[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 57

[REG-118315-12]

RIN 1545-BL20

Health Insurance Providers Fee

AGENCY: Internal Revenue Service (IRS), Treasury.

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

SUMMARY: This document contains proposed regulations that provide guidance on 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: Written or electronic comments must be received by **[INSERT DATE 90 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**.

Requests to speak and outlines of topics to be discussed at the public hearing scheduled for June 21, 2013, at 10:00 a.m., must be received by June 3, 2013**.**

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG-118315-12), Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-118315-12), Courier's Desk Internal Revenue

Service, 1111 Constitution Avenue, N.W., Washington, DC, or sent electronically via the IRS Internet site via the Federal eRulemaking Portal at www.regulations.gov (IRS REG-118315-12). The public hearing will be held in the IRS Auditorium at the Internal Revenue Building, 1111 Constitution Avenue, N.W., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the substance of the regulation, Charles J. Langley, Jr. at (202) 622-3130; concerning the submission of comments or the public hearing, Oluwafunmilayo (Funmi) Taylor at (202) 622-7180 (not toll-free calls).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by **[INSERT DATE THAT IS 60 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. Comments are specifically requested concerning:

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

The accuracy of the estimated burden associated with the proposed collection of information;

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

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

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

The collection of information in this proposed regulation is in §57.2(e)(2) and requires certain entities to maintain records of consent for a designated entity. This information is necessary to evaluate whether an entity has consented to the designation of another entity to report its net premiums written. The likely respondents are entities in the business of providing health insurance for United States health risks.

Estimated total annual reporting and/or recordkeeping burden: 400 hours.

Estimated average annual burden hours per respondent and/or recordkeeper varies from .25 hours to 1 hour, depending on individual circumstances, with an estimated average of .5 hours.

Estimated number of respondents and/or recordkeepers: 800.

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

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

Background

This document proposes to add 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 No. 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. 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 proposed regulations are references to the fee imposed by section 9010.

Statutory provisions

Section 9010(a) imposes an annual fee on each covered entity engaged in the business of providing health insurance. The fee is due by the annual date specified by the Secretary of the Treasury or his delegate (Secretary), but in no event later than September 30th of each calendar year in which a fee must be paid (fee year).

Section 9010(c)(1) provides that a covered entity is any entity that provides health insurance for any United States health risk during each fee year. Section 9010(c)(2) excludes the following entities from being covered entities: (A) any employer to the extent that the employer self-insures its employees' health risks; (B) any governmental entity; (C) any entity (i) that is incorporated as a nonprofit corporation under a 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 otherwise provided in section 501(h)), and which does not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) 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; and (D) any entity that is described in section 501(c)(9) (a voluntary employees' beneficiary association (VEBA)) and is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

Section 9010(c)(3)(A) provides a controlled group rule under which all persons treated as a single employer under section 52(a) or (b) or section 414(m) or (o) are treated as a single covered entity. If any entity described in section 9010(c)(2)(C) or (D) (relating to certain nonprofit corporations and non-employer-established VEBAs) is treated as included in a covered entity by reason of the application of section 9010(c)(3)(A), then the net premiums written for health insurance for any United States health risk of that entity are not taken into account.

Section 9010(c)(3)(B) provides that, for purposes of section 9010(c)(3)(A), in applying section 52(a) and (b), section 1563 is applied without regard to section 1563(b)(2)(C). As a result, a foreign entity subject to tax under section 881 can also be part of a controlled group that is treated as a single covered entity under section 9010(c)(3)(A). Section 9010(c)(4) provides that, if more than one person is liable to pay the fee on a single covered entity by reason of the application of the controlled group rule, then all such persons are jointly and severally liable for payment of the fee.

Section 9010 imposes the fee on each covered entity engaged in the business of providing health insurance for United States health risks. Section 9010(h)(3) excludes from health insurance any insurance coverage described in section 9832(c)(1)(A) (accident only or disability only or any combination thereof), any insurance coverage described in section 9832(c)(3) (coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance), any insurance for long-term care, or any Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act). Other than providing for these exclusions, section 9010 does not define health insurance.

Section 9010(d) defines United States health risk to mean a 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, during the period such individual is so located. Section 9010(h)(2) defines United States for purposes of section 9010 as the 50 States, the District of Columbia, and the possessions of the United States.

Section 9010(b) and (e) provide rules for determining the amount of the annual fee for each covered entity. Under section 9010(e)(1), the aggregate fee amount for all covered entities (referred to as the applicable amount) is $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018. Under section 9010(e)(2), the applicable amount for calendar year 2019 and thereafter is the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)) for the preceding calendar year. Section 9010(b)(1) requires the applicable amount for each year to be allocated, using a specified formula, among covered entities with aggregate net premiums written of over $25 million.

Section 9010(b)(1) provides that the annual fee for each covered entity is calculated by determining the ratio of (1) the covered entity's net premiums written for health insurance for any United States health risk that are taken into account during the preceding calendar year to (2) the aggregate net premiums written for such health insurance of all covered entities that are taken into account during the preceding calendar year. This ratio is then applied to the applicable amount.

Under section 9010(b)(2)(A), the amount of net premiums written that is taken into account for each covered entity per calendar year is 0 percent of net premiums written up to and including $25 million, 50 percent of net premiums written that are more than $25 million but not more than $50 million, and 100 percent of net premiums written that are over $50 million. Additionally, after the application of the dollar thresholds of section 9010(b)(2)(A), section 9010(b)(2)(B) excludes from the amount taken into account 50 percent of the remaining net premiums written for health insurance 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).

Section 9010(b)(3) requires the Secretary to calculate the amount of each covered entity's fee for any calendar year. In calculating the fee, the Secretary must determine each covered entity's net premiums written for United States health risks based on reports submitted to the Secretary by the covered entity and through the use of any other source of information available to the Secretary.

Section 9010(g)(1) requires that, not later than the date determined by the Secretary following the end of the calendar year preceding the fee year, each covered entity must report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written for health insurance for any United States health risk for that preceding calendar year.

Section 9010(g)(2)(A) imposes a penalty on a covered entity for any failure to report the required information by the date prescribed by the Secretary (determined with regard to any extension of time for filing), unless such failure is due to reasonable cause. The penalty is $10,000 plus the lesser of (i) an amount equal to $1,000, multiplied by the number of days during which the failure continues, or (ii) the amount of the fee for which the report was required. Section 9010(g)(2)(B) provides that the failure to report penalty (i) is treated as a penalty for purposes of subtitle F, (ii) must be paid on notice and demand by the Secretary and in the same manner as a tax under the Code, and (iii) is a penalty for which only civil actions for refund under procedures of subtitle F apply.

Section 9010(g)(3)(A) imposes an accuracy-related penalty on a covered entity for any understatement of the covered entity's net premiums written on the required report. Section 9010(g)(3)(B) defines an understatement as the difference between the amount of net premiums written reported by the covered entity and the amount of net premiums written that should have been reported. The penalty is equal to the excess of (i) the amount of the covered entity's fee for the fee year that the Secretary determines should have been paid in the absence of the understatement, over (ii) the amount of the fee that the Secretary determined based on the understatement. Section 9010(g)(3)(C) subjects the accuracy-related penalty to the provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

Section 9010(g)(4) provides that section 6103 (relating to the disclosure of returns and return information) does not apply to any information reported under section 9010(g).

Section 9010(f)(1) treats the fee as an excise tax for purposes of subtitle F to which only civil actions for refund apply. 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).

Section 9010(i) directs the Secretary to publish guidance necessary to carry out the purposes of section 9010 and 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 exempt entity under section 9010(c)(2).

Section 9010(j) provides that section 9010 is effective for calendar years beginning after December 31, 2013.

Explanation of Provisions

I. Overview

The proposed regulations provide guidance on the annual fee imposed on covered entities engaged in providing health insurance for United States health risks. Generally, each covered entity with aggregate net premiums written over $25 million in the calendar year immediately preceding the fee year (referred to in the proposed regulations as the data year) is liable for the annual fee due by September 30th of each fee year in an amount determined by the IRS under section 9010(b) and the proposed regulations.

II. Explanation of terms

The proposed regulations define numerous terms used in section 9010 and in these regulations, including the following key terms:

A. Covered entity

Section 9010(c)(1) provides that a covered entity is any entity that provides health insurance for any United States health risk during the fee year. The proposed regulations define the term covered entity to mean any entity with net premiums written for health insurance 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 that is 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 insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement

(MEWA). Under section 9832(b)(2), the term health insurance issuer generally refers to any insurance company, insurance service, or insurance organization that is subject to State laws that regulate insurance within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA). Under section 9832(b)(3), the term health maintenance organization generally refers to an organization that is recognized or regulated under State or Federal law as a health maintenance organization.

As previously noted, the proposed regulations provide that a covered entity includes a MEWA within the meaning of section 3(40) of 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 for purposes of section 9010 because, even though the MEWA receives premiums, it uses those premiums to pay an insurance company to provide the coverage being purchased. In this case, the insurance company is the covered entity because it, and not the MEWA, is providing health insurance. If the MEWA is not fully-insured, however, the MEWA is a covered entity for purposes of section 9010 to the extent that the premiums received by the MEWA are not used to pay an insurance company to provide the coverage being purchased (and are used instead by the MEWA to provide the health insurance itself). For example, if a MEWA received a $10,000 premium payment from a participating employer providing both major medical coverage and separate vision coverage for an individual participant, and the MEWA used $9,000 of that premium payment to pay the premium to cover such individual under a group insurance policy purchased from an insurance company and associated costs, and

$1,000 to pay direct reimbursements under the vision plan and associated costs directly, then the MEWA would be treated as a covered entity only with respect to the $1,000 portion of the premium intended to pay the MEWA for providing the vision coverage itself.

The proposed regulations exclude certain other MEWAs from the definition of a covered entity in accordance with one of the exclusions from the MEWA reporting requirements administered by the Department of Labor (DOL). Specifically, the proposed regulations would exclude MEWAs that are exempt from reporting under 29 CFR 2520.101-2(c)(2)(ii)(B).[1] 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. This type of MEWA is excluded from the definition of covered entity because it is temporary in nature and exempt from DOL reporting requirements.

The proposed regulations provide that, solely for purposes of section 9010, an Entity Claiming Exception (ECE) is subject to the same regime addressing MEWAs. Therefore, under the proposed regulations, a fully insured ECE is excluded from the definition of covered entity, but a non-fully insured ECE is treated as a covered entity to the extent the ECE is not insured. 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

[1] These final regulations were issued in 2003. In 2011, DOL proposed new regulations under these same sections. The analogous section in the 2011 proposed regulations that describes the MEWAs intended to be excluded from the definition of covered entity is also §2520.101-2(c)(2)(ii)(B) (RIN 1210-AB51). See 76 FR 76222. If and when the DOL finalizes these proposed regulations, the Treasury Department and the IRS intend to apply the new provision (or any analogous provision if modified in the final rule).

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.

Currently, in a number of States, entities have been established to make coverage for medical care available to high-risk individuals who may not have access to coverage in the open market. The Treasury Department and the IRS invite comments on the organization and structure of these entities, whether they would be considered covered entities under the general definition, and the extent to which they would qualify for exclusions under the proposed regulations.

B. Excluded entities

1. Self-insured employer

Section 9010(c)(2)(A) excludes any entity that is a self-insured employer to the extent that such employer self-insures its employees' health risks. The proposed regulations define the term self-insured employer to mean an employer that sponsors a self-insured medical reimbursement plan within the meaning of §1.105-11(b)(1)(i) and (ii) of the Income Tax Regulations. This includes an arrangement in which an employer provides self-insured employee health benefits to former employees, such as retired employees, or provides self-insured employee health benefits through an organization described in section 501(c)(9) (a VEBA). The proposed regulations clarify that a self-insured plan may use a third party for administration and bookkeeping functions and still be considered self-insured if there is no shifting of risk to the third party as described in §1.105-11(b)(1)(ii).

2. Governmental entities

Section 9010(c)(2)(B) excludes any governmental entity. The proposed regulations define the term governmental entity to mean (1) the United States, (2) any State, (3) the District of Columbia, (4) any possession of the United States, (5) any political subdivision of any of the foregoing (as defined for purposes of section 103), (6) any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)), or (7) any public agency that is created by a State or a political subdivision, organized as a nonprofit under State law, and contracts with the State to administer State Medicaid benefits through local providers or health maintenance organizations. See Joint Committee on Taxation, General Explanation of Tax Legislation Enacted by the 111th Congress, JCS-2-11 (March 2011) (JCT General Explanation) at 330.

A State health department or State insurance commission would be included within the meaning of governmental entity under section 9010. The proposed regulations do not include instrumentalities (within the meaning of Rev. Rul. 57-128, 1957-1 C.B. 311, see §601.601(d)(2)(ii)(b)) of a governmental entity in the definition of governmental entity. Instrumentalities that provide health insurance may qualify for other exclusions under section 9010, such as the exclusion for employers that self-insure their employees' health risks (section 9010(c)(2)(A)), the exclusion for certain nonprofit corporations (section 9010(c)(2)(C)), and the partial exclusion for certain high-risk insurance pools described in section 501(c)(26) (section 9010(b)(2)(B)). The Treasury Department and the IRS invite comments on the types of instrumentalities, if

any, that would be considered covered entities under the general definition and the extent to which they would qualify for exclusions consistent with the statute.

3. Certain nonprofit corporations

In accordance with section 9010(c)(2)(C), the proposed regulations exclude any entity that (1) is incorporated as a nonprofit corporation under State law, (2) meets certain requirements designed to ensure that the net earnings of the entity are not distributed to private parties and that the entity does not engage in political campaign activity or substantial lobbying, and (3) 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, and dual eligible plans). An entity is not required to be exempt from tax under section 501(a) to qualify for this exception. 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 adopt the standards set forth under section 501(c)(3) and the regulations thereunder. In accordance with section 9010(c)(2)(C)(ii), the proposed regulations provide that, for an entity that is exempt from tax under section 501(a) and is described in section 501(h)(3), the determination of whether the entity has engaged in substantial lobbying for purposes of section 9010(c)(2)(C)(ii) will be made under section 501(h).

The Treasury Department and the IRS invite comments with respect to how this exclusion is applied.

4. Voluntary employees' beneficiary associations (VEBAs)

In accordance with section 9010(c)(2)(D), the proposed regulations explicitly exclude any VEBA that is established by an entity other than an employer or employers for the purpose of providing health care benefits, such as a union. Also, if a MEWA or ECE provides health benefits through a VEBA, the VEBA is not a covered entity. Furthermore, if an employer or employers provide self-insured employee health benefits through a VEBA, the VEBA is not a covered entity because the exclusion for self-insured employers under section 9010(c)(2)(A) applies. 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. Therefore, the Treasury Department and the IRS are not aware of any VEBAs that would be covered entities under the proposed regulations. The Treasury Department and the IRS invite comments on the types of VEBAs, if any, that do not fall within the exclusions and therefore would be covered entities.

5. Educational institutions and student health insurance

Many educational institutions establish or administer programs that provide students with access to health insurance. In most instances, however, the educational institution uses premiums it receives from students to purchase insurance from a separate, unrelated issuer. This unrelated issuer and not the educational institution will be a covered entity for purposes of section 9010 and it will include the premiums paid by or on behalf of those students for purposes of determining the amount payable under section 9010. The Treasury Department and the IRS invite comments on the

circumstances, if any, under which an educational institution might qualify as a covered entity that is subject to the fee and not eligible for an exclusion (for example, a self-insured student health plan).

C. Controlled groups

1. In general

The proposed regulations define the term 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). To clarify how to treat persons that leave or enter a controlled group, the proposed regulations provide that, for purposes of section 9010, a person is treated as 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. In accordance with section 9010(c)(3), the proposed regulations treat a controlled group as a single covered entity for purposes of the fee. In determining net premiums written for health insurance for United States health risks of a controlled group, the controlled group generally must take into account the net premiums written for all members for the entire data year.

2. Designated entities

The proposed regulations provide that each controlled group must 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 provide that if the controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group that filed 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 an affiliated group that files a consolidated return for Federal income tax purposes, it may select a person as the designated entity on Form 8963, "Report of Health Insurance Provider Information." The proposed regulations require only the designated entity to report on behalf of the controlled group. However, the proposed regulations also require each member of a controlled group to maintain a record of its consent to the designated entity selection. The proposed regulations also require the designated entity to maintain a record of all member consents. If the controlled group does not select a person as a designated entity on its Form 8963, the IRS will select a person as a designated entity for the controlled group and advise the designated entity accordingly.

D. Health insurance

1. 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 only definition of health insurance or health insurance coverage in the Code is the definition of health insurance coverage in section 9832(b)(1)(A) for purposes of Chapter 100. The language of section 9832(b)(1)(A) is substantially similar

to the only definition of health insurance coverage referenced in the ACA.[2] Accordingly, the proposed regulations define the term health insurance by reference to section 9832(b)(1)(A) to mean benefits consisting of medical care (provided directly, through insurance, reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The proposed regulations exclude from the term health insurance all of the excepted benefits listed in section 9832(c) except for section 9832(c)(2)(A) (limited scope dental and vision benefits). In accordance with the explanation provided by the Joint Committee on Taxation, the proposed regulations include limited dental and vision coverage as health insurance for purposes of the fee. See JCT General Explanation at 331.

The proposed regulations also provide that, solely for purposes of section 9010, indemnity reinsurance is not health insurance. Thus, the fee continues to be imposed on the issuing company. For this purpose, the proposed regulations define the term indemnity reinsurance to mean 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. No inference is intended as to whether indemnity reinsurance may constitute health insurance for other purposes.

[2] See ACA section 1301(b)(2), referencing section 2791(b) of the Public Health Service Act (PHSA) (42 USC 300gg-91). The definition of health insurance coverage in section 2791(b) of the PHSA is substantially similar to the one provided in section 9832(b)(1)(A) of the Code.

2. Student administrative health fee arrangements

Many educational institutions have arrangements under which the 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). These arrangements are different from premiums and cost-sharing for group health plans and health insurance coverage because all students pay the fee regardless of whether they have student health insurance. Therefore, these arrangements do not constitute health insurance for purposes of section 9010. For a similar conclusion regarding other Federal laws applicable to student health insurance, see Student Health Insurance Coverage, 77 FR 16453, 16455-56 (March 21, 2012) (Department of Health and Human Services regulations establishing requirements for student health insurance coverage under the Public Health Service Act and ACA).

3. Travel insurance

The Treasury Department and the IRS are aware that certain travel insurance products may include limited health benefits. However, the term travel insurance does not have a definition for tax purposes and in other contexts has applied to a differing variety of products with different types of coverage, including some products providing only incidental health benefits. To assist in determining which types of travel-related insurance products provide health insurance for purposes of section 9010, the proposed regulations explicitly exclude travel insurance, defined as coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or

cancellation of a 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, travel insurance does not include major medical plans, which 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. This definition is a modified version of the National Association of Insurance Commissioners (NAIC) definition of travel insurance.

4. Retiree-only health plans

The proposed regulations do not provide any special exceptions related to health insurance provided under a plan covering only retired employees. These types of arrangements are not subject to the requirements of Chapter 100 of the Code, not because they do not provide health insurance or because retiree-only coverage is an excepted benefit, but because of an exception in section 9831(a)(2) for group health plans having fewer than two current employees. This exception is not relevant in determining whether the insurance provided is health insurance for purposes of section 9010, which covers issuers of health insurance regardless of whether the insurance is provided under a group health plan. Therefore, health insurance provided under these arrangements is health insurance for purposes of section 9010. However, an employer providing coverage to former employees, such as retired employees, under a self-insured arrangement generally would qualify for the exclusion for self-insured employers. See section II.B.1 of this preamble.

E. Net premiums written

The fee each year is based on each covered entity's share of net premiums written for health insurance of United States health risks during the data year. Section 9010 does not define net premiums written. The proposed regulations define 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. Because indemnity reinsurance is not considered health insurance for purposes of section 9010, net premiums written does not include premiums written for indemnity reinsurance (and is not reduced by indemnity reinsurance ceded). See section II.D.1 of this preamble. However, net premiums written does include premiums written (and excludes premiums ceded) for assumption reinsurance; that is, reinsurance for which there is a novation and the reinsurer takes over the entire risk pursuant to a new contract. Thus, for covered entities that file the Supplemental Health Care Exhibit (SHCE) with the 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. This definition of net premiums written for purposes of section 9010 differs from net adjusted premiums reported on the SHCE, which takes into account premiums from ceded and assumed reinsurance. Under current NAIC reporting rules, the amount reported as direct premiums written on the SHCE does not include ceding commissions, and thus there is no need to reduce direct premiums written for ceding commissions in determining net premiums written. However, the

SHCE separately accounts for any expected reductions in premiums resulting from MLR rebates with respect to the data year. These amounts are subtracted from direct premiums written in determining net premiums written. The Treasury Department and the IRS invite comments on how to compute MLR rebates with respect to the data year using data reported on the SHCE.

F. United States health risk

In accordance with section 9010(d), the proposed regulations define 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.

For purposes of determining whether an individual is located in the United States, the proposed regulations, in accordance with section 9010(h)(2), define the term United States to mean the 50 States, the District of Columbia, and any possession of the United States. The proposed regulations further define the term located in the United States to mean present in the United States under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937-1(c)(3)(i) (for presence in a possession of the United States). Subject to certain exceptions, those rules generally treat an individual as present in the United States on any day if the individual is physically present in the United States at any time during such day.

Section 9010(d)(2) refers to "resident of the United States (within the meaning of section 7701(b)(1)(A))." Under section 7701(b), the term United States means the 50 States and the District of Columbia, but it does not include the possessions of the

United States. See section 7701(a)(9). Therefore, under the proposed regulations, this narrower definition of United States applies for determining who is a "resident of the United States (within the meaning of section 7701(b)(1)(A))." Regardless of the narrower scope of resident of the United States, the Treasury Department and the IRS note that the term United States health risk includes the health risks of individuals in the possessions of the United States since they will either be United States citizens or considered as located in the United States.

Recognizing the unique characteristics of plans covering expatriates, the Treasury Department and the IRS seek specific comments on how the rules proposed in these regulations apply to such plans.

III. Reporting requirements, associated penalties, and disclosure

Section 9010(g)(1) requires each covered entity to report its net premiums written for health insurance for United States health risks during the data year. The proposed regulations require each covered entity, including each controlled group that is treated as a single covered entity, to annually report its net premiums written for health insurance of United States health risks during the data year to the IRS by May 1st of the fee year on Form 8963, "Report of Health Insurance Provider Information," in accordance with the instructions for the form. A covered entity with net premiums written under the $25 million threshold is not liable for a fee but must still report its net premiums written. The proposed regulations authorize the IRS to provide rules for the manner of reporting (including reporting by designated entities on behalf of controlled groups) in other guidance published in the Internal Revenue Bulletin.

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. The proposed regulations clarify that these penalties are in addition to the fee.

Section 9010(g)(4) provides that section 6103 (relating to the disclosure of returns and return information) does not apply to any information reported by the covered entities under section 9010(g). The Treasury Department and the IRS are considering making available to the public the information reported on Form 8963, "Report of Health Insurance Provider Information," 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. The Treasury Department and the IRS invite comments on which reported information the IRS should make publicly available.

IV. Fee calculation

Under section 9010 and the proposed regulations, the IRS will calculate a covered entity's fee based on the ratio of the covered entity's net premiums written that are taken into account to the total net premiums written taken into account of all covered entities. For each 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 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. Also, because a controlled group is treated as a single covered

entity, this reduction applies, in the aggregate, to the net premiums written of the entire controlled group. Additionally, after this reduction, if the covered entity (or any member of a controlled group treated as a single covered entity) is exempt from tax by section 501(a) and is described in section 501(c)(3) (generally, a charity), (4) (generally, a social welfare organization), (26) (generally, a high-risk health insurance pool), or (29) (a consumer operated and oriented plan (CO-OP) health insurance issuer), 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. The proposed regulations further provide that, in the case of a controlled group, the IRS will not take into account any net premiums written of any member that is a nonprofit corporation meeting the requirements of §57.2(b)(2)(iii) of the proposed regulations or a VEBA meeting the requirements of §57.2(b)(2)(iv).

Under the proposed regulations, the IRS will determine net premiums written based on the reports submitted by covered entities and any other source of information available to the IRS. Most covered entities are expected to file the SHCE, which supplements the annual statement filed with the NAIC under applicable State law. For these covered entities, net premiums written for health insurance generally will equal the amount reported on that exhibit 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.” In addition to the SHCE, other sources of information that the IRS may use to determine net premiums written include the NAIC annual statement, the Accident and Health Policy Experience Exhibit filed with the NAIC, and 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. The proposed regulations further provide that the entire amount reported on the SHCE as direct premiums written will be considered to be for United States health risks unless the covered entity can demonstrate otherwise. The Treasury Department and the IRS invite comments on this approach.

V. Notice of preliminary fee calculation

The proposed regulations provide that the IRS will send each covered entity a notice of preliminary fee calculation each fee year that will include the covered entity's allocated fee; the covered entity's net premiums written for health insurance of United States health risks; 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); the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and a reference to the error correction process set forth in other guidance published in the Internal Revenue Bulletin. The date by which the IRS will send the preliminary fee calculation notice will be specified in other guidance published in the Internal Revenue Bulletin.

VI. Error correction process

The proposed regulations establish an error correction process that allows a covered entity to submit error correction reports in response to the preliminary fee calculation for the IRS to consider before performing a final fee calculation. The IRS will specify in other guidance published in the Internal Revenue Bulletin the format for error correction report submissions and the date by which a covered entity must submit an

error correction report. In the interest of providing finality to the fee calculation process, no additional error correction reports will be accepted after the end of the established error correction period.

VII. Notification of final fee calculation and payment

Section 9010(a) requires the annual fee to be paid by the annual date specified by the Secretary, but in no event later than September 30th of each fee year. The proposed regulations provide that the IRS will send each covered entity its final fee calculation for a fee year no later than August 31st of that fee year, and that the covered entity must pay the fee by September 30th by electronic funds transfer. This notification will include the covered entity's allocated fee, the covered entity's net premiums written for health insurance of United States health risks, 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), the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities, and the final determination on the covered entity's error correction report.

Even if a covered entity did not file an error correction report, 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 each covered entity's fee because each covered entity's fee is a fraction of the aggregate fee collected from all covered entities.

There is no tax return to be filed with the payment of the fee.

VIII. Tax treatment of fee

Section 9010(f)(1) treats the fee for purposes of subtitle F of the Code (sections 6001 - 7874) as an excise tax to which only civil actions for refund apply. Thus, under the proposed regulations, the fee is treated as an excise tax for purposes of subtitle F to which the deficiency procedures of sections 6211 through 6216 do not apply. The proposed regulations require the IRS to assess the amount of the fee for any fee year within three years of September 30th of that fee year.

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). The Treasury Department and the IRS received comments stating that covered entities may attempt to recover a large portion of the fee from policyholders, either by a corresponding increase in premiums or by separately charging policyholders for a portion of the fee. Some comments requested guidance that recovered fee amounts are excluded from the gross income of covered entities. The income tax treatment of recovered fee amounts is outside the scope of the proposed regulations. However, 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. No exclusion provision applies to the recovered fee amount. Therefore, the covered entity's gross income includes fees recovered from policyholders, whether or not separately stated on any bill. The Treasury Department and the IRS invite 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.

IX. Refund claims

The proposed regulations require any claim for refund to be filed on Form 843, "Claim for Refund and Request for Abatement."

Proposed Effective/Applicability Date

These regulations are proposed to apply with respect to any fee that is due on or after September 30, 2014.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. 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 these regulations primarily affect large corporations. Thus, the Treasury Department and the IRS do not expect a substantial number of small entities to be affected. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f), this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before the proposed regulations are adopted as final regulations, consideration will be given to any written (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The Treasury Department and the IRS

invite comments on all aspects of the proposed regulations. All comments will be available for public inspection and copying.

A public hearing has been scheduled for June 21, 2013, at 10:00 a.m., in the IRS Auditorium, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the "FOR FURTHER INFORMATION CONTACT" section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit electronic or written comments and submit an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by **[INSERT DATE 90 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal 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 in 26 CFR Part 57

Health Insurance, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR chapter I is proposed to be amended by adding part 57 to subchapter D to read as follows:

PART 57 - HEALTH INSURANCE PROVIDERS FEE

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

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

§57.0 Table of contents.

This section lists the captions contained in §§57.1 through 57.10 and §57.6302-1.

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§57.6302-1 Method of paying the health insurance providers fee.
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(b) Effective/Applicability date.

§57.1 Overview.

(a) The regulations in this part 57 are designated “Health Insurance Providers Fee Regulations.”

(b) The regulations in this part 57 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 No. 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 these proposed regulations are references to section 9010 of the ACA, as amended. 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 for purposes of the fee.

(b) Covered entity--(1) In general. Except as provided under paragraph (c)(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) to include 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 the respective laws of such jurisdictions that regulate 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)(A)-(C) to include--

(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 is excepted from reporting under 29 CFR 2520.101-2(c)(2)(ii)(B). Solely for purposes of the application of section 9010, an Entity Claiming Exception (defined in 29 CFR 2520.101-2(b)) is treated as a MEWA.

(2) Exclusions--(i) Self-insured employer. A covered entity does not include any entity that is a self-insured employer 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 plan may use an insurance company or other third party to provide administrative or bookkeeping functions.

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

(A) 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 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 public agency that is created by a State or a political subdivision, organized as a nonprofit under State law, and contracts with the State to administer State Medicaid benefits through local providers or HMOs.

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

(A) Which 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) Which 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. A 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.

(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). A controlled group is treated as a single covered entity for purposes of the fee.

(2) 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. Each controlled group must have a designated entity. The term designated entity means the person within the 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 an error correction report for the group, if applicable, as described in §57.6; and

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

(2) Selection of designated entity--(i) In general. Except as provided in paragraph (e)(2)(ii) of this section, the controlled group may select its designated entity by filing Form 8963, "Report of Health Insurance Provider Information," 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 is required to 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. If a controlled group does not select a designated entity, the IRS will select the designated entity.

(ii) Requirement for affiliated groups; common parent. 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 as identified on the tax return filed for the data year.

(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.

(h) Health insurance--(1) In general. Except as provided in paragraph (h)(2) of this section, the term health insurance 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 offered by a health insurance issuer. The term health insurance includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) Exclusions. 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) Student administrative health fee arrangements, as defined in paragraph (h)(3);

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

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

(3) Student administrative health fee arrangement. For purposes of paragraph (h)(2)(xiii) 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)(xiv) 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, 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)(xv) and (k) of this section, the term indemnity reinsurance means an agreement between two or more insurance companies under which--

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

(B) The issuing company retains its liability to, and its contractual relationship with, the 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. 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, net premiums written does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, net premiums written does include premiums written and is reduced by premiums ceded for assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section.

(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 May 1st 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 for health insurance of United States health risks during the data year but does not have any amount taken into account as described in §57.4(a)(4) is still subject to this reporting requirement.

(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.

(b) Penalties--(1) Failure to report--(i) In general. If any covered entity fails to timely submit a report containing the information required by paragraph (a) of this section, the covered entity is liable for a penalty in the amount described in paragraph

(b)(1)(ii) of this section in addition to its fee liability, unless the failure is due to reasonable cause as defined in paragraph (b)(1)(iii) of this section.

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

(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 penalty for failure to timely submit a report described in paragraph (b)(1)(i) of this section is waived if the failure is due to reasonable cause. A failure will be due to a 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 timely submit the report described in paragraph (b)(1)(i) of this section 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. If any covered entity understates its net premiums written for health insurance of United States health risks in the report required under paragraph (a)(1) of this section, the covered entity is liable for a penalty in the amount described in paragraph (b)(2)(ii) of this section in addition to its fee liability.

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

(A) The amount of the covered entity's fee for the fee year that the Secretary 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 Secretary 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 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 person in a controlled group with an obligation 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 total 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 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent

(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 reduction for certain exempt activities. After the application of paragraph (a)(4)(i) of this section, if the covered entity is exempt from Federal income tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29), 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.

(b) Determination of net premiums written--(1) In general. The IRS will determine net premiums written for health insurance of United States health risks based on the reports submitted by the covered entities, 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 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 as direct premiums written will be considered to be for United States health risks as described in §57.2(k) (subject to any applicable exclusions for amounts that are not health insurance as described in §57.2(g)(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 ratio 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 ratio 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) A reference to the error correction procedures specified in guidance published in the Internal Revenue Bulletin.

(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 will have an opportunity to review this calculation, identify any errors, and submit to the IRS an error correction report.

(b) Time and manner. The IRS will specify in other guidance published in the Internal Revenue Bulletin the format for error correction report submissions and the date by which a covered entity must submit an error correction report. The IRS will provide its final determination regarding the covered entity's error correction report no later than the time the IRS provides a covered entity with a final fee calculation.

§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 the reports the covered entity provides as adjusted by the error correction process and other sources 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 error correction report, 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 an error correction report 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 each covered entity's fee because each covered entity's fee is 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 EIN as reported on Form 8963, "Report of Health Insurance Provider Information." 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), subject to examination and summons (section 7602), and subject to confidentiality rules (section 6103), 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.

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

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