Deduction Limit on Compensation Paid by Health Insurance Providers

This is the ninth issue in our series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking here.) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Patient Protection and Affordable Care Act (PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively the “Act”) contains several revenue-raising provisions to fund the expansion of health care, including a new limit on the deductibility of compensation paid by employers that qualify as covered health insurance providers. This new limit, which is highlighted in this issue, is very broadly worded, and may apply to many employers that would not normally be considered health insurance providers. Although the Department of the Treasury has not published formal guidance on these rules under the Act, the following discussion summarizes the relevant provisions of the Act, and guidance previously provided by the IRS on the limits on deductible compensation paid by financial companies that participate in the Troubled Asset Relief Program (TARP), which are similar in many respects to the new limits.

How Does the Act Limit Compensation Paid by Health Insurance Providers?

The Act added new subsection (m)(6) to Section 162(m) of the Internal Revenue Code of 1986, as amended (the “Code”). Code Section 162(m)(6) provides that, for tax years beginning on or after January 1, 2013, a covered health insurance provider (as defined below) may not deduct any compensation paid to an applicable individual in excess of $500,000. Although the Code already limited the deductibility of compensation paid to certain executive officers of publicly held companies in excess of $1,000,000, there are several key differences between the previous rules and the new limit under Code Section 162(m)(6), as applicable to covered health insurance providers:

- The new $500,000 limit applies to both publicly traded and privately held employers.
- The new $500,000 limit applies to all employees, directors and independent contractors. It is not limited to officers whose compensation is reportable on an annual proxy filing or any other smaller group of key employees.

To Whom Does the New $500,000 Limit Apply?

An “applicable individual,” for purposes of new Code Section 162(m)(6), is any employee, officer, director or independent contractor of a covered health insurance provider, or any company under common control with a health insurance provider.
There are no exceptions to the new $500,000 limit for performance based compensation, commissions, or compensation paid under existing contracts.

Code Section 162(m)(6) does not apply to current compensation until 2013 or later. However, it applies to deferred compensation paid in 2013 or later for services performed in 2010 or later. Accordingly, any deferred compensation (including long-term incentive plans and equity plans such as stock options) that is being currently earned in 2010 will be affected if paid in 2013 or later. It should be noted that stock options and stock appreciation rights are considered deferred compensation for this purpose even if granted at fair market value.

**What is a “Covered Health Insurance Provider”?**

For the 2010 through 2012 tax years, Code Section 162(m)(6) defines a “covered health insurance provider” as any employer that is a health insurance issuer receiving any amount of premiums from providing health insurance coverage. For tax years beginning on or after January 1, 2013, an employer is a covered health insurance provider only if at least 25% of those premiums are attributable to “minimum essential coverage.” Consequently, an employer may be a covered health insurance provider from 2010 through 2012, but not in 2013 or later.

Generally, a “health insurance issuer” is any insurance company, insurance service or insurance organization (including an HMO, as recognized under federal or state law) that is licensed under state law to engage in the business of insurance. “Health insurance coverage” means a policy or certificate (or HMO contract) offered by a health insurance issuer offering benefits consisting of medical care. Certain benefits (typically referred to as "excepted benefits") under which benefits for medical care are secondary or incidental to other insurance benefits are not treated as benefits consisting of medical care, including but not limited to the following:

- Accident-only coverage (including accidental death and dismemberment coverage),
- Disability income coverage,
- Coverage issued as a supplement to liability insurance,
- General or automobile liability insurance,
- Coverage for on-site medical clinics, and
- “Qualified” long-term care policies (i.e., policies that meet the requirements enacted by HIPAA so that premiums are deductible and benefits nontaxable).

“Minimum essential coverage” includes employer sponsored health insurance coverage, individual health insurance plans under applicable state law, grandfathered plans, coverage under a state high-risk insurance pool, and government-sponsored coverage (e.g., Medicare, Medicaid or TRICARE), but does not include excepted benefits (as described above) or the following types of coverage if provided under a separate policy: limited-scope dental or vision benefits, long-term care (other than that provided under qualified long-term policies, which, as described above, is an excepted benefit), nursing home care, home health care, community-based care, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance and Medicare supplemental coverage.

Since these specialized benefits are excluded from the definition of “minimum essential coverage” but not from the general definition of health insurance, the result is that an insurance company whose only health insurance-related coverage is one
of these benefits – such as a company that issues nonqualified long-term care policies but not any other type of health insurance – will be subject to the new $500,000 limitation during 2010 through 2012 but not beginning in 2013. (However, under a literal reading of the statute, deferred compensation earned in 2010 through 2012 will be subject to the limitation when paid after 2012 even if the company is no longer a health insurance provider.)

Among the many unresolved issues still awaiting IRS guidance are whether any of the following types of insurance may be considered health insurance coverage causing the issuer and all members of its controlled group to be subject to the new limits:

- Premiums received by a captive insurance company that only provides insurance for a single employer,
- Premiums received from re-insuring health risks, and
- Premiums received from issuing stop-loss insurance.

**Do the Controlled Group Rules Apply in Determining Applicable Individuals?**

Code Section 162(m)(6) provides that the Code’s parent-subsidiary aggregation rules generally apply. Under a plain reading, this means that if any company in a controlled group of companies (i.e., a group of companies with 80% common ownership) is a covered health insurance provider, then all companies within the group are covered health insurance providers and subject to the new $500,000 limit. Accordingly, unless the IRS narrows the scope of the controlled group rules, “applicable individuals” will include any individual who performs services for a company that is under common control with a health insurance issuer (subject to the 25% threshold described above for tax years on and after 2013).

As a result of the combination of the controlled group rules with the lack of any minimum amount of health insurance premiums that can be received, any employer, even if it is not itself an insurer, may find itself unable to deduct more than $500,000 in compensation if any member of the same controlled group receives even a dollar of health insurance premiums. Accordingly, employers that are part of a diversified corporate group should carefully examine the income earned by all members of the group to determine whether they may become subject to the new limits, and may wish to revise their deferred compensation policies prior to the end of 2010.

**How Does the New $500,000 Limit Apply to Deferred Compensation?**

As noted above, the new $500,000 deductibility limit applies to compensation paid in 2013 or later for services performed in 2010 or later. This includes payments in 2013 or later under (i) a long-term incentive or annual bonus plan with respect to a performance period that includes any part of the years 2010 through 2012, (ii) stock options and other equity grants that vest in whole or part during 2010 through 2012 but are exercised after 2012, or (iii) a nonqualified deferred compensation plan with respect to amounts deferred in 2010 through 2012. The following should be noted about the effect of the staggered effective dates:

- Although there is no limit on the deductibility of current compensation in 2010 through 2012, it appears that current compensation paid in any of such years will use up the $500,000 limit, causing deferred compensation earned during the year to be subject to the limitation when paid. Under a literal reading of the statute, this would be true even if the company is no longer a covered health insurance provider when the compensation is paid, although it has been suggested that this result was not intended by Congress.

- Even though Code Section 162(m)(6) was enacted after employees were required to make irrevocable deferral elections for 2010 compensation, such elections may not be revoked or modified to avoid the application of new
$500,000 limit without subjecting the employee to substantial penalties under Code Section 409A.

- It appears that annual bonuses earned in 2012 and paid by March 15, 2013, will not be subject to the limitation, provided that they can be properly accrued and deducted in 2012, but the Act is not completely clear on this point.

Mechanically, the $500,000 limit applies first to current compensation paid in a year, and then to any compensation that is deferred in the same year. To the extent that an employee’s current compensation is less than $500,000, the remainder of the limit for the year is carried forward and applied to compensation deferred in such year and paid in a later year. Consequently, an employer may take advantage of the full $500,000 limit, even if it cannot be satisfied in the year in which compensation is initially earned. For example, assume an employee of a health insurance provider earns $600,000 in 2013, and elects to defer $200,000 until termination of employment. Since her current compensation for 2013 (after the deferral) is only $400,000, it is fully deductible. The remaining $100,000 limit will allow the first $100,000 of the deferred compensation to be deducted when it is actually paid in the year she terminates employment. If the employee receives $500,000 in current compensation in the year she terminates employment, the employer will be allowed to deduct the $500,000 in current compensation and the first $100,000 of deferred compensation from 2013, but not the second $100,000 of deferred compensation.

For further details, or if you have any questions regarding the requirements for current or future plan years, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.