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**

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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

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"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)**

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“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?**

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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"

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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**

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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)**

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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))

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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**

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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

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Questions?

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