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

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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?

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