4371 shall attach at the time the premium payment is transferred to the foreign insurer or reinsurer (including transfers to any bank, trust fund, or similar recipient, designated by the foreign insurer or reinsurer), or to any nonresident agent, solicitor, or broker. A person required to pay tax under this section may remit such tax before the time the tax attaches if he keeps records consistent with such practice.

(c) *Payment of tax.* The tax imposed by section 4371 shall be paid on the basis of a return by the person who makes payment of the premium to a foreign insurer or reinsurer or to any nonresident agent, solicitor, or broker. If the tax is not paid by the person who paid the premium, the tax imposed by section 4371 shall be paid on the basis of a return by any person who makes, signs, issues, or sells any of the documents or instruments subject to the tax imposed by section 4371, or for whose use or benefit such document or instrument is made, signed, issued, or sold.

(d) *Penalty for failure to pay tax.* Any person who fails to comply with the requirements of this section with intent to evade the tax shall, in addition to other penalties provided therefor, pay a fine of double the amount of tax. (*See* section 7270.)

(e) *Effective date.* This section is applicable for premiums paid on or after November 27, 2002.

[T.D. 9024, 67 FR 70846, Nov. 27, 2002]

Subpart C—Fees on Insured and Self-insured Health Plans

SOURCE: T.D. 9602, 77 FR 72728, Dec. 6, 2012, unless otherwise noted.

§ 46.4375–1 Fee on issuers of specified health insurance policies.

(a) *In general.* An issuer of a specified health insurance policy is liable for a fee imposed by section 4375 for policy years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides definitions that apply for purposes of section 4375 and this section. Paragraph (c) of this section provides rules for calculating the fee under section 4375. Paragraph (d) of this section provides the applicability date. For rules relating to filing the required return and paying the fee, see §§ 40.6011(a)–1 and 40.6071(a)–1 of this chapter.

(b) *Definitions.* The following definitions apply for purposes of section 4375 and this section. See also § 46.4377–1 for additional definitions.

(1) *Specified health insurance policy*—(i) *In general.* Except as provided in paragraph (b)(1)(ii) of this section and § 46.4377–1, *specified health insurance policy* means any accident and health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States (as defined in § 46.4377–1(a)(2)), including prepaid health coverage arrangements described in paragraph (b)(2) of this section. *Specified health insurance policy* also includes any policy that provides accident and health coverage to an active employee, former employee, or qualifying beneficiary, as continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar continuation coverage under other Federal law or state law.

(ii) *Exceptions.* The term *specified health insurance policy* does not include—

(A) Any insurance policy if substantially all of its coverage is of excepted benefits described in section 9832(c);

(B) Any group policy issued to an employer where the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the United States (as defined in § 46.4377–1(a)(3));

(C) Any stop loss or indemnity reinsurance policy; or

(D) Any insurance policy to the extent it provides an employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

(iii) *Stop loss policy.* For purposes of paragraph (b)(1)(ii) of this section, *stop loss policy* means an insurance policy in which—

(A) The insurer that issues the policy to a person establishing or maintaining

a self-insured health plan becomes liable for all, or an agreed upon portion of, losses that person incurs in covering the applicable lives in excess of a specified amount; and

(B) The person establishing or maintaining the self-insured health plan retains its liability to, and its contractual relationship with, the applicable lives covered.

(iv) *Indemnity reinsurance policy.* For purposes of paragraph (b)(1)(ii) of this section, *indemnity reinsurance policy* means an agreement between two or more insurance companies under which—

(A) 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

(B) The issuing company retains its liability to, and its contractual relationship with, the applicable lives covered.

(2) *Prepaid health coverage arrangement.* The term *prepaid health coverage arrangement* means an arrangement under which fixed payments or premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident and health coverage to individuals residing in the United States, regardless of how such coverage is provided or arranged to be provided. For example, any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract is a specified health insurance policy.

(c) *Calculation of fee*—(1) *In general.* The amount of the fee for a policy for a policy year is equal to the product of the average number of lives covered under the policy for the policy year (determined in accordance with paragraphs (c)(2) and (c)(3) of this section) and the applicable dollar amount (determined in accordance with paragraph (c)(4) of this section). For purposes of computing the fee under this paragraph (c), in the case of an issuer that determines the average number of lives covered for all policies in effect during a calendar year using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section, the applicable dollar amount with respect to such issuer's policies for such calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year (determined in accordance with paragraph (c)(4) of this section), except that the applicable dollar amount with respect to such an issuer's policies for calendar year 2019 is the applicable dollar amount for policy years ending on September 30, 2019. For more information, see the examples in paragraphs (c)(2)(iii)(B), (c)(2)(iv)(B), (c)(2)(v)(B), and (c)(2)(vi)(B) of this section.

(2) *Determination of the average number of lives covered under a policy*—(i) *In general.* To determine the average number of lives covered under a specified health insurance policy during a policy year, an issuer must use one of the following methods—

(A) The actual count method (described in paragraph (c)(2)(iii) of this section);

(B) The snapshot method (described in paragraph (c)(2)(iv) of this section);

(C) The member months method (described in paragraph (c)(2)(v) of this section); or

(D) The state form method (described in paragraph (c)(2)(vi) of this section).

(ii) *Consistency requirements.* An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, ''Quarterly Federal Excise Tax Return,'' for a particular year, the issuer must use the same method of computing lives covered. An issuer that determines the average number of lives covered by using the actual count method described in paragraph (c)(2)(iii) of this section or the snapshot method described in paragraph (c)(2)(iv) of this section may change its method of computing the average lives covered to the snapshot method or actual count method, respectively, provided that the issuer uses the same method for computing the average lives covered for all policies for which a liability is reported on the Form 720 for that year. For example, an issuer with a policy having a

policy year that ends on June 30, Policy A, may determine the average number of lives covered under Policy A for July 1, 2013, to June 30, 2014, using the actual count method if the issuer uses the actual count method for all policies for which a liability will be reported on the Form 720 due by July 31, 2015 (the due date for return that will include the liability for the July 2013 to June 2014 policy year for Policy A). The issuer may change its method for determining the average number of lives covered under Policy A to the snapshot method for the July 1, 2014, to June 30, 2015, policy year, provided that the snapshot method is used for all policies for which a liability will be reported on the Form 720 due by July 31, 2016 (the due date for return that will include the liability for the July 2014 to June 2015 policy year for Policy A). An issuer that determines the average number of lives covered by using the member months method under paragraph (c)(2)(v) of this section or the state form method under paragraph (c)(2)(vi) of this section must use the same method for calculating lives covered for all policy years for which the fee applies.

(iii) *Actual count method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered for each day of the policy year and dividing that total by the number of days in the policy year.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iii)(A) of this section:

Example. Insurance Company A issues three policies that are in effect during 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company A must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company A chooses to use the actual count method under paragraph (c)(2)(iii)(A) of this section to determine average lives covered for policies having a policy year that ends in 2014. Insurance Company A calculates the sum of lives covered under Policy A for each day of the policy year ending November 30, 2014, as 3,285,000. The average number of lives covered under Policy A for the policy year ending November 30, 2014, is 3,285,000 divided by 365, or 9,000. Insurance Company A calculates the sum of lives covered under Policy B for each day of the policy year ending February 28, 2014, as 547,500. The average number of lives covered under Policy B for the policy year ending on February 28, 2014, is 547,500 divided by 365, or 1,500. Insurance Company A calculates the sum of lives covered under Policy C for each day of the policy year ending December 31, 2014, as 4,380,000. The average number of lives covered under Policy C for the policy year ending December 31, 2014, is 4,380,000 divided by 365, or 12,000. To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company A must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the average number of lives covered for that policy. Insurance Company A then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(iv) *Snapshot method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under a policy for a policy year by adding the totals of lives covered on a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter), and dividing that total by the number of dates on which a count is made. For purposes of this paragraph (c)(2)(iv)(A), each date used for the second, third and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must be within the same policy year. If an issuer uses multiple dates for the first quarter, the issuer must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within three days of such corresponding dates, and all dates used must be within the same policy year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31

is used as a counting date for a calendar year policy, June 30 is the corresponding date for the second quarter).

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(iv)(A) of this section:

Example. (i) Insurance Company B issues three policies with 12-month policy years that end in 2014, Group Health Insurance Policy A, which has a policy year from December 1 to November 30, Group Health Insurance Policy B, which has a policy year from March 1 to February 28, and Group Health Insurance Policy C, which has a policy year from January 1 to December 31. To calculate the average number of lives covered for 2014, Insurance Company B must calculate the average number of lives covered for each of its three policies for the policy year that ends in 2014. Insurance Company B chooses to determine the average lives covered using the snapshot method for all policies that have a policy year that ends in 2014 and chooses to count lives covered on a single date of the first month of each quarter of the policy years. Thus, for Policy A, Insurance Company B must count lives covered on a single date falling in each of December 2013, March 2014, June 2014 and September 2014; for Policy B, Insurance Company B must count lives covered on a single date falling in each of March 2014, June 2014, September 2014 and December 2014; and for Policy C, Insurance Company B must count lives covered on a single date falling in each of January 2014, April 2014, July 2014 and October 2014. In addition, the date for each of the second, third, and fourth quarters must fall within three days of the date in such quarter that corresponds to the date used for the first quarter, and must fall within the same policy year.

(ii) On December 6, 2013, Policy A covers 8,900 lives, on March 7, 2014, 9,100 lives, on June 6, 2014, 9,050 lives, and on September 5, 2014, 9,050 lives. Insurance Company B treats the average number of lives covered under Policy A for the policy year ending November 30, 2014, as 36,100 (8,900 + 9,100 + 9,050 + 9,050) divided by 4, or 9,025.

(iii) On March 4, 2013, Policy B covers 1,500 lives, on June 7, 2013, 1,350 lives, on September 6, 2013, 1,400 lives, and on December 6, 2013, 1,550 lives. Insurance Company B treats the average number of lives covered under Policy B for the policy year ending February 28, 2014, as 5,800 (1,500 + 1,350 + 1,400 + 1,550) divided by 4, or 1,450.

(iv) On January 6, 2014, Policy C covers 12,500 lives, on April 4, 2014, 12,250 lives, on July 7, 2014, 12,000 lives, and on October 3, 2014, 11,250 lives. Insurance Company B treats the average number of lives covered under Policy C for the policy year ending December 31, 2014, as 47,750 (12,500 + 12,250 + 12,000 + 11,250) divided by 4, or 12,000.

(v) To calculate the section 4375 fee under paragraph (c)(1) of this section for calendar year 2014, Insurance Company B must first determine the applicable dollar amount for each policy under paragraph (c)(4) of this section and multiply that amount by the number of average lives covered for that policy. Insurance Company B then adds the total fees for all three policies to determine the total fee under section 4375 that it must pay for calendar year 2014.

(v) *Member months method*—(A) *Calculation method.* An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

Example. Insurance Company C chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the member months method of paragraph (c)(2)(v)(A) of this section. Insurance Company C reports 12,000,000 as its member months on the NAIC Supplemental Health Care Exhibit filed for calendar year 2013. Under the member months method, Insurance Company C calculates the average number of lives covered for all its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company C multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(vi) *State form method*—(A) *Calculation method.* An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that

is filed with the issuer's state of domicile and a method similar to that described in paragraph (c)(2)(v) of this section, if the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

(B) *Example.* The following example illustrates the principles of paragraphs (c)(1) and (c)(2)(vi)(A) of this section:

Example. Insurance Company D is not required to file the NAIC Supplemental Health Care Exhibit, but files a form with its state of domicile. Insurance Company D chooses to determine the average number of lives covered for all years to which the section 4375 fee applies using the state form method of paragraph (c)(2)(vi)(A) of this section. The state form reports the number of lives covered in the same manner as member months is reported on the NAIC Supplemental Health Care Exhibit. For calendar year 2013, Insurance Company D reports 12,000,000 as its equivalent member months on the state form. Under the state form method, Insurance Company D calculates the average number of lives covered for all of its specified health insurance policies in force during calendar year 2013 by dividing 12,000,000 (equivalent member months) by 12 (number of months in the reporting period), which equals 1,000,000. To determine the section 4375 fee it must pay for calendar year 2013, Insurance Company D multiplies 1,000,000 by the applicable dollar amount that is in effect at the end of the calendar year under paragraph (c)(4) of this section.

(3) *Special rules for the first year and the last year the fee is in effect*—(i) *Calculation of the average number of lives covered under the policy for the first year the fee is in effect.* For issuers that determine the average number of lives covered using data reported on the 2012 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2012 calendar year, the average number of lives covered under all policies in effect for the 2012 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by ¼. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the actual count method under paragraph (c)(2)(iii) of this section may calculate the average number of lives covered using data from the period beginning May 14, 2012, through the end of the policy year. For policy years beginning before May 14, 2012, and ending on or after October 1, 2012, issuers that determine the average number of lives covered using the snapshot method under paragraph (c)(2)(iv) of this section may calculate the average number of lives covered using dates from the quarters remaining in the policy year starting on or after May 14, 2012. If an abbreviated year is used, the issuer will divide the number of lives covered by the number of days from May 14, 2012, through the end of the policy year (for the actual count method) or the number of days on which a count was made (for the snapshot method).

(ii) *Calculation of the average number of lives covered under the policy for the last year the fee is in effect.* For issuers that determine the average number of lives covered using data reported on the 2019 NAIC Supplemental Health Care Exhibit or a permitted state form that covers the 2019 calendar year, the average number of lives covered for all policies in effect during the 2019 calendar year equals the average number of lives covered for that year (as determined under paragraph (c)(2)(v) or (vi) of this section) multiplied by ¾. The resulting number is deemed to be the average number of lives covered for policies with policy years ending on or after January 1, 2019, and before October 1, 2019.

(iii) *Examples.* The following examples illustrate the principles of paragraph (c)(3) of this section:

Example 1. Insurance Company E issues Group Health Insurance Policy C, which has a policy year that ends on November 30, 2012. Insurance Company E determines the average number of lives covered under a policy by using the actual count method. Under that method, for that policy year, Insurance Company E calculates the sum of lives covered under Policy C for each day between May 14, 2012, and November 30, 2012, as 10,000. The average number of lives covered under Policy C for that policy year is 10,000 divided by the number of days from May 14, 2012, through November 30, 2012. Alternatively, Insurance Company E could have counted the

number of lives covered for the entire policy year and divided the sum by 365.

Example 2. Insurance Company F reports 12,000,000 as its member months on its NAIC Supplemental Health Care Exhibit filed for calendar year 2012. Under the member months method, Insurance Company F calculates the average number of lives covered for 2012 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), and then multiplying the result (1,000,000) by ¼, which equals 250,000. Accordingly, the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013, is 250,000.

(4) *Applicable dollar amount.* For policy years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1. For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2. For any policy year ending in any Federal fiscal year beginning on or after October 1, 2014, the applicable dollar amount is the sum of—

(i) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; and

(B) The percentage increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the Federal fiscal year.

(d) *Effective/Applicability date.* This section applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019.

§ 46.4376–1 Fee on sponsors of self-insured health plans.

(a) *In general*—(1) *General rule.* A plan sponsor of an applicable self-insured health plan is liable for a fee imposed by section 4376 for plans with plan years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides the definitions that apply for purposes of section 4376 and this section. Paragraph (c) of this section provides the requirements for calculating the fee imposed by section 4376. Paragraph (d) of this section provides the applicability date. For rules relating to filing the required return and paying the fee, see §§ 40.6011(a)–1 and 40.6071(a)–1.

(2) [Reserved]

(b) *Definitions.* The following definitions apply for purposes of section 4376 and this section. See § 46.4377–1 for additional definitions.

(1) *Applicable self-insured health plan*—(i) *In general.* Except as provided in paragraph (b)(1)(ii) of this section and § 46.4377–1, *applicable self-insured health plan* means a plan that provides for accident and health coverage (within the meaning of § 46.4377–1(a)) if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained—

(A) By one or more employers for the benefit of their employees or former employees;

(B) By one or more employee organizations for the benefit of their members or former members;

(C) Jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees;

(D) By a voluntary employees' beneficiary association, as described in section 501(c)(9);

(E) By an organization described in section 501(c)(6); or

(F) By a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA)), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural cooperative association (as defined in section 3(40)(B)(v) of ERISA).

(ii) *Exceptions.* The term *applicable self-insured health plan* does not include any of the following:

(A) A plan that provides benefits substantially all of which are excepted benefits, as defined in section 9832(c). For example, a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) that satisfies the requirements to be treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) of this chapter is not an applicable self-insured health plan. A health FSA that is not treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) is an applicable self-insured health plan.