INTERNAL REVENUE SERVICE
Index No. 104.01-00; 162.35-00
Number: **200007025**
Release Date: 2/18/2000

CC:EBEO:Br 6 PLR-112686-99

November 19,1999

Taxpayer =

Dear:

This is in reply to a letter dated July 15, 1999, requesting rulings on behalf of Taxpayer, concerning the federal income tax treatment of contributions and reimbursements under a self-insured medical expense reimbursement plan.

Taxpayer is a partnership that offers a group health plan (the "Plan") to both its partners and its non-partner employees. Currently, the Plan consists of a self-funded component for the benefit of its eligible non-partner employees and an insured component for the benefit of its eligible partners. As of June 1, 1999, there were over 200 partners participating in the insured component of the Plan and over 900 non-partner employees participating in the self-insured component of the Plan. Partners and non-partners alike may choose either single or family coverage. The premium payments for the insured component of the Plan are set by the insurer and are paid by each partner who is a participant in the Plan.

Taxpayer proposes to amend the Plan to eliminate the insured component of the Plan and cover all eligible persons, including eligible partners, under one self-funded health plan. After the amendment, the eligible medical expenses of partners and non-partner employees participating in the Plan will be reimbursed by the Plan from a dedicated account funded with premium payments made by the participants, both partners and non-partner employees, as well as contributions directly by Taxpayer.

The amount of the premium will be determined by Taxpayer prior to the beginning of each plan year in consultation with its independent third party administrators. The premium will be calculated by examining the past claims experience of the pool of Plan participants as a whole in order to project future claims and administration expenses. Taxpayer will then charge each participating partner and non-partner employee, on a monthly basis, a pro rata share of the projected claims and administrative costs of the Plan. Both partners and non-partner employees will be charged the same premium depending on the type of coverage elected (i.e., single or family coverage). Premiums

may vary among the various geographical locations where the Taxpayer maintains offices. However, it is not anticipated that premiums will vary for any other reason. Taxpayer will subsidize a portion of the premium on behalf of its non-partner employees.

All premium payments (including the portion of the non-partner employee premium paid by Taxpayer) will be deposited into a dedicated account from which administrative expenses and eligible medical expenses under the Plan will be paid on behalf of all Plan participants. If the total premium payments are in excess of the claims and expenses incurred for a plan year, the excess will be used to pay claims and expenses of the Plan incurred in the following plan year and thus reduce premium payments for all participants in that following (or subsequent) plan year. If the total premium payments for a plan year are less than the claims and expenses of the Plan for the year, Taxpayer will make a contribution to the dedicated account to cover the deficit. To the extent the deficit is allocable to partners, Taxpayer will charge a pro rata portion of that amount to each participating partner as additional premium unless the deficit is de minimus. The portion of the deficit allocable to non-partner employees will be paid by Taxpayer. Taxpayer will contract with an excess risk, or stop-loss, carrier to insure itself against catastrophic health claims covering eligible partners and non-partner employees.

You have requested rulings that: (1) The Plan, after the proposed amendment, will be "an arrangement having the effect of accident or health insurance" as that phrase it used in section 104(a)(3) of the Internal Revenue Code (the "Code"); (2) After the proposed amendment, payments from the Plan made to or for the benefit of partners for themselves and their dependents will be excludable from the partners' income under section 104(a)(3) of the Code; and (3) Premium payments made by individual partners for coverage under the Plan will be deductible by them under section 162(l) of the Code, subject to the limitations of that provision.

Section 61(a) of the Code provides that, except as otherwise specifically provided, gross income means all income from whatever source derived.

One specifically provided exception to inclusion under section 61(a) of the Code is section 104(a)(3) which provides that, except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 for any prior taxable year, gross income does not include amounts received through accident or health insurance (or through an arrangement having the effect of accident or health insurance) for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer).

Section 162(l)(1)(A) of the Code provides that in the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid

during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

The parenthetical language, "(or through an arrangement having the effect of accident and health insurance)" in section 104(a)(3), was added to the Code by section 311 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 1996-43 I.R.B. 7, effective for taxable years beginning after December 31, 1996. HIPAA Section 311 also increased the amount of the deduction under section 162(l)(1)(A) of the Code. The legislative history of section 311 "Increase in Deduction for Health Insurance Costs of Self-Employed Individuals", states that under present law, self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for the self-employed individual and the individual's spouse and dependents. The 30-percent deduction is available in the case of self-insurance as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

The House Conference Report states that the legislation provides that payments for personal injury or sickness through an arrangement having the effect of accident or health insurance (and that are not merely reimbursement arrangements) are excludable from income. In order for the exclusion to apply, the arrangement must be insurance (e.g., there must be adequate risk shifting). Section 311 equalizes the treatment of payments under commercial insurance and arrangements other than commercial insurance that have the effect of insurance. Thus under the provision, a self-employed individual who receives payments from such an arrangement could exclude the payments from income. H.R. Rep. No. 104-736, 104th Cong., 2d Sess. 293.

A self-employed individual may deduct payments to a self-funded health plan but only if the plan has the characteristics of insurance. An essential indicia of accident or health insurance is the shifting of risk. Insurance must shift the risk of economic loss from the insured and the insured's family to the insurance program and must distribute the risk of this economic loss among the participants in the program. Helvering v. Le Gierse, 312 U.S. 531 (1941). In the context of this type of insurance, risk shifting will occur when an insurer agrees to protect the insured (or a third-party beneficiary) against a direct or indirect economic loss arising from a defined contingency involving an accident or health risk. See, Allied Fidelity Corporation v. Commissioner, 66 T.C. 1068, 1074 (1976) and Haynes v. U.S., 353 U.S. 81, 83 (1957). The risk shifting occurs because the insurer assumes another's risk of economic loss in exchange for the payment of a premium by the insured or other payor.

In the instant case and under the specific facts presented, in return for the payment of a premium, the risk of economic loss in the event of personal injury or sickness is shifted from the partner and the partner's family to the Plan and distributed among the Plan's participants. Therefore, the Plan, as amended, is "an arrangement having the effect of accident or health insurance".

Accordingly, based on the representations made and authorities cited above we conclude as follows:

(1) The Plan, after the proposed amendment making it self-funded for its partners and non-partner employees alike, will be "an arrangement having the effect of accident or health insurance" as that phrase it used in section 104(a)(3) of the Code.

(2) After the proposed amendment making the Plan self-funded for its partners and non-partner employees alike, payments from the Plan made to or for the benefit of partners for themselves and their dependents will be excludable from the partners' income under section 104(a)(3) of the Code.

(3) Premium payments made by individual partners for coverage under the self-funded Plan will be deductible by them under section 162(l) of the Code, subject to the limitations of that provision.

No opinion is expressed or implied concerning the tax consequences under any other provision of the Code or regulations other than those specifically stated above.

These rulings are directed only to the Taxpayer who requested them. Section 6110(k)(3) of the Code provides that they may not be used or cited as precedent.

Sincerely yours,

_____

Harry Beker
Chief, Branch No.6
Office of the Associate
Chief Counsel
(Employee Benefits and
Exempt Organizations)

Enclosures:
Copy of this letter
Copy for section 6110 purposes