

[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 40 and 46

[REG-136008-11]

RIN 1545-BK59

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

AGENCY: Internal Revenue Service (IRS), Treasury.

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

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

DATES: Written or electronic comments must be received by **[INSERT DATE 90 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**.

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

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG-136008-11), Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington DC 20044.

Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-136008-11), Courier's Desk Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC, or sent electronically via the IRS Internet site via the Federal eRulemaking Portal at www.regulations.gov (IRS REG-136008-11). The public hearing will be held in the IRS Auditorium at the Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC.

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

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by **[INSERT 90 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. Comments are specifically requested concerning:

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

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

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

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

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

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

revised to include the reporting and payment of the fee imposed by sections 4375 and 4376.

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

Estimated number of respondents is 10,000.

Estimated average annual burden per respondent is 5 minutes.

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

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

Background

This document contains proposed amendments to 26 CFR part 40 (Excise Tax Procedural Regulations) and 26 CFR part 46 (relating to excise taxes imposed on policies issued by foreign insurers and obligations not in registered form) to implement the requirements under sections 4375 through 4377 of the Internal Revenue Code (Code). Sections 4375 and 4376 of the Code impose fees on issuers of specified health

insurance policies and plan sponsors of applicable self-insured health plans, and section 4377 contains special rules that apply to these issuers and plan sponsors with respect to these fees. Sections 4375, 4376, and 4377 were added to the Code by section 6301 of the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148 (124 Stat. 119 (2010)).

The Affordable Care Act includes provisions that promote research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of medical treatments, services, procedures, drugs, and other strategies or items that treat, manage, diagnose, or prevent illness or injury. One such provision relates to the establishment of the private, nonprofit corporation, the Patient-Centered Outcomes Research Institute (the "Institute"). The Institute will assist, through research, patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. The statute specifically prohibits the Secretary of Health and Human Services (HHS) from using the evidence or findings of the research conducted in determining coverage, reimbursement, or incentive programs unless it is through an iterative and transparent process which includes public comment and considers the effect on subpopulations. Nothing under this provision allows the Secretary of HHS to deny coverage of items or services solely on the basis of comparative clinical effectiveness research. The statute provides that the Institute will not develop a dollars-per-quality-life-year estimate as a threshold to establish effective or recommended care. Section 6301 of the Affordable Care Act amended the Code by adding new section 9511 to establish the Patient-

Centered Outcomes Research Trust Fund (the "Trust Fund"), which is the funding source for the Institute. Section 6301 of the Affordable Care Act also added new Code sections 4375, 4376, and 4377 to provide a funding source for the Trust Fund that is to be financed, in part, by fees to be paid by issuers of specified health insurance policies and sponsors of applicable self-insured health plans.

Statutory Provisions

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

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

accident or health coverage to residents of the United States, regardless of how the coverage is provided or arranged to be provided.

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

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

section 3(40)(B)(v) of ERISA), the plan sponsor is the cooperative or association that established or maintained the plan.

Section 4376(c) defines applicable self-insured health plan as any plan for providing accident or health coverage if any portion of the coverage is provided other than through an insurance policy, and the plan is established or maintained: (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a voluntary employees' beneficiary association described in section 501(c)(9), (5) by any organization described in section 501(c)(6), or (6) if not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of ERISA), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

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

Section 4377(b)(1)(B) provides that "[n]otwithstanding any other law or rule of law, governmental entities shall not be exempt from" the fee imposed by sections 4375 and 4376 unless the policy or plan is an exempt governmental program. Section 4377(b)(3) defines exempt governmental program as (1) any insurance program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et. seq.)

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

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

Notice 2011-35

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

Explanation of Provisions

Specified Health Insurance Policies Subject to the Fee under Section 4375

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

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

Commentators requested a bright-line rule for determining whether an individual covered by a policy is residing in the United States. Many commentators suggested that issuers should be able to rely on the address on file for the primary insured to determine whether individuals covered by the policy are residing in the United States. The Treasury Department and the IRS recognize that the address on file for the primary insured may be the only information the insurer has with respect to the residence of the individuals covered under the policy, and also that the address on file is likely the place of abode for most, if not all, of the covered individuals. Accordingly, the proposed regulations provide that if the address on file with the issuer or plan sponsor for the

primary insured is outside of the United States, the issuer or plan sponsor may treat the primary insured and the primary insured's spouse, dependents, or other beneficiaries covered under the policy as having the same place of abode and not residing in the United States. For this purpose, the term "primary insured" refers to the individual eligible for coverage other than due to his or her status as a spouse, dependent, or other beneficiary of another insured individual (for example, in the case of a group health plan for employees, the individual eligible for coverage due to his or her status as an employee).

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

Commentators requested that the regulations provide that stop loss and indemnity reinsurance policies not be considered specified health insurance policies.

Commentators argued that stop loss and indemnity reinsurance policies are not providing coverage for lives covered; rather, these types of policies are intended to limit the original obligor's financial exposure. Section 4375 imposes a fee based on the average number of lives covered. Because stop loss and indemnity reinsurance policies generally do not provide coverage based upon the number of lives covered, the proposed regulations provide that for purposes of section 4375, these policies are not specified health insurance policies subject to the fee under section 4375. No inference is intended as to whether stop loss or indemnity reinsurance policies may constitute health insurance policies for other purposes.

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

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

The fee under section 4376 is imposed on the plan sponsor of an applicable self-insured health plan. Under the statute and these proposed regulations, the fee must be calculated using the applicable dollar amount in effect for the plan year (for example, \$1 for plan years ending on or after October 1, 2012, and before October 1, 2013) and one of the permitted methods for determining the average number of lives covered under the plan during the plan year.

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

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

within one of the statutory definitions of an applicable self-insured health plan (for example, the plan is established or maintained by a section 501(c)(6) organization).

Notice 2011-35 (2011-25 IRB 879) invited comments on the type or types of health flexible spending arrangements (as described in section 106(c)(2)) (health FSAs) and health reimbursement arrangements (as described in Notice 2002-45 (2002-2 CB 93)) (HRAs) that would be excluded from the definition of an applicable self-insured health plan because they provide the kind of coverage that, if provided by an insurance policy, would not cause the policy to be treated as a specified health insurance policy, as defined in section 4375(c). Health FSAs and HRAs are both self-insured health plans.² See §601.601(d)(2).

Commentators generally requested that all health FSAs and HRAs be excluded from the definition of applicable self-insured health plan under section 4376.

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

Some commentators requested that if HRAs were not excluded from the definition of applicable self-insured health plan, the guidance limit the fee under section

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

4376 to HRAs that are not offered in connection with a major medical plan or permit treatment of an HRA that is offered in connection with a major medical plan as a single applicable self-insured health plan to avoid the fee applying twice with respect to individuals covered by a major medical plan and a related HRA.

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

These proposed regulations reflect the special rule in section 4375(c)(2), which is carried over to self-insured arrangements through the definition of "accident and health coverage" in section 4377(a)(1), that a specified health insurance policy does not

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

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

Commentators also requested that an employee assistance program (EAP) or wellness arrangement be exempt from the fee. Commentators argued that generally, under an EAP or wellness arrangement, benefits for medical care are secondary or incidental to non-medical benefits. In response, these proposed regulations exclude from the definition of applicable self-insured health plan an EAP, disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment.

For each type of applicable self-insured health plan identified in section 4376(c), the plan sponsor is the person responsible for the payment of the fee. Section 4376(b)(2) provides that in the case of a plan established or maintained by a single

employer, the plan sponsor is the employer, and in the case of a plan established or maintained by a single employee organization, the plan sponsor is the employee organization. Section 4376 does not contain rules that would treat related entities as a single entity. Accordingly, for example, under these proposed regulations, a plan that is maintained by multiple related employers is not a plan that is established or maintained by a single employer, but, for section 4376 purposes, is considered a plan that is established or maintained by two or more employers.

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

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

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

Several commentators requested that the guidance clarify that, in the case of an applicable self-insured health plan that is established or maintained by a board of trustees, plan assets (for example, amounts held in a trust) or the employer

contributions to the plan could be used to pay the fee under section 4376. Because the use of plan assets to pay the fee under section 4376 may have implications under various state and Federal laws (including, for example, ERISA's fiduciary provisions), the question of what the permissible sources of funds are for paying the fee under section 4376 is an issue that is outside the scope of these proposed regulations. The Treasury Department and the IRS have consulted the Department of Labor concerning comments on the appropriate sources to pay the fee under section 4376. The Department of Labor has advised the Treasury Department and the IRS that it is considering permissible funding sources for these fee payments by plan sponsors that are subject to ERISA's fiduciary provisions.

Calculation of the Fee Under Section 4375

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

Commentators generally favored a safe harbor that allows issuers to calculate the average number of lives covered under the policy based on data reported on the

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

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

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

The proposed regulations provide issuers the choice of using any of four alternative methods to determine the average number of lives covered under policies

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

The proposed regulations direct an issuer to apply a single method in determining the average number of lives covered under the policy for the year. In addition, issuers must use the same method of counting lives for all policies reported on a single return. Issuers using the actual count or snapshot method may change to the

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

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

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

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

The Treasury Department and the IRS understand that these proposed regulations are being issued after the beginning of some policy years to which the fee

under section 4375 will apply. Because issuers that do not use the member months method or state form method may not have started counting lives covered for policy years that end on or after October 1, 2012, but that began before **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]**, issuers using the actual count method may begin counting lives covered under a policy as of **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** rather than the first day of the policy year, and divide by the appropriate number of days remaining in the policy year. Similarly, for policy years that end on or after October 1, 2012, but that began before **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]**, issuers using the snapshot method may use counts from quarters beginning on or after **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** to determine the average number of lives covered under the policy. The Treasury Department and the IRS intend for these rules to facilitate compliance for the initial policy years covered by section 4375. Comments are requested as to whether any additional transition rules under section 4375 are needed for this purpose.

Calculation of the Fee Under Section 4376

The fee imposed on a plan sponsor of an applicable self-insured health plan under section 4376 is based on the average number of lives covered under the plan. Notice 2011-35 invited comments on reasonable methods that could reduce

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

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

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

would need to be converted to a number that accurately represents the average number of covered lives under the plan for the plan year.

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

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

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

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

The proposed regulations direct a plan sponsor to apply a single method in determining the average number of lives covered under the plan for the entire plan year.

However, a plan sponsor is not required to use the same method from one plan year to the next.

The Treasury Department and the IRS understand that these proposed regulations are being issued after the beginning of some plan years to which the fee under section 4376 will apply. Therefore, these proposed regulations include a special rule for the fee under section 4376 applicable for a plan year that ends on or after October 1, 2012, and began before **[INSERT DATE THAT IS 90 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]**. Because self-insured plans generally are not required to complete the Exhibit or determine the number of covered lives for other regulatory purposes, under this special rule, a plan sponsor may use any reasonable method to determine the average number of lives covered under the plan for purposes of calculating the fee under section 4376 for those plan years. For more information about the return filing requirements and payment of the fees, see the section in this preamble entitled “Application of Excise Tax Procedural Rules (Filing of Returns and Payment of Fees).”

Application of Subtitle F

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

examination and summons pursuant to section 7602, and subject to confidentiality rules pursuant to section 6103, in the same manner as other taxes imposed by the Code.

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

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

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

Under existing rules for chapter 34 excise taxes, taxpayers pay and report these taxes quarterly on Form 720, "Quarterly Federal Excise Tax Return," by the last day of the first calendar month following the calendar quarter for which it is filed. The proposed regulations amend this rule so that issuers and plan sponsors will report and pay the section 4375 and 4376 fees only once a year on Form 720, which will be due by July 31 of each year. A person that files a Form 720 only to report liability imposed by section 4375 or 4376 is not required to file a Form 720 at other times during the year. A return will generally cover policy years (section 4375) and plan years (section 4376) that end during the preceding calendar year, or in the case of an issuer that determines the

average number of lives covered for purposes of section 4375 using the member months method or the state form method, the return is for all policies in effect during the previous calendar year. The instructions for Form 720 inform filers how and when to file and pay. These instructions require that the filer (the issuer or plan sponsor, as applicable) have an Employer Identification Number (EIN) to use in filing the Form 720.

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

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

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

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

Electronic Filing of Returns

Form 720 may be filed electronically. For more information on e-file, see www.irs.gov/efile. Although electronic filing of the Form 720, "Quarterly Federal Excise Tax Return," is not required, the IRS encourages taxpayers to file the Form 720 electronically. Electronic filing of Form 720 is quick and easy, and it will allow the IRS to provide expedited and improved service and reliability to taxpayers while reducing processing time and errors. Forms 720 can be submitted on-line. A taxpayer wishing to

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

Third-Party Reporting and Payments

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

Proposed Effective Date

These regulations are proposed to apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019. Issuers and plan sponsors may rely on these proposed regulations for guidance pending the issuance of final regulations. Final regulations will be effective as of the date these proposed regulations are

published in the **Federal Register**. If and to the extent future guidance is more restrictive than the guidance in these proposed regulations, the future guidance will be applied without retroactive effect.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13653. Therefore, a regulatory assessment is not required. It is hereby certified that these proposed regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that small businesses generally do not have self-insured health plans and that these regulations will therefore primarily affect large corporations. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. The Treasury Department and the IRS specifically solicit comments from any party, particularly affected small entities, on the accuracy of this certification. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comments on its impact on small business.

Comments and Public Hearing

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

A public hearing has been scheduled for August 8, 2012, beginning at 10:00 a.m. in room the auditorium of the Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the “FOR FURTHER INFORMATION CONTACT” section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written or electronic comments and an outline of the topics to be discussed and the time to be devoted to each topic by July 30, 2012. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal authors of these regulations are Rebecca L. Baxter, Office of Associate Chief Counsel (Financial Institutions & Products), and R. Lisa Mojiri-Azad, Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the Treasury Department and the IRS participated in their development.

List of Subjects

26 CFR Part 40

Excise taxes, Reporting and recordkeeping requirements.

26 CFR Part 46

Excise taxes, Insurance, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

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

PART 40--EXCISE TAX PROCEDURAL REGULATIONS

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

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

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

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

§40.0-1 Introduction.

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

* * * * *

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

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

2. Paragraph (c) is added.

The addition reads as follows:

§40.6011(a)-1 Returns.

* * * * *

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

(2) Effective/applicability date. This paragraph (c) is applicable on **[INSERT DATE THIS DOCUMENT IS PUBLISHED IN THE FEDERAL REGISTER]**. This paragraph (c) applies to returns that report liability imposed by section 4375 or 4376 for all policies and plans to which section 4375 or 4376 applies.

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

1. Paragraph (c) is revised.
2. Paragraph (d) is added.

The revision and addition read as follows:

§40.6071(a)-1 Time for filing returns.

* * * * *

(c) Fees on health insurance policies and self-insured health plans. A return that reports liability for the fee imposed by section 4375 must be filed by July 31 of the calendar year immediately following the last day of the policy year. For issuers that determine the average number of lives covered under the policy for section 4375 using the member months method under §46.4375-1(c)(2)(v) of this chapter or the state form method under §46.4375-1(c)(2)(vi) of this chapter, the return must be filed by July 31 of the immediately following calendar year. A return that reports liability for the fee imposed by section 4376 for a plan year must be filed by July 31 of the calendar year immediately following the last day of the plan year. Thus, for example, a return that reports liability for the fee imposed by section 4375 for the year ending on December 31, 2012, must be filed by July 31, 2013. As another example, a return that reports liability for the fee imposed by section 4376 for the plan year ending on January 31, 2013, must be filed by July 31, 2014.

(d) Effective/applicability date. Paragraph (c) of this section is applicable on **[INSERT DATE OF PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. Paragraphs (a) and (b) of this section apply to returns for calendar quarters beginning on or after October 1, 2001, and paragraph (c) of this section applies to returns that report liability imposed by section 4375 or 4376 for all policies and plans to which section 4375 or 4376 applies.

§40.6091-1 [Amended]

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

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

§40.6302(c)-1 Use of Government depositaries.

* * * * *

(e) * * *

(1) * * *

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

* * * * *

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

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

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

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

§46.0-1 [Amended]

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

§46.0-2 [Removed]

Par. 10. Section 46.0-2 is removed.

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

Subpart C--Fees on Insured and Self-Insured Health Plans

Sec.

46.4375-1 Fee on issuers of specified health insurance policies.

46.4376-1 Fee on sponsors of self-insured health plans.

46.4377-1 Definitions and special rules.

Subpart C--Fees on Insured and Self-Insured Health Plans

§46.4375-1 Fee on issuers of specified health insurance policies.

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

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

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

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

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

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

(C) Any stop loss or indemnity reinsurance policy.

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

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

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

(iv) Indemnity reinsurance policy. For purposes of paragraph (b)(1)(ii) of this section, indemnity reinsurance policy means an agreement between two or more insurance companies under which--

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

(B) The issuing company retains its liability to, and its contractual relationship with, the applicable lives covered.

(2) Prepaid health coverage arrangement. The term prepaid health coverage arrangement means an arrangement under which fixed payments or premiums are

received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to individuals residing in the United States, regardless of how such coverage is provided or arranged to be provided. For example, any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract is a specified health insurance policy.

(c) Calculation of fee--(1) In general. The amount of the fee for a policy for a policy year is equal to the product of the average number of lives covered under the policy for the policy year (determined in accordance with paragraphs (c)(2) and (c)(3) of this section) and the applicable dollar amount (determined in accordance with paragraph (c)(4) of this section). For purposes of computing the fee under this paragraph (c), in the case of an issuer that determines the average number of lives covered for all policies in effect during a calendar year using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section, the applicable dollar amount with respect to such issuer's policies for such calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year (determined in accordance with paragraph (c)(4) of this section), except that the applicable dollar amount with respect to such an issuer's policies for calendar year 2019 shall be the applicable dollar amount for policy years ending on September 30, 2019. For more information, see the examples in paragraphs (c)(2)(iii)(B), (c)(2)(iv)(B), (c)(2)(v)(B), and (c)(2)(vi)(B) of this section.

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

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

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

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

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

(ii) Consistency requirements. An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, "Quarterly Federal Excise Tax Return," for a particular year, the issuer must use the same method of computing lives covered. An issuer that determines the average number of lives covered by using the actual count method described in paragraph (c)(2)(iii) of this section or the snapshot method described in paragraph (c)(2)(iv) of this section may change its method of computing the average lives covered to the snapshot method or actual count method, provided that the issuer uses the same method for computing the average lives covered for all policies for which a liability is reported on the Form 720 for that year. For example, an issuer with a policy having a policy year that ends on June 30, Policy A, may determine the average number of lives covered under Policy A for July 1, 2013, to June 30, 2014, using the actual count method if the issuer uses the actual count method for all policies for which a liability will be reported on the Form 720 due by July 31, 2015 (the due date for return that will

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

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

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

Example. Insurance Company A issues three policies that are in effect during 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company A must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company A chooses to use the actual count method under paragraph (c)(2)(iii)(A) of this section to determine average lives covered for policies having a policy year that ends in 2014. Insurance Company A calculates the sum of lives covered under Policy A for each day of the policy year ending November 30, 2014, as 3,285,000. The average number of lives covered under Policy A for the policy year ending November 30, 2014, is 3,285,000 divided by 365, or 9,000. Insurance Company A calculates the sum of lives covered under Policy B for each day of the policy year ending February 28, 2014, as 547,500.

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

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

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

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

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

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

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

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

(vi) State form method--(A) Calculation method. An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state of domicile and a method similar to that described in paragraph (c)(2)(v) of this section, if the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

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

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

(3) Special rules for the first year and the last year the fee is in effect--(i)

Calculation of the average number of lives covered under the policy for the first year the fee is in effect. For issuers that determine the average number of lives covered using data reported on the 2012 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2012 calendar year, the average number of lives covered under all policies in effect for the 2012 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by 1/4. The resulting number is deemed to be the average number of lives covered for

policies with policy years ending on or after October 1, 2012, and before January 1, 2013. For policy years beginning before **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the actual count method under paragraph (c)(2)(iii) of this section may calculate the average number of lives covered using data from the period beginning **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** through the end of the policy year. For policy years beginning before **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the snapshot method under paragraph (c)(2)(iv) of this section may calculate the average number of lives covered using dates from the quarters remaining in the policy year starting on or after **[INSERT DATE 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE FEDERAL REGISTER]**. If an abbreviated year is used, the issuer will divide the number of lives covered by the number of days from **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE FEDERAL REGISTER]** through the end of the policy year (for the actual count method) or the number of days on which a count was made (for the snapshot method).

(ii) Calculation of the average number of lives covered under the policy for the last year the fee is in effect. For issuers that determine the average number of lives

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

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

Example 1. Insurance Company E issues Group Health Insurance Policy C, which has a policy year that ends on November 30, 2012. Insurance Company E determines the average number of lives covered under a policy by using the actual count method. Under that method, for that policy year, Insurance Company E calculates the sum of lives covered under Policy C for each day between **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** and November 30, 2012 as 10,000. The average number of lives covered under Policy C for that policy year is 10,000 divided by the number of days from **[INSERT DATE THAT IS 30 DAYS AFTER THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** through November 30, 2012. Alternatively, Insurance Company E could have counted the number of lives covered for the entire policy year and divided the sum by 365.

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

(4) Applicable dollar amount. For policy years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is \$1. For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar

amount is \$2. For any policy years ending in any fiscal year beginning on or after October 1, 2014, the applicable dollar amount is the sum of--

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

(ii) The amount equal to the product of--

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

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

(d) Effective/applicability date. This section is effective on **[INSERT DATE OF PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. This section applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019.

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

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

to filing the required return and paying the fee, see §§40.6011(a)-1 and 40.6151(a)-1 of this chapter.

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

(1) Applicable self-insured health plan--(i) In general. Except as provided in paragraph (b)(1)(ii) of this section and §46.4377-1, applicable self-insured health plan means a plan that provides for accident or health coverage (within the meaning of §46.4377-1(a)) if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained--

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

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

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

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

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

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

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

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

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

(iii) Multiple self-insured arrangements established or maintained by the same plan sponsor. For purposes of section 4376, two or more arrangements established or maintained by the same plan sponsor that provides for accident and health coverage (within the meaning of §46.4377-1(a)) other than through an insurance policy and that have the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee imposed by section 4376. For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits, and a separate self-insured arrangement with the same plan year providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan. Similarly, if a plan sponsor provides a Health

Reimbursement Arrangement (HRA) that is integrated with another applicable self-insured health plan that provides major medical coverage, the HRA and the major medical plan may be treated as one applicable self-insured health plan.

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

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

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

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

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

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

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

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

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

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

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

Example 1. Employer XYZ is a holding company with no employees that owns all the issued and outstanding shares of Employer X, Employer Y, and Employer Z. Employer X, Employer Y, and Employer Z have established the XYZ Group Health Plan to provide accident and health coverage, provided other than through an insurance policy, for the benefit of their employees. The XYZ Group Health Plan has a calendar year plan year. In addition, there is no plan sponsor identified or designated in the plan document. As a self-insured health plan for employees of two or more employers, the XYZ Group Health Plan is an applicable self-insured health plan under section

4376(c)(2)(A) and paragraph (b)(1)(i)(A) of this section. However, a plan sponsor is not identified or designated in the governing plan document. Accordingly, the plan sponsor for purposes of section 4376 is identified under paragraph (b)(2)(i)(H) of this section as Employer X, Employer Y, and Employer Z, each with respect to its own employees covered under the plan. Accordingly, Employer X, Employer Y, and Employer Z each must file a Form 720 reflecting their separate liabilities under section 4376, calculated based upon lives covered that are employees of that employer, or spouses, dependents, or other beneficiaries of employees of that employer and the applicable dollar amount in effect for the plan year.

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

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

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

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

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

or

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

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

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

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

Example. Employer A is the plan sponsor of the Employer A Self-Insured Health Plan, which has a calendar year plan year. Employer A calculates the sum of covered lives under the plan for each day of the plan year ending December 31, 2013 as 3,285,000. The average number of covered lives under the plan for the plan year ending December 31, 2013 is 3,285,000 divided by 365, or 9,000. To calculate the section 4376 fee for the plan under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer A must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

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

in paragraph (c)(2)(iv)(B) of this section or the snapshot count method described in paragraph (c)(2)(iv)(C) of this section.

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

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

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

Example 1. Employer B is the plan sponsor of the Employer B Self-Insured Health Plan, which has a calendar year plan year. Employer B has designated the first day of each quarter of the plan year as the date that Employer B counts the covered lives under the Employer B Self-Insured Health Plan. On January 1, 2013, Employer B Self-Insured Health Plan covers 2,000 covered lives, on April 1, 2013, 2,100 covered lives, on July 1, 2013, 2,050 covered lives, and on October 1, 2013, 2,050 covered lives. Under the snapshot count method, Employer B must determine the average number of covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as $8,200 (2,000 + 2,100 + 2,050 + 2,050)$ divided by 4, or 2,050. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

Example 2. Same facts as Example 1, except Employer B determines the number of covered lives not covered by self-only coverage based on the number of participants with coverage other than self-only multiplied by 2.35 (the factor set forth in (c)(2)(iv) of this section). On January 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 1, 2013 and October 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees. Under the snapshot factor method, Employer B must determine the average number of

covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as 9,988 $[(600+(800 \times 2.35)) + (608 + (800 \times 2.35)) + (610 + (809 \times 2.35)) + (610 + (809 \times 2.35))]$ divided by 4, or 2,497. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by the average number of lives covered under the plan.

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

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

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

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

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

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

plan as described in paragraph (b)(2)(i) of this section.) See §601.601(d)(2) of this chapter.

(vii) Special rule for the first year the fee is in effect. Notwithstanding paragraph (c)(2)(i) of this section, for plan years beginning before **[INSERT DATE THAT IS 90 DAYS AFTER DATE THIS DOCUMENT IS FILED FOR PUBLIC INSPECTION WITH THE OFFICE OF THE FEDERAL REGISTER]** and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

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

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

(ii) The amount equal to the product of--

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

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

(d) Effective/applicability date. This section is effective on **[INSERT DATE THIS DOCUMENT IS PUBLISHED IN THE FEDERAL REGISTER]**. This section applies for plan years that end on or after October 1, 2012, and before October 1, 2019.

§46.4377-1 Definitions and special rules.

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

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

(2) Individual residing in the United States--(i) The term individual residing in the United States means an individual with a place of abode in the United States.

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

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

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

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

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

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

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

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

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

(c) Effective/applicability date. This section is effective on **[INSERT DATE THIS DOCUMENT IS PUBLISHED IN THE FEDERAL REGISTER]**. This section applies to all policies and plans to which section 4375 or 4376 applies.

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

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