belief, the document contains all the relevant facts relating to the document, and such facts are true, correct, and complete."

INFORMATION REPORTING

An issuer of qualified green building and sustainable design project bonds must complete Form 8038, *Information Return for Tax-Exempt Private Activity Bond Issues*, in accordance with the instructions and complete Part II by checking the box on Line 11m (Other), writing "qualified green building and sustainable design project bonds" in the space provided for the bond description, and entering the amount of the bonds in the Issue Price column.

DRAFTING INFORMATION

The principal author of this notice is Timothy L. Jones of the Office of Associate Chief Counsel (Tax Exempt & Government Entities). However, other personnel from the IRS, the Treasury Department, the Environmental Protection Agency, and the Energy Department participated in its development. For further information regarding this notice, contact Timothy L. Jones at (202) 622–3980 (not a toll-free call).

Qualification of Certain Arrangements as Insurance

Notice 2005–49

This notice requests comments on additional guidance concerning the standards for determining whether an arrangement constitutes insurance for federal income tax purposes.

In Rev. Rul. 2001–31, 2001–1 C.B. 1348, the Internal Revenue Service announced that it would no longer raise the "economic family theory" set forth in Rev. Rul. 77–316, 1977–2 C.B. 53, in addressing whether captive insurance transactions constitute insurance for federal income tax purposes. Since 2001, the Service and the Treasury Department have published four revenue rulings providing guidance on the standards to be used to determine whether a particular arrangement constitutes insurance. Most recently, Rev. Rul. 2005–40, page 4, this Bulletin, explains that (1) in order for an arrangement to qualify as insurance, both risk shifting and risk distribution must be present, and (2) the risk distribution requirement is not satisfied if the issuer of an "insurance" contract enters into such a contract with only one policyholder. *See also* Rev. Rul. 2002–89, 2002–2 C.B. 984 (setting forth circumstances under which arrangements between a domestic parent corporation and its wholly owned subsidiary constitute insurance); Rev. Rul. 2002–90, 2002–2 C.B. 985 (setting forth circumstances under which payments for professional liability coverage by a number of operating subsidiaries to an insurance subsidiary of a common parent constitute insurance); Rev. Rul. 2002–91, 2002–2 C.B. 991 (setting forth circumstances under which amounts paid to a group captive of unrelated insureds are deductible as insurance premiums and in which the group captive qualifies as an insurance company).

The Service and the Treasury Department are aware that further guidance is needed in this area and request comments on issues that should be addressed. In particular, comments are requested regarding (1) the factors to be taken into account in determining whether a cell captive arrangement constitutes insurance and, if so, the mechanics of any applicable federal tax elections; (2) circumstances under which the qualification of an arrangement between related parties as insurance may be affected by a loan back of amounts paid as "premiums;" (3) the relevance of homogeneity in determining whether risks are adequately distributed for an arrangement to qualify as insurance, and (4) federal income tax issues raised by transactions involving finite risk.

Comments should be submitted in writing on or before October 3, 2005, and should include a reference to Notice 2005–49. Comments may be submitted to CC:PA:LPD:PR (Notice 2005–49), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Alternatively, comments may be submitted electronically via the following e-mail address: *Notice.Comments@irscounsel.treas.gov*. Please include "Notice 2005–49" in the subject line of any electronic communications.

Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2005–49), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224. All comments will be available for public inspection and copying.

DRAFTING INFORMATION

For further information regarding this notice, contact William Sullivan or Thomas Preston of the Office of Associate Chief Counsel (Financial Institutions & Products) at (202) 622–3970 (not a toll-free call).

Miscellaneous Issues Arising in Connection With the Health Coverage Tax Credit

Notice 2005–50

This notice provides guidance on miscellaneous issues that have arisen under section 35 of the Internal Revenue Code (added by the Trade Act of 2002, Public Law 107–210). Section 35 provides a 65% tax credit for amounts certain individuals spend on certain kinds of health coverage for themselves and certain family members. This credit is referred to as the Health Coverage Tax Credit (HCTC).

INTRODUCTION

The HCTC may be claimed for eligible coverage months by eligible individuals. There are three categories of eligible individuals: (1) eligible TAA recipients (individuals eligible for trade adjustment assistance under a program administered by the Employment and Training Administration of the U.S. Department of Labor); (2) eligible ATAA recipients (individuals eligible for alternative trade adjustment assistance under a program administered by the Employment and Training Administration of the U.S. Department of Labor); and (3) eligible PBGC pension recipients (individuals who are at least age 55 and who are receiving a benefit any portion of which is paid by the Pension Benefit Guaranty Corporation). An eligible individual is entitled to claim the HCTC with respect to qualifying family members. Qualifying family

members include the eligible individual's spouse and any person the eligible individual can claim as a dependent on the eligible individual's federal income tax return.

An eligible individual can claim the HCTC only for qualified health coverage. There are ten categories of qualified health coverage. Seven of the categories are qualified coverage only if a state government elects them to be qualified. These are referred to as state-based coverage. The other three categories are COBRA coverage, coverage under a group health plan that is available through the employment of an eligible individual's spouse (spousal coverage), and certain individual insurance coverage.

An eligible individual who pays for qualified health coverage for a month is nevertheless not entitled to the HCTC for that month if the eligible individual has other specified coverage on the first day of the month. Other specified coverage generally includes health coverage 50 percent or more of the cost of which is paid or incurred by an employer or former employer of the eligible individual or of the eligible individual's spouse. For this purpose, the cost of coverage is treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d) of the Code). (For ATAA recipients, other specified coverage includes health coverage if the employer pays or incurs any portion of the cost of coverage.) Coverage under the following programs is also other specified coverage: Medicare, Medicaid, State Children's Health Insurance Program (S-CHIP), TRICARE coverage (for members of the military and their families), and FEHBP coverage (for federal civil employees).

Eligible individuals and their qualifying family members have certain rights with respect to state-based coverage if the eligible individual has at least three months of creditable coverage, does not have other specified coverage, and is not imprisoned under federal, state, or local authority. Such an eligible individual and the eligible individual's qualifying family members are referred to as qualifying individuals. They have guaranteed issue rights to state-based coverage, their state-based coverage cannot be subject to a preexisting condition exclusion, they cannot be charged more for state-based coverage than similarly situated individuals, and they must be entitled to the same benefits under state-based coverage as similarly situated individuals.

The HCTC can be claimed on the eligible individual's federal tax return. However, individuals can also claim the HCTC under an advance payment program authorized by section 7527 of the Code. Eligible individuals registering with the advance payment program can send the IRS 35% of the cost of qualified health coverage on a monthly basis and the IRS will pay the health coverage provider 100% of the cost of qualified health coverage. Amounts paid through the advance payment program cannot be claimed for the HCTC on the eligible individual's tax return.

QUESTIONS AND ANSWERS

Q–1. Is an individual who receives a lump sum payment from the Pension Benefit Guaranty Corporation (PBGC) on or after August 6, 2002, considered to be receiving monthly benefits from the PBGC?

A–1. Yes. An individual who receives a lump sum payment from the PBGC on or after August 6, 2002 (the date of enactment of the Trade Act of 2002), is considered to be receiving monthly benefits from the PBGC for as long as the individual would have received a PBGC annuity had the PBGC not paid the individual a lump sum of their PBGC benefit. Consequently, if such an individual is at least age 55 as of the first day of a month, the individual is an eligible individual for purposes of the Health Coverage Tax Credit (HCTC).

Q–2. Can an eligible individual claim the HCTC with respect to amounts paid for qualified health coverage of a qualifying family member if that qualified health coverage does not cover the eligible individual?

A–2. Yes, but only if the eligible individual has qualified health coverage for the month. However, that qualified health coverage need not be the same as that covering a qualifying family member in order for the eligible individual to be entitled to claim the HCTC with respect to amounts paid for the qualifying family member's qualified health coverage for that month. For example, if an eligible individual is enrolled in qualified state-based health coverage in a month and a qualifying family member of the eligible individual is enrolled in COBRA coverage in that month, the eligible individual is entitled to claim the HCTC for that month with respect to amounts paid both for the eligible individual's enrollment in the state-based coverage and for the qualifying family member's enrollment in the COBRA coverage.

Q–3. If qualified health coverage of an eligible individual or a qualifying family member also covers someone who is neither an eligible individual nor a qualifying family member (a nonqualifying beneficiary), how is the amount paid by the eligible individual for qualified coverage allocated between, on the one hand, the eligible individual and any qualifying family members, and, on the other hand, nonqualifying beneficiaries?

A–3. Amounts paid by an eligible individual for qualified health coverage covering one or more nonqualifying beneficiaries are allocated on an incremental basis, attributing those amounts first to the cost of covering the eligible individual and any qualifying family members and then to the cost of covering nonqualifying beneficiaries. Thus, if the cost of covering a nonqualifying beneficiary does not add to the cost of covering the eligible individual or any qualifying family members, then the cost of covering the nonqualifying beneficiary is zero. If the cost of covering a nonqualifying beneficiary adds to the cost of covering an eligible individual or any qualifying family member, it is the incremental cost that is ineligible for the HCTC. This incremental allocation rule for nonqualifying beneficiaries is illustrated by the following examples:

Example 1. Facts. Qualified health coverage of an eligible individual covers an eligible individual and the eligible individual's spouse and two children. The two children satisfy the conditions for being qualifying family members (that is, they do not have other specified coverage and the eligible individual is entitled to claim them as dependents on the eligible individual's federal income tax return). The spouse, however, is not a qualifying family member (because the spouse has other specified coverage). The eligible individual pays $800 per month for self-plus-two-or-more-dependents under the qualified coverage.

Conclusion. The amount the eligible individual pays for covering the eligible individual and the two children (the qualifying family members) under the qualified health coverage is $800 per month. The amount the eligible individual pays for the spouse (the nonqualifying beneficiary) is $0 per month. The

eligible individual is entitled to claim the HCTC with respect to $800 per month.

Example 2. *Facts*. The facts are the same as in *Example 1* of this Q&A–3 except that the eligible individual has only one child. Although the eligible individual pays $800 per month for self-plus-two-or-more-dependents under the qualified coverage, the eligible individual would be required to pay $600 per month for self-plus-one-dependent under the coverage.

Conclusion. The amount the eligible individual pays for covering the eligible individual and the child (the one qualifying family member) under the qualified health coverage is $600 per month. The amount the eligible individual pays for the spouse (the nonqualifying beneficiary) is $200 per month. The eligible individual is entitled to claim the HCTC with respect to $600 per month.

Q–4. Is entitlement to or receipt of benefits from the Veterans Administration other specified coverage?

A–4. No. The statute lists various forms of health coverage — including the entitlement to receive benefits under chapter 55 of title 10 of the United States Code (TRICARE) — as other specified coverage. Entitlement to or receipt of benefits from the Veterans Administration, however, comes under title 38 of the United States Code and does not fit any of the categories of other specified coverage.

Q–5. How is a determination made whether an employer pays or incurs at least 50% of the cost of coverage or any portion of the cost of coverage?

A–5. (a) The rules of this Q&A–5 are used to determine whether an employer pays or incurs at least 50% of the cost of coverage or any portion of the cost of coverage. The factors for making such a determination consist of (1) the basis for determining the dollar amount of the cost (described in paragraph (b) of this Q&A–5); (2) the effect of cafeteria plan contributions under section 125 of the Code (described in paragraph (c) of this Q&A–5); and (3) the category of coverage (described in paragraph (d) of this Q&A–5).

(b) The dollar amount of cost is determined in accordance with the rules in section 4980B(f)(4) of the Code (used in determining the applicable premium for COBRA continuation coverage).

(c) Any portion of the cost of coverage of an individual paid or incurred in lieu of a right to receive cash or other qualified benefits under a cafeteria plan under section 125 is considered to be paid or incurred by an employer.

(d) If the proportion of the cost of coverage paid or incurred by an employer varies with the category of coverage, the amount paid or incurred by the employer for each category is determined on an aggregate basis. Thus, for example, in a plan that makes coverage available in self-only and family categories, the portion of the cost of family coverage paid or incurred by the employer is determined by dividing the total cost of such coverage by the total amount the employer pays or incurs for such coverage. This rule is further illustrated in the following example:

Example. *Facts*. Employees participating in a group health plan maintained by an employer may choose among three categories of coverage: (1) self-only, (2) self-plus-one-dependent, and (3) self-plus-two-or-more-dependents. The total cost of the coverage, as determined under the rules of section 4980B(f)(4), is (1) $300 per month for self-only coverage, (2) $600 per month for self-plus-one-dependent coverage, and (3) $800 per month for self-plus-two-or-more-dependents coverage. No portion of the cost of coverage is paid or incurred under a cafeteria plan under section 125. The employer pays or incurs (1) $225 per month for self-only coverage, (2) $325 per month for self-plus-one-dependent coverage, and (3) $350 per month for self-plus-two-or-more-dependents coverage.

Conclusion. The portion of the cost of coverage that the employer pays for each category is (1) 75% for self-only coverage ($225/$300), (2) 54% for self-plus-one-dependent coverage ($325/$600, rounded to the nearest whole percentage), and (3) 44% for self-plus-two-or-more-dependents coverage ($350/$800, rounded to nearest whole percentage). Thus, for any eligible individual or qualifying family member receiving coverage under the plan, the categories self-only and self-plus-one-dependent are other specified coverage (and thus the eligible individual cannot claim the HCTC); the category self-plus-two-or-more-dependents is not other specified coverage (except in connection with the special rules that apply for ATAA recipients).

Q–6. May a plan providing COBRA coverage to an eligible individual or a qualifying family member reject payment from the HCTC advance payment program because it does not come directly from a COBRA qualified beneficiary?

A–6. No. Under the COBRA continuation coverage requirements of section 4980B of the Code, payment is merely required to be made; there is no requirement that it be made by the qualified beneficiary. If full payment by a third party (such as the HCTC advance payment program) is tendered timely to a plan for the COBRA coverage of a qualified beneficiary and the plan terminates the coverage of the qualified beneficiary for failure to make timely payment, the plan is not in compliance with the COBRA continuation coverage requirements and is subject to the excise tax of section 4980B (generally, $100 per day per beneficiary for each day that the plan is not in compliance with respect to that beneficiary).

Q–7. To be qualified health coverage, must a state-based plan allow qualifying individuals to pay for their coverage through the HCTC advance payment program?

A–7. Yes. Part of the guaranteed issue requirement for any state-based plan is that the plan allow qualifying individuals to pay for their coverage through the HCTC advance payment program.

Q–8. How is it determined if a qualifying family member of an eligible individual is a qualifying individual?

A–8. If the family member has met the requirements for being a qualifying family member (relationship to eligible individual and no other specified coverage) and the eligible individual is a qualifying individual, then the family member is a qualifying individual. There are no additional requirements for the family member to satisfy (such as having a certain amount of creditable coverage).

Q–9. How is it determined whether an eligible individual has three months or more of creditable coverage?

A–9. The rules of section 9801 of the Code and the regulations thereunder (including those rules describing what constitutes a significant break in coverage and tolling rules for significant breaks in coverage) apply in determining if an eligible individual has three months or more of creditable coverage as of any date. Those rules prescribe that creditable coverage is determined on the basis of days rather than months. In applying those rules under section 35, an individual who has at least 89 days of creditable coverage as of a certain date is considered to have three months or more of creditable coverage as of that date.

Q–10. Must a state-based plan restrict eligibility for enrollment among eligible individuals and qualifying family members to those who are also qualifying individuals in order for the state-based plan to be qualified health coverage?

A–10. No. A state-based plan does not fail to satisfy the requirements for qualified health coverage merely because it allows eligible individuals and qualifying

family members who are not qualifying individuals to enroll in the plan.

Q–11. Does a state-based plan fail to satisfy the guaranteed issue requirement merely because it restricts eligibility under the plan to residents of the state?

A–11. No. Moreover, if a state has a system of plans covering distinct geographic regions in the state, each plan may restrict eligibility to residents of that region as long as any qualifying individual in the state is eligible for at least one plan in the system.

Q–12. Are there other restrictions that a state-based plan can impose on the enrollment of qualifying individuals?

A–12. Yes. State-based plans can require qualifying individuals to enroll within a reasonable period after becoming qualifying individuals or during limited regular enrollment periods thereafter (such as annual enrollment periods), can deny enrollment to qualifying individuals for fraud or misrepresentation of material facts, and can deny enrollment for failure to make timely payment.

Q–13. Can state-based coverage (including a high risk pool) condition enrollment of a qualifying individual on being rejected for coverage in the individual or group health insurance market?

A–13. No. Any coverage elected by a state to be qualified health coverage must be made available to a qualifying individual if the qualifying individual pays for enrollment (or enrolls in the advance payment program and the IRS pays for enrollment on behalf of the qualifying individual) and cannot be subject to any condition other than those described in Q&A–11 and Q&A–12 of this notice.

DRAFTING INFORMATION

The principal author of this notice is Russ Weinheimer of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information about this notice, contact Mr. Weinheimer at (202) 622–6080 (not a toll-free call).