the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in §1.6695–1 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§56.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules relating to claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under chapter 41 of subtitle D of the Internal Revenue Code, the rules under §1.6696–1 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§56.7701–1 Tax return preparer.

(a) *In general.* For the definition of a tax return preparer, see §301.7701–15 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

PART 57—HEALTH INSURANCE PROVIDERS FEE

Sec.

AUTHORITY: 26 U.S.C. 7805; sec. 9010, Pub. L. 111–148 (124 Stat. 119 (2010)).

Section 57.3 also issued under 26 U.S.C. 6071(a)

Section 57.7 also issued under 26 U.S.C. 6302(a).

Section 57.6302–1 also issued under 26 U.S.C. 6302(a).

SOURCE: T.D. 9643, 78 FR 71487, Nov. 29, 2013, unless otherwise noted.

§57.1 Overview.

(a) The regulations in this part are designated ''Health Insurance Providers Fee Regulations.''

(b) The regulations in this part provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references to section 9010 in this part 57 are references to section 9010 of the ACA. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections are references to subtitles, chapters, subchapters and sections in the Internal Revenue Code and the related regulations.

(c) Section 9010(e)(1) sets an applicable fee amount for each year, beginning with 2014, that will be apportioned among covered entities with aggregate net premiums written over $25 million for health insurance for United States health risks. Generally, each covered entity is liable for a fee in each fee year that is based on its net premiums written during the data year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

§57.2 Explanation of terms.

(a) *In general.* This section explains the terms used in this part 57 for purposes of the fee.

(b) *Covered entity*—(1) *In general.* Except as provided in paragraph (b)(2) of this section, the term *covered entity* means any entity with net premiums written for health insurance for United

States health risks in the fee year if the entity is—

(i) A health insurance issuer within the meaning of section 9832(b)(2), defined in section 9832(b)(2) as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA));

(ii) A health maintenance organization within the meaning of section 9832(b)(3), defined in section 9832(b)(3) as—

(A) A Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) An organization recognized under State law as a health maintenance organization; or

(C) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization;

(iii) An insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a);

(iv) An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or

(v) A multiple employer welfare arrangement (MEWA), within the meaning of section 3(40) of ERISA, to the extent not fully insured, provided that for this purpose a covered entity does not include a MEWA that with respect to the plan year ending with or within the section 9010 data year satisfies the requirements to be exempt from reporting under 29 CFR 2520.101–2(c)(2)(ii)(A), (B), or (C).

(2) *Exclusions*—(i) *Self-insured employer.* The term *covered entity* does not include any entity (including a voluntary employees' beneficiary association under section 501(c)(9) (VEBA)) that is part of a self-insured employer plan to the extent that such entity self-insures its employees' health risks. The term *self-insured employer* means an employer that sponsors a self-insured medical reimbursement plan within the meaning of §1.105–11(b)(1)(i) of this chapter. Self-insured medical reimbursement plans include plans that do not involve shifting risk to an unrelated third party as described in §1.105–11(b)(1)(ii) of this chapter. A self-insured medical reimbursement plan may use an insurance company or other third party to provide administrative or bookkeeping functions. For purposes of this section, the term *self-insured employer* does not include a MEWA.

(ii) *Governmental entity.* The term *covered entity* does not include any governmental entity. For this purpose, the term *governmental entity* means—

(A) The government of the United States;

(B) Any State or a political subdivision thereof (as defined for purposes of section 103) including, for example, a State health department or a State insurance commission;

(C) Any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)); or

(D) Any agency or instrumentality of any of the foregoing.

(iii) *Certain nonprofit corporations.* The term *covered entity* does not include any entity—

(A) That is incorporated as a nonprofit corporation under a State law;

(B) No part of the net earnings of which inures to the benefit of any private shareholder or individual (within the meaning of §§1.501(a)–1(c) and 1.501(c)(3)–1(c)(2) of this chapter);

(C) No substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (within the meaning of §1.501(c)(3)–1(c)(3)(ii) of this chapter) (or which is described in section 501(h)(3) and is not denied exemption under section 501(a) by reason of section 501(h));

(D) That does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office (within the meaning of §1.501(c)(3)–1(c)(3)(iii) of this chapter); and

(E) More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(iv) *Certain voluntary employees' beneficiary associations (VEBAs).* The term *covered entity* does not include any entity that is described in section 501(c)(9) that is established by an entity (other than by an employer or employers) for purposes of providing health care benefits. This exclusion applies to a VEBA that is established by a union or established pursuant to a collective bargaining agreement and having a joint board of trustees (such as in the case of a multiemployer plan within the meaning of section 3(37) of ERISA or a single-employer plan described in section 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. 186(c)(5)). This exclusion does not apply to a MEWA.

(3) *State.* Solely for purposes of paragraph (b) of this section, the term *State* means any of the 50 States, the District of Columbia, or any of the possessions of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(c) *Controlled groups*—(1) *In general.* The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(2) *Treatment of controlled group.* A controlled group (as defined in paragraph (c)(1) of this section) is treated as a single covered entity for purposes of the fee.

(3) *Special rules.* For purposes of paragraph (c)(1) of this section (related to controlled groups)—

(i) A foreign entity subject to tax under section 881 is included within a controlled group under section 52(a) or (b); and

(ii) A person 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 December 31st of the data year.

(d) *Data year.* The term *data year* means the calendar year immediately before the fee year. Thus, for example, 2013 is the data year for fee year 2014.

(e) *Designated entity*—(1) *In general.* The term *designated entity* means the person within a controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to—

(i) Filing Form 8963, ''Report of Health Insurance Provider Information'';

(ii) Receiving IRS communications about the fee for the group;

(iii) Filing a corrected Form 8963 for the group, if applicable, as described in §57.6; and

(iv) Paying the fee for the group to the government.

(2) *Selection of designated entity*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, each controlled group must select a designated entity by having that entity file the Form 8963 in accordance with the form instructions. The designated entity must state under penalties of perjury that all persons that provide health insurance for United States health risks that are members of the group have consented to the selection of the designated entity. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity. The designated entity must maintain a record of all member consents.

(ii) *Requirement for consolidated groups; common parent.* If a controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group the common parent of which files a consolidated return for Federal income tax purposes, the designated entity is the agent for the group (within the meaning of §1.1502–77 of this chapter) for the data year.

(iii) *Failure to select a designated entity.* Excepted as provided in paragraph (e)(2)(ii) of this section, if a controlled group fails to select a designated entity as provided in paragraph (e)(2)(i) of this section, then the IRS will select a member of the controlled group to be the designated entity. If the IRS selects the designated entity, then all members of the controlled group that provide health insurance for a United States health risk will be deemed to

have consented to the IRS's selection of the designated entity.

(f) *Fee*. The term *fee* means the fee imposed by section 9010 on each covered entity engaged in the business of providing health insurance.

(g) *Fee year*. The term *fee year* means the calendar year in which the fee must be paid to the government. The first fee year is 2014.

(h) *Health insurance*—(1) *In general*. Except as provided in paragraph (h)(2) of this section, the term *health insurance* generally has the same meaning as the term *health insurance coverage* in section 9832(b)(1)(A), defined to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, when these benefits are offered by an entity that is one of the types of entities described in paragraph (b)(1)(i) through (b)(1)(v) of this section. The term *health insurance* includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) *Exclusions*. The term *health insurance* does not include—

(i) Coverage only for accident, or disability income insurance, or any combination thereof, within the meaning of section 9832(c)(1)(A);

(ii) Coverage issued as a supplement to liability insurance within the meaning of section 9832(c)(1)(B);

(iii) Liability insurance, including general liability insurance and automobile liability insurance, within the meaning of section 9832(c)(1)(C);

(iv) Workers' compensation or similar insurance within the meaning of section 9832(c)(1)(D);

(v) Automobile medical payment insurance within the meaning of section 9832(c)(1)(E);

(vi) Credit-only insurance within the meaning of section 9832(c)(1)(F);

(vii) Coverage for on-site medical clinics within the meaning of section 9832(c)(1)(G);

(viii) Other insurance coverage that is similar to the insurance coverage in paragraph (h)(2)(i) through (vii) of this section under which benefits for medical care are secondary or incidental to other insurance benefits, within the meaning of section 9832(c)(1)(H), to the extent such insurance coverage is specified in regulations under section 9832(c)(1)(H);

(ix) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section 9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C);

(x) Coverage only for a specified disease or illness within the meaning of section 9832(c)(3)(A);

(xi) Hospital indemnity or other fixed indemnity insurance within the meaning of section 9832(c)(3)(B);

(xii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan, within the meaning of section 9832(c)(4);

(xiii) Coverage under an employee assistance plan, a disease management plan, or a wellness plan, if the benefits provided under the plan constitute excepted benefits under section 9832(c)(2) (or do not otherwise provide benefits consisting of health insurance under paragraph (h)(1) of this section);

(xiv) Student administrative health fee arrangements, as defined in paragraph (h)(3);

(xv) Travel insurance, as defined in paragraph (h)(4) of this section; or

(xvi) Indemnity reinsurance, as defined in paragraph (h)(5)(i) of this section.

(3) *Student administrative health fee arrangement*. For purposes of paragraph (h)(2)(xiv) of this section, the term *student administrative health fee arrangement* means an arrangement under which an educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the

student purchases any available student health insurance coverage).

(4) *Travel insurance.* For purposes of paragraph (h)(2)(xv) of this section, the term *travel insurance* means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term *travel insurance* does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

(5) *Reinsurance*—(i) *Indemnity reinsurance.* For purposes of paragraphs (h)(2)(xvi) and (k) of this section, the term *indemnity reinsurance* means an agreement between one or more reinsuring companies and a covered entity 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 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.

(ii) *Assumption reinsurance.* For purposes of paragraph (k) of this section, the term *assumption reinsurance* means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(i) *Located in the United States.* The term *located in the United States* means present in the United States (within the meaning of paragraph (m) of this section) under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937–1(c)(3)(i) of this chapter (for presence in a possession of the United States).

(j) *NAIC.* The term *NAIC* means the National Association of Insurance Commissioners.

(k) *Net premiums written*—The term *net premiums written* means 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. For this purpose, MLR rebates are computed on an accrual basis in determining net premiums written. Because indemnity reinsurance within the meaning of paragraph (h)(5)(i) of this section is not health insurance under paragraph (h)(1) of this section, the term *net premiums written* does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, in the case of assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section, the term *net premiums written* does include premiums written for assumption reinsurance and is reduced by assumption reinsurance premiums ceded.

(l) *SHCE.* The term *SHCE* means the Supplemental Health Care Exhibit. The SHCE is a form published by the NAIC that most covered entities are required to file annually under State law.

(m) *United States.* For purposes of paragraph (i) of this section, the term *United States* means 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.

(n) *United States health risk.* The term *United States health risk* means the health risk of any individual who is—

(1) A United States citizen;

(2) A resident of the United States (within the meaning of section 7701(b)(1)(A)); or

(3) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

§57.3 Reporting requirements and associated penalties.

(a) *Reporting requirement*—(1) *In general.* Annually, each covered entity, including each controlled group that is treated as a single covered entity,