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A Tax Like No Other: The Health Insurer Fee

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"A tax, in the general understanding and in the strict constitutional sense, is an exaction for the support of Government; the term does not connote the expropriation of money from one group to be expended for another, as a necessary means in a plan of regulation. …" [1]

—Supreme Court Justice Owen Roberts

The Patient Protection and Affordable Care Act (PPACA) imposed a market-share-based health insurance provider fee, known as the "Section 9010 Fee," "Health Insurer Fee," or simply the "HIF,"[2] on each "covered entity" with net premiums written in excess of $25 million that is engaged in the business of providing health insurance coverage for United States health risks ("U.S. health risks").[3] The Section 9010 Fee was enacted to collect $8 billion in the aggregate from the health insurance industry in 2014, $11.3 billion in 2015 and in 2016, and increasing amounts in each year thereafter.[4] The fee is treated as an excise tax and is not deductible for federal income tax purposes.[5]

The Section 9010 Fee was imposed and payable beginning in 2014, the first "fee year."[6] In 2014, each covered entity was required to report its 2013 "data year" net premiums written for health insurance of U.S. risks to the Internal Revenue Service (IRS) on Form 8963, *Report of Health Insurance Provider Information*.[7] The IRS then determined each covered entity's portion of the $8 billion total fee for 2014, based on the data from all the Forms 8963 received for the 2013 data year. Each covered entity was billed for its portion of the $8 billion, and payment for the 2014 fee year was due by Sept. 30, 2014.

Health insurers have now weathered one year of the Section 9010 Fee cycle and are in the midst of year two. A number of definitional and practical issues persist, although the Department of the Treasury and the IRS have generally been very responsive to issues raised by health insurers and have provided timely guidance on certain of these issues.

This discussion provides background information to help unpack the language behind the Section 9010 Fee and highlights a few areas of special interest including merger-and-acquisition-related issues, application of the Section 9010 fee to expatriate plans, and considerations regarding fee administration.

BACKGROUND

When the PPACA was enacted, some lawmakers expressed the belief that health insurance companies would benefit economically from an expanded market for health insurance coverage due to the employer mandate, the individual mandate and state-created exchanges. In exchange for this anticipated health insurance market growth and additional revenue for health insurers, Congress chose to extract a fee from health insurance market participants. To this end, section 9010(a) of the PPACA imposes an annual fee on "covered entities" engaged in the business of providing health insurance for U.S. health risks.

WHAT IS A COVERED ENTITY?

A covered entity is any entity that provides health insurance for any U.S. health risk during the calendar year in which the fee is due, subject to certain exclusions.[8] The final Section 9010 Fee regulations[9] define the term generally to mean any entity with net premiums written for U.S. health risks during the fee year that is: (1) a health insurance issuer, i.e., a state licensed and regulated health insurance company, insurance service or insurance organization; (2) a health maintenance organization (HMO); (3) an insurance company that is subject to tax under subchapter L of the Internal Revenue Code (IRC), or that would be subject to tax under subchapter L but for being tax-exempt; (4) an entity that provides health insurance under Medicare Advantage, Medicare Part D or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).[10]

A controlled group rule applies to aggregate entities and treats them as a single covered entity if one of the entities within the group is a covered entity. This rule requires aggregation of all the net premiums written of the controlled group members (generally, entities connected by 50 percent common ownership) for purposes of meeting the $25 million net premiums written threshold, discussed below, for application of the Section 9010 Fee. The membership of a controlled group is determined as of Dec. 31 of the data year, which is the calendar year immediately preceding the fee year (i.e., 2013 was the first data year and 2014 was the corresponding fee year). Foreign entities are counted for purposes of applying the controlled group rule. A group that is treated as a covered entity must designate one of its members (the "designated entity") to be responsible for filing IRS Form 8963, receiving IRS communications about the fee for the group, filing a corrected Form 8963 for the group, if applicable, and paying the fee for the group.[11]

WHICH AMOUNTS ARE INCLUDED IN NET PREMIUMS WRITTEN?

A covered entity's net premiums written for health insurance of U.S. risks must be reported to the IRS annually via Form 8963. In this regard, there are three questions:

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(1) Is an amount received by a covered entity an amount received for health insurance?
(2) Is this amount included in the definition of "net premiums written"? and
(3) What amount of an entity's net premium written is attributable to U.S. health risks?

(1) What types of coverage are treated as health insurance?

"Health insurance" 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 HMO contract, when these benefits are offered by an entity that is a covered entity.[12] Limited-scope dental and vision benefits and retiree-only health insurance are within the scope of this definition.

The Treasury regulations set forth a host of exclusions from the definition of health insurance, most of which consist of excepted benefits under section 9832.[13] The regulations expressly exclude indemnity reinsurance from the definition of health insurance, and define indemnity reinsurance as "an agreement between one or more reinsuring companies and a covered entity 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 covered entity retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement." [14]

The Preamble to the final regulations notes that Treasury is considering whether stop-loss coverage should be treated as health insurance, and expressly does not treat stop-loss coverage as health insurance for purposes of the Section 9010 Fee. Thus, until further guidance is issued, stop-loss premiums are excluded from a covered entity's net premiums written subject to the fee. [15]

(2) Which amounts are included in net premiums written?

The Section 9010 Fee is allocated among health insurers based upon their respective market share of health insurance coverage, measured by a covered entity's net premiums written to the total net premiums written for all covered entities. The term "net premiums written" is not defined in the statute. The Treasury regulations provide that a covered entity's "net premiums written" reportable to the IRS annually on Form 8963 include "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."[16] Net premiums written do not include premiums written for indemnity reinsurance and are not reduced by indemnity reinsurance ceded because indemnity reinsurance is not considered to be health insurance—but do include premiums written for assumption reinsurance and are reduced by assumption reinsurance premiums ceded.[17]

By expressly excluding indemnity reinsurance from the definition of health insurance, combined with reducing net premiums written for risks ceded under assumption reinsurance, Treasury left a fee that is effectively calculated on the direct business that an insurer writes. By keeping indemnity reinsurance out of the Section 9010 Fee computation, Treasury may have hoped to minimize the likelihood that a U.S. health insurer would cede risk to an unrelated foreign entity on an indemnity reinsurance basis to avoid the fee.

A covered entity's first $25 million of net premiums written are not subject to the Section 9010 Fee.[18] Fifty percent of a covered entity's net premiums written above $25 million and up to $50 million are taken into account, and 100 percent of net premiums written above $50 million are taken into account.[19] So, for example, a covered entity with net premiums written of $50 million would be subject to the fee on only $12.5 million of its net premiums written. For a covered entity (or any member of a controlled group treated as a single covered entity) that is tax-exempt and is described in section 501(c)(3), 501(c)(4), 501(c)(26) or 501(c)(29) as of Dec. 31 of the data year, only 50 percent of its remaining net premiums written (after application of the rule described immediately above) are taken into account as net premiums written subject to the fee.[20]

(3) What types of risks are U.S. health risks?

The regulations define a U.S. health risk to mean the health risk of any individual who is (1) a U.S. citizen; (2) a U.S. resident within the meaning of IRC section 7701(b)(1)(A)[21] ; or (3) located in the United States during the period such individual is so located.[22] For these purposes, the United States includes 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.[23]

Criterion 3, the "location" criterion for U.S. risk, casts a somewhat wider net than would generally apply in determining U.S. risk for other U.S. excise tax purposes relevant to insurers, such as for purposes of the IRC section 4371 federal excise tax. Subject to special exceptions for commuters, individuals in transit, and certain crew members, an individual is "located" in the United States on a particular day if he/she is physically present in the United States at any time during that day,[24] and is located in a possession of the United States if he/she is present in the relevant possession for at least 183 days during the relevant year.[25] Tracking individual insureds who are "located in" the United States may prove difficult for U.S. health insurers; for some companies, special diligence rules and procedures may be necessary to ensure compliance with this location rule.

A presumption rule applies to any covered entity that files the Supplemental Health Care Exhibit (SHCE) with the National Association of Insurance Commissioners (NAIC) whereby the entire amount reported on

the SHCE as direct premiums written will be considered to be for health insurance of U.S. health risks (subject to any applicable exclusions for amounts that are not health insurance) unless the covered entity can demonstrate otherwise.[26] In this regard, special issues have arisen in the context of expatriate plans (see discussion below).

AREAS OF SPECIAL INTEREST

Mergers and Acquisitions

There has been and continues to be significant merger and acquisition (M&A) activity and a trend toward convergence in the health insurance market. Daily or weekly reports of potential and completed "deals" in the health care and health insurance industry are commonplace. Each company's or group's motivations for engaging in M&A activity differ, but some of the commonly cited reasons include synergies, diversification of health insurance product offerings, and cost savings.

The Section 9010 Fee is nondeductible, and the magnitude of the fee can cause a substantial reduction to economic income. Furthermore, a covered entity may have difficulty predicting the Section 9010 Fee for a particular fee year with a great degree of accuracy as the fee is a set amount to be collected by the U.S. government that is allocated to covered entities based on market share, and market share is continually in flux.[27] In this less-than-predictable tax environment, some health insurer groups may decide to restructure their business, for example, to separate their nonprofit entities from their for-profit entities so as to maximize the $37.5 million exclusion of net premiums written for the for-profit entities.

Some questions that have arisen from the increased M&A activity include the ownership of the fee amongst covered entities and what happens when purchasing excluded entities.

Whose fee is it?

The Section 9010 Fee regulations present the potential for mismatches between ownership of a covered entity and legal responsibility for the Section 9010 Fee attributable to the entity. Not all M&A deals close precisely on Dec. 31, yet the Section 9010 Fee regulations determine the members of a controlled group as of Dec. 31 of the data year.[28] The regulations do not include rules for handling acquisitions and dispositions, and do not make provision for partial-year fees.[29] Accordingly, in the M&A due diligence context covered entities face the questions of whether the acquiring group or the selling group will contractually bear responsibility for the fee for a particular fee year, and how the fee will be allocated between the buyer and the seller. If the fee is to be allocated, the basis for the allocation, e.g., by month, percentage of net premiums written, or some other criterion, should be negotiated, agreed to by the parties, and memorialized in the purchase agreement.

The two-year nature of the Section 9010 Fee, i.e., the data year/fee year distinction, raises issues in the M&A context. To determine the members of a controlled group that are treated as a single covered entity for Section 9010 Fee purposes, an entity 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 Dec. 31 of the *data* year. Yet the IRS determines a covered entity's fee in the subsequent year, the *fee* year. Application of this rule can produce some unexpected results if attention is not paid to the rule's mechanics. Assume, for example, Covered Entity is part of Controlled Group 1 ("Seller") in Year 1 (2013, the data year), and is sold June 30 of Year 2 (2014, the fee year) and becomes part of Controlled Group 2 ("Buyer"). Covered Entity has net premiums written for U.S. health risks in Year 2 of $100 million. In Year 2, $90 million of Covered Entity's net premiums written are attributable to the period from Jan. 1 through June 29, when it is a member of the Seller group; only $10 million in Covered Entity's net premiums written in Year 2 are attributable to the period during which Covered Entity is part of the Buyer group.

- In Year 2, which group, Seller group or Buyer group, is legally responsible for reporting Covered Entity's net premiums written for the Year 1 data year?

- In Year 2, which group, Seller group or Buyer group, is legally obligated to pay the Section 9010 Fee that is attributable to the Year 1 Covered Entity net premiums written?

Covered Entity was part of the Seller controlled group as of Dec. 31, 2013 of the data year. Covered Entity also had net premiums written as part of the Seller group in 2014, the fee year. Accordingly, the Seller group is legally responsible for reporting Covered Entity's net premiums written for the Year 1 data year. Yet as of July 15, Year 2, Seller group does not include

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Covered Entity. How can Buyer ensure that Seller will report Covered Entity's net premiums written and pay the associated Section 9010 Fee in the 2014 fee year? Ideally, this responsibility would be spelled out in the tax indemnification provisions of the purchase agreement. In the alternative, the parties may adjust the purchase price for the Covered Entity.

- In Year 3 (2015), is Buyer group required to report all of Covered Entity's premiums from Year 2 (2014) on Buyer's Form 8963?

- In Year 3, should Buyer group be responsible for 100 percent of the Section 9010 Fee attributable to Covered Entity's net premiums written in Year 2 even if only 10 percent of these premiums were written while Covered Entity was a member of the Buyer group?

Covered Entity was part of the Buyer controlled group as of Dec. 31, 2014. Covered Entity also had net premiums written as part of the Buyer group in 2015. Accordingly, the Buyer group is legally responsible for reporting Covered Entity's net premiums written for the 2014 data year and paying the Section 9010 Fee that is attributable to these premiums. However, 90 percent of Covered Entity's net premiums written for 2014 (data year) are attributable to the pre-acquisition time period. Should Buyer use this fact to negotiate a reduced purchase price for Covered Entity? Should the purchase agreement require Seller group to indemnify Buyer group for 90 percent of the Section 9010 Fee for 2015 that is attributable to Covered Entity?

Accordingly, entities that would not meet the definition of a covered entity due to their nonprofit status and premiums from government programs should engage in negotiations regarding their contractual exemption from a share of the buyer's and/or seller's Section 9010 Fee.

The questions raised above punctuate the need for due diligence around the Section 9010 Fee. The financial burden of the fee should be negotiated by the Buyer and Seller in these (and other) situations.

What about excluded entities?
Although the regulations do not address the types of M&A-generated partial year issues noted above, Notice 2014-47[30] does address exclusions from the definition of a covered entity and clarify that a controlled group is not required to report in the 2014 fee year the net premiums written for a controlled group member who would not qualify as a covered entity in the 2014 fee year if it were a standalone entity. Temporary regulations issued in early 2015 continue this rule for the 2015 fee year and beyond.[31]

Under Notice 2014-47 and the temporary regulations, an entity that was not a covered entity for both the data year and the fee year, such as an entity that qualified for the exclusion as a nonprofit entity with 80 percent of its premiums from certain government insurance programs in one of these years, is not subject to the Section 9010 Fee in the fee year. The temporary regulations adopt a "test year" concept; excluded status for an entity may be tested in either the data year or the fee year, and must be tested consistently.[32]

An excluded entity, however, is still to be treated as a member of the controlled group for other purposes, such as joint and several liability for the fee amount allocated to the controlled group. Accordingly, entities that would not meet the definition of a covered entity due to their nonprofit status and premiums from government programs should engage in negotiations regarding their contractual exemption from a share of the buyer's and/or seller's Section 9010 Fee.

Notice 2014-47 allows entities that reasonably project that they will qualify for an exclusion from covered entity status under § 9010(c)(2) (as nonprofits with 80 percent or more premiums attributable to certain government health insurance programs) for the entire 2014 fee year to submit a corrected Form 8963 on or before Aug. 18, 2014 for the 2014 fee year. For M&A activity in 2014, potential qualifying entities took into account this special rule.

Buyers of nonprofits should address in their purchase agreements the possibility that a particular acquired entity for which they did not expect to owe a Section 9010 Fee ends up attracting such a fee—due to reduced government health insurance program premiums, loss of nonprofit status, or other unexpected situations.

EXPATRIATE PLANS

An issue emerged in the context of expatriate plans—specifically, how to determine a covered entity's net premiums written for U.S. health risks where the entity covers non-U.S. individuals. Under the presumption rule in the final regulations, mentioned above, the entire amount reported on the SHCE of an insurer's Annual Statement is considered to be attributable to U.S. health risks unless the covered entity can demonstrate otherwise. Accordingly, insurance companies that did not issue health insurance policies solely to U.S. persons faced the issue of how to rebut this "100 percent U.S. health risk" presumption.

Comments to the proposed

Section 9010 Fee regulations requested clarification regarding how to treat expatriate plans and sought an exemption for these plans. The preamble to the final regulations issued in November 2013 notes that commenters expressed concern regarding the application of the 100 percent U.S. health risk presumption to expatriate policies. The preamble explains that Treasury and the IRS considered methods for a covered entity to account for its expatriate coverage but did not identify a method that would be verifiable and administrable.[34]

To address the expatriate plan concern while the issue was under study, in March 2014 the IRS issued Notice 2014-24,[35] which provided a temporary safe harbor for 2014 and 2015 for a covered entity that reported direct premiums written for expatriate plans on its SHCE that included coverage of at least one non-U.S. health risk. The SHCE includes separate reporting for expatriate plans, which are defined by reference to the definition of expatriate policies in the medical loss ratio (MLR) rules as group health insurance policies that provide coverage to employees, substantially all of whom are: (1) working outside their country of citizenship; (2) working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in their home country. Under Notice 2014-24 a covered entity that satisfied the requirements for the temporary safe harbor set forth in the notice was treated as rebutting the presumption that the entire amount of direct premiums written reported on its SHCE was for U.S. health risks, and could treat 50 percent of its specified premiums written for expatriate plans as attributable to non-U.S. health risks—and, thus, exclude this premium from its net premiums written for purposes of Form 8963 reporting.[36] Certain covered entities applied the Notice 2014-24 temporary safe harbor in reporting their direct premiums written for purposes of determining their 2014 fee, which was due on Sept. 30, 2014.

Meanwhile, a legislative fix was in the works—in December 2014 Congress enacted the Expatriate Health Coverage Clarification Act of 2014 (EHCCA).[37] Relevant sections of the EHCCA provide that the PPACA generally does not apply to expatriate health plans, and the EHCCA specifically excludes expatriate health plans from the Section 9010 Fee. For calendar years after 2015, a qualified expatriate (and any spouse, dependent, or any other individual enrolled in the plan) enrolled in an expatriate health plan is not considered a U.S. health risk. These new rules are generally effective for expatriate health plans issued or renewed on or after July 1, 2015. Furthermore, the EHCCA provides a special rule for the Section 9010 Fee due in fee years 2014 and 2015. That rule provides that expatriate health insurance issuers will pay a fee reduced proportionally for the premiums attributable to those plans but this reduction will have no impact on other fee-payers. To address the 2014 and 2015 fee years, in April 2015 the IRS issued Notice 2015-29,[38] rendering Notice 2014-24 obsolete and providing that expatriate policies should be excluded from the Section 9010 Fee as they do not cover U.S. health risks.

Notice 2015-29 announced that insurance companies that (1) had filed SHCEs for 2014 and/or 2015 reporting direct premiums written for expatriate health plans, (2) had reported some or all of these premiums on Form 8963, and (3) attach a prescribed certification to their 2015 Form 8963 would be eligible for refunds of their overpayments in the form of a reduced Section 9010 Fee for 2015.[39]

Notice 2015-29 also allows covered entities that did not file SHCEs to receive the benefit of a reduced net premiums written amount for 2015 by making the following certifications: (1) the covered entity is filing the statement pursuant to Notice 2015-29; (2) the aggregate dollar amount of direct premiums written for expatriate health plans that it included on its 2014 Form 8963; (3) the aggregate dollar amount of direct premiums written for expatriate health plans that it included on its 2015 Form 8963; and (4) the source of information that the covered entity has available on request for determining direct premiums written for expatriate health plans for 2014 and 2015.

The methodology to be applied by the IRS to reduce a certifying covered entity's Section 9010 Fee under Notice 2015-29 for the 2014 and 2015 fee years is as follows: (1) calculate the 2015 fee for all covered entities under Treas. Reg. § 57.4; (2) for a covered entity with premiums for expatriate health plans included in total direct premiums written reported for the 2015 fee year, adjust the covered entity's 2015 fee by (a) multiplying its 2015 fee amount by a fraction, the numerator of which is the amount of its expatriate health plan premiums taken into account that is included in net premiums written taken into account for the 2015

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fee year and the denominator of which is the covered entity's total net premiums written taken into account for the 2015 fee year; and (b) subtracting this amount from the 2015 fee; (3) for a covered entity with net premiums written for expatriate health plans included in total direct premiums written reported for the 2014 fee year, further adjust the entity's 2015 fee by (a) multiplying its 2014 fee amount by a fraction, the numerator of which is the amount of its expatriate health plan premiums taken into account that is included in net premiums written taken into account for the 2014 fee year and not previously excluded in determining the 2014 fee and the denominator of which is the covered entity's total net premiums written taken into account for the 2014 fee year; and (b) subtracting this amount from the 2015 fee.

As of the date this article is published, the 2015 filing season for the Section 9010 Fee is closed. Nonetheless, the active process that was used to rectify the expatriate plan issue is an excellent example of Treasury and IRS, as well as legislative, responsiveness to a practical problem for many health insurance providers.[40]

IRS ADMINISTRATION OF THE SECTION 9010 FEE

Administration of the Section 9010 Fee is still in its early stages. The IRS has been charged with ensuring the accuracy of the fee computation for each covered entity and is responsible for enforcement of the fee and associated penalties, even though the fee is not found in the IRC.

In each fee year each covered entity (including the designated entity for controlled groups) must report to the IRS its net premiums written for health insurance of U.S. health risks during the data year (e.g., 2013 premiums for the 2014 fee year) on Form 8963. Forms 8963 are due by April 15 of the fee year, and a covered entity's corrections to its previously filed Form 8963 for a given fee year are due by July 15 of the fee year.[41] A covered entity that has net premiums written during the data year is subject to this reporting requirement even if the entity does not have net premiums written in excess of $25 million or is otherwise partially or wholly exempt from the Section 9010 Fee. If, however, an entity is not in the business of providing health insurance for any U.S. health risk in the fee year, it is not a covered entity and does not have to report its net premiums written on Form 8963.[42] The information reported on Form 8963 is not treated as taxpayer information under IRC section 6103 and is to be open for public inspection and available upon request.[43]

As mentioned above, the IRS calculates each covered entity's portion of the annual aggregate Section 9010 Fee by dividing the entity's net premiums written for the data year by the aggregate net premiums written by all covered entities; this percentage of the total fee due from the entity is multiplied by the Section 9010 Fee to be collected, e.g., $8 billion for the 2014 fee year.[44] The IRS sends a preliminary fee determination to the covered entity by June 15 of the fee year, and sends a final bill for the fee to the covered entity by Aug. 31 of the fee year requesting payment of the assessed fee by Sept. 30.[45]

For any fee year, a covered entity has a limited opportunity to contest its assessed fee. A covered entity may file a corrected Form 8963 prior to the date that its fee is assessed. When a covered entity files a corrected Form 8963, this corrected form takes the place of the original filing.[46] The IRS will not accept corrected 8963s that are filed after the correction deadline has passed.[47] The window for filing corrected Forms 8963 in response to a preliminary fee assessment is narrow—from June 15 to July 15 of the fee year. This window is narrow because the final fee must be paid by Sept. 30, and thus the IRS must do everything necessary to provide feepayers with final bills in sufficient time to be paid by this statutory deadline.

The IRS is responsible for reviewing the Form 8963 filings and presumably is checking a covered entity's net premiums written as reported on its Form 8963 by reviewing the covered entity's SHCE, the accident and health experience report, and/or the MLR annual report form that is filed with the Centers for Medicare and Medicaid Services division of the U.S. Department of Health and Human Services. Covered entities should assume that the IRS will be attempting to match the amounts reported as net premiums written with externally available information. Indeed, there have already been IRS challenges to reported net premium written amounts and to non-filing of Form 8963 in situations where the IRS believes an entity should have filed.

The best enforcer of the accuracy of a covered entity's reporting, however, may prove to be the health insurance market participants themselves. As mentioned above, most large health insurance companies had a reasonable idea, based on their market share, of the amount of their allocated portion of the Section 9010 Fee before the first Forms 8963 were filed. Moreover, every covered entity's Section 9010 Fee filed information is publicly available. Because the Section 9010 Fee is structured as a zero-sum game, it is possible, or even likely, that certain market participants will "call out" other participants that they believe are underreporting net premiums written or not filing Form 8963 at all.

The Section 9010 Fee is treated as an excise tax, and the income tax deficiency procedures do not apply to the fee. There appears to be no method other than filing a corrected Form 8963 for changing a final assessment prior to payment of the fee; thus, a covered entity that believes its assessed fee is too high generally must pay the final fee and file a Form 843, Claim for Refund and Request for Abatement, to recover all or a portion of the Section 9010 Fee it has paid.[48] It will be interesting to see how the IRS will process these refund claims, and how many of the claims are granted.

The Section 9010 Fee reporting and assessment process is similar in some ways to the old differential earnings rate (DER) and recomputed DER (RDER) process under IRC section 809. As the DER was an industry-wide computation, companies were required to report information to the IRS and the IRS would use the information to compute and publish the applicable DER. Once more accurate information was obtained, the IRS published the RDER and companies would be entitled to a true-up of sorts. For Section 9010 Fee purposes, however, there is no true-up process. The preamble to the Section 9010 Fee regulations explains "[c]ommenters suggested that the final regulations create a 'true-up' process by which the fee will be continually adjusted from year to year. Because the fee is an allocated fee, allowing a true-up process for one covered entity will result in adjustments to the fee for all covered entities. In the interest of providing finality and certainty to fee liability, the final regulations do not adopt this suggestion."[49] Thus, when all is said and done, in some years the IRS may collect more than the statutory amount of the aggregate fee (e.g., in years where they have nonfilers that it is later determined should have paid the fee and are assessed a proportionate amount of the aggregate fee) and in other years the IRS may collect less than that statutory amount (e.g., when refund claims are granted to some feepayers).

The IRS must assess the amount of the fee for any fee year within three years of Sept. 30 of that fee year.[50] The statute does not provide for an extended statute of limitations for non-filers.

PENALTIES

A covered entity that fails to timely submit Form 8963 is liable for a failure to report penalty of $10,000, plus the lesser of (1) $1,000 for each day nonfiling continues or (2) the amount of the covered entity's Section 9010 Fee.[51] A reasonable cause exception to the penalty may apply 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 reasonable cause exception applies, the IRS is to consider all the facts and circumstances surrounding the failure to submit the report, and the burden of showing reasonable cause is on the taxpayer.[52]

If a covered entity files a Form 8963 but "understates" its net premiums written for health insurance of U.S. health risks, the entity will be liable for an accuracy-related penalty in the amount of the difference between the covered entity's Section 9010 Fee for the fee year that the IRS determines should have been paid in the absence of any understatement, and the amount of the covered entity's Section 9010 Fee for the fee year based on the understatement.[53]

Liability for any non-filing or accuracy-related penalties incurred by a controlled group that is treated as a covered entity is joint and several.[54] This rule may raise issues in the M&A context and as an entity enters or exits a controlled group.

WRAP-UP

As an allocated fee, the Section 9010 Fee involves a number of moving parts significantly impacting the bottom line of most health insurers covering U.S. health risks. This article covers only some of the issues that have been seen to date, and time will tell whether these issues smooth themselves out. It is also worth noting again that the final regulations and IRS notices have provided helpful guidance to the industry; however, some open questions remain. Therefore, as discussed, covered and excluded entities alike would benefit from taking the 9010 Fee into consideration during M&A negotiations. It also is important to keep records of the U.S. health risks and those that would qualify as expatriate plans, since this may not be obvious within the financial statements or other public filings. To date, the administration of the Section 9010 Fee has been relatively smooth, and the government's responsiveness in addressing specific situations and unintended consequences of the originally enacted statute have helped the process. ■

Note: The views expressed herein are those of the authors and do not necessarily reflect the views of KPMG LLP.

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END NOTES

[1] *United States v. Butler*, 297 U.S. 1 (1937).

[2] Pub. L. No. 111-148, § 9010, 124 Stat. 118, 865, as amended by Pub. L. No. 111-148, § 10905, 124 Stat. 118, 1017 (March 23, 2010) (PPACA), and further amended by Pub. L. No. 111-152, § 1406, 124 Stat. 1029, 1065 (March 30, 2010) (HCERA). We note that "section 9010" does not refer to an Internal Revenue Code section, as the fee is an off-Code provision enacted as Section 9010 of PPACA.

[3] See Treas. Reg. § 57.1(c).

[4] See Treas. Reg. § 57.4(a)(3) for the "applicable fee" schedule.

[5] PPACA § 9010(f)(2) provides that the fee is treated as a nondeductible excise tax under IRC § 275(a)(6). See also Treas. Reg. § 57.8(d); Rev. Rul. 2013-27, 2013-2 C.B. 676 (health insurer's recovery of the fee is included in insurer's income).

[6] The "fee year" is the calendar year in which the fee must be paid to the government. Treas. Reg. § 57.2(g).

[7] The "data year" is the calendar year immediately before the fee year. Treas. Reg. § 57.2(d).

[8] PPACA § 9010(c). Self-insured employers, governmental entities, certain nonprofit corporations, voluntary employees' beneficiary associations (VEBAs), and states, the District of Columbia, and U.S. possessions are excluded entities. Treas. Reg. § 57.2(b)(2).

[9] Treas. Reg. § 57.1-5.10, 57.6302-1, T.D. 9643, 78 Fed. Reg. 71476 (Nov. 29, 2013).

[10] Treas. Reg. § 57.2(b)(1).

[11] Treas. Reg. § 57.2(e)(1).

[12] Treas. Reg. § 57.2(h)(1).

[13] These exceptions include generally: accident and disability income insurance; coverage that is supplemental to liability insurance; liability insurance (including general and automobile liability); workers' compensation or similar insurance; automobile medical payment; credit-only insurance; coverage for on-site medical clinics; other insurance coverage that is similar to the aforementioned coverages under which benefits for medical care are "secondary or incidental to" other insurance benefits; long-term care, nursing home care, home health care, community-based care; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; Medicare supplemental health insurance; coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code for uniformed services, and similar supplemental coverage provided under a group health plan; certain coverage under employee assistance plans, disease management plans or wellness plans; student administrative health fee arrangements; travel insurance; and indemnity reinsurance. Treas. Reg. § 57.2(h)(2).

[14] Treas. Reg. § 57.2(h)(5)(i).

[15] Preamble to Treas. Reg. §§ 57.1-57-10, 78 Fed. Reg. 71476, 71481 (Nov. 29, 2013).

[16] Treas. Reg. § 57.2(k).

[17] Treas. Reg. § 57.2(k).

[18] PPACA § 9010(b)(2)(A); Treas. Reg. § 57.4(a)(4)(i).

[19] PPACA § 9010(b)(2)(A); Treas. Reg. § 57.4(a)(4)(i).

[20] Treas. Reg. § 57.4(a)(4)(iii). To qualify for this exclusion, an entity also must not be taxable under section 501(m) for providing commercial-type insurance. PPACA § 9010(b)(2)(B); see Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as amended, in Combination with the 'Patient Protection and Affordable Care Act,' 90, fn. 201 (March 21, 2010). The IRS intended to, but has not, issued proposed regulations regarding section 501(m). IRS Notice 2003-31; 2003-1 C.B. 948 (requesting comments regarding the content of proposed regulations under section 501(m)).

[21] A U.S. resident includes generally (1) a resident alien who is lawfully admitted for permanent residence in the United States, (2) a resident alien who meets the "substantial presence" test, and (3) an individual who makes an election for his/her first year of residence in the United States.

[22] Treas. Reg. § 57.2(n).

[23] Treas. Reg. § 57.2(m).

[24] IRC § 7701(b)(7).

[25] Treas. Reg. § 1.937-1(c)(3)(i).

[26] Treas. Reg. § 57.4(b)(2).

[27] While this is true in theory, many health insurers figured out their "approximate" Section 9010 Fee prior to the first fee year, based on market share data.

[28] Treas. Reg. § 57.2(c)(3)(ii).

[29] The IRS has noted informally that it would expect the parties to an M&A transaction to make an allocation of the fee for partial years, but did not want to complicate administration of the fee by developing allocation rules.

[30] 35 I.R.B. 522.

[31] Treas. Reg. § 57.2T, 80 Fed. Reg. 10333, 10335 (Feb. 26, 2015).

[32] Treas. Reg. § 57.2T(c)(i)-(iii).

[33] See comments from Aetna, America's Health Insurance Plans (AHIP), and the U.S. Chamber of Commerce dated June 3, 2013: *http://www.regulations.gov/#!docketBrowser;rpp=100;so=DESC;sb=docId;po=0;s=expatriate;dct=PS;D=IRS-2013-0011*.

[34] 78 Fed. Reg. 71476, 71486.

[35] 2014-1 C.B. 942

[36] Notice 2014-24, section 3.01. To qualify for the temporary safe harbor under Notice 2014-24, a covered entity was required to (1) file one or more SHCEs with the NAIC reporting direct premiums written for expatriate plans, (2) report direct premiums written for expatriate plans reported on its SHCE(s) that include coverage of at least one non-U.S. health risk, and (3) attach a certification statement to its Form 8963 certifying the following: (a) the covered entity's aggregate direct premiums written for expatriate plans reported on its SHCE include coverage of at least one non-U.S. health risk, (b) the covered entity is relying on the temporary safe harbor provided in Notice 2014-24, (c) the aggregate dollar amount of direct premiums written for expatriate plans reported on the covered entity's SHCE, and (d) the covered entity has excluded 50 percent of this aggregate amount in determining the amount of direct premiums reported on Form 8963.

[37] Pub. L. No. 113-235, 128 Stat. 2130 (Dec. 16, 2014).

[38] 2015-15 I.R.B. 873.

[39] The certifications required by Notice 2015-29 for SHCE filers are as follows: (1) the covered entity filed the SHCE for 2014, 2015, or both; (2) the covered entity is filing the statement pursuant to Notice 2015-29; (3) the aggregate dollar amount of direct premiums written for expatriate health plans reported on its SHCE for 2014 for that covered entity; (4) the amount of direct premiums written for expatriate health plans the covered entity excluded under Notice 2014-25 in determining the amount of direct premiums written reported in column (f), direct premiums written, on its 2014 Form 8963; and (5) the aggregate dollar amount of direct premiums written for expatriate health plans that is reported on the SHCE for 2015 for the covered entity and included in direct premiums written reported in column (f), direct premiums written, on the covered entity's 2015 Form 8963.

[40] IRS Notice 2015-43, 2015 IRB LEXIS 292 (June 30, 2015), provides additional, interim guidance regarding the application of certain PPACA provisions to expatriate health insurance issuers, expatriate health plans, and employers as sponsors of expatriate health plans. The Notice does not address the Section 9010 Fee so is not discussed herein.

[41] The regulations authorize the IRS to provide published guidance regarding the manner of reporting by a covered entity, Treas. Reg. § 57.3(a)(2). For the 2014 fee year the IRS exercised this authority to extend the due date for a covered entity's corrections to Form 8963 from July 15, 2014 to Aug. 18, 2014. Notice 2014-47, 35 I.R.B. 522.

[42] Treas. Reg. § 57.3(a)(1).

[43] PPACA § 9010(g)(4); Treas. Reg. § 57.3(a)(3). For the 2014 fee year, the IRS affirmatively published each covered entity's net premiums written, even though it was not required to do so. It seems likely the IRS would follow the same procedure for subsequent fee years rather than face requests for net premiums written information pursuant to the Freedom of Information Act.

[44] Treas. Reg. § 57.4(a)(2).

[45] Treas. Reg. § 57.7(a)-(b).

[46] Treas. Reg. § 57.6(a).

[47] Treas. Reg. § 57.6(c).

[48] Treas. Reg. § 57.9.

[49] 78 Fed. Reg. 71476, 71484.

[50] Treas. Reg. § 57.8.

[51] Treas. Reg. § 57.3(b)(1).

[52] Treas. Reg. § 57.3(b)(1).

[53] Treas. Reg. § 57.3(b)(2).

[54] Treas. Reg. §§ 57.3(b)(3), 57.7(e).

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