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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 40, 46, and 602

[TD 9602]

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: Final regulations.

SUMMARY: This document contains final 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 final regulations affect the issuers and plan sponsors that are directed to pay those fees.

DATES: Effective Date: These regulations are effective **[INSERT DATE OF**

PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER].

Applicability Dates: These regulations apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.

FOR FURTHER INFORMATION CONTACT: R. Lisa Mojiri-Azad at (202) 622-6080 (regarding self-insured health arrangements) or Rebecca L. Baxter at (202) 622-3970 (regarding health insurance policies).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545-2238. The collections of information in these final regulations are in §46.4375-1(c)(2)(iv) (use of the snapshot method to calculate the fee under section 4375); §46.4375-1(c)(2)(v) (use of the 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); §46.4376-1(c)(2)(iv) (use of snapshot method to calculate the fee under section 4376); and §46.4376-1(c)(2)(v) (use of the Form 5500, “Annual Return/Report of Employee Benefit Plan,” or Form 5500-SF, “Short Form Annual Return/Report of Employee Benefit Plan” to calculate the fee under section 4376).

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 final 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). The Treasury Department and the IRS issued proposed regulations under sections 4375 through 4377 on April 17, 2012 (77 FR 22,691). 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 provides for the establishment of the private, nonprofit corporation, the Patient-Centered Outcomes Research Institute (the "Institute"). Through research, the Institute will assist 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 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 a 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, 2019.¹ 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. 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 a 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

¹ The Department of Labor has advised that, because the fee is imposed on the plan sponsor under section 4376 (instead of the plan), paying the PCORI fee generally does not constitute a permissible expense of the plan for purposes of Title I of the Employee Retirement Income Security Act (ERISA), although special circumstances may exist in limited situations. The Department of Labor will provide guidance in the near future on PCORI fee payments under Title I of ERISA on its website, www.dol.gov/ebsa.

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 an 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 fees imposed by sections 4375 and 4376 unless the policy or plan is an exempt governmental program. Section 4377(b)(3) defines an 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 (sections 6001 through 7874 that set forth the rules of federal tax procedure and administration).

Notice 2011-35 and Proposed Regulations

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 (referred to collectively as the PCORI fee) 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 considered all comments in issuing proposed regulations under sections 4375, 4376, and 4377 (77 FR 22,691). The Treasury Department and the IRS received 26 written comments on the proposed regulations. After consideration of the comments, these final regulations adopt the provisions of the proposed regulations with certain modifications, the most significant of which are highlighted in the Summary of Comments and Explanation of Revisions. See §601.601(d)(2).

Summary of Comments and Explanation of Revisions

I. Health insurance policies subject to the PCORI fee

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.

Section 46.4375-1(b)(1) of these regulations defines a specified health insurance policy as any accident and health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States. Section 46.4375-1(b)(1)(ii) provides exceptions to the term specified health insurance policy. Section

4375(c)(2) and §46.4375-1(b)(1)(ii)(A) provide an exclusion for any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c). While §46.4376-1(b)(ii)(B) excludes from the definition of applicable self-insured health plan an employee assistance program (EAP), disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment, no similar exclusion was included in the proposed regulations for a specified health insurance policy.

One commentator explained that California and Nevada regulate EAPs that provide for four or more counseling, treatment, or therapy visits as insurance thereby requiring the issuance of an insurance policy. The commentator argued that in any other state, identical EAPs would be excluded from the definition of applicable self-insured plan and not subject to the PCORI fee. In recognition of the unique California and Nevada requirements that certain employee assistance plans be treated as insurance, the commentator asked that an exception be added to the definition of specified health insurance policy to exclude those EAPs. In response to this comment, these final regulations provide that the definition of a specified health insurance policy does not include any insurance policy to the extent that the policy provides for an EAP, disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment. No inference is intended whether the specific health benefits cited by the commentator constitute insignificant benefits.

II. Retiree coverage and retiree-only plans

As noted in the preamble to the proposed regulations, sections 4375 and 4376 may apply to a retiree-only plan because, although group health plans that have fewer than two participants who are current employees (such as retiree-only plans) are excluded from the requirements of chapter 100 (setting forth requirements applicable to group health plans such as portability, nondiscrimination, and market reform requirements), this exclusion does not apply to sections 4375 and 4376 because these sections are in chapter 34. In addition, section 4376(c)(2)(A) states 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. Some commentators requested that the final regulations exempt from the PCORI fee retiree coverage on public policy grounds, but generally agreed that a retiree-only insured plan or retiree coverage under an applicable self-insured health plan may be subject to the PCORI fee. Consistent with the statutory language, the final regulations apply the PCORI fee to specified health insurance policies or applicable self-insured health plans that provide accident and health coverage to retirees, including retiree-only policies and plans.

III. COBRA coverage

Commentators requested clarification of whether sections 4375 and 4376 apply to continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other federal law or under state law (referred to collectively as “continuation coverage”) and asked that the final regulations explicitly exclude continuation coverage from application of those sections. If the coverage provided under the continuation coverage

arrangement is accident and health coverage, there is no basis to exclude the arrangement from the PCORI fee. The requirements of sections 4375 and 4376 apply to specified health insurance policies that provide accident and health coverage and plans that are applicable self-insured health plans, regardless of whether provided through the individual market, to an active employee as part of a group health plan, or as continuation coverage to an active employee, former employee, or otherwise qualifying beneficiary. In response to comments, these final regulations state explicitly that continuation coverage must be taken into account in determining the PCORI fee, unless the arrangement is otherwise excluded.

IV. Lives taken into account in calculating the fee

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 during the policy year. 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 during the plan year.

Commentators acknowledged that separate fees are imposed by sections 4375 and 4376, but argued that this only reflects congressional intent for the PCORI fee to extend to both insured and self-insured arrangements. Several commentators requested that the final regulations provide that the PCORI fee does not apply multiple times if accident and health coverage is provided to one individual through more than one policy or self-insured arrangement (for example, where an individual is covered by a fully-insured major medical insurance policy and a self-insured prescription arrangement). Commentators also requested that the final regulations clarify that the

issuer or plan sponsor is required to pay only once with respect to each covered life under the specified health insurance policy or applicable self-insured health plan.

The final regulations do not adopt the requested change that the fee apply only once with respect to each covered life because it would be contrary to the explicit statutory language applying the fee to each specified health insurance policy or applicable self-insured health plan. For example, for an employee covered by both a group insurance policy and a health reimbursement arrangement (HRA), the group insurance policy falls within the definition of a specified health insurance policy to which section 4375 applies a fee, and the HRA falls within the definition of an applicable self-insured health plan, to which section 4376 applies a fee to the plan sponsor. Because there are no allocation rules or other method of applying the fee on an aggregated basis in the statute or legislative history, there is no evidence that the statutory provisions were intended to be applied in a manner that aggregated these separate arrangements for a single covered individual and allocated the fee between them. However, in response to comments, the final regulations permit an applicable self-insured health plan that provides accident and health coverage through fully-insured options and self-insured options to determine the fee imposed by section 4376 by disregarding the lives that are covered solely under the fully-insured options. (See also discussion under section V of this preamble relating to the special rule for plan sponsors that establish or maintain multiple self-insured arrangements with the same plan year and section VI of this preamble relating to special rules for health reimbursement arrangements and flexible spending arrangements). Except as otherwise provided, the final regulations do not permit an issuer or plan sponsor to disregard a covered life merely because that

individual is also covered under another specified health insurance policy or applicable self-insurance plan.

V. Lives covered under multiple policies or plans

Section 46.4376-1(b)(1)(iii) of the proposed regulations provided that for purposes of section 4376, two or more arrangements established or maintained by the same plan sponsor that provide for accident and health coverage 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.

A few commentators described self-insured arrangements that are coordinated with an underlying health plan, including a plan of an unrelated entity. Commentators pointed to collectively bargained arrangements under which the union sponsors a prescription-only or premium-only plan that is tied to an insured health plan of the employers that have entered into a collective bargaining agreement between the employee representatives and one or more employers. These commentators requested that the final regulations include special rules that exempt from the PCORI fee certain applicable self-insured health plans that are established or maintained by a union because the lives covered under the union plan are taken into account for the fee imposed on the employer, if the employer's plan is also an applicable self-insured health plan, or the issuer, if the employer's plan is an insured plan. One commentator requested that the final regulations permit collectively bargained plans to be aggregated with the employer's plan, without regard to whether they have the same sponsor or plan year, for purposes of determining the fee with respect to the same lives covered.

One commentator pointed out that the Medical Loss Ratio (MLR) Interim Final Rule issued by HHS allows affiliated issuers to report their premiums and expenditures on an aggregate basis if one issuer provides in-network coverage and the second provides out-of network coverage for one group health plan. The commentator requested the same approach provided in §46.4376-1(b)(1)(iii) (permitting two or more applicable self-insured health plans with the same plan sponsor and same plan year to be treated as a single applicable self-insured health plan) be provided for group health plans that provide separate benefits to a participant or beneficiary during the same plan year under two or more insurance policies or through a self-insured plan and an insured plan. Specifically, the commentator suggested that if insurance policies covering the same individual qualify for aggregation under the MLR rebate reporting rules, the IRS should allow issuers to aggregate their policies for purposes of the PCORI fee.

Sections 4375 and 4376 specifically apply the PCORI fee to, respectively, an issuer of a specified health insurance policy and to the sponsor of an applicable self-insured health plan (subject to certain exceptions). The commentators have shown no statutory basis for combining arrangements involving different issuers or different plan sponsors. The statute specifically contemplated that different arrangements having different plan sponsors would be subject to separate fees imposed by section 4376. See section 4376(b)(2) (naming the different types of plan sponsors for different types of applicable self-insured health plans). Commentators, however, point to the proposed rule, adopted in these final regulations, permitting a plan sponsor to treat two different applicable self-insured health plans with the same plan year and plan sponsor as one plan as the basis for adopting the suggested change. There is no significant difference

between that arrangement and a single plan, or “umbrella” plan containing both self-insured arrangements. In contrast, if the two arrangements are sponsored by two different plan sponsors, there is no single plan equivalent. Accordingly, this suggestion is not adopted in the final regulations.

VI. Health reimbursement arrangements (HRAs) and flexible spending arrangements (FSAs)

Section 46.4376-1(b)(1)(ii) of the proposed regulations defined an applicable self-insured health plan to include HRAs (as described in Notice 2002-45 (2002-2 CB 93)) and health flexible spending arrangements (as described in section 106(c)(2)) (FSAs) that do not satisfy the requirements to be treated as an excepted benefit (within the meaning of section 9832(c) and §54.9831-1(c)(3)(v)). The proposed regulations also provided additional rules that permitted the plan sponsor to assume one covered life for each employee with an HRA and for each employee with an FSA that is not an excepted benefit. The final regulations retain these rules. See §601.601(d)(2).

Commentators requested that the definition of applicable self-insured health plan be revised to exclude all HRAs, or alternatively that the final regulations exclude from the definition HRAs that are “integrated” with coverage under a self-insured or fully-insured arrangement. One commentator requested that the final regulations exempt from the definition of applicable self-insured health plan premium-only HRAs for Medicare-eligible retirees. As discussed in the preamble to the proposed regulations, an HRA is not subject to a separate fee under section 4376 if the plan sponsor also maintains a separate applicable self-insured health plan with a calendar year (referred to as the other plan). In such circumstances, the plan sponsor is permitted to treat the

HRA and other plan as a single applicable self-insured health plan for purposes of section 4376 and therefore determine and pay the PCORI fee once with respect to each life covered under the HRA and other plan. Because the statutory structure provides that the fee imposed by section 4375 is separate from the fee imposed by section 4376, these regulations do not permit a plan sponsor to treat the HRA and a fully-insured plan as a single plan or arrangement for purposes of the PCORI fee, and these final regulations include additional examples to clarify the application of the PCORI fee to an HRA, including an HRA and other plan.

For the same reasons, the final regulations do not adopt the request to provide that the PCORI fee does not apply to an employee's FSA that does not meet the requirements for being an excepted benefit if the employee is covered by a major medical plan.

VII. Determination of whether an individual is residing in the United States

The term specified health insurance policy includes only an accident and health insurance policy that is issued with respect to an individual residing in the United States. The final regulations adopt the rule in the proposed regulations that provides 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 covered by the policy whose eligibility for coverage was not due to his or her status as a spouse, dependent, or other beneficiary of another insured individual. Also as provided in the proposed regulations, these final

regulations clarify that for purposes of the PCORI fee, “an individual residing in the United States” means an individual who has a place of abode in the United States.

Two commentators suggested that an issuer or plan sponsor should be permitted to find that a primary insured who is on a temporary U.S. visa does not have a place of abode in the United States. The commentators argued that because many (if not most) health insurance issuers offering expatriate plans request, for compliance purposes, an overview of citizenship and visa status from an employee covered under an employer-sponsored international plan, visa information and citizenship information should be available to them and can be relied upon in determining whether the employee’s place of abode is the United States or elsewhere.

The final regulations do not adopt this requested change. To exclude covered individuals who are residing in the United States would be contrary to Congressional intent that the PCORI fee applies to policies and plans that cover individuals residing in the United States. An individual on a temporary U.S. visa who has a place of abode in the United States is residing in the United States. For purposes of sections 4375, 4376, and 4377, the determination of place of abode is based on the most recent address on file with the issuer or plan sponsor.

VIII. Self-insured expatriate plans

As in the proposed regulations, these final 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. One commentator requested clarification that similar self-insured

plans are also excepted for purposes of the fee under section 4376. The final regulations clarify that the term applicable self-insured health plan does not include a self-insured plan if the facts and circumstances show that the self-insured plan was designed specifically to cover primarily employees who are working and residing outside of the United States.

IX. Additional rules for determining the applicable fee

Under the proposed regulations, issuers and plan sponsors were permitted to use alternative methods for determining the average number of lives for the year. Issuers could choose 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: (1) the actual count method, (2) the snapshot method, (3) the member months method, or (4) the state form method. While the actual count and snapshot methods count lives covered on the 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 or 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. Plan sponsors could use one of three alternative methods to determine the average number of lives covered under a plan for purposes of the fee imposed by section 4376: (1) the actual count method, (2) the snapshot method, or (3) the Form 5500 method.

One of the permitted methods - the “snapshot method” – would have required issuers and plan sponsors to determine the average lives by adding the number of lives covered on one date (or an equal number of dates) in each quarter during the plan year or policy year and dividing that sum by the number of dates on which the count was

made. Commentators suggested that issuers and plan sponsors using the snapshot method should not be required to use the same date for each quarter, but should be permitted to use different dates to determine the number of lives covered during a quarter to address holidays, weekend days, or other similar issues. The Treasury Department and the IRS recognize the need for flexibility but also the need to avoid permitting issuers and plan sponsors to pick the most advantageous dates (that is, the dates on which the number of lives covered is the lowest so that under the facts and circumstances the snapshot method does not fairly approximate the average number of lives covered for the applicable year). In response to these comments, the final regulations require an issuer or a plan sponsor that uses the snapshot method to determine the counts used based on a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter). Each date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year. If an issuer or plan sponsor uses multiple dates for the first quarter, the issuer or plan sponsor must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of such corresponding dates, and all dates used must fall within the same policy year or plan year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or 31 are used as snapshot dates for a calendar year plan, June 30 is the corresponding date for the second quarter). Thus, for

example, under the final regulations, if a plan sponsor uses the snapshot method to determine the average number of lives covered under an applicable self-insured health plan with a calendar year plan year and uses Monday, January 7, 2013, as the counting date for the first quarter, the plan sponsor may use any date beginning with Thursday, April 4, 2013, and ending with Wednesday, April 10, 2013, as the counting date for the second quarter (because all of those days are within three days of April 7, 2013, the date that corresponds to the January 7, 2013 counting date for the first quarter).

One commentator stated that the actual count and snapshot methods may pose significant operational challenges for many issuers. Because these methods require a determination of the number of lives covered by reference to the policy year for each health insurance policy that is subject to the fee, the commentator anticipates that issuers with a significant number of insurance policies that have policy years that begin at different dates during a calendar year will have difficulty implementing this approach. The commentator suggested that, regardless of the actual policy year, issuers who choose to use the actual count method should be permitted to measure lives covered on all days of a calendar year and then divide the result by 365. The commentator also suggested that, regardless of the actual policy year, issuers who choose to use the snapshot method should be permitted to measure lives covered using calendar year quarters and then average the results.

The final regulations do not adopt this requested change. The fee imposed by section 4375 applies to policies based on their policy year. For administrative ease and to facilitate the use of available information that is compiled by issuers, these regulations provide the member months method and the state form method as

alternatives for all policies in effect during a calendar year. Under each of these alternatives, the data permitted to be used is already reported by the issuer based on the calendar year. Issuers may use calendar year information in lieu of policy year information only if they use the member months method or the state form method.

The member months data and the data reported on state forms are based on the calendar year. To adjust for the fee being applicable to policy years ending after September 30, 2012, but before January 1, 2013, and after December 31, 2018, but before October 1, 2019, these final regulations adopt the pro rata approach set out in the proposed regulations 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 treated 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.

Commentators suggested that the special 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 should be applied to all years the fee is in effect, to appropriately reflect the change in the fee during each of such intervening years. One commentator argued that this revision is needed to prevent issuers that use these methods from being unfairly penalized by paying the rate determined as of December

31 of each year, resulting in an unanticipated higher liability for an issuer using those methods.

The final regulations do not adopt this requested change. The special pro rata approach for calculating the average number of lives covered was the least administratively burdensome way for the first and last policy years to which the fee applies to incorporate data from the NAIC annual report and similar state reporting requirements with the applicability dates for the PCORI fee related to policy years ending in 2012 and 2019. Other years are not affected by the applicability date issues. In addition, issuers are not required to use the member months or state form method and can use another permissible method.

X. Plan years subject to the PCORI fee

The fee imposed by section 4376 applies to plan years ending on or after October 1, 2012, and before October 1, 2019. Under the proposed regulations, an applicable self-insured health plan was required to determine the fee using the applicable dollar amount that applies for the plan year and the average number of lives covered during the plan year. Unlike the section 4375 fee, which is based on policy years, the application and amount of the section 4376 fee is based on the applicable dollar amount under section 4376 that is in effect on the last day of the plan year. One commentator requested additional examples illustrating the plan years covered by the fee, including the first plan year to which the PCORI fee applies. In response, §46.4376-1(a) of the final regulations includes examples illustrating the plan years (calendar and fiscal years) subject to the PCORI fee and the applicable dollar amount that must be used to determine the section 4376 fee for that plan year.

XI. Reporting and payment deadline

Consistent with the proposed regulations, these final regulations require an issuer of a specified health insurance policy and plan sponsor of an applicable self-insured health plan to report and pay the PCORI fee for a policy year or plan year no later than July 31 of the year following the last day of the policy or plan year.

One commentator asked that the final regulations provide that the reporting and payment due date for a plan sponsor that uses the Form 5500 method to determine the PCORI fee be the due date (including extensions) for the plan's Form 5500. The extended due date for a Form 5500 for a plan with a calendar year plan year is generally October 15 of the following year. As discussed earlier in this preamble, the Institute is funded in part from the PCORI fee. Under current rules, the PCORI fee ceases to apply after the end of the last policy and plan year ending before October 1, 2019, (with a due date of July 31, 2020) and funding for the Institute terminates on September 30, 2019. This lag between the last year of the PCORI fee (policy and plan years ending before October 1, 2019) and the proposed due date for the fee for the last year (July 31, 2020) means that the PCORI fee collected for the last year will not be available to the Institute. A delay for policy or plan years ending in years before 2019, as requested, would permit the PCORI fee for the policy or plan year ending during 2018 to be paid after September 30, 2019, and result in the Institute losing an additional year of funding. Accordingly, the Treasury Department and IRS have determined that delaying the proposed due date would result in additional complications and burdens for the Institute. Thus, these final regulations retain the proposed rule set forth in

§40.6071(a)-1(c) that all plan sponsors and issuers report and pay the PCORI fee no later than July 31 of the calendar year following the last day of the policy or plan year.

XII. Correction and amendments of Form 720

One commentator requested that the final regulations provide that plan sponsors may correct, without penalty, inadvertent errors if correction is within a specified period or if the error is de minimis. These final regulations do not adopt this change and, therefore, do not explicitly address corrections. As discussed in the preamble to the proposed regulations, the PCORI fee must be reported and paid on the Form 720, “Quarterly Federal Excise Tax Return.”

The applicable penalties related to late filing of the applicable form or late payment of the applicable fee, however, may be waived or abated if the issuer or plan sponsor has reasonable cause and the failure was not due to willful neglect. See §301.6651-1(c) relating to rules for showing of reasonable cause. Issuers and plan sponsors may use Form 720X, “Amended Quarterly Federal Excise Tax Return,” to make adjustments to liabilities reported on a previously filed Form 720, including adjustments that result in an overpayment.

XIII. Special rules for first year fee is in effect

The Treasury Department and the IRS recognized when issuing the proposed regulations that in certain instances the policy or plan year to which the PCORI fee would apply had already commenced, and therefore that transition relief was appropriate for purposes of counting lives covered under the policy or plan during the period before the issuance of the proposed regulations. Two commentators requested additional transition relief, including extending the good faith compliance period

provided under the proposed regulations. These final regulations do not adopt this request because the Treasury Department and IRS have determined that the relief provided in the proposed regulations is sufficient.

Accordingly, consistent with the proposed regulations, these final regulations provide that an issuer using the actual count method for determining the average number of lives covered under a policy with a policy year that ends on or after October 1, 2012, could begin counting lives covered under a policy as of May 14, 2012 (30 days after the date that the proposed regulations were published in 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 May 14, 2012, these regulations provide that issuers using the snapshot method could use counts from quarters beginning on or after May 14, 2012, to determine the average number of lives covered under the policy. These final regulations also permit a plan sponsor to use any reasonable method to determine the average number of lives covered under an applicable self-insured health plan for a plan year beginning before July 11, 2012 (90 days after the date that the proposed regulations were published in the Federal Register), and ending on or after October 1, 2012.

XIV. Third-party or affiliated insurer reporting and payment

The proposed regulations did not permit third-party reporting or payment of the PCORI fee. One commentator requested that the final regulations permit third-party reporting and payment. Another commentator requested that the final regulations permit affiliated insurers to designate an insurer that will be responsible for payment of

the section 4375 fee as long as the responsible insurer consents to such designation. Because the PCORI fee ceases to apply to policy years and plan years that end on or after October 1, 2019, the Treasury Department and IRS have determined that the burden and complexity that would have to be addressed by issuers, plan sponsors and the IRS to develop and operate a third-party reporting and payment regime significantly outweigh the benefits of such a regime. Therefore, the final regulations do not permit or include rules for third-party reporting or payment of the PCORI fee.

Applicability Date

These regulations apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.

Special Analyses

It has been determined that these final regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It is hereby certified that these final regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that 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, the proposed regulations were submitted to the Chief Counsel for

Advocacy of the Small Business Administration for comments on its impact on small business and no comments were received.

Drafting Information

The principal authors of these regulations are R. Lisa Mojiri-Azad, Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), and Rebecca L. Baxter, Office of Associate Chief Counsel (Financial Institutions & Products). 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.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 40, 46, and 602 are 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 by:

1. Removing from the third sentence in paragraph (a) 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.

2. Adding a new sentence after the third sentence in paragraph (a).

The addition reads 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, and, for issuers that determine the average number of lives covered under a policy for purposes of section 4375 using the member months method under §46.4375-1(c)(2)(v) or the state form method under §46.4375-1(c)(2)(vi) 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) Applicability date. This paragraph (c) applies to returns that report liability imposed by section 4375 or 4376.

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

(2) Applicable self-insured health plans. 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 4376 for the plan year ending on January 31, 2013, must be filed by July 31, 2014.

(d) Effective/Applicability date. 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.

§40.6091-1 Amended

Par. 5. Section 40.6091-1, paragraph (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 paragraph (e)(1)(iv) to read as follows:

§40.6302(c)-1 Deposits.

* * * * *

(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, SELF-INSURED HEALTH PLANS, 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 and self-insured health plans” 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

applicability date. For rules relating to filing the required return and paying the fee, see §§40.6011(a)-1 and 40.6071(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 and 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 prepaid health coverage arrangements described in paragraph (b)(2) of this section. Specified health insurance policy also includes any policy that provides accident and health coverage to an active employee, former employee, or qualifying beneficiary, as continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other Federal law or state law.

(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 (as defined in §46.4377-1(a)(3));

(C) Any stop loss or indemnity reinsurance policy; or

(D) Any insurance policy to the extent it provides 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) 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 and 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 is 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, respectively, 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 a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter), and dividing that total by the number of dates on which a count is made. For purposes of this paragraph (c)(2)(iv)(A), each date used for the second, third and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must be within the same policy year. If an issuer uses multiple dates for the first quarter, the issuer must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of such corresponding dates, and all dates used must be within the same policy year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used as a counting date for a calendar year policy, June 30 is the corresponding date for the second quarter).

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

Example. (i) Insurance Company B issues three policies with 12-month policy years that end in 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 B 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 the 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

a single date of the first month of each quarter of the policy years. Thus, for Policy A, Insurance Company B must count lives covered on a single date falling in each of December 2013, March 2014, June 2014 and September 2014; for Policy B, Insurance Company B must count lives covered on a single date falling in each of March 2014, June 2014, September 2014 and December 2014; and for Policy C, Insurance Company B must count lives covered on a single date falling in each of January 2014, April 2014, July 2014 and October 2014. In addition, the date for each of the second, third, and fourth quarters must fall within three days of the date in such quarter that corresponds to the date used for the first quarter, and must fall within the same policy year.

(ii) On December 6, 2013, Policy A covers 8,900 lives, on March 7, 2014, 9,100 lives, on June 6, 2014, 9,050 lives, and on September 5, 2014, 9,050 lives. 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.

(iii) On March 4, 2013, Policy B covers 1,500 lives, on June 7, 2013, 1,350 lives, on September 6, 2013, 1,400 lives, and on December 6, 2013, 1,550 lives. 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.

(iv) On January 6, 2014, Policy C covers 12,500 lives, on April 4, 2014, 12,250 lives, on July 7, 2014, 12,000 lives, and on October 3, 2014, 11,250 lives. 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.

(v) 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 May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the actual count method under paragraph (c)(2)(iii) of this section may calculate the average number of lives covered using data from the period beginning May 14, 2012, through the end of the policy year. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the snapshot method under paragraph (c)(2)(iv) of this section may calculate the average number of lives covered using dates from the quarters remaining in the policy year starting on or after May 14, 2012. If an abbreviated year is used, the issuer will divide the number of lives covered by the number of days from May 14, 2012, through the end of the policy year (for the actual count method) or the number of days on which a count was made (for the snapshot method).

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

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

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

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

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

amount is \$2. For any policy year ending in any Federal 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 Federal fiscal year; plus

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

(A) The applicable dollar amount for the policy year ending in the previous Federal 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 Federal fiscal year.

(d) Effective/Applicability date. 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--(1) General rule. 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 applicability date. For rules relating to filing the required return and paying the fee, see §§40.6011(a)-1 and 40.6071(a)-1.

(2) [Reserved]

(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 and 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) and §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) and §54.9831-1(c)(3)(v) 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.

(C) A plan that, as demonstrated by the facts and circumstances surrounding the adoption and operation of the plan, was designed specifically to cover primarily employees who are working and residing outside the United States (as defined in §46.4377-1(a)(3)).

(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 provide 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 for purposes of calculating the fee. Similarly, if a plan sponsor provides a Health Reimbursement Arrangement (HRA) and 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 if the HRA and the self-insured plan have the same plan year.

(iv) Examples. The following examples illustrate the principle of this paragraph (b)(1):

Example 1. (i) Plan Sponsor D sponsors and maintains three separate plans to provide certain benefits to its employees – Plan 501, Plan 502, and Plan 503.

(ii) Plan 501 is a calendar year plan that provides accident and health benefits, other than through insurance (that is, on a self-insured basis), to employees of Plan Sponsor D. Plan 502 is a calendar year HRA that can be used to pay for qualified accident and medical expenses for employees of Plan Sponsor D and their eligible dependents. Plan 503 provides dental and vision benefits for employees of Plan Sponsor D and eligible dependents, other than through insurance (that is, on a self-insured basis).

(iii) Because Plan 501 and Plan 502 provide accident and health coverage (within the meaning of §46.4377-1(a)) and are maintained by Plan Sponsor D for the benefit of its employees, Plans 501 and 502 are applicable self-insured health plans that are subject to the fee imposed by section 4376. Because dental and vision benefits are excepted benefits, as defined in section 9832(c), Plan 503 is not an applicable self-insured health plan subject to the section 4376 fee. Under the special rule set forth in §46.4376-2(b)(1)(iii), Plan Sponsor D may treat Plans 501 and 502 (both self-insured plans with a calendar year plan year) as a single plan for purposes of calculating the fee imposed by section 4376.

Example 2. Same facts as Example 1, except Plan 503 is not a Plan that provides dental and vision benefits, but rather a plan that provides accident and health coverage solely to employees who are working and residing outside the United States and does not provide any benefits to employees who are not working and residing outside the United States. Plan 503 is designed specifically to provide coverage to employees working and residing outside the United States because it limits coverage to these employees. Therefore, in accordance with the exception described in §46.4376-1(b)(1)(ii)(C), Plan 503 is not an 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 (as defined in section 3(40) of ERISA);

(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 the terms of the document under which the plan is operated as the plan sponsor for section 4376 purposes, provided that designation is made in writing, and that person has consented to the designation in writing, 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 establishing or maintaining the plan (for example, one of the employers that establishes or maintains 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 establishes or maintains the plan (with respect to employees of that employer), each employee organization that establishes or maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative, or association that establishes or 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) Examples. The following examples illustrate the principles of paragraph (b)(2) of this section:

Example 1. (i) Corporation 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.

(ii) Because the XYZ Group Health Plan provides accident and health coverage other than through an insurance policy, and is established by one or more employers for the benefit of their employees, 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.

Because a plan sponsor is not identified or designated in the governing plan document, the plan sponsor, for purposes of section 4376, is determined under paragraph (b)(2)(i)(H) of this section as each employer that establishes or maintains the plan (Employer X, Employer Y, and Employer Z), each with respect to its 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 on 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 and Employer X consents to this designation no later than the due date for paying the fee under section 4376. Accordingly, the plan sponsor for purposes of section 4376 is determined 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).

(2) Determination of the average number of lives covered 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 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); 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) 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 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 lives covered under the plan for each day of the plan year ending December 31, 2013 as 3,285,000. The average number of lives covered 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 9,000.

(iv) Snapshot method--(A) In general. A plan sponsor may determine the average number of lives covered under an applicable self-insured health plan for a plan year by adding the totals of lives covered on a date during the first, second, or third month of each quarter of the plan year (or more dates in each quarter if an equal number of dates is used in each quarter), and dividing that total by the number of dates on which a count was made. For purposes of this paragraph (c)(2)(iv), each date used for the second, third and fourth quarter must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same plan year. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of

such corresponding dates, and all dates used must fall within the same plan year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used for a calendar year plan, June 30 is the corresponding date for the second quarter). 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--

- (i) The number of participants with self-only coverage on that date; plus
- (ii) The number of participants with coverage other than self-only coverage on the date multiplied by 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. (i) Employer B is the plan sponsor of the Employer B Self-Insured Health Plan, which has a calendar year plan year. Employer B uses the snapshot method to determine the average number of lives covered under the plan and uses the snapshot count method to determine the number of lives covered on a day in the first month of each calendar quarter of the plan year.

(ii) On January 4, 2013, the Employer B Self-Insured Health Plan covers 2,000 lives, on April 5, 2013, 2,100 lives, on July 5, 2013, 2,050 lives, and on October 4, 2013, 2,050 lives. Under the snapshot method, Employer B must determine the average number of lives covered 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 2,050.

Example 2. (i) Same facts as Example 1, except that for the 2014 plan year Employer B determines the number of lives covered that are not covered by self-only coverage using the snapshot factor method (that is, based on the number of participants with coverage other than self-only coverage multiplied by 2.35 (the factor set forth in (c)(2)(iv) of this section)).

(ii) On January 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 11, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 11, 2014 and October 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees.

(iii) Under the snapshot factor method, Employer B must determine the average number of lives covered under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2014 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, 2014, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,497.

(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 participants reported on the Form 5500, "Annual Return/Report of Employee Benefit Plan," or the Form 5500-SF, "Short Form Annual Return/Report of Small Employee Benefit Plan," that is filed for the applicable self-insured health plan for that plan year, provided that the Form 5500 or Form 5500-SF is filed no later than the due date for the fee imposed by section 4376 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 the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 or Form 5500-SF

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 or Form 5500-SF 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 calendar year plan year ending on December 31, 2013. Employer C is required to file a Form 5500 for the plan for the 2013 plan year by July 31, 2014. However, on July 30, 2014, Employer C obtains an automatic 2-1/2 month extension for filing the 2013 Form 5500. Employer C files the 2013 Form 5500 on September 30, 2014 (that is, before the October 15 extended due date). Employer C is not eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending on December 31, 2013, because the 2013 Form 5500 was not filed by the original due date (that is, by July 31, 2014) for the return that reports liability for the fee imposed by section 4376 for the 2013 plan year.

Example 2. Same facts as Example 1, except that the Employer C Self-Insured Health Plan 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 (the 2012 Form 5500), on the extended due date for filing the 2012 Form 5500 (May 15, 2014). Employer C is eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending on July 31, 2013, because the 2012 Form 5500 had been filed by the due date for the return that reports liability for the fee imposed by section 4376 for that plan year (July 31, 2014).

Example 3. Same facts as Example 2, provided further that the Employer C Self-Insured Health Plan 2012 Form 5500 reports 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the 2012 plan year. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of lives covered 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 4,100.

Example 4. Same facts as Example 3, 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 lives covered 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 8,200.

(vi) Special rule for health FSAs and HRAs. For purposes of this section, if a plan sponsor does not establish or 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 life (and therefore the plan sponsor is not required to include as lives covered 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 and plan year 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 covered 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 lives covered solely by the fully-insured options under an applicable self-insured health plan--(A) In general. If an applicable self-insured health plan provides accident and health coverage through fully-insured options and self-insured options, the plan sponsor is permitted to disregard the lives that are covered solely under the fully-insured options in determining the lives covered taken into account for the actual count method (described in paragraph (c)(2)(iii) of this section), the snapshot method (described in paragraph (c)(2)(iv) of this section), and the Form 5500 method (described in paragraph (c)(2)(v) of this section).

(B) Example. The following example illustrates the principles of paragraph (c)(2)(vii) of this section:

Example. (i) Employer C is the plan sponsor of the Employer C Health Plan (Plan P). The Plan offers self-only or family health and accident coverage under fully-insured or self-insured options. On June 28, 2015, Employer C files a Form 5500 for Plan P for the plan year ending December 31, 2014 indicating: (1) a total of 4,000 plan participants on the first day of the 2014 plan year; and (2) a total of 4,200 plan participants on the last day of the plan year. Employer C determines that there were 3,000 plan participants (and their families, as applicable) covered under the fully-insured option offered under the plan on the first day of the 2014 plan year, and 2,900 plan participants (and their families, as applicable) covered under the fully-insured option on the last day of the 2014 plan year. Employer C uses the Form 5500 method to calculate the number of lives covered for the 2014 plan year.

(ii) Pursuant to paragraph (c)(2)(vii) of this section, Employer C determines the number of lives covered for the 2014 plan year as: the sum of 1,000 (4,000 total participants on the first day of the plan year – 3,000 participants covered by the specified health insurance policy on the first day of the plan year) and 1,300 (4,200 total participants – 2,900 participants covered by the specified health insurance policy on the first day of the plan year), or 2,300. To calculate the section 4376 fee under paragraph (c)(1) of this section for the 2014 plan year, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,300.

(viii) Special rule for the first year the fee is in effect. Notwithstanding paragraph (c)(2)(i) of this section, for a plan year beginning before July 11, 2012, and ending on or

after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

(3) Applicable dollar amount. For a plan year ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is \$1. For a plan year 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 Federal 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 the plan year ending in the previous Federal fiscal year; plus

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

(A) The applicable dollar amount for the plan year ending in the previous Federal 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 Federal fiscal year.

(4) Examples. The following examples illustrate the principle of paragraph (c)(3) of this section.

Example 1. (Calendar year plan). (i) Plan Sponsor C maintains Plan X which has a calendar year plan year; the plan continues in operation for the entire calendar years 2012 through 2019. Plan X is an applicable self-insured health plan, within the meaning of §46.4376-1(b)(1), and Plan Sponsor C is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year – the plan year beginning January 1, 2012, and ending December 31, 2012 – and ending with the 2018 plan year – the plan year beginning January 1, 2018, and ending December 31, 2018. In accordance with §40.6071(a)-1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2012 plan year (January 1, 2012, through December 31, 2012) and must be filed no later than July 31, 2013, and the fee reported on this

form must be calculated by multiplying the average number lives by \$1 (the applicable dollar amount in effect for plans with plan years beginning on or after October 1, 2012, and before October 1, 2013); and

(ii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (January 1, 2018, through December 31, 2018) and must be filed no later than July 31, 2019, and the fee reported on this form must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

Example 2. (Fiscal year plan). (i) Plan Sponsor B maintains Plan W, which has a fiscal year plan year ending on July 31; the plan continues in operation for the entire fiscal year plan years from August 1, 2012, through July 31, 2019. Plan W is an applicable self-insured health plan, within the meaning of §46.4376-1(b)(1), and Plan Sponsor B is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year – the plan year beginning on August 1, 2012, and ending on July 31, 2013 – and ending with the 2018 plan year – plan year beginning on August 1, 2018, and ending July 31, 2019. In accordance with §40.6071(a)-1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2012 plan year (August 1, 2012, through July 31, 2013) and must be filed no later than July 31, 2014, and the fee reported on this form must be calculated by multiplying the average number lives by \$1 (the applicable dollar amount in effect for plans with plans years beginning on or after October 1, 2012, and before October 1, 2013); and

(iii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (August 1, 2018, through July 31, 2019) and must be filed no later than July 31, 2020, and the fee must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

(d) Effective/Applicability date. 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 insurance policy (as defined in section 4375(c) and §46.4375-1(b)(1)). Accident and health coverage also includes coverage for an active employee, a former employee, or a qualifying beneficiary that is continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other federal law or under state law.

(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 whose eligibility for coverage was not 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) Federal fiscal year. The term Federal 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 applies to all policy and plan years that end on or after October 1, 2012, and before October 1, 2019.

PART 602--OMB CONTROL NUMBERS UNDER THE PAPERWORK
REDUCTION ACT

Par. 12. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 13. In §602.101, paragraph (b) is amended by adding the following entries in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
46.4375-1.....	1545-2238
46.4376-1.....	1545-2238
* * * * *	

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

Approved: November 28, 2012.

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

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