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From: [redacted]
Sent: Monday, February 22, 2016 12:06:36 PM
To: [redacted]
Cc: [redacted]
Bcc:
Subject: IRC Section 9832(b)(2) and State Medicaid Health Plans

Hi ,

These are responses to the questions raised in your December 9, 2015 email regarding risk-bearing and non-risk bearing entities. Please let us know if we can be of more help.

Thanks,

Issue

Whether an entity providing Medicaid services is a "health insurance issuer" receiving premiums from providing "health insurance coverage," as those terms are defined in section 9832(b), and thus within the definition of "covered health insurance provider" for purposes of section 162(m)(6).

In particular:

(1) Is a non-risk bearing entity a "health insurance issuer" within the meaning of section 9832(b)(2)?

(2) Is a risk-bearing entity a "health insurance issuer" within the meaning of section 9832(b)(2)?

(3) If a risk-bearing entity becomes licensed as an insurance company under state law in order to submit a bid for a Medicaid contract, is that entity a "health insurance issuer" within the meaning of section 9832(b)(2)?

(4) Do payments from a state under a Medicaid contract to a risk-bearing entity that is a health insurance issuer qualify as "premiums" so that the entity may be a "covered health insurance provider" under section 162(m)(6) if, for taxpayer years beginning after December 31, 2012, not less than 25 percent of the gross premiums received from providing health insurance coverage is from minimum essential coverage (as defined in section 5000A(f)?

Background

Covered health insurance provider. The statute and regulations under section 162(m)(6) limit the available compensation deduction for a "covered health insurance provider" for a taxable year to $500,000 per service provider (which includes an employee). The statute and regulations define the term "covered health insurance provider" as a (A) "health insurance issuer" as defined in section 9832(b)(2) which (B) receives premiums from providing "health insurance coverage" as defined in section 9832(b)(1).

Section 9832(b)(2) and §54.9801-2 provide that the term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (b)(3)) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section).

Section 9832(b)(1)(A) and §54.9801-2 provide that the term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Section 1.162-31(b)(5) provides that, for purposes of section 162(m)(6), "premiums" from providing health insurance coverage are premiums written determined in a manner consistent with the requirements for reporting under the Supplemental Health Care Exhibit published by the NAIC or the MLR Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services.

Section 1.162-31(b)(iv) excludes direct service payments from the definition of premiums. Section 1.162-31(b)(iv) defines a direct service payment as a payment "made by a health insurance issuer or other entity that received premiums from providing health insurance coverage (as defined in section 9832(b)(1)) to another organization as compensation for providing, managing, or arranging for the provision of healthcare services by physicians, hospitals, or other healthcare providers."

Neither the Internal Revenue Code nor any accompanying regulations define the term "insurance" or "insurance contract." The United States Supreme Court, however, has explained that in order for an arrangement to constitute insurance for federal income tax purposes, both risk-shifting and risk-distribution must be present. See Helvering v. Le Gierse, 312 U.S. 531 (1941).

Neither section 162(m)(6) nor the accompanying regulations categorically except from the definition of "covered health insurance provider" an entity that provides Medicaid services. The preamble of the final regulations specifically notes that the Treasury Department and the IRS do not adopt the suggestion to provide in the final regulations that clinical risk-bearing entities, Medicare and Medicaid providers, and other recipients of payments from government entities in connection with providing benefits under government sponsored health care programs are categorically excluded from being covered health insurance providers or that the amounts received by these organizations are categorically excluded from classification as premiums from providing health insurance coverage.

The preamble further acknowledges that to be a covered health insurance provider under section 162(m)(6), a person must be a health insurance issuer (as defined in section 9832(b)(2)) that receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)) and that meets certain other requirements. Therefore, if a person is not a health insurance issuer or does not receive premiums from providing health insurance coverage, the person is not a covered health insurance provider for purposes of section 162(m)(6).

Medicaid. The Medicaid Program provides medical benefits to low-income people who have no medical insurance or have inadequate medical insurance. The Medicaid program is jointly funded by the federal

government and states. The federal government pays states for a specified percentage of program expenditures. The federal government establishes general guidelines for the administration of Medicaid benefits. However, specific eligibility requirements to receive Medicaid benefits, as well as the type and scope of services provided, are determined by each individual state.

States generally pay for Medicaid services through risk-bearing and non-risk-bearing arrangements. Under non-risk-bearing arrangements, states pay providers directly for services. Such arrangements can include an entity paid an administrative fee for case management services, although actual medical care is reimbursed on a fee-for-service basis; that is, the states reimburse providers directly for each individual to whom services are furnished.

Under risk-bearing arrangements, in exchange for capitation payments or other set payments, an entity provides the prescribed medical services or arranges for providers to provide the prescribed medical services to Medicaid enrollees on a similar basis as services are provided to other Medicaid beneficiaries. Under risk-bearing arrangements, the entity assumes risk for the cost of furnishing the services under the arrangement and incurs loss if the cost of furnishing the services exceeds the set payments under the arrangement (or gain if the cost of services is less than the set payments).

In many cases, licensure as an insurance company under state law is a requirement that must be satisfied before an entity may participate in a state Medicaid contract bidding process. The entity participating in the bidding process may be either a risk-bearing or non-risk-bearing entity.

Analysis and Conclusions

(1) Is a non-risk bearing entity a ‘‘health insurance issuer’’ under section 9832(b)(2)?

A non-risk-bearing entity providing services under a state Medicaid program does not have the risk-shifting or risk-distribution elements of insurance and consequently a non-risk-bearing entity is not a health insurance issuer under section 9832(b)(2). Because the state reimburses the entity for medical care provided on a fee-for-service basis based on the actual services provided to the covered individuals, the entity generally is not at risk for the cost of the services exceeding the amount of reimbursements paid by the state.

(2) Is a risk-bearing entity a “health insurance issuer” under section 9832(b)(2)?

A risk-bearing entity that is licensed to engage in the business of insurance in a state and is subject to state law which regulates insurance and that has the risk-shifting or risk-distribution elements of insurance is a “health insurance issuer” under section 9832(b)(2). Because a risk-bearing entity is at risk of loss for the cost of the services exceeding the amount of payments received from the state, or has the possibility of gain in cases in which the amount of payments paid by the state exceeds the cost of services provided, the entity is at risk for the cost of the services exceeding the amount of reimbursements paid by the state.

(3) If a risk-bearing entity becomes licensed as an insurance company under state law in order to submit a bid for a Medicaid contract, is that entity considered to be a “health insurance issuer” under section 9832(b)(2)?

A risk-bearing entity that becomes licensed as an insurance company under state law, whether to satisfy a contractual requirement or otherwise, is licensed to engage in the business of insurance in the state and satisfies the requirement under section 9832(b)(2) that a “health insurance issuer” be an insurance company licensed to engage in the business of insurance in a state. Moreover, as an insurance company licensed to engage in the business of insurance in a state, that entity is also subject to the state laws which regulate insurance, which is the other requirement under section 9832(b)(2) for an entity to be a “health insurance issuer.” As such, that entity is a “health insurance issuer.” This is in contrast to

situations in which the entity's contract with the state imposes conditions similar or identical to the state law requirements but the entity is not, in fact, directly subject to the state insurance laws.

(4) Do payments from a state under a Medicaid contract to a risk-bearing entity that is a health insurance issuer qualify as "premiums" so that the entity is a "covered health insurance provider" under section 162(m)(6)?

Even if an entity is a health insurance issuer under section 9832(b)(2), there remains the question of whether payments received by the risk-bearing entity are premiums from providing health insurance coverage. Direct service payments under §1.162-31(b)(iv) are excluded from the definition of premiums. A direct service payment is a payment "made by a health insurance issuer or other entity that received premiums from providing health insurance coverage (as defined in section 9832(b)(1)) to another organization."

Section 1.162-31(b)(5) provides that "premiums" from providing health insurance coverage are premiums written determined in a manner consistent with the requirements for reporting under the Supplemental Health Care Exhibit published by the NAIC or the MLR Annual Reporting form filed with the CMS CIIIO of HHS. But as reflected in the treatment of direct service payments, to constitute the payment of a premium for health insurance coverage the payment must result in a legal relationship between the covered individual and the entity receiving the payment. Whether this relationship exists depends on whether the Medicaid beneficiaries could assert rights against the entity analogous to those between covered individuals and health insurance issuers in the private market and as required under state law. If this type of relationship exists between the entity and the Medicaid beneficiaries (whether directly or indirectly), the payments received by the entity are premiums from provided health insurance coverage paid by the state on behalf of the Medicaid beneficiaries. If this type of relationship does not exist because, for example, the individual's rights under the arrangement are only enforceable against the state, then the relationship between the state and the entity is more akin to a direct service provider. See the preamble to the section 162(m)(6) proposed regulations (REG-106796-12) at 78 FR 19950-01, 19953. Whether there is an insurance relationship between the covered individual and the state is not necessary to determine because a state would not meet the definition