SUTHERLAND

LEGAL ALERT

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IRS Proposes Rules on Health Insurer Fee

The Internal Revenue Service (IRS) has released proposed regulations on the health insurer fee under section 9010 of the Patient Protection and Affordable Care Act (PPACA). The regulations, which were published in the Federal Register on March 4, provide much needed guidance on the types of health insurance that will subject an insurer to the fee, the reporting requirements, how the fee will be assessed, and how it is to be paid. However, the proposed regulations also say that certain details will be published later in the Internal Revenue Bulletin. 78 FR 14034, *et seq*., Treas. Reg. §§ 5 7.0 – 57.6302-1.

Background

Under section 9010 of PPACA, health insurance issuers will be assessed an annual fee (HI Tax or fee) for a portion of the "applicable dollar amount" payable by the entire industry for each year. The fee is first due in 2014. The applicable dollar 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, with increases after 2018 indexed based on net premium growth. Each issuer's annual payment will be assessed based on a ratio designed to reflect the issuer's relative market share of the U.S. health insurance business.

Although PPACA did not amend the Internal Revenue Code of 1986, as amended (Code) to include provisions implementing this fee, PPACA section 9010 provides that the fee is treated as an excise tax and is not deductible. In addition, section 9010 specifies that the Secretary of Treasury is to administer collection of the fee and has the authority to issue regulations and any other guidance needed for administration of the HI Tax.

HI Tax Assessment

The proposed regulations provide that the annual assessment will be applied based on a "covered entity's" total net premiums written, including assumption reinsurance premiums, but reduced by ceded assumption reinsurance, ceding commissions, and medical loss ratio (MLR) rebates during the calendar year immediately before the year in which the payment is due, which the regulations refer to as the "data year." (Under the proposed rule, the data year for the first HI Tax filing in 2014 is 2013.) However, the portion of an insurer's net premiums written used to calculate the HI Tax payable for any year depends on the insurer's aggregate net premiums written for the applicable data year, with a $25 million threshold for liability for any fee.

Amount of Entity's Net Premiums Written in Data Year	Percentage of Premium Taken into Account
$25M	0%
$25M-$50M	50%
Over $50M	100%

The preamble to the regulations notes that for insurers that report premiums on the Supplemental Health Care Exhibit (SHCE) with their NAIC annual filings this definition of net premiums written will be the same as direct premiums written reported on the SHCE minus MLR rebates and minus exclusions for premiums

for coverage that is not treated as health insurance for purposes of these rules. The IRS invited comments on possible methods for calculating MLR rebates for a data year based on data reported on the SHCE.

Definition of Covered Entity

Under the statute and the proposed rule, a "covered entity" is an entity that is engaged in the business of providing health insurance to "U.S. Health Risks" and is one of five types of health issuers identified in the proposed regulations. These entities include: (1) a health insurance issuer, as defined in Code § 9832(b)(2), which includes an insurance company, insurance service or insurance organization subject to state insurance regulation; (2) an HMO under Code § 9832(b)(3); (3) an insurance company subject to tax under part I or part II of subchapter L of the Code; (4) an entity that provides Medicare Advantage, Medicare Part D, or Medicaid coverage (which we understand does not include an insurer acting solely as a third-party administrator for Medicare Part D or other aspects of Medicare or Medicaid); and (5) a multiple employer welfare arrangement that is not fully insured and that is not exempt from reporting under applicable Department of Labor regulations, which will include a self-insured or partially self-insured Entity Claiming Exemption under the Labor regulations. Self-insured plans, government entities and certain non-profit corporations, as well as voluntary employee beneficiary associations (VEBAs) established by an entity other than an employer or a group of employers, are specifically excluded from the definition of covered entity under the proposed rule. The preamble asks for comments on the exclusions for government entities, non-profits and VEBAs and also asks if state-arranged high risk pools would be covered entities under the general definition or would meet one of the exclusions.

Definition of Health Insurance

The proposed rule defines "health insurance" for purposes of section 9010. Health insurance is defined as benefits consisting of medical care (provided directly, through reinsurance, or otherwise) under any hospital or medical service policy or certificate, plan contract, or HMO contract offered by a health insurance issuer. The regulations specifically state that the definition includes limited scope dental and vision benefits (defined as "excepted benefits" for purposes of Code § 9832(c)(2)(A)) and retiree-only health insurance, but excludes other excepted benefits. The excluded excepted benefits are: (1) accident-only coverage, or disability income insurance, or a combination of the two under Code § 9832(c)(1)(a); (2) coverage issued as a supplement to liability insurance under Code § 9832(c)(1)(B); (3) general liability, auto liability and other liability insurance under Code § 9832(c)(1)(C); (4) workers' compensation under Code § 9832(c)(1)(D); (5) automobile medical payment insurance under Code § 9832(c)(1)(E); (6) credit-only insurance under Code § 9832(c)(1)(F); (7) on-site medical clinics under Code § 9832(c)(1)(G); (8) to the extent provided in regulations, other insurance similar to the types described in items (1) – (7); (9) coverage for long-term care, nursing home care, home health care, community-based care or any combination under Code § 9832(c)(2)(B) and similar, limited benefits specified in regulations under Code § 9832(c)(2)(C); (10) independent, non-coordinated benefits for a specified disease or illness under Code § 9832(c)(3)(A); (11) independent, non-coordinated benefits for hospital indemnity or other fixed indemnity insurance under Code § 9832(c)(3)(B); and (12) separate Medicare supplemental insurance and similar coverage supplemental to a group health plan under Code § 9832(c)(4). As of yet, there have been no regulations issued to specify additional excepted benefits in the categories in items (8), (9) and (12) above, although the IRS, the Department of Labor and the Department of Health and Human Services have issued guidance on a non-enforcement safe harbor for supplemental coverage that will be considered similar to Medicare supplemental insurance.

Under the proposed rule, the definition of health insurance for the HI Tax also excludes travel insurance, but only to the extent that (1) the insurance coverage is for personal risks incident to planned travel (such

as interruption or cancellation of trip, loss of baggage or personal effects, or sickness, accident, or disability occurring during travel) and (2) any health benefits offered under the coverage are not offered on a stand-alone basis, and are incidental to other coverage. However, major medical plans that provide comprehensive medical protection for travellers with trips lasting six months or longer, including, for example, employees working overseas as expatriots or deployed military personnel, are included in the definition of health insurance. To the extent that Transamerica issues comprehensive major medical travel insurance or its travel insurance does not fit the definition of excludible travel insurance, the premiums for travel insurance will need to be aggregated with premiums for other coverage considered health insurance under these rules to determine the company's net premiums written, regardless of the filing status of the travel insurance product(s) in each state.

In addition, the proposed regulations provide that indemnity reinsurance is excluded from the definition of health insurance for purposes of the HI Tax, as well as student administrative health fee arrangements. The proposed rule says indemnity reinsurance means an agreement under which the reinsurer indemnifies the original insurance issuer while the original issuer remains fully liable to insured persons, as opposed to assumption reinsurance under which the reinsurer takes on the entire risk and there is a novation of the contract between the original insurer and the insured. An excluded student health arrangement is further defined as an arrangement under which a college or other educational institution charges students periodic fees to help pay the cost of a health clinic and care, provided that the arrangement is not insured and students are charged the fee regardless of their use of the clinic and whether they have purchased student health insurance made available by the school. In the preamble to the proposed rule, the IRS invited comments on other health programs or arrangements a school might have or other circumstances that could result in it being treated as a covered entity.

Definition of U.S. Health Risks

A covered entity is subject to the HI Tax only to the extent that it provides health insurance to "U.S. Health Risks." U.S. Health Risks are defined in the proposed rule as health risks of a U.S. citizen, a U.S. resident or someone located in the U.S. A U.S. resident is defined in Code § 7701(b)(1)(A) as an alien (*i.e.,* not a U.S. citizen) who is a lawfully admitted permanent resident of the U.S. (*i.e.*, of any of the 50 states or the District of Columbia), meets the substantial presence test set forth in the Code, and makes a certain election for the first year of residence. An individual is located in the U.S., under the proposed regulations, if he or she is in any of the 50 states, the District of Columbia or any U.S. possession, which includes American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands. The preamble asks for comments on the application of these rules to plans for expatriots, citing the unique character of those plans.

Controlled Group Rules

A controlled group is considered a single covered entity for purposes of the HI Tax. Under the proposed rule, a "controlled group" is a group of entities treated as a single employer under Code §§ 52(a) or 52(b) (including a foreign entity subject to tax under Code § 881), or under Code §§ 414(m) or 414(o). Code § 52(a) applies to parent-subsidiary groups and brother-sister groups of corporations, including entities with more than 50% common ownership, rather than at least 80% common ownership. Code § 52(b) applies to similar groups that include partnerships or other unincorporated entities or a combination of incorporated or unincorporated entities. An entity is a member of a controlled group for this purpose if it is a member of the group at the end of the day on December 31 of the data year, *e.g.*, for 2014, a member of the group on December 31, 2013.

Each controlled group that includes a covered entity must designate an entity to act on behalf of the controlled group for purposes of the fee (a "designated entity"). If the controlled group (without regard to any foreign corporations) is also an affiliated group that files a consolidated return, the common parent of the affiliated group as identified on the return is the designated entity. Otherwise, the controlled group members may select which entity will be the designated entity.

Reporting Requirements

The designated entity is responsible for filing Form 8963 to report the covered entity's (*i.e.,* the controlled group's) net premiums written for the data year to the IRS by May 1 of the year for which a fee is due, which is referred to in the regulations as the "fee year." A covered entity whose net written premiums are less than the $25 million threshold must still file the report. The proposed rule states that the IRS may publish further guidance in the Internal Revenue Bulletin regarding reporting by controlled groups. The preamble notes that since these forms are not filed under provisions of the Code, the reports are not subject to the non-disclosure rules that apply to tax return information. The preamble further says that the IRS is considering disclosing the information reported on these forms and asks for comments on which information should be made public.

Failure to report results in a penalty in the amount of $10,000 plus the lesser of (1) $1,000 per day while the failure continues, or (2) the amount of the fee imposed for which the report was required, unless the failure is due to reasonable cause. Such a penalty is due on notice and demand from the IRS and is treated as a penalty under the Code. An accuracy-related penalty also applies in the case of any understatement of a covered entity's net premiums written. Controlled group members are jointly and severally liable for either type of penalty.

Remittance of the HI Tax

Each year that the fee is due, the IRS will make a preliminary fee assessment by a specified date and will notify the covered entity of that assessment and provide information on how it was calculated, including the IRS's determination of the entity's net premiums written. The proposed rule does not specify the date on which this preliminary assessment will be made but instead indicates that the IRS will publish the date in the Internal Revenue Bulletin at a later time. The assessment will be based on the filings submitted by the covered entities along with "any other source of information available to the IRS," including the SHCE, annual statements filed under state law, or the Accident and Health Policy Experience filed with NAIC, the MLR Annual Reporting Form, or any similar statement filed with NAIC, any state government, or the federal government. The proposed regulations say that the entire amount reported on an SHCE will be considered to be for U.S. Health Risks (subject to any exclusions for amounts that are not health insurance), unless the covered entity can demonstrate otherwise. The preamble invites comments on this approach.

Upon receipt of the preliminary assessment, the covered entity will have an opportunity to correct errors and submit an error correction report based on procedures to be published in the Internal Revenue Bulletin. The IRS will then make a final calculation of net premiums written and provide the covered entity with a notice of the amount by August 31 of the fee year. The designated entity is responsible for paying the HI Tax. The amount due must be paid by September 30 of the fee year via electronic funds transfer as if it were a depository tax. There is no tax return required to be filed with the payment; however, for a controlled group, the payment must be made using the employer identification number of the designated entity for the group as it was shown on the Form 8963.

All members of the controlled group are jointly and severally liable for the fee. The IRS may separately assess each member of the controlled group for the full amount of the controlled group's fee if it is not paid.

If a covered entity seeks a refund of a fee for any reason, the claim can be made by filing Form 843. The claim must be made by the entity that paid the fee.

Tax Treatment of the HI Tax

The proposed rule provides that the fee is treated as an excise tax for purposes of Subtitle F of the Code, which is the subtitle that provides for filing of returns, payment of tax, assessment and collection of tax, penalties, and similar procedural and administrative rules. The regulations further say that the IRS must assess any fee due for a fee year within three years after September 30 of the fee year. In addition, the fee is treated as a non-deductible tax.

The preamble to the regulations notes that the IRS has received comments from insurers indicating that they intend to recover the fee from their contractholders through increases in premiums or a separate charge, and that some commenters asked whether recovered fees would be included in the insurers' gross income. According to the preamble, although this aspect of the tax treatment is outside the scope of the regulations, there is no applicable exclusion from income for recovered fees. Thus, the IRS requested comments on whether the final regulations should clarify that any recovered fees must be included in income.

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