

[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 57 and 602

[TD 9643]

RIN 1545-BL20

Health Insurance Providers Fee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to the annual fee imposed on covered entities engaged in the business of providing health insurance for United States health risks. This fee is imposed by section 9010 of the Patient Protection and Affordable Care Act, as amended. The regulations affect persons engaged in the business of providing health insurance for United States health risks.

DATES: Effective date: These regulations are effective on **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Applicability date: For dates of applicability see §§57.10 and 57.6302-1.

FOR FURTHER INFORMATION CONTACT: Charles J. Langley, Jr. at (202) 317-6855 (not a toll-free number).

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 under control number

1545-2249. The collection of information in these final regulations is in §57.2(e)(2)(i). The information is required to be maintained, in the case of a controlled group, by the designated entity and each member of the controlled group. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by section 6103.

Background

This document adds the Health Insurance Providers Fee Regulations to the Code of Federal Regulations (26 CFR part 57) under section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references in this preamble to section 9010 are references to the ACA. Section 9010 did not amend the Internal Revenue Code (Code) but contains cross-references to specified Code sections.

A notice of proposed rulemaking (REG-118315-12, 78 FR 14034) was published in the **Federal Register** on March 4, 2013 (the proposed regulations). The Department of the Treasury (Treasury Department) and the IRS received over 80 written comments from the public in response to the proposed regulations. A public hearing was held on

June 21, 2013. After considering the public written comments and hearing testimony, the proposed regulations are adopted as final regulations by this Treasury decision with certain changes as described in this preamble.

Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections in this preamble are references to subtitles, chapters, subchapters, and sections in the Code and related regulations. All references to “fee” in the final regulations are references to the fee imposed by section 9010.

Explanation of Provisions and Summary of Comments

Covered Entities and Exclusions

In General

Section 9010(a) imposes an annual fee, beginning in 2014, on each covered entity engaged in the business of providing health insurance. Section 9010(c) provides that a covered entity is any entity that provides health insurance for any United States health risk during each year, subject to certain exclusions. The proposed regulations defined the term covered entity generally to mean any entity with net premiums written for United States health risks during the fee year that is: (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a); (4) an entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).

With respect to the first category of covered entity, the proposed regulations provided that a health insurance issuer within the meaning of section 9832(b)(2) means an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance. A commenter suggested that the final regulations eliminate any State licensing requirement for a covered entity because an entity may provide health insurance for a United States health risk and not be licensed. The final regulations do not adopt this suggestion. The final regulations modify this category of covered entity to more closely align with section 9832(b)(2), which provides that a health insurance issuer must be licensed to engage in the business of insurance in a State and not merely required to be licensed as stated in the proposed regulations. A health insurance issuer within the meaning of section 9832(b)(2) cannot lawfully engage in the business of selling insurance in a State unless it is licensed to engage in the business of insurance in that State.

Notwithstanding this licensing limitation for the first category of covered entity, the term covered entity is not limited to an entity that is a health insurance issuer within the meaning of section 9832(b)(2). An insurance company subject to tax under subchapter L, an entity providing health insurance under Medicare Advantage, Medicare Part D, or Medicaid, or a MEWA may also be a covered entity under these regulations, whether or not that entity is licensed to engage in the business of insurance in a State.

Multiple Employer Welfare Arrangements (MEWAs)

The proposed regulations provided that the term covered entity includes a MEWA within the meaning of section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. chapter 18) (ERISA), to the extent that the MEWA is not a fully-insured MEWA, regardless of whether the MEWA is subject to regulation under State insurance law. In the case of a fully-insured MEWA, the MEWA is not a covered entity because, even though the MEWA receives premiums, it applies those premiums to pay an insurance company to provide the coverage it purchases. If the MEWA is not fully insured, however, the MEWA is a covered entity to the extent that it uses the premiums it receives to provide the health coverage rather than to pay an insurance company to provide the coverage.

Commenters suggested that a MEWA not be treated as a covered entity, stating that Federal and State law do not support the interpretation that a MEWA offers “insurance.” Commenters also stated that an employer who participates in a non-fully insured MEWA should be treated the same as an employer who offers a self-insured plan. The final regulations do not adopt these suggestions. By participating in a non-fully insured MEWA, a participating employer generally is pooling its health insurance risks, transferring those risks to the MEWA, or both, similar to the way an employer pools and transfers those risks by purchasing a group insurance policy from an insurance company. In a non-fully insured MEWA, the responsibility for a claim that a participant makes against it lies with the MEWA, and possibly with all of the contributing employers. Therefore, a MEWA is different from a self-insured plan in which responsibility for a participant’s claim lies solely with the claimant’s employer.

Moreover, section 514(b)(6) of ERISA provides that a MEWA is subject to State insurance law and regulation as an insurance provider, unlike non-MEWA ERISA-covered employee benefit plans which are not subject to State insurance law and regulation due to Federal preemption. For example, a non-fully insured multiemployer plan, defined under section 3(37) of ERISA, generally would not be subject to State insurance law, whereas an ERISA-covered MEWA, within the meaning of section 3(40) of ERISA, that is not fully insured (as defined in section 514(b)(6)(D) of ERISA) generally would be subject to State insurance law.

The Joint Committee on Taxation General Explanation also indicates that a MEWA is intended to be a covered entity under section 9010: “A covered entity does not include an organization that qualifies as a VEBA [voluntary employees’ beneficiary association] under section 501(c)(9) that is established by an entity other than the employer (i.e., a union) for the purpose of providing health care benefits. This exclusion does not apply to multi-employer [sic] welfare arrangements (‘MEWAs’).” See General Explanation of Tax Legislation Enacted by the 111th Congress, JCS-2-11 (March 2011) (JCT General Explanation) at 330.

For these reasons, the Treasury Department and the IRS have concluded that a MEWA within the meaning of section 3(40) of ERISA is an entity that provides health insurance for purposes of section 9010 to the extent that the MEWA is not a fully-insured MEWA and regardless of whether the MEWA is subject to regulation under State insurance law. In addition, such a MEWA is not eligible for the exception from the fee under section 9010(c)(2)(A) for self-insured employers.

The proposed regulations excluded a MEWA that is exempt from Department of Labor (DOL) reporting requirements under 29 CFR 2520.101-2(c)(2)(ii)(B). This section of the DOL regulations generally excludes a MEWA that provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that occurs for a purpose other than to avoid the reporting requirements and does not extend beyond a limited time. A commenter suggested that the final regulations also exclude a MEWA that is exempt from reporting under 29 CFR 2520.101-2(c)(2)(ii)(A), which generally applies to an entity that would not be a MEWA but for the fact that it provides coverage to two or more trades or businesses that share a common control interest of at least 25 percent (applying principles similar to the principles of section 414(c)) at any time during the plan year. The commenter also suggested that the final regulations exclude a MEWA that is exempt from reporting under 29 CFR 2520.101-2(c)(2)(ii)(C), which generally applies to an entity that would not be a MEWA but for the fact that it provides coverage to persons who are not employees or former employees of the plan sponsor (such as non-employee members of the board of directors or independent contractors), if coverage of such persons does not exceed one percent of the total number of employees or former employees covered by the arrangement, determined as of the last day of the year to be reported, or determined as of the 60th day following the date the MEWA began operating in a manner such that a filing is required pursuant to 29 CFR 2520.101-2(e)(2) or (3).

The final regulations adopt these suggestions and follow the DOL rules excepting these entities from the DOL reporting requirements under 29 CFR 2520.101-2 governing MEWAs. The reasons supporting the DOL's filing exemption also justify

exempting these arrangements from section 9010 as more akin to health coverage provided by a self-insured employer. Similar to the filing exemption for certain temporary MEWAs, these two filing exemptions are intended to address situations in which the status as a MEWA derives not from the design of the arrangement but instead from the limited participation by individuals who are not the employees of a single employer or from a desire to have a single plan for entities sharing substantial common ownership (though not sufficient to be treated as a single employer under the controlled group rules). Accordingly, a MEWA will not be considered a covered entity if it satisfies the requirements of 29 CFR 2520.101-2(c)(2)(ii)(A), (B), or (C) for the plan year ending with or within the section 9010 data year.

The proposed regulations provided that, solely for purposes of section 9010, an Entity Claiming Exception (ECE)¹ is subject to the same regime addressing MEWAs. Commenters requested that an ECE not categorically be treated as a MEWA for purposes of section 9010. Commenters pointed out that some ECEs are multiemployer plans and coverage during the period of their status as an ECE would not be consistent with this status. In addition, as a practical matter, an entity's status as an ECE is only relevant for reporting during a limited period of time. For these reasons, the final regulations adopt this suggestion so that whether an entity is or is not an ECE is not relevant to whether the entity is subject to section 9010.

¹ An ECE is defined in 29 CFR 2520.101-2(b) as an entity that claims it is not a MEWA on the basis that the entity is established or maintained pursuant to one or more agreements that the Secretary of Labor finds to be collective bargaining agreements within the meaning of section 3(40)(A)(i) of ERISA and 29 CFR 2510.3-40. We also note that ERISA section 501(b) imposes criminal penalties on any person who is convicted of violating the prohibition in ERISA section 519 against making false statements or representations of fact in connection with the marketing or sale of a MEWA.

Voluntary Employees' Beneficiary Associations (VEBAs)

In accordance with section 9010(c)(2)(D), the proposed regulations explicitly excluded any VEBA that is established by an entity other than an employer or employers for the purpose of providing health care benefits. Further, the preamble to the proposed regulations stated that, if an employer provides self-insured employee health benefits through a VEBA, the VEBA is not a covered entity because the exclusion for employers with self-insured arrangements under section 9010(c)(2)(A) applies. The preamble also stated that, if a VEBA purchases health insurance to cover the beneficiaries of the VEBA, the VEBA is not a covered entity because the issuer providing the health insurance that the VEBA purchases is the covered entity subject to the fee rather than the VEBA. The preamble stated that the Treasury Department and the IRS were not aware of any VEBAs that would be covered entities under the proposed regulations and invited comments on the types of VEBAs, if any, that do not fall within the exclusions and therefore would be covered entities.

A commenter requested that the final regulations clarify that a VEBA established by a union qualifies for the section 9010(c)(2)(D) exclusion. Commenters also asked for clarification that the section 9010(c)(2)(D) exclusion applies to any VEBA established by a joint board of trustees in the case of a multiemployer plan within the meaning of section 3(37) of ERISA. The final regulations adopt these suggestions with respect to plans established by unions and joint boards of trustees because the union or joint board of trustees is an entity other than the employer or employers. Thus, in the case of a multiemployer plan that maintains a VEBA, neither the plan nor the VEBA is a covered entity.

Commenters also requested that the final regulations clarify the application of the section 9010(c)(2)(D) exclusion to a VEBA that is part of a single-employer plan established pursuant to a collective bargaining agreement and having a joint board of trustees. As in the case of a multiemployer plan, a VEBA that is, for example, part of a single-employer plan established by a joint board of trustees pursuant to section 302(c)(5) of the Labor Management Relations Act of 1947, is considered to be established by an entity other than the employer or employers and so is eligible for the section 9010(c)(2)(D) exclusion.

The preamble to the proposed regulations stated that, if a MEWA provides health benefits through a VEBA, the VEBA is not a covered entity. A commenter asked whether the section 9010(c)(2)(D) exclusion applies to a non-fully insured MEWA that is also a VEBA. The section 9010(c)(2)(D) exclusion does not apply to an entity that is both a non-fully insured MEWA and a VEBA because, for section 9010 purposes, the entity has been established by the employers whose employees participate in the MEWA, and the section 9010(c)(2)(D) exclusion does not apply to an employer-established VEBA. Additionally, the entity does not qualify as a self-insured arrangement that is eligible for the exclusion for self-insured employers under section 9010(c)(2)(A) because, as previously described in the section of this preamble titled “Multiple Employer Welfare Arrangements (MEWAs),” a non-fully insured MEWA is not a self-insured employer. Accordingly, a MEWA that is also a VEBA is a covered entity.

Section 9010(c)(2)(C) Exclusion

In accordance with section 9010(c)(2)(C)(i)-(iii), the proposed regulations excluded any entity (i) that is incorporated as a nonprofit corporation under State law;

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to, influence legislation (except as provided in section 501(h)), and that does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office; and (iii) that receives more than 80 percent of its gross revenues from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act (which include Medicare, Medicaid, the Children's Health Insurance Plan (CHIP), and dual eligible plans).

Commenters suggested that the final regulations exclude a for-profit entity that meets the section 9010(c)(2)(C)(ii) and (iii) requirements. According to the commenters, imposing the fee on these for-profit entities will effectively reduce benefits provided under Medicare and Medicaid, require the entities to pass the cost of the fee back to the government, and competitively disadvantage these entities in favor of excluded nonprofit corporations. Another commenter suggested that the final regulations permit an entity that is treated as a nonprofit entity under State law to satisfy the section 9010(c)(2)(C)(i) requirement even if it is not incorporated as a nonprofit corporation. Commenters also suggested that the final regulations exclude an entity that meets the section 9010(c)(2)(C)(i) and (ii) requirements and that targets low-income, elderly, or disabled populations described in section 9010(c)(2)(C)(iii), but whose income is not derived from title XVIII, XIX, or XXI programs, but rather from similar types of programs that do not come under those titles. The final regulations do not adopt these suggested changes. The statutory language sets forth specific

requirements for an entity to qualify for the exception, including that the entity be a nonprofit corporation and that the entity receive the required portion of its gross income from the enumerated Federal government programs.

Commenters suggested that the final regulations interpret the requirement set forth in section 9010(c)(2)(C)(iii), that the entity receive more than 80 percent of its gross revenues from enumerated Federal government programs to qualify for that exception, to apply only to revenues that relate to net premiums written. Because gross revenues include all revenues of the covered entity without taking into account their source, the final regulations do not adopt this suggestion.

As explained in the preamble to the proposed regulations, an entity is not required to be exempt from tax under section 501(a) to qualify for the section 9010(c)(2)(C) exclusion. However, because the provisions of section 9010(c)(2)(C)(ii) relating to private inurement, lobbying, and political campaign activity are the same as those provisions applicable to organizations described in section 501(c)(3), for purposes of applying these requirements, the proposed regulations adopted the standards set forth under section 501(c)(3) and the related regulations. Commenters generally agreed with this approach, which is adopted in the final regulations.

One commenter suggested that the final regulations incorporate a “safe harbor” under which a transaction will not violate the private inurement prohibition under section 9010(c)(2)(C)(ii) if either the transaction complies with applicable State insurance laws governing the reasonableness of transactions between a health insurance provider and its affiliates or the transaction is approved in accordance with certain procedures set forth in the regulations under section 4958 (relating to taxes on excess benefit

transactions). The final regulations do not adopt this suggestion. The private inurement prohibition under section 501(c)(3) contains no exception for transactions that comply with State insurance laws or other applicable State or Federal laws. Similarly, while most situations that constitute inurement will also violate the general rules of section 4958, the two standards are not the same. See §1.501(c)(3)-1(f)(2) of the Income Tax Regulations and §53.4958-8(a) of the Foundation and Similar Excise Tax Regulations.

Agencies and Instrumentalities as Governmental Entities

Section 9010(c)(2)(B) excludes any governmental entity from the definition of covered entity. In defining the term governmental entity, the proposed regulations did not include instrumentalities. The preamble to the proposed regulations requested comments on the types of instrumentalities, if any, that would be considered covered entities under the general definition of covered entity and the extent to which those entities would qualify for other exclusions consistent with the statute.

Commenters suggested that the final regulations define governmental entity to include an instrumentality, citing statutory language that excludes “any” governmental entity and arguing that, in certain instances, an instrumentality that provides health insurance performs a governmental function and therefore should be excluded. For those reasons, the final regulations adopt this suggestion and define governmental entity to include any agency or instrumentality of the United States, a State, a political subdivision of a State, an Indian tribal government, or a subdivision of an Indian tribal government.

The final regulations also revise the governmental entity definition to delete the specific provision relating to any public agency that is created by a State or political

subdivision thereof and contracts with the State to administer State Medicaid benefits through local providers or health maintenance organizations (HMOs). The Treasury Department and the IRS intend that such a public agency would qualify as an agency or instrumentality of a State or political subdivision thereof for purposes of the governmental entity definition. See JCT General Explanation at 330.

Determinations of whether an entity is an agency or instrumentality have typically been analyzed on a facts and circumstances basis. In determining whether an entity is an agency or instrumentality, courts have applied a test similar to the six-factor test in Revenue Ruling 57-128 (1957-1 CB 311), which generally provides guidance on whether an entity is an instrumentality for purposes of the exemption from employment taxes under sections 3121(b)(7) and 3306(c)(7). See, for example, Bernini v. Federal Reserve Bank of St. Louis, Eighth District, 420 F.Supp. 2d 1021 (E.D. Mo. 2005) and Rose v. Long Island Railroad Pension Plan, 828 F.2d 910, 918 (2d Cir. 1987), cert. denied, 485 U.S. 936 (1988). For further background information relating to agency or instrumentality determinations, see the “Background” section of the preamble in the section 414(d) draft general regulations in the Appendix to the ANPRM (REG-157714-06) relating to governmental plan determinations, 76 FR 69172 (November 8, 2011).

Applying principles similar to those described in Revenue Ruling 57-128, in determining whether an entity is an agency or instrumentality for purposes of section 9010, factors taken into consideration include whether the entity is used for a governmental purpose and performs a governmental function. The Treasury Department and the IRS question whether providing health insurance on a commercial market in direct competition with non-governmental commercial entities is a

governmental function, absent particular circumstances. Accordingly, an entity may jeopardize its status as an agency or instrumentality if it engages in the business of providing insurance on the commercial market on a continuing and regular basis.

Further, section 9010(i) authorizes the IRS to prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of section 9010, including inappropriate actions taken to qualify as an excluded entity under section 9010(c)(2). If the Treasury Department and the IRS conclude that agencies or instrumentalities have entered the commercial market in competition with commercial entities in a manner that makes it inappropriate to apply the governmental entity exclusion under section 9010(c)(2)(B), the Treasury Department and the IRS may reconsider the exclusion of agencies and instrumentalities and exercise the authority under section 9010(i) to address particular concerns in this area.

Educational Institutions

A commenter suggested that the final regulations exclude educational institutions from the definition of covered entity. The final regulations do not adopt this request. The statute does not exclude educational institutions from the definition of covered entity, but as noted in the preamble to the proposed regulations, other exceptions may apply. For example, if an educational institution uses the premiums it receives from students to purchase insurance from a separate, unrelated issuer, the issuer, and not the educational institution, will be the covered entity for purposes of section 9010. If an educational institution provides students with health coverage through a self-insured arrangement, the exclusion for self-insuring employers does not apply because the institution is not providing health coverage as an employer. However, other exclusions

may apply. For example, the exclusion for governmental entities applies if an educational institution is a wholly-owned instrumentality of a State. In addition, although an educational institution that is a covered entity must report to the IRS its net premiums written, it will not be subject to the fee unless the institution (or its controlled group that is treated as a single covered entity) has net premiums written for United States health risks of more than \$25 million pursuant to section 9010(b)(2)(A).

Other Entities

Commenters suggested that the final regulations exclude certain section 501(c)(5) labor organizations that provide health coverage under the Federal Employees Health Benefit Plan (FEHBP) on the basis that providing health coverage is part of their exempt function as a section 501(c)(5) entity. The commenters asserted that, although a section 501(c)(5) entity is not organized as a VEBA, it operates like a VEBA because of the various FEHBP rules (including, for example, on use of reserves) and therefore should be treated as a VEBA for section 9010 purposes. The final regulations do not adopt this suggestion. Congress identified specific exclusions from section 9010 and there is no statutory exclusion for section 501(c)(5) entities.

Another commenter suggested that the final regulations exclude high risk pools under section 1101 of the ACA, which will expire on December 31, 2013. Section 9010(c)(1) defines a covered entity to mean any entity that provides health insurance for a United States health risk in the year that the fee is due. The first year the fee is due is 2014. Therefore, for the first fee year, an entity is not a covered entity unless it provides health insurance for United States health risks in 2014. Because high risk pools will expire on December 31, 2013, they will not provide health insurance in 2014 and will not

be covered entities. In the event a high risk pool provides health insurance for United States health risks in 2014, it will be a covered entity if it does not meet one of the exclusions described in section 9010(c)(2).

A commenter requested that the final regulations provide an exclusion for an entity that is selling or otherwise failing to continue the majority of its health insurance business by December 31, 2013, but is contractually required to provide some residual health insurance. The entity's fee liability for 2014 based on the 2013 data year will be significantly larger than the total amount of net premiums written that the entity will collect in 2014. The final regulations do not adopt this request because it is inconsistent with the statute, which bases the fee liability on net premiums written during the data year.

The proposed regulations defined the term covered entity to include an HMO, as defined in section 9832(b)(3). A commenter requested that the final regulations exclude an HMO that is a tax-exempt organization described in section 501(c)(3) or (4) on the basis that Congress did not intend to subject a tax-exempt HMO to the fee. The final regulations do not adopt this suggestion. Section 9010(c)(2) describes the entities that are excluded from the definition of covered entity. While section 9010(c)(2)(D) excludes certain types of VEBAAs described in section 501(c)(9), there is no similar exclusion for an entity that qualifies as a tax-exempt organization under either section 501(c)(3) or (4). However, such a tax-exempt organization would be eligible for the partial exclusion under section 9010(b)(2)(B).

Disregarded Entities

Two commenters requested further guidance on how to treat disregarded entities for purposes of section 9010. One commenter suggested that the final regulations specifically state that the general rules for disregarded entities apply. A second commenter suggested that, solely for section 9010 purposes, a disregarded entity should always be regarded as a corporation. The final regulations do not adopt any special entity classification rules. Thus, if a covered entity is an eligible entity under §301.7701-3(a) of the Procedure and Administration Regulations, has a single owner, and does not elect to be classified as a corporation under §301.7701-3(c), then the covered entity is disregarded as an entity separate from its owner and its activities are treated in the same manner as a branch or division of its owner pursuant to §301.7701-2(a). Additionally, although §301.7701-2(c)(2)(v) treats a disregarded entity as a corporation for certain enumerated excise taxes, the fee under section 9010 is not among the enumerated excise taxes. However, an insurance company is a corporation under §301.7701-2(b)(4) and cannot be disregarded as an entity separate from its owner. See also Rev. Rul. 83-132 (1983-2 CB 270). Under sections 816(a) and 831(c), a company is an insurance company if more than half of its business during the taxable year is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies. Therefore, if the covered entity is an insurance company under sections 816(a) and 831(c), then it is a corporation and cannot be disregarded as an entity separate from its owner.

Controlled Groups

In accordance with section 9010(c)(3), the proposed regulations treated a controlled group as a single covered entity, and defined a controlled group as a group of two or more persons, including at least one person that is a covered entity, that are treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

Section 52(a) and (b) provide rules that treat all organizations that are members of a controlled group as a single entity. Generally, section 52(a) provides that the term controlled group of corporations has the meaning given to such term by section 1563(a), except that “more than 50 percent” is substituted for “at least 80 percent” each place it appears in section 1563(a)(1) and the determination is made without regard to section 1563(a)(4) (relating to special rules for certain insurance companies) and 1563(e)(3)(C) (relating to attribution rules for ownership interest held under a trust described in section 401(a) that is exempt from tax under section 501). Section 52(b) provides similar rules for determining whether trades or businesses (whether or not incorporated) are under common control. Section 414(m) requires that all members of an affiliated service group be treated as a single organization, and section 414(o) provides authority for additional rules that may be necessary to prevent the avoidance of certain requirements related to employee benefits.

A commenter suggested that the final regulations clarify the circumstances under which nonprofit organizations are included in controlled groups under section 9010(c)(3). The Treasury Department and the IRS are considering whether further guidance is needed under section 52(a) or (b) to address either organizations exempt from tax under section 501(a) or nonprofit organizations that, although not exempt from

tax under section 501(a), do not have members or shareholders that are entitled to receive distributions of the organization's income or assets (including upon dissolution) or that otherwise retain equity interests similar to those generally held by owners of for-profit entities. Until further guidance is issued, those two types of organizations may either rely on a reasonable, good-faith application of section 52(a) and (b) (taking into account the reasons for which the controlled group rules are incorporated into section 9010) or apply the rules set forth in §1.414(c)-5(a) through (d) (but substituting "more than 50 percent" in place of "at least 80 percent" each place it appears in §1.414(c)-5).

Health Insurance

In General

Section 9010 does not define health insurance, providing in section 9010(h)(3) only that health insurance does not include coverage only for accident, or disability income insurance, or any combination thereof as described in section 9832(c)(1)(A); coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance as described in section 9832(c)(3); insurance for long-term care; or Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act). The proposed regulations generally defined the term health insurance, subject to certain exclusions, by reference to section 9832(b)(1)(A) to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. The final regulations clarify that these benefits constitute health insurance when they are offered

by any type of covered entity, and not solely by a health insurance issuer within the meaning of section 9832(b)(2).

Stop-Loss Coverage

Several comments requested that the final regulations clarify the treatment of stop-loss coverage. Employers that self-insure their employees' health benefits frequently purchase stop-loss coverage to mitigate risk. The stop-loss provider assumes the risk of claims above a certain agreed-upon threshold known as the attachment point. Some commenters suggested including stop-loss coverage in the definition of health insurance for purposes of section 9010, whereas other commenters suggested excluding it. The DOL, the Department of Health and Human Services (HHS), and the Treasury Department are concerned that more employers in small group markets with healthier employees may pursue self-insured arrangements with stop-loss arrangements that have low attachment points as a functionally equivalent alternative to an insured group health plan. As a result, the three agencies issued a Request for Information (RFI) regarding such practices, with a focus on the prevalence and consequences of stop-loss coverage at low attachment points. See 77 FR 25788 (May 1, 2012). Because the scope of stop-loss coverage that may constitute health insurance, if any, has not been determined, the final regulations do not expressly include stop-loss coverage in the definition of health insurance. Accordingly, section 9010 will not apply to stop-loss coverage until such time and only to the extent that future guidance addresses the issue of whether, and if so under what circumstances, stop-loss coverage constitutes health insurance.

Limited Scope Dental and Vision Benefits

The proposed regulations defined health insurance to include limited scope dental and vision benefits under section 9832(c)(2)(A). Commenters suggested revising the definition of health insurance to exclude limited scope dental and vision benefits (sometimes referred to as stand-alone dental and vision benefits). Alternatively, commenters suggested including only those dental and vision policies that can be offered on an Exchange, such as pediatric dental plans. The final regulations do not adopt these suggestions. The JCT General Explanation indicates that dental and vision benefits are intended to be included as health insurance for purposes of section 9010 and the comments received do not compel a different conclusion. See JCT General Explanation at 331. Accordingly, the final regulations retain the rule in the proposed regulations and provide that limited scope dental and vision benefits, including arrangements that may be sold on an Exchange (for example, pediatric dental coverage), are health insurance for purposes of section 9010.

Coverage Funded by Targeted Government Programs

Commenters suggested that the final regulations exclude coverage funded by government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act (which include Medicare, Medicaid, CHIP, and dual eligible plans) from the definition of health insurance or exclude revenues received from these government programs from net premiums written. The final regulations do not adopt these suggestions. A full exclusion for these types of coverage or associated revenues would not be consistent with section 9010. Section 9010(c)(2)(C) excludes a limited subset of entities that provide coverage funded by

these governmental programs, which indicates that entities providing such coverage are otherwise providing health insurance that is subject to the fee. The JCT General Explanation further indicates that Medicare and Medicaid coverage is health insurance that is subject to the fee. Thus, an entity providing this type of coverage is a covered entity unless it qualifies for a statutory exclusion from the definition of a covered entity, such as the section 9010(c)(2)(C) exclusion. See JCT General Explanation at 330 and 331.

Indemnity Reinsurance

The proposed regulations provided that, solely for purposes of section 9010, health insurance does not include indemnity reinsurance, defined as an agreement between two or more insurance companies under which 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 the issuing company retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement. A commenter suggested that the final regulations clarify that the definition of indemnity reinsurance extends to reinsurance obtained by HMOs. The final regulations adopt this suggestion and clarify that the issuer of the policies specified in the indemnity reinsurance agreement may be any covered entity.

Commenters asked about the treatment of a “carve-out” arrangement or similar types of arrangement in which one insurer accepts responsibility for all or part of the health risk within a defined category of medical benefits that another insurer is obligated to provide. For example, a full-service insurer that includes dental benefits as part of its health insurance plan may contract with a dental insurer to provide those benefits to

plan members, but still retain an exclusive contractual relationship with plan members and liability for benefits. The commenters expressed concern that premiums received by both the full-service insurer and the secondary services insurer for these benefits could be subject to the fee. Although the final regulations do not expressly address a carve-out arrangement, the secondary services insurer in such an arrangement is not providing health insurance for purposes of section 9010 to the extent the arrangement meets the definition of indemnity reinsurance.

Subcapitation

A commenter requested that the final regulations clarify the treatment of a subcapitation arrangement. Under a typical subcapitation arrangement, a Medicaid plan provider contracts with a separate service provider to provide certain services to the Medicaid plan participants and share some of the provider's risk. A Medicaid plan provider that enters into a subcapitation arrangement remains fully liable on the underlying plans, and any amounts paid to compensate the service provider for the subcapitation arrangement are not considered premiums for State regulatory purposes or reported as such. Therefore, although the final regulations do not directly address a subcapitation arrangement, amounts paid to a service provider under such an arrangement are not included in net premiums written for health insurance to the extent they are not treated as premiums for State regulatory and reporting purposes.

Employee Assistance Programs

Commenters requested that the final regulations exclude benefits under an employee assistance program (EAP) from the definition of health insurance, including an EAP that is treated as insurance in California or Nevada. Generally, an EAP does

not exhibit the risk pooling and risk transferring characteristics of insurance, but certain States regulate benefits under an EAP as insurance in some situations. The Treasury Department, DOL, and HHS currently are considering guidance that would treat benefits under an EAP as an excepted benefit under section 9832(c) (as well as corresponding provisions of ERISA and the Public Health Service Act (42 U.S.C. chapter 6A) (PHSA)), and provided in Q&A 9 of Notice 2013-54 (2013-40 IRB 287; September 30, 2013) that until that separate rulemaking is finalized in other guidance, and through at least 2014, a taxpayer may treat an EAP that does not provide significant benefits in the nature of medical care or treatment as constituting excepted benefits. Whether and under what conditions an EAP provides health insurance coverage has been a longstanding issue that this other guidance is intended to address by defining an EAP and setting forth the conditions under which the benefits under an EAP will be treated as excepted benefits.

Because the extent to which benefits under an EAP may constitute health insurance has not been determined, the final regulations do not expressly define health insurance to include benefits under an EAP. If an EAP provides significant benefits in the nature of medical care or treatment, those benefits would meet the definition of health insurance for section 9010 purposes. Otherwise, benefits under an EAP will not be treated as health insurance for section 9010 purposes until such time and only to the extent that the Treasury Department, DOL and HHS determine such benefits do not qualify as an excepted benefit.

Commenters also requested that the final regulations exclude coverage under a disease management program or a wellness program from the definition of health insurance. The final regulations do not specifically address the treatment of a stand-

alone wellness plan or disease management program. These programs generally do not exhibit the risk shifting and risk distribution characteristics of insurance.

Additionally, a program of this type may be contained within an EAP that satisfies the standard in Q&A 9 of Notice 2013-54 for being an excepted benefit (taking into account the benefits provided under the programs in determining whether the EAP provides substantial benefits in the nature of medical treatment). For these reasons, the final regulations do not expressly define health insurance to include coverage under a disease management program or wellness program. If these programs provide significant benefits in the nature of medical care or treatment, those benefits would meet the definition of health insurance for section 9010 purposes. Otherwise, coverage under these programs will not be treated as health insurance for section 9010 purposes until such time and only to the extent that the three agencies determine these benefits do not qualify as an excepted benefit.

Long-Term Care

The proposed regulations excluded from the definition of health insurance any benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section 9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C). A commenter questioned whether this exclusion applies to Medicaid managed long-term care premiums, such as those provided to covered entities that may participate in State Medicaid managed long-term care programs. To the extent Medicaid plan providers can separately identify premiums received for long-

term care, these amounts are not for health insurance and are not included in net premiums written.

Medicare Advantage and Medicare Part D Plans

Some employers or unions provide Medicare Advantage or Medicare Part D benefits in connection with an Employer Group Waiver Plan (EGWP) for employees and retirees who are Medicare beneficiaries. According to commenters, an employer or union can provide these benefits on a self-insured basis. Commenters requested that the final regulations clarify whether a union or employer that provides Medicare Advantage and Medicare part D benefits under an EGWP or similar arrangement is a covered entity subject to section 9010 with respect to premiums received for the coverage. No change was made in the final regulations to specifically address this issue. However, while the benefits provided by these arrangements may constitute health insurance within the meaning of section 9010, an employer or union that provides benefits under an EGWP or similar arrangement is not a covered entity to the extent the arrangement is eligible for the self-insuring employer exception under section 9010(c)(2)(A).

Medicare Cost Contract Plans

A commenter asked that the final regulations clarify how section 9010 applies to the Medicare cost contract portion of an entity's business. A Medicare cost contract plan is a type of plan established by section 1876 of Title XVIII of the Social Security Act. Cost contract plans are paid based on the reasonable costs incurred by delivering Medicare-covered services to plan members. Although the final regulations do not specifically address the treatment of a Medicare cost contract plan, benefits under a

Medicare cost contract plan are health insurance for section 9010 purposes if they meet the general definition of health insurance and do not qualify for a specific exclusion.

Section 9010(b)(2)(B) Partial Exclusion

After applying section 9010(b)(2)(A) to determine the amount of net premiums written for health insurance of United States health risks that are taken into account, the proposed regulations excluded under section 9010(b)(2)(B) 50 percent of the remaining net premiums written for health insurance of United States health risks that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513) of any covered entity qualifying under section 501(c)(3), (4), (26), or (29) and exempt from tax under section 501(a). Commenters requested that the final regulations apply this exclusion to a for-profit hospital health plan (HHP) that is owned and controlled by an entity exempt from tax under section 501(a) and further described in section 501(c). According to the commenters, an HHP functions like a nonprofit entity because it reinvests whatever profits it produces each year in its parent owner's charitable mission. The final regulations do not adopt this request. By statute, the partial exclusion only applies to a covered entity that is a section 501(c)(3), (4), (26), or (29) entity, and even then only with respect to premium revenue from its exempt activities.

One commenter suggested that the final regulations require any covered entity claiming the partial exclusion to submit an IRS determination letter recognizing it as tax-exempt under section 501(c)(3), (4), (26), or (29). Another commenter objected to this suggestion on the basis that the Code does not require all tax-exempt entities to apply to the IRS for recognition of tax-exempt status. The final regulations do not impose any

additional requirements on entities claiming the partial exclusion. For purposes of section 9010, whether an entity qualifies as exempt from Federal income tax under section 501(a) as an organization described in section 501(c)(3), (4), (26), or (29) will be determined under the Code provisions applicable to those organizations. To provide greater certainty, the final regulations provide that an entity is eligible for the section 9010(b)(2)(B) partial exclusion if it meets the requirements for that exclusion as of December 31st of the data year.

Reporting and Penalties

Section 9010(g)(1) requires each covered entity to report to the IRS its net premiums written for health insurance for United States health risks during the data year. The proposed regulations required that this information be reported on Form 8963, "Report of Health Insurance Provider Information." Commenters suggested that the final regulations require an entity that qualifies for an exclusion from the definition of covered entity to report its net premiums written to claim the exclusion. The final regulations do not adopt this suggestion. The required reporting under section 9010(g)(1) only applies to covered entities.

A commenter requested that each covered entity be required to report even if it receives no more than \$25 million in net premiums written and therefore is not liable for the fee. The proposed regulations already imposed this requirement in accordance with the statute. The final regulations retain this requirement.

Section 9010(g)(2) imposes a penalty for failing to timely submit a report containing the required information unless the covered entity can show that the failure is due to reasonable cause. Section 9010(g)(3) imposes an accuracy-related penalty for

any understatement of a covered entity's net premiums written. Commenters requested that the final regulations provide a reasonable cause exception for the accuracy-related penalty similar to the reasonable cause exception for the failure to report penalty.

Unlike section 9010(g)(2), section 9010(g)(3) does not contain a reasonable cause exception. Therefore, the final regulations do not create a reasonable cause exception for the accuracy-related penalty. However, the final regulations require a covered entity to submit a corrected Form 8963 during the error correction period if the entity believes there are any errors in the preliminary fee calculation. The corrected Form 8963 will replace the original Form 8963 for all purposes, including for the purpose of determining whether an accuracy-related penalty applies, except that a covered entity remains subject to the failure to report penalty if it fails to timely submit the original Form 8963.

The proposed regulations clarified that the failure to report penalty and the accuracy-related penalty apply in addition to the fee. The final regulations retain this clarification and further clarify that a covered entity may be liable for both penalties.

A commenter suggested that the final regulations create a safe harbor for the failure to report penalty imposed by section 9010(g)(2) and waive or reduce the penalty for small businesses, or exclude small businesses altogether from the definition of covered entity so that the penalty does not apply. The final regulations do not adopt this suggestion. The statute does not exclude small businesses from either the definition of covered entity or the requirement to report. However, certain statutory provisions will mitigate the impact on small business. Although a small business that is a covered entity must report its net premiums written, it will not be subject to the fee if its net premiums written are \$25 million or less pursuant to section 9010(b)(2)(A). Further,

section 9010(g)(2) allows the IRS to waive the failure to report penalty if there is reasonable cause for such failure. The IRS will determine whether reasonable cause exists for a covered entity's failure to report based on the facts and circumstances.

Commenters requested that the IRS wait to assess the accuracy-related penalty until the error correction process is complete. Under section 9010(g)(3)(A), the amount of the accuracy-related penalty is equal to the excess of the amount of the covered entity's fee determined in the absence of the understatement (that is, the correct fee amount) over the amount of the fee determined based on the understatement (that is, the amount of the fee based on understated reporting). Because the fee is allocated among covered entities based on each entity's net premiums written, the IRS must determine the correct amount of net premiums written for all covered entities before it can determine the correct fee amount for a covered entity. Therefore, the IRS cannot compute and assess any accuracy-related penalties until the conclusion of the error correction process when the IRS computes the final bills. As stated earlier in this preamble, if the covered entity timely submits a corrected Form 8963 during the error correction period, the corrected Form 8963 will replace the original Form 8963 for the purpose of determining whether an accuracy-related penalty applies.

Fee Calculation and Error Correction Process

In General

The proposed regulations required each covered entity to report annually its net premiums written for health insurance of United States health risks during the data year to the IRS on Form 8963 by May 1st of the fee year. The proposed regulations also required the IRS to send each covered entity its final fee calculation no later than

August 31st, and required the covered entity to pay the fee by September 30th by electronic funds transfer. In addition, the proposed regulations required the IRS to send preliminary fee calculations and give covered entities an opportunity to submit error correction reports, with the time and manner of error correction reporting to be specified in other guidance published in the Internal Revenue Bulletin.

The final regulations adopt April 15th as the date on which the Form 8963 is due, rather than May 1st, to provide additional time to prepare the preliminary fee calculation for each covered entity. Also, to ensure that any errors are timely corrected, the final regulations require a covered entity to review its preliminary fee calculation and, if it believes there are any errors, to timely submit to the IRS a corrected Form 8963 during the error correction period. As stated earlier in this preamble, the corrected Form 8963 will replace the original Form 8963. In the case of a controlled group, if the preliminary fee calculation for the controlled group contains one or more errors, the corrected Form 8963 must include all of the required information for the entire controlled group, including members that do not have corrections. Further rules regarding the manner for submitting Form 8963, the time and manner for notifying covered entities of their preliminary fee calculation, and the time and manner for submitting error correction reports for the error correction process are contained in other guidance in the Internal Revenue Bulletin being published concurrently with these final regulations.

Commenters suggested that the final regulations create a “true-up” process by which the fee will be continually adjusted from year to year. Because the fee is an allocated fee, allowing a true-up process for one covered entity will result in adjustments

to the fee for all covered entities. In the interest of providing finality and certainty to fee liability, the final regulations do not adopt this suggestion.

Source of Data Used to Calculate the Fee

The proposed regulations defined the term net premiums written to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. The preamble to the proposed regulations explained that, for covered entities that file the Supplemental Health Care Exhibit (SHCE) with the National Association of Insurance Commissioners (NAIC), net premiums written for health insurance generally will equal the amount reported on the SHCE as direct premiums written minus MLR rebates with respect to the data year, subject to any applicable exclusions under section 9010 such as exclusions from the term health insurance.

Commenters suggested that the final regulations require a covered entity to use the SHCE and any equivalent forms as the basis for determining net premiums written if it is required to file the SHCE and any equivalent forms pursuant to State reporting requirements. The final regulations do not adopt this suggestion because forms can change. The instructions to Form 8963 provide additional information on how to determine net premiums written using the SHCE and any equivalent forms as the source of data, and can be updated to reflect changes in forms.

Medical Loss Ratio (MLR) Rebates

The proposed regulations invited comments on how to compute MLR rebates with respect to the data year using data reported on the SHCE. Commenters suggested that MLR rebates be computed on an accrual basis using lines 5.3, 5.4, and

5.5 of the 2012 SHCE. In response to this comment, the final regulations clarify that MLR rebates are computed on an accrual basis. The final regulations do not designate specific SHCE line numbers as the source of data for computing MLR rebates because forms can change. Instead, the instructions to Form 8963 provide this information.

Medicaid Bonuses

A commenter requested that the final regulations address the treatment of Medicaid bonuses in determining net premiums written. According to the commenter, Medicaid plans sometimes receive bonuses for meeting plan goals. In some cases, the bonuses are paid up front and must be returned if the plan does not meet its goals, and in other cases, bonuses are paid only after the plan meets its goals. The final regulations do not create a special rule for the treatment of Medicaid bonuses. The treatment of Medicaid bonuses in determining net premiums written depends on whether and when these amounts are treated as premiums written for State or other Federal regulatory and reporting purposes.

Amounts Taken Into Account

In accordance with section 9010(b)(2)(A), the proposed regulations provided that, for each covered entity (or each controlled group treated as a single covered entity), the IRS will not take into account the first \$25 million of net premiums written. The IRS will take into account 50 percent of the net premiums written for amounts over \$25 million and up to \$50 million, and 100 percent of the net premiums written that are over \$50 million. Thus, for any covered entity with net premiums written of \$50 million or more, the IRS will not take into account the first \$37.5 million of net premiums written. Additionally, after this reduction, the proposed regulations provided that, in accordance

with section 9010(b)(2)(B), if the covered entity (or any member of the controlled group treated as a single covered entity) is exempt from tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29), the IRS will take into account only 50 percent of the remaining net premiums written of that entity (or member) that are attributable to its exempt activities.

A commenter asked how the fee will be calculated for a controlled group that is treated as a single covered entity when some but not all of the group's members qualify for the 50-percent exclusion under section 9010(b)(2)(B). The final regulations clarify that, in this circumstance, the section 9010(b)(2)(A) exclusion applies first to each member of the controlled group on a pro rata basis, and then the section 9010(b)(2)(B) exclusion applies only to eligible members of the group.

For example, if a controlled group consists of one member with \$100 million in net premiums written and a second member with \$50 million in net premiums written, two-thirds of the group's total \$37.5 million reduction under section 9010(b)(2)(A), or \$25 million, applies to the first member, and the remaining one-third, or \$12.5 million, applies to the second member. Therefore, after this initial reduction, the first member has \$75 million of net premiums written (\$100 million minus \$25 million), and the second member has \$37.5 million of net premiums written (\$50 million minus \$12.5 million). If the second member is eligible for the 50-percent exclusion under section 9010(b)(2)(B), the 50-percent exclusion applies to this member's remaining net premiums written, resulting in \$18.75 million (50 percent of \$37.5 million) being taken into account. Thus, total net premiums written taken into account for this controlled group are \$93.75 million (\$150 million minus \$37.5 million minus \$18.75 million).

Designated Entities

The proposed regulations required each controlled group to have a designated entity, defined as a person within the controlled group that is designated to act on behalf of the controlled group with regard to the fee. The proposed regulations further provided that if the controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group that files a consolidated return for Federal income tax purposes, the designated entity is the common parent of the affiliated group identified on the tax return filed for the data year. If the controlled group is not a part of an affiliated group that files a consolidated return, the proposed regulations allowed the controlled group to select its designated entity but did not require it to do so. The proposed regulations also required each member of a controlled group to maintain a record of its consent to the designated entity selection and required the designated entity to maintain a record of all member consents. Under the proposed regulations, if the controlled group did not select a person as its designated entity, the IRS would select a person as a designated entity for the controlled group and advise the designated entity accordingly.

The final regulations modify the proposed regulations, which provided that the common parent of a consolidated group was the designated entity in all cases. To better coordinate with the consolidated return regulations, the final regulations provide that the designated entity of a controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), that is a consolidated group (within the meaning of §1.1502-1(h)) is the agent for the group (within the meaning of §1.1502-77). In the case of a controlled group that is not a part of an affiliated group that files a

consolidated return, the Treasury Department and the IRS believe that the controlled group members are in the best position to determine which of its members should be the designated entity. To promote greater certainty and ease of administration in the fee reporting and determination process, the final regulations thus require, rather than permit, a controlled group that is not also a consolidated group to select its designated entity. The final regulations further provide that the IRS will select a member of the controlled group to be the designated entity for the controlled group if a controlled group fails to do so, but the controlled group may be liable for penalties for failure to meet its filing requirements. In the event the controlled group fails to select a designated entity and the IRS selects a designated entity for the controlled group, the final regulations deem all members of the controlled group that provide health insurance for a United States health risk to have consented to the IRS's selection of the designated entity.

Disclosure

Section 9010(g)(4) provides that section 6103 (relating to the confidentiality and disclosure of returns and return information) does not apply to any information reported by the covered entities under section 9010(g). The preamble to the proposed regulations stated that the Treasury Department and the IRS are considering making available to the public the information reported on Form 8963, including the identity of the covered entity and the amount of its net premiums written, at the time the notice of preliminary fee calculation is sent, and invited comments on which reported information the IRS should make publicly available. Numerous commenters requested that the IRS make all information reported on Form 8963 available to the public, and several commenters requested that this information be reported on the IRS website no later

than 15 days after the reporting deadline to promote transparency and assist health insurers in determining whether an error correction request is necessary. One commenter requested that consumers have access to the information that shows how much each covered entity will pay. In response to comments, the final regulations provide that the information reported on each Form 8963 will be open for public inspection or available upon request. The Treasury Department and the IRS expect that, at a time to be determined, certain information will be made available on www.irs.gov, including the identity of each reporting entity and the amount of its reported net premiums written.

Expatriate Policies

In accordance with section 9010(d), the proposed regulations defined the term United States health risk to mean the health risk of any individual who is (1) a United States citizen, (2) a resident of the United States (within the meaning of section 7701(b)(1)(A)), or (3) located in the United States, with respect to the period such individual is so located. The preamble to the proposed regulations requested comments on how the final regulations should apply to expatriate policies. The medical loss ratio final rule issued by HHS (MLR final rule) defines expatriate policies as predominantly group health insurance policies that provide coverage to employees, substantially all of whom are: (1) working outside their country of citizenship; (2) working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in their home country. 45 CFR 158.120(d)(4). The NAIC tracks the definition in the MLR final rule for purposes of State reporting requirements.

The proposed regulations did not provide specific rules for expatriate policies. However, the definitions of covered entity and health insurance in the proposed regulations only extended to entities and policies that are subject to State or Federal regulation. Commenters expressed the concern that the proposed regulations provided an unfair advantage to foreign health insurers. Not all foreign insurers issuing expatriate policies on United States health risks are subject to State regulation or to Federal regulation under ERISA. As a result, commenters asserted that a foreign insurance company that is not a covered entity will be able to charge less than a U.S. insurance company for nearly identical expatriate policies. Commenters suggested that the final regulations exclude expatriate policies (or defer their inclusion until more facts can be gathered). Alternatively, commenters suggested broadening the definition of covered entity to include a foreign insurer regardless of whether it is subject to State or Federal regulation.

The final regulations do not adopt these suggestions. Section 9010 defines a United States health risk to include the health risk of a U.S. citizen or a resident alien. An insurer that issues a policy to a U.S. citizen or resident living abroad is still providing coverage for a United States health risk, despite the fact that the individual may not be currently residing in the United States. Thus, excluding expatriate policies is inconsistent with the language of section 9010(d).

Alternatively, broadening the definition of covered entity to include a foreign insurer that does not do business in the United States is not in the interest of sound tax administration. Legal and practical restrictions significantly limit the ability of the IRS to compel an entity that does not do business in the United States to file a report and pay

a tax or fee. Further, the Treasury Department and the IRS expect that, in the overwhelming majority of cases, foreign insurers that do not do business in the United States will not have more than \$25 million in net premiums written for United States health risks and thus will not be subject to liability for the fee. Therefore, the final regulations do not expand the definition of covered entity to include a foreign insurer that does not do business in the United States.

The proposed regulations created a presumption under which the entire amount reported on the SHCE filed with the NAIC pursuant to State reporting requirements will be considered to be for United States health risks unless the covered entity can demonstrate otherwise. Commenters expressed concern that the data necessary to affirmatively establish that an individual is not a United States health risk will be difficult for covered entities to obtain because they will need to know the location of each insured individual at all times and that individual's nationality. Moreover, commenters contended that such information may not be clear or accurate because location or nationality can vary among multiple members of the same family (some of whom may hold dual citizenship), and that covered entities may simply be unable to obtain such information because of the constant mobility of those covered. Commenters suggested allowing a covered entity to determine expatriate net premiums written for United States health risks by multiplying its total expatriate net premiums written by the ratio of claims paid in the United States to claims paid worldwide. The final regulations do not adopt this suggestion. A ratio based on claims paid in the United States would not accurately represent the relative proportion of United States health risks because a United States health risk includes the health risks of U.S. citizens who are living abroad. The

Treasury Department and the IRS also considered alternative methods for a covered entity to account for its expatriate policies, but were unable to identify any that would be verifiable and administrable. Therefore, the final regulations retain the presumption in the proposed regulations and allow a covered entity to demonstrate that certain net premiums written are not for a United States health risk.

United States Possessions

Commenters suggested that the fee should not apply to health insurance providers in Puerto Rico and Guam. The final regulations do not adopt this suggestion. Section 9010(h)(2) specifically states that the term United States includes the U.S. possessions. Section 9010(c)(1) defines a covered entity as any entity that provides health insurance for any United States health risk, and under section 9010(d)(3), a United States health risk includes coverage of the health risk of any individual located in the U.S. possessions. To aid in determining whether an entity qualifies as a covered entity, the proposed regulations incorporated the definition of health insurance issuer under section 9832(b)(2) as one category of covered entity. The only definition of health insurance issuer in the Code is the definition of health insurance issuer in section 9832(b)(2), and the language of this provision is substantially similar to the only definition of health insurance issuer referenced in the ACA.² Section 9832(b)(2) defines a health insurance issuer as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a State and that is subject to State laws that regulate insurance within the meaning of section 514(b)(2)

² See ACA section 1301(b)(2), referencing section 2791(b) of the PHS (42 USC 300gg-91). The definition of health insurance issuer in section 2791(b) of the PHS is substantially similar to the definition in section 9832(b)(2) of the Code.

of ERISA. Under section 514(b)(2) of ERISA, State law that regulates insurance generally means any State regulation. Section 3(10) of ERISA defines State for purposes of ERISA to include the U.S. possessions. Accordingly, the references to State and State law in section 9832(b)(2) encompass the 50 States, the District of Columbia, and the U.S. possessions.

Taxability and Other Treatment of the Fee

Section 9010(f)(2) treats the fee as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed). Before issuing the proposed regulations, the Treasury Department and the IRS received comments stating that covered entities may attempt to pass on the cost of the fee to policyholders, either by a corresponding increase in premiums or by separately charging policyholders for a portion of the fee. The preamble to the proposed regulations stated that, under section 61(a), gross income means all income from whatever source derived unless a provision of the Code or other law specifically excludes the payment from gross income. Therefore, a covered entity's gross income includes amounts received from policyholders to offset the cost of the fee, whether or not separately stated on any bill. The preamble requested comments on whether the text of the regulations should be revised to clarify that recovered fee amounts are included in a covered entity's gross income. Numerous commenters disagreed with the preamble statement and requested that the final regulations permit covered entities to exclude from income any amounts collected from policyholders to offset the cost of the fee. One commenter alternatively suggested that the payment of income taxes on the fee should count towards the payment of the fee itself. The final regulations do not adopt these suggestions. The Treasury Department

and the IRS will issue separate guidance to clarify that covered entities must include in income under section 61(a) any amounts they collect from policyholders to offset the cost of the fee.

Commenters suggested that the final regulations prohibit a covered entity from collecting amounts to offset the cost of the fee when they collect premiums from excluded entities such as governmental entities and VEBAs. The final regulations do not adopt this suggestion. The health insurance provider, and not the payor of premiums, is liable for the fee. Therefore, any exclusions apply at the health insurance provider level.

A commenter asked if a covered entity must disclose to its policyholders the extent to which the cost of the fee is included in a policyholder's premium. Because the health insurance provider, and not the policyholder, is liable for the fee, the final regulations do not require a covered entity to disclose to its policyholders any amounts included in premiums to offset the cost of the fee, although nothing in the final regulations prohibits a covered entity from disclosing these amounts. However, a covered entity may be subject to State or other Federal rules, if any, regarding disclosures of these amounts.

Availability of IRS Documents

The IRS revenue rulings cited in this preamble are published in the Internal Revenue Cumulative Bulletin and are available from the superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. The IRS notice cited in this preamble is available at www.irs.gov.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. This regulation merely implements the fee imposed by section 9010 and does not impose the fee itself. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the only collection burden imposed by these regulations is the requirement to maintain a record of consent to the selection of a designated entity, and this collection burden applies only to designated entities of controlled groups, which tend to be large corporations, and their members. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f), the notice of proposed rulemaking was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

Drafting Information

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

List of Subjects

26 CFR Part 57

Health insurance, Reporting and recordkeeping requirements.

26 CFR 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR chapter 1 is amended as follows:

Paragraph 1. Part 57 is added to read as follows:

PART 57 - HEALTH INSURANCE PROVIDERS FEE

Sec.

57.1 Overview.

57.2 Explanation of terms.

57.3 Reporting requirements and associated penalties.

57.4 Fee calculation.

57.5 Notice of preliminary fee calculation.

57.6 Error correction process.

57.7 Notification and fee payment.

57.8 Tax treatment of fee.

57.9 Refund claims.

57.10 Effective/applicability date.

57.6302-1 Method of paying the health insurance providers fee.

Authority: 26 U.S.C. 7805; sec. 9010, Public Law 111-148 (124 Stat. 119 (2010)).

Section 57.3 also issued under 26 U.S.C. 6071(a)

Section 57.7 also issued under 26 U.S.C. 6302(a).

Section 57.6302-1 also issued under 26 U.S.C. 6302(a).

§57.1 Overview.

(a) The regulations in this part are designated “Health Insurance Providers Fee Regulations.”

(b) The regulations in this part provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by

section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references to section 9010 in this part 57 are references to section 9010 of the ACA. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections are references to subtitles, chapters, subchapters and sections in the Internal Revenue Code and the related regulations.

(c) Section 9010(e)(1) sets an applicable fee amount for each year, beginning with 2014, that will be apportioned among covered entities with aggregate net premiums written over \$25 million for health insurance for United States health risks. Generally, each covered entity is liable for a fee in each fee year that is based on its net premiums written during the data year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

§57.2 Explanation of terms.

(a) In general. This section explains the terms used in this part 57 for purposes of the fee.

(b) Covered entity--(1) In general. Except as provided in paragraph (b)(2) of this section, the term covered entity means any entity with net premiums written for health insurance for United States health risks in the fee year if the entity is--

(i) A health insurance issuer within the meaning of section 9832(b)(2), defined in section 9832(b)(2) as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA));

(ii) A health maintenance organization within the meaning of section 9832(b)(3), defined in section 9832(b)(3) as--

(A) A Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) An organization recognized under State law as a health maintenance organization; or

(C) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization;

(iii) An insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a);

(iv) An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or

(v) A multiple employer welfare arrangement (MEWA), within the meaning of section 3(40) of ERISA, to the extent not fully insured, provided that for this purpose a covered entity does not include a MEWA that with respect to the plan year ending with or within the section 9010 data year satisfies the requirements to be exempt from reporting under 29 CFR 2520.101-2(c)(2)(ii)(A), (B), or (C).

(2) Exclusions--(i) Self-insured employer. The term covered entity does not include any entity (including a voluntary employees' beneficiary association under section 501(c)(9) (VEBA)) that is part of a self-insured employer plan to the extent that such entity self-insures its employees' health risks. The term self-insured employer means an employer that sponsors a self-insured medical reimbursement plan within the

meaning of §1.105-11(b)(1)(i) of this chapter. Self-insured medical reimbursement plans include plans that do not involve shifting risk to an unrelated third party as described in §1.105-11(b)(1)(ii) of this chapter. A self-insured medical reimbursement plan may use an insurance company or other third party to provide administrative or bookkeeping functions. For purposes of this section, the term self-insured employer does not include a MEWA.

(ii) Governmental entity. The term covered entity does not include any governmental entity. For this purpose, the term governmental entity means--

(A) The government of the United States;

(B) Any State or a political subdivision thereof (as defined for purposes of section 103) including, for example, a State health department or a State insurance commission;

(C) Any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)); or

(D) Any agency or instrumentality of any of the foregoing.

(iii) Certain nonprofit corporations. The term covered entity does not include any entity--

(A) That is incorporated as a nonprofit corporation under a State law;

(B) No part of the net earnings of which inures to the benefit of any private shareholder or individual (within the meaning of §§1.501(a)-1(c) and 1.501(c)(3)-1(c)(2) of this chapter);

(C) No substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (within the meaning of §1.501(c)(3)-

1(c)(3)(ii) of this chapter) (or which is described in section 501(h)(3) and is not denied exemption under section 501(a) by reason of section 501(h));

(D) That does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office (within the meaning of §1.501(c)(3)-1(c)(3)(iii) of this chapter); and

(E) More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(iv) Certain voluntary employees' beneficiary associations (VEBAs). The term covered entity does not include any entity that is described in section 501(c)(9) that is established by an entity (other than by an employer or employers) for purposes of providing health care benefits. This exclusion applies to a VEBA that is established by a union or established pursuant to a collective bargaining agreement and having a joint board of trustees (such as in the case of a multiemployer plan within the meaning of section 3(37) of ERISA or a single-employer plan described in section 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. 186(c)(5)). This exclusion does not apply to a MEWA.

(3) State. Solely for purposes of paragraph (b) of this section, the term State means any of the 50 States, the District of Columbia, or any of the possessions of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(c) Controlled groups--(1) In general. The term controlled group means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(2) Treatment of controlled group. A controlled group (as defined in paragraph (c)(1) of this section) is treated as a single covered entity for purposes of the fee.

(3) Special rules. For purposes of paragraph (c)(1) of this section (related to controlled groups)--

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

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

(d) Data year. The term data year means the calendar year immediately before the fee year. Thus, for example, 2013 is the data year for fee year 2014.

(e) Designated entity--(1) In general. The term designated entity means the person within a controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to--

(i) Filing Form 8963, "Report of Health Insurance Provider Information";

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

(iii) Filing a corrected Form 8963 for the group, if applicable, as described in §57.6; and

(iv) Paying the fee for the group to the government.

(2) Selection of designated entity--(i) In general. Except as provided in paragraph (e)(2)(ii) of this section, each controlled group must select a designated entity

by having that entity file the Form 8963 in accordance with the form instructions. The designated entity must state under penalties of perjury that all persons that provide health insurance for United States health risks that are members of the group have consented to the selection of the designated entity. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity. The designated entity must maintain a record of all member consents.

(ii) Requirement for consolidated groups; common parent. If a controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group the common parent of which files a consolidated return for Federal income tax purposes, the designated entity is the agent for the group (within the meaning of §1.1502-77 of this chapter) for the data year.

(iii) Failure to select a designated entity. Excepted as provided in paragraph (e)(2)(ii) of this section, if a controlled group fails to select a designated entity as provided in paragraph (e)(2)(i) of this section, then the IRS will select a member of the controlled group to be the designated entity. If the IRS selects the designated entity, then all members of the controlled group that provide health insurance for a United States health risk will be deemed to have consented to the IRS's selection of the designated entity.

(f) Fee. The term fee means the fee imposed by section 9010 on each covered entity engaged in the business of providing health insurance.

(g) Fee year. The term fee year means the calendar year in which the fee must be paid to the government. The first fee year is 2014.

(h) Health insurance--(1) In general. Except as provided in paragraph (h)(2) of this section, the term health insurance generally has the same meaning as the term health insurance coverage in section 9832(b)(1)(A), defined to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, when these benefits are offered by an entity that is one of the types of entities described in paragraph (b)(1)(i) through (b)(1)(v) of this section. The term health insurance includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) Exclusions. The term health insurance does not include--

(i) Coverage only for accident, or disability income insurance, or any combination thereof, within the meaning of section 9832(c)(1)(A);

(ii) Coverage issued as a supplement to liability insurance within the meaning of section 9832(c)(1)(B);

(iii) Liability insurance, including general liability insurance and automobile liability insurance, within the meaning of section 9832(c)(1)(C);

(iv) Workers' compensation or similar insurance within the meaning of section 9832(c)(1)(D);

(v) Automobile medical payment insurance within the meaning of section 9832(c)(1)(E);

(vi) Credit-only insurance within the meaning of section 9832(c)(1)(F);

(vii) Coverage for on-site medical clinics within the meaning of section 9832(c)(1)(G);

(viii) Other insurance coverage that is similar to the insurance coverage in paragraph (h)(2)(i) through (vii) of this section under which benefits for medical care are secondary or incidental to other insurance benefits, within the meaning of section 9832(c)(1)(H), to the extent such insurance coverage is specified in regulations under section 9832(c)(1)(H);

(ix) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section 9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C);

(x) Coverage only for a specified disease or illness within the meaning of section 9832(c)(3)(A);

(xi) Hospital indemnity or other fixed indemnity insurance within the meaning of section 9832(c)(3)(B);

(xii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan, within the meaning of section 9832(c)(4);

(xiii) Coverage under an employee assistance plan, a disease management plan, or a wellness plan, if the benefits provided under the plan constitute excepted benefits under section 9832(c)(2) (or do not otherwise provide benefits consisting of health insurance under paragraph (h)(1) of this section);

(xiv) Student administrative health fee arrangements, as defined in paragraph (h)(3);

(xv) Travel insurance, as defined in paragraph (h)(4) of this section; or

(xvi) Indemnity reinsurance, as defined in paragraph (h)(5)(i) of this section.

(3) Student administrative health fee arrangement. For purposes of paragraph (h)(2)(xiv) of this section, the term student administrative health fee arrangement means an arrangement under which an educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the student purchases any available student health insurance coverage).

(4) Travel insurance. For purposes of paragraph (h)(2)(xv) of this section, the term travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

(5) Reinsurance--(i) Indemnity reinsurance. For purposes of paragraphs (h)(2)(xvi) and (k) of this section, the term indemnity reinsurance means an agreement between one or more reinsuring companies and a covered entity 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 covered entity retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement.

(ii) Assumption reinsurance. For purposes of paragraph (k) of this section, the term assumption reinsurance means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(i) Located in the United States. The term located in the United States means present in the United States (within the meaning of paragraph (m) of this section) under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937-1(c)(3)(i) of this chapter (for presence in a possession of the United States).

(j) NAIC. The term NAIC means the National Association of Insurance Commissioners.

(k) Net premiums written--The term net premiums written means premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. For this purpose, MLR rebates are computed on an accrual basis in determining net premiums written. Because indemnity reinsurance within the meaning of paragraph (h)(5)(i) of this section is not health insurance under paragraph (h)(1) of

this section, the term net premiums written does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, in the case of assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section, the term net premiums written does include premiums written for assumption reinsurance and is reduced by assumption reinsurance premiums ceded.

(l) SHCE. The term SHCE means the Supplemental Health Care Exhibit. The SHCE is a form published by the NAIC that most covered entities are required to file annually under State law.

(m) United States. For purposes of paragraph (i) of this section, the term United States means the 50 States, the District of Columbia, and any possession of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(n) United States health risk. The term United States health risk means the health risk of any individual who is--

(1) A United States citizen;

(2) A resident of the United States (within the meaning of section 7701(b)(1)(A));

or

(3) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

§57.3 Reporting requirements and associated penalties.

(a) Reporting requirement--(1) In general. Annually, each covered entity, including each controlled group that is treated as a single covered entity, must report its net premiums written for health insurance of United States health risks during the data

year to the IRS by April 15th of the fee year on Form 8963, "Report of Health Insurance Provider Information," in accordance with the instructions for the form. A covered entity that has net premiums written during the data year is subject to this reporting requirement even if it does not have any amount taken into account as described in §57.4(a)(4). If an entity is not in the business of providing health insurance for any United States health risk in the fee year, it is not a covered entity and does not have to report.

(2) Manner of reporting. The IRS may provide rules in guidance published in the Internal Revenue Bulletin for the manner of reporting by a covered entity under this section, including rules for reporting by a designated entity on behalf of a controlled group that is treated as a single covered entity.

(3) Disclosure of reported information. Pursuant to section 9010(g)(4), the information reported on each original and corrected Form 8963 will be open for public inspection or available upon request.

(b) Penalties--(1) Failure to report--(i) In general. A covered entity that fails to timely submit a report containing the information required by paragraph (a) of this section is liable for a failure to report penalty in the amount described in paragraph (b)(1)(ii) of this section in addition to its fee liability and any other applicable penalty, unless the failure is due to reasonable cause as defined in paragraph (b)(1)(iii) of this section.

(ii) Amount. The amount of the failure to report penalty described in paragraph (b)(1)(i) of this section is--

(A) \$10,000, plus

(B) The lesser of--

(1) An amount equal to \$1,000 multiplied by the number of days during which such failure continues; or

(2) The amount of the covered entity's fee for which the report was required.

(iii) Reasonable cause. The failure to report penalty described in paragraph (b)(1)(i) of this section is waived if the failure is due to reasonable cause. A failure is due to reasonable cause if the covered entity exercised ordinary business care and prudence and was nevertheless unable to submit the report within the prescribed time. In determining whether the covered entity was unable to submit the report timely despite the exercise of ordinary business care and prudence, the IRS will consider all the facts and circumstances surrounding the failure to submit the report.

(iv) Treatment of penalty. The failure to report penalty described in this paragraph (b)(1)--

(A) Is treated as a penalty under subtitle F;

(B) Must be paid on notice and demand by the IRS and in the same manner as a tax under the Internal Revenue Code; and

(C) Is a penalty for which only civil actions for refund under procedures of subtitle F apply.

(2) Accuracy-related penalty--(i) In general. A covered entity that understates its net premiums written for health insurance of United States health risks in the report required under paragraph (a)(1) of this section is liable for an accuracy-related penalty in the amount described in paragraph (b)(2)(ii) of this section, in addition to its fee liability and any other applicable penalty.

(ii) Amount. The amount of the accuracy-related penalty described in paragraph (b)(2)(i) of this section is the excess of--

(A) The amount of the covered entity's fee for the fee year that the IRS determines should have been paid in the absence of any understatement; over

(B) The amount of the covered entity's fee for the fee year that the IRS determined based on the understatement.

(iii) Understatement. An understatement of a covered entity's net premiums written for health insurance of United States health risks is the difference between the amount of net premiums written that the covered entity reported and the amount of net premiums written that the IRS determines the covered entity should have reported.

(iv) Treatment of penalty. The accuracy-related penalty is subject to the provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

(3) Controlled groups. Each member of a controlled group that is required to provide information to the controlled group's designated entity for purposes of the report required to be submitted by the designated entity on behalf of the controlled group is jointly and severally liable for any penalties described in this paragraph (b) for any reporting failures by the designated entity.

§57.4 Fee calculation.

(a) Fee components--(1) In general. For every fee year, the IRS will calculate a covered entity's allocated fee as described in this section.

(2) Calculation of net premiums written. Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's net premiums written for health insurance of United States health

risks during the data year taken into account bears to the aggregate net premiums written for health insurance of United States health risks of all covered entities during the data year taken into account.

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

Fee year	Applicable amount
2014	\$ 8,000,000,000
2015	\$ 11,300,000,000
2016	\$ 11,300,000,000
2017	\$ 13,900,000,000
2018	\$ 14,300,000,000
2019 and thereafter	The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)).

(4) Net premiums written taken into account--(i) In general. A covered entity's net premiums written for health insurance of United States health risks during any data year are taken into account as follows:

Covered entity's net premiums written during the data year that are:	Percentage of net premiums written taken into account is:
Not more than \$25,000,000	0
More than \$25,000,000 but not more than \$50,000,000	50
More than \$50,000,000	100

(ii) Controlled groups. In the case of a controlled group, paragraph (a)(4)(i) of this section applies to all net premiums written for health insurance of United States health risks during the data year, in the aggregate, of the entire controlled group, except

that any net premiums written by any member of the controlled group that is a nonprofit corporation meeting the requirements of §57.2(b)(2)(iii) or a voluntary employees' beneficiary association meeting the requirements of §57.2(b)(2)(iv) are not taken into account.

(iii) Partial exclusion for certain exempt activities. After the application of paragraph (a)(4)(i) of this section, if the covered entity (or any member of a controlled group treated as a single covered entity) is exempt from Federal income tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29) as of December 31st of the data year, then only 50 percent of its remaining net premiums written for health insurance of United States health risks that are attributable to its exempt activities (and not to activities of an unrelated trade or business as defined in section 513) during the data year are taken into account. If an entity to which this partial exclusion applies is a member of a controlled group, then the partial exclusion applies to that entity after first applying paragraph (a)(4)(i) on a pro rata basis to all members of the controlled group.

(b) Determination of net premiums written--(1) In general. The IRS will determine net premiums written for health insurance of United States health risks for each covered entity based on the Form 8963, "Report of Health Insurance Provider Information," submitted by each covered entity, together with any other source of information available to the IRS. Other sources of information that the IRS may use to determine net premiums written for each covered entity include the SHCE, which supplements the annual statement filed with the NAIC pursuant to State law, the annual statement itself or the Accident and Health Policy Experience filed with the NAIC, the MLR Annual

Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services, or any similar statements filed with the NAIC, with any State government, or with the Federal government pursuant to applicable State or Federal requirements.

(2) Presumption for United States health risks. For any covered entity that files the SHCE with the NAIC, the entire amount reported on the SHCE as direct premiums written will be considered to be for health insurance of United States health risks as described in §57.2(n) (subject to any applicable exclusions for amounts that are not health insurance as described in §57.2(h)(2)) unless the covered entity can demonstrate otherwise.

(c) Determination of amounts taken into account. (1) For each fee year and for each covered entity, the IRS will calculate the net premiums written for health insurance of United States health risks taken into account during the data year. The resulting number is the numerator of the fraction described in paragraph (d)(1) of this section.

(2) For each fee year, the IRS will calculate the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities during the data year. The resulting number is the denominator of the fraction described in paragraph (d)(2) of this section.

(d) Allocated fee calculated. For each covered entity for each fee year, the IRS will calculate the covered entity's allocated fee by multiplying the applicable amount from paragraph (a)(3) of this section by a fraction--

(1) The numerator of which is the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate net premiums written for health insurance of United States health risks for all covered entities during the data year taken into account (described in paragraph (c)(2) of this section).

§57.5 Notice of preliminary fee calculation.

(a) Content of notice. Each fee year, the IRS will make a preliminary calculation of the fee for each covered entity as described in §57.4. The IRS will notify each covered entity of its preliminary fee calculation for that fee year. The notification to a covered entity of its preliminary fee calculation will include--

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) Instructions for how to submit a corrected Form 8963, "Report of Health Insurance Provider Information," to correct any errors through the error correction process.

(b) Timing of notice. The IRS will specify in other guidance published in the Internal Revenue Bulletin the date by which it will send each covered entity a notice of its preliminary fee calculation.

§57.6 Error correction process.

(a) In general. Upon receipt of its preliminary fee calculation, each covered entity must review this calculation during the error correction period. If the covered entity identifies one or more errors in its preliminary fee calculation, the covered entity must timely submit to the IRS a corrected Form 8963, "Report of Health Insurance Provider Information," during the error correction period. The corrected Form 8963 will replace the original Form 8963 for all purposes, including for the purpose of determining whether an accuracy-related penalty applies, except that a covered entity remains subject to the failure to report penalty if it fails to timely submit the original Form 8963. In the case of a controlled group, if the preliminary fee calculation for the controlled group contains one or more errors, the corrected Form 8963 must include all of the required information for the entire controlled group, including members that do not have corrections.

(b) Time and manner. The IRS will specify in other guidance published in the Internal Revenue Bulletin the time and manner by which a covered entity must submit a corrected Form 8963. The IRS will provide its final determination regarding the covered entity's submission no later than the time the IRS provides a covered entity with a final fee calculation.

(c) Finality. Covered entities must assert any basis for contesting their preliminary fee calculation during the error correction period. In the interest of providing

finality to the fee calculation process, the IRS will not accept a corrected Form 8963 after the end of the error correction period or alter final fee calculations on the basis of information provided after the end of the error correction period.

§57.7 Notification and fee payment.

(a) Content of notice. Each fee year, the IRS will make a final calculation of the fee for each covered entity as described in §57.4. The IRS will base its final fee calculation on each covered entity's original or corrected Form 8963, "Report of Health Insurance Provider Information," as adjusted by other sources of information described in §57.4(b)(1). The notification to a covered entity of its final fee calculation will include-

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) The final determination on the covered entity's corrected Form 8963, "Report of Health Insurance Provider Information," if any.

(b) Timing of notice. The IRS will send each covered entity a notice of its final fee calculation by August 31st of the fee year.

(c) Differences in preliminary fee calculation and final calculation. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the error correction process

described in §57.6 or because the IRS discovered additional information relevant to the fee calculation through other information sources as described in §57.4(b)(1). Even if a covered entity did not file a corrected Form 8963 described in §57.6, a covered entity's final fee may differ from a covered entity's preliminary fee because of information discovered about that covered entity through other information sources. In addition, a change in aggregate net premiums written for health insurance of United States health risks can affect every covered entity's fee because each covered entity's fee is equal to a fraction of the aggregate fee collected from all covered entities.

(d) Payment of final fee. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's Employer Identification Number as reported on Form 8963. The fee must be paid by electronic funds transfer as required by §57.6302-1. There is no tax return to be filed with the payment of the fee.

(e) Controlled groups. In the case of a controlled group that is liable for the fee, all members of the controlled group are jointly and severally liable for the fee. Accordingly, if a controlled group's fee is not paid, the IRS may separately assess each member of the controlled group for the full amount of the controlled group's fee.

§57.8 Tax treatment of fee.

(a) Treatment as an excise tax. The fee is treated as an excise tax for purposes of subtitle F (sections 6001-7874). Thus, references in subtitle F to "taxes imposed by this title," "internal revenue tax," and similar references, are also references to the fee. For example, the fee is assessed (section 6201), collected (sections 6301, 6321, and

6331), enforced (section 7602), and subject to examination and summons (section 7602) in the same manner as taxes imposed by the Code.

(b) Deficiency procedures. The deficiency procedures of sections 6211-6216 do not apply to the fee.

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

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

§57.9 Refund claims.

Any claim for a refund of the fee must be made by the entity that paid the fee to the government and must be made on Form 843, "Claim for Refund and Request for Abatement," in accordance with the instructions for that form.

§57.10 Effective/applicability date.

Sections 57.1 through 57.9 apply to any fee that is due on or after September 30, 2014.

§57.6302-1 Method of paying the health insurance providers fee.

(a) Fee to be paid by electronic funds transfer. Under the authority of section 6302(a), the fee imposed on covered entities engaged in the business of providing health insurance for United States health risks under section 9010 and §57.4 must be paid by electronic funds transfer as defined in §31.6302-1(h)(4)(i) of this chapter, as if the fee were a depository tax. For the time for paying the fee, see §57.7.

(b) Effective/Applicability date. This section applies with respect to any fee that is due on or after September 30, 2014.

PART 602 - OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 2. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 3. In §602.101, paragraph (b) is amended by adding the following entry 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.
* * * * *	
57.2(e)(2)(i).....	1545-2249
* * * * *	

John Dalrymple

Deputy Commissioner for Services and Enforcement.

Approved: November 13, 2013

Mark J. Mazur

Assistant Secretary of the Treasury (Tax Policy)