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Department of the Treasury
Washington, DC 20224

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PLR-129857-06
Date: October 26, 2006

LEGEND:

Taxpayer =

Dear :

This is in reply to a letter dated May 19, 2006, requesting rulings on behalf of Taxpayer concerning the federal income tax treatment of contributions and reimbursements made under a self-insured medical expense reimbursement plan.

Taxpayer is a partnership that offers a group health plan (the "Plan") to its eligible partners and its non-partner employees. The Plan is a self-funded arrangement for the benefit of Taxpayer's partners and eligible non-partner employees. As of June 1, 2006, 72 partners and 380 employees were eligible to participate in the Plan.

All eligible participants (partners and non-partner employees) and their dependents receive group health benefits through a self-insured plan. The Plan offers two benefit options that differ in the level of deductibles and out-of-pocked maximums Plan participants pay. Within each benefit option, levels of coverage are offered for employee only, employee plus one, or family coverage.

Eligible medical expenses of partners and non-partner employees (and their respective covered spouses and dependents) are reimbursed by the Plan from a general 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 for each benefit option and for each level of coverage is determined by Taxpayer prior to the beginning of each Plan year, in consultation with the Plan's independent third-party administrator. Premiums are calculated by adding the cost of projected claims plus 25%, the cost of stop-loss insurance, the cost of an administrative service charge and a consulting service fee. Taxpayer will then charge each participating partner and non-partner employee, on a monthly basis, a pro rata share of these projected and actual costs of the Plan. Partners and non-partner employees will be charged the same premium depending on the benefit option and type of coverage elected. Premiums will not vary among participants. Taxpayer subsidizes a portion of the premium on behalf of its non-partner employees.

All premium payments are paid to Taxpayer's general account. Plan administrative expenses and eligible medical expenses under the Plan are paid from this account. If the total premium payments exceed the claims and expenses incurred for a Plan year, the excess is used to pay claims and expenses of the Plan incurred in the following Plan year, thus reducing 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 Plan year, Taxpayer will make a contribution to the general account to cover the deficiency. Taxpayer contracts with an insurer to cover the excess risk to the Taxpayer of catastrophic health claims.

RULINGS REQUESTED

You have requested rulings that: (1) The Plan constitutes "an arrangement having the effect of accident or health insurance" as that phrase is used in section 104(a)(3) of the Internal Revenue Code (the "Code"); (2) Payments from the Plan made to or for the benefit of partners, for covered health services received by them or their dependents, will be excludable from the partner's 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.

LAW AND ANALYSIS

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

One specific 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 Corp. v. Commissioner, 66 T.C. 1068, 1074 (1976) and Haynes v. U.S., 353 U.S. 81, 83. 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.

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 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 is "an arrangement having the effect of accident or health insurance" as that phrase it used in section 104(a)(3) of the Code.

(2) Payments from the Plan made to or for the benefit of partners for themselves and their spouses and dependents are excludable from the partners' income under section 104(a)(3) of the Code.

(3) Premium payments made by individual partners for coverage under the Plan are 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 herein.

This ruling is directed only to the Taxpayer who requested them. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

In accordance with the Power of Attorney on file with this office, a copy of this ruling is being sent to your authorized representative.

Sincerely,

Harry Beker, Chief
Health & Welfare Branch
Office of Division Counsel/Associate
Chief Counsel (Tax Exempt &
Government Entities)