fined in section 106(c)(2)), or under HRAs that are treated as employer-provided coverage under accident or health plans for purposes of section 106. This amendment is effective for payments made after December 31, 2002.

Pursuant to section 7805(b)(8), the Form 1099 requirement described in Rev. Rul. 2003–43 will be applied without retroactive effect for payments made under FSAs and HRAs prior to January 1, 2003. This action is taken to assure employers and third party administrators that FSA and HRA payments for medical care will not be subject to information reporting prior to the effective date of the amendment to section 6041 in the Medicare Act.

The principal author of this notice is Nancy Rose of the Office of Associate Chief Counsel (Procedure and Administration), Administrative Provisions and Judicial Practice Division. For further information regarding this notice, contact Ms. Rose at (202) 622–4910 (not a toll-free call).

Section 35.—Health Insurance Costs of Eligible Individuals

Rev. Proc. 2004–12

SECTION 1. PURPOSE

This revenue procedure provides guidance on how a state elects a health program to be qualified health insurance for purposes of the health coverage tax credit (HCTC) under section 35 of the Internal Revenue Code.

SECTION 2. BACKGROUND

.01 On August 6, 2002, President Bush signed into law the Trade Act of 2002 ("the Act"), Pub. L. 107–210, 116 Stat. 933 (2002). Title II of the Act contains provisions that make assistance available to certain individuals participating in the Trade Adjustment Assistance program (TAA) or receiving payments from the Pension Benefit Guaranty Corporation (PBGC), to enable them to purchase health insurance. The primary mechanism for such assistance is a federal tax credit that is equal to 65 percent of the amount paid by the eligible individual for coverage for the individual and qualifying family members under qualified health insurance. The health coverage tax credit became available on December 1, 2002, and is claimed on the eligible individual's income tax return. Beginning August 1, 2003, the HCTC is also available on a monthly basis as the premium is paid. Under the advance HCTC program, the government's share — 65 percent of the premium amount paid by the individual — is combined with the eligible individual's payment of the other 35 percent and paid on a monthly basis, in general to the qualified health plan in which the individual has enrolled.

.02 There are two basic categories of individuals who may be eligible for the HCTC:

(1) TAA recipients (as described in section 2.03 of this revenue procedure), and

(2) PBGC pension recipients who have attained age 55 but who do not have Medicare coverage (as described in section 2.04 of this revenue procedure).

.03 A TAA recipient is any individual who is receiving a trade readjustment allowance under the Trade Act of 1974 for any day of a month, or any individual who would be eligible for such an allowance except that the individual has not exhausted the individual's regular unemployment insurance benefits. In addition, for purposes of this revenue procedure, any individual receiving benefits under the alternative trade adjustment assistance program, established under § 246 of the Trade Act of 1974, 19 U.S.C. §§ 2271–2275 (2003), is also a TAA recipient. All TAA recipients remain eligible for the HCTC (and thus are still considered TAA recipients) for one month after the end of the month that their eligibility for TAA ceases.

.04 A PBGC pension recipient is a person who is receiving a benefit payment from the PBGC for a month and who has attained age 55 (but who is not entitled to Medicare) on the first day of the month.

.05 There are ten categories of health insurance that may be qualified coverage for purposes of the HCTC:

(1) COBRA coverage: Coverage under a COBRA continuation provision (under § 4980B of the Code; part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1161–1168 (2003); or title XXII of the Public Health Service Act, 42 U.S.C. §§ 300bb–1-300bb–8 (2003));

(2) State-based continuation coverage: Coverage under a state law that requires continuation coverage;

(3) High risk pool: Coverage offered through a qualified state high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act, 42 U.S.C. § 300gg–44(c)(2) (2003));

(4) State employees' health plan: Coverage under a health insurance program offered for state employees;

(5) Comparable state employees' health plan: Coverage under a state-based health insurance program that is comparable to the health insurance program offered for state employees;

(6) State arrangement: An arrangement to offer coverage to HCTC eligible individuals entered into by a state with —

(a) an issuer of health insurance coverage;

(b) an administrator;

(c) an employer; or

(d) a group health plan (including a multiemployer plan);

(7) Private purchasing pool: Coverage offered through a state arrangement with a private sector health care coverage purchasing pool;

(8) Other state plans: Coverage under a state-operated health plan that does not receive any federal financial assistance;

(9) Spousal coverage: Coverage under a group health plan that is available through the employment of the HCTC eligible individual's spouse (but only if the spouse's employer contributes less than 50 percent of the total cost of coverage for the spouse, the eligible individual, and any dependents); and

(10) Individual health insurance: Coverage under individual health insurance if the HCTC eligible individual was covered under the insurance during the entire 30-day period that ended on the date that the individual became separated from the employment that qualifies the individual as a TAA or PBGC recipient.

.06 Coverage described in paragraphs (1), (9), and (10) of section 2.05 of this revenue procedure — COBRA coverage, spousal coverage, and individual health in-

surance — satisfies the requirements for "qualified health insurance" for all HCTC eligible individuals without any action required by any state.

.07 Coverage described in paragraphs (2) through (8) of section 2.05 of this revenue procedure (state-based continuation coverage or other state-based plans) satisfies the requirements for qualified health insurance only if the state elects to have such coverage treated as qualified health insurance and the coverage satisfies the following requirements:

(1) Qualifying individuals (as defined in section 2.08 of this revenue procedure) must be guaranteed enrollment regardless of their medical status and must be permitted to remain enrolled so long as they pay the premium;

(2) No preexisting condition restriction may be imposed on qualifying individuals;

(3) The premium charged for a qualifying individual may not be greater than the premium for a similarly situated individual who is not a qualifying individual; and

(4) Benefits for qualifying individuals are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

.08 "Qualifying individuals" are HCTC eligible individuals who have at least 3 months of "creditable coverage" (within the meaning of § 9801 of the Code) prior to seeking enrollment in coverage described in paragraphs (2) through (8) of section 2.05 of this revenue procedure.

SECTION 3. PROCEDURE FOR ELECTING TREATMENT AS QUALIFIED HEALTH INSURANCE

.01 This section sets forth the procedures that a state must follow in order to elect to have coverage described in paragraphs (2) through (8) of section 2.05 of this revenue procedure (state-based continuation coverage or coverage under other state-based plans) treated as qualified health insurance. As described in section 2.07 of this revenue procedure, such coverage is not qualified health insurance unless such an election is made.

.02 To make an election, a state must provide a letter that contains the following information:

(1) Identifies and is signed by the governor or other state official responsible for implementing this decision, including address and telephone number;

(2) Specifies the category or categories of health coverage chosen by the state (from among the categories described in paragraphs (2) through (8) of section 2.05 of this revenue procedure (state-based continuation coverage or other state-based plans));

(3) Provides the name and policy form number or other unique identifier for each qualifying plan in each category, and provides a name and contact number for the plan administrator or insurance carrier official who can provide additional information, if necessary. This information is required only for coverage described in paragraphs (3) through (8) of section 2.05 of this revenue procedure; it need not be provided for state-based continuation coverage described in paragraph (2) of section 2.05 of this revenue procedure; and

(4) Certifies that the four requirements described in section 2.07 of this revenue procedure are met for each plan being elected under each category.

.03 The letter must be sent to:

Director, Health Coverage Tax Credit
Internal Revenue Service
1111 Constitution Ave., N.W.
W:HCTC/CNN 750
Washington, D.C. 20224

SECTION 4. EFFECTIVE DATE

This revenue procedure is effective March 1, 2004. Elections made before the effective date of this revenue procedure continue to be effective, including those sent to a different address; they do not need to be renewed.

SECTION 5. PAPERWORK REDUCTION ACT

The collection of information contained in this revenue procedure has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1875.

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 OMB control number.

The collection of information in this revenue procedure is in section 3. This information will be used to determine if a state health plan is qualified health insurance for purposes of the HCTC. This information collection is voluntary. If a state makes an election, eligible residents of the state may be able to more easily find qualified health insurance for which they can claim the HCTC.

The likely respondents are states. The estimated total annual reporting burden is 26 hours. The estimated annual burden per respondent varies from 1/4 hour to 1 hour, depending on individual circumstances, with an estimated average of 1/2 hour. The estimated total number of respondents is 51. The estimated frequency of responses is one-time.

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

DRAFTING INFORMATION

The principal author of this revenue procedure is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this revenue procedure, contact Mr. Stephen Finan at (202) 622–1446 or Ms. Tanner at (202) 622–6080 (not toll-free numbers).

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26 CFR 601.201: Rulings and determination letters. (Also, Part I, §§ 25, 103, 143.)

Rev. Proc. 2004–18

SECTION 1. PURPOSE

This revenue procedure provides issuers of qualified mortgage bonds, as defined in section 143(a) of the Internal Revenue Code, and issuers of mortgage credit certificates, as defined in section 25(c), with (1) the nationwide average purchase price for residences located in the United States, and (2) average area purchase price safe harbors for residences located in statistical areas in each state, the District of Columbia, Puerto Rico,