April 2014

Wolters Kluwer Law & Business White Paper

Compensation Deduction Limit May Ensnare Unsuspecting Employers as Covered Health Insurance Providers

Inside

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Executive Summary

Proposed regulations implementing the deduction limit imposed by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) on compensation paid to highly paid employees of health insurance providers should caution employers, including those that do not provide health insurance coverage, of the potentially broad reach of the limit.

The ACA limits the tax deduction available to companies for the remuneration of certain executive employees. Whether an entity is a "covered health insurance provider" can prove problematic, especially when applying complicated aggregation rules and accounting for mergers and other corporate transactions between entities with different tax years. The IRS addressed many of the outstanding concerns in Notice 2011-2 (2011-1 CB 260, Dec. 23, 2010).

The Treasury and IRS, subsequently issued sweeping proposed regulations (IRS Proposed Reg. 1.162-31), which incorporate Notice 2011-2 and provide further guidance on implementing the deduction limit. The application of IRS guidance to the determination of covered health insurance providers is the subject of this White Paper.

The analysis, supplemented by numerous examples, highlights the broad scope of the deduction limitation and should be a caution to unsuspecting employers that may find themselves subject to the rules.

Introduction

In an attempt to preemptively rechannel the windfall of premium payments expected to flow to health insurance providers, the ACA limits the tax deduction available to the companies for the remuneration of certain executive employees. Code Sec. 162(m)(6), as added by ACA, limits the allowable deduction to $500,000 per year for individual remuneration and deferred deduction remuneration attributable to services performed by "applicable individuals" (*i.e.*, officers, directors, employees of a covered health insurance provider or one who provides services on behalf of the insurance provider (including some independent contractors)) that is otherwise deductible by a covered health insurance provider in tax years beginning after December 31, 2012.

The threshold issue of whether an entity is a "covered health insurance provider" can prove problematic, especially when applying complicated aggregation rules and accounting for mergers and other corporate transac-

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tions between entities with different tax years. The IRS addressed many of the outstanding concerns in Notice 2011-2 (2011-1 CB 260, Dec. 23, 2010), authorizing an exception from the deduction limit for health insurers that receive health insurance premiums that are only a de minimis percentage of total revenues and an exclusion from the limit for remuneration earned by certain independent contractors that provide services to multiple unrelated companies.

The Treasury and IRS, subsequently, in April 2013, issued sweeping proposed regulations (IRS Proposed Reg. 1.162-31), which incorporate Notice 2011-2 and provide further guidance on implementing the deduction limit. The proposed rules, which apply to tax years that begin after December 31, 2012 and end on or after April 2, 2013, may be immediately relied upon by taxpayers until the issuance of the final rules. The IRS anticipates that the final rules will be issued before covered health insurance providers are required to file income tax returns reflecting application of the deduction limitation. In the event the final rules are more restrictive, however, taxpayers may continue to rely on the proposed rules in applying the deduction limit to their first tax year after December 31, 2012.

The application of the IRS guidance to the determination of covered health insurance providers, including issues related to: the de minimis exception; the exception for entities maintaining self-insured medical reimbursement plans; the application of transition relief following corporate mergers, acquisitions, dispositions, and reorganizations; the extension of the cap under the aggregation rules to entities that are not health insurance issuers and that do not provide health insurance coverage; and the exclusion from premiums of amounts received under indemnity reinsurance contracts, is the subject of this *White Paper*. The proposed rules highlight the broad scope of the deduction limitation and should be caution to unsuspecting employers that may find themselves subject to the rules.

Note: While this *White Paper* is limited to the rules governing the determination of a covered health insurance provider, the proposed regulations address many issues related to the deduction limitation, including: premiums, disqualified tax years, applicable individuals, individual remuneration, deferred deduction remuneration, aggregate remuneration, grandfathered amounts attributable to services performed before January 1, 2010, transition rules applicable to certain deferred deduction remuneration, and the coordination of the limit under Code Sec. 162(m)(6) with the $1 million limit under Code Sec. 162(m)(1).

Limitation on Excessive Remuneration

Code Sec. 162(m)(6), effective for tax years after December 31, 2012, limits to $500,000 the allowable deduction for aggregate applicable individual remuneration (IRS Proposed Reg. 1.162-31(b)(10)) and deferred deduction remuneration (IRS Proposed Reg. 1.162-31(b)(11)) attributable to services performed by an applicable individual for a "covered health insurance provider" in disqualified tax years (*i.e.*, years in which the entity is a covered health insurance provider) beginning after December 31, 2013 that would otherwise be tax deductible. Deferred deduction remuneration attributable to services performed in a disqualified tax year beginning after December 31, 2009 and before January 1, 2013 that becomes otherwise deductible in tax years beginning after December 31, 2012 is also subject to the $500,000 deduction cap, determined as if the deduction limit applies to disqualified tax years beginning after December 31, 2009.

Note: Legislative history indicates that the impetus underlying the Code Sec. 162(m)(6) deduction cap was to encourage health insurance issuers to apply the increased premium revenues provided by the new customers generated by the ACA to lower health insurance rates (155 Cong. Rec. S12, 540 (Dec. 6, 2009) (statement of Senator Blanche Lincoln, D-Ark.)). While the deduction limit may not "encourage" insurers to lower health insurance rates, it may "discourage" insurers from applying the premium windfalls to enhance executive compensation.

Covered Health Insurance Providers

The threshold issue in applying the compensation deduction cap is whether an entity is a covered health insurance provider. The rules vary depending on an entity's applicable tax year, as a health insurance issuer may be a covered insurance provider in one tax year, but not another. In addition, it is important to note that an entity that is under common control with a covered provider may be subject to the deduction cap, pursuant to the governing aggregation rules, even if it is not a health insurance issuer.

Health Insurance Issuer

The conditions under which an entity will be considered a covered health insurance provider are narrower for tax

years beginning after December 31, 2012 than for tax years beginning before January 1, 2013.

Under Code Sec. 162(m)(6)(C)(i)(I), for tax years beginning after December 31, 2009 and before January 1, 2013, a health insurance issuer qualifies as a covered health insurance provider for a tax year if the issuer receives premiums (IRS Proposed Reg. 1.162-31(b)(5)) for providing health insurance coverage during the tax year.

However, in tax years beginning after December 31, 2012, Code Sec. 162(m)(6)(C)(i)(II) will not treat a health insurance issuer as a covered health insurance provider for a tax year unless not less than 25 percent of the gross premiums that the provider receives from providing health insurance coverage during the year are for "minimum essential coverage."

Minimum essential coverage, as defined under Code Sec. 5000A(f), generally refers to coverage provided under: government sponsored programs (*e.g.*, Medicare and Medicaid), employer sponsored plans, plans offered in the individual market of a state, grandfathered health plans, and other health benefits coverage (*e.g.*, state health benefits risk pools) as may be recognized by Health and Human Services.

Note: An issue that arose following the enactment of Code Sec. 162(m) (6) concerned pre-2013 covered health insurance providers that did not qualify as post-2012 covered health insurance providers. The issue was whether the deduction limit should apply to deferred deduction remuneration attributable to services performed during the tax years when the health insurance issuer was a pre-2013 covered health insurance provider. The proposed regulations clarify that the deduction limit applies to deferred deduction remuneration attributable to services performed in a tax year beginning after December 31, 2009 and before January 1, 2013, only if the covered health insurance provider is a pre-2013 covered health insurance provider for the tax year to which the deferred deduction remuneration is attributable and a post-2012 covered health insurance provider for the tax year in which that deferred deduction remuneration is otherwise deductible (IRS Proposed Reg. 1.162-31(i)).

Aggregation Rules

Under the aggregation rules of Code Sec. 162(m)(6)(C)(ii), two or more persons that are treated as a single employer (pursuant to the aggregation rules of Code Sec. 414) will be treated a single employer in determining whether a person is a covered health insurance provider. Persons will be treated as a single employer under the rules of Code Secs. 414(b) (members of a controlled group of corporations), 414(c) (partnerships, proprietorships, etc., under common control), 414(m) (affiliated service groups), and 414(o) (employers treated by the IRS as related employers). However, the rules relating to brother-sister groups and combined groups of corporations (Code Sec. 1562(a)(2) and (3)) are disregarded. The proposed regulations further exclude consideration of the rules under IRS Reg. 1.414(c)-2(c), governing trades or business under common control, in determining the aggregate group (IRS Proposed Reg. 1.162-31(b)(2)).

The threshold issue in applying the compensation deduction cap is whether an entity is a covered health insurance provider.

Significantly, the proposed regulations clarify that, under the aggregation rules, each member of an aggregated group that includes a health insurance issuer at any time during a tax year is also a covered health insurance provide for purpose of the deduction limit, even if the member is not a health insurance issuer and does not provide health insurance coverage.

Note: Although specific application of the $500,000 deduction limit is generally beyond the scope of this article, it is instructive to note the effect of the deduction limit on individual members of an aggregated group. In applying the deduction limit, all members of an aggregated group are treated as a single employer. Thus, IRS explains one $500,000 deduction limit applies to the aggregate applicable individual remuneration and deferred deduction remuneration attributable to services performed by an applicable individual during a disqualified year for any member of the aggregated group.

In the event two or more members of an aggregated group are entitled to deduct individual remuneration or deferred deduction remuneration that exceeds the deduction limit for that tax year, the deduction limit is prorated. The deduction is allocated to the members of the aggregated group in proportion to the applicable individual remuneration or deferred deduction remuneration that each would (but for Code Sec. 162(m)(6))

otherwise be entitled to deduct in the tax year (IRS Proposed Reg. 1.162-3(e) (4)(ii)).

Broader Definition of Covered Health Insurance Providers

Integrating the above rules, covered health insurance providers, under the proposed regulations include:

1. Health insurance issuers that, for any tax years beginning after December 31, 2009 and before January 1 , 2013, receive premiums for providing health insurance coverage;
2. Health insurance issuers that, for any tax year beginning after December 31, 2012, receive premiums from providing health insurance coverage, at least 25% of which are for providing minimum essential coverage;
3. The "parent entity" of an aggregated group of which one or more health insurance issuers are members for the tax year of the parent entity with which , or in which, ends the tax year of any such health insurance issuer ; and
4. Each other member of an aggregated group of which one or more health insurance issuers are members for the tax year of the other member ending with, or within , the partner's entity's tax year (IRS Proposed Reg. 1.162-31(b)(4)(i)).

Thus, IRS explains, the parent entity of an aggregated group is a covered health insurance provider for its tax year with which, or in which, ends the tax year of the health insurance issuer that is a covered health insurance provider in the aggregated group of which the parent entity is a member. Each other member of an aggregated group is a covered health insurance provider for its tax year that ends with, or within, the tax year of the parent entity during which the parent entity is a covered health insurance provider (Preamble to IRS Proposed Reg. 1.162-31).

Parent Entity

A parent entity, for purposes of the aggregation rues, would be either:

(a) The common parent of a parent-subsidiary controlled group of corporations (under Code Sec. 414(b)), or a parent-subsidiary group of trades or businesses under common control (under Code Sec. 414(c)) that includes a health insurance issuer; or

(b) The health insurance issuer in an aggregated group that is an affiliated service group (under Code Sec. 414(m) or other group that the IRS treats as related employers (Code Sec. 414(o)) (IRS Proposed Reg. 1.162-31(b)(3)(i)).

Aggregated Groups with Multiple Health Insurance Issuers

The parent entity with respect to the aggregated group that is an affiliated service group under Code Sec. 414(m) or other group under Code Sec. 414(o) will be the health insurance issuer in the aggregated group if the group includes only one health insurance issuer. However, if an aggregated group that is an affiliated service group or other group under Code Sec. 414(o) includes more than one health insurance issuer, the parent entity will be the health insurance issuer in the aggregated group that is designated in writing by the other members of the group to act as the parent entity, provided the group treats that health insurance issuer as the parent entity consistently for all tax years. However, if the members of the aggregated group fail to designate a parent entity in writing (or fail to apply the designation consistently for all tax years) the parent entity of the group is deemed to be an entity with a tax year that is the calendar year, without regard to whether the aggregated group includes an entity with a calendar tax year (IRS Proposed Reg. 1.162-31(b)(3)(ii)).

Note: A health insurance issuer that has been designated as the parent entity of an aggregated group may leave that group as a result of merger, disposition of assets, or other corporate transaction, inviting successorship issues. The IRS is, accordingly, soliciting comments on the circumstances under which a successor parent entity may be designated and the appropriate transition rules.

Self-Insured Medical Reimbursement Plan Exception

The proposed regulations provide an exception from the deduction cap for employers that sponsor a self-insured medical reimbursement plan. Employers will not be treated as covered health insurance providers solely because they maintain a self-insured medical reimbursement plan (IRS Proposed Reg. 1.162-31(b)(4)(ii)).

A self-insured medical reimbursement plan is a separate written plan maintained for the benefit of the employer's employees (including former employees) that provides for the reimbursement of employee medical expenses (under Code Sec. 105(b)). For purposes of the exception, the plan may not provide for reimbursement under an individual or group policy of accident or

health insurance issued by a licensed insurance company or under an arrangement in the nature of a pre-paid health care plan that is regulated under federal or state law in a manner similar to the regulation of insurance companies. However, plans maintained by voluntary employee beneficiary associations (VEBAs) do qualify for the exemption.

Note: IRS cautions that a captive insurance company will be treated as a covered health insurance provider if it is a health insurance issuer under Code Sec. 162(m)(6)(C) (Preamble to IRS Proposed Reg. 1.162-31).

De Minimis Exception

The proposed regulations adopt the de minimis exception authorized in IRS Notice 2011-2. Under the exception, a health insurer and any member of its aggregated group that would otherwise be a covered health insurance provider for a tax year beginning after December 31, 2009 and before January 1, 2013, will not be treated as a covered health insurance provider if the premiums received by the health insurance issuer and any other health issuer in its aggregated group from providing health insurance coverage are less than two percent of the gross revenues of the health insurance issuer and other members of its aggregated group for that tax year (IRS Proposed Reg. 1.162-31(b)(4)(iii)(A)).

For tax years beginning after December 31, 2012, the exception would be available if the premiums received by the health insurance issuer (and other health insurance issuers in its aggregated group) for providing health insurance coverage "that constitute minimum essential coverage" are less than two percent of the gross revenues of the health insurance issuer and all members of its aggregated group for the tax year.

Applying De Minimis Exception to Members of Aggregate Group with Different Tax Years

In applying the de minimis exception to members of the aggregate group with different tax years, IRS advises that taxpayers will need to focus on the premiums and gross revenues of: (1) the health insurance issuer for its tax year, (2) the parent entity for its tax year with which, or in which, ends the tax year of the health insurance issuer, and (3) each other member of the aggregated group for its tax year that ends with, or within, the tax year of the parent entity (Preamble to IRS Proposed Reg. 1.162-31).

De Minimis Exception Based on Revenues, Not Compensation

The proposed regulations reflect an express rejection by the IRS of the suggestion that the de minimis exception be based on compensation, instead of revenues. It had been maintained by some taxpayers that a health insurance issuer and members of tis aggregated group should not be treated as a covered health insurance provider if the compensation paid by the issuer was less than two percent of the total compensation paid by all members of the aggregated group. Advocates of this position argued that basing the de minimis exception on gross revenues would overemphasize the importance of health insurance activities, which may generate relatively higher revenue, but operate on slimmer profit margins. The IRS, however, believes comparing premiums with gross revenue provides a better measure of the importance of the health insurance business to an aggregated group. In addition, the IRS suggested that a de minimis exception based on compensation would prove administratively difficult because it would require taxpayers and the IRS to allocate compensation between members of an aggregated group for individuals who perform services for more than one member of the aggregated group.

The proposed regulations reflect an express rejection by the IRS of the suggestion that the de minimis exception be based on compensation, instead of revenues.

One-Year Grace Period

Unexpected changes in the revenue sources of an aggregated group and other events could affect application of the de minimis exception. Accordingly, the proposed regulations provide that if a health insurance issuer or member of an aggregated group qualifies for the de minimis exception for a tax year, but fails to meet the requirement for the "immediately following" tax year, it will not be treated as a covered health insurance provider for that immediately following year (IRS Proposed Reg. 1.162-31(b)(4)(iii)(B)).

Example: XYZ and ABC are members of an aggregated group. XYZ is a health insurance issuer that is a covered health insurance provider and receives premiums for providing minimum essential health coverage during its 2015 tax year in an amount that is less than two percent of the combined gross revenues of XYZ and ABC for their 2015 tax years. ABC is not a health insurance issuer.

XYZ and ABC are exempt from treatment as covered health insurance providers for the 2015 tax year under the de minimis exception (IRS Proposed Reg. 1.162-31(b)(4)(iii)(C), Example 1).

Example: Corps. V, W, and X are members of an aggregated group. V is a health insurance issuer that is a covered health insurance provider. However, W and X are not health insurance issuers. W is the parent entity of the aggregated group. V's tax year ends on December 31, W's tax year ends on June 30, and X's tax year end on September 30.

For its tax year ending December 31, 2016, V receives $4X of premiums for providing minimum essential coverage for its tax year ending June 30, 2016, but has no other revenue. W has $100X in gross revenue for the tax year ending June 30, 2017. X has $60X in gross revenue for the tax year ending September 30, 2016. The members of the V, W, and X aggregated group were not treated as covered health insurance providers for tax years ending December 31, 2015, June 30, 2016, and September 30, 2015, respectively (their immediately preceding tax years) solely by reason of the de minimis exception.

The premiums received by the members of the aggregated group for providing minimum essential coverage are more than two percent of the gross revenues of the aggregated group for the tax years during which the members would be treated as health insurance providers (because $4x is greater than two percent of $164X). However, they were not treated as covered health insurance providers for their immediately preceding tax years solely because of the de minimis exception.

V, W, and X will not be treated as covered health insurance providers for their tax years ending December 31, 2016 , June 30, 2017, and September 30, 2016, respectively, because of the 1-year grace period. However, the members of the V, W, X aggregated group will be covered health insurance providers for subsequent tax years if they would otherwise qualify as covered health insurance providers for those tax years (IRS Proposed Reg. 1.162-31(b)(4)(iii)(C), Example 2).

Premiums Received Under Indemnity Reinsurance Contracts

An indemnity reinsurance contract allows a health insurer to reinsure a portion of its risks. Under the contract with the reinsurer, a reinsurance claim is payable only after the health insurance issuer has paid an amount for health benefits under its own insurance agreement with the policy holder. The arrangements invited the issue of whether premiums for reinsurance coverage should be treated as premiums for providing health insurance coverage when determining whether a taxpayer is a coved health insurance provider. In addressing the issue, the proposed regulations, consistent with IRS Notice 2011-2, provide that, solely for purposes of determining whether a person is a covered health insurance provider, premiums received under an indemnity reinsurance contract will not be treated as premiums for providing health insurance coverage (IRS Proposed Reg. 1.162-31(b)(5)(ii)). However, the exception will apply only if, under the reinsurance contract: (1) the reinsuring company agrees to indemnify the health insurance issuer for all or part of the risk of loss under policies specified in the agreement, and (2) the health insurance issuer retains its liability to, and its contractual relationship with, the insured individual.

Corporate Transactions Affecting Covered Health Insurance Provider Status

A corporation or other person may become a covered health insurance provider following a merger, acquisition of assets or stock, disposition, reorganization, consolidation, separation, or any other transaction (*e.g.,* purchase or sale of stock or other equity interest) resulting in a change in the composition of its aggregated group. Under the aggregation rules, if a member of an aggregated group purchases a health insurance issuer that is a covered health insurance provider, causing the issuer to become a member of the aggregated group, each member of the acquiring aggregate group will be a covered health insurance provider for the tax year in which the corporate transaction occurs. This status will continue for each subsequent tax year in which the issuer continues to be a member of the group (absent application of the de minims exception) (IRS Proposed Reg. 1.162-31(f)(1)(i)).

In order to ease the administrative burden imposed on persons that become covered health insurance providers solely as a result of a corporate transaction, the proposed regulations provide a transition rule that would shield such persons from treatment as a covered service providers for the tax year in which the transaction occurs (IRS Proposed Reg. 1.162-31(f)(1)(ii)(A)). However, the transition relief will not apply to a person that was a covered health insurance provider immediately before a corporate transaction, as that person would not have become a covered health insurance provide solely as result of the corporate transaction.

The transition relief will also not encompass remuneration provided to applicable individuals of a health insurance issuer that is a covered health insurance provider during the tax year of the transaction, even if the remuneration is attributable to services performed for a party that is eligible for the transition relief (IRS Proposed Reg. 1.162-31(f)(1)(ii)(B)). Therefore, each member of an acquiring aggregated group that would become a covered health insurance provider solely as a result of a corporate transaction, but that is not treated as a covered health insurance provider under the transition relief, will remain subject to the deduction limit for the tax year during the transition period with respect to applicable individual remuneration and deferred deduction remuneration attributable to services performed by an applicable individual of the acquired health insurance issuer that is a covered health insurance provider.

Short Tax Year Resulting from a Corporate Transaction

A covered health insurance provider's tax year may end or begin as a result of corporate transaction.

Under the proposed rules, a covered health insurance provider whose tax year ends as a result of corporate transaction will be treated as a covered health insurance provider for that short tax year if it is a covered health insurance provider for the short tax year that ends as a result of the corporate transaction (IRS Proposed Reg. 1.162-31 (f)(1)(iii)(A)). However, the de minimis exception will be available for that short tax year only if applied to the covered health insurance provider for the preceding tax year.

Similarly, a health insurance issuer that is a covered health insurance provider whose tax year begins as a result of a corporate transaction is treated as a covered health insurance provider for the tax year that begins as a result of the corporate transaction, if the covered health insurance provider is otherwise a covered health insurance provider for the tax year that begins as a result of the corporate transaction (IRS Proposed Reg. 1.162-31 (f)(1)(iii)(B)).

Deduction limit is not prorated for short tax years. It is important to note that, in the event a corporate transaction results in a short tax year for a covered health insurance provider, the $500,000 deduction limit for that year is neither prorated nor reduced (IRS Proposed Reg. 1.162-31 (f)(1)(iii)(C)).Thus, if a corporate transaction results in a short tax year of 3 months, the deduction limit will not be reduced to $125,000, but will remain $500,000.

In the event a corporate transaction results in a short tax year for a covered health insurance provider, the $500,000 deduction limit for that year is neither prorated nor reduced.

Partnership Transactions

The rules addressing the effect of corporate transactions on the deduction limit also apply by analogy to transactions involving partnerships (IRS Proposed Reg. 1.162-31 (f)(2)).

Example: ABC Corp merges with XYZ Corp. June 30, 2015, with XYZ being the surviving entity. As a result of the merger, ABC's tax year ends on June 30, 2015. For its taxable year ending June 30, 2015, ABC is a covered health insurance provider. For all taxable years before the taxable year of the merger, XYZ was not a covered health insurance provider. However, solely as a result of the merger, XYZH becomes a covered health insurance provider for its 2015 taxable year.

ABC Corp. is a covered health insurance provider for its short tax year ending June 30, 2015. Pursuant to the transition period relief, XYZ Corp. is not treated as a covered health insurance provider for its 2015 tax year. However, XYZ Corp. will be a covered health insurance provider for its 2016 tax year and all subsequent tax years for which it is a covered health insurance provider (IRS Proposed Reg. 1.162-31(f)(3), Example 1).

Example: As of January 1, 2016, Ace Health, and Corps. X and Y are members of a controlled group. Ace is a covered health insurance provider. Corps. X and Y are not health insurance issuers, but are treated as covered health insurance providers as related entities to Ace . Y's tax year is a fiscal year ending on September 30. Susan is an applicable individual of Y for all taxable years.

On May 1, 2016, a different controlled group, comprised of Corps. Big and Bigger purchases all of the stock of corporation Y, resulting in a controlled group consisting of Corporations Big, Bigger, and Y. Big and Bigger are not health insurance issuers. The resultant controlled group is a consolidated group (within the meaning of IRS Reg. 1.1502-1(h)). Accordingly, Y's tax year ends on May 1, 2016 (under IRS Reg. 1.1502- 76(b)(1)(ii)(A)(1)). Y becomes part of the acquiring Y consolidated group for the tax year ending December 31, 2016.

Ace and Corp. X are covered health insurance providers for the tax year ending December 31, 2016 because they were in an aggregated group with Y for a portion of their tax year. Therefore, Ace and Corp. X are subject to the $500,000 deduction limit for their tax years ending December 31, 2016. Big and Bigger, fall under the transition relief, and are not treated as covered health insurance providers for their tax year ending December 31, 2016. Corp. Y, however, is a covered health insurance provider for its tax year ending May 1, 2016, and for its tax year ending December 31, 2016.

Susan's remuneration is subject to the deduction limitation for Y's short tax year ending May 1, 2016. In addition, remuneration for services by Susan for Big, Bigger, or Corp. Y after May 1, 2016, during the tax year of the consolidated group ending December 31, 2016, will be subject to the deduction cap, even though Big and Bigger are not treated as covered health insurance providers for their tax year ending December 31, 2016 (IRS Proposed Reg. 1.162-31(f)(3), Example 2).

Example: Assume the same facts as the immediately preceding Example, except that Corp. X is a health insurance issuer that is a covered health insurance provider and Corp. Y is not a health insurance issuer. Jack is an applicable individual of Corp. Y for all tax years.

Corp. Y is a covered health insurance provider for its short tax year ending May 1, 2016. However, because Corp. Y is not a health insurance issuer that is a covered health insurance provider, it is not treated as a covered health insurance provider for its short, post-acquisition taxable year ending December 31, 2016, during which it is a member of the consolidated group comprised of Big, Bigger and Corp. Y.

Jack's remuneration is subject to the deduction limitation for Y's short tax year ending May 1, 2016. However, because Corp. Y is not a health insurance issuer, remuneration for Jack's services for Big, Bigger, or Corp. Y after May 1, 2016, during the tax year of the consolidated group ending December 31, 2016, will not be subject to the $500,000 deduction limitation (IRS Proposed Reg. 1.162-31(f)(3), Example 3).

Conclusion

The Code Sec. 162(m)(6) deduction limit imposed under ACA could potentially affect many unsuspecting employers, including those who are not in the business of providing health insurance coverage. The IRS has authorized exceptions and provided limited transition relief that could moderate the impact of the deduction limit on employers who might otherwise qualify as covered health insurance providers. However, the proposed regulations should alert employers, especially those that are members of controlled groups or the subject of mergers and acquisitions, to the broad scope of the deduction limit.