Legislative Brief

Health Care Reform - Health Insurance Providers Fee

Health Insurance Providers Fee Due September 30, 2014

The Affordable Care Act (ACA) imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee, which is treated as an excise tax, is required to be paid by Sept. 30 of each calendar year beginning in 2014 (**first payment is due Sept. 30, 2014**).

On Nov. 29, 2013, the Internal Revenue Service (IRS) issued a **final rule** to implement the ACA's health insurance providers fee. In connection with the final rule, the IRS also issued **Revenue Ruling 2013-27** to address tax issues related to the fee, and **Notice 2013-76** to provide procedural and administrative guidance on the fee's collection.

In addition, on March 31, 2014, the IRS released **Notice 2014-24** to provide a temporary safe harbor for 2014 and 2015 for covered entities that **report direct premiums written for expatriate plans on a Supplemental Health Care Exhibit (SHCE)**. If certain requirements are met, this temporary safe harbor allows a covered entity to treat 50 percent of certain premiums written for expatriate plans as being attributable to non-United States health risks.

Covered entities may try to shift the cost of the fee onto policyholders, either by a corresponding increase in premiums or by separately charging policyholders for a portion of the fee. In Revenue Ruling 2013-17, the IRS provides that a covered entity **must include in income** any amounts it collects from policyholders to offset the cost of the fee.

According to the IRS, the ACA imposes the health insurance providers fee on a covered entity, not on the covered entity's health insurance policyholders. The fee is part of the covered entity's cost of doing business. No exemption or exclusion from gross income applies to additional amounts that the covered entity charges its policyholders to cover the cost of this fee.

COVERED ENTITIES

The health insurance providers fee applies to all "covered entities," defined as any entity that provides health insurance for any United States health risk. The fee will be assessed on health insurers' premium revenue with respect to health insurance above $25 million. Specifically, the fee applies to:

- Health insurers;
- Health maintenance organizations (HMOs);
- Providers of Medicare Advantage, Medicare Part D prescription drug coverage or Medicaid coverage; and
- Non-fully insured multiple employer welfare arrangements (MEWAs).

The term "health insurance" does not include single employer self-funded plans or coverage for specific diseases, accident or disability only, hospital indemnity, long-term care or Medicare supplemental health insurance. However, **limited dental and vision coverage are included** as health insurance for purposes of this fee.

A "United States health risk" means a health risk of an individual who is a U.S. citizen, U.S. resident (whether or not located in the U.S.) or located in the U.S., with respect to the period that the individual is located there.

Controlled Group Rule

To determine if a company is a "covered entity," a controlled group rule applies for companies that are related or commonly owned. For purposes of the health insurance providers fee, a "controlled group" is 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 the Internal Revenue Code (Code) sections 52(a), 52(b), 414(m) or 414(o).

A controlled group is **treated as a single covered entity** for purposes of the health insurance providers fee. In determining net premiums written of a controlled group, the controlled group generally must take into account the net premiums written for all members for the entire data year.
Each controlled group must generally select a "designated entity" that will be responsible for filing and reporting the group's net premiums written. However, all group members are jointly and severally liable for the final fee for a given fee year. 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.

Excluded Entities

The fee does not apply to companies whose net premiums written are $25 million or less. Additionally, the fee program specifically excludes all of the following entities:

Employers who provide retiree's health care benefits under a self-insured arrangement generally would qualify for the exclusion for self-insured employers. Also, a self-insured plan may use a third party, such as a commercial insurer, for administration and remain exempt from the fee, as long as there is no shifting of risk to the third party.

Self-insured employers	Governmental entities	Certain nonprofit entities	Certain voluntary employee's beneficiary associations (VEBAs)

Multiple Employer Welfare Arrangements (MEWAs)

A fully-insured MEWA will not be subject to the fee even though it receives premiums, because 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.

The fee also does not apply to certain MEWAs that are exempt from DOL reporting requirements. According to the IRS, this limited exception is intended to address situations where MEWA status does not come from the arrangement's design, but instead, from the limited participation by individuals who are not the employees of a single employer, or from a desire to have a single plan for entities sharing substantial common ownership.

Stop-loss Coverage

Stop-loss coverage is *not included* in the definition of "health insurance" subject to the health insurance providers fee. However, the agencies are concerned that more small employers with healthier employees may pursue self-insured plans with stop-loss arrangements that have low attachment points as an alternative to an insured group health plan. However, the final rule provides that the health insurance providers fee will not apply to stop-loss coverage until future guidance is issued addressing the circumstances in which stop-loss coverage constitutes health insurance.

Fee Amount

The aggregate annual fee for all covered entities (referred to as the "**applicable amount**") will be:

- **$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.

Beginning in 2019, the cost of the fee will increase based on the rate of premium growth.

The applicable amount will be apportioned among the covered entities according to their respective market shares, as measured by net premiums written for health insurance. This means that the IRS will assess a portion of the applicable amount to each covered entity based on the ratio of:

- The covered entity's net premiums written for health insurance during the preceding calendar year; to
- The aggregate net premiums for health insurance of all covered entities during the preceding calendar year.

A covered entity's net premiums written during the calendar year that are not more than $25 million are not taken into account when allocating the fee. With respect to a covered entity's net premiums written that are more than $25 million but not more than $50

million, 50 percent are taken into account. One-hundred percent of net premiums written in excess of $50 million are taken into account.

REPORTING REQUIREMENTS AND FEE DETERMINATION

A covered entity will be required to report to the IRS the amount of its net premiums written for health insurance of United States health risks during the data year by **April 15 of each fee year**, using **Form 8963** (Report of Health Insurance Provider Information). The fee year is the calendar year in which the fee must be paid to the government, and the data year is the calendar year immediately before the fee year. A covered entity with net premiums written under the $25 million threshold is not liable for the fee, but still must report its net premiums written.

The information submitted on Form 8963 is **not confidential**. All information on Form 8963 will be open for public inspection or available upon request. The IRS expects that certain information will be made available on www.irs.gov, including the identity of each reporting entity and the amount of its reported net premiums written.

Fee Determination

The IRS will mail each covered entity a notice of its preliminary fee calculation by **June 15** of each fee year.

If the covered entity believes that the notice of preliminary fee calculation contains one or more errors, the covered entity must provide a corrected report to the IRS by **July 15** of each fee year. The covered entity will make an error correction report by completing in full a new Form 8963 and checking the "Corrected Report" box on the form. The corrected Form 8963 will replace the original Form 8963, and must contain all of the information required by the form's instructions. The IRS will validate the data submitted on the Form 8963 to ensure accuracy and completeness.

Notification and Payment

The IRS will notify each covered entity of its final fee calculation on or before **Aug. 31** of each fee year. Each covered entity (or designated entity, if applicable) must pay this fee by **Sept. 30** of each fee year. The health insurance providers fee must be paid by electronic funds transfer.

TEMPORARY SAFE HARBOR FOR CERTAIN COVERED ENTITIES

On March 31, 2014, the IRS issued Notice 2014-24 to provide a temporary safe harbor for covered entities that **report direct premiums written for expatriate plans on a Supplemental Health Care Exhibit (SHCE)**. A covered entity may apply this temporary safe harbor for purposes of reporting direct premiums written on Form.

The health insurance providers fee final regulations do not provide specific rules for expatriate policies. However, the SHCE includes separate reporting for expatriate plans, which are defined as group health insurance policies that provide coverage to employees, substantially all of whom are:

- Working outside their country of citizenship;
- Working outside their country of citizenship and outside the employer's country of domicile; or
- Non-U.S. citizens working in their home country.

The final regulations provide that the entire amount reported as direct premiums written on the SHCE (including direct premiums written for expatriate plans) will be considered to be for United States health risks, unless the covered entity can demonstrate otherwise.

The IRS notes that data collected under the section 6055 reporting requirements ultimately could provide insurers with information they need to determine more precisely the health risks covered by their expatriate plans. IRS Notice 2013-45, however, delays the section 6055 reporting until 2016 for coverage in 2015. In the interim, Notice 2014-24 provides a **temporary safe harbor for 2014 and 2015** for a covered entity that reports direct premiums written for expatriate plans on its SHCE that include coverage of at least one non-United States health risk. This temporary safe harbor allows a covered entity to **treat 50 percent of certain premiums written for expatriate plans as being attributable to non-United States health risks**.

Because information collected under the section 6055 reporting rules could provide more detailed information on the health risks covered by these plans, this safe harbor only applies for **fee years 2014 and 2015**.

To be eligible for this temporary safe harbor, the covered entity (including controlled group members, if any) must:

- File one or more SHCEs with the NAIC reporting direct premiums written for expatriate plans; and
- Have aggregate direct premiums written for expatriate plans reported on its SHCE(s) that include coverage of at least one non-United States health risk.

In addition, the covered entity must **attach a statement to its Form 8963 certifying the following information**:

- The covered entity's aggregate direct premiums written for expatriate plans reported on its SHCE(s) include coverage of at least one non-United States health risk;
- The covered entity is relying on the temporary safe harbor provided in Notice 2014-24;
- The aggregate dollar amount of direct premiums written for expatriate plans reported on its SHCE(s) for that covered entity (including the amounts for all members of the controlled group, if applicable); and
- The covered entity has excluded 50 percent of this aggregate amount in determining the amount of direct premiums reported on Form 8963.

A covered entity that satisfies these requirements will be considered to have rebutted the presumption that the entire amount of direct premiums written reported on its SHCE is for United States health risks. In that event, the covered entity may, for fee years 2014 and 2015:

- Treat 50 percent of the aggregate dollar amount of its direct premiums written for expatriate plans as reported on its SHCE (including the amounts for all members of the covered entity's controlled group, if applicable) as direct premiums written for health risks that are not United States health risks; and
- Exclude this amount in reporting direct premiums written on Form 8963.

The following example illustrates this temporary safe harbor:

Company X, the designated entity of a controlled group, and X's controlled group members (collectively, X Group) reported $1 million in direct premiums written for expatriate plans, in the aggregate, on their SHCEs for 2014. X Group determines that at least one of its expatriate plans covers at least one non-United States health risk. X Group intends to use the temporary safe harbor described in this notice for purposes of reporting on Form 8963. For the 2014 fee year, Company X may reduce the amount of direct premiums written reported for X Group on Form 8963 by $500,000, provided it attaches the following statement to its Form 8963:

> *Company X hereby declares that: (1) the aggregate direct premiums written for expatriate plans reported on the X Group SHCEs for 2014 include coverage of at least one non-United States health risk; (2) X Group is relying on the temporary safe harbor provided in Section 3 of Notice 2014-24; (3) X Group reported an aggregate of $1,000,000 in direct premiums written for expatriate plans on its 2014 SHCEs; and (4) X Group excluded 50% of this amount, or $500,000, in determining the aggregate amount of direct premiums written for all X Group members reported on Form 8963.*

PENALTIES

A penalty will apply to each covered entity for **failure to timely file** Form 8963, unless it is shown that the failure is due to reasonable cause. The penalty, which applies *in addition to* the fee amount, will be **$10,000** plus the lesser of:

- $1,000 per day while the failure continues; or
- The amount of the fee imposed for which the report was required.

A penalty will also apply for **underreporting** of a covered entity's net premiums written. The penalty is equal to the amount of the fee that should have been paid in the absence of an understatement over the amount of the fee determined based on the understatement. A covered entity may be liable for both the failure to report penalty and the accuracy-related penalty.

The health care reform law—the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Please contact Kapnick Insurance Group with any questions about how you can prepare for any of the health care reform requirements. This Kapnick Insurance Group Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal or tax advice. The information contained in this communication is intended to provide general information regarding health care reform and related topics, and is based on general information available at the time it was prepared. Readers should contact their tax and/or legal counsel for advice that is appropriate to their specific circumstances. This information cannot be used by any taxpayer to avoid tax penalties.