July 10, 2014

The Honorable John A. Koskinen
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments on Proposed Treasury Regulations under Section 162(m)(6)

Dear Commissioner Koskinen:

Enclosed are comments on proposed Treasury regulations under Section 162(m)(6) ("Comments"). These Comments represent the view of the American Bar Association Section of Taxation. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association, and should not be construed as representing the policy of the American Bar Association.

The Section would be pleased to discuss the Comments with you or your staff if that would be helpful.

Sincerely,

Michael Hirschfeld
Chair

Enclosure

cc: Mark J. Mazur, Assistant Secretary (Tax Policy), Department of the Treasury
William J. Wilkins, Chief Counsel, Internal Revenue Service
J. Mark Iwry, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy, Department of the Treasury
George H. Bostick, Benefits Tax Counsel, Department of the Treasury
Robert J. Neis, Deputy Benefits Tax Counsel, Department of the Treasury
Ilya Enkishev, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities)
These comments (“Comments”) are submitted on behalf of the American Bar Association Section of Taxation and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, they should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Andrew L. Oringer of the Employee Benefits Committee of the Section of Taxation. Substantive contributions were made by Robert A. Miller and Susan A. Wetzel, also of the Employee Benefits Committee. The Comments were reviewed by Martha L. Hutzelman, Employee Benefits Committee Chair. The Comments were further reviewed by James R. Raborn of the Section’s Committee on Government Submissions, by Roberta Casper Watson of the Employee Benefits Committee’s Quality Assurance Group and by Pamela Baker, Council Director for the Employee Benefits Committee.

Although the members of the Section of Taxation who participated in preparing these Comments have clients who would be affected by the federal income tax principles addressed by these Comments, or have advised clients on the application of such rules, no such member (or the firm or organization to which such member belongs) has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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July 10, 2014
EXECUTIVE SUMMARY

The following Comments are submitted in response to the request for comments made by the Department of the Treasury (the “Treasury”) and the Internal Revenue Service (the “Service” or “IRS”) in a Notice of Proposed Rulemaking dated April 2, 2013, regarding Proposed Treasury Regulation section 1.162-311 (the “Proposed Regulations”) issued under Section 162(m)(6) of the Internal Revenue Code of 1986, as amended (the “Code”).

We want to express our appreciation to the Treasury and the Service for their guidance on a number of difficult issues under Section 162(m)(6) and the invitation for taxpayer comments on many specific issues. We are aware that a number of comments have already been submitted that provide suggestions regarding a variety of issues under the Proposed Regulations. We have therefore focused our comments on several specific issues related to the scope of the entities covered by Section 162(m)(6) that we do not believe have otherwise been addressed in comments. In this regard, our comments focus on the de minimis rule (the “De Minimis Rule”) contained in the Proposed Regulations, both (i) specifically with respect to premiums derived from coverage of a company’s own service providers (such as in the case of captive insurance companies), and (ii) as a more general matter.

In the final regulations, in order to address concerns related to premiums derived from coverage of a company’s own service providers:

1. We recommend that, in applying the De Minimis Rule to determine whether a health insurance issuer and other service recipients which are part of an aggregated group as defined in the Proposed Regulations (“Aggregated Group”) constitute a “covered health insurance provider” (a “CHIP”) for a taxable year, the premiums the health insurance issuer receives for health insurance coverage should be excluded from the definition of “premiums” (or otherwise disregarded) if the premiums are attributable to health insurance coverage of present and former employees of (or other service providers to) members of the Aggregated Group.

2. We recommend that the premiums excluded (or otherwise disregarded) in applying the De Minimis Rule should also include those attributable to coverage of present and former employees of (or other service providers to) (a) any other service recipients which are treated as a single employer with the health insurance issuer under Sections 414(b) or 414(c), or would be so treated if “50%” were substituted for “80%” in each place where the latter is used in the underlying rules thereof and (b) any other entity having a relationship with the health insurance issuer of a type which


\[2\] References to a “Section” in the text of these Comments are to a section of the Code, unless otherwise indicated.
would, in a qualified plan context, give rise to a “legitimate business reason” for granting imputed or pre-participation service with respect to such individuals under the Section 401(a)(4) regulations.

In addition, with respect to the application of the De Minimis Rule generally:

3. We recommend that the de minimis threshold be raised from 2% to 5%, so that if the premiums received by the group for providing insured health insurance coverage are less than 5% of the gross revenues of the group, the Aggregated Group and its members will not constitute a “covered health insurance provider.”

4. We also recommend that final regulations expressly provide that the Service is authorized to provide for additional de minimis exclusions from Section 162(m)(6) or similar rules through the use of notices, regulations and other published guidance.
DISCUSSION

BACKGROUND

Section 162(m)(6) sets forth a limitation of $500,000 per year on the deduction allowed for remuneration paid to individuals who provide services to CHIPS. Generally, a CHIP is a health insurance issuer at least 25% of the income of which from health insurance premiums in each year derives from providing “minimum essential coverage.” An aggregation rule provides generally that, if any member of the Aggregated Group is a CHIP, then every other member of the applicable controlled group is also treated as a CHIP. The Proposed Regulations, consistent with IRS Notice 2011-2, contain the De Minimis Rule, under which an Aggregated Group will not be treated as a CHIP if less than 2% of its gross revenues for the year are from premiums for providing minimum essential coverage.

PART ONE: Changes to the De Minimis Rule to Address Premiums from Coverage of a Company’s Own Service Providers (Recommendations 1 and 2)

General Issue

Certain employers may use captive insurance companies to provide health and welfare benefits coverage to their employees and other service providers, or otherwise collect premiums in connection with covering their own service providers. In our experience, most often this use is found in the case of a captive insurance company that insures property and casualty or workers’-compensation risks, with the health and welfare coverage being in addition to these other types of insurance. Captive insurance companies may be used by an employer to insure benefits generally, or instead, on a more limited basis, to provide “stop loss” protection. Other arrangements involving coverage of a company’s own service providers are also possible.

The Proposed Regulations provide that an employer is not a CHIP solely because it maintains a self-insured medical reimbursement plan. The Preamble, however, in a single sentence with no further express background, states that a captive insurance company is treated as a CHIP if it is a health insurance issuer that is otherwise described in Section 162(m)(6)(C). While we acknowledge that, in some cases, the existing De Minimis Rule would allow employers that utilize captive insurance companies to fall outside of Section 162(m)(6), we believe that the underlying policy of Section 162(m)(6) merits providing broader relief with respect to the provision of insurance coverage to a

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3 Prop. Treas. Reg. § 1.162-31(b)(4)(ii). A self-insured medical reimbursement plan means a separate written plan maintained for the benefit of employees (including former employees) that provides for reimbursement of employee medical expenses referred to in Section 105(b) and that does 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 prepaid health care plan that is regulated under federal or state law in a manner similar to the regulation of insurance companies. Id.

4 Preamble at 19,952.
company’s own service providers. Below, we recommend that Treasury and the IRS take
an approach to captives and other “inside” coverage that is different than the one set forth
in the Proposed Regulations, by relaxing the De Minimis Rule to exclude premiums
received for coverage of employees and service providers in the health insurance issuer’s
Aggregated Group and certain other related companies.

We emphasize at the outset that we do not herein mean to address the efficacy
under current law - whether as a legal, tax or practical matter - of the use of a captive
insurance company that would satisfy the requirements that we are proposing for
exclusion from the scope of Section 162(m)(6). We also do not comment on whether the
originally proposed de minimis relief might in any number of cases moot these issues in
practice in the current marketplace. Rather, our purpose is to identify an analytical
approach for captives and other “inside” coverage that would serve as a basis for
administering Section 162(m)(6) regardless of the manner in which the rules surrounding
captives, the market for captives and the characteristics of captives and the other use of
“inside” insurance might evolve over time. As explained in further detail below, our
point is not to cause Section 162(m)(6) to provide an incentive for the use of captives or
otherwise for benefits insured by the employer or other service recipient (or its affiliates);
rather, our goal is to avoid the result that Section 162(m)(6) would provide an
inappropriate disincentive to the use of captives or other “inside” coverage.

First Recommendation
Disregarding Premiums for Coverage Within the Aggregated Group in General

We recommend that, in applying the De Minimis Rule to determine whether a
health insurance issuer and other service recipients which are part of the same
Aggregated Group (as defined in the Proposed Regulations) constitute a CHIP for a
taxable year, the premiums the health insurance issuer receives for health insurance
coverage should be excluded from the definition of “premiums” (or otherwise
disregarded) if the premiums received for that year for providing health insurance
coverage are attributable to coverage of present and former employees of (or other
service providers to) members of the Aggregated Group.

Explanation

The Proposed Regulations, and in particular the Preamble, presently would regard
a captive no differently than other insurance companies for purposes of Section
162(m)(6). For the reasons discussed below, we believe that a service recipient’s (or its
affiliate’s) coverage of its own service providers should not lead to coverage by Section
162(m)(6). Specifically, we propose that the premiums received for providing health
insurance coverage should be excluded from the definition of “premiums” under Section
1.162-31(b)(5) of the Proposed Regulations, in the same way direct service payments and
indemnity reinsurance payments are excluded. These premiums would thus be ignored
for purposes of determining whether the Aggregated Group meets any otherwise
applicable de minimis tests (or the premiums should otherwise be disregarded).
Section 162(m)(6) was intended to be a tax-based incentive to insurers that offer minimum essential coverage to the public to maintain executive compensation below a certain maximum and thereby in turn exert downward pressure on costs and pricing of the insurance being offered to the public. Senator Blanche Lincoln made comments to this effect when she introduced the provision; and Senator Max Baucus, the Chairman of the Committee on Finance, reiterated a similar approach in a news release issued to celebrate the passage of the Senate predecessor of the Patient Protection and Affordable Care Act (“PPACA”), which ultimately added Section 162(m)(6) to the Code. According to Senator Baucus, Section 162(m)(6) was one of the measures that would “ensure Americans have quality, affordable, health care coverage.” Notably, one of the significant goals of PPACA generally was the reduction of health insurance costs. Section 1501(a)(2)(J) of PPACA identifies Congress’s goal of “significantly reduc[ing] administrative costs [for private health insurance] and lower[ing] health insurance premiums,” and Section 1501(a)(2) generally otherwise makes repeated references to the “health insurance market.” Consistent with the foregoing, the Proposed Regulations already contain an exception for employers who maintain self-insured plans, which do not involve marketing to the public.

An employer may provide health coverage to its employees by obtaining insurance from a third party, through a captive subsidiary, or by self-insuring. The choice made from among these alternatives should not be a basis for determining whether Section 162(m)(6) is applicable to the employer. Such an employer is not setting the prices for minimal essential coverage offered to the public, and, we submit, is not within the type of employers whose executive compensation costs were the intended target of Section 162(m)(6).

The Proposed Regulations correctly recognize that employers who purchase insurance on the market or who self-insure are not within the intended reach of Section 162(m)(6). We cannot find any reason why an employer who insures health coverage (e.g., through a captive that insure health coverage) with respect to related party employees should be treated any more adversely under Section 162(m)(6).

If premiums from a service recipient’s (or its affiliate’s) own service providers were to give rise to CHIP status, the CHIP aggregation rule could effectively taint all of the members of Aggregated Group of which the CHIP is a member, even if the business of the Aggregated Group is otherwise completely unrelated to health insurance. We are concerned that an effect of the Proposed Regulations’ treatment of captives, and failure to provide special rules for such premiums, could be to push employers who are using or otherwise would use a captive or other affiliated insurer to instead utilize a different method of providing health coverage to their employees. We believe that this would not be an intended or desirable consequence of Section 162(m)(6).

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5 Press Release, Sen. Max Baucus, Finance Committee Approves Baucus’ America’s Healthy Future Act (Oct. 13, 2009), available at http://www.finance.senate.gov/newsroom/chairman/release/?id=889f90a3-f2f4-49a4-ba1f-30083ae4ba6e (mentioning that the bill would “[l]imit tax deductions for insurance companies that give their executives excessive salaries”).
We note expressly that we are not suggesting that Treasury and the IRS give consideration to improving the treatment of captives or another affiliated insurers as compared to their treatment before the enactment of Section 162(m)(6). Rather, we believe that Section 162(m)(6) should neither discourage nor encourage employers to use captive or other affiliated insurance companies for health coverage. If such insurance companies were accorded treatment under Section 162(m)(6) that is different than the treatment accorded employers with self-funded plans, then the unintended, but potentially inefficient effect would be to cause Section 162(m)(6) to apply to this select group of employers, on the basis of a criteria (in particular, the method of funding of health coverage for employees) that appears to have nothing to do with the policies behind Section 162(m)(6).

Thus, we are proposing that premiums received for a year by a captive or other health insurance issuer that are attributable to coverage of present and former employees of (and other service providers to) members of the Aggregated Group that includes the health insurance issuer should not be taken into account for purposes of determining CHIP status and should be excluded from the definition of “premiums” under Section 1.162-31(b)(5) of the Proposed Regulations, in the same way that direct service payment and indemnity reinsurance payments would presently be excluded thereunder.

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6 We are not certain of the extent to which companies are, in light of, among other things, current tax and other legal concerns, actually offering health coverage to active employees or exclusively to their own service providers through their captives or other affiliated insurance companies. Regardless, we believe that the clarifications we are suggesting are appropriate, both because it is possible that the issues regarding affiliated providers may be present in the market at least in certain cases, and because it is by no means clear how the market for and applicable legal rules regarding affiliated insurers will evolve over time. We acknowledge that, at this time, it appears that when a captive insurer is used to provide employee benefits to an employer's own employees, the captive generally provides reinsurance and the direct provision of insurance is by an unaffiliated insurer. We understand that this approach has been used at least in part because the Department of Labor, where considering prohibited transaction exemptions with respect to captives under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), has tended to grant exemptive relief only where an unaffiliated insurer provides the direct insurance (examples include Columbia Energy (2000), Archer Daniels Midland (2003), International Paper (2003), SunMicrosystems (2005), AGL Resources (2006), Wells Fargo (2006), Cephalon (2008), Dow Corning (2009), Deutsche Bank (2011), Verizon (2011), Google (2012), Microsoft (2012) and Coca-Cola (2013)). However, again, it is by no means clear that market practices and applicable legal rules will not evolve over time, and thus we believe that clarification of the applicable Section 162(m)(6) analysis in accordance with our suggestions is appropriate.

7 We acknowledge generally that that the overall tax issues relating to captives are not straightforward. For the reasons set forth above, however, we believe that the premiums for providing health benefits to employees and service providers of the Aggregated Group, whether through a captive (or other health insurance issuer) that is part of the Aggregated Group, should not, themselves, be taken into account in determining whether the captive (or other health insurance issuer) is a CHIP under Section 162(m)(6). To the extent a captive solely provides health insurance coverage to employees and service providers of the Aggregated Group, the captive would not be a CHIP under our proposed rule, but that would be the result of not providing sufficient coverage to the broader marketplace to come within the purpose of Section 162(m)(6)), rather than the result of any special exclusion for captives, per se.
Second Recommendation
Level of Affiliation for Disregarding Premiums for Coverage

We recommend that the premiums excluded (or otherwise disregarded) in applying the De Minimis Rule should also include those attributable to coverage of present and former employees of (or other service providers to) (a) any other service recipients which are treated as a single employer with the health insurance issuer under Sections 414(b) or 414(c), or would be so treated if “50%” were substituted for “80%” in each place where the latter is used in the underlying rules thereof and (b) any other entity having a relationship with the health insurance issuer of a type which would, in a qualified plan context, give rise to a “legitimate business reason” for granting imputed or pre-participation service with respect to such individuals under the Section 401(a)(4) regulations.

Explanation

We believe that, because the underlying policy of section 162(m)(6) relates in our view to health insurance coverage provided to the public (as opposed to coverage of employees and other service providers), the level of affiliation between the health insurance issuer and the other companies for whose employees it provides health insurance coverage should encompass more than simply the health insurance issuer’s Aggregated Group.

First, as defined in the Proposed Regulations, the Aggregated Group does not include brother-sister groups and combined groups, even though such companies would be treated as a single employer with the health insurance issuer under the regular controlled group rules of Sections 414(b) and 414(c). It is not unusual for brother-sister controlled groups to maintain a common set of employee benefit plans, since the Section 410(b) coverage rules may require such a result at least with respect to qualified plans. Consequently, premiums for covering employees and service providers of such controlled group members should be disregarded in determining CHIP status for the same reasons described above respect to employees and service providers of members of the Aggregated Group.

Similar considerations also favor disregarding premiums for covering employees or service providers of entities that would be part of a Section 414(b) or (c) controlled group if references in the underlying rules to “at least 80%” were replaced with references to “more than 50%”.  

We further propose that premiums received for health insurance coverage would be excluded from the definition of “premiums” (or otherwise disregarded) in connection

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8 Cf., e.g., Treas. Reg. § 1.409A-1(b)(5)(iii)(E) (lowering the Section 414 affiliation threshold from 80% to 50% or under certain circumstances 20%, in the context of “service recipient stock” under Section 409A); Section 415(h) (lowering the affiliation threshold to 50% for purposes of the application of the Section 415 limits); ERISA § 3(40) (permitting the Department of Labor to lower the affiliation threshold to as little as 25% for purposes of the “multiple employer welfare arrangement” rules).
with the determination of CHIP status for a taxable year for health insurance coverage the insurance company provides to present and former employees of (or other service providers to) other related companies where the insurance company would have a “legitimate business reason” (within the meaning of Treas. Reg. § 1.401(a)(4)-11(d)(3)(iii)(B)(1)) for providing the coverage, based on all facts and circumstances, to the employees of (or other service providers to) such other related companies. The existing rule under Treas. Reg. § 1.401(a)(4)-11(d)(3)(iii)(B)(1) governs whether a tax-qualified retirement plan can credit certain imputed or pre-participation service, thereby implicating the critical requirement under Section 401(a) that a tax-qualified trust be for the “exclusive benefit” of the employees of the plan’s sponsoring employer(s) (and the employees’ beneficiaries). We believe this test also could be extended to the instant context, in that the question of whether an insurance company provides health insurance to the public essentially relates to whether the Aggregated Group should be considered to be provided to truly outside consumers.

PART TWO: General Changes to the De Minimis Rule (Recommendations 3 and 4)

Issue Generally

We acknowledge and appreciate Treasury’s and the IRS’s efforts to make Section 162(m)(6) more administrable and to narrow the scope of Section 162(m)(6) to its intended scope through the use of the existing De Minimis Rule in the Proposed Regulations. Indeed, the inclusion of a De Minimis Rule was sufficiently critical so as to merit inclusion in Notice 2011-2, which was issued as a stop-gap with respect to certain key issues pending the development of regulations. The existing De Minimis Rule is essentially the same as the de minimis rule contained in Notice 2011-2. The existing De Minimis Rule applies (for taxable years beginning after 2012) if the premiums received

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9 The Treasury Regulations elaborate on the concept of “legitimate business reason” as follows:

The following are examples of relevant facts and circumstances for determining whether a legitimate business reason exists for a plan to credit pre-participation or imputed service for a period of service with another employer as service with the employer: whether one employer has a significant ownership, control, or similar interest in, or relationship with, the other employer (though not enough to cause the two employers to be treated as a single employer under section 414); whether the two employers share interrelated business operations; whether the employers maintain the same multiple-employer plan; whether the employers share similar attributes, such as operation in the same industry or the same geographic area; and whether the employees are an acquired group of employees or the employees became employed by the other employer in a transaction between the two employers that was a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of a trade or business. . . .

by the Aggregated Group for providing health insurance coverage are less than 2% of the gross revenues of the Aggregated Group as determined in accordance with generally accepted accounting principles.

Notice 2011-2 specifically asked for comments on possible alternative de minimis exceptions. Although this request was not repeated in the Preamble to the Proposed Regulations, we believe that there may indeed be fact patterns that would also warrant exclusion from Section 162(m)(6) in which the 2% standard in the Proposed Regulations is too low. We remain concerned that the effect on an entire Aggregated Group of the presence of a CHIP could be draconian, and that the existing De Minimis Rule may be insufficient to ameliorate possible overbreadth in the application of Section 162(m)(6).

Thus, we think that relaxing the de minimis exclusions could play an important role in limiting the application of Section 162(m)(6) to the types of employers that Congress intended to be covered. For this reason, we make two proposals - one specific and one general - relating to the De Minimis Rules.

**Third Recommendation**

*Proposed Relaxation of De Minimis Rule*

**Issue**

Even where the premiums received by the Aggregated Group for providing health insurance coverage marginally exceed 2% or more of the group’s total gross revenues, the business unit that provides the health insurance coverage may still remain such a relatively small portion of the group that applying the provisions of Section 162(m)(6) would be unwarranted, especially as to the group as a whole. In other words, utilizing a 2% threshold for the De Minimis Rule seems relatively low, in light of the effect and purpose of the provision.

**Recommendation**

We recommend that the threshold in the De Minimis Rule be raised from 2% to 5%, so that if the premiums received by the group for providing insured health insurance coverage are less than 5% of the gross revenues of the group, the Aggregated Group and its members will not constitute a CHIP.

**Explanation**

We believe the 2% threshold is too low a threshold to use in the De Minimis Rule, in the context of the purposes of the statute and the resulting impact of imposing the deduction limitation across employees of the entire Aggregated Group. Under the De Minimis Rule and the 2% threshold as currently structured in the proposed regulations, if the Aggregated Group includes as a very small part of its operations a health insurance business which generates a mere 3% of its gross revenues, the $500,000 deduction limitation, and the complexities involved, will apply across all employees in the control group, from the CEO of the parent company through employees of operating companies.
that may be in completely different lines of business. In such a situation, the vast majority of the impacted employees will be providing little if any services with respect to the health insurance business. Having the deduction limit apply with respect to the compensation of such employees would seem unlikely to have any meaningful, positive impact with respect to constraining health care premiums charged by the health insurance business, which as noted above, appears to be the purpose of the deduction limitation.

Obviously, adopting any particular bright-line de minimis threshold means that employers just above that threshold would be brought within the rules, and those below it would remain outside the rule, but where the potential impact is so significant, it would seem appropriate for the threshold to be sufficiently high so that there would be a reasonable likelihood that at least a significant portion of the employees in the broader controlled group who would be impacted by the rule would be spending some meaningful portion of their time providing services to the health insurance business. We submit that a threshold level of 5% would be more appropriate in this regard, as a business unit which represents 1/20th or more of the business of the overall Aggregated Group would appear more likely to require and receive a material degree of oversight and assistance from other employees within the Aggregated Group (whose compensation would be swept into the impact of the deduction limitation) than a business unit which represents significantly less of the business of the overall Aggregated Group (such as merely 1/50th, the existing de minimis standard).

We note also that the impact of the deduction limitation with respect to employees outside the insurance business may operate as a disincentive for companies to acquire or retain ownership of health insurance operations. Such a disincentive could mean loss of economies of scale and synergies which potentially could reduce the health insurance premiums that the health insurance business would charge. Thus, using a higher de minimis percentage could, in our view, appropriately result in reduced interference with the market regarding corporate transactions involving purchases and sales of businesses that provide such health insurance coverage.

We recognize that the argument in favor of increasing the de minimis threshold may be stronger the more separate the health insurance business is from the broader Aggregated Group, and possibly also the more different its business is from the other businesses of the Aggregated Group. Thus, in the event the IRS and Treasury is uncomfortable with simply increasing the threshold from 2% to 5% in all cases, it could consider providing the higher de minimis threshold only in situations where the health insurance business meets requirements similar to the line of business and separate organization, workforce and management requirements in the qualified separate line of business regulations under Section 414(r) (see Treas. §§ 1.414(r)-2 and -3). It could also consider requiring satisfaction of the general administrative scrutiny requirement or the separate SIC codes or industry segment safe harbors under those regulations (see Treas. §§ 1.414(r)-5(c), -5(e), -6).

A further alternative that could also be considered would be to limit the impact of the deduction limitation under Section 162(m)(6) to those employees who are substantial service employees with respect to the separate line of business containing the health
insurance issuer or otherwise receive compensation from the health insurance issuer. Such an approach would appear to meet the policy goals of the statute because it would apply the constraint of the deduction limitation to the compensation costs that would most directly impact the health insurance issuer (thereby hopefully helping to reduce the premiums charged), without raising the overbreadth concerns noted above.\textsuperscript{10}

Although the statute does on its face provide for the deduction limitation to apply across members of the Aggregated Group, we believe it is reasonably within the regulatory authority of the IRS and Treasury to utilize an approach under which the impact of the deduction limitation applies only with respect to employees of a separate line of business housing the health insurance issuer. Section 162(m)(6)(H) gives Treasury and IRS broad authority to “prescribe such guidance, rules or regulations as are necessary to carry out the purposes of” Section 162(m)(6). Further, if Treasury and the IRS have the authority to except from the reach of Section 162(m)(6) the entire Aggregated Group in some cases, as has been done under the existing De Minimis Rule, then it would seem that Treasury and the IRS should have the authority to except from the reach of Section 162(m) a portion, rather than the entirety, of the Aggregated Group. Just as the separate line of business rules are meant to ameliorate some of the harsh results and complexities that could occur from a rigid application of the controlled group rules in the qualified plan area, utilizing a similar approach with respect to Section 162(m)(6) would ameliorate potentially harsh, complex and possibly counterproductive impacts of a rigid application of the Aggregated Group rules in this area. We recognize, however, that the adoption of such an approach may require more time than remains available in connection with finalization of the Proposed Regulations, and consequently do not make a formal recommendation at this juncture regarding the possibility of using rules similar to the separate line of business rules to limit the application of Section 162(m)(6) to employees of a separate line of business that includes health insurance issuers.

\textit{Fourth Recommendation}

\textit{Authority for Additional De Minimis Tests by Notice or Other Authority}

\textbf{Issue}

We think it is possible that, once the final regulations are issued, more Aggregated Groups will emerge that appear appropriate for de minimis relief. We recognize that rule making through regulations is a long process and that, in other contexts, final regulations have been issued that authorize the IRS to add to the rules in limited specified ways through notices and other guidance.

\textsuperscript{10} Another approach could be to increase the applicable percentage (\textit{e.g.}, to 5\%) under the De Minimis Rule only in those cases in which the business unit that provides any type of insurance is a relatively small part (\textit{e.g.}, 20\% or less in gross assets or gross revenues) of the overall Aggregated Group of which the unit is a part.
**Recommendation**

We recommend that the final regulations expressly provide that the IRS is authorized to provide for additional de minimis exclusions from Section 162(m)(6) or similar rules through the use of notices, regulations and other published guidance.

**Explanation**

We are concerned that neither Treasury and the IRS nor we and other commentators have sufficiently identified all of the possible scenarios in which de minimis or similar rules might be sensible for adoption under Section 162(m)(6), and believe that experience with the provision over time may help to inform what additional rules may be appropriate. In particular, we are concerned that the CHIP aggregation rule could operate in practice in a manner that inappropriately distorts the impact of Section 162(m)(6) by extending its reach to corporate groups that are not within the intended focus of the new provision. We therefore suggest that final regulations authorize the IRS to adopt additional de minimis and similar rules through notices or other published guidance.