IRS Provides Guidance on Code Section 162(m)(6) Limits

In Notice 2011-02, the IRS provides guidance on the deductible compensation limits of new Code Section 162(m)(6), as added by PPACA. The Notice clarifies that deductions for compensation paid after 2012 for services performed before 2013 are limited only if the employer is a covered health care provider at both times. The Notice also includes a de minimis rule that exempts a health care provider from being treated as covered if specified premiums (the definition differs before 2013 and after 2012) are less than 2% of gross revenues.
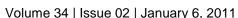
Code Section 162(m)(6)

The Patient Protection and Affordable Care Act (PPACA) amends the Internal Revenue Code (Code) to limit the amount that certain health care insurers may deduct for a tax year starting after 2012 for compensation to any employee in excess of $500,000. New Code Section 162(m)(6) applies only to certain health care insurers but otherwise has a far broader impact than the general deduction limit under Code Section 162(m). Section 162(m) limits the amount a publicly-held corporation may deduct for compensation paid to a narrow group of executives to $1 million per year per executive, makes an exception for performance-based compensation and commissions, and excludes the compensation paid to former covered executives once they are no longer covered.

Code Section 162(m)(6) applies only to health insurance providers. However, it applies regardless of whether the health insurer's stock is publicly traded, limits the deduction to $500,000 per individual, and makes no exception for performance-based compensation or commissions. In addition, the limit applies to compensation, including deferred compensation, paid to all current and former employees and most independent contractors, not just to compensation paid to a narrow group of current top executives.

The new rule is generally effective for employer tax years beginning after December 31, 2012. However, the $500,000 limit includes any deferred compensation paid out after 2012 even if it was attributable to services performed for a covered health insurance provider in 2010, 2011, or 2012. The application of Code Section 162(m)(6) to deferred compensation earned prior to 2013 but paid out after 2012 has caused confusion because Section 162(m)(6) defines a "covered health insurance provider" in broader terms for 2010, 2011, and 2012 than for 2013 and later.

Starting in 2013, a health insurance provider is "covered" only if 25% or more of its gross premiums received from providing health insurance coverage is from "minimum essential coverage," which, as defined in Code Section 5000A(f), generally means group or individual medical coverage needed to satisfy the individual coverage

mandate under PPACA. The term "minimum essential coverage" does not include limited scope dental or vision benefits, home nursing care, home health care, community-based care, and specified disease or fixed indemnity policies. For 2010, 2011, and 2012, in addition to premiums on medical coverage, premiums on plans and policies providing the excluded benefits that are listed in the prior sentence arguably count as relevant premiums. (Both definitions exclude insurance under which medical care is secondary or incidental to other insurance benefits such as accident and disability income insurance, liability insurance, workers' compensation, automobile liability insurance, and on-site medical clinic coverage.)

> **BUCK COMMENT.** *The pre-2013 definition of covered health insurance provider (receiving any premium) applies to more employers than the post-2012 definition (receiving at least 25% of premiums from offering minimum essential coverage).*

Notice 2011-02

In Notice 2011-02, the IRS provides clarity and relief on who is a covered insurance provider under Code Section 162(m)(6).

Pre-2013 Covered Health Care Providers

The Notice provides that if an entity is not a covered health insurance provider after 2012, when Code Section 162(m)(6) will first limit deductions, the deduction of amounts deferred before 2013 (even if the entity is a covered health insurance provider before 2013) is not limited by Section 162(m)(6). Under the guidance, the IRS applies the Section 162(m)(6) deduction limit to deferred compensation earned for services provided in 2010, 2011, and 2012 and paid in a year after 2012 only if the entity is a covered health insurance provider under the post-2012 definition in the year the deferred compensation is paid.

> **BUCK COMMENT.** *The idea that an entity that was not a covered health insurance provider after 2012, when the deduction limit goes into effect, could still have their deductions limited if compensation deferred from 2010, 2011, or 2012 was paid out after 2012 came as a surprise to many entities. Notice 2011-02 eliminates that possibility.*

Post-2012 Rules

Similarly, the deduction limits apply to amounts deferred in a post-2012 year only if the post-2012 year in which the deferred compensation is paid is a year in which the employer is a covered health insurance provider. The reverse also applies. If the employer was not a covered health insurance provider in the year the services for the deferred compensation were performed, then it is irrelevant, with respect to that deferred compensation, whether the employer is a covered health insurance provider in the year the deferred compensation is paid.

BUCK COMMENT. Health insurance providers who are near the covered cutoff of 25% of premiums from minimum essential coverage will have to be careful; however, it is likely that most employers will be far under or far above the cutoff.

De Minimis Exception

The IRS exempts an employer from being a covered health insurance provider if the employer and members of its parent-subsidiary controlled group collectively meet a 2% test. For pre-2013 years, all premiums received for providing health insurance coverage must be less than 2% of the employer's gross revenue for that year. For 2013 and later years, the 2% is based only on premiums from providing minimum essential coverage (as discussed above).

BUCK COMMENT. This exception should remove health insurance providers, such as captive insurance companies, that are a small part of a bigger enterprise from triggering the limitation for the whole controlled group.

Applicable Individual and Reinsurers

The limitation applies to "applicable individuals." That term includes all officers, directors, and employees and most independent contractors. However, the term excludes independent contractors who would not be subject to Code Section 409A because they provide substantial services to multiple unrelated customers.

The Notice does not count premiums received under an indemnity reinsurance contract as premiums for purposes of meeting either the 2%-of-general-revenue test or the 25%-from-premiums test.
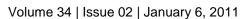
Request for Comments

The IRS recognizes that the Notice only addresses the issues of most immediate concern and that there are many other issues requiring clarification. As a result, the RS has asked for comments on the relief provided and also on how the deduction limit should apply to the following:

- Captive insurers and those who provide reinsurance or stop-loss insurance (distinguishing between low and high trigger points);

- Mergers, acquisitions, or reorganizations; and

- Providers whose activity is still de minimis but above 2%.

The IRS also asks for comments on how to allocate deferred compensation to services provided in specific taxable years.

Conclusion

The IRS has provided welcome relief from the possible broad interpretation of the statutory provision. Guidance on other issues is possible before the provision becomes effective in 2013.

Buck's consultants are available to provide assistance in understanding the Notice and Code Section 162(m)(6) or to assist you in commenting to the IRS on the guidance.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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