

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 1**

[TD 9694]

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The \$500,000 Deduction Limitation for Remuneration Provided by Certain Health Insurance Providers**AGENCY:** Internal Revenue Service (IRS), Treasury.**ACTION:** Final regulations.

SUMMARY: This document contains final regulations on the application of the \$500,000 deduction limitation for remuneration provided by certain health insurance providers under section 162(m)(6) of the Internal Revenue Code (Code). These regulations affect certain health insurance providers providing remuneration that exceeds the deduction limitation.

DATES: *Effective date:* These regulations are effective on September 23, 2014.

Applicability date: For dates of applicability, see § 1.162-31(j).

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SUPPLEMENTARY INFORMATION:**Background**

This document contains final amendments to the Income Tax Regulations (26 CFR part 1) under section 162(m)(6) of the Code. Section 162(m)(6) limits the allowable deduction for remuneration attributable to services performed by applicable individuals to certain health insurance providers that receive premiums from providing health insurance coverage. Section 162(m)(6) was added to the Code by section 9014 of the Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148, 124 Stat. 119, 868 (2010)).

In general, section 162(m)(6) limits to \$500,000 the allowable deduction for remuneration attributable to services performed by an applicable individual for a covered health insurance provider in a taxable year beginning after December 31, 2012, that, but for section 162(m)(6), is otherwise deductible under chapter 1 of the Code (referred to in this preamble and the final regulations as remuneration that is otherwise deductible). Remuneration attributable to services performed for a covered health insurance provider in a disqualified taxable year beginning after December 31, 2009, and before January 1, 2013, that becomes otherwise

deductible in a taxable year beginning after December 31, 2012, is also subject to the \$500,000 deduction limitation, determined as if the deduction limitation applied to disqualified taxable years beginning after December 31, 2009. If remuneration that is attributable to services performed by an applicable individual for a covered health insurance provider in a disqualified taxable year exceeds \$500,000, the amount of the remuneration that exceeds \$500,000 is not allowable as a deduction in any taxable year.

On December 23, 2010, the Department of the Treasury (Treasury Department) and the IRS released Notice 2011-2 (2011-1 IRB 260), which provides guidance on certain issues under section 162(m)(6). A notice of proposed rulemaking (REG-106796-12) was published in the **Federal Register** (78 FR 19950) on April 2, 2013 (the proposed regulations). The Treasury Department and the IRS received written comments in response to the notice and the proposed regulations. After consideration of these comments, the Treasury Department adopts the proposed regulations as final regulations, with the modifications set forth in this Treasury decision.

Summary of Comments and Explanation of Modifications*I. Definition of Covered Health Insurance Provider**A. In General*

Section 162(m)(6)(C) provides that a covered health insurance provider is any health insurance issuer described in section 162(m)(6)(C)(i) and certain persons that are treated as a single employer with that health insurance issuer, as described in section 162(m)(6)(C)(ii). A person may be a covered health insurance provider for one taxable year, but not be a covered health insurance provider for another taxable year, depending on whether that person meets the requirements to be a covered health insurance provider under section 162(m)(6)(C) for a particular taxable year. These final regulations generally adopt the rules described in the proposed regulations for determining whether a health insurance issuer or any other person is a covered health insurance provider for any taxable year, except as described herein.

B. Health Insurance Issuers

For taxable years beginning after December 31, 2012, section 162(m)(6)(C)(i)(II) provides that a health insurance issuer (as defined in section

9832(b)(2)) is a covered health insurance provider for a taxable year if not less than 25 percent of the gross premiums that it receives from providing health insurance coverage (as defined in section 9832(b)(1)) during the taxable year are from minimum essential coverage (as defined in section 5000A(f)). For taxable years beginning after December 31, 2009 and before January 1, 2013, section 162(m)(6)(C)(i)(I) provides that a health insurance issuer (as defined in section 9832(b)(2)) is a covered health insurance provider for a taxable year if it receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)) during the taxable year.

C. Persons Treated as a Single Employer With a Health Insurance Provider

Section 162(m)(6)(C)(ii) provides that two or more persons that are treated as a single employer under sections 414(b), (c), (m), or (o) are treated as a single employer for purposes of determining whether a person is a covered health insurance provider, except that in applying section 1563(a) for purposes of these subsections, sections 1563(a)(2) and (3) (describing brother-sister controlled groups and combined groups) are disregarded. The final regulations, like the proposed regulations, generally provide that each member of an aggregated group that includes a covered health insurance provider described in section 162(m)(6)(C)(i) at any time during a taxable year is also a covered health insurance provider for purposes of section 162(m)(6), even if the member is not a health insurance issuer and does not provide health insurance coverage. For this purpose, the final regulations, like the proposed regulations, define the term *aggregated group* as a health insurance issuer (as defined in section 9832(b)(2)) and all persons that are treated as a single employer with the health insurance issuer under sections 414(b), (c), (m) or (o), disregarding sections 1563(a)(2) and (3) (with respect to controlled groups of corporations) and § 1.414(c)-(2)(c) and (d) (with respect to trades or businesses under common control).

The proposed regulations include rules for determining whether a member of an aggregated group that is not a health insurance issuer is a covered health insurance provider for a particular taxable year. Under these rules, the parent entity of an aggregated group is generally a covered health insurance provider for its taxable year with which, or in which, ends the taxable year of any health insurance issuer that is a covered health insurance

provider in an aggregated group with the parent entity. Each other member of the parent entity's aggregated group is a covered health insurance provider for its taxable year that ends with, or within, the taxable year of the parent entity during which the parent entity is a covered health insurance provider. The final regulations generally adopt these rules.

The final regulations, like the proposed regulations, provide that, in an aggregated group that is a parent-subsubsidiary controlled group of corporations (within the meaning of section 414(b)) or a parent-subsubsidiary group of trades or businesses under common control (within the meaning of section 414(c)), the parent entity is the common parent of the aggregated group.

With respect to an aggregated group that is an affiliated service group within the meaning of section 414(m) or a group described in section 414(o), the final regulations adopt the rules described in the proposed regulations and provide that the parent entity is the health insurance issuer in the aggregated group. If, however, two or more health insurance issuers are members of an aggregated group that is an affiliated service group (within the meaning of section 414(m)) or a group described in section 414(o), then any health insurance issuer in the aggregated group that is designated in writing by the other members of the aggregated group is the parent entity for purposes of section 162(m)(6). If the members of an aggregated group that includes two or more health insurance issuers that is an affiliated service group or group described in section 414(o) fail to designate a parent entity in writing, the members of the group are deemed for all taxable years to have a parent entity with a taxable year that is the calendar year.

In the preamble to the proposed regulations, the Treasury Department and the IRS requested comments on the circumstances under which a new parent entity could be designated, such as when a health insurance issuer that has been designated as the parent entity of an aggregated group ceases to be a member of the aggregated group as a result of a corporate transaction, and any transition rules that may be necessary in such situation. One commenter suggested that the final regulations should provide that when a parent entity (a *predecessor parent entity*) ceases to be a member of an aggregated group under section 414(m) and another health insurance issuer that has the same taxable year as the predecessor parent entity remains in the aggregated group, the remaining

members of the aggregated group must designate that health insurance issuer as the new parent entity (the *successor parent entity*). The commenter also suggested that if no health insurance issuer remaining in the aggregated group has the same taxable year as the predecessor parent entity, then the group should be permitted to designate any health insurance issuer in the aggregated group as the successor parent entity. The final regulations generally adopt these suggestions.

The final regulations also provide transition rules for determining when a member of an aggregated group is a covered health insurance provider if, as a result of a change in the identity of the parent entity or for any other reason, the taxable year of the parent entity is less than 12 consecutive months. The final regulations provide that if the taxable year of the parent entity is less than 12 months, then, solely for purposes of determining whether it is a covered health insurance provider for its short taxable year and for purposes of determining whether each other member of the parent entity's aggregated group is a covered health insurance provider for its taxable year ending with or within the taxable year of the parent entity, the taxable year of the parent entity is treated as the 12-month period ending on the last day of its short taxable year. The purpose of this rule is to ensure consistency and continuity in the treatment of members of an aggregated group as covered health insurance providers. Without this rule, certain members of an aggregated group that are generally treated as covered health insurance providers may not be treated as covered health insurance providers for one taxable year because they do not have a taxable year ending with or within the short taxable year of the parent entity.

One commenter suggested that an entity should not be a covered health insurance provider if all of the services performed by its employees and independent contractors are unrelated to the direct or indirect generation of health insurance premiums and if the entity is geographically separate from any entity within the aggregated group that receives premiums from providing health insurance. These final regulations do not adopt this suggestion. Such a rule would be inconsistent with section 162(m)(6)(C)(ii), which provides that all members of an aggregated group that includes a health insurance issuer described in section 162(m)(6)(C)(i) are covered health insurance providers.

D. United States Possessions

One commenter suggested that health insurance providers located in Puerto Rico should not be considered health insurance issuers under section 9832(b)(1) and, therefore, should not be covered health insurance providers under section 162(m)(6)(C)(i). The commenter also suggested that health insurance companies (and similar health insurance providers) located in Puerto Rico should not be considered covered health insurance providers under section 162(m)(6)(C) because the benefits of the ACA do not inure to Puerto Rican insurance companies and because American taxpayers do not subsidize compensation paid by health insurance providers in Puerto Rico through tax deductions. These final regulations do not adopt this suggestion. In regulations issued under section 9010 of the ACA (TD 9643, 78 FR 71476, November 29, 2013), the Treasury Department and the IRS concluded that a health insurance company, health insurance service, or insurance organization may be a health insurance issuer under section 9832(b)(2) even if it is located in Puerto Rico. Accordingly, a health insurance issuer that is otherwise a covered health insurance provider under section 162(m)(6) will not fail to be a covered health insurance provider solely because it is located in Puerto Rico.

E. Self-insurers

These final regulations, like the proposed regulations, provide that an employer is not a covered health insurance provider solely because it maintains a self-insured medical reimbursement plan. For this purpose, the term *self-insured medical reimbursement plan* means a separate written plan for the benefit of employees (which may include 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, and may include a plan maintained by an employee organization described in section 501(c)(9).

One commenter noted that, in addition to providing a self-insured medical reimbursement plan, some employers provide coverage for other

health care costs through an insurance policy (for example, through separate insured coverage for prescription drugs). The commenter requested clarification that an employer that maintains a self-insured medical reimbursement plan will not be a covered health insurance provider solely because the employer provides additional coverage through an insurance policy. The Treasury Department and the IRS agree that this is correct.

F. De Minimis Exception

The final regulations retain the *de minimis* exception described in the proposed regulations with certain clarifications. The final regulations provide that a person that would otherwise be a covered health insurance provider under section 162(m)(6)(C)(i)(II) for any taxable year beginning after December 31, 2012, is not a covered health insurance provider for that taxable year if the premiums received by that person and all other members of its aggregated group from providing health insurance coverage that is minimum essential coverage are less than two percent of the gross revenue of that person and all other members of its aggregated group for that taxable year. For taxable years beginning after December 31, 2009, and before January 1, 2013, a person that would otherwise be a covered health insurance provider under section 162(m)(6)(C)(I) is not a covered health insurance provider for that taxable year if the premiums received by that person and all other members of its aggregated group from providing health insurance coverage are less than two percent of the gross revenue of that person and all other members of its aggregated group for that taxable year.

Commenters suggested that the two-percent threshold for the *de minimis* exception should be increased to a level as high as five percent. In response to Notice 2011–2, which requested comments on the *de minimis* exception, some commenters requested that the threshold not be increased because a higher threshold would allow health insurance issuers that sell significant amounts of health coverage to be exempt from the deduction limit under section 162(m)(6) and thereby provide them with a competitive advantage. After careful consideration of all comments on the *de minimis* exception, the Treasury Department and the IRS have concluded that the two-percent threshold strikes the appropriate balance between exempting persons that receive health insurance premiums that are insignificant in relation to their overall activities and ensuring that

persons that sell a significant amount of health insurance are not exempted from the deduction limitation. Accordingly, the final regulations do not adopt the suggestion to increase the *de minimis* threshold.

II. Premiums

A. In General

Section 162(m)(6)(C)(i) provides that a health insurance issuer is a covered health insurance provider for a taxable year only if it receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)). The proposed regulations provide that amounts received under an indemnity reinsurance contract and amounts that are direct service payments are not treated as premiums from providing health insurance coverage for purposes of section 162(m)(6)(C)(i). The final regulations generally adopt the rules set forth in the proposed regulations.

B. Direct Service Payments

A health insurance issuer or other person that receives premiums from providing health insurance coverage may enter into an arrangement with a third party to provide, manage, or arrange for the provision of services by physicians, hospitals, or other healthcare providers. In connection with this arrangement, the health insurance issuer or other person that receives premiums from providing health insurance coverage may pay compensation to the third party in the form of capitated, prepaid, periodic, or other payments, and the third party may bear some or all of the risk that the compensation is insufficient to pay the full cost of providing, managing, or arranging for the provision of services by physicians, hospitals, or other healthcare providers as required under the arrangement. In addition, the third party may be subject to healthcare provider, health insurance, licensing, financial solvency, or other regulation under state insurance law.

The final regulations follow the proposed regulations, and provide that capitated, prepaid, periodic, or other payments (referred to as direct service payments) made by a health insurance issuer or other person that receives premiums from providing health insurance coverage to a third party as compensation for providing, managing, or arranging for the provision of healthcare services by physicians, hospitals, or other healthcare providers are not treated as premiums from providing health insurance coverage for purposes of section 162(m)(6), regardless of whether the third party is

subject to healthcare provider, health insurance, licensing, financial solvency, or other similar regulatory requirements under state law. In the preamble to the proposed regulations, the Treasury Department and the IRS requested comments on whether capitated, prepaid, or periodic payments made by a government entity to a third party to provide, manage, or arrange for the provision of services by physicians, hospitals, or other healthcare providers should be treated as premiums from providing health insurance coverage for purposes of section 162(m)(6).

One commenter suggested that payments from a government entity to certain medical care providers that accept risk-based payments in exchange for providing medical care (referred to in this preamble as clinical risk-bearing entities) should not be treated as premiums from providing health insurance coverage. The commenter observed that the term *health insurance coverage* is defined in section 9832(b)(1) as “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.” The commenter asserted that clinical risk-bearing entities do not provide health insurance coverage under section 9832(b)(1) because they do not issue policies, certificates, or contracts of insurance to the individuals to whom they provide medical care. Specifically, the commenter suggested that capitated payments under the Medicare Shared Savings program or the Medicare Pioneer ACO Program to a clinical risk-bearing entity should not be treated as premiums from providing health insurance coverage for this reason.

The commenter further noted that the definition of the term *health insurance coverage* was added to the Code in 1996 as part of the market reforms under the Health Insurance Portability and Accountability Act (HIPAA) and that virtually identical definitions of the term health insurance coverage were added to the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act (ERISA) at that time. The commenter pointed out that the Secretaries of the Treasury Department, Health and Human Services (HHS), and the Department of Labor (DOL) are required to administer the definitions of the term health insurance coverage consistently in all three statutes pursuant to section 104 of HIPAA.

The commenter also noted that the Centers for Medicare and Medicaid Services (CMS) have published guidance indicating that payments made by a health insurance issuer to a clinical risk-bearing entity may qualify as incurred claims for purposes of determining the issuer's Medical Loss Ratio under certain circumstances. See CMS, CCIIO Technical Guidance (CCIIO 2012-001): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule (February 10, 2012). According to the commenter, the treatment of payments to a clinical risk-bearing entity as incurred claims suggests that such payments are not premiums from providing health insurance coverage. The commenter urged the Treasury Department and the IRS to clarify that clinical risk-bearing entities are not covered health insurance providers subject to the deduction limitation under section 162(m)(6) unless they offer policies, certificates, or contracts of insurance to enrollees.

Another commenter asserted that Medicaid managed care organizations (MCOs) and providers of Medicare Advantage and Medicare Part D prescription drug plans should not be considered health insurance issuers that provide health insurance coverage for purposes of sections 9832(b)(1) and (2) and 162(m)(6). Like the other commenter, this commenter also pointed to guidance issued by CMS to support its position. See CMS, CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation (April 20, 2012). The commenter urged the Treasury Department and the IRS to treat fees paid to companies with healthcare business under governmental healthcare programs, including Medicare and Medicaid, as direct service payments, and not as premiums for purposes of determining whether a person is a health insurance issuer that provides health insurance coverage for purposes of Code section 162(m)(6).

The Treasury Department and the IRS agree with the commenters that a person cannot be a covered health insurance provider under section 162(m)(6) unless it is a health insurance issuer within the meaning of section 9832(b)(2) that receives premiums from providing health insurance coverage within the meaning of section 9832(b)(1). The Treasury Department and the IRS also acknowledge that section 104 of HIPAA generally requires the Treasury Department, HHS, and DOL to interpret consistently the terms *health insurance issuer* and *health insurance coverage*, as used in the Code, the PHSA, and ERISA.

The Treasury Department and the IRS, however, 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 not covered health insurance providers or that the amounts received by these organizations are not premiums from providing health insurance coverage.

The commenters correctly observe 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 provides health insurance coverage (as defined in section 9832(b)(1)) and meets certain other requirements. If the 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.

The definitions of the terms *health insurance coverage* and *health insurance issuer* have significant importance in many sections of the Code, the PHSA, and ERISA. The Treasury Department and the IRS have concluded that it would be inappropriate to provide broad guidance on the interpretation of sections 9832(b)(1) and 9832(b)(2) because it would require full consideration of the possible effects of that guidance on other statutory provisions. The consideration of these wide-ranging implications is outside of the scope of these regulations under section 162(m)(6). However, additional guidance on the meaning of the terms *health insurance issuer* and *health insurance coverage* may be provided in future regulations, notices, revenue rulings, or other guidance of general applicability published in the Internal Revenue Bulletin.

C. Stop-Loss Coverage

Stop-loss coverage allows an employer to self-insure for a set amount of claims costs, with the stop-loss coverage covering all or most of the claims costs that exceed the set amount. Several commenters requested that the final regulations clarify the treatment of stop-loss coverage. Specifically, commenters suggested that payments for stop-loss coverage not be treated as premiums from providing health insurance coverage because stop-loss coverage does not provide insurance coverage for the health risk of an individual or for medical care for an individual. Other commenters suggested that the final regulations adopt the

model standards of the National Association of Insurance Commissioners for determining whether payments for stop-loss insurance coverage qualify as premiums from providing health coverage.

The DOL, HHS, and the Treasury Department have expressed concern that employers in small group markets with healthier employees may pursue nominally self-insured arrangements with stop-loss coverage at low attachment points as functionally equivalent alternatives to insured group health plans. The three agencies issued a request for information regarding such practices, with a focus on the prevalence and consequences of stop-loss coverage at low attachment points. 77 FR 25788 (May 1, 2012). Because the scope of stop-loss coverage that may constitute health insurance, if any, has not been determined, premiums under a stop-loss contract will not be considered premiums from providing health insurance coverage for purposes of section 162(m)(6) until such time and to the extent that future guidance addresses the issue of whether and, if so, under what circumstances, stop-loss coverage constitutes health insurance.

D. Captive Insurance Companies

Under the final regulations, as under the proposed regulations, a captive insurance company is a covered health insurance provider if it is a health insurance issuer that is otherwise described in section 162(m)(6)(C). One commenter recommended that premiums received by a captive insurance company or other health insurance issuer that are attributable to coverage provided for current and former employees of members of an aggregated group that includes the captive insurance company or other health insurance issuer should be excluded from the definition of premiums. The commenter also suggested that premiums received by a health insurance issuer for providing health insurance coverage to current and former employees of other related businesses outside of the health insurance issuer's aggregated group should be excluded from the definition of premiums under certain circumstances. The final regulations do not adopt these suggestions.

Section 406 of ERISA generally prohibits transactions between an employee benefit plan and a party in interest, and, under Section 3(14)(C) of ERISA, employers are generally parties in interest with respect to the plans that they sponsor. In addition, Section 3(14)(G) of ERISA provides that entities that are more than 50 percent owned by

employers are also parties in interest. Accordingly, captive insurance companies that are more than 50 percent owned by the sponsor of an employee benefit plan are generally parties in interest, and the payment of premiums to such a captive insurance company to provide insurance to an employee benefit plan maintained by the owner of a captive insurance company would generally be a prohibited transaction and be subject to an excise tax under section 4975.

The DOL, however, has granted a prohibited transaction class exemption and numerous individual prohibited transaction exemptions that apply to captive insurance arrangements in certain circumstances. Under the class exemption, a captive insurance company can directly insure the employee benefit plan risks of a related employer if the captive insurance company and the arrangement meet certain requirements, one of which is that at least 50 percent of the captive insurer's business is unrelated to the employer sponsor of the plan.

The individual exemptions apply to circumstances in which a captive insurance company provides reinsurance to an unrelated insurance company that directly insures the health risks of a plan sponsor's employees. Under this type of arrangement, an employer purchases health insurance for its employees through an unrelated insurance company and pays premiums for that coverage to the unrelated insurance company. The unrelated insurance company then reinsures these health risks through the employer's captive insurance company under an indemnity reinsurance arrangement.

It is the understanding of the Treasury Department and the IRS that employers insuring the health risks of their employees through captive insurance companies generally use the approach outlined in the individual exemptions to avoid engaging in a prohibited transaction and incurring an excise tax under section 4975. Because the amounts received by a captive insurance company under this type of arrangement are solely payments for providing indemnity reinsurance, those payments are not treated as premiums under existing provisions of these regulations, and no special rule is needed for these types of payments. In the case of captive insurance arrangements that rely on the class exemption, the Treasury Department and the IRS have concluded that a special rule for premiums paid by a plan sponsor or its related businesses or their employees would be inappropriate because the captive insurance company would be required

under the terms of the class exemption to conduct a significant portion of its insurance business with unrelated third parties.

The commenter acknowledged that captive insurance companies generally follow the approach outlined in the DOL's individual prohibited transaction exemptions but asserted that an exemption for captive insurance companies is nonetheless necessary because the law in this area may change in the future to permit captive insurance companies to receive significant premium payments directly from a related employer. The Treasury Department and the IRS have concluded that a special exception is not necessary at this time for amounts paid to captive insurance companies.

III. Disqualified Taxable Year

Consistent with section 162(m)(6)(B) and the proposed regulations, the final regulations provide that a disqualified taxable year is, with respect to any employer, any taxable year for which the employer is a covered health insurance provider.

IV. Applicable Individual

Section 162(m)(6)(F) provides that, with respect to a covered health insurance provider for a disqualified taxable year, an applicable individual is any individual (i) who is an officer, director, or employee in such taxable year, or (ii) who provides services for, or on behalf of, the covered health insurance provider during the taxable year. The final regulations adopt the proposed regulations and provide that remuneration for services performed by an independent contractor to a covered health insurance provider will not be subject to the deduction limitation under section 162(m)(6) if certain conditions are met. The conditions that must be met under the final regulations for the independent contractor exception to apply are the same as those provided in the proposed regulations.

Section 162(m)(6)(F) defines an applicable individual as an "individual" described in that section. Therefore, a corporation, partnership, or other entity that is not a natural person generally would not be an applicable individual. The preamble to the proposed regulations explains that the Treasury Department and the IRS are concerned that covered health insurance providers may attempt to avoid the application of the deduction limitation under section 162(m)(6) by encouraging employees and independent contractors who are natural persons to form small or single-member personal service corporations or other similar entities to

provide services that are historically provided by natural persons. In the preamble to the proposed regulations, the Treasury Department and the IRS invited comments regarding how the final regulations might address this potential abuse.

One commenter suggested that if a covered health insurance provider reports remuneration payments on a Form 1099 or W-2 issued directly to a natural person, then that person should be the service provider for purposes of section 162(m)(6). Conversely, if a covered health insurance provider reports remuneration as having been paid to an entity other than a natural person, and that reporting is not found to be incorrect under section 6041, the entity should be the recipient of the remuneration for purposes of section 162(m)(6).

The final regulations do not adopt these suggestions. In general, section 6041 requires information reporting for payments to independent contractors and employees. The purpose of section 6041 is simply to track payments that may constitute gross income to the payee. Section 6041 information reporting does not typically require the payor to look beyond the identity of the recipient of a payment. Accordingly, it would be inappropriate to rely on section 6041 information reporting to identify potentially abusive arrangements.

The Treasury Department and the IRS remain concerned about employment arrangements that may be structured for the purpose of avoiding the deduction limitation under section 162(m)(6). Accordingly, while the final regulations recognize that an applicable individual generally will be a natural person, they provide that the Treasury Department and the IRS may issue guidance in the future identifying situations in which services performed by an entity will be treated as services performed by an individual for purposes of section 162(m)(6).

V. Applicable Individual Remuneration (AIR)

As required under section 162(m)(6)(D), the final regulations, like the proposed regulations, provide that AIR is the aggregate amount that is allowable as a deduction (determined without regard to section 162(m)) with respect to an applicable individual for a disqualified taxable year for remuneration for services performed by that individual (whether or not during the taxable year), except that AIR does not include any amount that is deferred deduction remuneration.

VI. Deferred Deduction Remuneration (DDR)

Section 162(m)(6)(E) and the final regulations, like the proposed regulations, provide that DDR is remuneration that would be AIR for services that an applicable individual performs during a disqualified taxable year but for the fact that it is not deductible until a later taxable year (such as generally occurs, for example, with nonqualified deferred compensation).

VII. Attribution of Remuneration to Services Performed in Taxable Years

The \$500,000 deduction limitation under section 162(m)(6) applies to the AIR and DDR that is attributable to services performed by an applicable individual for a covered health insurance provider in a disqualified taxable year. Accordingly, at the time that an amount of AIR or DDR for an applicable individual becomes otherwise deductible (and not before that time), the remuneration must be attributed to services performed by the applicable individual during a particular taxable year or years of a covered health insurance provider.

A. In General

The final regulations, like the proposed regulations, provide that, except as otherwise specifically provided in the regulations, remuneration is attributable to services performed by an applicable individual in the taxable year of the covered health insurance provider in which the applicable individual obtains a legally binding right to the remuneration. In addition, the final regulations, like the proposed regulations, provide that remuneration is not attributable to a taxable year during which the applicable individual is not a service provider. For these purposes, an individual is a service provider of a covered health insurance provider for any period during which the individual is an officer, director, or employee of, or providing services for, or on behalf of, the covered health insurance provider or any member of its aggregated group.

In the preamble to the proposed regulations, the Treasury Department and the IRS requested comments on an appropriate method for attributing increases in an applicable individual's benefit that accrue in taxable years of a covered health insurance provider beginning after the applicable individual ceases providing services (referred to in this preamble as post-termination remuneration) to taxable years during which the applicable

individual was a service provider. Comments were specifically requested on the appropriate methods for attributing increases under an account balance plan (defined as a plan described in § 1.409A-1(c)(2)(i)(A) or (B)) and a nonaccount balance plan (defined as a plan described in § 1.409A-1(c)(2)(i)(C)). In the context of nonaccount balance plans, one commenter suggested that each payment to or on behalf of an applicable individual under a nonaccount balance plan should be attributed to taxable years of a covered health insurance provider during which the applicable individual was a service provider in proportion to the increase in the applicable individual's benefit under the plan during those years. For example, if an applicable individual is a service provider for a covered health insurance provider for two years and participates in a deferred compensation plan during that time, and the applicable individual's benefit under the plan increases by an equal amount in both of those years, then 50 percent of each payment under the plan (whenever the payment is made and even if it includes post-termination remuneration) would be attributable to services performed in each of the two taxable years. According to the commenter, this method would provide a relatively simple method for attributing payments, including payments that include post-termination remuneration, to services performed in taxable years of a covered health insurance provider.

The Treasury Department and the IRS agree with the commenter that this approach to the attribution of deferred compensation payments will ease administration for taxpayers and the IRS and will result in a consistent and principled attribution of payments to taxable years during which an applicable individual is a service provider. Although the commenter proposed this attribution method in the context of nonaccount balance plans, the Treasury Department and the IRS have concluded that this approach is an appropriate method for attributing amounts that become otherwise deductible under account balance plans as well. Accordingly, the Treasury Department and the IRS generally adopt this approach to the attribution of payments from account balance plans and nonaccount balance plans.

B. Account Balance Plans

The proposed regulations provide two methods for attributing remuneration under an account balance plan to services performed by an applicable

individual in a taxable year of the covered health insurance provider. The proposed regulations refer to these methods as the standard attribution method and the alternative attribution method. Under the standard attribution method, the amount of remuneration attributable to services performed in a taxable year of a covered health insurance provider is equal to the excess of the account balance as of the last day of the taxable year, plus any payments made from that account during the taxable year, over the account balance as of the last day of the immediately preceding taxable year. To the extent that an amount that becomes otherwise deductible under an account balance plan (such as a payment) could be attributed to services performed by an applicable individual in two or more taxable years of a covered health insurance provider, the proposed regulations provide that the amount must be attributed first to services performed by the applicable individual in the earliest taxable year to which the amount could be attributed.

The proposed regulations also provide that, under the standard attribution method, any increases or decreases in an account balance that occur in taxable years of a covered health insurance provider in which an applicable individual is not a service provider must be attributed to taxable years during which the applicable individual is a service provider and has an account balance under the plan. The preamble to the proposed regulations provides that for taxable years beginning in 2013, and thereafter until the Treasury Department and the IRS issue further guidance prescribing the method for attributing post-termination remuneration to these taxable years, post-termination remuneration may be attributed using any reasonable method to taxable years of a covered health insurance provider during which an applicable individual is a service provider and has an account balance under the plan. For this purpose, a method is reasonable only if it is consistent with a reasonable, good faith interpretation of section 162(m)(6) and is applied consistently for all remuneration provided by the covered health insurance provider under substantially similar plans or arrangements.

Under the alternative method described in the proposed regulations, an amount paid to or on behalf of an applicable individual from an account balance plan is attributable to services performed by the applicable individual in the taxable year of a covered health insurance provider in which the principal addition related to the amount

was credited to the applicable individual's account under the plan. To the extent that an amount paid from the plan includes earnings on a principal addition (including post-termination remuneration), the amount is attributable to services performed in the taxable year in which the principal addition was credited to the account.

The final regulations also provide that two methods are available for attributing remuneration under account balance plans. One method, which is different from the methods described in the proposed regulations, is referred to as the account balance ratio method, and the other, which is similar to the alternative method described in the proposed regulations, is referred to as the principal additions method. The final regulations, like the proposed regulations, provide that a covered health insurance provider and each member of its aggregated group must use the same method consistently to attribute remuneration under all of its account balance plans for all taxable years, with certain limited exceptions.

1. Account Balance Ratio Method

The account balance ratio method is based on the proportional attribution principles described previously in section VII.A of this preamble. However, it is similar to the standard attribution method described in the proposed regulations in that the amount attributed to services performed by an applicable individual in a particular taxable year of a covered health insurance provider is based on the increase in the applicable individual's account balance during that year. Under the account balance ratio method, remuneration that becomes otherwise deductible (for example, because it is paid or made available to or for an applicable individual) is attributed to services performed by the applicable individual in each taxable year of the covered health insurance provider in which the applicable individual was a service provider and for which the account balance increased. The amount attributed to each of these taxable years is equal to the total amount that becomes otherwise deductible for the year multiplied by a fraction. The numerator of the fraction is the increase in the account balance for that taxable year, and the denominator of is the sum of all increases in the account balance for all taxable years during which the applicable individual was a service provider.

For this purpose, an increase in an account balance occurs for a taxable year only if the account balance on the last day of the taxable year is greater

than the highest account balance on the last day of every prior taxable year. The amount of the increase for any taxable year is the excess of the account balance as of the last day of the taxable year over the highest account balance as of the last day of any prior taxable year.

For example, if an applicable individual's account balance is \$10× on the last day of Year 1, \$5× on the last day of Year 2, \$7× on the last day of Year 3, and \$12× on the last day of Year 4, with the fluctuations due solely to changes in investment returns and not due to payments under the plan, the only year in which an increase occurs is Year 4, and the increase is equal to \$2× (\$12×−\$10× (the highest account balance in a prior year)). For post-termination payments, the account balance ratio for each taxable year will generally remain constant, and the same ratios will generally apply to all future payments. The Treasury Department and the IRS anticipate that this method will be significantly easier to administer than the standard attribution method described in the proposed regulations.

Under the account balance ratio method, certain adjustments are made to account balances for in-service payments and for the payment of grandfathered amounts (as described in section XI of this preamble). For this purpose, an in-service payment is any payment made in a taxable year during which an applicable individual is a service provider, and it includes a payment made after an applicable individual permanently ceases to be a service provider (for example, because the applicable individual retires) if the applicable individual was a service provider at any time during the taxable year of the covered health insurance provider in which the payment was made. These adjustments are necessary because an in-service payment that is made from an account balance plan during a year when an applicable individual is accumulating benefits would reduce or eliminate any increase in the year-end account balance that would have occurred in the absence of the in-service payment. The adjustments required for in-service payments and grandfathered amounts are intended to eliminate this effect.

Under the account balance ratio method, if an applicable individual obtains a legally binding right in a taxable year during which the applicable individual is a service provider to an additional contribution under the plan (other than earnings) that will be made in a taxable year in which the applicable individual is not a service provider, the additional contribution is attributed to services

performed in the first taxable year preceding the taxable year of the contribution in which the applicable individual was a service provider.

In response to the request for comments in the proposed regulations on an appropriate method for attributing post-termination earnings to taxable years in which an applicable individual is a service provider, one commenter suggested that any increases (or decreases) in an account balance that occur in taxable years in which an applicable individual is not a service provider should be attributed *pro rata* beginning with the taxable year in which the applicable individual begins participating in the plan and ending with the taxable year in which the individual ceases to be a service provider. The final regulations do not adopt this suggestion because it could result in an allocation of earnings largely unrelated to the years in which amounts were credited under the plan as remuneration for services performed.

2. Principal Additions Method

The alternative method described in the proposed regulations provides that a principal addition and earnings (or losses) thereon (including earnings and losses in taxable years during which an applicable individual is not a service provider) are attributed to the taxable year in which the related principal addition is made (including earnings and losses that occur in taxable years during which an applicable individual is not a service provider). The final regulations generally adopt the alternative method with certain modifications and refer to it as the principal additions method.

Under the principal additions method, earnings on a principal addition (including post-termination earnings) are attributed to the taxable year in which an applicable individual is credited with the principal addition under the plan. For example, if a principal addition is credited to the account balance of an applicable individual in the 2015 taxable year, earnings on that principal addition in 2028 are treated as additional remuneration for the 2015 taxable year, and not the 2028 taxable year.

When an amount is paid from an account balance plan, it is attributed under the principal additions method to services performed in the taxable year in which the principal addition to which the amount relates was credited under the plan. The final regulations clarify that the principal additions method is available only for account balance plans that separately account for each principal addition to the plan and any

earnings thereon and that can trace any amount that becomes otherwise deductible under the plan, through separate accounting, to a principal addition made in a taxable year of a covered health insurance provider. The Treasury Department and the IRS understand that certain plans already track contributions of principal additions and the earnings thereon from the time those principal additions are credited under the plan to the time they are paid, generally as part of the administration of the plan's method of compliance with section 409A. The ability to trace payments from the plan to principal additions made in a particular taxable year is integral to the purpose of this attribution method, and the Treasury Department and the IRS believe it is appropriate to limit the use of this method to plans that maintain the separate accounting necessary to trace these amounts.

C. Nonaccount Balance Plans.

The proposed regulations provide that remuneration under a nonaccount balance plan is attributable to services performed by an applicable individual in a taxable year based on the increase in the present value of the applicable individual's benefit under the plan during the taxable year. Under this method, the amount of remuneration attributable to services performed in a taxable year of a covered health insurance provider is equal to the increase (or decrease) in the present value of the future payment or payments due under the plan as of the last day of the taxable year of the covered health insurance provider, increased by any payments made during that year, over the present value of the future payment or payments as of the last day of the covered health insurance provider's preceding taxable year. For purposes of determining the increase (or decrease) in the present value of a future payment or payments, the rules of § 31.3121(v)(2)-1(c)(2) apply. To the extent that an amount that becomes otherwise deductible under a nonaccount balance plan (such as a payment) could be attributed to services performed by an applicable individual in two or more taxable years of a covered health insurance provider, the proposed regulations provide that the amount must be attributed first to services performed by the applicable individual in the earliest taxable year to which the amount could be attributed.

In response to comments, the final regulations adopt two different attribution methods for nonaccount balance plans based on proportional attribution principles and provide that a

covered health insurance provider may choose either of these two methods to attribute remuneration to taxable years under a nonaccount balance plan. These two methods are referred to in the final regulations as the present value ratio method and the formula benefit ratio method. A covered health insurance provider and each member of its aggregated group must use the same method consistently to attribute remuneration under all of their nonaccount balance plans consistently for all taxable years, with certain limited exceptions.

1. Present Value Ratio Method.

Under the present value ratio method, each time an amount becomes otherwise deductible, such as when a payment is made under the plan, the amount is attributed to services performed in a taxable year or years of a covered health insurance provider during which an applicable individual was a service provider and for which there was an increase in the present value of payment(s) due under the plan. The amount attributed to each of these taxable years is equal to the total amount that is otherwise deductible multiplied by a fraction. The numerator of the fraction is the increase in the present value of the applicable individual's benefit for the taxable year, and the denominator of the fraction is the sum of all such increases in present value for all taxable years during which the applicable individual was a service provider. In other words, each time an amount becomes otherwise deductible, the amount is attributed proportionately to each taxable year in which the applicable individual was a service provider based on the increase in the present value of the applicable individual's benefit under the plan during that year.

For purposes of the present value ratio method, an increase in the present value of an applicable individual's benefit occurs for a taxable year only if the present value of the benefit on the last day of the covered health insurance provider's taxable year is greater than the present value of the benefit on the last day of every prior taxable year. The amount of the increase for the taxable year is the excess of the present value of the benefit on the last day of the taxable year over the greatest present value of the benefit on the last day of any prior taxable year. If the present value of the applicable individual's benefit as of the last day of the taxable year is less than or equal to the present value of the benefit on the last day of any prior taxable year, there is no increase in the present value for that

year for purposes of this calculation. For purposes of determining the present value of a future payment or payments, the rules of § 31.3121(v)(2)-1(c)(2) apply. Like the rules under the account balance ratio method, the final regulations also provide for adjustments in the present value of an applicable individual's benefit to the extent that the present value is reduced by in-service payments or includes grandfathered amounts.

Although the present value ratio method adopts proportional attribution principles for purposes of attributing each payment to services performed by an applicable individual in taxable years of a covered health insurance provider, it is similar to the attribution method for nonaccount balance plans described in the proposed regulations in that amounts paid from the plan are attributed to taxable years based on an increase in the present value of the applicable individual's benefit. The Treasury Department and the IRS believe that the present value ratio method will be significantly easier for both taxpayers and the IRS to administer than the nonaccount balance attribution method described in the proposed regulations. For applicable individuals who begin receiving benefits under a nonaccount balance plan after termination of employment, the present value ratio for each taxable year will generally remain constant, and the payments can be attributed to a taxable year or years simply by multiplying the amount of the payment by the applicable fraction or percentage.

2. Formula Benefit Ratio Method.

In response to the request for comments on the attribution method for nonaccount balance plans set forth in the proposed regulations, one commenter suggested that covered health insurance providers should not be required to determine the present value of an applicable individual's benefit for each taxable year to determine the taxable years to which an amount should be attributed. The commenter observed that plans do not ordinarily determine the present value of benefits on an individual basis before amounts are paid, if ever, and that this calculation would add significant complexity to process for attributing payments to services performed. The commenter suggested that the Treasury Department and the IRS provide an alternative attribution method based on year-over-year increases in the final benefit that an applicable individual is entitled to receive under the plan's benefit formula, without reducing that benefit to its present value. These final

regulations generally adopt this suggestion, with minor modifications, and refer to the method as the formula benefit ratio method.

Under the formula benefit ratio method, remuneration provided to an applicable individual under a nonaccount balance plan is attributable to each taxable year in which the applicable individual provided services and for which there was an increase in the formula benefit. For these purposes, an applicable individual's formula benefit is the benefit that the applicable individual has a legally binding right to receive under the plan in the form that the remuneration being attributed has become otherwise deductible, which will generally be the form in which the remuneration is paid. If a portion of an applicable individual's benefit is paid or becomes otherwise deductible in one form (for example, a lump sum) and another portion of the benefit is paid or becomes otherwise deductible in another form (for example, a life annuity), the applicable individual has two separate formula benefits under the plan, and any increase in the formula benefit is determined separately for each portion of the benefit. If an amount becomes otherwise deductible under a plan but is not paid (for example, if an individual is in constructive receipt of an amount but does not receive payment of that amount), the form in which the benefit will be paid, if the actual form of payment is known, must be used to determine the formula benefit, and, if the actual form of payment is unknown, the formula benefit may be determined using any form of benefit in which the amount may be paid under the plan. In that case, the amount would not be attributed again when it is ultimately paid because it does not become otherwise deductible in the year of actual payment.

Similar to the manner in which amounts are attributed to services provided in taxable years of a covered health insurance provider under the account balance ratio method and the present value ratio method, the amounts attributable under the formula benefit ratio method to each taxable year in which an applicable individual provides services and for which there was an increase in the formula benefit is equal to the amount that becomes otherwise deductible multiplied by a fraction. The numerator of the fraction is the increase in the formula benefit for the taxable year, and the denominator is the sum of all such increases during which the applicable individual was a service provider (which, in most cases, will equal the amount that has become otherwise deductible). Thus, each

payment is attributed to taxable years based on the proportion of the increase in the formula benefit under the plan during the taxable year to the total formula benefit to which the applicable individual has a legally binding right when the payment is made.

The amount of the increase in the formula benefit for a taxable year is equal to the excess of the formula benefit to which the individual has a legally binding right under the plan as of the measurement date for that taxable year (generally in the actual form of payment) over the greatest formula benefit to which the applicable individual had a legally binding right under the plan as of any measurement date in any earlier taxable year (in that same form of payment). Special rules apply for purposes of determining whether an increase occurs, and the amount of any increase, in the taxable year in which a payment occurs.

D. Equity-Based Remuneration

The final regulations generally adopt the rules described in the proposed regulations for attributing remuneration resulting from equity-based compensation, which includes stock options, stock appreciation rights (SARs), restricted stock, and restricted stock units (RSUs), with certain modifications made in response to comments.

The proposed regulations provide that remuneration resulting from the exercise of stock options and SARs is attributable on a daily *pro rata* basis to services performed by an applicable individual over the period beginning on the date of grant of the stock option or SAR and ending on the date that the stock option or SAR is exercised, excluding any days on which the applicable individual is not a service provider.

Commenters suggested that, for a stock option or SAR that is subject to a substantial risk of forfeiture, a covered health insurance provider should be permitted to attribute remuneration resulting from the exercise of the stock option or SAR on a daily *pro rata* basis over the period beginning on the date the stock option or SAR is granted and ending on either the date the stock option or SAR is exercised or the date the stock option or SAR is no longer subject to a substantial risk of forfeiture, in either case excluding any days the applicable individual is not a service provider. The commenters explained that permitting attribution over the vesting period would be simpler for some covered health insurance providers because this method is commonly used for other financial

accounting and regulatory purposes. The final regulations adopt this suggestion. However, the final regulations also provide that the covered health insurance provider must choose one of the two permissible methods and use it consistently for all stock options or SARs that it issues, unless certain exceptions apply.

One commenter suggested that, instead of attributing equity-based remuneration on a daily *pro rata* basis over the period from the grant date to the date of exercise or the date of vesting, a covered health insurance provider should be permitted to attribute equity-based remuneration entirely to the taxable year in which the equity-based remuneration vests, is exercised, or is otherwise includible in income. Specifically, the commenter suggested that if equity-based remuneration vests in connection with a corporate transaction, a covered health insurance provider should be permitted to attribute pre-transaction appreciation entirely to the year of vesting. The final regulations do not adopt this suggestion. Attributing equity-based remuneration with a multiple-year vesting period to a single taxable year would not result in a reasonable attribution of remuneration to the taxable years in which the services were performed to earn the remuneration, as required by section 162(m)(6)(A).

The final regulations reserve on attribution rules applicable to grants of equity-based remuneration in situations in which the remuneration is determined by reference to equity in an entity treated as a partnership for federal tax purposes or by reference to equity interests in an entity described in § 1.409A-1(b)(5)(iii) (for example a mutual company). However, until the Treasury Department and the IRS issue further guidance on the attribution of this type of remuneration, the rules applicable to stock options, SARs, restricted stock, and RSUs, as described in the final regulations, may be applied by analogy (subject to any applicable rule under the Code (including subchapter K of the Code) affecting the timing, availability or amount of any deduction).

E. Involuntary Separation Pay

The final regulations, like the proposed regulations, provide that involuntary separation pay is attributable to services performed by an applicable individual during the taxable year of a covered health insurance provider in which the involuntary separation from service occurs. Alternatively, involuntary separation pay may be attributable, on a daily *pro*

rata basis, to services performed by the applicable individual beginning on the date that the applicable individual obtains a legally binding right to the involuntary separation pay and ending on the date of the applicable individual's involuntary separation from service with the covered health insurance provider and all members of its aggregated group. For this purpose, involuntary separation pay is defined as remuneration to which an applicable individual has a right to payment solely as a result of an involuntary separation from service. If involuntary separation pay is attributed to services performed in multiple taxable years, each payment of involuntary separation pay must be attributed to the same taxable years in the same proportion that the total amount of separation pay is attributed to those taxable years.

F. Substantial Risk of Forfeiture

The final regulations, like the proposed regulations, provide a two-step process for attributing certain remuneration to taxable years of the covered health insurance provider if the remuneration is subject to a substantial risk of forfeiture for more than one taxable year of a covered health insurance provider. This two-step process applies to amounts that are attributable under the general rule providing that remuneration is attributable to services performed by an applicable individual in the taxable year in which an applicable individual obtains a legally binding right to the remuneration and under the rules for account balance and nonaccount balance plans. Under this two-step process, the remuneration that is subject to the substantial risk of forfeiture is first attributed to the taxable year or years of the covered health insurance provider under the attribution rules that otherwise apply. Then, that remuneration is reattributed on a daily *pro rata* basis over the period that it is subject to a substantial risk of forfeiture (in other words, reattributed evenly over the vesting period).

One commenter suggested that the final regulations make this two-step attribution method optional, rather than mandatory, and permit covered health insurance providers to choose whether to apply this two-step method on a plan-by-plan basis. The final regulations do not adopt this suggestion. Attributing remuneration evenly over the vesting period results in a more accurate matching of remuneration to the taxable years in which the services were performed to earn the remuneration and is consistent with the treatment of

equity-based compensation that is subject to a substantial risk of forfeiture.

VII. Application of the \$500,000 Deduction Limitation

A. In General

The final regulations generally adopt the rules described in the proposed regulations for applying the \$500,000 deduction limitation of section 162(m)(6). The deduction limitation applies to the aggregate AIR and DDR attributable to services performed by an applicable individual for a covered health insurance provider in a disqualified taxable year. Accordingly, if AIR, DDR, or a combination of AIR and DDR, attributable to services performed by an applicable individual for a covered health insurance provider in a disqualified taxable year exceeds \$500,000, the amount of the remuneration that exceeds \$500,000 is not allowable as a deduction in any taxable year. When the \$500,000 deduction limit is applied to an amount of AIR attributable to services performed by an applicable individual in a disqualified taxable year, the deduction limit with respect to that applicable individual for that disqualified taxable year is reduced, but not below zero, by the amount of the AIR to which the deduction limit is applied. If the applicable individual also has an amount of DDR attributable to services performed in that disqualified taxable year that becomes otherwise deductible in a subsequent taxable year, the deduction limit, as reduced, is applied to that amount of DDR in the first taxable year in which that DDR becomes otherwise deductible. If the amount of the DDR that becomes otherwise deductible is less than the reduced deduction limit, then the full amount of the DDR is deductible in that taxable year. To the extent that the amount of the DDR exceeds the reduced deduction limit, the covered health insurance provider's deduction for the DDR is limited to the amount of the reduced deduction limit and the amount of the DDR that exceeds the deduction limit cannot be deducted in any taxable year.

B. Application of Deduction Limitation to Payments

The final regulations generally adopt rules described in the proposed regulations for applying the deduction limitation to payments of remuneration. Any payment to an applicable individual may include remuneration that is attributable to services performed by the applicable individual in one or more taxable years of a covered health insurance provider under the rules set

out in the final regulations. For example, remuneration resulting from the vesting of restricted stock that is subject to a substantial risk of forfeiture for five full taxable years of a covered health insurance provider is attributable to services performed by the applicable individual in each of the five years during which the restricted stock was subject to a substantial risk of forfeiture. In that case, a separate deduction limit applies to each portion of the payment that is attributed to services performed in a different disqualified taxable year of the covered health insurance provider. Any portion of the payment that is attributed to a disqualified taxable year is deductible only to the extent that it does not exceed the deduction limit that applies to the applicable individual for that disqualified taxable year, as that deduction limit may have been previously reduced by the amount of any AIR or DDR attributable to services performed in that disqualified taxable year that was previously deductible. The final regulations contain several examples to illustrate how these rules apply to services performed and compensation payments made over multiple taxable years.

VIII. Corporate Transactions

A. In General

A corporation or other person may become a covered health insurance provider as a result of certain transactions such as a merger, acquisition or disposition of assets or stock (or other equity interests), reorganization, consolidation, separation, or other transaction resulting in a change in the composition of an aggregated group (generally referred to in this preamble and the final regulations as a corporate transaction). For example, as a result of the aggregation rules, members of a controlled group of corporations that does not include a health insurance issuer may become covered health insurance providers if a health insurance issuer that is a covered health insurance provider becomes a member of the controlled group.

B. Transition Period Relief

The final regulations, like the proposed regulations, provide a transition period to ease the administrative burden on a person that becomes a covered health insurance provider solely as a result of a corporate transaction. Specifically, the final regulations provide that if a person that is not otherwise a covered health insurance provider would become a covered health insurance provider

solely as a result of a corporate transaction, the person generally is not a covered health insurance provider for the taxable year in which the transaction occurs (referred to in this preamble and the final regulations as transition period relief). The person, however, is a covered health insurance provider for any subsequent taxable year if it is a covered health insurance provider for the taxable year under the generally applicable rules for determining whether a person is a covered health insurance provider. A person that is a covered health insurance provider immediately before a corporate transaction is not eligible for this transition period relief because the person does not become a covered health insurance provider solely as a result of the corporate transaction (but may be eligible for certain transition relief relating to the attribution method it is permitted to use for the taxable year in which the corporate transaction occurs).

One commenter suggested that if a person becomes a covered health insurance provider as a result of a corporate transaction, the person should not be treated as a covered health insurance provider until the first taxable year beginning at least six months after the transaction. The commenter asserted that the additional time is necessary to provide for an adequate transition period. The final regulations do not adopt this suggestion. Section 162(m)(6)(C)(ii) treats the members of an aggregated group as a single employer. The statute does not specifically provide that a person must be treated as a covered health insurance provider for its entire taxable year if it is a member of an aggregated group that includes a health insurance issuer for only a portion of the year. Therefore, the Treasury Department and the IRS have concluded that providing transition relief for corporate transactions during the taxable year that the corporate transaction occurs is consistent with the statute. However, providing transition relief for a taxable year in which a person is a member of an aggregated group that includes a health insurance issuer for its entire taxable year would be inconsistent with the statute.

C. Certain Applicable Individuals

The proposed regulations provide that, in certain circumstances, the deduction limitation under section 162(m)(6) may apply to a person that is not treated as a covered health insurance provider during the transition period. Specifically, the proposed regulations provide that the transition period otherwise applicable to certain

members of an aggregated group does not extend to remuneration provided to applicable individuals of a health insurance issuer that is a covered health insurance provider and that is not eligible for the transition period relief because it does not become a covered health insurance provider solely as a result of a corporate transaction.

The final regulations generally adopt this rule, but expand it to include applicable individuals of not only health insurance issuers, but also other employers that would have been covered health insurance providers in the taxable year that the corporate transaction occurs, without regard to the corporate transaction. For example, if a controlled group of corporations that are not covered health insurance providers acquires a health insurance issuer and its non-health insurance issuer subsidiary, both of which are covered health insurance providers before the corporate transaction, the deduction limitation under section 162(m)(6) applies to all remuneration provided to the applicable individuals of the health insurance issuer and the non-health insurance issuer subsidiary, even if the remuneration is provided by a member of the acquiring controlled group that is otherwise eligible for transition period relief during the year of the acquisition.

D. Consistency Rule Relief

As explained previously in this preamble, a covered health insurance provider and all members of its aggregated group that provide remuneration under an account balance plan, a nonaccount balance plan, or through stock options or SARs generally must use the same attribution method for each type of plan (that is, account balance plans, nonaccount balance plans, and stock options or SARs) for all taxable years. As a result of a corporate transaction, however, a covered health insurance provider that uses a particular attribution method for one or more of these types of plans may become a member of an aggregated group that has a member that uses a different attribution method. To maintain consistency within the aggregated group, one or more covered health insurance providers would need to change attribution methods.

As noted in the preamble to the proposed regulations, once remuneration provided to an applicable individual from a plan has been attributed to a taxable year under a particular method (for example, because a payment has been made to the applicable individual), it would be administratively difficult to change the attribution method for amounts that

become deductible with respect to that applicable individual in future years and still provide a reasonably accurate attribution of remuneration from that plan to the taxable years in which the applicable individual performed the services to earn the remuneration. In addition, the Treasury Department and the IRS are concerned that the ability to change attribution methods may lead to selective use of methods to maximize deductions. However, recognizing that there may be valid business reasons for changing attribution methods, such as a merger or acquisition, change in compensation structure, or change in accounting method, the Treasury Department and the IRS requested comments on the standards that should apply to determine whether and when an attribution method may be changed, and how that change would apply if deductions for amounts provided under the plan or arrangement have already been taken.

Commenters generally asked for flexibility in applying the consistency rules after a corporate transaction. The final regulations generally adopt this suggestion and provide that, if a covered health insurance provider that uses an attribution method for a particular type of plan (that is, an account balance plan, a nonaccount balance plan, or a stock option or SAR) becomes a member of an aggregated group with one or more covered health insurance providers that used a different attribution method for that type of plan before the corporate transaction, the covered health insurance provider will not violate the otherwise applicable consistency rules for the taxable year in which the corporate transaction takes place if it continues to use the same attribution method for that type of plan that it used before the transaction, even if it is different from the attribution method used by other members of the aggregated group. Further, the final regulations provide that, in this situation, a member of the aggregated group may change its attribution method to be the same as the attribution method used by other members of its aggregated group, subject to limitations or modifications that the Treasury Department and the IRS may provide in future guidance published in the Internal Revenue Bulletin.

One commenter suggested that application of the consistency rules following a corporate transaction should not require a retroactive change in attribution methods. The commenter noted that changing attribution methods retroactively would be administratively difficult. The final regulations generally adopt this suggestion and provide that, if an attribution method has been used

to attribute remuneration provided to an applicable individual under an account balance plan, a nonaccount balance plan, or a stock option or SAR before a corporate transaction, that same method must be used in all future taxable years to attribute any remuneration provided to the applicable individual under the same type of plan to the extent that the applicable individual had a legally binding right to the remuneration as of the date of the corporate transaction.

Because a covered health insurance provider does not need to use an attribution method for amounts that become deductible during a taxable year until it files its tax return for that taxable year, the Treasury Department and the IRS have concluded that the exceptions to the consistency rules described in this section of the preamble and the final regulations will provide covered health insurance providers adequate time to make any adjustments to their attribution methods necessary to comply with the otherwise applicable consistency rules.

E. Application of the De Minimis Rule

One commenter suggested that the final regulations clarify that if a person ceases to be a member of an aggregated group, the *de minimis* exception is applied taking into account only the revenues and premiums of the person for the period during which it was a member of the aggregated group. The final regulations adopt this suggestion.

XI. Grandfathered Amounts Attributable to Services Performed Before January 1, 2010

The deduction limitation under section 162(m)(6) only applies to AIR attributable to services performed by an applicable individual in taxable years beginning after December 31, 2012 and to DDR attributable to services performed by an applicable individual in taxable years beginning after December 31, 2009. It does not apply to remuneration attributable to services performed in taxable years beginning before January 1, 2010.

The proposed regulations provide that for purposes of determining whether remuneration provided under an account balance plan is attributable to services performed in taxable years beginning before January 1, 2010, a covered health insurance provider is required to use the same attribution method that it otherwise uses to attribute remuneration to taxable years, except that any substantial risk of forfeiture is disregarded.

A commenter suggested that a covered health insurance provider be permitted to use any method that is permissible

for purposes of attributing remuneration to taxable years for purposes of determining the amount of remuneration that is attributable to services performed before January 1, 2010, even if the method is different from the method it otherwise uses to attribute remuneration to taxable years. The final regulations provide that if a covered health insurance provider uses a method for attributing amounts that become deductible under an account balance plan or a nonaccount balance plan to taxable years beginning after December 31, 2009, it must use that same method consistently for attributing amounts to taxable years beginning before January 1, 2010, except that, if it uses the account balance ratio method to attribute remuneration under an account balance plan to taxable years beginning after December 31, 2009, it may use the principal additions method to attribute amounts to taxable years beginning before January 1, 2010. The final regulations require certain adjustments to account balances for purposes of applying the account balance ratio method if this is done.

For nonaccount balance plans, the proposed regulations provide that the amount attributable to services provided in taxable years beginning before January 1, 2010, equals the present value of the remuneration to which the applicable individual would have been entitled under the plan if the applicable individual voluntarily terminated services without cause on the last day of the first taxable year of the covered health insurance provider beginning before January 1, 2010. The proposed regulations further provide that, for any subsequent taxable year of the covered health insurance provider, this amount may increase to the present value of the benefit the applicable individual actually becomes entitled to receive, in the form and at the time actually paid, determined under the terms of the plan (including applicable limits under the Code) as in effect on the last day of the first taxable year beginning before January 1, 2010, without regard to any further services required by the individual after that date or any other events affecting the amount of, or the entitlement to, benefits (other than the applicable individual's election with respect to the time or form of an available benefit).

The final regulations provide that for purposes of determining whether remuneration provided under a nonaccount balance plan is attributable to services performed in taxable years beginning before January 1, 2010, a covered health insurance provider is required to use the attribution method

that it otherwise uses to attribute remuneration to taxable years. Although the amounts attributable to services performed in taxable years beginning before January 1, 2010, are determined differently under the final regulations, the amounts attributable to services performed in taxable years beginning before January 1, 2010, under the formula benefit ratio method generally will be similar to the amounts attributable to those years under the proposed regulations. For equity-based remuneration, the final regulations generally follow the rules described in the proposed regulations and provide that any remuneration resulting from equity-based compensation granted in a taxable year beginning before January 1, 2010, is not subject to the deduction limitation, regardless of whether the equity-based remuneration is subject to a substantial risk of forfeiture during a taxable year beginning after December 31, 2009. Earnings on these grandfathered amounts, including earnings accruing in taxable years beginning after December 31, 2009, are also generally treated as remuneration attributable to services performed in taxable years beginning before January 1, 2010.

One commenter suggested that the final regulations should clarify that the grandfathering rules apply to remuneration provided under all types of arrangements (not only remuneration from account balance plans, nonaccount balance plans, and equity-based remuneration) and that grandfathered amounts be determined based on the attribution rules generally applicable to the arrangement under which remuneration was provided. The final regulations adopt this suggestion.

XII. Transition Rules for Certain DDR

Section 162(m)(6) applies to DDR attributable to services performed in a disqualified taxable year beginning after December 31, 2009 that is otherwise deductible in a taxable year beginning after December 31, 2012. As described in section I.B of this preamble, for taxable years beginning before January 1, 2013, a covered health insurance provider is any 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)) (a pre-2013 covered health insurance provider). For taxable years beginning after December 31, 2012, a covered health insurance provider is any health insurance issuer (as defined in section 9832(b)(2)) that receives at least 25 percent of its gross premiums from providing minimum essential coverage (as defined in section

5000A(f) (a post-2012 covered health insurance provider). Thus, the definition of the term *covered health insurance provider* is narrower for taxable years beginning after December 31, 2012, than it is for taxable years beginning before January 1, 2013. The proposed regulations include transition rules under which the section 162(m)(6) deduction limitation applies to DDR attributable to services performed in taxable years 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 taxable year to which the DDR is attributable and a post-2012 covered health insurance provider for the taxable year in which that DDR is otherwise deductible. The final regulations retain this transition rule.

XIII. Effective/Applicability Date

The final regulations are effective on September 23, 2014. The final regulations apply to taxable years beginning after September 23, 2014. In addition, taxpayers may rely on these final regulations for taxable years beginning on or before September 23, 2014.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of the regulations is Ilya Enkishev of the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS and the Treasury Department participated in their drafting and development.

List of Subjects in 26 CFR Part 1

Income Taxes, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 1.162–31 is added to read as follows:

§ 1.162–31 The \$500,000 deduction limitation for remuneration provided by certain health insurance providers.

(a) *Scope.* This section sets forth rules regarding the deduction limitation under section 162(m)(6), which provides that a covered health insurance provider's deduction for applicable individual remuneration (AIR) and deferred deduction remuneration (DDR) attributable to services performed by an applicable individual in a disqualified taxable year is limited to \$500,000. Paragraph (b) of this section sets forth definitions of the terms used in this section. Paragraph (c) of this section explains the general limitation on deductions under section 162(m)(6). Paragraph (d) of this section sets forth the methods that must be used to attribute AIR and DDR to services performed in one or more taxable years of a covered health insurance provider. Paragraph (e) of this section sets forth rules on how the deduction limit applies to AIR and DDR that is otherwise deductible under chapter 1 of the Internal Revenue Code (Code) but for the deduction limitation under section 162(m)(6) (referred to in this section as remuneration that is otherwise deductible). Paragraph (f) of this section sets forth additional rules for persons participating in certain corporate transactions. Paragraph (g) of this section explains the interaction of section 162(m)(6) with sections 162(m)(1) and 280G. Paragraph (h) of this section sets forth rules for determining the amounts of remuneration that are not subject to the deduction limitation under section 162(m)(6) due to the statutory effective date (referred to in this section as grandfathered amounts). Paragraph (i) of this section sets forth transition rules for DDR that is attributable to services performed in taxable years beginning after December 31, 2009 and before January 1, 2013. Paragraph (j) of this section sets forth the effective and applicability dates of the rules in this section.

(b) *Definitions*—(1) *Health insurance issuer.* For purposes of this section, a *health insurance issuer* is a health insurance issuer as defined in section 9832(b)(2).

(2) *Aggregated group.* For purposes of this section, an *aggregated group* is a health insurance issuer and each other person that is treated as a single employer with the health insurance issuer at any time during the taxable year of the health insurance issuer under sections 414(b) (controlled groups of corporations), 414(c) (partnerships, proprietorships, etc. under common control), 414(m) (affiliated service groups), or 414(o), except that the rules in section 1563(a)(2) and (3) (with respect to corporations) and § 1.414(c)–2(c) and (d) (with respect to trades or businesses under common control) for brother-sister groups and combined groups are disregarded.

(3) *Parent entity*—(i) *In general.* For purposes of this section, a *parent entity* is either—

(A) The common parent of a parent-subsubsidiary controlled group of corporations (within the meaning of section 414(b)) or a parent-subsubsidiary group of trades or businesses under common control (within the meaning of section 414(c)) that includes a health insurance issuer, or

(B) the health insurance issuer in an aggregated group that is an affiliated service group (within the meaning of section 414(m)) or a group described in section 414(o).

(ii) *Certain aggregated groups with multiple health insurance issuers*—(A) *In general.* If two or more health insurance issuers are members of an aggregated group that is an affiliated service group (within the meaning of section 414(m)) or group described in section 414(o), the parent entity is the health insurance issuer in the aggregated group that is designated in writing by the other members of the aggregated group to act as the parent entity.

(B) *Successor parent entities.* If a health insurance issuer that is the parent entity of an aggregated group pursuant to paragraph (b)(3)(ii)(A) of this section (a predecessor parent entity) ceases to be a member of the aggregated group (for example, as a result of a corporate transaction) and, after the predecessor parent entity ceases to be a member of the aggregated group, two or more health insurance issuers are members of the aggregated group, the new parent entity (the successor parent entity) is another member of the aggregated group designated in writing by the remaining members of the aggregated group. The successor parent

entity must be a health insurance issuer in the aggregated group that has the same taxable year as the predecessor parent entity; provided, however, that if no health insurance issuer in the aggregated group has the same taxable year as the predecessor parent entity, the members of the aggregated group may designate in writing any other health insurance issuer in the aggregated group to be the parent entity.

(C) *Failure to designate a parent entity.* If the members of an aggregated group that includes two or more health insurance issuers and that is an affiliated service group (within the meaning of section 414(m)) or a group described in section 414(o) fail to designate in writing a health insurance issuer to act as the parent entity of the aggregated group, the parent entity of the aggregated group for all taxable years is deemed to be an entity with a taxable year that is the calendar year (without regard to whether the aggregated group includes or has ever included an entity with a calendar year taxable year) for all purposes under this section for which a parent entity's taxable year is relevant.

(4) *Covered health insurance provider—(i) In general.* For purposes of this section and except as otherwise provided in this paragraph (b)(4), a covered health insurance provider is—

(A) A health insurance issuer for any of its taxable years beginning after December 31, 2012 in which at least 25 percent of the gross premiums it receives from providing health insurance coverage (as defined in section 9832(b)(1)) are from providing minimum essential coverage (as defined in section 5000A(f)),

(B) a health insurance issuer for any of its taxable years beginning after December 31, 2009 and before January 1, 2013 in which it receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)),

(C) the parent entity of an aggregated group of which one or more health insurance issuers described in paragraphs (b)(4)(i)(A) or (B) of this section are members for the taxable year of the parent entity with which, or in which, ends the taxable year of any such health insurance issuer; however, if the parent entity of an aggregated group is a health insurance issuer described in paragraphs (b)(4)(i)(A) or (B) of this section, that health insurance issuer is a covered health insurance provider for any taxable year that it is otherwise a covered health insurance provider, without regard to whether the taxable year of any other health insurance issuer described in paragraphs (b)(4)(i)(A) or

(B) of this section ends with or within its taxable year, and

(D) each other member of an aggregated group of which one or more health insurance issuers described in paragraphs (b)(4)(i)(A) or (B) of this section are members for the taxable year of the other member ending with, or within, the parent entity's taxable year.

(ii) *Parent entities with short taxable years.* If for any reason a parent entity has a taxable year that is less than 12 months (for example, because the taxable year of a predecessor parent entity ends when it ceases to be a member of an aggregated group), then, for purposes of determining whether the parent entity and each other member of the aggregated group is a covered health insurance provider with respect to the parent entity's short taxable year (that is, for purposes of determining whether the taxable year of a health insurance issuer described in paragraph (b)(4)(i)(A) or (B) of this section ends with or within the short taxable year of the parent entity and for purposes of determining whether another member of the aggregated group has a taxable year ending with or within the short taxable year of the parent entity), the taxable year of the parent entity is treated as the 12-month period ending on the last day of the short taxable year. Accordingly, a parent entity is a covered health insurance provider for its short taxable year if it is a health insurance issuer described in paragraph (b)(4)(i)(A) or (B) of this section or if the taxable year of a health insurance issuer described in paragraph (b)(4)(i)(A) or (B) of this section in an aggregated group with the parent entity ends with or within the 12-month period ending on the last day of the parent entity's short taxable year. Similarly, each other member of the parent entity's aggregated group is a covered health insurance provider for its taxable year ending with or within the 12-month period ending on the last day of the parent entity's short taxable year.

(iii) *Predecessor and successor parent entities.* If the parent entity of an aggregated group changes, the members of the aggregated group may be covered health insurance providers based on their relationship to either or both parent entities with respect to the taxable years of the parent entities in which the change occurs.

(iv) *Self-insured plans.* For purposes of this section, a person is not a covered health insurance provider solely because it maintains a self-insured medical reimbursement plan. For this purpose, a self-insured medical reimbursement plan is a separate written plan for the benefit of

employees (including former employees) that provides for reimbursement of medical expenses referred to in section 105(b) and 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, and may include a plan maintained by an employee organization described in section 501(c)(9).

(v) *De minimis exception—(A) In general.* A health insurance issuer and any member of its aggregated group that would otherwise be a covered health insurance provider under paragraph (b)(4)(i), (ii), or (iii) of this section for a taxable year beginning after December 31, 2012 is not a covered health insurance provider under this section for that taxable year if the premiums received by the health insurance issuer and any other health insurance issuers in its aggregated group from providing health insurance coverage (as defined in section 9832(b)(1)) that constitutes minimum essential coverage (as defined in section 5000A(f)) are less than two percent of the gross revenues of the health insurance issuer and all other members of its aggregated group for that taxable year. A health insurance issuer and any member of its aggregated group that would otherwise be a covered health insurance provider under paragraph (b)(4)(i), (ii), or (iii) of this section for a taxable year beginning after December 31, 2009 and before January 1, 2013 is not a covered health insurance provider for purposes of this section for that taxable year if the premiums received by the health insurance issuer and any other health insurance issuers in its aggregated group from providing health insurance coverage (as defined in section 9832(b)(1)) are less than two percent of the gross revenues of the health insurance issuer and all other members of its aggregated group for that taxable year. In determining whether premiums constitute less than two percent of gross revenues, the amount of gross revenues must be determined in accordance with generally accepted accounting principles. For the definition of the term *premiums*, see paragraph (b)(5) of this section. A person that would be a covered health insurance provider for a taxable year in an aggregated group with a predecessor parent entity and that would also be a covered health insurance provider for that taxable year

in an aggregated group with a successor parent entity is not a covered health insurance provider under the *de minimis* exception only if the aggregated groups of which the person is a member meet the requirements of the *de minimis* exception based on both the taxable year of the predecessor parent entity and the taxable year of the successor parent entity.

(B) *One-year de minimis exception transition period.* If a health insurance issuer or a member of an aggregated group is not a covered health insurance provider for a taxable year solely by reason of the *de minimis* exception described in paragraph (b)(4)(v)(A) of this section, but fails to meet the requirements of the *de minimis* exception described in paragraph (b)(4)(v)(A) of this section for the immediately following taxable year, that health insurance issuer or member of an aggregated group will not be a covered health insurance provider for that immediately following taxable year.

(vi) *Examples.* The following examples illustrate the principles of this paragraph (b)(4). For purposes of these examples, each corporation has a taxable year that is the calendar year, unless the example provides otherwise.

Example 1. (i) Corporations Y and Z are members of an aggregated group under paragraph (b)(2) of this section. Y is a health insurance issuer that is a covered health insurance provider pursuant to paragraph (b)(4)(i)(A) of this section and receives premiums for providing health insurance coverage that is minimum essential coverage during its 2015 taxable year in an amount that is less than two percent of the combined gross revenues of Y and Z for their 2015 taxable years. Z is not a health insurance issuer.

(ii) Y and Z are not covered health insurance providers under paragraph (b)(4) of this section for their 2015 taxable years because they meet the requirements of the *de minimis* exception under paragraph (b)(4)(v)(A) of this section.

Example 2. (i) Corporations V, W, and X are members of an aggregated group under paragraph (b)(2) of this section. V is a health insurance issuer that is a covered health insurance provider pursuant to paragraph (b)(4)(i)(A) of this section, but neither W nor X is a health insurance issuer. W is the parent entity of the aggregated group. V's taxable year ends on December 31, W's taxable year ends on June 30, and X's taxable year ends on September 30. For its taxable year ending December 31, 2016, V receives \$3x of premiums from providing minimum essential coverage and has no other revenue. For its taxable year ending June 30, 2017, W has \$100x in gross revenue. For its taxable year ending September 30, 2016, X has \$60x in gross revenue.

(ii) But for the *de minimis* exception, V (the health insurance issuer) would be a

covered health insurance provider for its taxable year ending December 31, 2016; W (the parent entity) would be a covered health insurance provider for its taxable year ending June 30, 2017 (its taxable year with which, or within which, ends the taxable year of the health insurance issuer); and X (the other member of the aggregated group) would be a covered health insurance provider for its taxable year ending on September 30, 2016 (its taxable year ending with, or within, the taxable year of the parent entity). However, the premiums received by V (the health insurance issuer) from providing minimum essential coverage during the taxable year that it would otherwise be a covered health insurance provider under paragraph (b)(4)(i)(A) of this section are less than two percent of the combined gross revenues of V, W, and X for the related taxable years that they would otherwise be covered health insurance providers under paragraph (b)(4)(i) of this section (\$3x is less than \$3.26x (two percent of \$163x)). Therefore, the *de minimis* exception of paragraph (b)(4)(v)(A) of this section applies, and V, W, and X are not covered health insurance providers for these taxable years.

Example 3. (i) The facts are the same as *Example 2*, except that V receives \$4x of premiums for providing minimum essential coverage for its taxable year ending December 31, 2016. In addition, the members of the VWX aggregated group were not covered health insurance providers for their taxable years ending December 31, 2015, June 30, 2016, and September 30, 2015, respectively (their immediately preceding taxable years) solely by reason of the *de minimis* exception of paragraph (b)(4)(v)(A) of this section.

(ii) Although the premiums received by the members of the aggregated group from providing minimum essential coverage are more than two percent of the gross revenues of the aggregated group for the taxable years during which the members would otherwise be treated as covered health insurance providers under paragraph (b)(4)(i) of this section (\$4x is greater than \$3.28x (two percent of \$164x)), they were not covered health insurance providers for their immediately preceding taxable years solely because of the *de minimis* exception of paragraph (b)(4)(v)(A) of this section. Therefore, V, W, and X are not covered health insurance providers for their taxable years ending on December 31, 2016, June 30, 2017, and September 30, 2016, respectively, because of the one-year transition period under paragraph (b)(4)(v)(B) of this section. However, the members of the VWX aggregated group will be covered health insurance providers for their subsequent taxable years if they would otherwise be covered health insurance providers for those taxable years under paragraph (b)(4) of this section.

Example 4. (i) Corporations W, X, Y, and Z are members of a controlled group described in section 414(b) that is an aggregated group under paragraph (b)(2) of this section. W and X are health insurance issuers. Y and Z are not health insurance issuers. W is the parent entity of the aggregated group. W's and Y's taxable years end on December 31; X's taxable year ends

on March 31; and Z's taxable year ends on June 30. As a result of a corporate transaction, W is no longer a member of the WXYZ aggregated group as of September 30, 2016, and W's taxable year ends on that date. Following the corporate transaction, X becomes the parent entity of the XYZ aggregated group.

(ii) Because W's taxable year is treated as the 12-month period ending on September 30, 2016, W is the parent entity for X's taxable year ending March 31, 2016, Z's taxable year ending June 30, 2016, and Y's taxable year ending December 31, 2015. Because X's taxable year begins on April 1, 2016 and ends on March 31, 2017, for purposes of paragraph (b)(4) of this section, X is the parent entity for Z's taxable year ending June 30, 2016, Y's taxable year ending December 31, 2016, and W's taxable year ending September 30, 2016.

Example 5. (i) The facts are the same as *Example 4*. In addition, W receives \$4x of premiums for providing minimum essential coverage and no other revenue for its taxable year beginning January 1, 2016 and ending September 30, 2016. X receives \$2x of premiums for providing minimum essential coverage and has no other revenue for its taxable year ending March 31, 2016. X receives \$1x of premiums for providing minimum essential coverage and no other revenue for its taxable year ending March 31, 2017. For its taxable year ending December 31, 2015, Y has \$100x in gross revenue. For its taxable year ending December 31, 2016, Y has \$200x in gross revenue. For its taxable year ending June 30, 2016, Z has \$120x in gross revenue (none of which constitute premiums for providing health insurance coverage that constitutes minimum essential coverage (as defined in section 5000A(f)). W, X, Y, and Z did not qualify for the *de minimis* exception in any prior taxable years.

(ii) For its taxable year ending June 30, 2016, Z does not meet the requirements for the *de minimis* exception described in paragraph (b)(4)(v)(A). Even though Z meets the requirements for the *de minimis* exception with respect to the taxable year of parent entity X ending March 31, 2017 (\$5x is less than two percent of \$325x), Z does not meet the requirements for the *de minimis* exception based on the premiums and gross revenues of the taxable years of its aggregated group members ending with or within the deemed 12-month taxable year of parent entity W ending September 30, 2016 (\$6x is more than two percent of \$226x). Therefore, Z is a covered health insurance provider for its June 30, 2016 taxable year.

(iii) For its taxable year ending December 31, 2015, Y does not meet the requirements for the *de minimis* exception described in paragraph (b)(4)(v)(A) (\$6x is more than two percent of \$325x). For its taxable year ending December 31, 2016, Y meets the requirements for the *de minimis* exception described in paragraph (b)(4)(v)(A) (\$5x is less than two percent of \$325x). Therefore, Y is a covered health insurance provider for its December 31, 2015 taxable year, but is not a covered health insurance provider for its December 31, 2016 taxable year.

(iv) For its taxable year ending September 30, 2016, W does not meet the requirements

for the *de minimis* exception described in paragraph (b)(4)(v)(A). Even though W meets the requirements for the *de minimis* exception with respect to X's taxable year ending March 31, 2017 (\$5x is less than two percent of \$325x), W does not meet the requirements for the *de minimis* exception with respect to its taxable year ending September 30, 2016 (\$6x is more than two percent of \$226x). Therefore, W is a covered health insurance provider for its September 30, 2016 taxable year.

(v) For its taxable year ending March 31, 2016, X does not meet the requirements for the *de minimis* exception (\$6x is more than two percent of \$226x). For its taxable year ending March 31, 2017, X meets the requirements for the *de minimis* exception (\$5x is less than two percent of \$325x). Therefore, X is a covered health insurance provider for its March 31, 2016 taxable year, but is not a covered health insurance provider for its March 31, 2017 taxable year.

(5) *Premiums*—(i) For purposes of this section, the term *premiums* means premiums written (including premiums written for assumption reinsurance, but reduced by assumption reinsurance ceded (as described in paragraph (b)(5)(ii) of this section), excluding indemnity reinsurance written (as described in paragraph (b)(5)(iii) of this section) and direct service payments (as described in paragraph (b)(5)(iv) of this section), but without reduction for ceding commissions or medical loss ratio rebates, determined in a manner consistent with the requirements for reporting under the Supplemental Health Care Exhibit published by the National Association of Insurance Commissioners 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 (or any successor or replacement exhibits or forms).

(ii) *Assumption reinsurance*. For purposes of this paragraph (b)(5), the term *assumption reinsurance* means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(iii) *Indemnity reinsurance*. For purposes of this paragraph (b)(5), the term *indemnity reinsurance* means reinsurance provided pursuant to an agreement between a health insurance issuer and a reinsuring company under which 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 the health insurance issuer retains its liability to provide health insurance coverage (as defined in section 9832(b)(1)) to, and its contractual relationship with, the insured.

(iv) *Direct service payments*. For purposes of this paragraph (b)(5), the term *direct service payment* means a capitated, prepaid, periodic, or other payment made by a health insurance issuer or another entity that receives 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, regardless of whether the organization that receives the compensation is subject to healthcare provider, health insurance, health plan licensing, financial solvency, or other similar regulatory requirements under state insurance law.

(6) *Disqualified taxable year*. For purposes of this section, the term *disqualified taxable year* means, with respect to any person, any taxable year for which the person is a covered health insurance provider.

(7) *Applicable individual*—(i) *In general*. For purposes of this section, except as provided in paragraph (b)(7)(ii) of this section, the term *applicable individual* means, with respect to any covered health insurance provider for any disqualified taxable year, any individual (or any other person described in guidance of general applicability published in the Internal Revenue Bulletin)—

(A) who is an officer, director, or employee in that taxable year, or

(B) who provides services for or on behalf of the covered health insurance provider during that taxable year.

(ii) *Independent contractors*—Remuneration for services performed by an independent contractor for a covered health insurance provider is subject to the deduction limitation under section 162(m)(6). However, an independent contractor is not an applicable individual with respect to a covered health insurance provider for a disqualified taxable year if each of the following requirements is satisfied:

(A) The independent contractor is actively engaged in the trade or business of providing services to recipients, other than as an employee or as a member of the board of directors of a corporation (or similar position with respect to an entity that is not a corporation);

(B) The independent contractor provides significant services (as defined in § 1.409A-1(f)(2)(iii)) to two or more persons to which the independent contractor is not related and that are not related to one another (as defined in § 1.409A-1(f)(2)(ii)); and

(C) The independent contractor is not related to the covered health insurance

provider or any member of its aggregated group, applying the definition of related person contained in § 1.409A-1(f)(2)(ii), subject to the modification that for purposes of applying the references to sections 267(b) and 707(b)(1), the language “20 percent” is not used instead of “50 percent” each place “50 percent” appears in sections 267(b) and 707(b)(1).

(8) *Service provider*. For purposes of this section, the term *service provider* means, with respect to a covered health insurance provider for any period, an individual who is an officer, director, or employee, or who provides services for, or on behalf of, the covered health insurance provider or any member of its aggregated group.

(9) *Remuneration*—(i) *In general*. For purposes of this section, except as provided in paragraph (b)(9)(ii) of this section, the term *remuneration* has the same meaning as the term *applicable employee remuneration*, as defined in section 162(m)(4), but without regard to the exceptions under section 162(m)(4)(B) (remuneration payable on a commission basis), section 162(m)(4)(C) (performance-based compensation), and section 162(m)(4)(D) (existing binding contracts), and the regulations under those sections.

(ii) *Exceptions*. For purposes of this section, remuneration does not include—

(A) A payment made to, or for the benefit of, an applicable individual from or to a trust described in section 401(a) within the meaning of section 3121(a)(5)(A),

(B) A payment made under an annuity plan described in section 403(a) within the meaning of section 3121(a)(5)(B),

(C) A payment made under a simplified employee pension plan described in section 408(k)(1) within the meaning of section 3121(a)(5)(C),

(D) A payment made under an annuity contract described in section 403(b) within the meaning of section 3121(a)(5)(D),

(E) Salary reduction contributions described in section 3121(v)(1), and

(F) Remuneration consisting of any benefit provided to, or on behalf of, an employee if, at the time the benefit is provided, it is reasonable to believe that the employee will be able to exclude the value of the benefit from gross income.

(10) *Applicable Individual Remuneration or AIR*. For purposes of this section, the term *applicable individual remuneration* or *AIR* means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for that taxable year (determined without regard

to section 162(m) for remuneration for services performed by that applicable individual (whether or not in that taxable year). AIR does not include any DDR with respect to services performed during any taxable year. AIR for a disqualified taxable year may include remuneration for services performed in a taxable year before the taxable year in which the deduction for the remuneration is allowable. For example, a discretionary bonus granted and paid to an applicable individual in a disqualified taxable year in recognition of services performed in prior taxable years is AIR for the disqualified taxable year in which the bonus is granted and paid. In addition, a grant of restricted stock in a disqualified taxable year with respect to which an applicable individual makes an election under section 83(b) is AIR for the disqualified taxable year of the covered health insurance provider in which the grant of the restricted stock is made. See paragraph (b)(9)(ii) of this section for certain remuneration that is not treated as AIR for purposes of this section.

(11) *Deferred Deduction Remuneration or DDR.* For purposes of this section, the term *deferred deduction remuneration* or *DDR* means remuneration that would be AIR for services performed in a disqualified taxable year but for the fact that the deduction (determined without regard to section 162(m)(6)) for the remuneration is allowable in a subsequent taxable year. Whether remuneration is DDR is determined without regard to when the remuneration is paid, except to the extent that the timing of the payment affects the taxable year in which the remuneration is otherwise deductible. For example, payments that are otherwise deductible by a covered health insurance provider in an initial taxable year, but are paid to an applicable individual by the 15th day of the third month of the immediately subsequent taxable year of the covered health insurance provider (as described in § 1.404(b)-1T, Q&A-2(b)(1)), are AIR for the initial taxable year (and not DDR) because the deduction for the payments is allowable in the initial taxable year, and not a subsequent taxable year. Except as otherwise provided in paragraph (i) of this section (regarding transition rules for certain DDR attributable to services performed in taxable years beginning before January 1, 2013), DDR that is attributable to services performed in a disqualified taxable year of a covered health insurance provider is subject to the section 162(m)(6) deduction limitation

even if the taxable year in which the remuneration is otherwise deductible is not a disqualified taxable year. Similarly, DDR is subject to the section 162(m)(6) deduction limitation regardless of whether an applicable individual is a service provider of the covered health insurance provider in the taxable year in which the DDR is otherwise deductible. However, remuneration that is attributable to services performed in a taxable year that is not a disqualified taxable year is not DDR even if the remuneration is otherwise deductible in a disqualified taxable year. See also paragraph (b)(9)(ii) of this section for certain remuneration that is not treated as DDR for purposes of this section.

(12) *Substantial risk of forfeiture.* For purposes of this section, the term *substantial risk of forfeiture* has the same meaning as provided in § 1.409A-1(d).

(13) *In-service payment.* An *in-service payment* is any amount that is paid with respect to an applicable individual from an account balance plan described in § 1.409A-1(c)(2)(i)(A) or (B) or a nonaccount balance plan described in § 1.409A-1(c)(2)(i)(C) in a taxable year of a covered health insurance provider during which at any time the applicable individual is a service provider (including amounts that became otherwise deductible, but were not paid, in a previous taxable year of a covered health insurance provider). Amounts that are paid in the last year that an applicable individual is a service provider (for example, amounts paid at separation from service) are in-service payments if the applicable individual is a service provider at any time during the taxable year of the covered health insurance provider in which the payment is made.

(14) *Payment year.* For purposes of this section, the term *payment year* means the taxable year of a covered health insurance provider for which remuneration becomes otherwise deductible.

(15) *Measurement date.* For purposes of this section, the term *measurement date* means the last day of the taxable year of a covered health insurance provider.

(c) *Deduction Limitation*—(1) *AIR.* For any disqualified taxable year beginning after December 31, 2012, no deduction is allowed under this chapter for AIR that is attributable to services performed by an applicable individual in that taxable year to the extent that the amount of that remuneration exceeds \$500,000.

(2) *DDR.* For any taxable year beginning after December 31, 2012, no

deduction is allowed under this chapter for DDR that is attributable to services performed by an applicable individual in any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of:

(i) The AIR for that applicable individual for that disqualified taxable year; and

(ii) The portion of the DDR for those services that was subject to the deduction limitation under section 162(m)(6)(A)(ii) and this paragraph (c)(2) in a preceding taxable year, or would have been subject to the deduction limitation under section 162(m)(6)(A)(ii) and this paragraph (c)(2) in a preceding taxable year if section 162(m)(6) was effective for taxable years beginning after December 31, 2009 and before January 1, 2013.

(d) *Services to which remuneration is attributable*—(1) *Attribution to a taxable year*—(i) *In general.* The deduction limitation under section 162(m)(6) applies to AIR and DDR attributable to services performed by an applicable individual in a disqualified taxable year of a covered health insurance provider. When an amount of AIR or DDR becomes otherwise deductible (and not before that time), that remuneration must be attributed to services performed by an applicable individual in a taxable year of the covered health insurance provider in accordance with the rules of this paragraph (d). After the remuneration has been attributed to services performed by an applicable individual in a taxable year of a covered health insurance provider, the rules of paragraph (e) of this section are then applied to determine whether the deduction with respect to the remuneration is limited by section 162(m)(6).

(ii) *Overview.* Paragraphs (d)(1)(iii) through (v) of this section, and paragraph (d)(2) of this section, set forth rules of general applicability for attributing remuneration to services performed by an applicable individual in a taxable year of a covered health insurance provider. Paragraph (d)(3) sets forth two methods for attributing remuneration provided under an account balance plan—the account balance ratio method (described in paragraph (d)(3)(ii) of this section) and the principal additions method (described in paragraph (d)(3)(iii) of this section). Paragraph (d)(4) of this section sets forth two methods for attributing remuneration provided under a nonaccount balance plan—the present value ratio method (described in paragraph (d)(4)(ii) of this section) and

the formula benefit ratio method (described in paragraph (d)(4)(iii) of this section). Paragraph (d)(5) of this section sets forth rules for attributing remuneration resulting from equity-based remuneration (such as stock options, stock appreciation rights, restricted stock, and restricted stock units). Paragraph (d)(6) of this section sets forth rules for attributing remuneration that is involuntary separation pay. Paragraph (d)(7) of this section sets forth rules for attributing remuneration that is received under a reimbursement arrangement, and paragraph (d)(8) of this section sets forth rules for attributing remuneration that results from a split-dollar life insurance arrangement.

(iii) *No attribution to taxable years during which no services are performed or before a legally binding right arises—*(A) *In general.* For purposes of this section, remuneration is not attributable—

(1) To a taxable year of a covered health insurance provider ending before the later of the date the applicable individual begins providing services to the covered health insurance provider (or any member of its aggregated group) and the date the applicable individual obtains a legally binding right to the remuneration, or

(2) To any other taxable year of a covered health insurance provider during which the applicable individual is not a service provider.

(B) *Attribution of remuneration before the commencement of services or a legally binding right arises.* To the extent that remuneration would otherwise be attributable in accordance with paragraphs (d)(2) through (11) of this section to a taxable year ending before the later of the date an applicable individual begins providing services to a covered health insurance provider (or any member of its aggregated group) and the date the applicable individual obtains a legally binding right to the remuneration, the remuneration is attributed to services performed in the taxable year in which the later of these dates occurs. For example, if an applicable individual obtains a contractual right to remuneration in a taxable year of a covered health insurance provider and the remuneration would otherwise be attributable to that taxable year pursuant to paragraph (d)(2) of this section, but the applicable individual does not begin providing services to the covered health insurance provider until the next taxable year, the remuneration is attributable to the taxable year in which the applicable individual begins providing services.

(iv) *Attribution to 12-month periods.* To the extent that a covered health insurance provider is required to attribute remuneration on a daily *pro rata* basis under this paragraph (d), it may treat any 12-month period as having 365 days (and so may ignore the extra day in leap years).

(v) *Remuneration subject to nonlapse restriction or similar formula.* For purposes of this section, if stock or other property is subject to a nonlapse restriction (as defined in § 1.83-3(h)), or if the remuneration payable to an applicable individual is determined under a formula that, if applied to stock or other property, would be a nonlapse restriction, the amount of the remuneration and the attribution of that remuneration to taxable years must be determined based upon application of the nonlapse restriction or formula. For example, if the earnings or losses on an account under an account balance plan are determined based upon the performance of company stock, the valuation of which is based on a formula that if applied to the stock would be a nonlapse restriction, then that formula must be used consistently for purposes of determining the amount of the remuneration credited to that account balance in taxable years and the attribution of that remuneration to taxable years.

(2) *Legally binding right.* Unless attributable to services performed in a different taxable year pursuant to paragraphs (d)(3) through (11) of this section, remuneration is attributable to services performed in the taxable year of a covered health insurance provider in which an applicable individual obtains a legally binding right to the remuneration. An applicable individual does not have a legally binding right to remuneration if the remuneration may be reduced unilaterally or eliminated by a covered health insurance provider or other person after the services creating the right to the remuneration have been performed. However, if the facts and circumstances indicate that the discretion to reduce or eliminate the remuneration is available or exercisable only upon a condition, or the discretion to reduce or eliminate the remuneration lacks substantive significance, an applicable individual will be considered to have a legally binding right to the remuneration. For this purpose, remuneration is not considered to be subject to unilateral reduction or elimination merely because it may be reduced or eliminated by operation of the objective terms of a plan, such as the application of a nondiscretionary, objective provision creating a substantial risk of forfeiture.

(3) *Account balance plans—*(i) *In general.* When remuneration for services performed by an applicable individual for a covered health insurance provider becomes otherwise deductible (for example, because the amount was paid or made available during that taxable year) from a plan described in § 1.409A-1(c)(2)(i)(A) or (B) (an *account balance plan*), that remuneration must be attributed to services performed by the applicable individual in a taxable year of the covered health insurance provider in accordance with an attribution method described in either paragraph (d)(3)(ii) or (d)(3)(iii) of this section. However, except as provided in paragraphs (d)(3)(ii)(D) and (f)(3) of this section, the covered health insurance provider and all members of its aggregated group must apply the same attribution method under this paragraph (d)(3) consistently for all taxable years beginning after September 23, 2014 for all amounts that become otherwise deductible under all account balance plans.

(ii) *Account balance ratio method—*(A) *In general.* Under this method, remuneration for services performed by an applicable individual for a covered health insurance provider that becomes otherwise deductible under an account balance plan must be attributed to services performed by the applicable individual in each taxable year of the covered health insurance provider ending with or before the payment year during which the applicable individual was a service provider and for which the account balance of the applicable individual increased (determined in accordance with paragraph (d)(3)(ii)(B) and (C) of this section). The amount attributed to each such taxable year is equal to the amount of remuneration that becomes otherwise deductible multiplied by a fraction, the numerator of which is the increase in the applicable individual's account balance under the plan for the taxable year, and the denominator of which is the sum of all such increases for all taxable years during which the applicable individual was a service provider. Thus, remuneration that becomes otherwise deductible under a plan is attributed to a taxable year of the covered health insurance provider in proportion to the increase in the applicable individual's account balance for that taxable year.

(B) *Increase in the account balance.* For purposes of this paragraph (d)(3)(ii), an increase in an account balance under an account balance plan occurs for a taxable year if the account balance as of the measurement date in that taxable year is greater than the account balance as of the measurement date in every

earlier taxable year. In that case, the amount of the increase for that taxable year is equal to the excess of the applicable individual's account balance as of the measurement date for that taxable year over the greatest of the applicable individual's account balances under the plan as of the measurement date in every earlier taxable year. If the applicable individual's account balance as of the measurement date in a taxable year is less than or equal to the applicable individual's account balance as of the measurement date in any earlier taxable year, there is no increase in the account balance for that later taxable year.

(C) *Certain account balance adjustments.* For purposes of determining the account balance on a measurement date under paragraph (d)(3)(ii)(B) of this section, the account balance is adjusted as provided in this paragraph (d)(3)(ii)(C).

(1) *In-service payments.* If an in-service payment is made from the account of an applicable individual under an account balance plan in any taxable year of a covered health insurance provider, then the rules of this paragraph (d)(3)(ii)(C)(1) apply.

(i) Solely for purposes of determining the increase in the applicable individual's account balance as of the measurement date in the payment year (and not for purposes of attributing any amount that becomes otherwise deductible in any later taxable year), the account balance as of the measurement date for that taxable year is increased by the amount of all in-service payments made from the plan during that taxable year.

(ii) For purposes of attributing any amount that becomes otherwise deductible under the plan in any taxable year after the payment year of the in-service payment—

(A) the account balance as of the measurement date in each taxable year that ends before the taxable year to which the in-service payment is attributed pursuant to this paragraph (d)(3)(ii) is reduced by the sum of the amount of the in-service payment that is attributed to that taxable year and the amount of the in-service payment that is attributed to each taxable year that ends before that taxable year, if any, and

(B) to the extent that the in-service payment includes an amount that was deductible by the covered health insurance provider in a previous taxable year and, therefore, was previously attributable to services performed by the applicable individual in one or more taxable years of the covered health insurance provider (for example, because the amount was made available

in a previous taxable year but was not paid at that time), the account balance as of the measurement date for each taxable year that ends before the taxable year to which the in-service payment is attributed pursuant to this paragraph (d)(3)(ii) is reduced by the sum of the amount of the in-service payment previously attributable to that taxable year and the amount of the in-service payment previously attributable to each taxable year that ends before that taxable year, if any.

(2) *Certain increases after ceasing to be a service provider.* Any addition (other than income or earnings) to an account balance plan made in a taxable year that begins after an applicable individual ceases to be a service provider (and that ends before the applicable individual becomes a service provider again, if applicable) is added to the account balance of the applicable individual as of the measurement date of the first preceding taxable year in which the applicable individual was a service provider.

(3) *Account balance adjustments for grandfathered amounts.* If a covered health insurance provider uses the principal additions method for determining grandfathered amounts for an applicable individual under paragraph (h) of this section, then, for purposes of determining the increase in the applicable individual's account balance, the account balance as of any measurement date is reduced by the amount of any grandfathered amounts otherwise included in the account balance.

(D) *Transition rule for amounts attributed before the applicability date of the final regulations.* Amounts that become otherwise deductible in taxable years beginning before September 23, 2014 may be attributed to services performed in taxable years of a covered health insurance provider under the rules set forth in the proposed regulations. If a covered health insurance provider attributes an amount paid to an applicable individual pursuant to a method permitted under the proposed regulations and then chooses to use the account balance ratio method to attribute amounts that subsequently become otherwise deductible with respect to that applicable individual, then, for purposes of applying the account balance ratio method to attribute any amount that becomes otherwise deductible under the plan after the taxable year in which the last payment was made that was attributed pursuant to the proposed regulations, the account balance as of the measurement date for each taxable year that ends before the

taxable year in which the last payment that was attributed pursuant to the proposed regulations is reduced by the sum of the amount previously attributed to that taxable year under the proposed regulations and the amount previously attributable to each taxable year that ends prior to that taxable year under the proposed regulations, if any.

(iii) *Principal additions method—(A) In general.* Under this method, remuneration that becomes otherwise deductible under an account balance plan during a payment year must be attributed to services performed by the applicable individual in the taxable year of the covered health insurance provider during which the applicable individual was a service provider and in which the principal addition to which the amount relates is credited under the plan (determined in accordance with paragraph (d)(3)(iii)(B) and (C) of this section). An amount relates to a principal addition if the amount is a payment of the principal addition or earnings on the principal addition, based on a separate accounting of these amounts. The principal additions method described in this paragraph may be used to attribute amounts that become otherwise deductible under an account balance plan only if the covered health insurance provider separately accounts for each principal addition to the plan (and any earnings thereon) and traces each amount that becomes otherwise deductible under the plan to a principal addition made in a taxable year of the covered health insurance provider.

(B) *Principal addition—(1) For purposes of this paragraph (d)(3)(iii), the excess (if any) of the sum of the account balance of an applicable individual in an account balance plan as of the last day of a taxable year and any payments made during the taxable year over the account balance as of the last day of the immediately preceding taxable year, that is not due to earnings or losses (as described in paragraph (d)(3)(iii)(C) of this section), is treated as a principal addition that is credited to the plan in that taxable year if the applicable individual was a service provider during that taxable year. If the applicable individual was not a service provider during that taxable year, the excess described in the preceding sentence is treated as a principal addition that is credited to the plan in accordance with paragraph (d)(3)(iii)(B)(2) of this section.*

(2) *Principal additions after termination of employment.* Any principal addition to an account balance plan made in a taxable year that begins after an applicable individual ceases to

be a service provider (and that ends before the applicable individual becomes a service provider again, if applicable) is treated as a principal addition that is credited in the first preceding taxable year in which the applicable individual was a service provider.

(C) *Earnings.* Whether remuneration constitutes earnings on a principal addition is determined under the principles defining income attributable to an amount taken into account under § 31.3121(v)(2)–1(d)(2). Therefore, for an account balance plan, earnings on an amount deferred generally include an amount credited on behalf of an applicable individual under the terms of the arrangement that reflects a rate of return that does not exceed either the rate of return on a predetermined actual investment (as defined in § 31.3121(v)(2)–1(d)(2)(i)(B)), or, if the income does not reflect the rate of return on a predetermined actual investment, a rate of return that reflects a reasonable rate of interest (as defined in § 31.3121(v)(2)–1(d)(2)(i)(C)). For purposes of this paragraph (d)(3)(iii), the use of a rate of return that is not based on a predetermined actual investment or a reasonable rate of interest generally will result in the treatment of some or all of the remuneration as a principal addition that is attributable to services performed by an applicable individual in a taxable year of a covered health insurance provider in accordance with this paragraph (d)(3)(iii) of this section.

(4) *Nonaccount balance plans*—(i) *In general.* When remuneration for services performed by an applicable individual for a covered health insurance provider becomes otherwise deductible under a plan described in § 1.409A–1(c)(2)(i)(C) (a nonaccount balance plan), that remuneration must be attributed to services performed by the applicable individual in a taxable year of the covered health insurance provider in accordance with the attribution method described in either paragraph (d)(4)(ii) or (d)(4)(iii) of this section. However, except as provided in paragraphs (d)(4)(ii)(D) and (d)(4)(iii)(D) and (f)(3) of this section, the covered health insurance provider and all members of its aggregated group must apply the same attribution method under this paragraph (d)(4) consistently for all taxable years beginning after September 23, 2014 for all amounts that become deductible under all nonaccount balance plans.

(ii) *Present value ratio attribution method*—(A) *In general.* Under this method, remuneration for services performed by an applicable individual for a covered health insurance provider

that becomes otherwise deductible under a nonaccount balance plan must be attributed to services performed by the applicable individual in each taxable year of the covered health insurance provider ending with or before the payment year during which the applicable individual was a service provider for which the present value of the future payment(s) to be made to or on behalf of the applicable individual under the plan increased (determined in accordance with paragraph (d)(3)(ii)(B) and (C) of this section). The amount attributed to each such taxable year is equal to the amount of remuneration that becomes otherwise deductible under the plan multiplied by a fraction, the numerator of which is the increase in the present value of the future payment(s) to which the applicable individual has a legally binding right under the plan for the taxable year, and the denominator of which is the sum of all such increases for all taxable years during which the applicable individual was a service provider. Thus, remuneration that becomes otherwise deductible under a plan is attributed to a taxable year of the covered health insurance provider in proportion to the increase in the present value of the future payment(s) under the plan for that taxable year.

(B) *Increase in present value of future payments.* For purposes of this paragraph (d)(4)(ii), for a taxable year of a covered health insurance provider, an increase in the present value of the future payment(s) to which an applicable individual has a legally binding right under a nonaccount balance plan occurs if the present value of the future payment(s) as of the measurement date in the taxable year is greater than the present value of the future payment(s) as of the measurement date in every earlier taxable year. In that case, the amount of the increase for that taxable year is equal to the excess of the present value of the future payment(s) to which the applicable individual has a legally binding right under the plan as of the measurement date for that taxable year over the greatest present value of the future payment(s) to which the applicable individual had a legally binding right under the plan as of the measurement date in every earlier taxable year. If the present value of the future payment(s) as of a measurement date in a taxable year is less than or equal to the present value of the future payment(s) as of the measurement date in any earlier taxable year, then there is no increase in the present value of the future payment(s) to which the

applicable individual has a legally binding right under the plan for that later taxable year. For purposes of determining the increase (or decrease) in the present value of a future payment(s) under a nonaccount balance plan, the rules of § 31.3121(v)(2)–1(c)(2) apply (including the requirement that reasonable actuarial assumptions and methods be used).

(C) *Certain present value adjustments.* For purposes of determining the present value of the future payment(s) to which an applicable individual has a legally binding right to receive as of a measurement date under paragraph (d)(4)(ii)(B) of this section, the present value is adjusted as provided in this paragraph (d)(3)(iii)(C).

(1) *In-service payments.* If an in-service payment is made to or on behalf of an applicable individual under a nonaccount balance plan in any taxable year of a covered health insurance provider, then the rules of this paragraph (d)(3)(iii)(C)(1) apply.

(i) Solely for purposes of determining the increase in the present value of the future payment(s) under the plan for the payment year (and not for purposes of attributing any amount that becomes otherwise deductible in any later taxable year), the present value of the future payment(s) under the plan as of the measurement date in the payment year is increased by the amount of any reduction in the present value of the future payment(s) resulting from the in-service payment made from the plan during that taxable year.

(ii) For purposes of attributing any amount that becomes otherwise deductible under the plan in any taxable year after the payment year of the in-service payment, the present value of the future payment(s) as of the measurement date for each taxable year that ends before the payment year is reduced by the present value of the future payment to which the applicable individual had a legally binding right to be paid on the date of the in-service payment (determined as of the measurement date based upon all of the applicable factors under the plan as of the measurement date, such as compensation and years of service on that date).

(2) *Increases in the present value of future payments after ceasing to be a service provider.* Any increase in the present value of the future payment(s) under a plan in a taxable year that begins after an applicable individual ceases to be a service provider (and that ends before the applicable individual becomes a service provider again, if applicable) that is not due merely to the passage of time or a change in the

reasonable actuarial assumptions used to determine the present value of the future payment(s) is added to the present value of the future payment(s) for the applicable individual as of the measurement date of the most recent preceding taxable year in which the applicable individual was a service provider.

(D) *Transition rule for amounts attributed before the effective date of the final regulations.* Amounts that become otherwise deductible in taxable years beginning before September 23, 2014 may be attributed under the rules set forth in the proposed regulations. If a covered health insurance provider attributes an amount paid to an applicable individual pursuant to the proposed regulations and then chooses to use the present value ratio method to attribute amounts that subsequently become otherwise deductible with respect to that applicable individual, then, for purposes of applying the present value ratio method to attribute any amount that becomes otherwise deductible under the plan in any taxable year after the taxable year in which the last payment was made that was attributed pursuant to the proposed regulations, the present value of the future payment(s) as of the measurement date for each taxable year that ends before the taxable year in which the last payment that was attributed pursuant to the proposed regulations is reduced by the present value of each future payment to which the applicable individual had a legally binding right to be paid that was attributed pursuant to the proposed regulations (determined as of the measurement date based upon all of the applicable factors under the plan as of the measurement date, such as compensation and years of service on that date), with no adjustment for an amount that became otherwise deductible, but was not paid.

(iii) *Formula benefit ratio method—*
(A) *In general.* Under this method, remuneration that becomes otherwise deductible under a nonaccount balance plan on a date (referred to for these purposes as the *date of payment*) must be attributed to services performed by the applicable individual in each taxable year of the covered health insurance provider ending with or before the payment year during which the applicable individual was a service provider and for which the formula benefit of the applicable individual under the plan increased (determined in accordance with paragraph (d)(3)(iii)(B), (C) and (D) of this section). The amount attributed to each such taxable year is equal to the amount of remuneration

that becomes otherwise deductible under the plan on the date of payment multiplied by a fraction, the numerator of which is the increase in the applicable individual's formula benefit under the plan for the taxable year and the denominator of which is the sum of all such increases for all taxable years during which the applicable individual was a service provider (which will generally be the amount that becomes otherwise deductible under the plan on the date of payment). Thus, remuneration that becomes otherwise deductible under a plan is attributed to a taxable year of the covered health insurance provider in proportion to the increase in the applicable individual's formula benefit under the plan in that taxable year.

(B) *Formula benefit.* For purposes of this paragraph (d)(4)(iii), an applicable individual's formula benefit as of any date is the benefit (or portion thereof) to which the applicable individual has a legally binding right under a nonaccount balance plan as of that date determined based upon all of the applicable factors under the plan (for example, compensation and years of service as of that date), disregarding any substantial risk of forfeiture and assuming that the applicable individual meets any applicable eligibility requirements for the benefit as of that date. For this purpose, the formula benefit is expressed in the form that it has become otherwise deductible. For example, if an applicable individual's benefit under a plan is paid in the form of a single lump sum, then the applicable individual's formula benefit under the plan is expressed in the form of a single lump sum for all purposes under this paragraph (d)(4)(iii). If the amount that becomes otherwise deductible is payable in more than one form of payment (for example, 50 percent of the benefit is paid in the form of a lump sum and 50 percent is paid in the form of a life annuity), then each separate form of payment is treated as a separate formula benefit to which this paragraph (d)(4)(iii) is applied separately.

(C) *Increase in formula benefit.* For purposes of this paragraph (d)(4)(iii), an increase in an applicable individual's formula benefit under a nonaccount balance plan occurs for a taxable year of a covered health insurance provider if the formula benefit as of the measurement date in that taxable year is greater than the formula benefit as of the measurement date in every earlier taxable year. In that case, the amount of the increase for that taxable year is equal to excess of the formula benefit as of the measurement date in that taxable

year over the greatest formula benefit as of any measurement date in any earlier taxable year. If the applicable individual's formula benefit as of a measurement date in a taxable year is less than or equal to the applicable individual's formula benefit as of the measurement date in any earlier taxable year, there is no increase in the formula benefit to which the applicable individual has a legally binding right under the plan for that later taxable year.

(D) *Certain adjustments.* For purposes of determining the increase in the formula benefit as of a date of payment under paragraph (d)(4)(iii)(C) of this section, the rules of this paragraph (d)(3)(iii)(D) apply—

(1) *Attribution to payment year.* Solely for purposes of attributing a payment under this paragraph (d)(4)(iii) (including an in-service payment), the date of payment is substituted for the measurement date in the payment year to determine whether an increase in the formula benefit occurs in the payment year and the amount of any such increase.

(2) *Amounts not paid.* If an amount becomes otherwise deductible under a nonaccount balance plan, but is not paid, the formula benefit for that amount must be determined using the form in which it will be paid, if that form is known, or any form in which it may be paid, if the actual form of payment is unknown.

(3) *Increases in the formula benefit after ceasing to be a service provider.* Any increase in the formula benefit with respect to an applicable individual resulting from a legally binding right arising in a taxable year that begins after the applicable individual ceases to be a service provider (and that ends before the applicable individual becomes a service provider again, if applicable) is added to the formula benefit with respect to the applicable individual as of the measurement date of the first preceding taxable year in which the applicable individual was a service provider. However, any increase in the formula benefit resulting from a legally binding right arising in a taxable year that begins before the applicable individual ceases to be a service provider is added to the formula benefit with respect to the applicable individual as of the measurement date of the taxable year in which the legally binding right arises, even if the increase is not reflected until after the applicable individual ceases to be a service provider (such as in the case of a cost of living adjustment).

(5) *Equity-based remuneration—(i) Stock options and stock appreciation*

rights—(A) *In general.* Except as provided in paragraph (d)(5)(i)(B) of this section, remuneration resulting from the exercise of a stock option (including compensation income arising at the time of a disqualifying disposition of an incentive stock option described in section 422 or an option under an employee stock purchase plan described in section 423) or a stock appreciation right (SAR) is attributable to services performed by an applicable individual for a covered health insurance provider on a daily *pro rata* basis over the period beginning on the date of grant (within the meaning of § 1.409A-1(b)(5)(vi)(B)) of the stock option or SAR and ending on the date that the stock option or SAR is exercised, excluding any days on which the applicable individual is not a service provider.

(B) *Stock options or SARs subject to a substantial risk of forfeiture.* If a stock option or SAR is subject to a substantial risk of forfeiture, a covered health insurance provider may attribute remuneration resulting from the exercise of the stock option or SAR to services performed by an applicable individual in a taxable year on a daily *pro rata* basis over the period beginning on the date of grant (within the meaning of § 1.409A-1(b)(5)(vi)(B)) of the stock option or SAR and ending on the first date that the stock option or SAR is no longer subject to a substantial risk of forfeiture, but only if the covered health insurance provider uses this attribution method consistently for all stock options or SARs exercised in taxable years of a covered health insurance provider beginning after September 23, 2014, except as provided in paragraph (f)(3) of this section.

(ii) *Restricted stock.* Remuneration resulting from restricted stock, for which an election under section 83(b) has not been made, that becomes substantially vested or transferred is attributed on a daily *pro rata* basis to services performed by an applicable individual for a covered health insurance provider over the period, excluding any days on which the applicable individual is not a service provider, beginning on the date the applicable individual obtains a legally binding right to the restricted stock and ending on the earliest of—

(A) The date the restricted stock becomes substantially vested, or

(B) The date the restricted stock is transferred by the applicable individual.

(iii) *Restricted stock units.*

Remuneration resulting from a restricted stock unit (RSU) is attributed on a daily *pro rata* basis to services performed by an applicable individual for a covered health insurance provider over the

period beginning on the date the applicable individual obtains a legally binding right to the RSU and ending on the date the remuneration is paid or made available, excluding any days on which the applicable individual is not a service provider.

(iv) *Partnership interests and other equity.* [Reserved]

(6) *Involuntary separation pay.* Involuntary separation pay is attributable to services performed by an applicable individual for a covered health insurance provider in the taxable year in which the involuntary separation from service occurs. Alternatively, the covered health insurance provider may attribute involuntary separation pay to services performed by an applicable individual on a daily *pro rata* basis beginning on the date that the applicable individual obtains a legally binding right to the involuntary separation pay and ending on the date of the involuntary separation from service. Involuntary separation pay to different individuals may be attributed using different methods; however, if involuntary separation payments are made to the same individual over multiple taxable years, all the payments must be attributed using the same method. For purposes of this section, the term *involuntary separation pay* means remuneration to which an applicable individual has a right to payment solely as a result of the individual's involuntary separation from service (within the meaning of § 1.409A-1(n)). To the extent that involuntary separation pay is attributed to services performed in two or more taxable years of a covered health insurance provider as permitted under this paragraph, any amount of involuntary separation pay that is paid or made available must be attributed to services performed in all of those taxable years in the same proportion that the total involuntary separation pay is attributed to taxable years of the covered health insurance provider.

(7) *Reimbursements.* Remuneration that is provided in the form of a reimbursement or benefit provided in-kind (other than cash) is attributable to services performed by an applicable individual in the taxable year of a covered health insurance provider in which the applicable individual makes a payment for which the applicable individual has a right to reimbursement or receives an in-kind benefit, except that remuneration provided in the form of a reimbursement or in-kind benefit during a taxable year of a covered health insurance provider in which an applicable individual is not a service

provider is attributable to services performed in the most recent preceding taxable year of the covered health insurance provider in which the applicable individual is a service provider.

(8) *Split-dollar life insurance.* Remuneration resulting from a split-dollar life insurance arrangement (as defined in § 1.61-22(b)) under which an applicable individual has a legally binding right to economic benefits described in § 1.61-22(d)(2)(ii) (policy cash value to which the non-owner has current access within the meaning of § 1.61-22(d)(4)(ii)) or § 1.61-22(d)(2)(iii) (any other economic benefits provided to the non-owner) is attributable to services performed in the taxable year of the covered health insurance provider in which the legally binding right arises. Split-dollar life insurance arrangements under which payments are treated as split-dollar loans under § 1.7872-15 generally will not give rise to DDR within the meaning of paragraph (b)(11) of this section, although they may give rise to AIR. However, in certain situations, this type of arrangement may give rise to DDR for purposes of section 162(m)(6), for example, if amounts due on a split-dollar loan are waived, cancelled, or forgiven.

(9) *Examples.* The following examples illustrate the principles of paragraphs (d)(1) through (8) of this section. For purposes of these examples, each corporation has a taxable year that is the calendar year and is a covered health insurance provider for all relevant taxable years, DDR is otherwise deductible in the taxable year in which it is paid, and amounts payable under nonaccount balance plans are not forfeitable upon the death of the applicable individual. For purposes of these examples, the interest rates used in these examples are assumed to be reasonable.

Example 1 (Account balance plan—account balance ratio method with earnings and a single payment). (i) B is an applicable individual of corporation Y for all relevant taxable years. On January 1, 2016, B begins participating in a nonqualified deferred compensation plan of Y that is an account balance plan. Under the terms of the plan, all amounts are fully vested at all times, and Y will pay B's entire account balance on January 1, 2019. B's account earns five percent interest per year, compounded annually. Y credits \$10,000 to B under the plan annually on January 1 for three years beginning on January 1, 2016. Thus, B's account balance is \$10,500 (\$10,000 + (\$10,000 × 5%)) on December 31, 2016; \$21,525 (\$10,500 + \$10,000 + (\$20,500 × 5%)) on December 31, 2017; and \$33,101 (\$21,525 + \$10,000 + (\$31,525 × 5%)) on December 31, 2018. On January 1, 2019, Y

pays B \$33,101, the entire account balance. Y attributes payments under its account balance plans using the account balance ratio method described in paragraph (d)(3)(i) of this section.

(ii) The increase in B's account balance during 2016 is \$10,500 (\$10,500 – zero); the increase in B's account balance for 2017 is \$11,025 (\$21,525 – \$10,500); and the increase in B's account balance for 2018 is \$11,576 (\$33,101 – \$21,525). The sum of all the increases is \$33,101 (\$10,500 + \$11,025 + \$11,576). Accordingly, for Y's 2016 taxable year, the attribution fraction is .3172 (\$10,500/\$33,101); for Y's 2017 taxable year, the attribution fraction is .3331 (\$11,025/\$33,101); and for Y's 2018 taxable year, the attribution fraction is .3497 (\$11,576/\$33,101).

(iii) With respect to the \$33,301 payment made on January 1, 2019, \$10,500 (\$33,101 × .3172) of DDR is attributable to services performed by B in Y's 2016 taxable year; \$11,026 (\$33,101 × .3331) of DDR is attributable to services performed by B in Y's 2017 taxable year; and \$11,575 (\$33,101 × .3497) of DDR is attributable to services performed by B in Y's 2018 taxable year.

Example 2 (Account balance plan—principal additions method with earnings and a single payment). (i) The facts are the same as in *Example 1*, except that Y attributes remuneration using the principal additions method described in paragraph (d)(3)(ii) of this section.

(ii) The \$10,000 principal addition made on January 1, 2016 and \$1,576 of earnings thereon (interest on the 2016 \$10,000 principal addition at five percent for three years compounded annually) are attributable to services performed by B in Y's 2016 taxable year; the principal addition of \$10,000 on January 1, 2017 and \$1,025 of earnings thereon (interest on the 2017 \$10,000 principal addition at five percent for two years compounded annually) are attributable to services performed by B in Y's 2017 taxable year; and the principal addition of \$10,000 to B's account on January 1, 2018 and \$500 of earnings thereon (interest on the 2018 \$10,000 principal addition at five percent for one year compounded annually) are attributable to services performed by B in Y's 2018 taxable year. Accordingly, with respect to the \$33,301 payment made on January 1, 2019, \$11,576 (\$10,000 + \$1,576) is attributable to services performed by B in Y's 2016 taxable year; \$11,025 (\$10,000 + \$1,025) is attributable to services performed in Y's 2017 taxable year; and \$10,500 (\$10,000 + \$500) is attributable to services performed by B in Y's 2018 taxable year.

Example 3 (Account balance plan—account balance ratio method with earnings and losses). (i) J is an applicable individual of corporation Z for all relevant taxable years. On January 1, 2016, J begins participating in a nonqualified deferred compensation plan of Z that is an account balance plan. Under the terms of the plan, all amounts are fully vested at all times, and Z will pay J's entire account balance on January 1, 2019. Z credits \$10,000 to J under the plan on January 1, 2016 and January 1, 2018. Earnings under the

terms of the plan are based on a predetermined actual investment (as defined in § 31.3121(v)(2)–1(e)(2)(i)(B)), which results in J's account balance increasing by five percent in the 2016 taxable year, decreasing by five percent in the 2017 taxable year, and increasing again by five percent in the 2018 taxable year. Therefore, on December 31, 2016, J's account balance is \$10,500 (\$10,000 + (\$10,000 × 5%)); on December 31, 2017, J's account balance is \$9,975 (\$10,500 – (\$10,500 × 5%)); and on December 31, 2018, J's account balance is \$20,974 (\$9,975 + \$10,000 + (\$9,975 × 5%)). On January 1, 2019, Z pays J the entire account balance of \$20,974.

(ii) The increase in J's account balance for 2016 is \$10,500 (\$10,500 – zero); the increase in J's account balance for 2017 is zero (because J's account balance decreased by \$525 (\$9,975 – \$10,500)); the increase in J's account balance for 2018 is \$10,474 (\$20,974 – \$10,500, which is the highest account balance in any prior taxable year). The sum of all the increases is \$20,974 (\$10,500 + \$10,474). Thus, for Z's 2016 taxable year the attribution fraction is .5006 (\$10,500/\$20,974); for Z's 2017 taxable year the attribution fraction is zero because there was a decrease in the account balance for the year; and for Z's 2018 taxable year the attribution fraction is .4994 (\$10,474/\$20,974).

(iii) Accordingly, with respect to the \$20,974 payment made on January 1, 2019, \$10,499 (\$20,974 × .5006) of DDR is attributable to services performed by J in Z's 2016 taxable year, and \$10,474 (\$20,974 × .4994) of DDR is attributable to services performed by J in Z's 2018 taxable year. No amount is attributable to services performed by J in Z's 2017 taxable year because there was no increase in the account balance for that taxable year.

Example 4 (Account balance plan—principal additions method with earnings and losses). (i) The facts are the same as in *Example 3*, except that Z attributes remuneration using the principal additions method described in paragraph (d)(3)(ii) of this section.

(ii) The \$10,000 principal addition made on January 1, 2016 and the \$474 of net earnings thereon (\$500 of earnings for 2016, \$525 of losses for 2017, and \$499 of earnings for 2018) are attributable to services performed by J in Z's 2016 taxable year; and the \$10,000 principal addition made on January 1, 2018 and the \$500 of earnings thereon are attributable to services performed by J in Z's 2018 taxable year. Accordingly, with respect to the \$20,974 payment made on January 1, 2019, \$10,474 (\$10,000 + \$474) of DDR is attributable to services performed by J in Z's 2016 taxable year, and \$10,500 (\$10,000 + \$500) of DDR is attributable to services performed by J in Z's 2018 taxable year.

Example 5 (Account balance plan—account balance ratio method with losses and an in-service payment). (i) N is an applicable individual of corporation M for all relevant taxable years. On January 1, 2016, N begins participating in a nonqualified deferred compensation plan sponsored by M that is an account balance plan. Under the

plan, all amounts are fully vested at all times. The balances in N's account are \$110,000 on December 31, 2016; \$90,000 on December 31, 2017; \$250,000 on December 31, 2018; and \$240,000 on December 31, 2019. N ceases providing services to N on December 31, 2019. In accordance with the plan terms, M pays to N \$10,000 on September 30, 2017, \$150,000 on January 1, 2021, and \$100,000 on January 1, 2022. M attributes payments under its account balance plans using the account balance ratio method described in paragraph (d)(3)(i) of this section.

(ii) For purposes of attributing the \$10,000 payment made on September 30, 2017 to taxable years, the increase in N's account balance for 2016 is \$110,000 (\$110,000 – zero). N's account balance for 2017 is treated as \$100,000 (\$90,000 + \$10,000 payment on September 30, 2017), but, because the account balance of \$100,000 is less than the account balance in an earlier year, the increase in N's account balance for 2017 is zero. The sum of all the increases in N's account balance is \$110,000 (\$110,000 + \$0). Thus, the attribution fraction for 2016 is 1 (\$110,000/\$110,000), and the attribution fraction for 2017 is zero (\$0/\$110,000). Accordingly, with respect to the \$10,000 payment made on September 30, 2017, the entire \$10,000 is attributable to services performed by N in M's 2016 taxable year, and no amount is attributable to services performed by N in M's 2017 taxable year.

(iii) After attributing the September 30, 2017 payment of \$10,000 to 2016, N's account balance for 2016 is treated as being \$100,000 (\$110,000 – \$10,000), and the increase for 2016 is likewise treated as \$100,000; N's account balance for 2017 decreased; the increase in N's account balance for 2018 is \$150,000 (\$250,000 – \$100,000); and N's account balance for 2018 decreased. The sum of all the increases is \$250,000 (\$100,000 + \$150,000). Thus, the attribution fraction for 2016 is .40 (\$100,000/\$250,000); the attribution fraction for 2017 is zero (\$0/\$250,000); the attribution fraction for 2018 is .60 (\$150,000/\$250,000); and the attribution fraction for 2019 is zero (\$0/\$250,000).

(iv) Accordingly, with respect to the \$150,000 payment made on January 1, 2021, \$60,000 (\$150,000 × .40) is attributable to services performed by N in M's 2016 taxable year, and \$90,000 (\$150,000 × .60) is attributable to services performed by N in M's 2018 taxable year. With respect to the \$100,000 payment made on January 1, 2022, \$40,000 (\$100,000 × .40) is attributable to services performed by N in M's 2016 taxable year, and \$60,000 (\$100,000 × .60) is attributable to services performed by N in M's 2018 taxable year. No amount is attributable to services performed by N in M's 2017 and 2019 taxable years.

Example 6 (Account balance plan—principal additions method with multiple payments). (i) O is an applicable individual of corporation L for all relevant taxable years. On January 1, 2016, O begins participating in a nonqualified deferred compensation plan sponsored by L that is an account balance plan. Under the plan, all amounts are fully vested at all times. L credits principal additions to O's account each year, and

credits earnings based on a predetermined actual investment within the meaning of § 31.3121(v)(2)–1(d)(2)(i)(B). L makes principal additions of \$90,000 on June 30, 2016; \$140,000 on June 30, 2017; and \$180,000 on June 30, 2018. The predetermined actual investment earns five percent for 2016, seven percent for 2017; eight percent for 2018; and nine percent for 2019. Thus, as of December 31, 2018, the earnings with respect to the \$90,000 principal addition made on June 30, 2016 are \$16,605, for a total of \$106,605; and the earnings with respect to the \$140,000 principal addition made on June 30, 2017 are \$16,492, for a total of \$156,492. As of January 1, 2020, the earnings with respect to the \$180,000 principal addition made on June 30, 2018 are \$24,048, for a total of \$204,048. Under the terms of the plan, the principal addition (and earnings thereon) made on June 30, 2016 and June 30, 2017 are payable on December 31, 2018, and the principal addition (and earnings thereon) made on June 30, 2018 is payable on January 1, 2020. On December 31, 2018, L pays O \$263,097 in accordance with the plan terms. On January 1, 2020, L pays O the remaining account balance of \$204,048 in accordance with the plan terms.

(ii) The \$263,097 payment made on December 31, 2018 is attributed to services performed by O in the 2016 and 2017 taxable years. Of the \$263,097 payment, \$106,605 is attributable to services performed by O in L's 2016 taxable year because this amount represents the \$90,000 principal addition made on June 30, 2016 and earnings thereon. The remaining \$156,492 is attributable to services performed by O in L's 2017 taxable year because this amount represents the \$140,000 principal addition made on June 30, 2017 and earnings thereon. The \$204,048 payment made on January 1, 2020 is attributable to services performed by O in L's 2018 taxable year because this amount represents the \$180,000 principal addition made on June 30, 2018 and earnings thereon.

Example 7 (Account balance plan—account balance ratio method with an employer contribution after the applicable individual ceases to be a service provider).

(i) A is an applicable individual of corporation Z for all relevant taxable years. On January 1, 2016, A begins participating in a nonqualified deferred compensation plan of Z that is an account balance plan. Under the terms of the plan, all amounts are fully vested at all times. The balances in A's account (including employer contributions and earnings) are \$20,000 on December 31, 2016, and \$60,000 on December 31, 2017. On December 31, 2017, A ceases providing services to Z. On January 1, 2019, Z makes a discretionary contribution of \$30,000 to A's account balance plan. On December 31, 2019, in accordance with the plan terms, Z pays \$120,000 to A, which is N's entire account balance. Z attributes payments under its account balance plans using the account balance ratio method described in paragraph (d)(3)(i) of this section.

(ii) The increase in A's account balance for 2016 is \$20,000; the increase in A's account balance for 2017 is \$40,000. The discretionary contribution made on January

1, 2019 of \$30,000 is added to the account balance for 2017. Thus, the discretionary contribution of \$30,000 on January 1, 2019, is treated as increasing A's account balance for 2017 by \$30,000. The increase in A's account balance for 2016 is \$20,000, and the increase in A's account balance for 2017 is \$70,000 (\$40,000 + \$30,000). The sum of all the increases is \$90,000 (\$20,000+\$70,000).

(iii) Thus, the attribution fraction for 2016 is .2222 (\$20,000/\$90,000); and the attribution fraction for 2017 is .7778 (\$70,000/\$90,000). Accordingly, with respect to the \$120,000 payment made on January 1, 2019, \$26,664 (\$120,000 × .2222) is attributable to services performed by A in Z's 2016 taxable year, and \$93,336 (\$120,000 × .7778) is attributable to services performed by A in Z's 2017 taxable year.

Example 8 (Account balance plan—principal additions method with a principal addition after the applicable individual ceases to be a service provider).

(i) C is an applicable individual of corporation X for all relevant taxable years. On January 1, 2016, C begins participating in a nonqualified deferred compensation plan of X that is an account balance plan. Earnings under the terms of the plan are based on a predetermined actual investment (as defined in § 31.3121(v)(2)–1(e)(2)(i)(B)). Under the terms of the plan, all amounts are fully vested at all times. X credits a \$10,000 principal addition to C under the plan on April 1, 2016, and a \$20,000 principal addition to C on April 1, 2017. C ceases providing services to X on December 31, 2017. On January 1, 2019, X credits \$30,000 to C's account in recognition of C's past services. The \$10,000 principal addition made on April 1, 2016 increases to \$15,000 as of December 31, 2019, as a result of earnings. The \$20,000 principal addition made on April 1, 2017, increases to \$28,000 as of December 31, 2019 as a result of earnings. The January 1, 2019, contribution of \$30,000 increases to \$33,000 as of December 31, 2019, as a result of earnings. On December 31, 2019, in accordance with the plan terms, X pays C's entire account balance of \$76,000. X attributes payments under its account balance plans using the principal additions method described in paragraph (d)(3)(ii) of this section.

(ii) When the \$76,000 payment is made to C on December 31, 2019, the remuneration becomes attributable to service performed by C in prior taxable years. The \$10,000 principal addition in 2016 plus earnings thereon of \$5,000 are attributable to services performed by C in X's 2016 taxable year, and the \$20,000 principal addition in 2017 (plus earnings thereon of \$8,000) are attributable to services performed by C in X's 2017 taxable year. The principal addition of \$30,000 plus earnings thereon of \$3,000 (\$33,000) are also attributable to services performed by C in X's 2017 taxable year. Thus, \$16,500 of the \$33,000 is attributed to services performed by C in X's 2017 taxable year.

(iii) Accordingly, with respect to the \$76,000 payment by X to C on December 31, 2019, \$15,000 (\$10,000 + \$5,000) is attributed to services performed by C in X's 2016 taxable year, and \$61,000 (\$20,000 + \$8,000 + \$33,000) is attributed to services performed by C in X's 2017 taxable year.

Example 9 (Nonaccount balance plan—present value ratio method with a single payment). (i) C is an applicable individual of corporation X for all relevant taxable years. On January 1, 2015, X grants C a vested right to a \$100,000 payment on January 1, 2020. C ceases providing services on December 31, 2019. The payment of \$100,000 is made on January 1, 2020. X determines the present value of the payment using an interest rate of five percent for all years.

(ii) The present value of \$100,000 payable on January 1, 2020, determined using a five percent interest rate, is \$82,270 as of December 31, 2015; \$86,384 as of December 31, 2016; \$90,703 as of December 31, 2017; \$95,238 as of December 31, 2018, and \$100,000 as of December 31, 2019. Accordingly, \$82,270 is the amount of the increase in the present value of the future payment of \$100,000 for X's 2015 taxable year (\$82,270 – \$0); \$4,114 (\$86,384 – \$82,270) is the increase in the present value of the future payment for X's 2016 taxable year; \$4,319 (\$90,703 – \$86,384) is the increase in the present value of the future payment for X's 2017 taxable year; \$4,535 (\$95,238 – \$90,703) is the increase in the present value of the future payment for X's 2018 taxable year; and \$4,762 (\$100,000 – \$95,238) is the increase in the present value of the future payment for X's 2019 taxable year. The sum of all the increases is \$100,000 (\$82,270 + \$4,114 + \$4,319 + \$4,535 + \$4,762). Thus, the attribution fraction for 2015 is .8227 (\$82,270/\$100,000); the attribution fraction for 2016 is .0411 (\$4,114/\$100,000); the attribution fraction for 2017 is .0432 (\$4,319/\$100,000); the attribution fraction for 2018 is .0454 (\$4,535/\$100,000); and the attribution fraction for 2019 is .0476 (\$4,762/\$100,000).

(iii) The \$100,000 payment made on January 1, 2020 is multiplied by the attribution fraction for each taxable year, and the result is the amount that is attributable to service performed by C for that taxable year. Accordingly, \$82,270 (\$100,000 × .8227) is attributable to services performed by C in X's 2015 taxable year; \$4,114 (\$100,000 × .0411) is attributable to services performed by C in X's 2016 taxable year; \$4,319 (\$100,000 × .0432) is attributable to services performed by C in X's 2017 taxable year; \$4,535 (\$100,000 × .0454) is attributable to services performed by C in X's 2018 taxable year; and \$4,762 (\$100,000 × .0476) is attributable to services performed by C in X's 2019 taxable year.

Example 10. (Nonaccount balance plan—present value ratio method with an in-service payment). (i) The facts are the same as *Example 9*, except that X grants C a vested right to a \$40,000 payment on June 30, 2018 and a vested right to a \$60,000 payment on January 1, 2020.

(ii) The present value of the future payments (\$40,000 payable on June 30, 2018 and \$60,000 payable on January 1, 2020), determined using a five percent interest rate, is \$84,758 as of December 31, 2015; \$88,996 as of December 31, 2016; \$93,446 as of December 31, 2017; and \$57,143 as of December 31, 2018. However, for purposes of determining the increase in the present value of the future payments during 2018 (the year

of the in-service payment), \$57,143 must be increased by \$40,000, the amount of the in-service payment, resulting in a present value of future payments as of December 31, 2018, of \$97,143 solely for purposes of attributing the \$40,000 in-service payment. Accordingly, \$84,758 is the amount of the increase in the present value of the future payments for X's 2015 taxable year, \$4,238 (\$88,896 – \$84,758) is the increase in the present value of the future payments for X's 2016 taxable year, \$4,450 (\$93,446 – \$88,996) is the increase in the present value of the future payments for X's 2017 taxable year, and \$3,697 (\$97,143 – \$93,446) is the increase in the present value of the future payments for X's 2018 taxable year. The sum of all the increases is \$97,143 (\$84,758 + \$4,238 + \$4,450 + \$3,697). Thus, the attribution fraction for 2015 is .8725 (\$84,758/\$97,143); the attribution fraction for 2016 is .0436 (\$4,238/\$97,143); the attribution fraction for 2017 is .0458 (\$4,450/\$97,143); and the attribution fraction for 2018 is .0381 (\$3,697/\$97,143).

(iii) Accordingly, with respect to the \$40,000 payment made on June 30, 2018, \$34,900 (\$40,000 × .8725) is attributable to services performed by C in X's 2015 taxable year; \$1,744 (\$40,000 × .0436) is attributable to services performed by C in X's 2016 taxable year; \$1,832 (\$40,000 × .0458) is attributable to services performed by C in X's 2017 taxable year; and \$1,524 (\$40,000 × .0381) is attributable to services performed by C in X's 2018 taxable year.

(iv) For purposes of attributing the \$60,000 payment made on January 1, 2020, the present value of the future payments for each taxable year that ends prior to the taxable year in which the \$40,000 in-service payment is paid is reduced by the present value of the future payment to which the applicable individual had a legally binding right to be paid on the date the \$40,000 in-service is paid (based on the applicable factors and plan provisions as of the measurement date in each such taxable year). The present value of that future payment is \$35,396 as of December 31, 2015; \$37,166 as of December 31, 2016; and \$39,024 as of December 31, 2017. Therefore, for purposes of attributing the \$60,000 payment on January 1, 2020, the present value of future payments as of December 31, 2015, is \$49,362 (\$84,758 – \$35,396); the present value of future payments as of December 31, 2016, is \$51,830 (\$88,996 – \$37,166); the present value of future payments as of December 31, 2017, is \$54,422 (\$93,446 – \$39,024). The present value of future payments as of December 31, 2018, is \$57,143. Accordingly, \$49,362 is the increase in the present value of the future payment of \$60,000 for X's 2015 taxable year; \$2,468 (\$51,830 – \$49,362) is the increase in the present value of the future payment for X's 2016 taxable year; \$2,592 (\$54,422 – \$51,830) is the increase in the future value of the payment for X's 2017 taxable year; \$2,721 (\$57,143 – \$54,422) is the increase in the future value of the payments for X's 2018 taxable year; and \$2,857 (\$60,000 – \$57,143) is the increase in the future value of the payment for X's 2019 taxable year. The sum of all the increases is \$60,000 (\$49,362 + \$2,468 + \$2,592 + \$2,721

+ \$2,857). Thus, the attribution fraction for 2015 is .8227 (\$49,362/\$60,000); the attribution fraction for 2016 is .0411 (\$2,468/\$60,000); the attribution fraction for 2017 is .0432 (\$2,592/\$60,000); the attribution fraction for 2018 is .0454 (\$2,721/\$60,000); and the attribution fraction for 2019 is .0476 (\$2,857/\$60,000).

(v) Accordingly, with respect to the \$60,000 payment made on January 1, 2020, \$49,362 (\$60,000 × .8227) is attributable to services performed by C in X's 2015 taxable year; \$2,468 (\$60,000 × .0411) is attributable to services performed by C in X's 2016 taxable year; \$2,592 (\$60,000 × .0432) is attributable to services performed by C in X's 2017 taxable year; \$2,721 (\$60,000 × .0454) is attributable to services performed by C in X's 2018 taxable year; and \$2,857 (\$60,000 × .0476) is attributable to services performed by C in X's 2019 taxable year.

Example 11 (Nonaccount balance plan—formula benefit ratio method with losses and multiple payments). (i) D is an applicable individual of W for all relevant taxable years. D becomes a participant in a nonaccount balance plan sponsored by R on January 1, 2018. The plan provides W with the vested right to receive a five annual installments each equal to \$20,000 times the full years of service that D completes. The first payment is to be made on the later of December 31, 2027, or on the December 31 of the first year in which D is no longer a service provider. D has a break in service in 2020 and does not accrue an additional benefit during 2020. D ceases to be a service provider on December 31, 2022, after having completed four years of service, entitling D to five annual payments equal to \$80,000 per year commencing on December 31, 2027. W determines the present value of amounts to be paid under the plan using an interest rate of five percent for 2018 and 2019, and seven percent for 2021, 2022, and 2023. W uses the formula benefit ratio method described in paragraph (d)(4)(ii) of this section.

(ii) Under the plan formula, in 2018, E accrued the right to a \$20,000 annual payment for five years, and E accrued an additional \$20,000 in annual payments in 2019, 2021, and 2022, resulting in the right to receive an annual payment of \$80,000 commencing on December 31, 2027. Thus, the attribution fraction is .25 for 2018 (\$20,000/\$80,000), .25 for 2019 (\$20,000/\$80,000), .25 for 2021 (\$20,000/\$80,000), and .25 for 2022 (\$20,000/\$80,000). The attribution fraction for 2020 is zero because no additional formula benefit accrued during that year.

(iii) The attribution fraction for each disqualified taxable year is multiplied by each payment and the result is attributed to that taxable year. Accordingly, with respect to each \$80,000 payment, \$20,000 (\$80,000 × .25) is attributable to services performed by D in W's 2018 taxable year; \$20,000 (\$80,000 × .25) is attributable to services performed by D in W's 2019 taxable year; \$20,000 (\$80,000 × .25) is attributable to services performed by D in W's 2021 taxable year; and \$20,000 (\$80,000 × .25) is attributable to services performed by D in W's 2022 taxable year. No amount is attributable to services performed by D in W's 2020 taxable year.

Example 12 (Stock option). (i) E is an applicable individual of corporation V for all relevant taxable years. On January 1, 2016, V grants E an option to purchase 100 shares of V common stock at an exercise price of \$50 per share (the fair market value of V common stock on the date of grant). The stock option is not subject to a substantial risk of forfeiture. On December 31, 2017, E ceases to be a service provider of V or any member of V's aggregated group. On January 1, 2019, E resumes providing services for V and again becomes both a service provider and an applicable individual of V. On December 31, 2020, when the fair market value of V common stock is \$196 per share, E exercises the stock option. The remuneration resulting from the stock option exercise is \$14,600 ((\$196 – \$50) × 100).

(ii) The \$14,600 is attributed *pro rata* over the 1,460 days from January 1, 2016 to December 31, 2017 and from January 1, 2019 to December 31, 2020 (365 days per year for the 2016, 2017, 2019, and 2020 taxable years), so that \$10 (\$14,600 divided by 1,460) is attributed to each calendar day in this period, and \$3,650 (365 days × \$10) of remuneration is attributed to services performed by E in each of V's 2016, 2017, 2019, and 2020 taxable years.

Example 13 (Stock option subject to a substantial risk of forfeiture). (i) The facts are the same as *Example 14*, except that the stock option is subject to a substantial risk of forfeiture that lapses on December 31, 2017, and is not transferable until that date, and V chooses to attribute remuneration resulting from the exercise of stock options that are subject to a substantial risk of forfeiture over the period beginning on the date of grant and ending on the date the substantial risk of forfeiture lapses, as permitted under paragraph (d)(5)(i)(B) of this section.

(ii) The \$14,600 is attributed *pro rata* over the 730 days from January 1, 2016 to December 31, 2017 (365 days per year for the 2016 and 2017 taxable years), so that \$20 (\$14,600 divided by 730) is attributed to each calendar day in this period, and \$7,300 (365 days × \$20) is attributed to services performed by E in each of V's 2016 and 2017 taxable years.

Example 14 (Restricted stock). (i) F is an applicable individual of corporation U for all relevant taxable years. On January 1, 2017, U grants to F 1000 shares of restricted U common stock. Under the terms of the grant, the shares will be forfeited if F voluntarily terminates employment before December 31, 2019 (so that the shares are subject to a substantial risk of forfeiture through that date) and are nontransferable until the substantial risk of forfeiture lapses. F does not make an election under section 83(b) and continues in employment with U through December 31, 2019, at which time F's rights in the stock become substantially vested within the meaning of § 1.83-3(b) and the fair market value of a share of the stock is \$109.50. The remuneration resulting from the vesting of the restricted stock is \$109,500 (\$109.50 × 1000).

(ii) The \$109,500 of remuneration is attributed to services performed by F over the 1,095 days between January 1, 2017 and December 31, 2019 (365 days per year for the

2017, 2018, and 2019 taxable years), so that \$100 (\$109,500 divided by 1,095) is attributed to each calendar day in this period, and remuneration of \$36,500 (365 days × \$100) is attributed to services performed by F in each of U's 2017, 2018, and 2019 taxable years.

Example 15 (RSUs). (i) G is an applicable individual of corporation T for all relevant taxable years. On January 1, 2018, T grants to G 1000 RSUs. Under the terms of the grant, T will pay G an amount on December 31, 2020 equal to the fair market value of 1000 shares of T common stock on that date, but only if G continues to provide substantial services to T (so that the RSU is subject to a substantial risk of forfeiture) through December 31, 2020. G remains employed by T through December 31, 2020, at which time the fair market value of a share of the stock is \$219, and T pays G \$219,000 (219×1000).

(ii) The \$219,000 in remuneration is attributed to services performed by G over the 1,095 days beginning on January 1, 2018 and ending on December 31, 2020 (365 days per year for the 2018, 2019, and 2020 taxable years), so that \$200 ($219,000/1,095$) is attributed to each calendar day in this period, and \$73,000 ($365 \text{ days} \times \200) is attributed to service performed by G in each of T's 2018, 2019, and 2020 taxable years.

Example 16 (Involuntary separation pay).

(i) H is an applicable individual of corporation S. On January 1, 2015, H and S enter into an employment contract providing that S will make two payments of \$150,000 each to H if H has an involuntary separation from service. Under the terms of the contract, the first payment is due on January 1 following the involuntary separation from service, and the second payment is due on January 1 of the following year. On December 31, 2016, H has an involuntary separation from service. S pays H \$150,000 on January 1, 2017 and \$150,000 on January 1, 2018.

(ii) Pursuant to paragraph (d)(6) of this section, involuntary separation pay may be attributed to services performed by H in the taxable year of S in which the involuntary separation from service occurs. Alternatively, involuntary separation pay may be attributed to services performed by H on a daily *pro rata* basis beginning on the date H obtains a legally binding right to the involuntary separation pay and ending on the date of the involuntary separation from service. The entire \$300,000 amount, including both \$150,000 payments, must be attributed using the same method. Therefore, the entire \$300,000 amount (comprised of two \$150,000 payments) may be attributed to services performed by H in S's 2016 taxable year, which is the taxable year in which the involuntary separation from service occurs. Alternatively, each \$150,000 payment may be attributed on a daily *pro rata* basis to the period beginning on January 1, 2015 and ending December 31, 2016, so that \$410.96 ($(\$150,000 \times 2)/(365 \times 2)$) is attributed to each day of S's 2015 and 2016 taxable years. Accordingly, \$150,000 is attributed to services performed by H in each of S's 2015 and 2016 taxable years.

Example 17 (Reimbursement after termination of services). (i) I is an applicable

individual of corporation R. On January 1, 2018, I enters into an agreement with R under which R will reimburse I's country club dues for two years following I's separation from service. On December 31, 2020, I ceases to be a service provider of R. I pays \$50,000 in country club dues on January 1, 2021 and \$50,000 on January 2, 2022. Pursuant to the agreement, R reimburses I \$50,000 for the country club dues in 2021 and \$50,000 in 2022.

(ii) \$100,000 is attributed to services performed in R's 2020 taxable year, the taxable year in which I ceases to be a service provider.

(10) *Certain remuneration subject to a substantial risk of forfeiture.* If

remuneration is attributable in accordance with paragraphs (d)(2) (legally binding right), (d)(3) (account balance plan), or (d)(4) (nonaccount balance plan) of this section to services performed in a period that includes two or more taxable years of a covered health insurance provider during which the remuneration is subject to a substantial risk of forfeiture, that remuneration must be attributed using a two-step process. First, the remuneration must be attributed to the taxable years of the covered health insurance provider in accordance with paragraph (d)(2), (3), or (4) of this section, as applicable. Second, the remuneration attributed to the period during which the remuneration is subject to a substantial risk of forfeiture (the vesting period) must be reattributed on a daily *pro rata* basis over that period beginning on the date that the applicable individual obtains a legally binding right to the remuneration and ending on the date that the substantial risk of forfeiture lapses. If a vesting period begins on a day other than the first day of a covered health insurance provider's taxable year or ends on a day other than the last day of the covered health insurance provider's taxable year, the remuneration attributable to that taxable year under the first step of the attribution process is divided between the portion of the taxable year that includes the vesting period and the portion of the taxable year that does not include the vesting period. The amount attributed to the portion of the taxable year that includes the vesting period is equal to the total amount of remuneration that would be attributable to the taxable year under the first step of the attribution process, multiplied by a fraction, the numerator of which is the number of days during the taxable year that the amount is subject to a substantial risk of forfeiture and the denominator of which is the number of days in such taxable year. The remaining amount is attributed to the portion of the taxable year that does not

include the vesting period and, therefore, is not reattributed under the second step of the attribution process.

(11) *Example.* The following example illustrates the principles of paragraph (d)(10) of this section. For purposes of this example, the corporation has a taxable year that is the calendar year and is a covered health insurance provider for all relevant taxable years, DDR is otherwise deductible in the taxable year in which it is paid, and amounts payable under nonaccount balance plans are not forfeitable upon the death of the applicable individual.

Example (Account balance plan subject to a substantial risk of forfeiture using the principal additions method). (i) J is an applicable individual of corporation Q for all relevant taxable years. On January 1, 2016, J begins participating in a nonqualified deferred compensation plan that is an account balance plan. Under the terms of the plan, Q will pay J's account balance on January 1, 2021, but only if J continues to provide substantial services to Q through December 31, 2018 (so that the amount credited to J's account is subject to a substantial risk of forfeiture through that date). Q credits \$10,000 to J's account annually for five years on January 1 of each year beginning on January 1, 2016. The account earns interest at a fixed rate of five percent per year, compounded annually, which solely for the purposes of this example, is assumed to be a reasonable rate of interest. Q attributes increases in account balances under the plan using the principal additions method described in paragraph (d)(3)(ii) of this section.

(ii) Earnings on a principal addition are attributed to the same disqualified taxable year of Q to which the principal addition is attributed; therefore, the amount initially attributable to Q's 2016 taxable year is \$12,763 (the \$10,000 principal addition in 2016 at five percent interest for five years); the amount initially attributable to Q's 2017 taxable year is \$12,155 (the \$10,000 principal addition in 2017 at five percent interest for four years); the amount initially attributable to Q's 2018 taxable year is \$11,576 (the \$10,000 principal addition in 2018 at five percent interest for three years); the amount attributable to Q's 2019 taxable year is \$11,025 (the \$10,000 principal addition in 2019 at five percent interest for two years); and the amount attributable to Q's 2020 taxable year is \$10,500 (the \$10,000 principal addition in 2020 at five percent interest for one year).

(iii) Remuneration that is attributable to two or more taxable years of Q during which it is subject to a substantial risk of forfeiture must be reattributed on a daily *pro rata* basis to the period beginning on the date that J obtains a legally binding right to the remuneration and ending on the date that the substantial risk of forfeiture lapses. Therefore, \$36,494 ($\$12,763 + \$12,155 + \$11,576$) is reattributed on a daily *pro rata* basis over the period beginning on January 1, 2016, and ending on December 31, 2018. Thus, \$12,165 is attributed to services

performed by J in each of Q's 2016, 2017, and 2018 taxable years.

(e) *Application of the deduction limitation*—(1) *Application to aggregate amounts.* The \$500,000 deduction limitation is applied to the aggregate amount of AIR and DDR attributable to services performed by an applicable individual in a disqualified taxable year. The aggregate amount of AIR and DDR attributable to services performed by an applicable individual in a disqualified taxable year that exceeds the \$500,000 deduction limit is not allowed as a deduction in any taxable year.

Therefore, for example, if an applicable individual has more than \$500,000 of AIR attributable to services performed for a covered health insurance provider in a disqualified taxable year, the amount of that AIR that exceeds \$500,000 is not deductible in any taxable year, and no DDR attributable to services performed by the applicable individual in that disqualified taxable year is deductible in any taxable year. However, if an applicable individual has AIR for a disqualified taxable year that is \$500,000 or less and DDR attributable to services performed in the same disqualified taxable year that, when combined with the AIR for the year, exceeds \$500,000, all of the AIR is deductible in that disqualified taxable year, but the amount of DDR attributable to that taxable year that is deductible in future taxable years is limited to an amount equal to \$500,000 less the amount of the AIR for that taxable year.

(2) *Order of application and calculation of deduction limitation*—(i) *In general.* The deduction limitation with respect to any applicable individual for any disqualified taxable year is applied to AIR and DDR attributable to services performed by that applicable individual in that disqualified taxable year at the time that the remuneration becomes otherwise deductible, and each time the deduction limitation is applied to an amount that is otherwise deductible, the deduction limit is reduced (but not below zero) by the amount against which it is applied. Accordingly, the deduction limitation is applied first to an applicable individual's AIR attributable to services performed in a disqualified taxable year and is reduced (but not below zero) by the amount of the AIR to which the deduction limit is applied. If the applicable individual also has an amount of DDR attributable to services performed in that disqualified taxable year that becomes otherwise deductible in a subsequent taxable year, the deduction limit, as reduced, is applied to that amount of DDR in the first

taxable in which the DDR becomes otherwise deductible. The deduction limit is then further reduced (but not below zero) by the amount of the DDR to which the deduction limit is applied. If the applicable individual has an additional amount of DDR attributable to services performed in the original disqualified taxable year that becomes otherwise deductible in a subsequent taxable year, the deduction limit, as further reduced, is applied to that amount of DDR in the taxable year in which it is otherwise deductible. This process continues for future taxable years in which DDR attributable to services performed by the applicable individual in the original disqualified taxable year is otherwise deductible. No deduction is allowed in any taxable year for any AIR or DDR attributable to services performed by an applicable individual in a disqualified taxable year for the excess of those amounts over the deduction limit (as reduced, if applicable) for that disqualified taxable year at the time the deduction limitation is applied to the remuneration.

(ii) *Application to payments*—(A) *In general.* Any payment of remuneration may include amounts that are attributable to services performed by an applicable individual in one or more taxable years of a covered health insurance provider pursuant to paragraphs (d)(2) through (11) of this section. In that case, a separate deduction limitation applies to each portion of the payment that is attributed to services performed in a different disqualified taxable year. Any portion of a payment that is attributed to a taxable year that is a disqualified taxable year is deductible only to the extent that it does not exceed the deduction limit that applies with respect to the applicable individual for that disqualified taxable year, as reduced by the amount, if any, of AIR and DDR attributable to services performed in that disqualified taxable year that was deductible in an earlier taxable year.

(3) *Examples.* The following examples illustrate the rules of paragraphs (e)(1) and (2) of this section. For purposes of these examples, each corporation has a taxable year that is the calendar year and is a covered health insurance provider for all relevant taxable years; DDR is otherwise deductible in the taxable year in which it is paid; and amounts payable under nonaccount balance plans are not forfeitable upon the death of the applicable individual.

Example 1 (Lump-sum payment of DDR attributable to a single taxable year). (i) L is an applicable individual of corporation O. During O's 2015 taxable year, O pays L \$550,000 in salary, which is AIR, and grants

L a right to \$50,000 of DDR payable upon L's separation from service from O. L has a separation from service in 2020, at which time O pays L the \$50,000 of DDR attributable to services performed by L in O's 2015 taxable year.

(ii) The \$500,000 deduction limitation for 2015 is applied first to L's \$550,000 of AIR for 2015. Because the \$550,000 of AIR in 2015 is greater than the deduction limit, O may deduct only \$500,000 of the AIR for 2015, and \$50,000 of the \$550,000 of AIR is not deductible for any taxable year. The deduction limit for remuneration attributable to services provided by L in O's 2015 taxable year is then reduced to zero. Because the \$50,000 in DDR attributable to services performed by L in 2015 exceeds the reduced deduction limit of zero, that \$50,000 is not deductible for any taxable year.

Example 2 (Installment payments of DDR attributable to a single taxable year). (i) M is an applicable individual of corporation N. During N's 2016 taxable year, N pays M \$300,000 in salary, which is AIR, and grants M a right to \$220,000 of DDR payable on a fixed schedule beginning upon M's separation from service. The \$220,000 is attributable to services provided by M in N's 2016 taxable year. M ceases providing services on December 31, 2016. In 2020, N pays M \$120,000 of DDR that is attributable to services performed in N's 2016 taxable year. In 2021, N pays M the remaining \$100,000 of DDR attributable to services performed by M in N's 2016 taxable year.

(ii) The \$500,000 deduction limitation for 2016 is applied first to M's \$300,000 of AIR for 2016. Because the deduction limit is greater than the AIR, N may deduct the entire \$300,000 of AIR paid in 2016. The \$500,000 deduction limit is then reduced to \$200,000 because the limitation is reduced by the amount of AIR (\$500,000 – \$300,000). The reduced deduction limit is then applied to M's \$120,000 of DDR attributable to services performed by M in N's 2016 taxable year that is paid in 2020. Because the reduced deduction limit of \$200,000 is greater than the \$120,000 of DDR, N may deduct the entire \$120,000 of DDR paid in 2020. The \$200,000 deduction limit is reduced to \$80,000 by the \$120,000 in DDR because the limit is reduced by the amount of DDR to which the deduction limit applied (\$200,000 – \$120,000). The reduced deduction limit of \$80,000 is then applied to the remaining \$100,000 payment of DDR attributable to services performed by M in N's 2016 taxable year. Because the \$100,000 payment by N for 2021 exceeds the reduced deduction limit of \$80,000, N may deduct only \$80,000 of the payment for the 2021 taxable year, and \$20,000 of the \$100,000 payment is not deductible by N for any taxable year.

Example 3 (Lump-sum payment attributable to multiple years from an account balance plan using the account balance ratio method). (i) N is an applicable individual of corporation M for all relevant taxable years. On January 1, 2015, N begins participating in a nonqualified deferred compensation plan sponsored by M that is an account balance plan. Under the plan, all amounts are fully vested at all times. The balances in N's account (including earnings)

are \$50,000 on December 31, 2015, \$100,000 on December 31, 2016, and \$200,000 on December 31, 2017. N's AIR from M is \$425,000 for 2015, \$450,000 for 2016, and \$500,000 for 2017. On January 1, 2018, in accordance with the plan terms, M pays \$200,000 to N, which is a payment of N's entire account balance under the plan. M uses the account balance ratio method to attribute amounts to services performed in taxable years.

(ii) To determine the extent to which M is entitled to a deduction for any portion of the \$200,000 payment under the plan, the payment must first be attributed to services performed by N in M's taxable years in accordance with the attribution rules set forth in paragraph (d) of this section. The increase in N's account balance during 2015 is \$50,000 (\$50,000 – zero); the increase in N's account balance for 2016 is \$50,000 (\$100,000 – \$50,000); and the increase in N's account balance for 2017 is \$100,000 (\$200,000 – \$100,000). The sum of all the increases is \$200,000 (\$50,000 + \$50,000 + \$100,000). Accordingly, for N's 2015 taxable year, the attribution fraction is .25 (\$50,000/\$200,000); for N's 2016, taxable year, the attribution fraction is .25 (\$50,000/\$200,000); and for N's 2017 taxable year, the attribution fraction is .50 (\$100,000/\$200,000).

(iii) With respect to the \$200,000 payment made on January 1, 2018, \$50,000 (\$200,000 × .25) of DDR is attributable to services performed by N in M's 2015 taxable year; \$50,000 (\$200,000 × .25) of DDR is attributable to services performed by N in M's 2016 taxable year; and \$100,000 (\$200,000 × .50) of DDR is attributable to services performed by N in M's 2017 taxable year.

(iv) The \$500,000 deduction limitation for 2015 is applied first to N's \$425,000 of AIR for 2015. Because the deduction limit is greater than the AIR, M may deduct the entire \$425,000 of AIR paid in 2015. The \$500,000 deduction limit is then reduced to \$75,000 by the amount of AIR against which it is applied (\$500,000 – \$425,000). The reduced deduction limit is then applied to N's \$50,000 of DDR attributable to services performed by N in M's 2015 taxable year that is paid in 2018. Because \$50,000 does not exceed the reduced deduction limit of \$75,000, all \$50,000 of the DDR attributable to services performed by N in M's 2015 taxable year is deductible for 2018, the year of payment. The deduction limit for remuneration attributable to services performed by N in 2015 is then reduced to \$25,000 (\$75,000 – \$50,000), and this reduced limit is applied to any future payment of DDR attributable to services performed by N in 2015. With respect to M's 2016 taxable year, the \$500,000 deduction limit for 2016 is applied first to N's \$450,000 of AIR for 2016. Because the deduction limit is greater than the AIR, M may deduct the entire \$450,000 of AIR paid in 2016. The \$500,000 deduction limit is then reduced to \$50,000 by the AIR (\$500,000 – \$450,000). The reduced deduction limit is then applied to N's \$50,000 of DDR attributable to services performed by N in M's 2016 taxable year that is paid in 2018. Because \$50,000 does not exceed the reduced deduction limit of

\$50,000, all \$50,000 of the DDR attributed to M's 2016 taxable year is deductible for 2018, the year of payment. The deduction limit for remuneration attributable to services performed by N in 2016 is then reduced to zero, and this reduced limit is applied to any future payment of DDR attributable to services performed by N in 2016. With respect to M's 2017 taxable year, the \$500,000 deduction limit for 2017 is applied first to N's \$500,000 of AIR for 2017. Because the deduction limit is not greater than the AIR, M may deduct the entire \$500,000 of AIR paid in 2017. The \$500,000 deduction limit is then reduced to zero by the amount of the AIR against which it is applied (\$500,000 – \$500,000). The reduced deduction limit is applied to N's \$100,000 of DDR attributable to services performed by N in M's 2017 taxable year that is paid in 2018. Because \$100,000 exceeds the reduced deduction limit of zero, the \$100,000 of the DDR attributed to services performed by N in M's 2017 taxable year is not deductible for the year of payment (or any other taxable year). As a result, \$100,000 of the \$200,000 payment (\$50,000 + \$50,000 + \$0) is deductible by M for M's 2018 taxable year, and the remaining \$100,000 is not deductible by M for any taxable year.

Example 4 (Installment payments and in-service payment attributable to multiple taxable years from an account balance plan using the account balance ratio method). (i) O is an applicable individual of corporation L for all relevant taxable years. On January 1, 2016, O begins participating in a nonqualified deferred compensation plan sponsored by L that is an account balance plan. Under the plan, all amounts are fully vested at all times. L makes contributions to O's account each year and credits earnings based on a predetermined actual investment within the meaning of § 31.3121(v)(2)–1(d)(2)(i)(B). The closing balances in O's account (including contributions, earnings, and distributions made during the year) are \$100,000 on December 31, 2016, \$250,000 on December 31, 2017, and \$500,000 on December 31, 2018. O's AIR from L is \$500,000 for 2016, \$300,000 for 2017, and \$450,000 for 2018. On December 31, 2018, L pays O \$400,000 in accordance with the plan terms. On December 31, 2019, O's account balance is \$200,000, reflecting additional credits of \$125,000 made during the year and earnings on the account. O's AIR from L is \$200,000 for 2019. O ceases providing services to L on December 31, 2019. On January 1, 2020, L pays O \$200,000 in accordance with the plan terms. L uses the account balance ratio method to attribute amounts to services performed in taxable years.

(ii) To determine the extent to which L is entitled to a deduction for any portion of either of the payments under the plan, O's payments under the plan must first be attributed to services performed by O in L's taxable years in accordance with the attribution rules set forth in paragraph (d) of this section. For purposes of attributing the \$400,000 payment made on December 31, 2018 to a taxable year, the increase in O's account balance during 2016 is \$100,000 (\$100,000 – zero); the increase in O's

account balance for 2017 is \$150,000 (\$250,000 – \$100,000); and the increase in O's account balance for 2018 is \$200,000 (\$50,000 – \$250,000 + \$400,000 (payment on December 31, 2018)). The sum of all the increases is \$450,000 (\$100,000 + \$150,000 + \$200,000). Thus, for L's 2016 taxable year, the attribution fraction is .2222 (\$100,000/\$450,000); for L's 2017 taxable year, the attribution fraction is .3333 (\$150,000/\$450,000); and for L's 2018 taxable year, the attribution fraction is .4444 (\$200,000/\$450,000). Accordingly, with respect to the \$400,000 payment made on December 31, 2019, \$88,889 (\$400,000 × .2222) is attributable to services performed by O in L's 2016 taxable year; \$133,333 (\$400,000 × .3333) is attributable to services performed by O in L's 2017 taxable year; and \$177,778 (\$400,000 × .4444) is attributable to services performed by O in L's 2018 taxable year.

(iii) The portion of the \$400,000 payment attributed to services performed in a disqualified taxable year under paragraph (d) of this section that exceeds the deduction limit for that disqualified taxable year, as reduced through the date of payment, is not deductible in any taxable year. The \$500,000 deduction limit for 2016 is applied first to O's \$500,000 of AIR for 2016. Because the deduction limit is equal to the \$500,000 of AIR, L may deduct the entire \$500,000 of AIR paid in 2016. The \$500,000 deduction limit is then reduced to zero by the amount of the AIR (\$500,000 – \$500,000). The reduced deduction limit is applied to O's \$88,889 of DDR attributable to services performed by O in L's 2016 taxable year that is paid in 2018. Because \$88,889 exceeds the reduced deduction limit of zero, the \$88,889 of DDR attributed to 2016 is not deductible for L's 2018 taxable year or any other taxable year. With respect to L's 2017 taxable year, the \$500,000 deduction limitation for 2017 is applied first to O's \$300,000 of AIR for 2017. Because the \$500,000 deduction limit is greater than the \$300,000 of AIR, L may deduct the entire \$300,000 of AIR paid in 2017. The \$500,000 deduction limit is reduced to \$200,000 by the amount of the AIR (\$500,000 – \$300,000). The reduced deduction limit is then applied to O's \$133,333 of DDR attributable to services performed by O in L's 2017 taxable year that is paid in 2018. Because \$133,333 does not exceed that reduced deduction limit of \$200,000, the \$133,333 is deductible for 2018. The deduction limit for remuneration attributable to services performed by O in 2017 is then reduced to \$66,667 (\$200,000 – \$133,333), and this reduced limit is applied to any future payment of DDR attributable to services performed by O in 2017. With respect to L's 2018 taxable year, the \$500,000 deduction limit for 2018 is applied first to O's \$450,000 of AIR for 2018. Because the deduction limit is greater than the AIR, L may deduct the entire \$450,000 of AIR paid in 2017. The \$500,000 deduction limit is reduced to \$50,000 by the amount of the AIR (\$500,000 – \$450,000). The reduced deduction limit is applied to O's \$177,778 attributable to services performed by O in L's 2018 taxable year that is paid in 2018. Because the \$177,778 exceeds the reduced deduction limit of \$50,000, \$50,000 of DDR

is deductible for L's 2018 taxable year, and \$127,778 of the \$177,778 is not deductible for L's 2018 taxable year or any other taxable year. As a result, \$183,333 of the \$400,000 payment (\$0 + \$133,333 + \$50,000) is deductible by L for L's 2018 taxable year, and the remaining \$216,667 is not deductible by L for any taxable year.

(iv) For purposes of attributing amounts paid or made available from the plan in future taxable years, the following adjustments are made to O's account balances to reflect the in-service payment of \$400,000 in 2018. O's account balance as of December 31, 2016 is reduced by the \$88,889 attributable to 2016; and for 2017 is reduced by the sum of the \$133,333 attributable to 2017 and the \$88,889 attributable to 2016. Therefore, after attributing the \$400,000 payment, O's adjusted closing account balance as of December 31, 2016, is \$11,111 (\$100,000 - \$88,889), and as of December 31, 2017, is \$27,778 (\$250,000 - \$133,333 - \$88,889).

(v) For purposes of attributing the \$200,000 payment made on January 1, 2020, to services performed in the taxable years of S, the increase in O's account balance during 2016 is \$11,111 (\$11,111 - \$0); the increase in O's account balance for 2017 is \$16,667 (\$27,778 - \$11,111); the increase in O's account balance for 2018 is \$22,222 (\$50,000 - \$27,778), and the increase in O's account balance for 2019 is \$150,000 (\$200,000 - \$50,000). The sum of all such increases is \$200,000 (\$11,111 + \$16,667 + \$22,222 + \$150,000). Thus, for O's 2016 taxable year, the attribution fraction is .0556 (\$11,111/\$200,000); for O's 2017, taxable year, the attribution fraction is .0833 (\$16,667/\$200,000); for O's 2018 taxable year, the attribution fraction is .1111 (\$22,222/\$200,000); for O's 2019 taxable year, the attribution fraction is .7500 (\$150,000/\$200,000). Accordingly, with respect to the \$200,000 payment made on January 1, 2020, \$11,111 ($\$200,000 \times .0556$) of DDR is attributable to services performed by O in L's 2016 taxable year; \$16,667 ($\$200,000 \times .0833$) of DDR is attributable to services performed by O in L's 2017 taxable year; \$22,222 ($\$200,000 \times .1111$) of DDR is attributable to services performed by O in L's 2018 taxable year; and \$150,000 ($\$200,000 \times .7500$) of DDR is attributable to services performed by O in L's 2019 taxable year.

(vi) The portion of the DDR attributed to a disqualified taxable year under paragraph (d) of this section that exceeds the deduction limit for that disqualified taxable year, as reduced, is not deductible for any taxable year. For L's 2016 taxable year, the deduction limit is reduced to zero by the \$500,000 of AIR for that year. Because \$11,111 exceeds the reduced deduction limit of zero, \$11,111 of the DDR is not deductible for L's 2020 taxable year or any other taxable year. For L's 2017 taxable year, the deduction limit is reduced to \$200,000 by the \$300,000 of AIR for that year and further reduced to \$66,667 by the \$133,333 of DDR previously attributed to 2017. Because \$16,667 does not exceed the \$66,667 deduction limit, the \$16,667 of DDR is deductible for L's 2020 taxable year, the year of payment. The deduction limit for remuneration attributable to services

performed by O in 2017 is then reduced to \$50,000 (\$66,667 - \$16,667), and this reduced limit is applied to any future payment attributable to services performed by O in 2017. For L's 2018 taxable year, the deduction limit is reduced to zero by the \$450,000 of AIR for that year and the \$50,000 of DDR previously attributed to 2018. Because \$22,222 exceeds the reduced deduction limit of zero for 2018, the \$22,222 of DDR is not deductible for L's 2020 taxable year or any other taxable year. For L's 2019 taxable year, the \$500,000 deduction limit for 2019 is applied first to O's \$200,000 of AIR for 2019. Because the deduction limit is greater than the AIR, L may deduct the entire \$200,000 of AIR paid in 2019. The \$500,000 deduction limit is reduced to \$300,000 by the amount of the AIR (\$500,000 - \$200,000). The reduced deduction limit is applied to O's \$150,000 of DDR attributable to services performed by O in L's 2019 taxable year that is paid in 2020. Because \$150,000 does not exceed the \$300,000 limit, the \$150,000 of DDR is deductible for L's 2020 taxable year, the year of payment. The deduction limit for remuneration attributable to services performed by O in 2019 is then reduced to \$150,000 (\$500,000 - \$200,000 - \$150,000), and this reduced limit is applied to any future payment attributable to services performed by O in 2019. As a result, \$166,667 of the \$200,000 payment (\$0 + \$16,667 + \$0 + \$150,000) is deductible by L for L's 2020 taxable year, the year of payment, and the remaining \$33,333 is not deductible by L for any taxable year.

Example 5 (Installment payments and in-service payment attributable to multiple taxable years from an account balance plan using the principal additions method). (i) The facts are the same as set forth in *Example 4*, paragraph (i), except that L uses the principal additions method for attributing remuneration from an account balance plan; principal additions under the plan are \$100,000 in 2016, \$125,000 in 2017, \$150,000 in 2018, and \$125,000 in 2019; as of the December 31, 2018 initial date of payment, earnings on the 2016, 2017, and 2018 principal additions are \$40,000, \$30,000, and \$5,000 respectively. Under the terms of the plan, the \$400,000 payment made on December 31, 2018, is from principal additions in 2016, 2017, and 2018, and earnings thereon, and the \$200,000 payment made on January 1, 2020, is from principal additions in 2018 and 2019, and earnings thereon.

(ii) To determine the extent to which L is entitled to a deduction for any portion of either payment under the plan, the payments to O under the plan must first be attributed to services performed by O in F's taxable years in accordance with the attribution rules set forth in paragraph (d) of this section. Under the rules in paragraph (d)(3)(ii) of this section, the \$400,000 payment on January 1, 2019, is attributed to services performed by O in the taxable year to which the payment relates under the terms of the plan. DDR including principal additions and earnings thereon are attributed to services performed by O in a taxable year of L when the \$400,000 payment is made to O on December 31, 2018. Under the terms of the plan, the \$400,000

payment made on December 31, 2018 is attributed to services performed by O in L's 2016 taxable year in the amount of \$140,000, and is attributed to services performed by O in L's 2017 taxable year in the amount of \$155,000, and the remaining \$105,000 (\$400,000 - \$140,000 - \$155,000) is attributed to services performed by O in L's 2018 taxable year.

(iii) The portion of the DDR attributable to services performed in a disqualified taxable year under paragraph (d) of this section that exceeds the deduction limit for that disqualified taxable year, as reduced, is not deductible for any taxable year. The \$500,000 deduction limitation for 2016 is applied first to O's \$500,000 of AIR for 2016. Because the deduction limit is equal to the \$500,000 of AIR, L may deduct the entire \$500,000 of AIR paid in 2016. The \$500,000 deduction limit is then reduced to zero by the amount of the AIR (\$500,000 - \$500,000). The reduced deduction limit is applied to O's \$140,000 of DDR attributable to services performed by O in L's 2016 taxable year that is paid in 2018. Because \$140,000 exceeds the reduced deduction limit of zero, the \$140,000 is not deductible for L's 2018 taxable year (the year of payment), or any other taxable year. For L's 2017 taxable year, the \$500,000 deduction limit for 2017 is applied first to O's \$300,000 of AIR for 2017. Because the deduction limit is greater than the AIR, L may deduct the entire \$300,000 of AIR paid in 2017. The \$500,000 deduction limit is then reduced to \$200,000 by the amount of the AIR (\$500,000 - \$300,000). The reduced deduction limit is applied to O's \$155,000 of DDR attributable to services performed by O in L's 2017 taxable year that is paid in 2018. Because \$155,000 does not exceed the reduced deduction limit of \$200,000, the \$155,000 payment is deductible for 2018. For L's 2018 taxable year, the \$500,000 deduction limitation for 2018 is applied first to O's \$450,000 of AIR for 2018. Because the deduction limit is greater than the AIR, L may deduct the entire \$450,000 of AIR paid in 2018. The \$500,000 deduction limit is then reduced to \$50,000 by the amount of the AIR (\$500,000 - \$450,000). The reduced deduction limit is applied to O's \$105,000 of DDR attributable to services performed by O in L's 2018 taxable year that is paid in 2018. Because \$105,000 exceeds the reduced deduction limit of \$50,000, \$55,000 of the \$105,000 attributable to L's 2018 taxable year is not deductible for 2018 (the year of payment), or any other taxable year. As a result, \$205,000 of the \$400,000 payment (\$0 + \$155,000 + \$50,000) is deductible by L for L's 2018 taxable year (the year of payment) and the remaining \$195,000 is not deductible by L for any taxable year.

(iv) Earnings through January 1, 2020 on the principal addition for L's 2018 taxable year (\$50,000) that was not paid as part of the December 31, 2018 payment are \$5,000. Earnings through January 1, 2020 on the \$125,000 credited to O's account on January 1, 2019 are \$20,000. On December 31, 2018, after the \$400,000 payment is applied to 2016, 2017, and 2018, the account balance for 2016 and 2017 is reduced to zero, and the account balance for 2018 is reduced to \$50,000 (\$150,000 + \$5,000 (earnings) -

\$105,000). Under the terms of the plan, the \$200,000 payment made on January 1, 2020, is attributable to services performed by O in L's 2018 and 2019 taxable years. Therefore, the \$200,000 payment on January 1, 2020 is attributed to services performed by O in L's taxable years as follows: \$55,000 (\$50,000 + \$5,000) to 2018 and \$145,000 (\$125,000 + \$20,000) to 2019.

(v) The portion of the DDR attributed to a disqualified taxable year under paragraph (d) of this section that exceeds the deduction limit for that disqualified taxable year, as reduced, is not deductible for any taxable year. For L's 2018 taxable year, the deduction limit is reduced to zero by the \$450,000 of AIR for that year and the payment of \$50,000 of DDR attributable to that year. Because \$55,000 exceeds the reduced deduction limit of zero, the \$55,000 is not deductible for 2020, the year of payment (or any other taxable year). With respect to L's 2019 taxable year, the \$500,000 deduction limit for 2019 is applied first to O's \$200,000 of AIR for 2019. Because the deduction limit is greater than the AIR, L may deduct the entire \$200,000 of AIR paid in 2019. The \$500,000 deduction limit is then reduced to \$300,000 by the amount of the AIR (\$500,000 – \$200,000). The reduced deduction limit is applied to O's \$145,000 of DDR attributable to services performed by O in L's 2019 taxable year that is paid in 2020. Because \$145,000 does not exceed the \$300,000 reduced limit, the \$145,000 is deductible for 2020 (the year of payment). As a result, \$145,000 of the \$200,000 payment (\$0 + \$145,000) is deductible for L's 2020 taxable year, and the remaining \$55,000 is not deductible by L for any taxable year.

(4) *Application of deduction limitation to aggregated groups of covered health insurance providers—(i) In general.* The total combined deduction for AIR and DDR attributable to services performed by an applicable individual in a disqualified taxable year allowed for all members of an aggregated group that are covered health insurance providers for any taxable year is limited to \$500,000. Therefore, if two or more members of an aggregated group that are covered health insurance providers may otherwise deduct AIR or DDR attributable to services performed by an applicable individual in a disqualified taxable year, the AIR and DDR otherwise deductible by all members of the aggregated group is combined, and the deduction limitation is applied to the total amount.

(ii) *Proration of deduction limitation.* If the total amount of AIR or DDR attributable to services performed by an applicable individual in a disqualified taxable year that is otherwise deductible by two or more members of an aggregated group in any taxable year exceeds the \$500,000 deduction limit (as reduced by previously deductible AIR or DDR, if applicable), the deduction limit is prorated based on the

AIR or DDR otherwise deductible by the members of the aggregated group in the taxable year and allocated to each member of the aggregated group. The deduction limit allocated to each member of the aggregated group is determined by multiplying the deduction limit for the disqualified taxable year (as previously reduced, if applicable) by a fraction, the numerator of which is the AIR or DDR otherwise deductible by that member in that taxable year that is attributable to services performed by the applicable individual in the disqualified taxable year, and the denominator of which is the total AIR or DDR otherwise deductible by all members of the aggregated group in that taxable year that is attributable to services performed by the applicable individual in the disqualified taxable year. The amount of AIR or DDR otherwise deductible by a member of the aggregated group in excess of the portion of the deduction limit allocated to that member is not deductible in any taxable year. If a covered health insurance provider is a member of more than one aggregated group, the deduction limit for that covered health insurance provider under section 162(m)(6) may in no event exceed \$500,000 for AIR and DDR attributable to services performed by an applicable individual in a disqualified taxable year.

(5) *Examples.* The following examples illustrate the rules of paragraph (e)(4) of this section. For purposes of these examples, each corporation has a taxable year that is the calendar year and is a covered health insurance provider for all relevant taxable years, and DDR is otherwise deductible by the covered health insurance provider in the taxable year in which it is paid.

Example 1. (i) Corporations I, J, and K are members of the same aggregated group under paragraph (b)(3) of this section. At separate times during 2016, C is an employee of, and performs services for, I, J, and K. C's total AIR for 2016 is \$1,500,000, which consists of \$750,000 of AIR for services performed to K; \$450,000 of AIR for services provided to J; and \$300,000 of AIR for services to I.

(ii) Because I, J, and K are members of the same aggregated group, the AIR otherwise deductible by them is aggregated for purposes of applying the deduction limitation. Further, because the aggregate AIR otherwise deductible by I, J, and K for 2016 exceeds the deduction limitation for C for that taxable year, the deduction limit is prorated and allocated to the members of the aggregated group in proportion to the AIR otherwise deductible by each member of the aggregated group for that taxable year. Therefore, the deduction limit that applies to the AIR otherwise deductible by K is \$250,000 ($\$500,000 \times (\$750,000 / \$1,500,000)$); the deduction limit that applies to the AIR

otherwise deductible by J is \$150,000 ($\$500,000 \times (\$450,000 / \$1,500,000)$); and the deduction limit that applies to AIR otherwise deductible by I is \$100,000 ($\$500,000 \times (\$300,000 / \$1,500,000)$). For the 2016 taxable year, K may not deduct \$500,000 of the \$750,000 of AIR paid to C ($\$750,000 - \$250,000$); J may not deduct \$300,000 of the \$450,000 of AIR paid to C ($\$450,000 - \$150,000$); and I may not deduct \$200,000 of the \$300,000 of AIR paid to C ($\$300,000 - \$100,000$).

Example 2. (i) The facts are the same as *Example 1*, except that C's total AIR for 2016 is \$400,000, which consists of \$75,000 for services provided to K; \$150,000 for services provided to J; and \$175,000 for services provided to I. In addition, C becomes entitled to \$60,000 of DDR attributable to services provided to K in 2016, which is payable (and paid) on April 1, 2018, and \$75,000 of DDR attributable to services provided to J in 2016, which is payable (and paid) on April 1, 2019.

(ii) Because C's total AIR of \$400,000 for 2016 for services provided to K, J, and I do not exceed the \$500,000 limitation, K, J, and I may deduct \$75,000, \$150,000, and \$175,000, respectively, for 2016. The deduction limit is then reduced to \$100,000 by the total AIR deductible by all members of the aggregated group ($\$500,000 - \$400,000$). The deduction limit, as reduced, is then applied to any DDR attributable to services provided by C in 2016 in the first subsequent taxable year that DDR becomes deductible. The first year that DDR for 2016 becomes deductible is 2018, due to the \$60,000 payment made on April 1, 2018. Because the \$60,000 of DDR otherwise deductible by K does not exceed the 2016 \$100,000 deduction limit, K may deduct the entire \$60,000 for its 2018 taxable year. The \$100,000 deduction limit is then reduced by the \$60,000 of DDR deductible by K for 2018, and the reduced deduction limit of \$40,000 ($\$100,000 - \$60,000$) is applied to the \$75,000 of DDR that is otherwise deductible for 2019. Because the DDR of \$75,000 otherwise deductible by J exceeds the reduced deduction limit of \$40,000, J may deduct only \$40,000, and the remaining \$35,000 ($\$75,000 - \$40,000$) is not deductible by J for that taxable year or any other taxable year.

Example 3. (i) The facts are the same as *Example 2*, except that C's DDR of \$75,000 attributable to services performed by C in J's 2016 taxable year is payable (and paid) on July 1, 2018.

(ii) The results are the same as *Example 2*, except that the reduced deduction limit of \$100,000 is prorated between K and J in proportion to the DDR otherwise deductible by them for 2018. Accordingly, \$44,444 of the remaining deduction limit is allocated to K ($\$100,000 \times (\$60,000 / \$135,000)$), and \$55,556 of the remaining deduction limit is allocated to J ($\$100,000 \times (\$75,000 / \$135,000)$). Because the \$60,000 of DDR otherwise deductible by K exceeds the \$44,444 deduction limit applied to that remuneration, K may deduct only \$44,444 of the \$60,000 payment, and \$15,556 may not be deducted by K for the 2018 taxable year or any other taxable year. Similarly, because the \$75,000 of DDR otherwise deductible by

J exceeds the \$55,556 deduction limit applied to that remuneration, J may deduct only \$55,556 of the \$75,000 payment, and \$19,444 may not be deducted by J for that taxable year or any other taxable year.

(f) *Corporate transactions*—(1) *Treatment as a covered health insurance provider in connection with a corporate transaction.* Except as otherwise provided in this paragraph (f), a person that participates in a corporate transaction is a covered health insurance provider for the taxable year in which the corporate transaction occurs (and any other taxable year) if it would otherwise be a covered health insurance provider under paragraph (b)(4) of this section for that taxable year. For example, if a member of an aggregated group that did not previously include a health insurance issuer purchases a health insurance issuer that is a covered health insurance provider (so that the health insurance issuer becomes a member of the aggregated group), each member of the acquiring aggregated group will be a covered health insurance provider for its full taxable year in which the corporate transaction occurs and each subsequent taxable year in which the health insurance issuer continues to be a member of the group, if it would otherwise be a covered health insurance provider under paragraph (b)(4), except as otherwise provided in this paragraph (f). For purposes of this section, the term *corporate transaction* means a merger, acquisition or disposition of assets or stock, reorganization, consolidation, separation, or any other transaction resulting in a change in the composition of an aggregated group.

(2) *Transition period relief for a person becoming a covered health insurance provider solely as a result of a corporate transaction*—(i) *In general.* Except as provided in paragraph (f)(2)(ii) of this section, a person that is not a covered health insurance provider before a corporate transaction, but would (except for application of this paragraph (f)(2)(i)) become a covered health insurance provider solely because it becomes a member of an aggregated group with another person that is a health insurance issuer as a result of the corporate transaction, is not a covered health insurance provider subject to the deduction limitation of section 162(m)(6) for the taxable year of that person in which the corporate transaction occurs (the *transition period relief*).

(ii) *Certain applicable individuals.* The transition period relief described in paragraph (f)(2)(i) of this section does not apply with respect to the remuneration of any individual who is

an applicable individual of a person that would have been a covered health insurance provider for the taxable year in which the corporate transaction occurred without regard to the occurrence of the corporate transaction (for example, the applicable individuals of a health insurance issuer and the members of its affiliated group that were covered health insurance issuers before the occurrence of a corporate transaction). This exception to the transition period relief applies even with respect to remuneration attributable to services performed by the applicable individual for a person that is eligible for the transition period relief described in paragraph (f)(1)(ii)(A) of this section. Accordingly, each member of an acquiring aggregated group that would become a covered health insurance provider solely as a result of a corporate transaction, but is not a covered health insurance provider under the transition period relief described in paragraph (f)(1)(ii)(A) of this section, is subject to the deduction limitation of section 162(m)(6) for its taxable year in which the corporate transaction occurs with respect to AIR and DDR attributable to services performed by any individual who is an applicable individual of the acquired health insurance issuer and any member of its aggregated group that would have been a covered health insurance provider in the taxable year in which the corporate transaction occurred, even if the corporate transaction had not occurred.

(3) *Transition relief from the attribution consistency requirements*—(i) *In general.* Paragraphs (d)(3)(i), (d)(4)(i) and (d)(5)(i)(B) of this section require a covered health insurance provider and all members of its aggregated group to use the same method for attributing remuneration to services performed by applicable individuals consistently for all taxable years (*attribution consistency requirements*). As a result of a corporate transaction, however, a covered health insurance provider that uses an attribution method for its account balance plans, nonaccount balance plans, or stock options or SARs may become a member of an aggregated group with another covered health insurance provider that uses a different attribution method for those types of plans or arrangements. In that case, neither member of the aggregated group will be treated as violating the attribution consistency requirements merely because it uses an attribution method that is different from the attribution method used by another

member of its aggregated group to attribute remuneration that becomes otherwise deductible in the taxable year in which the corporate transaction occurs. However, the attribution consistency requirements apply with respect to remuneration that becomes otherwise deductible in all subsequent taxable years. Following the date of the corporate transaction, any member of the aggregated group may change the attribution method that it used before the date of the corporate transaction to attribute remuneration under its account balance plans, nonaccount balance plans, or stock options or SARs to make its method consistent with the method used by any other member of the aggregated group. Notwithstanding the foregoing, the Secretary may subject this change in attribution method to limitations, or may otherwise modify the attribution consistency requirements, pursuant to a notice, revenue ruling, or other guidance of general applicability published in the Internal Revenue Bulletin.

(ii) *Exception for certain applicable individuals.* Notwithstanding the transition relief described in paragraphs (f)(2)(A) of this section, if a covered health insurance provider has attributed remuneration under a method described in paragraphs (d)(3), (d)(4), or (d)(5) of this section with respect to an applicable individual before a corporate transaction, the covered health insurance provider must continue at all times to use that attribution method for all other remuneration that becomes otherwise deductible under the same type of plan (that is, an account balance plan, a nonaccount balance plan, or a stock option or SAR) to which the applicable individual has a legally binding right as of the corporate transaction.

(4) *Deduction limitation not prorated for short taxable years.* If a corporate transaction results in a short taxable year for a covered health insurance provider, the \$500,000 deduction limit for the short taxable year is neither prorated nor reduced. For example, if a corporate transaction results in a short taxable year of three months, the deduction limit under section 162(m)(6) for that short taxable year is \$500,000 (and is not reduced to \$125,000).

(5) *Effect of a corporate transaction on the application of the de minimis exception.* If a person becomes or ceases to be a member of an aggregated group, only the premiums and gross revenues of that person for the portion of its taxable year during which it is a member of the aggregated group are taken into account for purposes of

determining whether the *de minimis* exception applies.

(6) *Examples.* The following examples illustrate the principles of this paragraph (f). For purposes of these examples, each corporation has a taxable year that is the calendar year unless stated otherwise, and none of the corporations qualify for the *de minimis* exception under paragraph (b)(4)(v) of this section.

Example 1. (i) Corporation J merges with and into corporation H on June 30, 2015, such that H is the surviving entity. As a result of the merger, J's taxable year ends on June 30, 2015. For its taxable year ending June 30, 2015, J is a health insurance issuer that is a covered health insurance provider. For all taxable years before the taxable year of the merger, H is not a covered health insurance provider.

(ii) Corporation J is a covered health insurance provider for its short taxable year ending June 30, 2015. As a result of the merger, H becomes a covered health insurance provider for its 2015 taxable year, but Corporation H is not a covered health insurance provider for its 2015 taxable year by reason of the transition period relief in paragraph (f)(1)(ii)(A) of this section. However, applicable individuals of J continue to be subject to the deduction limit under section 162(m)(6) for amounts that become otherwise deductible in the 2015 taxable year and DDR that is attributable to services performed by applicable individuals of J, and H is a covered health insurance provider for all subsequent taxable years for which it is a covered health insurance provider under paragraph (b)(4) of this section.

Example 2. (i) On January 1, 2016, corporations D, E, and F are members of a controlled group within the meaning of section 414(b). F is a health insurance issuer that is a covered health insurance provider under paragraph (b)(4)(i)(A) of this section. D and E are not health insurance issuers (but are covered health insurance providers pursuant to paragraphs (b)(4)(i)(C) and (D) of this section). D is the parent entity of the DEF aggregated group. F's taxable year ends on September 30. P is an applicable individual of F for all taxable years. On May 1, 2016, a controlled group within the meaning of section 414(b) consisting of corporations C and B purchases all of the stock of corporation F, resulting in a controlled group within the meaning of section 414(b) consisting of corporations C, B, and F. The amount of premiums received by F from providing minimum essential coverage during the portion of its taxable year when it was a member of the DEF aggregated group constitute more than two percent of the gross revenues of the aggregated group for the taxable year of D (the parent entity) ending on December 31, 2016, and the taxable years of E and F ending with or within D's taxable year (December 31, 2016 and May 1, 2016 respectively). C and B are not health insurance issuers. C is the parent entity of the CBF aggregated group. The CBF aggregated group is also a consolidated group within the meaning of § 1.1502-1(h). Thus, F's taxable

year ends on May 1, 2016 by reason of § 1.1502-76(b)(1)(ii)(A)(1), and F becomes part of the CBF consolidated group for the taxable year ending December 31, 2016.

(ii) D and E are covered health insurance providers for the taxable year ending December 31, 2016, and the *de minimis* exception does not apply because the amount of premiums received by F from providing minimum essential coverage during the short taxable year that it was a member of the DEF aggregated group are more than two percent of the gross revenues of the aggregated group for the taxable years during which the members would otherwise be a covered health insurance providers under paragraph (b)(4)(i) of this section. Accordingly, D and E are subject to the deduction limitation under section 162(m)(6) for their taxable years ending December 31, 2016. C and B are not covered health insurance providers for their taxable year ending December 31, 2016, by reason of the transition period relief of paragraph (f)(1)(ii)(A) of this section.

(iii) As a result of leaving the aggregated group, F has a new taxable year beginning on May 2, 2016 and ending on December 31, 2016. F is a covered health insurance provider within the meaning of paragraph (b)(4) of this section for its new taxable year ending on December 31, 2016 (even though C and B are not covered health insurance providers for their taxable years ending December 31, 2016) unless the CBF aggregated group qualifies for the *de minimis* exception for that taxable year.

(iv) P is an applicable individual whose remuneration from F is subject to the deduction limitation under section 162(m)(6) for F's short taxable year ending May 1, 2016 and F's taxable year ending December 31, 2016. In addition, any remuneration provided to P by C or B at any time for services provided by P from May 1, 2016 to December 31, 2016 is also subject to the deduction limitation under section 162(m)(6), even though C and B are not covered health insurance providers for their taxable years ending December 31, 2016 by reason of the transition period relief of paragraph (f)(1)(ii)(A) of this section. Remuneration to which P had the legally binding right on or before the date of the transaction is subject to the deduction limitation when that remuneration becomes otherwise deductible.

Example 3. (i) The same facts as *Example 2*, except that E is a health insurance issuer that is a covered health insurance provider under paragraph (b)(4) of this section and thus receives premiums from providing minimum essential coverage (instead of F), and F is not a health insurance issuer.

(ii) F is a covered health insurance provider for its short taxable year ending May 1, 2016. However, because F is not a health insurance issuer that is a covered health insurance provider and there are no other health insurance issuers in the CBF aggregated group, F is not a covered health insurance provider for its short, post-acquisition taxable year ending December 31, 2016.

(iii) With respect to P, remuneration to which P had the legally binding right on or before the date of the transaction is subject

to the deduction limitation. However, remuneration to which P obtains the legally binding right after the date of the corporate transaction is not subject to the deduction limitation.

Example 4. (i) Corporations N, O, and P are members of an aggregated group as described in paragraph (b)(2) of this section. N is a health insurance issuer that is a covered health insurance provider pursuant to paragraph (b)(4)(i)(A) of this section, but neither O nor P is a health insurance issuer. P is the parent entity of the aggregated group. On April 1, 2016, O ceases to be a member of the NOP aggregated group as the result of a corporate transaction. O's taxable year does not end as a result of the corporate transaction.

(ii) Because O was a member of the NOP aggregated group during a portion of its taxable year, O is a covered health insurance provider for its taxable year ending December 31, 2016.

Example 5. (i) Corporations V, W, and X are members of an aggregated group as described in paragraph (b)(2) of this section. V is a health insurance issuer that is a covered health insurance provider pursuant to paragraph (b)(4)(i)(A) of this section, but neither W nor X is a health insurance issuer. W is the parent entity of the aggregated group. V's taxable year ends on December 31; W's taxable year ends on June 30; and X's taxable year ends on September 30. For its taxable year ending June 30, 2017, W has \$100x in gross revenue. For its taxable year ending September 30, 2016, X has \$60x in gross revenue. For its taxable year ending December 31, 2016, V receives \$4x of premiums from providing minimum essential coverage and has no other revenue. As of September 30, 2016, V ceases to be a member of the VWX aggregated group. V's taxable year does not end on September 30, 2016 as a result of the transaction. Of the \$4x that V receives for providing minimum essential coverage during its taxable year ending December 31, 2016, \$3x is received during the period from January 1, 2016 through September 30, 2016. As a result of the corporate transaction, V's taxable year ends on September 30, 2016. The *de minimis* exception of paragraph (b)(4)(v)(A) of this section did not apply to the members of the VWX aggregated group for their immediately preceding taxable years ending December 31, 2015, June 30, 2016, and September 30, 2015, respectively.

(ii) For purposes of applying the *de minimis* exception to an aggregated group for a taxable year during which a person leaves or joins the aggregated group, only the premiums and revenues of the person for the portion of its taxable year during which it was a member of the aggregated group are taken into account. The premiums from providing minimum essential coverage received by the VWX aggregated group for W's taxable year ending June 30, 2017 are \$3x. The revenues of the V, W, and X aggregated group for W's taxable year ending June 30, 2017 are \$163x. Accordingly, the premiums received by the members of the aggregated group from providing minimum essential coverage are less than two percent of the gross revenues of the aggregated group

(\$3x is less than \$3.26x (two percent of \$163x)). Therefore, V, W and X are not covered health insurance providers for their taxable years ending December 31, 2016, June 30, 2017, and September 30, 2016, respectively.

Example 6. (i) The facts are the same as *Example 5*, except that F received \$4x of premiums during the period from January 1, 2016 to September 30, 2016, and the members of the VWX aggregated group were not covered health insurance providers for their taxable years ending December 31, 2015, June 30, 2016, and September 30, 2015, respectively (their immediately preceding taxable years) solely by reason of the *de minimis* exception of paragraph (b)(4)(v)(A) of this section.

(ii) The premiums from providing minimum essential coverage received by the VWX aggregated group for W's taxable year ending June 30, 2017 are \$4x. The revenues of the VWX aggregated group for W's taxable year ending June 30, 2017 are \$164x. Accordingly, the premiums received by the members of the aggregated group from providing minimum essential coverage are greater than two percent of the gross revenues of the aggregated group (\$4x is greater than \$3.28x (two percent of \$164x)). Therefore, V, W, and X do not qualify for the *de minimis* exception for their taxable years ending December 31, 2016, June 30, 2017, and September 30, 2016, respectively. However, V, W, and X are not covered health insurance providers for these taxable years by reason of the *de minimis* exception one year transition period described in paragraph (b)(4)(v)(B) of this section.

Example 7. (i) Corporation N is a health insurance issuer that is a covered health insurance provider. Corporation O is also a health insurance issuer that is a covered health insurance provider. Both N and O have taxable years ending December 31. N uses the account balance ratio method to attribute remuneration that becomes otherwise deductible under its account balance plans. O uses the principal additions method to attribute amounts that become otherwise deductible under its account balance plans. On June 30, 2016, O purchases all of the stock of N.

(ii) For the taxable year of N and O ending December 31, 2016, N may continue to attribute amounts that become deductible under its account balance plans using the account balance ratio method, and O can continue to attribute amounts that become otherwise deductible under its account balance plan using the principal additions method, even though they are members of the same aggregated group, pursuant to the transition period relief described in paragraph (f)(2) of this section. In all subsequent taxable years, N and O must use the same method to attribute amounts that become otherwise deductible under their account balance plans. Either N or O may change the method that it uses to attribute amounts under its account balance plans to be consistent with the attribution method used by the other.

Example 8. (i) The facts are the same as *Example 7*. In addition, B is an applicable individual of N before the corporate transaction and is a participant in an account balance plan of N. On December 31, 2015, N made a payment to B, and N used the account balance ratio method described in paragraph (d)(3)(ii) of this section to attribute the payment to services performed by B in taxable years of N.

(ii) Because N used the account balance ratio method described in paragraph (d)(3)(ii) of this section to attribute an amount that became otherwise deductible under the plan before the corporate transaction, N must continue to use the account balance ratio method for attributing amounts to which B had a legally binding right as of the corporate transaction, whenever those amounts become otherwise deductible.

(g) *Coordination—(1) Coordination with section 162(m)(1).* If section 162(m)(1) and section 162(m)(6) both otherwise would apply with respect to the remuneration of an applicable individual, the deduction limitation under section 162(m)(6) applies without regard to section 162(m)(1). For example, if an applicable individual is both a covered employee of a publicly held corporation (see sections 162(m)(2) and (3); § 1.162–27) and an applicable individual within the meaning of paragraph (b)(7) of this section, remuneration earned by the applicable individual that is attributable to a disqualified taxable year of a covered health insurance provider is subject to the \$500,000 deduction limitation under section 162(m)(6) with respect to such disqualified taxable year, without regard to section 162(m)(1).

(2) *Coordination with disallowed excess parachute payments—(i) In general.* The \$500,000 deduction limitation of section 162(m)(6) is reduced (but not below zero) by the amount (if any) that would have been included in the AIR or DDR of the applicable individual for a taxable year but for the deduction for the AIR or DDR being disallowed by reason of section 280G.

(ii) *Example.* The following example illustrates the rule of this paragraph (g)(2).

Example. Corporation A, a covered health insurance provider, pays \$750,000 of AIR to P, an applicable individual, during A's disqualified taxable year ending December 31, 2016. Of the \$750,000, \$300,000 is an excess parachute payment as defined in section 280G(b)(1), the deduction for which is disallowed by reason of that section. The excess parachute payment reduces the \$500,000 deduction limit to \$200,000 (\$500,000 – \$300,000). Therefore, A may deduct only \$200,000 of the \$750,000 in AIR, and \$250,000 of the payment is not deductible by reason of section 162(m)(6).

(h) *Grandfathered amounts attributable to services performed in taxable years beginning before January 1, 2010—(1) In general.* The section 162(m)(6) deduction limitation does not apply to remuneration attributable to services performed in taxable years of a covered health insurance provider beginning before January 1, 2010 (*grandfathered amounts*). For purposes of this paragraph (h), whether remuneration is attributable to services performed in a taxable year beginning before January 1, 2010, is determined by applying an attribution method described in paragraph (h)(2) of this section.

(2) *Identification of services performed in taxable years beginning before January 1, 2010—(i) In general.* DDR described in paragraphs (d)(2) (legally binding right), (d)(3) (account balance plans), (d)(4) (nonaccount balance plans), (d)(6) (involuntary separation pay), (d)(7) (reimbursements), and (d)(8) (split dollar life insurance) of this section is attributable to services performed in a taxable year beginning before January 1, 2010 if it is attributable to services performed before that date under the rules of these paragraphs, without regard to whether that remuneration is subject to a substantial risk of forfeiture on or after that date. Notwithstanding the requirement under paragraph (d)(3)(i) of this section that a covered health insurance provider must use the same attribution method for its account balance plans for all taxable years, a covered health insurance provider that uses the account balance ratio method described in paragraph (d)(3)(i) of this section to attribute remuneration to services performed in taxable years beginning after December 31, 2009 may use the principal additions method described in paragraph (d)(3)(ii) of this section to attribute remuneration under an account balance plan to services performed in a taxable year beginning before January 1, 2010 for purposes of determining grandfathered amounts under the plan. (See paragraph (d)(3)(ii)(C)(3) of this section for required account balance adjustments if a covered health insurance provider generally uses the account balance ratio method to attribute amounts otherwise deductible under its account balance plans but uses the principal additions method to attribute remuneration to services performed in taxable years beginning before January 1, 2010.)

(ii) *Equity-based remuneration.* For purposes of this section, all remuneration resulting from a stock option, stock appreciation right, restricted stock, or restricted stock unit

and the right to any associated dividends or dividend equivalents (together, referred to as *equity-based remuneration*) granted before the first day of the taxable year of the covered health insurance provider beginning on or after January 1, 2010, is attributable to services performed in taxable years beginning before January 1, 2010, regardless of the date on which the equity-based remuneration is exercised (in the case of a stock option or SAR), the date on which the amounts due under the equity-based remuneration are paid or includible in income, or whether the equity-based remuneration is subject to a substantial risk of forfeiture on or after the first day of the taxable year of the covered health insurance provider beginning on or after January 1, 2010. For example, appreciation in the value of restricted shares granted before the first day of the taxable year beginning on or after January 1, 2010 is treated as remuneration that is attributable to services performed in taxable years beginning before January 1, 2010, regardless of whether the shares are vested at that time.

(i) *Transition rules for certain DDR—*
 (1) *Transition rule for DDR attributable to services performed in taxable years of the covered health insurance provider beginning after December 31, 2009 and before January 1, 2013.* The deduction limitation under section 162(m)(6) applies to DDR attributable to services performed in a disqualified taxable year of a covered health insurance provider beginning after December 31, 2009 and before January 1, 2013, only if that remuneration is otherwise deductible in a disqualified taxable year of the covered health insurance provider beginning after December 31, 2012. However, if the deduction limitation applies to DDR attributable to services performed by an applicable individual in a disqualified taxable year of a covered health insurance provider beginning after December 31, 2009 and before January 1, 2013, the deduction limitation is calculated as if it had been applied to the applicable individual's

AIR and DDR deductible in those taxable years.

(2) *Examples.* The following examples illustrate the principles of this paragraph (i). For purposes of these examples, each corporation has a taxable year that is the calendar year, and DDR is otherwise deductible by the covered health insurance provider in the taxable year in which it is paid.

Example 1. (i) Q is an applicable individual of corporation Z. Z's 2010, 2011, and 2012 taxable years are disqualified taxable years. Z's 2013, 2014, and 2015 taxable years are not disqualified taxable years. However, Z's 2016 taxable year and all subsequent taxable years are disqualified taxable years. Q receives \$200,000 of AIR from Z for 2012, and becomes entitled to \$800,000 of DDR that is attributable to services performed by Q in 2012. Z pays Q \$350,000 of the DDR in 2015, and the remaining \$450,000 of the DDR in 2016. These payments are otherwise deductible by Z in 2015 and 2016, respectively.

(ii) DDR attributable to services performed by Q in Z's 2010, 2011, and 2012 taxable years that is otherwise deductible in Z's 2013, 2014, or 2015 taxable years is not subject to the deduction limitation under section 162(m)(6) by reason of the transition rule under paragraph (i)(1) of this section. However, DDR attributable to services performed in Z's 2010, 2011, and 2012 taxable years that is otherwise deductible in a later taxable year that is a disqualified taxable year (in this case, Z's 2016 and subsequent taxable years) is subject to the deduction limitation under section 162(m)(6). Accordingly, the deduction limitation with respect to AIR and DDR attributable to services performed by Q in 2012 is determined by reducing the \$500,000 deduction limit by the \$200,000 of AIR paid to Q by Z for 2012 (\$500,000 – \$200,000). Under the transition rule of paragraph (i)(1) of this section, no portion of the reduced deduction limit of \$300,000 for the 2012 taxable year is applied against the \$350,000 payment made in 2015, and accordingly, the deduction limit is not reduced by the amount of that payment. The reduced deduction limit is then applied to Q's \$450,000 of DDR attributable to services performed by Q in 2012 that is paid to Q and becomes otherwise deductible in 2016. Because the reduced deduction limit of \$300,000 is less than the \$450,000 otherwise deductible by Z in 2016, Z may deduct only \$300,000 of the DDR, and

\$150,000 of the \$450,000 payment is not deductible by Z in that taxable year or any taxable year.

Example 2. (i) R is an applicable individual of corporation Y, which is a covered health insurance provider for all relevant taxable years. During 2010, Y pays R \$400,000 in salary and grants R a right to \$200,000 in DDR payable on a fixed schedule in 2011, 2012, and 2013. Pursuant to the fixed schedule, Y pays R \$50,000 of DDR in 2011, \$50,000 of DDR in 2012, and the remaining \$100,000 of DDR in 2013.

(ii) Because the deduction limitation for DDR under section 162(m)(6)(A)(ii) is effective for DDR that is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009 that would otherwise be deductible in a taxable year beginning after December 31, 2012, only the DDR paid by Y in 2013 is subject to the deduction limitation. However, the limitation is applied as if section 162(m)(6) and paragraph (c)(2) of this section were effective for taxable years beginning after December 31, 2009 and before January 1, 2013. Accordingly, the deduction limitation with respect to remuneration for services performed by R in 2010 is determined by reducing the \$500,000 deduction limit by the \$400,000 of AIR paid to R for 2010 (\$500,000 – \$400,000). The reduced deduction limit of \$100,000 is further reduced to zero by the \$50,000 of DDR attributable to services performed by R in Y's 2010 taxable year that is deductible in each of 2011 and 2012 ((\$100,000 – \$50,000 – \$50,000)). Because the deduction limit is reduced to zero, none of the \$100,000 of DDR attributable to services performed by R in Y's 2010 taxable year and paid to R in 2013 is deductible.

(j) *Effective/applicability dates.* These regulations are effective on September 23, 2014. The regulations apply to taxable years beginning on or after September 23, 2014.

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

Approved: September 15, 2014.

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