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# Overview of the November 29, 2013 Final Rule on the Health Insurance Provider Fee

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## Introduction

On November 29, 2013, the Internal Revenue Service (IRS) issued final regulations on the *Health Insurance Provider Fee*: http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28412.pdf. This final rule provides guidance on the annual fee imposed on covered entities that provide health insurance in the U.S., including guidance on exclusions and the fee methodology. This document provides a high-level summary of this final rule.

## 26 CFR Parts 57 and 602 – Health Insurance Providers Fee

### *Covered Entities and Exclusions*

Beginning in 2014, a covered entity that provides health insurance will be assessed an annual fee. A covered entity is "*any entity with net premiums written for U.S. health risks during the fee year*" that is one of the following:

- A health insurance issuer
- A health maintenance organization (HMO)
- An insurance company subject to tax or tax exempt under section 501(a) – "*Exemption from tax on corporations, certain trusts, etc"*
- An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid
- A non-fully-insured multiple employer welfare arrangement (MEWA)

#### MEWAs

If a MEWA is fully-insured, it is not considered a covered entity and therefore is not subject to the health insurance provider fee. The IRS explained that fully-insured MEWAs use premiums received to pay an insurance company to provide coverage. Conversely, a MEWA that is not fully-insured is a covered entity because premiums received are used to provide the health coverage rather than to pay an insurance company.

#### Section 9010(c)(2)(C) Exclusions

In this section, the IRS excludes the following from the definition of covered entity for purposes of the annual health insurance provider fee:

- A self-insured employer.

- A governmental entity.
- Certain nonprofit corporations, including:
    - An entity that is incorporated as a nonprofit corporation under state law.
    - An entity where no part of net earnings benefit private shareholders or individuals.
    - An entity with no substantial participation in activities that carry on propaganda (or otherwise attempt to influence legislation) and does not participate in (or intervene in, including the publishing and distributing of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.
    - An entity that receives more than 80 percent of its gross revenues from government programs that target low-income, elderly, or disabled populations under Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and dual-eligible plans.
- Certain Voluntary Employees Beneficiary Associations (VEBAs):
    - VEBAs established by an entity other than an employer for the purpose of providing health care benefits are excluded from the annual health insurance provider fee.

### Educational Institutions

The IRS does not exclude educational institutions from the definition of covered entity. However, some exceptions may apply, including the following:

- In the case of an educational institution using premiums received from students to purchase insurance from a separate, unrelated issuer. In this arrangement, the issuer would be the covered entity.
- In the case of an educational institution being a wholly-owned instrumentality of a state.

### Other Entities

In response to comments, the IRS provided guidance on the inclusion and exclusion of various entities:

- *Labor Organizations* – Outside of the §9010 exclusions, there is no statutory exclusion for §501(c)(5) entities.
- *High Risk Pools* – High risk pools will expire on December 31, 2013. As a result, they will not be providing health insurance in the first fee year (2014) and will not be considered a covered entity. Where a high risk pool provides health insurance in 2014, it *will* be considered a covered entity and will be subject to the fee.

- *Residual Health Insurance* – An entity that is selling or otherwise failing to continue the majority of its health insurance business by December 31, 2013, but is contractually obligated to provide some residual health insurance in 2014 is not excluded.
- *Tax-Exempt Health Maintenance Organizations (HMOs)* – Tax-exempt HMOs are not excluded from the definition of covered entity and will be subject to the fee. The IRS emphasized that there are no exclusions for entities that qualify as a tax-exempt organization under §501(c) (3) or (4). However, the IRS noted that a tax-exempt organization would be eligible for the partial exclusion.

## Disregarded Entities

In this section, the IRS clarified the treatment of a "disregarded entity," or entity that is separate from its owner but elects not to be classified as separate for federal tax purposes (see 26 USC §301.7701-3). The IRS clarified that there are no special classifications for a disregarded entity under this final rule. Still, a disregarded entity that is an insurance company[1] cannot be disregarded and will be deemed as 1) a separate entity from its owner and 2) a covered entity for purposes of this rule.

## Controlled Groups

In this section, the IRS defined a controlled group as a single covered entity consisting of two or more individuals who are treated as a single employer under IRS rules. The controlled group includes at least one individual that is a covered entity. The IRS is considering whether further guidance is needed to clarify circumstances where nonprofit organizations (both tax-exempt under §501(a) of the Internal Revenue Code (IRC) and non-exempt but having no members or shareholders who are entitled to receive distributions of income or assets from the organization) are included in controlled groups.

Until it issues further guidance, those organizations may rely on reasonable, good-faith application of IRC §52(a) or (b) – "*controlled group of corporations*;" "*employees of partnerships, proprietorships, etc., which are under common control*" or apply the rules set forth in §1.414(c)-5(a) through (d) of Treasury rules – substituting "more than 50 percent" in place of "at least 80 percent."

[1] The IRS explains that a company is an insurance company if "more than half of its business during the taxable year is the issuing of insurance or annuity contracts or reinsuring of risks underwritten by insurance companies." (See Internal Revenue Code §816(a) and §831(c)).

### *Health Insurance*

In this section, the IRS defined health insurance for the purposes of the health insurance provider fee requirement. Under these rules, "health insurance" is defined, subject to certain exclusions, to include benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. The IRS clarified that these benefits constitute health insurance when offered by any type of covered entity and not solely by a health insurance issuer.

#### Stop-Loss Coverage

Self-insured employers often purchase stop-loss coverage, where the stop-loss provider assumes the risk for claims above a certain threshold amount. Some comments on the proposed rule suggested that the IRS include stop-loss coverage in the definition of health insurance; other comments suggested excluding it. There is concern that small group employers with healthier employees may purchase stop-loss coverage with low attachment points as an alternative to a group-insured plan. As a result, the Department of Labor, HHS, and the Treasury Department issued a Request for Information on the prevalence and consequences of stop-loss coverage with low attachment points. At this time, the IRS is not including stop-loss coverage in the definition of health insurance, and the health insurance provider fee requirement will not apply to stop-loss coverage issuers until future guidance addresses the issue.

#### Limited Scope Dental and Vision Benefits

In this section, the IRS clarified that the definition of health insurance includes limited scope (or stand-alone) dental and vision benefits. The IRS emphasized that such benefits are included in the definition of health insurance for the purposes of the health insurance provider fee.

#### Coverage Funded by Targeted Government Programs

In this section, the IRS clarified that coverage funded by government programs targeting low-income, elderly, or disabled populations (such as Medicare, Medicaid, and dual-eligible plans) are not excluded from the definition of health insurance. The IRS noted, however, that a limited group of such entities targeting these populations (nonprofit corporations, non-employer-established VEBAs) are excluded from the definition of health insurance for the purposes of the health insurance provider fee.

#### Indemnity Reinsurance

In this section, the IRS clarified that the definition of health insurance does not include indemnity reinsurance. An issuer of the policies specified in the indemnity insurance agreement may be any covered entity. In situations where two insurance issuers contract to provide benefits

but only one issuer retains an exclusive relationship with the enrollee, the IRS noted that while these final regulations do not expressly address a carve-out arrangement for the other issuer, that second issuer would not be considered to provide health insurance for the purposes of the health insurance provider fee to the extent the arrangement between the two issuers meets the definition of indemnity reinsurance.

### Subcapitation

In this section, the IRS clarified that—although not specifically addressed in the final rule—amounts paid to a service provider under a subcapitation arrangement are not included in net premiums written for health insurance. The IRS noted that this exclusion is applied only to the extent that such amounts are not treated as premiums for state regulatory and reporting purposes.

### Employee Assistance Programs

In this section, the IRS noted that it is currently considering guidance to treat benefits under an employee assistance program (EAP) as an excluded benefit. The IRS clarified that until this rulemaking—and through at least 2014—an EAP that did not provide significant benefits in the nature of medical care or treatment may not be treated as health insurance by the taxpayer.

### Long-Term Care

In this section, the IRS excluded any benefits for long-term care, nursing home care, home health care, community-based care, or any combination from the definition of health insurance for the purposes of the health insurance provider fee. The IRS noted that, to the extent Medicaid plan providers separately identify premiums received for long-term care, these amounts are not considered health insurance and can be excluded from the net premiums written.

### Medicare Advantage and Medicare Part D Plans

In this section, the IRS noted that an employer or union that provided Medicare Advantage or Medicare Part D benefits under an Employer Group Waiver Plan (EGWP) or similar arrangement is not a covered entity to the extent the arrangement is eligible for self-insuring employer exclusion.

### Medicare Cost Contract Plans

In this section, the IRS discussed Medicare cost contract plans. These plans are paid based on the reasonable costs incurred by delivering Medicare-covered services to plan members. The IRS clarified that benefits under a Medicare cost contract plan are considered health insurance if they meet the general definition of health insurance, as defined above, and do not qualify for a specific exclusion.

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

In this section, the IRS detailed the methodology of the partial exclusion from the health insurance provider fee. The IRS notes that, after determining the amount of net premiums written for health insurance of U.S. health risks that are attributable to the activities of any covered entity, 50 percent of the remaining net premiums written for health insurance of U.S. health risks are excluded.

This partial exclusion applies to a covered entity that is an IRC §501(c) (3), (4), (26), or (29) entity. Moreover, the partial exclusion is only applied to premium revenue from its exempt activities. An entity will be eligible for the partial exclusion if it meets the specified federal tax-exemption requirements as of December 31 of the data year.

### *Reporting and Penalties*

In this section, the IRS required each covered entity to report to the IRS its net premiums written for health insurance for U.S. health risks during the data year. The IRS will impose penalties relating to the following reporting failures:

- Failing to timely report information unless the covered entity can show that such failure is due to reasonable cause
- Failing to submit accurate Form 8963

The IRS clarified that there is no reasonable cause exception for the accuracy-related penalty. Covered entities will be required to submit a corrected Form 8963. The accuracy-related penalty will be equal to the amount of the covered entity's health insurance provider fee determined in the absence of the understatement (that is, the correct fee amount) over the amount of the fee determined based on the understatement (that is, the amount of the fee based on understated reporting). The failure to report penalty and accuracy-related penalty apply in addition to the health insurance provider fee. A covered entity will be liable for both penalties.

The IRS explained that it must determine the correct amount of net premiums written for all covered entities before it can determine the correct health insurance provider fee amount for a covered entity. Due to this limitation, the IRS cannot compute and assess any accuracy-related penalties until the conclusion of the error correction process.

### *Fee Calculation and Error Correction Process*

#### In General

In this section, the IRS required each covered entity to report its net premiums written for health insurance for U.S. health risks during the data year to the IRS on Form 8963 by April 15 of each

fee year. In addition, the IRS is required to send each covered entity its final fee calculation no later than August 31 and requires the covered entity to pay the fee by September 30 through electronic funds transfer.

The IRS will send preliminary fee calculations and give covered entities an opportunity to submit error correction reports. A covered entity is required to review its preliminary fee calculation and, if it believes there are any errors, to timely submit to the IRS a corrected Form 8963 during the error correction period.

The IRS intends to publish future guidance on the time and manner of error correction reporting.

### Source of Data Used to Calculate the Fee

In this section, the IRS defined *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 within the data year.

For entities that file the Supplemental Health Care Exhibit (SHCE) with the National Association of Insurance Commissioners (NAIC), net premiums written for health insurance generally will equal the amount reported on the SHCE as direct premiums written, minus MLR rebates with respect to the data year, subject to any applicable exclusions (such as exclusions from the definition of health insurance).

### MLR Rebates

In this section, the IRS clarified that MLR rebates are computed on an accrual basis. In addition, the IRS did not designate specific SHCE line numbers as the source of data for computing MLR rebates because forms can change. Instead, the IRS noted that the instructions for Form 8963 provide this information.

### Medicaid Bonuses

In this section, the IRS did not create a special rule for the treatment of Medicaid bonuses (e.g., incentives Medicaid plans receive for meeting plan goals). The treatment of Medicaid bonuses in determining net premiums written depends on whether and when these amounts are treated as premiums written for state and federal regulatory and reporting purposes.

### Amounts Taken into Account

In this section, the IRS noted that, for each covered entity, the first $25 million of net premiums written will not be taken into account for the purposes of calculating the health insurance provider fee. After that amount, the IRS will take into account 50 percent of the net premiums written up to $50 million. The IRS will take into account 100 percent of net premium amounts over $50 million.

In addition, if a covered entity (or any member of the controlled group treated as a single covered entity) is exempt from taxation under IRC §501(a) and is described in IRC §501(c) (3), (4), (26), or (29), the IRS will take into account only 50 percent of the remaining net premiums written that are attributable to its exempt activities. The IRS clarified that, in these circumstances, the exclusion applies first to each member of the controlled group on a pro rata basis, and the exclusion for specified tax-exempt entities will be applied to eligible members of the group.

### *Designated Entities*

In this section, the IRS required each controlled group to have a designated entity, defined as an individual within the controlled group who would act on behalf of the controlled group with regard to the health insurance provider fee.

With regard to foreign corporations, if the controlled group is also an affiliated group that filed a consolidated federal corporate income tax return, the designated entity is the common parent of the affiliated group identified on the tax return for the data year. The IRS clarified that, in order to better coordinate this final rule with consolidated return regulations, the designated entity is the agent for the group.

### *Disclosure*

In this section, the IRS noted that the requirements relating to the confidentiality and disclosure of returns and return information does not apply to any information reported by covered entities. The IRS provided that the information reported on each Form 8963 will be open for public inspection or available upon request. Certain information will be made available online, including the identity of each reporting entity and the amount of its reported net premiums written.

### *Expatriate Policies*

In this section, the IRS clarified that an insurer issuing a policy to a U.S. citizen or resident living abroad is still providing coverage for a U.S. health risk. In addition, the IRS emphasized that foreign insurers are not considered covered entities.

In verifying the number of U.S. health risks for each covered entity, the IRS created a presumption under which the entire amount of net premiums written on the SHCE filed with the NAIC related to state reporting requirements will be considered to be for U.S. health risks unless the covered entity can demonstrate otherwise.

### *United States Possessions*

In this section, the IRS clarified that possessions (such as Puerto Rico, Guam, U.S. Virgin Islands, and the Northern Mariana Islands) are included as a U.S. health risk.

### *Taxability and Other Treatment of the Fee*

In this section, the IRS clarified that the health insurance provider fee will be treated as a tax. Some commenters noted that covered entities may attempt to pass the cost of the fee to policyholders by (1) a corresponding increase in premiums or (2) separately charging policyholders for a portion of the fee.

The IRS emphasized that, for the purposes of calculating the health insurance provider fee, a covered entity's gross income includes amounts received from policyholders to offset the cost of the fee, whether or not separately stated on any bill.

The IRS will issue separate guidance to clarify that covered entities must include in reported income any amounts collected from policyholders to offset the cost of the fee.

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