

**American Benefits Council
and
America's Health Insurance Plans**

**Joint Briefing on
Potentially Broad Reach of New Compensation
Deduction Limits on Entities
Receiving Health Insurance Premiums**



Randy Hardock & Seth Perretta

**DAVIS &
HARMAN** LLP



Overview

- New Code section 162(m)(6) limits deduction for certain compensation paid by health insurance companies
 - **Ostensibly aimed at insurers providing major medical coverage**
 - **But statutory language could sweep in numerous entities that would not generally be considered health insurers**
- For entities that are subject to the 162(m)(6) limits, the financial and administrative burdens could be substantial
- Agenda today:
 - **Overview of section 162(m)**
 - **Discussion of some of the many open questions**
 - **Question and answer session**



General

- New Code section 162(m)(6)

Denies the deduction for “remuneration” in excess of \$500,000 paid to an “applicable individual” by a “health insurance provider”

- Effective date

Applies to remuneration paid after 2012, but deferred compensation attributable to services performed in 2010, 2011, and/or 2012 that is paid after 2012 may also be subject to the deduction limitation

- There are two definitions of “health insurance provider”

A “Pre-2013 Definition” & “Post-2012 Definition”

- Controlled group rules generally apply 80% ownership test

Generally an 80% ownership test applies



“Remuneration”

- Defined broadly to include both “individual remuneration” and “deferred deduction remuneration”
 - **Essentially all current and deferred compensation (other than through a “qualified” retirement plan)**
 - **Unlike general 162(m) deduction limit, no exception for performance-based compensation, commissions, or binding contracts**
- Complex allocation and recordkeeping rules likely for restricted or otherwise unvested compensation and other forms of deferred compensation
 - **162(m)(6) is based on the stringent limitations that apply to Troubled Asset Relief Program (“TARP”) participants and Treasury will likely look to existing TARP guidance as precedent (e.g., IRS Notice 2008-94)**



“Applicable Individual”

- “Applicable individual” is defined very broadly as any “individual... who is an officer, director, or employee” or “who provides services for or on behalf” of the insurer
 - **Not limited to certain number of top-paid employees**
 - **Not limited to officers or executives**
 - **Not even limited to employees**
- Scope of “provides services” phrase raises numerous questions:
 - **Treatment of payments to independent contractors**
 - **“Individual” vs. “Person”**
 - **Outside service providers – accounting firms, law firms?**



Pre-2013 “Health Insurance Provider”

An entity is a “Health Insurance Provider” for 2010-2012 if it is a:

“Health Insurance Issuer”
under Code section 9832(b)(2)



that receives premiums
from providing



“Health Insurance Coverage”
as defined in Code section 9832(b)(1)



“Health Insurance Issuer”

- Means an insurance company or insurance organization (*e.g.*, an HMO) licensed to engage in the business of insurance in a State and subject to State law which regulates insurance
- Specifically excludes group health plans of an employer (including self-funded plans) that provide health care to employees
- Thus, employer will NOT be subject to the 162(m)(6) rules merely because it maintains a “self-insured” health plan



“Health Insurance Coverage”

- Means benefits consisting of “medical care” under a policy or contract offered by a health insurance issuer
- “HIPAA-excepted” benefits described in Code section 9832(c)(1) are specifically deemed NOT to be coverage for medical care and are thus not “health insurance coverage”
- HIPAA-excepted benefits described in Code sections 9832(c)(2), (3) & (4) (with the likely exception of qualified LTC insurance) appear to constitute “health insurance coverage”



Issues Re: Health Insurance Coverage Definition

- Treatment of Reinsurance
 - Statute is silent on reinsurance
 - If no privity of contract between the insured individual and reinsurer, arguably it is not health insurance coverage
 - Prior HHS guidance concluded that reinsurers are not “health insurance issuers” (under an almost identical definition in the Public Health Service Act (“PHSA”))
- Treatment of Stop-Loss Insurers
 - Issues similar to reinsurance, but here no primary insurer
 - Prior HHS guidance held that stop-loss insurance is not a group health plan because it doesn’t provide for “medical care”
- Treatment of Captive Insurers
 - Often more like group health plans (which are excluded) than health insurance issuers because coverage is generally NOT available to the general public and may be limited to affiliates



Pre-2013 “Health Insurance Provider” Issues

- An entity that receives even \$1 of health insurance premiums might be a health insurance provider (with respect to deferred compensation paid after 2012 that was earned in 2010, 2011, or 2012)
- Most HIPAA-excepted benefits listed in Code sections 9832(c)(2), (c)(3), and (c)(4) are generally counted
 - **Issuers of these types of coverages, even if they do not sell any “major medical insurance”, would appear to meet the Pre-2013 Definition and could be subject to the 162(m)(6) limits for 2010-2012**
 - **Strong argument that qualified LTC insurance is not health insurance coverage for purposes of 162(m)(6)**



Post-2012 Health Insurance Provider

- For years after 2012, an entity is a “health insurance provider” only if 25% or more of the gross premiums received by a health insurance issuer are derived from the provision of “minimum essential coverage” (the “25% Test”)

You are a Post-2012 Health Insurance Provider

if “A” (The “Numerator”)

is **at least 25%** of

“B” (the “Denominator”)

“A”

Premiums from
“Minimum Essential Coverage”
(generally Major Medical Insurance)

“B”

Gross Premiums from
“Health Insurance Coverage” (as
defined in Code section 9832(b)(1))



Post-2012 Health Insurance Provider (Cont'd)

- Treatment of HIPAA-excepted benefits
 - **All HIPAA-excepted benefits are excluded from the numerator for purposes of applying the 25% Test**
 - **But, only some HIPAA-excepted benefits are included in the denominator for purposes of the 25% Test**
 - Stand-alone dental and vision (Code section 9832(c)(2))
 - Independent specified disease and hospital or other fixed indemnity (Code section 9832(c)(3))
 - Separately sold Medicare supplemental policies (Code section 9832(c)(4))
 - **After 2012, inclusion of HIPAA-excepted benefits in the denominator seems advantageous, so if qualified LTC insurance is not health insurance coverage, could be a disadvantage after 2012**



General “Health Insurance Provider” Issues

- The 25% Test is slightly more flexible than the definition in effect before 2013, but unless the entity has premiums from HIPAA-excepted benefits that are included in the denominator, it could still be a health insurance provider with even \$1 of major medical insurance premiums
- The statute does NOT provide for any de minimis rule either under Pre-2013 or Post-2012 Definitions
- Because the 25% Test ignores the entity’s revenues not associated with health insurance premiums, it is possible that a large controlled group of corporations could be swept into the rule by a subsidiary that receives any major medical premiums



Questions?

Randy Hardock
rhardock@davis-harman.com

Seth Perretta
stperretta@davis-harman.com

Davis & Harman LLP
202.347.2230

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