Patient Protection and Affordable Care Act: Health Insurance Providers Fee

[REG-118315-12]

Summary of Proposed Rule

I. INTRODUCTION

On March 4, 2013, the Internal Revenue Service (IRS) caused to have published in the *Federal Register* a proposed rule to implement section 9010 of the Patient Protection and Affordable Care Act, as amended, which imposes an annual fee on certain entities engaged in the business of providing health insurance for United States (US) health risks. Written comments are due by June 3, 2013; the IRS will also hold a public hearing on June 21, 2013.

Section 9010 establishes aggregate amounts of revenue that are to be raised each year from entities that are not otherwise exempted from the fee under the terms of the statute or regulation (referred to as covered entities). The aggregate fee amount (called the applicable amount) for all affected covered entities is $8 billion for 2014, $11.3 billion for each of 2015 and 2016, $13.9 billion for 2017, $14.3 billion for 2018, and for 2019 and succeeding years is equal to the amount in the preceding year increased by the rate of premium growth for the preceding year.

The amount each covered entity must pay is based roughly on its relative market share of the US health insurance business; the proposed methodology for calculating a covered entity's specific fee amount is described below. The first annual fees would be due September 30, 2014 based on net premiums written during 2013.

II. DEFINITIONS

Covered entity. Under the proposed rule, this term would mean any of the following entities with net premiums written in a year:

- A health insurance issuer under section 9832(b)(2) of the Internal Revenue Code (IRC).
- A health maintenance organization (HMO) under section 9832(b)(3) of the IRC.
- An insurance company subject to tax under part I or II of subchapter L of the IRC, 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) of the IRC.
- An entity that provides health insurance under the Medicare Advantage, Medicare Part D, or Medicaid programs.
- A multiple employer welfare arrangement (MEWA) under section 3(40) of Employee Retirement Income Security Act of 1974 (ERISA) to the extent the MEWA is not fully insured, regardless if it is regulated under State insurance law.

A health insurance issuer would include an insurance company, insurance service, or insurance organization licensed to engage in the business of insurance in a State and that is subject to the

laws of the State that regulate insurance (within the meaning of section 514(b)(2) of ERISA). An HMO would include a Federally qualified health maintenance organization under section 1301(a) of the Public Health Service Act and an organization recognized under State law as an HMO or regulated under State law for solvency as an HMO.

A covered entity MEWA does not include i) a fully insured MEWA or ii) a MEWA that provides coverage for a limited time to employees of two or more employers due to a change in control of business and which is exempted from reporting under 29 CFR 2520.101-2(c)(2)(ii)(B). However, solely for purposes of section 9010, a fully insured Entity Claiming Exception (meaning an entity defined in 29 CFR 2520.101-2(b) that claims it is not a MEWA due to its establishment or maintenance through collective bargaining agreements) is excluded from the definition of a covered entity, while one that is not fully insured is considered a covered entity to the extent it is not fully insured.

The IRS notes that there are entities established to provide medical care coverage for high-risk individuals who lack access to coverage in the open market, and the agency invites comments as to whether these entities should be included as covered entities.

The following entities would be excluded from the definition of a covered entity:

- A self-insured employer to the extent it self-insures its employees' health risks.
- A governmental entity.
- Certain nonprofit corporations.
- A 501(c)(9) voluntary employees' beneficiary association (VEBA) that is established by an entity (other than an employer) to provide health care benefits.

A self-insured employer means an employer that sponsors a self-insured medical reimbursement plan. The IRS notes that self-insured medical reimbursement plans include plans that do not involve shifting risk to an unrelated third party, and that a self-insured plan may use an insurance company or other third party to provide administrative or bookkeeping functions. Governmental entities would include the US; any state or political subdivision thereof; any Indian tribal government or subdivision thereof; or any public agency created by a State or a political subdivision, organized as a nonprofit under State law, and that contracts with the State to administer State Medicaid benefits through local providers or HMOs. The proposed rule would exclude instrumentalities of governmental entities from the governmental entity exception but notes that these instrumentalities may qualify for another exception; the IRS invites comments.

The exception for nonprofit corporations is limited to those corporations—

i) 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;
iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation;
iv) which does not participate in, or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office; and

v) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under the Medicare, Medicaid or SCHIP program.

The agency invites comments on how the exclusion for nonprofit corporations would be applied as well as comments on the types of VEBAs that might not fall within the proposed definition and thus would be considered covered entities.

The IRS notes that educational institutions that provide students with access to health insurance would not be considered covered entities where they use premiums received from students to purchase health insurance from a separate unrelated issuer; in this case, the issuer is the covered entity. The agency invites comment on whether there are circumstances where an educational institution could be treated as a covered entity not eligible for an exclusion and subject to the fee.

Net premiums written. The IRS would define this as premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. The IRS invites comments on how to compute MLR rebates for a data year using data reported on the Supplemental Health Care Exhibit (SHCE) published by the National Association of Insurance Commissioners. It would not include premiums written for indemnity reinsurance and would not be reduced by indemnity reinsurance ceded; however, it would include premiums written, and would be reduced by premiums ceded, for assumption reinsurance. See below for more on reinsurance.

Health insurance. This term would be given the definition under section 9832(b) of the IRC, which means "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 would also include limited scope dental and vision benefits under section 9832(c)(2)(A) of the IRC as well as retiree-only health insurance, though the IRS notes that employers providing coverage to former employees under a self-insured arrangement would generally qualify for the exclusion for self-insured employers.

The proposed rule would exclude the following types of insurance products: accident only, disability income insurance only, or any combination thereof; supplementary coverage to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation; automobile medical payment insurance; credit-only insurance; on-site medical clinic coverage; and other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

It would also exclude benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof as well as other similar, limited benefits insurance products; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; Medigap policies; supplemental coverage for TRICARE and similar supplemental coverage provided to coverage under a group health plan; student administrative health fee arrangements; travel insurance; and indemnity reinsurance.

The IRS seeks comment on its proposal to limit the exclusion for travel insurance to insurance coverage for personal risks incident to planned travel; the exclusion would not apply to major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer typically used by expatriates. The IRS also seeks comment on its clarification that a student administrative health fee arrangement is an arrangement whereby an educational institution charges students administrative health fees on a periodic basis to help cover the cost of student health clinic operations and care delivery, other than through an insured arrangement.

In the proposed rule, the IRS distinguishes between two forms of reinsurance: indemnity reinsurance which is not health insurance and assumption reinsurance which is. Indemnity reinsurance is 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. By contrast, assumption reinsurance means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss under a new contract.

US health risk. This term would be defined to mean the health risk of any individual who is a US citizen, a US resident, or present in the US; the IRS seeks comment on how to apply the rules in the case of health insurance coverage of expatriates.

Controlled group. A controlled group would be treated as a single covered entity for purposes of section 9010. The term is defined under the proposed rule as 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) of the IRC. The IRS also notes that a person would be 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; it also clarifies that a foreign entity subject to tax under section 881 of the IRC is included within a controlled group under IRC section 52(a) or 52(b).

The IRS would require that each controlled group designate a person (referred to as the designated entity) within the group to act on the group's behalf with respect to the fee. Additionally, if the controlled group is also an affiliated group that files a consolidated Federal income tax return, the designated entity would be the common parent of that affiliated group. The designated entity would report on behalf of the controlled group, and members of the group must maintain records of their consent to the selection of the designated entity as well as other related consents. Where a controlled group fails to select a designated entity, the IRS will do so.

III. CALCULATION OF FEE

Unless an entity is excluded from the definition of covered entity, it would have to report to the IRS (using IRS Form 8963) by May 1 of the fee year (the year in which the fee must be paid) its net premiums written for the preceding year (the data year), even if its aggregate net premiums written for the data year are less than the $25 million threshold. This duty would also apply to each controlled group that is treated as a single covered entity. A covered entity that fails to

submit reports to the IRS would be subject to a penalty unless it can show reasonable cause for the failure. A covered entity that fails to report accurately (i.e., underreporting) would also be liable for a penalty for that inaccurate reporting.

The IRS would make a preliminary calculation of the amount of the fee owed by a covered entity based on submitted reports as well as other sources of data, such as the SHCE that most covered entities are required to file annually under State law. The IRS notes that the entire amount reported on the SHCE as direct premiums written would be considered to be for US health risks unless the covered entity can demonstrate otherwise. The preliminary calculation as well as other related information would be available to the covered entity for review and, where necessary, correction. The IRS would review any proposed correction and include its final determination on those corrections with the final calculation of the fee owed.

The IRS would determine for each covered entity the ratio of 1) the net premiums written by the entity during the data year for health insurance for any US health risk to 2) the aggregate net premiums for all covered entities for the data year. That ratio is then multiplied times the applicable amount for the year; in 2014, the applicable amount is $8 billion. However, Congress intended to focus the impact of the fee on larger insurers, and thus there are a series of disregards when calculating net premiums written during the data year, as follows:

I. If the covered entity wrote less than $25 million in net premiums in the data year, then none of its net premiums is taken into account and thus it pays no fee for that fee year.
II. If the covered entity wrote more than $25 million but less $50 million in net premiums in the data year, 50 percent of the amount above the $25 million threshold is taken into account. For these covered entities, the IRS will disregard the first $25 million in net premiums, as well as 50 percent above the $25 million threshold, in calculating the fee for the fee year.
III. If the covered entity wrote more than $50 million in net premiums in the data year, 100 percent of that amount above $50 million threshold, as well as 50 percent of the difference between $50 million and $25 million (see item II above), are taken into account. For these covered entities, the IRS will disregard the first $37.5 million in calculating the fee for the fee year.

For controlled groups, the rules for the calculation of net premiums above apply to all net premiums written for health insurance of US health risks during the data year, in the aggregate, of the entire controlled group. However, the IRS would not take into account the net premiums written by any member of the controlled group that is not a covered entity by reason of the exception for certain nonprofit corporations or VEBAs.

After applying the rules above, in the case of certain tax exempt entities[1], only 50 percent of net premiums that are attributable to exempt activities are taken into account when calculating the fee for the fee year.

[1] These are 501(c)(3) charitable organizations, 501(c)(4) social welfare organizations, 501(c)(26) high-risk health insurance pools, and 501(c)(29) consumer operated and oriented plan (CO-OP) issuers.

The IRS would distribute fee notices by August 31st of a fee year with payment due, through electronic funds transfer, by September 30th. Controlled groups would have to make payment using the designated entity's employer identification number as reported on IRS Form 8963. Of special concern to controlled groups, the IRS proposes to hold all members of the controlled group jointly and severally liable for any fee, and failure to pay the fee would give rise to separate assessments on each member of the controlled group of the full amount of the fee.

IV. EXCISE TAX; PENALTIES

The IRS proposes to treat the fee as an excise tax, for which no deduction applies. The IRS would have up to three years from a September 30th fee due date for a given fee year to assess the section 9010 fee for that year. Claims for refunds would be permitted, but only those submitted by the covered entity that paid the fee. Responding to concerns that covered entities may attempt to recover some or all of the fees through premium increases or separate fees on policyholders, the IRS notes that those fees or premium increases would be included in the definition of gross income subject to taxation and invites comments on whether it should include clarifying text in the regulations on this point.

As noted above, the statute imposes penalties for any failure to report and for inaccurate reports. The amount of penalty varies: for failure to report absent reasonable cause, the penalty is $10,000 plus lesser of i) $1,000 per day while the failure continues, or ii) the amount of the fee imposed for which the report was required. Payment of the penalty is due upon notice. For underreporting net written premiums, the amount of the penalty equals the difference between the amount of the excise tax that the IRS determines should have been paid absent the understatement and the amount of the excise tax determined based on the understatement. Each person in a controlled group that must provide information to the controlled group's designated entity for the report is jointly and severally liable for any penalties for any reporting failures or inaccuracies by the designated entity.

V. Paperwork Reduction Act Estimates

The IRS believes the likely respondents to paperwork requests are entities in the business of providing health insurance for US health risks and estimates 800 total respondents and/or recordkeepers. It also estimates 400 hours of total annual reporting and/or recordkeeping burden, and an average of 0.5 annual burden hours per respondent and/or recordkeeper.

The IRS does not believe a regulatory assessment is required because the proposed rule is not a significant regulatory action within the meaning of Executive Order 12866; it also believes the proposed rule will principally affect large corporations and thus would not have a significant economic impact on a substantial of small entities.