as follows:

§ 51.10 Refund claims.

Any claim for a refund of the fee must be made by the person that paid the fee to the government and must be made on Form 843, "Claim for Refund and Request

for Abatement," in accordance with the instructions for that form.

§ 51.10T [Removed]

Par. 21. Section 51.10T is removed.

Par. 22. Section 51.11T is revised to read as follows:

§ 51.11T Effective/applicability date.

(a) through (b) [Reserved]. For further guidance see § 51.11(a) through (b).

(c) Section 51.2T(e)(3) applies to any fee on branded prescription drug sales that is due on or after January 1, 2015.

(d) The applicability of § 51.2T(e)(3) expires on July 24, 2017.

Par. 23. Section 51.11 is added to read as follows:

§ 51.11 Effective/applicability date.

(a) Except as otherwise provided in this section, §§ 51.1 through 51.10 apply on and after July 28, 2014.

(b) Section 51.2(e)(3) applies on July 28, 2014 through December 31, 2014.

(c) [Reserved]. For further guidance see § 51.11T(c).

§ 51.12T [Removed]

Par. 24. Section 51.12T is removed.

Par. 25. Section 51.6302–1 is added to read as follows:

§ 51.6302–1 Method of paying the branded prescription drug fee.

(a) *Fee to be paid by electronic funds transfer.* Under the authority of section 6302(a), the fee imposed on branded prescription drug sales by section 9008 and § 51.5 must be paid by electronic funds transfer as defined in § 31.6302–1(h)(4)(i) of this title, as if the fee were a depository tax. For the time for paying the fee, see § 51.8.

(b) *Effective/applicability date.* This section applies on and after July 28, 2014.

§ 51.6302–1T [Removed]

Par. 26. Section 51.6302–1T is removed.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 27. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 28. In § 602.101, paragraph (b) is amended by:

1. Removing the entry for 51.8T from the table; and
2. Adding entries, in numerical order, for 51.2(f)(2)(ii) and 51.7 to the table to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control no.
* * * * *	
51.2(f)(2)(ii)	1545-2209
51.7.....	1545-2209
* * * * *	

John Dalrymple,
Deputy Commissioner for Services and Enforcement.

Approved July 22, 2014.

Mark J. Mazur,
Assistant Secretary of the Treasury (Tax Policy).

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Part III. Administrative, Procedural, and Miscellaneous

26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also §§ 36B, 5000A, 1.36B–2, 1.36B–2T, 1.36B–3, 1.36B–3T, 1.5000A–3.)

Rev. Proc. 2014–37

SECTION 1. PURPOSE

This revenue procedure provides indexing adjustments for certain provisions under sections 36B and 5000A of the Internal Revenue Code. In particular, it updates the Applicable Percentage Table in § 36B(b)(3)(A)(i). This table is used to calculate an individual's premium tax credit for taxable years beginning after calendar year 2014. This revenue procedure also updates the required contribution percentage in § 36B(c)(2)(C)(i)(II), which is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage under § 36B for plan years beginning after calendar year 2014. Additionally, this revenue procedure cross-references the required contribution percentage under § 5000A(e)(1)(A) for plan years beginning after calendar year 2014, as determined under guidance issued by the Department of Health and Human Services. This percentage is used to determine whether an individual is eligible for an exemption from the individual shared responsibility payment because of a lack of affordable minimum essential coverage.

SECTION 2. BACKGROUND

.01 Under § 36B(a), certain taxpayers are allowed a refundable premium tax credit to help individuals and families afford health insurance purchased through an Exchange.

.02 Section 36B(b)(2) provides that a taxpayer's premium tax credit is the lesser of the premiums for the plan or plans in which the taxpayer or one or more members of the taxpayer's family enroll and the excess of the premiums for the applicable second lowest cost silver plan covering the taxpayer's family, sometimes called the benchmark plan, over the taxpayer's contribution amount. A taxpayer's contribution amount is the product of the taxpayer's household income and an applicable percentage that increases as the taxpayer's household income increases. The applicable percentage is determined under rules specified in § 36B(b)(3)(A)(i).

.03 Taxpayers must use the percentage table in § 36B(b)(3)(A)(i) to compute their applicable percentages. Section 36B(b)(3)(A)(ii) provides that, for taxable years beginning in 2015, the percentages in the table under § 36B(b)(3)(A)(i) must be adjusted to reflect the excess of the rate of premium growth over the rate of income growth for the preceding calendar year.

.04 Section 36B(c)(2)(B) provides that a coverage month does not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage in the individual market described in § 5000A(f)(1)(C). Under § 36B(c)(2)(C), an individual is not treated as eligible for employer-sponsored minimum essential coverage if the required contribution with respect to the plan exceeds 9.5 percent (the Section 36B Required Contribution Percentage) of the applicable taxpayer's household income. Section 36B(c)(2)(C)(iv) provides that, for plan years beginning in 2015, the Section 36B Required Contribution Percentage is updated in the same manner that the applicable percentage is adjusted under § 36B(b)(3)(A)(ii).

.05 Temporary and final regulations released on July 24, 2014, (T.D. 9683) provide that the percentages in the Applicable Percentage Table and the Section 36B Required Contribution Percentage will be updated by the ratio of premium growth in the preceding calendar year to income growth in the preceding calendar year. *See* §§ 1.36B–2T(c)(3)(v)(C), and 1.36B–3T(g)(1) of the temporary Income Tax Regulations.

.06 Sections 1.36B–2T(c)(3)(v)(C) and 1.36B–3T(g)(1) further provide that the percentages in the Applicable Percentage Table and the Section 36B Required Contribution Percentage may be further adjusted to reflect updates to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or updates to the data sources used to the compute the ratio of premium growth to income growth.

.07 Starting in 2014, § 5000A provides for each individual to have minimum essential coverage for each month, qualify for an exemption, or make a payment (the individual shared responsibility payment) when filing his or her federal income tax return.

.08 Section 5000A(e)(1)(A) provides that an individual is exempt from § 5000A for a month if the individual's required contribution for minimum essential coverage exceeds 8 percent (the Section 5000A required contribution percentage) of the individual's household income. Section 5000A(e)(1)(D) provides that, for plan years beginning after 2014, the Section 5000A required contribution percentage is the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for that period.

SECTION 3. DEFINITIONS

.01 *Premium Growth for the Preceding Calendar Year* means the quotient determined by dividing the projected per enrollee spending for employer-sponsored private health insurance for the preceding calendar year by the projected per enrollee spending for employer-sponsored private health insurance for the calendar year two years prior. The projections are the National Health Expenditure Projections published by the Centers for Medicare and Medicaid Services Office of the Actuary.

.02 *Income Growth for the Preceding Calendar Year* means the quotient determined by dividing the projected GDP per capita for the preceding calendar year by projected GDP per capita for the calendar year two years prior. The projections are the National Health Expenditure Projections published by the Centers for Medicare and Medicaid Services Office of the Actuary.

.03 *Adjustment Ratio* means the quotient determined by dividing (1) the premium growth for the preceding calendar year by (2) the income growth for the preceding calendar year.

.04 *Applicable Percentage Table* means the table provided for in § 36B(b)(3)(A)(i).

.05 *Section 36B Required Contribution Percentage* means the percentage provided for in § 36B(c)(2)(C)(i)(II).

.06 *Preceding Year Applicable Percentage Table* means (1) the preceding calendar year's Applicable Percentage Table as calculated pursuant to this revenue procedure, or (2) for the 2015 calendar year, the Applicable Percentage Table provided in § 36B(b)(3)(A)(i) and § 1.36B–3T(g).

.07 *Preceding Year Section 36B Required Contribution Percentage* means (1) the preceding calendar year's Section 36B Required Contribution Percentage as calculated pursuant to this revenue procedure, or (2) for the 2015 calendar year, the required contribution percentage provided in § 36B(c)(2)(C)(i)(II) and § 1.36B–2T(c)(3)(v)(C).

SECTION 4. ADJUSTMENT METHODOLOGY

The Applicable Percentage Table is adjusted annually by multiplying each premium percentage in the Preceding Year Applicable Percentage Table by the Adjustment Ratio. The Section 36B Required Contribution Percentage is adjusted annually by multiplying the Preceding Year Section 36B Required Contribution Percentage by the Adjustment Ratio. The Applicable Percentage Table and the Section 36B Required Contribution Percentage calculated under this revenue procedure are rounded to hundredths of a percentage point.

The Applicable Percentage Table and the Section 36B Required Contribution Percentage may be further adjusted to reflect updates to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or updates to the data sources used to compute the ratio of premium growth to income growth.

SECTION 5. ADJUSTED ITEMS

.01 *Applicable Percentage Table for 2015*. For taxable years beginning in 2015, the Applicable Percentage Table for purposes of § 36B(b)(3)(A)(i) and § 1.36B–3T(g) is:

Household income percentage of Federal poverty line:	Initial percentage	Final percentage
Less than 133%	2.01%	2.01%
At least 133% but less than 150%	3.02%	4.02%
At least 150% but less than 200%	4.02%	6.34%
At least 200% but less than 250%	6.34%	8.10%
At least 250% but less than 300%	8.10%	9.56%
At least 300% but not more than 400%	9.56%	9.56%

.02 *Section 36B Required Contribution Percentage for 2015*. For plan years beginning in 2015, the required contribution percentage for purposes of § 36B(c)(2)(C)(i)(II) and § 1.36B–2T(c)(3)(v)(C) is 9.56%.

.03 *Section 5000A Required Contribution Percentage*. As specified in the Market Standards for 2015 and Beyond final rule, 79 Fed. Reg. 30240 (May 27, 2014), for plan years beginning in 2015, the Section 5000A required contribution percentage for purposes of § 5000A(e)(1)(A) and § 1.5000A–3(e)(2) is 8.05%.

SECTION 6. EFFECTIVE DATE

This revenue procedure is effective for taxable years and plan years beginning after December 31, 2014.

SECTION 7. DRAFTING INFORMATION

The principal author of this revenue procedure is Arvind Ravichandran of the Office of Associate Chief Counsel (Income Tax and Accounting). For further information regarding this revenue procedure, contact Mr. Ravichandran at (202) 317-4718 (not a toll-free Number).

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26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also Part 1, § 36B).

Rev. Proc. 2014–41

SECTION 1. PURPOSE

This revenue procedure provides guidance that a taxpayer may use to compute the deduction under § 162 of the Internal Revenue Code for health insurance costs for self-employed individuals and the premium tax credit allowed under § 36B.

SECTION 2. BACKGROUND

.01 Under § 162(l), a taxpayer who is an employee within the meaning of § 401(c)(1)—generally, a self-employed individual—is allowed a deduction for all or a portion of the taxpayer's premiums paid during the taxable year for health insurance for the taxpayer, the taxpayer's spouse, the taxpayer's dependents, and any child of the taxpayer under the age of 27. The deduction allowed under § 162(l) is limited to the taxpayer's earned income from the trade or business with respect to which the health insurance plan is established. A taxpayer's § 162(l) deduction is allowed in computing adjusted gross income. See § 62(a)(1).

.02 Section 36B allows a premium tax credit to taxpayers who enroll in a qualified health plan, as defined in § 1.36B–1(c) of the Income Tax Regulations, to assist with the cost of health care coverage. The amount of a taxpayer's premium tax credit is based on the taxpayer's household income as defined in § 36B(d)(2)(A). A taxpayer's household income is calculated using modified adjusted gross income. Modified adjusted gross income is adjusted gross income

plus certain items enumerated in § 36B(b)(2)(B). Consequently, the amount of a taxpayer's premium tax credit is based in part on the amount of the taxpayer's adjusted gross income.

.03 Some taxpayers enrolled in a qualified health plan and eligible for the premium tax credit may also be allowed a deduction under § 162(l). Section 1.162(l)–1T of the Temporary Income Tax Regulations provides rules for taxpayers who claim a § 162(l) deduction and also may be eligible for a § 36B credit for the same qualified health plan or plans. Under § 1.162(l)–1T(a)(1), a taxpayer is allowed a § 162(l) deduction for specified premiums not to exceed an amount equal to the lesser of (1) the specified premiums less the premium tax credit attributable to the specified premiums, and (2) the sum of the specified premiums not paid through advance credit payments and the additional tax imposed under § 36B(f)(2)(A) and § 1.36B–4(a)(1) with respect to the specified premiums after the application of the limitation on additional tax in § 36B(f)(2)(B) and § 1.36B–4(a)(3). Specified premiums are premiums for a specified qualified health plan or plans for which the taxpayer may otherwise claim a deduction under § 162(l). A specified qualified health plan is a qualified health plan, as defined in §1.36B–1(c), covering the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer (enrolled family member) for a month that is a coverage month within the meaning of § 1.36B–3(c) for the enrolled family member. *See* § 1.162(l)–1T(a)(2). If a specified qualified health plan covers individuals other than enrolled family members, the specified premiums include only the portion of the premiums for the specified qualified health plan that is allocable to the enrolled family members under rules similar to § 1.36B–3(h), which provides rules for determining the amount under § 1.36B–3(d)(1) when two families are enrolled in the same qualified health plan. *See* § 1.162(l)–1T(a)(2). Specified premiums not paid through advance credit payments equal the amount of the specified premiums minus the advance credit payments attributable to the specified premiums. *See* § 1.162(l)–1T(a)(3).

.04 Taxpayers who receive advance credit payments for a plan for which they claim a § 162(l) deduction determine the limit on additional tax under § 36B(f)(2)(B) using the rules in § 1.36B–4T(a)(3)(iii). These rules require the taxpayer to determine whether the taxpayer can meet the requirements to use a limitation on additional tax by testing the lowest limitation amount and sequentially moving up to the highest limitation amount. To meet the requirements for a limitation amount, the taxpayer's household income as a percentage of the Federal poverty line must be less than or equal to the maximum household income as a percentage of the Federal poverty line for which that limitation is available. For these purposes, household income is determined by using a § 162(l) deduction equal to the sum of specified premiums for the plan not paid through advance credit payments and the limitation amount in addition to any deduction allowable under § 162(l) for premiums other than specified premiums. If the taxpayer cannot meet the requirements for any limitation amount, the limitation on additional tax in § 36B(f)(2)(B) does not apply to the taxpayer.

.05 Because the § 162(l) deduction is allowed in computing adjusted gross income and because adjusted gross income is necessary for computing the premium tax credit, the taxpayer must know the allowable § 162(l) deduction to compute the premium tax credit. Thus, the amount of the § 162(l) deduction is based on the amount of the § 36B premium tax credit, and the amount of the credit is based on the amount of the deduction – a circular relationship. Consequently, a taxpayer eligible for both a § 162(l) deduction for premiums paid for qualified health plans and a § 36B premium tax credit may have difficulty determining the amounts of those items.

SECTION 3. SCOPE

This revenue procedure applies to a taxpayer who is allowed a deduction under § 162(l) for the taxable year for specified premiums, as defined in § 1.162(l)–1T(a)(2). This revenue procedure is intended to provide taxpayers with calculation methods that resolve the circular relationship between the § 162(l) deduction and the § 36B tax credit and that satisfy the requirements of applicable tax law. Using the calculations in this revenue procedure is optional. A taxpayer may determine amounts of the § 162(l) deduction and the § 36B tax credit using any method, provided that the amounts claimed satisfy the requirements of applicable tax law, including § 36B, § 162(l), and the regulations issued under those sections.

SECTION 4. DEDUCTION FOR PREMIUMS OTHER THAN SPECIFIED PREMIUMS

The calculations in section 5 of this revenue procedure apply only to specified premiums, as defined in § 1.162(l)–1T(a)(2). A taxpayer should not apply the calculations or the rules in this revenue procedure to premiums that are not specified premiums. Examples of premiums that are not specified premiums are: premiums paid for coverage other than a qualified health plan; premiums paid for a qualified health plan other than during a coverage month; and premiums paid to cover an individual other than the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer. To the extent a taxpayer may claim a § 162(l) deduction for premiums that are not specified premiums, the taxpayer should treat the deductions as the taxpayer treats all other deductions in determining adjusted gross income, modified adjusted gross income, and household income. *See* Example 3 of section 7 for an example illustrating the application of this section 4.

SECTION 5. COMPUTATIONS

A taxpayer described in section 3 of this revenue procedure may use the calculations described in this section 5 to determine the amounts of the § 162(l) deduction for specified premiums and the premium tax credit. Taxpayers who received advance credit payments should determine which limit on additional tax applies by following the rules in § 1.36B–4T(a)(3)(iii) before performing the computations in this section. Taxpayers may use either the iterative calculation in section 5.01 or the alternative calculation described in section 5.02 to compute the § 162(l) deduction for specified premiums and the premium tax credit. Section 5.03 provides additional detail on applying the

limitations in § 162(l) when performing the calculations in sections 5.01 and 5.02.

.01 *Iterative calculation*

(1) Step 1: Determine adjusted gross income, modified adjusted gross income, and household income by taking a § 162(l) deduction for the amount of specified premiums after applying the limit in section 5.03;

(2) Step 2: Compute the premium tax credit using the adjusted gross income, modified adjusted gross income, and household income determined in Step 1;

(3) Step 3: Determine the § 162(l) deduction by subtracting the Step 2 premium tax credit amount from the specified premiums and then applying the limit in section 5.03;

(4) Step 4: Compute the premium tax credit using the adjusted gross income, modified adjusted gross income and household income determined by taking into account the § 162(l) deduction in Step 3;

(5) Step 5: Repeat Step 3 by substituting the Step 4 premium tax credit for the Step 2 premium tax credit.

(6) Step 6: If changes in both the § 162(l) deduction and the premium tax credit from Steps 2 and 3 to Steps 4 and 5 are less than $1, use the section 162(l) deduction and premium tax credit amounts for the specified premiums determined in Steps 4 and 5. If the change in either the § 162(l) deduction or the premium tax credit from Steps 2 and 3 to Steps 4 and 5 is not less than $1, repeat Steps 4 and 5 (using amounts determined in the immediately preceding iteration) until changes in both the § 162(l) deduction and the premium tax credit between iterations are less than $1.

The taxpayer may claim a premium tax credit and § 162(l) deduction for the specified premiums equal to the amounts determined under Step 6. If a taxpayer is unable to complete Step 6 because changes between iterations always exceed $1, the taxpayer should not use the iterative calculation method, but may use the alternative calculation method in section 5.03 or another method that produces amounts that satisfy applicable tax law.

.02 *Alternative calculation*

(1) Step 1: Determine adjusted gross income, modified adjusted gross income, and household income by taking a § 162(l) deduction for the amount of specified premiums after applying the limit in section 5.03;

(2) Step 2: Compute the initial premium tax credit using the adjusted gross income, modified adjusted gross income, and household income determined in Step 1;

(3) Step 3: Determine the § 162(l) deduction by subtracting the Step 2 premium tax credit amount from the specified premiums and then applying the limit in section 5.03;

(4) Step 4: Compute the final premium tax credit using the adjusted gross income, modified adjusted gross income and household income determined by taking into account the § 162(l) deduction in Step 3.

The taxpayer may claim the amount of the premium tax credit determined under Step 4 and the amount of § 162(l) deduction for the specified premiums determined under Step 3.

.03 *Limits on § 162(l) deduction*

(1) This section 5.03 applies to the iterative calculation in section 5.01 and the alternative calculation in section 5.02. *See* Example 1 of section 7 for an example illustrating this section 5.03.

(2) A taxpayer's § 162(l) deduction may not exceed the lesser of:

(A) The taxpayer's earned income (within the meaning of § 401(c)) derived by the taxpayer from the trade or business with respect to which the health insurance is established; and

(B) The sum of (1) the specified premiums not paid through advance credit payments, and (2) the limitation on additional tax determined under § 1.36B–4T(a)(3)(iii).

SECTION 6. TAXPAYERS WITH COVERAGE MONTHS FOR WHICH NO SECTION 162(l) DEDUCTION IS ALLOWED

This section 6 applies to taxpayers described in section 3 of this revenue procedure who have a premium assistance amount, as described in § 36B(b)(2) and § 1.36B–3(d), for one or more coverage months for premiums that are not specified premiums. For example, if a taxpayer has a premium assistance amount for all months of a taxable year but, because the taxpayer began operating a trade or business in September of the year, has specified premiums for just the last four months of the taxable year, this section 6 applies. Taxpayers to whom this section 6 applies should complete Step 3 of the alternative calculation, and Step 3 and the corresponding succeeding Steps in the iterative calculation, except substituting "premium tax credit determined in Step 2 but only with respect to months in which specified premiums were paid" for "premium tax credit determined in Step 2."

See Example 4 of section 7 for an example illustrating the application of this section 6.

SECTION 7. EXAMPLES

Example 1: In 2014, A, A's spouse, and their two dependent children enroll in the second-lowest-cost silver plan, with an annual premium of $14,000. A is engaged in a trade or business as a sole proprietor and has household income (before taking into account the § 162(l) deduction) of $82,425, which includes $75,000 of earned income (within the meaning of § 401(c)) derived by the taxpayer from the trade or business with respect to which the health insurance is established. A received $10,500 in advance credit payments for the year. Because A received advance credit payments, A determines which limitation on additional tax applies under § 1.36B–4T(a)(3)(iii) and determines that A's limitation on additional tax is $2,500. A performs the alternative calculation as follows:

(1) Step 1. A determines the § 162(l) deduction after application of the limit in section 5.03. Under section 5.03, A's § 162(l) deduction is $6,000, the sum of (1) the specified premiums not paid through advance credit payments, $3,500 ($14,000 premiums − $10,500 of advance credit payments); and (2) the limitation on additional tax determined under § 1.36B–4T(a)(3)(iii), $2,500. A's Step 1 household income is $76,425 ($82,425 − $6,000), which is 325 percent of the Federal poverty line for a family of 4 (applicable percentage of 9.5).

(2) Step 2. A's initial premium tax credit based on household income of $76,425 is $6,740 ($76,425 × .095 = $7,260; $14,000 − $7,260 = $6,740).

(3) Step 3. A computes the specified premiums minus the premium tax credit as $7,260 ($14,000 − $6,740). However, as in Step 1, the limit in section 5.03 applies so that A's § 162(l) deduction may not exceed $6,000.

(4) Step 4. A's household income based on a § 162(l) deduction of $6,000 is $76,425. A's premium tax credit based on household income of $76,425 is $6,740 ($76,425 × .095 = $7,260; $14,000 − $7,260 = $6,740).

A's allowable § 162(l) deduction is the amount determined under Step 3, $6,000,

and A's premium tax credit is the amount determined under Step 4, $6,740.

If A chose to use the iterative calculation, the result would be the same.

Example 2: In 2014, B, B's spouse, and their two dependent children enroll in the applicable second-lowest-cost silver plan, with an annual premium of $14,000. B is engaged in a trade or business as a sole proprietor and has household income (before taking into account the § 162(l) deduction for specified qualified health plans) of $82,425, which includes $75,000 of earned income (within the meaning of § 401(c)) derived by B from the trade or business with respect to which the health insurance is established. B has no advance credit payments for the taxable year. B uses the alternative calculation in section 5.02 to determine the allowable § 162(l) deduction and premium tax credit as follows:

(1) Step 1. Specified premiums are $14,000 and B has no advance credit payments. B's Step 1 household income is $68,425 ($82,425 − $14,000), which is 291 percent of the Federal poverty line for a family of 4 (applicable percentage of 9.24). B's § 162(l) deduction is not limited under section 5.03 because B has more than $14,000 of earned income from the trade or business and B has no advance credit payments.

(2) Step 2. B's initial premium tax credit based on household income of $68,425 is $7,678 ($68,425 × .0924 = $6,322; $14,000 − $6,322 = $7,678).

(3) Step 3. B's § 162(l) deduction is $6,322 ($14,000 − $7,678). B's § 162(l) deduction is not limited under section 5.03 because B has more than $6,322 of earned income from the trade or business and B has no advance credit payments.

(4) Step 4. B's household income is $76,103 ($82,425 − $6,322), which is 323 percent of the Federal poverty line for B's family size (applicable percentage of 9.5). B's premium tax credit based on household income of $76,103 is $6,770 ($76,103 × .095 = $7,230; $14,000 − $7,230 = $6,770).

B's allowable § 162(l) deduction is the amount determined under Step 3, $6,322, and B's premium tax credit is the amount determined under Step 4, $6,770.

If B instead uses the iterative calculation under section 5.01, B would repeat Steps 3 and 4 using premium tax credit and § 162(l) deduction amounts in the immediately preceding iteration until changes in the credit and § 162(l) deduction between iterations are less than $1. In this case, B's allowable § 162(l) deduction would be $7,151 and B's premium tax credit would be $6,849.

Example 3: Same facts as Example 2, except that B also enrolls his non-dependent, 26-year old daughter in individual market coverage not offered on an Exchange. This coverage has an annual premium of $3,000. Under § 162(l)(1)(D), B is allowed a deduction for the premiums for coverage of the non-dependent 26-year old child. However, because the daughter is not a dependent, months of coverage for the daughter are not coverage months, and B may not receive a premium tax credit for B's daughter's coverage. B uses the alternative calculation in section 5.02 to determine the allowable § 162(l) deduction and premium tax credit as follows:

(1) Because none of the months of coverage for B's non-dependent are coverage months, B should apply the rule in section 4 first. Under section 4, B reduces his household income by the § 162(l) deduction he may claim for the non-dependent—$3,000—before performing any calculations in section 5 of this revenue procedure. B also does not include this portion of the § 162(l) deduction in performing either the iterative or the alternative calculation. Thus, before performing Step 1 of the alternative calculation, B begins with household income of $79,425 ($82,425 − $3,000) and specified premiums of $14,000 ($17,000 − $3,000).

(2) Step 1. Specified premiums are $14,000 and B has no advance credit payments. B's Step 1 household income is $65,425 ($79,425 − $14,000), which is 278 percent of the Federal poverty line for a family of 4 (applicable percentage of 8.86). B's § 162(l) deduction is not limited under section 5.03 because B has $72,000 of earned income not already offset by a § 162(l) deduction ($75,000 − $3,000 already deducted above), which is more than $14,000 and B has no advance credit payments.

(3) Step 2. B's initial premium tax credit based on household income of $65,425 is $8,203 ($65,425 × .0886 = $5,797; $14,000 − $5,797 = $8,203).

(4) Step 3. B's § 162(l) deduction is $5,797 ($14,000 − $8,203). B's § 162(l) deduction is not limited under section 5.03 because B has more than $5,797 of earned income from the trade or business and B has no advance credit payments.

(5) Step 4. B's household income is $73,628 ($79,425 − $5,797), which is 313 percent of the Federal poverty line for B's family size (applicable percentage of 9.5). B's premium tax credit based on household income of $73,628 is $7,005 ($73,628 × .095 = $6,995; $14,000 − $6,995 = $7,005). B's allowable § 162(l) deduction is $5,797, and B's premium tax credit is $7,005. B's § 162(l) deduction of $5,797 may be claimed in addition to the $3,000 § 162(l) deduction for the daughter's coverage, as described above.

If B chose to use the iterative calculation, B's allowable § 162(l) deduction for specified premiums would be $6,891and B's premium tax credit would be $7,109. B's § 162(l) deduction of $6,891 would be allowable in addition to the $3,000 § 162(l) deduction for the daughter's coverage, as described above.

Example 4: In 2014, C, C's spouse, and their two dependent children enroll in the applicable second-lowest-cost silver plan, with a monthly premium of $1,000. C is engaged in a trade or business as a sole proprietor and has household income (before taking into account the § 162(l) deduction for specified qualified health plans) of $82,425, which includes $18,000 of earned income (within the meaning of § 401(c)) derived by the taxpayer from the trade or business with respect to which the health insurance is established. C has no advance credit payments for the taxable year. C only operates a business from September to December. Because C is a taxpayer described in section 3 and has a premium assistance amount for one or more coverage months for premiums that are not specified premiums, section 6 applies to C. C uses the alternative calculation in section 5.02 to determine the allowable § 162(l) deduction and premium tax credit as follows:

(1) Step 1. Specified premiums are $4,000 (4 × $1,000) and C has no advance credit payments. C's Step 1 household income is $78,425 ($82,425 − $4,000), which is 333 percent of the Federal poverty line for a family of 4 (applicable percentage of 9.5). C's § 162(l) deduction is not limited under section 5.03 because C has more than $4,000 of earned income from the trade or business and does not have advance credit payments.

(2) Step 2. C's initial premium tax credit based on household income of $78,425 is $4,550 ($78,425 × .095 = $7,450; $12,000 − $7,450 = $4,550). (3) Step 3. Under section 6, C completes Step 3 using "premium tax credit determined in Step 2 but only with respect to months in which specified premiums were paid." C's Step 2 premium tax credit with respect to months for which specified premiums were paid is $1,517 ($4,550 × 4/12 = $1,517). Thus, C's § 162(l) deduction is $2,483 ($4,000 − $1,517). C's § 162(l) deduction is not limited because C has more than $2,483 of earned income from the trade or business and has no advance credit payments.

(4) Step 4. C's household income is $79,942 ($82,425 − $2,483), which is 339 percent of the Federal poverty line for C's family size (applicable percentage of 9.5). C's premium tax credit based on household income of $79,942 is $4,406 ($79,942 × .095 = $7,594; $12,000 − $7,594 = $4,406).

C's allowable § 162(l) deduction for specified premiums is the amount determined under Step 3, $2,483, and C's premium tax credit is the amount determined under Step 4, $4,406.

If C chose to use the iterative calculation, C's allowable § 162(l) deduction for specified premiums would be $2,530 and C's premium tax credit would be $4,410.

SECTION 8. EFFECTIVE DATE

This revenue procedure is effective for taxable years beginning after December 31, 2013.

SECTION 9. DRAFTING INFORMATION

The principal author of this revenue procedure is Arvind Ravichandran of the Office of the Associate Chief Counsel (Income Tax and Accounting). For further information regarding this notice, contact Mr. Ravichandran at (202) 622-4920 (not a toll-free number).

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26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also Part I, §§ 5000A; 1.5000A–4.)

Rev. Proc. 2014–46

SECTION 1. PURPOSE

This revenue procedure provides the 2014 monthly national average premium for qualified health plans that have a

bronze level of coverage for taxpayers to use in determining their maximum individual shared responsibility payment under § 5000A(c)(1)(B) of the Internal Revenue Code and § 1.5000A–4 of the Income Tax Regulations. This revenue procedure also provides an explanation of the methodology used to determine the monthly national average premium amount.

SECTION 2. BACKGROUND AND METHODOLOGY

.01 Under § 5000A, beginning in 2014, if a taxpayer or an individual for whom the taxpayer is liable is not covered under minimum essential coverage for one or more months, then, unless an exemption applies, the taxpayer is liable for the individual shared responsibility payment when filing his or her federal income tax return. Married individuals who file a joint return for a taxable year are jointly liable for any individual shared responsibility payment for a month included in the taxable year. *See* §§ 5000A(b)(3)(B) and 1.5000A–1(c)(3).

.02 The amount of a taxpayer's shared responsibility payment is based, in part, on the number of individuals a taxpayer is responsible for under § 5000A who do not have minimum essential coverage and who are not exempt. *See* §§ 5000A(c)(3)(B) and 1.5000A–4.

.03 For each taxable year, the individual shared responsibility payment is the lesser of (1) the sum of the monthly penalty amounts, or (2) the sum of the monthly national average bronze plan premiums for the shared responsibility family. *See* § 1.5000A–4(a). Shared responsibility family means, for a month in a taxable year, all nonexempt individuals for whom the taxpayer and the taxpayer's spouse, if the taxpayer is married and files a joint return with the spouse, are liable for the shared responsibility payment under § 5000A for that taxable year. *See* § 1.5000A–1(d)(17).

.04 The monthly national average bronze plan premium means, for a month for which a shared responsibility payment is imposed, 1/12 of the annual national average premium for qualified health plans that (1) have a bronze level of coverage, (2) would provide coverage for the taxpayer's shared responsibility family members, and (3) are offered through Exchanges for plan years beginning in a calendar year with or within which the taxable year ends. *See* §§ 5000A(c)(1)(B) and 1.5000A–4(c).

.05 Regulations issued by the United States Department of Health and Human Services (HHS) provide that nongrandfathered health insurance coverage, including qualified health plans offered through Exchanges, may set individual premiums on the basis of only four factors: the rating area, age, tobacco use, and family size. *See* 45 CFR § 147.102.

.06 A rating area is a geographic region representing all or a portion of a state that is established by the state or HHS. *See* § 2701(a)(2) of the Public Health Service Act (42 U.S.C. § 300gg(a)(2)) and 45 CFR § 147.102(b). Rating areas are generally defined to include one or more counties. Rating areas are not necessarily drawn on the basis of county lines, but, in almost all cases, individual counties fall entirely within a single rating area. Accordingly, the monthly national average bronze plan premium is based on the bronze-level qualified health plans available to qualified residents of each county or county equivalent in the United States. To limit the effect of outlier premiums, the median bronze-level premium in each county is used in computing the monthly national average premium. To account for variations in population between counties or county equivalents, each county's or county equivalent's median premium is weighted based upon that county's or county equivalent's population, as determined by the most recent population estimates available from the United States Census Bureau.

.07 Section 5000A(c)(1)(B) does not specify what age should be assumed in finding the national average bronze plan premium. HHS regulations concerning age rating distinguish between coverage for individuals who are age 21 and older (adults) and coverage of individuals under age 21. *See* 45 CFR pt. 147. Premium rates for adults age 21 and older may vary by age but not by more than 3:1 for adults in the same rating area and consistent with a uniform age curve established by the state or HHS. *See* 45 CFR § 147.102(a)(1)(iii). Premiums for individuals under age 21 may vary only if supported by actuarial evidence. *See* 45 CFR § 147.102(a)(1)(iii). In 2014, premiums for individuals under age 21 are uniformly lower than premiums for individuals aged 21 and older for the same plan. Under the age rating curve developed by HHS, which is used in states accounting for approximately 85 percent of the U.S. population, the premium for individuals under age 21 is set at 63.5 percent of the premium for individuals aged 21. Similar ratios are found in the other states. Thus, premiums for individuals aged 21 are generally somewhat higher than premiums for individuals under age 21 and are lower than premiums for most other adults.

.08 To simplify the calculation of the § 5000A individual shared responsibility payment and to help ensure that individuals subject to the limitation on the amount of the individual shared responsibility payment are generally not liable for a payment that materially exceeds the individual's actual cost of coverage, the monthly national average bronze plan premium is based upon the premium charged to individuals aged 21.

.09 HHS regulations also provide that premiums may vary, but not by more than 1.5:1 for individuals who use tobacco (as defined in 45 CFR 147.102(a)(1)(iii)) and may legally do so under federal and state law. *See* 5 CFR § 147.102(a)(1)(iv). According to the Centers for Disease Control and Prevention, most individuals in the United States are not tobacco users. To ensure that the higher health care costs associated with tobacco use do not raise the amount of the individual shared responsibility payment for the majority of taxpayers who are not tobacco users, the monthly national average bronze plan premium does not take into account the tobacco-use rating factor.

.10 Accordingly, for each nonexempt individual in a shared responsibility family who does not have minimum essential coverage, the monthly national average bronze plan premium is determined using a population-weighted average of the premium in each county or county equivalent that would be charged to a 21-year old individual who does not use tobacco.

.11 Under 45 CFR § 147.102(c)(1), premiums for family coverage (coverage

of more than one family member) generally are determined by finding the premium for each member of the family and adding them together, according to the number of members in the family covered under the plan. Under these regulations, the premiums for no more than the three oldest covered individuals under age 21 may be taken into account in determining the total family premium. As few affected families have more than two adults, generally no more than five family members are counted in determining the premium for family coverage. Therefore, consistent with HHS regulations, in determining a taxpayer's monthly national average bronze plan premium, the age-21 nontobacco user premium described above is multiplied by the number of individuals in the shared responsibility family, up to a maximum of five.

SECTION 3. MONTHLY NATIONAL AVERAGE BRONZE PLAN PREMIUM FOR 2014

.01 *Monthly National Average Bronze Plan Premium*. For purposes of § 5000A(c)(1)(B) and § 1.5000A–4, the monthly national average premium for qualified health plans that have a bronze level of coverage and are offered through Exchanges in 2014 is $204 per individual.

.02 *Maximum Monthly National Average Bronze Plan Premium*. For purposes of § 5000A(c)(1)(B) and § 1.5000A–4, the monthly national average premium for qualified health plans that have a bronze level of coverage and are offered through Exchanges in 2014 is $1,020 for a shared responsibility family with five or more members.

SECTION 4. EFFECTIVE DATE

This revenue procedure is effective for taxable years ending after December 31, 2013.

SECTION 5. DRAFTING INFORMATION

The principal author of this revenue procedure is John B. Lovelace of the Office of Associate Chief Counsel (Income Tax and Accounting). For further information regarding this revenue procedure, contact Mr. Lovelace at (202) 317-7006 (not a toll-free number).

Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

Rules Regarding the Health Insurance Premium Tax Credit

REG–104579–13

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: In the Rules and Regulations section of this issue the **Bulletin**, the IRS is issuing final and temporary regulations under section 36B of the Internal Revenue Code (Code) relating to the health insurance premium tax credit. The regulations provide guidance to individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Comments and requests for a public hearing must be received by October 27, 2014.

ADDRESSES: Send submissions to: CC: PA:LPD:PR (REG–104579–13), Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Taxpayers also may submit comments electronically via the Federal eRulemaking Portal at *www.regulations.gov* (IRS REG–104579–13).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Arvind Ravichandran, (202) 317-4718; concerning submission of comments or to request a hearing, Oluwafunmilayo Taylor, (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background and Explanation of Provisions

Final and temporary regulations in the Rules and Regulations section of this issue of the **Bulletin** amend the Income Tax Regulations (26 CFR Part 1) relating to section 36B and section 162(l) of the Code. The final and temporary regulations provide guidance for individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the final and temporary regulations explains the amendments.

Proposed Effective Date

These regulations are proposed to apply for taxable years ending after December 31, 2013. *See* § 1.36B–1(o). Taxpayers must apply the final and temporary regulations until publication of final regulations.

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 also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the 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, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

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

Drafting Information

The principal authors of these regulations are Arvind Ravichandran, Shareen Pflanz and Steve Toomey of the Office of Associate Chief Counsel (Income Tax & Accounting). However, other personnel from the IRS and the Treasury Department participated in their development.

* * * * *

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 1.36B–2 is amended by revising paragraphs (b)(2) and (c)(3)(v)(C), and adding paragraph (d) to read as follows:

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(b) * * *

(2) [The text of the proposed amendment to § 1.36B–2(b)(2) is the same as the text of § 1.36B–2T(b)(2) published elsewhere in this issue of the **Bulletin**].

* * * * *

(c) * * *

(3) * * *

(v) * * *

(C) [The text of the proposed amendment to § 1.36B–2(c)(3)(v)(C) is the same

as the text of § 1.36B–2T(c)(3)(v)(C) published elsewhere in this issue of the **Bulletin**].

* * * * *

(d) [The text of the proposed amendment to § 1.36B–2(d) is the same as the text of § 1.36B–2T(d) published elsewhere in this issue of the **Bulletin**].

Par. 3. Section 1.36B–3 is amended by revising paragraph (g)(1) and adding paragraph (m) to read as follows:

§ 1.36B–3 Computing the premium assistance credit amount.

* * * * *

(g) * * *

(1) [The text of the proposed amendment to § 1.36B–3(g)(1) is the same as the text of § 1.36B–3T(g)(1) published elsewhere in this issue of the **Bulletin**].

* * * * *

(m) [The text of the proposed amendment to § 1.36B–3(m) is the same as the text of § 1.36B–3T(m) published elsewhere in this issue of the **Bulletin**].

Par. 4. Section 1.36B–4 is amended by:

1. Revising paragraph (a)(1)(ii).
2. Adding paragraph (a)(3)(iii).
3. In paragraph (a)(4), revising *Example 4* and adding *Examples 10*, *11*, *12*, *13*, and *14*.
4. Revising paragraphs (b)(3) and (b)(4).
5. Removing paragraph (b)(5).
6. Redesignating paragraph (b)(6) as paragraph (b)(5), and revising *Example 9*, and adding *Example 10* to newly redesignated paragraph (b)(5).
7. Adding paragraph (c).

§ 1.36B–4 Reconciling the premium tax credit with advance credit payments.

(a) * * *

(1) * * *

(ii) [The text of the proposed amendment to § 1.36B–4(a)(1)(ii) is the same as the text of § 1.36B–4T(a)(1)(ii) published elsewhere in this issue of the **Bulletin**].

* * * * *

(3) * * *

(iii) [The text of the proposed amendment to § 1.36B–4(a)(3)(iii) is the same as the text of § 1.36B–4T(a)(3)(iii) published elsewhere in this issue of the **Bulletin**].

(4) [The text of the proposed amendment to § 1.36B–4, *Example 4*, *Example 10*, *Example 11*, *Example 12*, *Example 13*, and *Example 14* of paragraph (a)(4) is the same as the text of § 1.36B–4T(a)(4), *Example 4*, *Example 10*, *Example 11*, *Example 12*, *Example 13*, and *Example 14* published elsewhere in this issue of the **Bulletin**].

* * * * *

(b) * * *

(3) [The text of the proposed amendment to § 1.36B–4(b)(3) is the same as the text of § 1.36B–4T(b)(3) published elsewhere in this issue of the **Bulletin**].

(4) [The text of the proposed amendment to § 1.36B–4(b)(4) is the same as the text of § 1.36B–4T(b)(4) published elsewhere in this issue of the **Bulletin**].

(5) *Examples*. * * *

[The text of the proposed amendment to § 1.36B–4, *Example 9* and *Example 10* of paragraph (b)(5) is the same as the text of § 1.36B–4T, *Example 9* and *Example 10* of paragraph (b)(5) published elsewhere in this issue of the **Bulletin**].

* * * * *

(c) [The text of the proposed amendment to § 1.36B–4(c) is the same as the text of § 1.36B–4T(c) published elsewhere in this issue of the **Bulletin**].

Par 5. Section 1.162(l)–1 is added to read as follows:

§ 1.162(l)–1. Deduction for health insurance costs of self-employed individuals.

[The text of the proposed amendment to § 1.162(l)–1(a) through (c) is the same as the text of § 1.162(l)–1T(a) through (c) published elsewhere in this issue of the **Bulletin**].

John Dalrymple,
Deputy Commissioner for Services and Enforcement.

(Filed by the Office of the Federal Register on July 24, 2014, 4:15 p.m., and published in the issue of the Federal Register for July 28, 2014, 70 F.R. 43622)

Notice of Proposed Rulemaking and Notice of Public Hearing

Method of Accounting for Gains and Losses on Shares in Certain Money Market Funds; Broker Returns with Respect to Sales of Shares in Money Market Funds

REG–107012–14

AGENCY: Internal Revenue Service (IRS), Treasury.

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

SUMMARY: This document contains proposed regulations that provide a simplified method of accounting for gains and losses on shares in money market funds (MMFs) that distribute, redeem, and repurchase their shares at prices that reflect market-based valuation of the MMFs' portfolios and more precise rounding than has been required previously (floating net asset value MMFs, or floating-NAV MMFs). The proposed regulations also provide guidance regarding information reporting requirements for shares in MMFs. The proposed regulations respond to Securities and Exchange Commission (SEC) rules that change how certain MMF shares are priced. The proposed regulations affect floating-NAV MMFs and their shareholders. This document also contains requests for comments and provides notice of a public hearing on these proposed regulations.

DATES: Written or electronic comments must be received by October 27, 2014. Outlines of topics to be discussed at the public hearing scheduled for November 19, 2014, must be received by October 27, 2014.

ADDRESSES: Send submissions to: CC: PA:LPD:PR (REG–107012–14), 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–107012–14), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC, or sent electronically, via the Federal eRulemaking portal at *www.regulations.gov* (IRS REG–107012–14). The public hearing will be held in the IRS Auditorium, Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Grace E. Cho at (202) 317-6895; concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing, Oluwafunmilayo (Funmi) Taylor at (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to 26 CFR part 1 (Income Tax Regulations) under sections 446 and 6045 of the Internal Revenue Code (Code). These proposed regulations provide a method of accounting for gain or loss on shares in floating-NAV MMFs. The proposed regulations are intended to simplify tax compliance for holders of shares in MMFs affected by SEC regulations that change how certain MMF shares are priced. See Money Market Fund Reform; Amendments to Form PF, Securities Act Release No. 33–9616, Investment Advisers Act Release No. IA–3879, Investment Company Act Release No. IC–31166, Financial Reporting Codification No. FR–84 (SEC MMF Reform Rules).

An MMF is a type of investment company registered under the Investment Company Act of 1940 (1940 Act) and regulated as an MMF under Rule 2a–7 under the 1940 Act (17 CFR § 270.2a–7). Unlike other types of mutual funds, MMFs have historically sought to keep stable (typically at $1.00) the prices at which their shares are distributed, redeemed, and repurchased.

To hold itself out to investors as an MMF, an investment company must meet the requirements specified in Rule 2a–7, which, among other things, establishes limitations as to the maturity, quality, diversification, and liquidity of an MMF's investments. Generally, an MMF must hold a diversified portfolio of short-term, low-risk, liquid securities. The securities that an MMF holds generally result in no more than minimal fluctuations in the MMF's net asset value per share (NAV).

Until the SEC MMF Reform Rules change how certain MMFs price their shares, Rule 2a–7 permits any MMF meeting the other requirements of Rule 2a–7 to compute its price per share for purposes of distribution, redemption, and repurchase by using either or both of (a) the amortized cost method of valuation, and (b) the penny-rounding method of pricing. Under the amortized cost method, an MMF's NAV is determined by valuing the fund's portfolio securities at their acquisition cost, adjusted for amortization of premium or accretion of discount. Under the penny-rounding method, an MMF's NAV is rounded to the nearest one percent in computing the price per share for purposes of distribution, redemption, and repurchase. These methods have enabled MMFs to maintain constant share prices except in situations in which the "deviation [of the current net asset value per share calculated using available market quotations] from the money market fund's amortized cost price per share exceeds ½ of 1 percent" (commonly called "breaking the buck"). 17 CFR § 270.2a–7(c)(8)(ii)(B).

The perceived safety and simplicity of MMFs have led to their widespread use for cash management purposes. It is therefore common for investors to purchase and redeem MMF shares frequently. An MMF is often used as an account into which, or from which, cash is automatically deposited, or withdrawn, on a daily basis (commonly referred to as a sweep arrangement). MMFs generally declare dividends daily and distribute them monthly. MMF shareholders typically reinvest these distributions automatically in the MMF.

In June 2013, the SEC proposed rules that would change how certain MMF shares are priced. See Money Market Fund Reform; Amendments to Form PF, Securities Act Release No. 33–9408, Investment Advisors Act Release No. IA–3616, Investment Company Act Release No. IC–30551, 78 FR 36834 (June 19, 2013) (SEC MMF Reform Proposal). The SEC MMF Reform Rules adopt the general approach of the SEC MMF Reform Proposal, but include various modifications in response to comments and combine the two principal reform alternatives. (These alternatives were Floating Net Asset Value and Standby Liquidity Fees and Gates. See SEC MMF Reform Proposal at 36849 and 36878. The proposal included a number of other possibilities, including a combination of these two.) The SEC MMF Reform Rules generally bar the use of the amortized cost method of valuation and the use of the penny-rounding method of pricing, except by government MMFs and retail MMFs. A government MMF is an MMF that "invests 99.5 percent or more of its total assets in cash, government securities, and/or repurchase agreements that are collateralized fully." SEC MMF Reform Rules, § 270.2a–7(a)(16). A retail MMF is an MMF that "has policies and procedures reasonably designed to limit all beneficial owners of the fund to natural persons." *Id.* § 270.2a–7(a)(25). In the case of an MMF that is neither a government MMF nor a retail MMF, the SEC MMF Reform Rules require the MMF to value its portfolio securities using market-based factors and to "compute its price per share for purposes of distribution, redemption and repurchase by rounding the fund's current net asset value per share to a minimum of the fourth decimal place in the case of a fund with a $1.0000 share price or an equivalent or more precise level of accuracy for money market funds with a different share price (*e.g.* $10.000 per share, or $100.00 per share)." *Id.* § 270.2a–7(c)(1)(ii). (This method of computing the price per share is referred to hereafter as "basis point rounding.")

An MMF that uses market factors to value its securities and uses basis point rounding to price its shares for purposes of distribution, redemption, and repurchase has a share price that is expected to change regularly, or "float." (This fact explains the origin of the term "floating-NAV MMF.") Floating-NAV MMFs therefore resemble in some respects other mutual funds that are not MMFs, but they remain subject to the risk-limiting conditions in Rule 2a–7 and are expected to continue to fulfill MMFs' unique role. In the absence of the simplified method of accounting proposed in this document,

current law would require shareholders to compute gain or loss on every redemption of shares in a floating-NAV MMF.

Stable share prices simplify the taxation of transactions in MMF shares because a shareholder does not realize gain or loss when a share is redeemed for an amount equal to its basis. Shareholders typically will realize gain or loss, however, on redemptions of floating-NAV MMF shares. Comments received by the SEC in response to the SEC MMF Reform Proposal expressed concern about tracking and reporting gains and losses from shares in floating-NAV MMFs. The commenters observed that the frequent purchase and redemption of MMF shares combined with relatively small changes in share values could result in tax compliance burdens that, in the opinion of these commenters, would be disproportionate to the amounts of gain or loss at issue.

Explanation of Provisions

1. *Simplified Method of Accounting for Floating-NAV MMF Shares (NAV Method)*

Section 446(b) provides that, if no method of accounting has been regularly used by the taxpayer, taxable income shall be computed under a method that, in the opinion of the Secretary, clearly reflects income. The term "method of accounting" includes a taxpayer's overall method of accounting and the accounting treatment of any item. § 1.446–1(a)(1).

In response to concerns regarding the tax compliance burdens associated with frequent redemptions of shares in floating-NAV MMFs, these proposed regulations describe a permissible, simplified method of accounting for gain or loss on shares in a floating-NAV MMF (the net asset value method, or NAV method). The NAV method, in the opinion of the Commissioner of Internal Revenue, is a method of accounting that clearly reflects income from gain or loss on shares in floating-NAV MMFs. Under this method, gain or loss is based on the change in the aggregate value of the shares in the floating-NAV MMF during a computation period (which may be the taxpayer's taxable year or certain shorter periods) and the net amount of the purchases and redemptions during the period. More specifically, the taxpayer's net gain or loss from shares in a floating-NAV MMF for a computation period generally equals the value of the taxpayer's shares in the MMF at the end of the period, minus the value of the taxpayer's shares in the MMF at the end of the prior period, minus the taxpayer's net investment in the MMF during the period. The NAV method does not change the tax treatment of, or broker reporting requirements for, dividends from floating-NAV MMFs.

The proposed method simplifies tax computations by basing them on the aggregate of all transactions in a period and on aggregate fair market values. Every floating-NAV MMF must compute these fair market values for non-tax purposes regardless of how—or even whether—the MMF's shareholders are taxed on transactions in the MMF shares. The NAV method takes into account changes in value of floating-NAV MMF shares without regard to realization.

Under the NAV method, the character of a shareholder's net gain or loss depends on the character of the underlying MMF shares in the shareholder's hands. If all of a taxpayer's floating-NAV MMF shares in an account would yield capital (or ordinary) gain or loss, then net gain or loss under the NAV method is also capital (or ordinary). When shareholders recognize a net capital gain or loss under the NAV method, the proposed regulations provide that this gain or loss is short term. This holding period convention is necessary because the aggregation that is part of the method makes normal holding period determinations impracticable.

Under the NAV method, any basis adjustment imposed under internal revenue law with respect to shares in floating-NAV MMFs will generally give rise to gain or loss in the year of the adjustment. For example, if the basis of shares in a floating-NAV MMF is reduced under section 108(b)(2)(E) as a result of a discharge of indebtedness or under section 301(c)(2) as a result of receipt of a distribution that, in whole or in part, is not a dividend, then the gain on the shares in the MMF would be increased (or the loss would be decreased) by the amount of the adjustment. Comments are requested on the appropriate treatment of these or any other basis adjustments that might be imposed under internal revenue law with respect to shares in floating-NAV MMFs.

Taxpayers may adopt the NAV method pursuant to rules under § 1.446–1(e) by use of the NAV method in the Federal income tax return for the first taxable year in which the taxpayer holds shares in a floating-NAV MMF. See Rev. Rul. 90–38 (1990–1 CB 57). Once a taxpayer has adopted a method of accounting for gains and losses on shares in floating-NAV MMFs, any change from that method (including a change to or from the NAV method) is a change in method of accounting to which the provisions of section 446 and the accompanying regulations apply. The proposed regulations provide that the change is implemented on a cut-off basis.

In addition to requiring some MMFs to become floating-NAV MMFs, the SEC MMF Reform Rules also provide that, in appropriate circumstances, MMFs may impose liquidity fees. When a liquidity fee is in place, the proceeds received by any shareholder that redeems shares are reduced by the liquidity fee even though the redeemed shares may be in an MMF that uses penny-rounding to price its shares (a stable-value MMF). Because the cost of each stable-value MMF share redeemed (generally $1.00) will exceed the net amount of proceeds received for that share ($1.00, minus the liquidity fee), these redemptions would produce recognized losses under standard tax accounting. If the acquisition of other shares causes a redemption to be a wash sale under section 1091, then under section 1091(d), the acquired shares will have a basis greater than $1.00.

Because of the rarity of gains and losses on the shares in stable-value MMFs, both the MMFs themselves and their shareholders may lack the systems necessary to record the losses and to track the basis of any shares whose basis exceeds $1.00. In these circumstances, if the NAV method were available to the stable-value MMF shareholders, use of that method would reduce the shareholders' tax compliance burden. Accordingly, comments are requested regarding whether the NAV method should be available to shareholders of a stable-value MMF that has imposed a liquidity fee.

2. *Information Reporting for Floating-NAV MMF Shares*

Sections 6045, 6045A, and 6045B establish certain reporting requirements relating to securities. Section 1.6045–1(c)(3)(vi) provides an exception to the broker reporting requirement under section 6045 for shares in an MMF "that computes its current price per share for purposes of distributions, redemptions, and purchases so as to stabilize the price per share at a constant amount that approximates its issue price or the price at which it was originally sold to the public." Sections 1.6045A–1(a)(1)(v) and 1.6045B–1(a)(5) cross-reference § 1.6045–1(c)(3)(vi) to provide similar exceptions from the requirements of sections 6045A and 6045B, respectively. Comments received by the SEC in response to the SEC MMF Reform Proposal expressed concern that the existing exception would not apply to floating-NAV MMFs and suggested that requiring transaction-by-transaction information reporting would impose significant new costs on floating-NAV MMFs and intermediaries. The Treasury Department and the IRS believe that imposing broker reporting requirements on floating-NAV MMFs would result in administrative burdens that are not justified in light of the expected relative stability of floating-NAV MMF share prices. Therefore, the proposed regulations revise § 1.6045–1(c)(3)(vi) to clarify that the exceptions under sections 6045, 6045A, and 6045B continue to apply to all MMFs, including floating-NAV MMFs.

3. *Wash Sale Rules*

When the SEC MMF Reform Proposal was issued, commenters expressed concern about the difficulty of applying the wash sale rules of section 1091 to floating-NAV MMFs, especially the difficulty of tracking the basis under section 1091(d) of acquired shares. Use of the NAV method will eliminate those difficulties. Under the NAV method, net gain or loss is determined for each computation period, and no gain or loss is determined for any particular redemption of a taxpayer's shares in a floating-NAV MMF. Without a determination of loss, a particular redemption does not implicate the wash sale rules.

A shareholder of a floating-NAV MMF that does not use the NAV method, however, may experience frequent wash sales. For a shareholder with a substantial volume of transactions in floating-NAV MMF shares, tracking wash sales of MMF shares could present significant practical challenges. On July 29, 2013, the IRS published Notice 2013–48 (2013–31 IRB 120) in response to the SEC MMF Reform Proposal. The notice proposed a revenue procedure providing that the IRS would not treat a loss realized upon a redemption of a floating-NAV MMF share as subject to the wash sale rules if the amount of the loss was not more than one half of one percent of the taxpayer's basis in that share. The IRS received comments indicating that the proposed revenue procedure would not significantly reduce the tax compliance burdens associated with applying the wash sale rules to floating-NAV MMFs because shareholders would still have to track all wash sales to determine whether the amount of any particular wash sale exceeds the 0.5% *de minimis* test. The comments requested that floating-NAV MMFs be exempted entirely from the wash sale rules in section 1091.

Concurrently with these proposed regulations, the Treasury Department and the IRS are releasing a final revenue procedure providing that the wash sale rules will not be applied to redemptions of shares in floating-NAV MMFs. This revenue procedure will apply to redemptions of shares in floating-NAV MMFs on or after the effective date of the SEC MMF Reform Rules (expected to be 60 days after their publication in the Federal Register).

Proposed Effective/Applicability Dates

These regulations concerning the NAV method are proposed to apply to taxable years ending on or after the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations. Shareholders of floating-NAV MMFs, however, may rely on the rules in the regulations concerning the NAV method for taxable years ending on or after July 28, 2014, and beginning before the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations.

These regulations concerning information reporting are proposed to apply to calendar years beginning on or after the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations. Taxpayers and brokers (as defined in § 1.6045–1(a)(1)) may rely upon the rules in the regulations concerning information reporting for calendar years beginning before the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the 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, 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 (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS as prescribed in this preamble under the "Addresses" heading. The Treasury Department and the IRS request comments on all aspects of the proposed rules. Comments are specifically requested on the appropriate treatment of basis adjustments that might be imposed under sections 108(b)(2)(E), 301(c)(2), or any other provision of internal revenue law with respect to shares in floating-NAV MMFs. Comments are also requested regarding whether the NAV method should be avail-

able to shareholders of a non-floating-NAV MMF that has imposed a liquidity fee under § 270.2a–7(c)(2) of the SEC MMF Reform Rules. All comments will be available for public inspection and copying at *www.regulations.gov* or upon request.

A public hearing has been scheduled for November 19, 2014, at 10:00 a.m., in the IRS Auditorium, Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC. Due to building security procedures, visitors must enter through the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this 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 (signed original and eight (8) copies) or electronic comments and an outline of the topics to be discussed and the time to be devoted to each topic by October 27, 2014. 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 author of the proposed regulations is Grace E. Cho, IRS Office of the Associate Chief Counsel (Financial Institutions and Products). However, other personnel from the Treasury Department and the IRS participated in their development.

*** * * * ***

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 is amended by adding an entry in numerical order to read in part as follows:

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

Section 1.446–7 also issued under 26 U.S.C. 446. * * *

Par. 2. Section 1.446–7 is added to read as follows:

§ 1.446–7 Net asset value method for certain money market fund shares.

(a) *In general*. This section provides a permissible method of accounting for gain or loss on shares in a floating-NAV MMF (the net asset value method, or NAV method).

(b) *Definitions*. For purposes of this section—

(1) *Computation period*. The *computation period* is the period that a taxpayer selects for computing gain and loss under the NAV method for a floating-NAV MMF. The computation period may be the taxpayer's taxable year or a shorter period, such as a month, or a number of months, weeks, or days, provided that—

(i) Computation periods must be of approximately equal duration (except for initial or final computation periods in a taxable year);

(ii) Every day during the taxable year must fall within one, and only one, computation period; and

(iii) Each computation period must contain days from only one taxable year.

(2) *Ending value*. The *ending value* of a taxpayer's shares in a floating-NAV MMF for a computation period is the aggregate fair market value of the taxpayer's shares at the end of that computation period.

(3) *Floating-NAV MMF*. A *floating-NAV MMF* is an MMF that distributes, redeems, and repurchases its shares at prices that are computed by rounding the MMF's current net asset value per share to a minimum of the fourth decimal place in the case of an MMF with a share price at or about $1.0000 or an equivalent or more precise level of accuracy for an MMF with a different share price.

(4) *Money market fund (MMF)*. A *money market fund (MMF)* is a regulated investment company that is permitted to hold itself out to investors as a money market fund under Rule 2a–7 under the Investment Company Act of 1940.

(5) *Net investment*—(i) *In general*. The *net investment* in an MMF for a computation period may be a positive amount, a negative amount, or zero, and is equal to—

(A) The aggregate cost of shares in the MMF purchased during the computation period (including purchases through reinvestment of dividends); minus

(B) The aggregate amount received during the computation period in redemption of (or otherwise in exchange for) shares in the MMF if the transaction is one in which gain or loss would be recognized.

(ii) *Adjustments*—(A) *Dispositions in which gain or loss is not recognized*. If, during the computation period, any shares in an MMF are disposed of in transactions in which gain or loss would not be recognized, the net investment in the MMF for the computation period is decreased by the fair market value of each such share at the time of its disposition.

(B) *Acquisitions other than by purchase*. If, during the computation period, any shares in an MMF are acquired other than by purchase, the net investment in the MMF for the computation period is increased by the adjusted basis (for purposes of determining loss) of each such share immediately after its acquisition. If the adjusted basis referred to in the preceding sentence would be determined by reference to the basis of one or more shares in an MMF that are being disposed of by the taxpayer in a transaction that is governed by paragraph (b)(5)(ii)(A) of this section, then the basis of each such disposed share is treated as being the fair market value of that share at the time of its disposition.

(6) *Starting basis*. The *starting basis* of a taxpayer's shares in a floating-NAV MMF for a computation period is—

(i) Except as provided in paragraph (b)(6)(ii) of this section, the ending value of the taxpayer's shares for the immediately preceding computation period.

(ii) For the first computation period in a taxable year, if the taxpayer did not use the NAV method for the immediately preceding taxable year, the aggregate adjusted basis of the taxpayer's shares in the

floating-NAV MMF at the end of the immediately preceding taxable year.

(c) *NAV method*—(1) *Scope*. A taxpayer may use the NAV method described in this section to determine the gain or loss for the taxable year on the taxpayer's shares in each MMF that, at any time during the taxable year, was a floating-NAV MMF at a time when the taxpayer owned shares in the MMF. If a taxpayer uses the NAV method for shares in any floating-NAV MMF for a taxable year, the taxpayer must use the NAV method for that taxable year for the shares in every floating-NAV MMF in which the taxpayer holds shares. See paragraph (c)(6) of this section for rules applicable to accounting method changes.

(2) *Net gain or loss for a taxable year*—(i) *Determination for each computation period*. Subject to any adjustment under paragraph (c)(2)(ii) of this section, the net gain or loss for each computation period on the shares in a floating-NAV MMF to which the NAV method applies equals the ending value, minus the starting basis, minus the net investment in the floating-NAV MMF for the computation period. If the computation produces a result that is greater than zero, the taxpayer has a gain for the computation period with respect to shares in the MMF; if the computation produces a result that is less than zero, the taxpayer has a loss for the computation period on shares in the MMF; and if the computation produces a result that is equal to zero, the taxpayer has no gain or loss for the computation period on shares in the MMF.

(ii) *Adjustment of gain or loss to reflect any basis adjustments*. If, during a computation period, there is any downward (or upward) adjustment to the taxpayer's basis in the shares in the floating-NAV MMF under any provision of internal revenue law, then the net gain or loss for the computation period on shares in the floating-NAV MMF determined under paragraph (c)(2)(i) of this section is increased (or decreased) by the amount of the adjustment.

(iii) *Determination of net gain or loss for each taxable year*. The taxpayer's net gain or loss for a taxable year on shares in a floating-NAV MMF is the sum of the net gains or losses on shares in the floating-NAV MMF for the computation period (or computation periods) that comprise the taxable year.

(3) *Character*—(i) *In general*. If a taxpayer uses the NAV method for shares in a floating-NAV MMF and each of those shares otherwise would give rise to capital gain or loss if sold or exchanged in a computation period, then the gain or loss from the shares in the MMF is treated as capital. If a taxpayer uses the NAV method for shares in a floating-NAV MMF and each of those shares otherwise would give rise to ordinary gain or loss if sold or exchanged in a computation period, then the gain or loss from the shares in the MMF is treated as ordinary.

(ii) *Mixed character*. If a taxpayer uses the NAV method for shares in a floating-NAV MMF and those shares would otherwise give rise to both ordinary gain or loss and capital gain or loss if sold or exchanged in a computation period, then all gain or loss from the shares in this MMF is treated as capital gain or loss.

(iii) *Multiple accounts*. See paragraph (c)(5) of this section for the treatment of multiple accounts.

(4) *Holding period*. Capital gains and losses determined under the NAV method are treated as short-term capital gains and losses.

(5) *More than one account*. If a taxpayer holds shares in a floating-NAV MMF through more than one brokerage account, the taxpayer must treat its holdings in each account as a separate floating-NAV MMF for purposes of the NAV method and must separately apply the method to each such account.

(6) *Accounting method changes*. A change to or from the NAV method is a change in method of accounting to which the provisions of section 446 and the accompanying regulations apply. A taxpayer seeking to change to or from the NAV method must secure the consent of the Commissioner in accordance with § 1.446–1(e) and follow the administrative procedures issued under § 1.446–1(e)(3)(ii) for obtaining the Commissioner's consent to change the taxpayer's accounting method. Any such change will be made on a cut-off basis. Because there will be no duplication or omission of amounts as a result of such a change to or from the NAV method, no adjustment under section 481(a) is required or permitted.

(d) *Example*. The provisions of this section may be illustrated by the following example:

Example. (i) Fund is an MMF. Shareholder is a person whose taxable year is the calendar year. On January 1 of Year 1, Shareholder owns 5,000,000 shares in Fund in a single account with an adjusted basis of $5,000,000.00. On that date, Fund prices its shares using penny rounding under Rule 2a–7(c) under the Investment Company Act of 1940. On February 1 of Year 1, Fund becomes a floating-NAV MMF. During Year 1, Shareholder receives $32,158.23 in taxable dividends from Fund and makes 120 purchases of additional shares in Fund (including purchases through the reinvestment of those dividends) totaling $1,253,256.37 and 28 redemptions totaling $1,124,591.71. The fair market value of Shareholder's shares in Fund at the end of Year 1 is $5,129,750.00. All of Shareholder's shares in Fund are held as capital assets. There is no adjustment to the basis in Shareholder's shares in Fund under any provision of internal revenue law during Year 1.

(ii) Shareholder adopts the NAV method with its taxable year as the computation period. Shareholder's net investment in Fund for Year 1 equals $128,664.66 (the $1,253,256.37 in purchases, minus the $1,124,591.71 in redemptions). Shareholder's gain therefore is $1,085.34, which is the ending value of Shareholder's shares ($5,129,750.00), minus the starting basis of Shareholder's shares ($5,000,000.00), minus Shareholder's net investment in the fund for the taxable year ($128,664.66). The gain of $1,085.34 is treated as short-term capital gain. Shareholder's starting basis for Year 2 is $5,129,750.00. Shareholder must also include the $32,158.23 in dividends in its income for Year 1 in the same manner as if Shareholder did not use the NAV method.

(iii) If Shareholder had instead adopted the calendar month as its computation period, it would have used the NAV method for January of Year 1, even though Fund was not yet a floating-NAV MMF.

(e) *Effective/applicability date*. This section applies to taxable years ending on or after the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations. Taxpayers may rely on this section for taxable years ending on or after July 28, 2014, and beginning before the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations.

Par. 3. Section 1.6045–1 is amended by revising paragraph (c)(3)(vi) to read as follows:

§ 1.6045–1 Returns of information of brokers and barter exchanges.

* * * * *

(c) * * *

(3) * * *

(vi) *Money market funds*—(A) *In general*. No return of information is required with respect to a sale of shares in a regulated investment company that is permitted to hold itself out to investors as a money market fund under Rule 2a–7 under the Investment Company Act of 1940.

(B) *Effective/applicability date*. Paragraph (c)(3)(vi)(A) of this section applies to sales of shares in calendar years beginning on or after the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations. Taxpayers and brokers, however, may rely on paragraph (c)(3)(vi)(A) of this section for sales of shares in calendar years beginning before the date of publication in the **Federal Register** of a Treasury decision adopting these proposed regulations as final regulations.

* * * * *

John Dalrymple,
Deputy Commissioner for Services and Enforcement.

(Filed by the Office of the Federal Register on July 23, 4:15 p.m., and published in the issue of the Federal Register for July 28, 2014, 79 F.R. 43694)

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations.

Branded Prescription Drug Fee

REG–123286–14

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: In the Rules and Regulations section of this issue of the **Bulletin**, the IRS is issuing temporary regulations relating to the branded prescription drug fee. This fee was enacted by section 9008 of the Patient Protection and Affordable Care Act, as amended by section 1404 of the Health Care and Education Reconciliation Act of 2010, and the Health Care and Reconciliation Act of 2010 (collectively the ACA). The proposed regulations modify the definition of controlled group for purposes of the branded prescription drug fee. The proposed regulations affect persons engaged in the business of manufacturing or importing certain branded prescription drugs. The text of the temporary regulations also serves as the text of the proposed regulations.

DATES: Comments and requests for a public hearing must be received by October 27, 2014.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–123286–14), room 5205, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:PA:LPD:PR Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–123286–14), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC, or sent electronically via the Federal eRulemaking Portal at *www.regulations.gov* (IRS REG–123286–14).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Celia Gabrysh, (202) 317-6855; concerning submissions of comments and request for a hearing, Oluwafunmilayo Taylor, (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

Temporary regulations in the Rules and Regulations section of this issue of the **Bulletin** amend §§ 51.2(e)(3) and 51.11(c) of the Branded Prescription Drug Fee Regulations, 26 CFR Part 51. The text of those regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the amendment.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory flexibility assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. Because these regulations do not impose a collection of information on small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

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

Drafting Information

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

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 51 is proposed to be amended as follows:

PART 51—BRANDED PRESCRIPTION DRUGS

Paragraph 1. The authority citation for part 51 continues to read in part as follows:

Authority: Authority: 26 U.S.C. 7805; sec. 9008, Public Law 111–347 (124 Stat. 119).

* * * * *

Par. 2. Section 51.2 is amended by revising paragraph (e)(3) to read as follows:

§ 51.2 Explanation of terms.

* * * * *

(e) * * *

(3) [The text of proposed § 51.2(e)(3) is the same as the text of § 51.2T(e)(3) published elsewhere in this issue of the **Bulletin**.]

Par. 3. Section 51.11 is amended by revising paragraph (c) to read as follows:

§ 51.11 Effective/applicability date.

* * * * *

(c) [The text of proposed § 51.11(c) is the same as the text of § 51.11T(c) published elsewhere in this issue of the **Bulletin**.]

John Dalrymple,
Deputy Commissioner for Services and Enforcement.

(Filed by the Office of the Federal Register on July 24, 2014, 4:15 p.m., and published in the issue of the Federal Register for July 28, 2014, 79 F.R. 43699)

Definition of Terms

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

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

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[1]A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2014–01 through 2014–26 is in Internal Revenue Bulletin 2014–26, dated June 30, 2014.

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Key to Abbreviations:

Ann	Announcement
CD	Court Decision
DO	Delegation Order
EO	Executive Order
PL	Public Law
PTE	Prohibited Transaction Exemption
RP	Revenue Procedure
RR	Revenue Ruling
SPR	Statement of Procedural Rules
TC	Tax Convention
TD	Treasury Decision
TDO	Treasury Department Order

ADMINISTRATIVE

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Internal Revenue Service
Washington, DC 20224

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INTERNAL REVENUE BULLETIN

The Introduction at the beginning of this issue describes the purpose and content of this publication. The weekly Internal Revenue Bulletins are available at *www.irs.gov/irb/*.

CUMULATIVE BULLETINS

The contents of the weekly Bulletins were consolidated semiannually into permanent, indexed, Cumulative Bulletins through the 2008–2 edition.

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We Welcome Comments About the Internal Revenue Bulletin

If you have comments concerning the format or production of the Internal Revenue Bulletin or suggestions for improving it, we would be pleased to hear from you. You can email us your suggestions or comments through the IRS Internet Home Page (*www.irs.gov*) or write to the IRS Bulletin Unit, SE:W:CAR:MP:P:SPA, Washington, DC 20224.