DAVIS & HARMAN LLP

PRIVILEGED AND CONFIDENTIAL

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MEMORANDUM

PPACA IMPOSES NEW ANNUAL FEE ON CERTAIN HEALTH INSURERS

Beginning in 2014, an annual fee will be imposed on "covered entities" in connection with the provision of "health insurance" with respect to "United States health risks."[1] The fee – which is treated as a nondeductible excise tax[2] – will be imposed for calendar years beginning after 2013.[3] As discussed below, application of the fee largely turns on the definition of certain key terms and the amount of a covered entity's "net premiums written" with respect to health insurance. Although the statutory language and the legislative history provide a general framework for understanding the scope and mechanics of the annual fee, significant questions remain.

WHICH ENTITIES ARE POTENTIALLY SUBJECT TO THE ANNUAL FEE?

Covered Entity. The annual fee is generally applicable to any "covered entity." A covered entity is defined generally to be any entity that provides "health insurance" for any "United States health risk."

Health Insurance. Significantly, the statute does not include an affirmative definition of what constitutes "health insurance" for purposes of the new annual fee. Rather, the statute defines health insurance in the negative, *i.e.*, by reference to what is not health insurance. Specifically, health insurance is defined to exclude the following:

- Coverage for "HIPAA-excepted" accident or disability income (or a combination thereof), specified disease or illness, and hospital/fixed indemnity coverage (as defined in Internal Revenue Code ("Code") sections 9832(c)(1)(A) and (3) respectively);[4]

- "Long-term care" (which is not defined by reference to Code section 9832 or otherwise and which, therefore, appear to encompass both qualified and nonqualified coverage);[5] and

- Medicare supplemental coverage defined by reference to section 1882(g)(1) of the Social Security Act, and thus would encompass "HIPAA-excepted" Medicare supplemental

[1] Section 9010 of the Patient Protection and Affordable Care Act ("PPACA"). PPACA, as amended by the Health Care Education and Reconciliation Act of 2010 ("HCERA"), was signed into law by President Obama on March 23, 2010 of this year. A copy is attached.

[2] PPACA section 9010(f)(1).

[3] PPACA section 9010(a)(1).

[4] PPACA section 9010(h)(3)(A).

[5] PPACA section 9010(h)(3)(B).

coverage as defined in Code section 9832(c)(4), but would not include other supplemental coverage described in section 9832(4)(4), Medicare Advantage, or Part D plans).[6]

The legislative history provides some guidance as to what types of insurance likely constitute health insurance for purposes of the new annual fee. Specifically, the Joint Committee on Taxation's technical explanation and the Senate Committee on Finance's report state that health risks are intended to include comprehensive (hospital and medical), vision, dental, Federal Employees Health Benefit plan, Medicare, Medicaid, and other health.[7] Nonetheless, many questions are likely to remain unanswered regarding what constitutes health insurance for purposes of the annual fee unless and until additional guidance is issued.

United States Health Risk. To be a covered entity, one must derive premiums from health insurance with respect to a "United States heath risk." The term "United States health risk" is defined by statute to mean the health risk of an individual who is a United States citizen, a United States resident (whether or not located in the United States), or located in the United States (with respect to the period that the individual is located in the United States).[8] For purposes of the provision, the term "United States" is defined broadly to include the individual states, the District of Columbia, Puerto Rico, and "the possessions of the United States," *i.e.*, territories.[9]

Certain Entities Are Excepted from Being a Covered Entity. The statute expressly excepts the following entities from the definition of covered entity:

- Employers that self-insure their employees' health risks,[10]
- Governmental entities,[11]
- Certain nonprofits that derive gross revenues primarily from government programs targeted to the poor, elderly, or disabled,[12] and

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[6] PPACA section 9010(h)(3)(C).

[7] Notably, the Senate Committee on Finance's report indicates that the term "health risk" was intended to also include Medicare supplemental insurance. *See* S. REP. NO. 111-89, at 348 (2009). The report, however, was based on the original bill, as introduced by Senate Finance Committee Chairman Max Baucus. As part of the reconciliation legislation, *i.e.*, HCERA, Congress amended PPACA section 9010 to expressly except Medicare supplemental insurance from the term "health insurance" only for purposes of the annual fee. Notably, the technical explanation issued by the Joint Committee on Taxation, which was issued after the passage of HCERA, does not include a reference to Medicare supplemental insurance as "health insurance" for purposes of PPACA section 9010. *See* Staff of Jt. Com. on Tax'n, 111th Cong., 2d. Sess., Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act", at 89 (Jt. Com. Print, JCX-18-10, Mar. 21, 2010) .

Jt. Com. on Tax'n, at 89.

[8] PPACA section 9010(d).

[9] PPACA section 9010(h)(2).

[10] PPACA section 9010(c)(2)(A).

[11] PPACA section 9010(c)(2)(B)

[12] PPACA section 9010(c)(2)(C). A nonprofit excepted from the fee is an entity (i) which is incorporated as a nonprofit corporation under a state law, (ii) no part of the net earnings of which inures to the benefit of any private

- Voluntary employee beneficiary associations ("VEBAs"), but not if established by an employer or employers.[13]

Controlled Group Rules Apply When Determining Covered Entity Status But Not When Applying Statutory Exceptions. For purposes of the annual fee provision, all persons treated as a single employer under Code sections 52(a) or (b) and 414(m) or (o) are treated as a single covered entity, and the otherwise applicable exclusion of foreign corporations under those rules is disregarded.[14] In general, these cross references incorporate a greater than 50% common control test. As noted above, certain entities are statutorily excepted from being covered entities for purposes of the new annual fee. The Joint Committee on Taxation's technical explanation makes clear that the exceptions to the definition of covered entity are applied on a separate entity basis only, rather than on a controlled group basis.[15]

Imposition of Joint and Several liability for Controlled Group Members. The statute also provides that if more than one person is liable for payment of the fee by reason of being treated as a single covered entity, all such persons are jointly and severally liable for payment of the fee.[16] Thus, although not entirely clear, it appears that an entity could be jointly and severally liable for any fee owed by a controlled group member, even where the entity is itself statutorily excepted from being a covered entity.

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shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise permitted in Code section 501(h)), and which 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, and (iii) 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.

[13] PPACA section 9010(c)(2)(D). VEBAs established solely by an employer or employers do not fall within this exception to the annual fee.

[14] PPACA section 9010(c)(3). Code sections 52(a), 52(b), and 414(m) provide criteria for determining whether trades or businesses are under common control, including corporations (with a 50% controlled group threshold), partnerships, and affiliated service groups. Code section 414(o) provides for regulations to prevent avoidance of qualification requirements through use of separate organizations, employee leasing, or other arrangements. By referencing Code sections 52(a) and (b) for this purpose versus Code sections 414(a) and (b), it appears that Congress intended for the use of a stricter 50% common control test (relative to the 80% test that applies for purposes of Code sections 414(a) and (b)). As a result, there is a greater likelihood that entities will be treated as part of a common controlled group for purposes of the new annual fee. (Compare this to PPACA section 9014, which expressly uses an 80% common controlled group test for purposes of the new deduction limitation on remuneration paid by health insurers.)

[15] Jt. Com. on Tax'n, at 91. It would appear to be the case that a parent company that is a covered entity cannot avoid being a covered entity by reason of the fact that one or more members of its controlled group is statutorily excepted from being a covered entity. It is not entirely clear, however, whether any net premiums written of such excepted controlled group members are taken into account for purposes of determining any annual fee that would apply to the controlled group as a whole (although the answer would appear to be that such premiums are disregarded).

[16] PPACA section 9010(c)(4).

HOW MUCH IS THE ANNUAL FEE?

The Total Annual Fee. The fee is established as an aggregate annual fee that will be apportioned among all covered entities required to pay the fee in each calendar year beginning after 2013.[17] The aggregate annual fee is $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.[18] After 2018, the fee is indexed to the rate of premium growth.[19]

The Aggregate Amount of the Annual Health Insurer Fee for Each Year						
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019+**
Total fee in $ billions	**$8.0**	**$11.3**	**$11.3**	**$13.9**	**$14.3**	**Indexed to medical premium inflation**

The annual payment date for a calendar year will be determined by the Secretary of the Treasury, but will be prior to October 1 of each calendar year.[20]

How to Apportion the Annual Fee. Apportionment of the aggregate annual fee among all covered entities subject to the fee will be based on an entity's relative market share of the United States health insurance business. Specifically, a covered entity will pay a fee for a calendar year that bears the same ratio to the aggregate amount as (i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the *preceding* calendar year, bears to (ii) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such *preceding* calendar year.[21]

Tiered Structure for Determining a Covered Entity's Net Premiums Written, Including the $25 Million Special Exception. In determining a covered entity's net premiums written, the statute provides a tiered structure based on the aggregate annual premiums received by an insurer from the provision of health insurance for any United States health risk. Unfortunately, the statutory language is a bit unclear in this regard, and thus is open to differing interpretations.

[17] PPACA section 9010(b), (e).

[18] PPACA section 9010(e)(1).

[19] PPACA section 9010(e)(2).

[20] PPACA section 9010(a)(2).

[21] PPACA section 9010(b).

The statute provides:

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000.	.50 percent
More than $50,000,000	.100 percent

What is clear based on the foregoing is that even if an entity is a covered entity, it will not be liable for any annual fee to the extent that it does not derive premiums in excess of $25 million annually from the provision of health insurance for any United States health risk.[22] This is confirmed in the technical explanation provided by the Joint Committee on Taxation, "a covered entity's net premiums written during the calendar year that are not more $25 million are not taken into account for this purpose."

What is somewhat less clear, however, is whether an insurer with aggregate premiums exceeding $25 million can also take advantage of the special rule excepting the first $25 million for purposes of determining one's share of the annual fee. Similarly unclear is whether an entity with aggregate premiums in excess of $50 million can disregard the first $25 million of premiums and also apply the reduced 50 percent multiplier to up to $25 million of additional premiums.

The answer to the above question will materially alter the amount of a covered entity's net premiums written for purposes of apportioning the annual fee. For example, assume an insurer has aggregate net premiums written of $60 million annually. To the extent that the insurer is precluded from utilizing the $25 million exception and the 50 percent reduced multiplier on premiums from $25 million to $50 million, the insurer's net premiums written would be equal to the full $60 million. However, to the extent that the insurer is able to take advantage of the exception and the reduced multiplier, the insurer's net premiums written are reduced to only $22.5 million [($60 million - $25 million – ($25 million x 50 percent) = $22.5 million)].

Significantly, the legislative history appears to support a reading of the statute that an insurer may utilize the $25 million exception and the reduced 50 percent multiplier regardless of aggregate annual premiums. In its technical explanation, the Joint Committee on Taxation appears to construe the statutory language cited above to make available to a single covered entity both exceptions regardless of aggregate annual premiums. Specifically, the technical explanation states: "[w]ith respect to a covered entity's net premiums written during the calendar year that are more than $25 million but not more than

[22] PPACA section 9010(b)(2)(A).

$50 million, 50 percent are taken into account, and 100 percent of net premiums written in excess of $50 million are taken into account."[23]

Special Rule for Certain Tax-Exempt Covered Entities. With respect to certain entities, a special exclusion applies to further reduce the amount of net premiums written that are taken into account for purposes of determining the amount of any annual fee.[24] Specifically, the special exclusion provides that, *after applying the above dollar thresholds*, any remaining net premiums written are reduced by 50% where attributable to the exempt activities of the following tax-exempt organizations:

- Code section 501(c)(3) charities;
- Code section 501(c)(4) social welfare organizations;
- Code section 501(c)(26) high-risk health insurance pools;[25] and
- Code section 501(c)(29) consumer operated and oriented plan ("CO-OP") health insurance issuers.[26]

Additional Considerations Regarding Apportionment of the Fee. Because the amount of net premiums written is determinative of how much of the annual fee will be apportioned to a covered entity, it is important to ascertain the amount of net premiums written. Notably, the legislative history also makes clear that net premiums written do not include amounts arising under arrangements that are not treated as insurance, *i.e.*, in the absence of sufficient risk shifting and distribution.[27] Thus, cost-plus arrangements and the like are unlikely to constitute new premiums written for purposes of the annual fee.

The statute is silent regarding the treatment of reinsurance. The legislative history, however, includes an express statement indicating that reinsurers would be liable for the fee to the extent of ceded net premiums written (subject to the minimum $25 million threshold as discussed above).[28] Specifically, both the Joint Committee on Taxation's technical explanation and the Senate Finance Committee report state that the term net premiums written "is intended to mean

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[23] Jt. Com. on Tax'n, at 89-90. We note that this reading is consistent with a policy that avoids "cliffs" (*i.e.*, this reading does not result in a substantial increase at precisely the point where the insurer receives one additional dollar of premium beyond $25 million or $50 million).

[24] PPACA section 9010(b)(2)(B).

[25] A high-risk health insurance pool is a state-sponsored membership organization providing medical coverage to persons with medical conditions or histories that effectively shut such persons out of commercial insurance markets (or that cause such persons to be able to acquire coverage only at a rate substantially in excess of the rate for such coverage through the pool). Certain criteria set forth in Code section 501(c)(26) must be satisfied for exemption.

[26] Code section 501(c)(29) was added by PPACA section 1322(h), and provides a tax exemption for CO-OP health insurance issuers. Generally, CO-OP health insurance issuers are certain health insurance issuers (i) organized under state law as nonprofit, member corporations, (ii) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each state in which the issuers are licensed to issue such plans, (iii) that meet other requirements set forth in PPACA section 1322, and (iv) that meet certain criteria for exemption set forth in Code section 501(c)(29) (including having received a loan or a grant under the CO-OP program).

[27] S. Rep. No. 111-89, at 347; Jt. Com. on Tax'n, at 89.

[28] S. REP. NO. 111-89, at 347; Jt. Com. on Tax'n, at 89.

premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions."[29] Although a bit unclear, it appears that the $25 million exception (along with the reduced 50 percent multiplier discussed above) that applies to covered entities generally under PPACA section 9010 would apply to reinsurers. If so, reinsurers, like original issuers, would only be subject to the annual fee to the extent they have qualifying net premiums written in excess of the $25 million threshold.[30]

Who Calculates the Fee? The Secretary of the Treasury is responsible for calculating the amount of each covered entity's fee for any given calendar year, which is done on the basis of reports submitted by the covered entity and "through the use of any other source of information available to the Treasury Department."[31] Per the legislative history, "[i]t is intended that the Treasury Department [shall] be able to rely on published aggregate annual statement data to the extent necessary, and may use annual statement data and filed annual statements that are publicly available to verify or supplement the reports submitted by covered entities."[32]

Mandatory Reporting. The amount of net premiums written must be reported annually to the Secretary of the Treasury for purposes of determining the fee,[33] and an accuracy-related penalty applies in the case of an understatement of a covered entity's net premiums written.[34] If the reporting requirements are not satisfied, subject to an exception for reasonable cause, the covered entity will be subject to a penalty equal to $10,000 plus the lesser of (i) $1,000 multiplied by the number of days during which the failure continues, or (ii) the amount of the fee.[35] It is important to note that Code section 6103, regarding confidentiality of returns and return information, does not apply to the information reported as described in this paragraph.[36]

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[29] *See* Id.

[30] The treatment of reinsurance under the new annual fee provision raises some interesting issues. Most notably, it appears to provide opportunities for issuers of record to lower the amount of any annual fee (to potentially $0) by reinsuring some or all of their qualifying health insurance. This would appear to be the case even where the respective reinsurer's aggregate qualifying premiums (from reinsurance or otherwise) fall below the minimum $25 million threshold. Take, for example, an issuer who is a covered entity and would have net premiums written of $45 million but for the fact that it cedes $20 million of such premiums to a reinsurer who reinsures no other qualifying health insurance and has no other net premiums written of its own. Under this scenario, based on the language of the statute, it appears that the issuer may be able to avoid the annual fee altogether by reason of the reinsurance agreement (because its net premiums written would be below the minimum $25 million threshold after taking into account the $20 million of ceded premiums). Moreover, it appears that the reinsurer also would not be subject to the annual fee since its net premiums written are less than the $25 million threshold. Significantly, this would seem to shift liability for the annual fee to all other issuers who are covered entities and subject to the fee, resulting in such other issuers having to bear a greater percentage of the aggregate annual fee.

[31] PPACA section 9010(b)(3).

[32] S. REP. NO. 111-89, at 347; Jt. Com. on Tax'n, at 89.

[33] PPACA section 9010(g)(1).

[34] PPACA section 9010(g)(3).

[35] PPACA section 9010(g)(2)(A).

[36] PPACA section 9010(g)(4).

Treatment as a Nondeductible Excise Tax. As briefly noted above, the statute expressly provides that the annual fee shall be treated as a nondeductible excise tax.[37] This effectively increases the relative cost of the fee for taxable insurers because they will not be permitted to deduct any annual fee paid as an ordinary and necessary business expense for purposes of determining their federal tax liability. Should they recoup the fee in higher premiums, it will in effect increase their fee the following year.

Treasury Provided with Authority to Publish Necessary Guidance. The provision provides authority for the Secretary of the Treasury to publish guidance necessary to carry out the purposes of the provision and to prescribe regulations necessary or appropriate to prevent avoidance of the purposes of the provision, including inappropriate actions taken to qualify as an exempt entity under the provision.[38]

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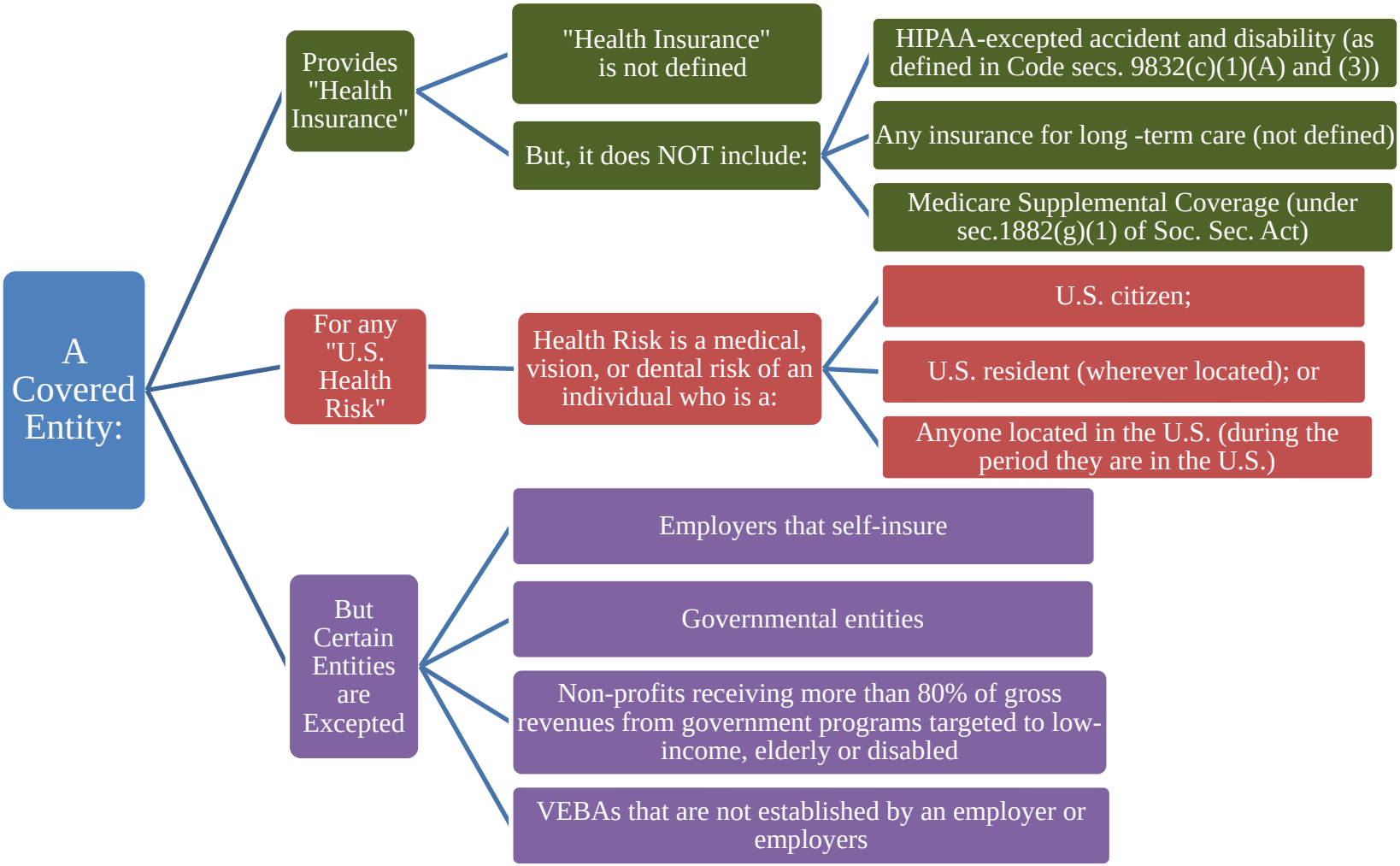
[37] PPACA section 9010(f)(2).

[38] PPACA section 9010(i).

Which Entities Are Potentially Subject to the Fee?



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Section 9010 of the Patient Protection and Affordable Care Act (PPACA) as excerpted from the consolidated PPACA and Health Care and Education Reconciliation Act of 2010 (HCERA) document as prepared by the House Office of the Legislative Counsel[39]

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b). **[***Amended by section 10905(f)(1) and section 1406(a)(1) of HCERA***]**

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—**[***Replaced by section 10905(b)***]**

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—**[***As revised by section 1406(a)(2) of HCERA***]**

(A) IN GENERAL.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

[39] Document number F:\P11\NHI\COMP\PPACA-CONSOLIDATED_003.XML is a copy of the Patient Protection and Affordable Care Act (Public Law 111-148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), as prepared by the House Office of the Legislative Counsel and posted to the United States Senate Committee on Finance's website, including a disclaimer that this is not an official document of the House of Representatives or its committees and may not be cited as "the law".

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000 ……	0 percent
More than $25,000,000 but not more than $50,000,000.	50 percent
More than $50,000,000 ……	100 percent.

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—**[***As revised by section 1406(a)(3) of HCERA***]**

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity, **[***As revised by section 10905(f)(2)***]**

(C) any entity— **[***Subparagraphs (C) through (E) revised by section 10905(c) and subsequently rewritten in entirety, including striking subparagraph (E), by section 1406(a)(3) of HCERA***]**

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual,

no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which 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, and

(iii) 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, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)). **[***Note: sentence at end should have been inserted at end of this subparagraph***]**

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

If any entity described in **[***executed to reflect probable intent of amendment made by section 1406(a)(3)(C)***]** subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section. **[***Previous sentence added by section 10905(f)(3) ''at the end'' of this paragraph; likely placement should have been at end of subparagraph (A).***]**

(4) JOINT AND SEVERAL LIABILITY.—**[***As added by section 1406(a)(3)(D) of HCERA***]** If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, 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) of the Internal Revenue Code of 1986), or
(3) located in the United States, with respect to the period such individual is so located.

(e) APPLICABLE AMOUNT.—**[***Replaced by section 10905(b) and subsequently revised by section 1306(a)(4) of HCERA***]** For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

Calendar year	**Applicable amount**
2014	$8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000.

(2) YEARS AFTER 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—
(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and
(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—
(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk for such calendar year. **[***As revised by section 10904(f)(4)***]**
(2) PENALTY FOR FAILURE TO REPORT.—
(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report,

an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—**[***As added by section 1406(a)(5) of HCERA*]

(A) IN GENERAL.—In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.—**[***As added by section 1406(a)(5) of HCERA***]** Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—**[***Replaced by section 10905(d)***]** The term "health insurance" shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2). **[***As revised by section 10905(e)***]**

(j) EFFECTIVE DATE.—**[***Replaced by section 1406(a)(6) of HCERA; previous amendment by section 19095(f)(5)(A) was unexecutable***]** This section shall apply to calendar years beginning after December 31, 2013.