19-1762
TAX TYPE: INCOME TAX
TAX YEAR: 2016 and 2017
DATE SIGNED: 7/07/2020
COMMISSIONERS: J. VALENTINE, R. ROCKWELL, M. CRAGUN, L. WALTERS
GUIDING DECISION

BEFORE THE UTAH STATE TAX COMMISSION

TAXPAYER-1, & TAXPAYER-2 Petitioners, v. AUDITING DIVISION OF THE UTAH STATE TAX COMMISSION,	**INITIAL HEARING ORDER** Appeal No. 19-1762 Account No. #### Tax Type: Income Tax Tax Year: 2016 and 2017 Judge: Nielson-Larios

Presiding:
Aimee Nielson-Larios, Administrative Law Judge

Appearances:
For Petitioners: TAXPAYER-1
For Respondent: RESPONDENT, Auditing Division

STATEMENT OF THE CASE

This matter came before the Utah State Tax Commission on June 23, 2020, for an Initial Hearing in accordance with Utah Code Ann. § 59-1-502.5. The Taxpayers claimed $$$$$ health benefit plan credits ("Credit(s)") on their Utah individual income tax returns for the 2016 and 2017 tax years. The Division audited those returns and issued Notices of Deficiency disallowing the Credits. The Notices of Deficiency show the following amounts owing:

Tax Year	Audit Tax	Audit Interest	Audit Penalties	Audit Total Due
2016	$$$$$	$$$$$	$$$$$	$$$$$
2017	$$$$$	$$$$$	$$$$$	$$$$$

Audit interest was calculated through September 25, 2019, and continues to accrue on any unpaid balance. The Taxpayers claim that they qualify for the Credits.

APPLICABLE LAW

Utah Code Ann. § 59-1-1417(1) states, "In a proceeding before the commission, the burden of proof is on the petitioner [taxpayer] . . ."

Utah Code Ann. § 59-10-1023 (2008-present) provides **the health benefit plan credit**, stating the following in part:

> (1) As used in this section:
> . . . .
> (d) (i) "Health benefit plan" is as defined in Section 31A-1-301.
> (ii) "Health benefit plan" does not include equivalent self-insurance as defined by the Insurance Department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
> ….
> (2) Subject to Subsection (3), and except as provided in Subsection (4), for taxable years beginning on or after January 1, 2009, a claimant may claim a nonrefundable tax credit equal to the product of:
> (a) the difference between:
> (i) the total amount the claimant pays during the taxable year for:
> (A) insurance offered under a health benefit plan; and
> (B) an eligible insured individual; and
> (ii) excluded expenses; and
> (b) 5%.
> (3) The maximum amount of a tax credit described in Subsection (2) a claimant may claim on a return for a taxable year is:
> (a) for a single claimant with no dependents, $300;
> (b) for a joint claimant with no dependents, $600; or
> (c) for a claimant with dependents, $900.
> (4) A claimant may not claim a tax credit under this section if the claimant is eligible to participate in insurance offered under a health benefit plan maintained and funded in whole or in part by:
> (a) the claimant's employer; or
> (b) another person's employer.
> . . . .

Utah Code Ann. § 31A-1-301 provides the definitions of "**health benefit plan**" for the 2016 and 2017 tax years. Utah Code Ann. § 31A-1-301(76) (2016) (effective 5/10/2016, superseded 5/9/2017) defines "health benefit plan" as follows:[1]

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[1] One of the types of insurance under § 31A-1-301(76)(a) (2016) is "health care insurance," which is defined in Utah Code Ann. § 31A-1-301(78) (2016) as follows in part:

> (a) "Health care insurance" or "health insurance" means insurance providing:
> (i) a health care benefit; or
> (ii) payment of an incurred health care expense.
> (b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:
> (i) replacement of income;
> (ii) short-term accident;
> (iii) fixed indemnity;

(a) Except as provided in Subsection (76)(b), "health benefit plan" means a policy or certificate that:
  (i) provides health care insurance;
  (ii) provides major medical expense insurance; or
  (iii) is offered as a substitute for hospital or medical expense insurance, such as:
    (A) a hospital confinement indemnity; or
    (B) a limited benefit plan.
(b) "Health benefit plan" does not include a policy or certificate that:
  (i) provides benefits solely for:
    (A) accident;
    (B) dental;
    (C) income replacement;
    (D) long-term care;
    (E) a Medicare supplement;
    (F) a specified disease;
    (G) vision; or
    (H) a short-term limited duration; or
  (ii) is offered and marketed as supplemental health insurance.

Utah Code Ann. § 31A-1-301(77) (2017) (effective 5/9/2017, superseded 5/8/2018) defines "**health benefit plan**" as follows:

(a) "Health benefit plan" means, except as provided in Subsection (77)(b), a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care.
(b) "Health benefit plan" does not include:
  (i) coverage only for accident or disability income insurance, or any combination thereof;
  (ii) coverage issued as a supplement to liability insurance;
  (iii) liability insurance, including general liability insurance and automobile liability insurance;
  (iv) workers' compensation or similar insurance;
  (v) automobile medical payment insurance;
  (vi) credit-only insurance;
  (vii) coverage for on-site medical clinics;
  (viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits;
  (ix) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
    (A) limited scope dental or vision benefits;
    (B) benefits for long-term care, nursing home care, home health care,

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  (iv) credit accident and health;
  (v) supplements to liability;
  (vi) workers' compensation;
  (vii) automobile medical payment;
  (viii) no-fault automobile;
  (ix) equivalent self-insurance; or
  (x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

community-based care, or any combination thereof; or
(C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191;

(x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan:
(A) coverage only for specified disease or illness; or
(B) hospital indemnity or other fixed indemnity insurance; and

(xi) the following if offered as a separate policy, certificate, or contract of insurance:
(A) Medicare supplemental health insurance as defined under the Social Security Act, 42 U.S.C. Sec. 1395ss(g)(1);
(B) coverage supplemental to the coverage provided under United States Code, Title 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or
(C) similar supplemental coverage provided to coverage under a group health insurance plan.

The definitions of "health benefit plan" found in § 31A-1-301 use the term, "**insurance**." Utah Code Ann. § 31A-1-301(87) (2016) (effective 5/10/2016, superseded 5/9/2017) and Utah Code Ann. § 31A-1-301(89) (2017) (effective 5/9/2017, superseded 5/8/2018) define "insurance" as follows:

(a) "Insurance" means:
(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or
(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:
(i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;
(ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and
(iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

Subsection 59-10-1023(1)(d)(ii), quoted earlier in this section, provides that a "'[h]ealth benefit plan' does not include equivalent self-insurance as defined by the Insurance Department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act." Utah Code Ann. § 31A-1-301(157) (2016) (effective 5/10/2016, superseded 5/9/2017) defines "**self-insurance**" as follows:

(a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.
(b) Except as provided in this Subsection (157), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.
(c) "Self-insurance" includes:
(i) an arrangement by which a governmental entity undertakes to indemnify an

employee for liability arising out of the employee's employment; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk that is related to the relationship or employment.

(d) "Self-insurance" does not include an arrangement with an independent contractor.

For 2017, the definition of "self-insurance" was renumbered to Utah Code Ann. § 31A-1-301(161) (2017) (effective 5/9/2017, superseded 5/8/2018).

DISCUSSION

The Taxpayers filed individual income tax returns as full-year Utah residents with married-filling-joint filing status for the 2016 and 2017 tax years. They were not eligible to participate in insurance offered under a health benefit plan maintained and funded in whole or in part by the Taxpayers' or another person's employer or former employer.

They paid COMPANY-1("COMPANY-1") $$$$$ per month purportedly for insurance coverage for the Taxpayers and their son. The $$$$$-per-month checks were written from the Taxpayers' personal bank account and deposited into the COMPANY-1's financial accounts. TAXPAYER ("Taxpayer") explained that after 2017, he and his son were removed from the COMPANY-1 plan, and that in October 2020, his wife will be removed, as well. The COMPANY-1 covered only the Taxpayers and their son on the COMPANY-1 plan. The COMPANY-1 has not and will not cover anyone else. The written COMPANY-1 plan between the Taxpayers and the COMPANY-1 consists of the following:

- One-page proof of health insurance coverage letters for 2016 and 2017, which state in part, "The health insurance coverage will be the identical coverage you had last year through INSURANCE COMPANY-1. (See SPD)."

- The first four pages of an eight-page document issued by INSURANCE COMPANY-1 for the 2015 year, which provided the 2015 deductibles, out of pocket limits, copayments, and coinsurance payment percentages for allowed amounts for services provided by in-network and out-of-network providers.

The COMPANY-1 has no contracts with specific health care providers to have in-network or out-of-network providers for the COMPANY-1 plan. The COMPANY-1 did not write its own policy listing its benefits/coverages, maximum out-of-pocket amounts, etc. The Taxpayer explained the COMPANY-1 plan covers the same doctors as those the Taxpayers were seeing under the INSURANCE COMPANY-1 plan. The Taxpayer explained that unless the Taxpayers' deductibles exceeded $$$$$ for a year, neither the COMPANY-1 plan nor the 2015 INSURANCE COMPANY-1 plan would cover any of the Taxpayers' medical expenses. For the 2016 and 2017 tax years, the COMPANY-1 paid no medical

expenses for the Taxpayers or for their son.[2] The Taxpayer explained that they switched from the 2015 INSURANCE COMPANY-1 plan to the COMPANY-1 plan for multiple reasons: first, before 2016, he had an ACCIDENT that caused him to require medical care, but the INSURANCE COMPANY-1 plan did not pay anything because he did not reach the $$$$$ deductible; second, the INSURANCE COMPANY-1 plan's monthly premiums were increasing from about $$$$$ per month to about $$$$$-$$$$$ per month; and third, the Taxpayers were willing to take a risk for their medical coverage because they knew they only needed coverage for a short period of time and the COMPANY-1 had sufficient assets to cover any medical expenses they might incur.

The Taxpayers wholly-own and control the COMPANY-1; are managing members, each owning 50 percent. The COMPANY-1 holds financial assets that generate income and losses such as interest income, dividend income, and capital gains and losses. The COMPANY-1 reported the $$$$$-per-month payments from the Taxpayers as ordinary business income. The COMPANY-1 reported the COMPANY-1's income/loss activities to the Taxpayers through K-1 forms, and the Taxpayers report the K-1 income/loss activities on their personal individual income tax returns. It was undisputed that the $$$$$-per-month payments flowed from the COMPANY-1 to the Taxpayers' individual income tax returns as income subject to tax. On Form 1065, the COMPANY-1 reported "total assets" of $$$$$ for 2016 and $$$$$ for 2017. These total asset amounts were approximately equal to the Taxpayers' ending capital accounts for 2016 and 2017.[3] The COMPANY-1 has no employees, and the COMPANY-1 has the same address as the Taxpayers'. On Form 1065, the COMPANY-1 described its "principal business activity" as "COMPANY-2"; its "principal product or service" as "Investments"; and its "business code number" as "#####."

Taxpayers' Arguments

The Taxpayer argued that the Taxpayers' $$$$$-per-month payments to the COMPANY-1 were for insurance offered under a health benefit plan and those payments were not equivalent self-insurance. He explained that the Taxpayers contracted with the COMPANY-1 for health insurance and the COMPANY-1 is a separate legal entity. He asserted that, through the contract, the Taxpayers shifted their risk for medical expenses above $$$$$ to the COMPANY-1 and the COMPANY-1 has substantial assets to cover those expenses. The Taxpayers timely made all $$$$$ monthly payments to the COMPANY-1. The Taxpayer asserted the COMPANY-1 plan was an arm's-length transaction between

[2] The 2015 COMPANY-2 covered preventative care/screening/immunization at "no charge" to insured persons. It is unknown if the Taxpayers or their son had preventative care, such as annual physicals, which would have been covered at "no charge" to the Taxpayers if the 2015 COMPANY-2 had been in effect for 2016 and 2017.

[3] The Taxpayers' ending capital accounts of $$$$$ and $$$$$ totaled $$$$$ for 2016, which is $$$$$ less than the total assets of $$$$$ for that year. The Taxpayers' ending capital accounts of $$$$$ and $$$$$ totaled $$$$$ for 2017, which is $$$$$ more than the total assets of $$$$$ for that year.

the Taxpayers and COMPANY-1.[4] The Taxpayer asserted that they paid income tax on the $$$$$-per-month payments, so they did not receive a net benefit from Utah when they received the Credits. The Taxpayer asked that the Commission allow the Taxpayers an offset for the $$$$$-per-month payments reported as income on their Utah income tax returns if the Commission finds that the Taxpayers are not entitled to the Credits.

The Taxpayer also argued that the COMPANY-1 plan was **not self-insurance**, as defined in § 31A-1-301(157) (2016) and § 31A-1-301(161) (2017). The Taxpayer asserts that the COMPANY-1 plan meets the exception provided in Subsection (b), which provides the following, in part:

> "[S]elf-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

The Taxpayer asserted that the risk was transferred from the Taxpayers to the COMPANY-1; thus, the Taxpayers and the COMPANY-1 spread the Taxpayers' risk among themselves. The Taxpayer explained that if the Taxpayers had paid self-insurance, they would **not** have been taxed on the $$$$$-per-month payments they made to the COMPANY-1. He argued that because they were taxed on the $$$$$-per-month payments as business income from health insurance premiums, then the $$$$$-per-month payments should be treated as health insurance premiums for the health benefit plan credit.

In response to the Judge's questions, the Taxpayer asserted that the COMPANY-1 was a "health carrier" that is not required to register with the Utah Insurance Department. He asserted that the COMPANY-1 is similar to companies that insure their own employees and are also not required to file with the Utah Insurance Department; both the COMPANY-1 and the companies that insure their own employees provide protection against economic losses from medical expenses for a small group of people.

Division's Arguments

The Division argued that the Taxpayers do not qualify for the Credits because the COMPANY-1 plan is self-insurance. The Division explained that the Division audited the Taxpayer for the 2016 and 2017 tax years, and the Taxpayers responded to the Division's request for information by explaining the Taxpayers paid premiums to COMPANY-1. The Division had not seen the COMPANY-1 before as a seller of health insurance, so the Division researched the COMPANY-1 further. The Division found that the COMPANY-1 was not registered with the Utah Insurance Department; that the COMPANY-1 was not identified by Google searches as being a company selling insurance; and that the COMPANY-1's

[4] Investopedia.com defines "arm's length transaction" as follows: "An arm's length transaction refers to a business deal in which buyers and sellers act independently without one party influencing the other." The Taxpayers have not shown they engaged in an arm's length transaction with their COMPANY-1.

business code number of ##### did not identify the COMPANY-1 as only being an insurance company. The Division reviewed the COMPANY-1's K-1 forms and found that the Taxpayers wholly owned the COMPANY-1.

The Division explained why the Division thinks the COMPANY-1 plan meets the definition of self-insurance. The Division first found that the COMPANY-1 plan meets Subsection (a) of § 31A-1-301(157) (2016) and Utah Code Ann. § 31A-1-301(161) (2017), which states the following:

> "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

Next, the Division found that the COMPANY-1 plan did not meet Subsection (b), which states the following:

> "[S]elf-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

The Division asserted that Subsection (b) was not met because the Taxpayers are 100% owners of the COMPANY-1; the COMPANY-1 offered the plan only to the Taxpayers, not to the general public; and the COMPANY-1 did not write its own plan but only had a plan based on the INSURANCE COMPANY-1's plan documents. The Division further noted that the COMPANY-1 paid no medical expenses under the COMPANY-1 plan for the 2016 and 2017 tax years. The Division explained that the Division inquired of the Utah Insurance Department about the COMPANY-1 plan, and the Utah Insurance Department could not say whether the COMPANY-1 plan was or was not self-insurance because a number of factors must be considered in determining self-insurance. The Division also addressed Subsections (c) and (d). Subsection (c) includes in "self-insurance" arrangements to manage risks related to employment, not to medical expenses. Subsection (d) excludes from "self-insurance" "an arrangement with an independent contractor." The Division explained that the COMPANY-1 plan did not meet these subsections.

In response to the Judge's questions, the Division agreed with the Taxpayers that the $$$$$-per-month payments were for "insurance." The Division accepted that the Taxpayers had a plan as shown by the coverage letters and the INSURANCE COMPANY-1 plan pages and that the Taxpayers transferred risk to the COMPANY-1. The Division reiterated that their disagreement with the Taxpayers was about whether the COMPANY-1 plan was "equivalent self-insurance" for purposes of § 59-10-1023(1)(d)(ii).

Analysis

After considering the parties' information and arguments, the Taxpayers are not entitled to the Credits for the 2016 and 2017 tax years. The Credit is provided in § 59-10-1023, which states the following in part:

(2) Subject to Subsection (3), and except as provided in Subsection (4), for taxable years beginning on or after January 1, 2009, a claimant may claim a nonrefundable tax credit equal to the product of:
  (a) the difference between:
    (i) the total amount the claimant pays during the taxable year for:
      (A) insurance offered under a health benefit plan; and
      (B) an eligible insured individual; and
    (ii) excluded expenses; and
  (b) 5%.
(3) The maximum amount of a tax credit described in Subsection (2) a claimant may claim on a return for a taxable year is:
  (a) for a single claimant with no dependents, $300;
  (b) for a joint claimant with no dependents, $600; or
  (c) for a claimant with dependents, $900.
(4) A claimant may not claim a tax credit under this section if the claimant is eligible to participate in insurance offered under a health benefit plan maintained and funded in whole or in part by:
  (a) the claimant's employer; or
  (b) another person's employer.

(Emphasis added.) The Taxpayers are not disqualified from claiming the Credit under Subsection (4), and the requirement of Subsections (3) is not at issue. Additionally, no information suggests that the Taxpayers were not "eligible insured individual[s]" for Subsection (2)(a)(i)(B) or that the Taxpayers had "excluded expenses" for Subsection (2)(a)(ii). The area at issue for this appeal is Subsection (2)(a)(i)(A). If the Taxpayers' payments of $$$$$ per month, totaling $$$$$ per year for 2016 and 2017, are amounts the Taxpayers paid for "insurance offered under a health benefit plan," then the Taxpayers are allowed $$$$$ Credits for 2016 and 2017. Alternatively, if the Taxpayers' payments are **not** amounts the Taxpayers paid for "insurance offered under a health benefit plan," then the Taxpayers do not qualify for the Credits for 2016 and 2017.

"Health benefit plan" is defined in § 59-10-1023(1)(d) as follows:

(i) "Health benefit plan" is as defined in Section 31A-1-301.
(ii) "Health benefit plan" does not include equivalent self-insurance as defined by the Insurance Department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Thus, to be a "health benefit plan" for purposes of the Credits, the plan must meet the definition found in § 31A-1-301 and must not be "equivalent self-insurance." For the 2016 and 2017 tax years, "self-insurance" was defined in the Utah Code, rather than by an administrative rule. *See* § 31A-1-301(157) (2016) and § 31A-1-301(161) (2017).

Definitions for "health benefit plan" are found in § 31A-1-301(76) (2016) and § 31A-1-301(77) (2017). The definition for each tax year is analyzed separately below.

Analysis for the 2016 Tax Year

For 2016, § 31A-1-301(76)(b) (2016) defined "health benefit plan" as excluding certain plans, as follows in part:

> "Health benefit plan" does not include a policy or certificate that . . . provides benefits solely for: . . . accident[,] dental[, etc.] or . . . is offered and marketed as supplemental health insurance.

The COMPANY-1 plan is not excluded by § 31A-1-301(76)(b) (2016) from possibly being a health benefit plan. Subsection 31A-1-301(76)(a) (2016) further defines "health benefit plan" as follows, in part:

> Except as provided in Subsection (76)(b), "health benefit plan" means a policy or certificate that . . . provides health care **insurance**; . . . provides major medical expense **insurance**; or . . . is offered as a substitute for hospital or medical expense **insurance** . . .

(Emphasis added.) Thus, to meet the definition of "health benefit plan," the COMPANY-1 plan must provide "insurance" or be offered as a substitute for "insurance." Subsection 31A-1-301(87) (2016) defines "insurance" through its Subsections (a)(i)-(ii) and (b)(i)-(iii). Subsection (a)(i) states the following in part:

> "Insurance" means . . . an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons . . .

Subsection (a)(i) requires a transfer of risk, but the COMPANY-1 plan does not transfer risk from the Taxpayers, as explained below. The COMPANY-1 plan, in form, transfers the liability from being only on the Taxpayers to being on both the Taxpayers and their COMPANY-1, which is wholly-owned and controlled by the Taxpayers. However, in substance, the COMPANY-1 plan does not transfer risk from the Taxpayers. The COMPANY-1 plan reimburses the Taxpayers for medical expenses above the $$$$$ deductible. If the COMPANY-1 pays a reimbursement, the Taxpayer's assets outside of the COMPANY-1 increase by the reimbursement amount; however, the value of their COMPANY-1 membership interests decrease by approximately the same amount because their COMPANY-1's assets decrease by the reimbursement amount. Thus, regardless of whether the COMPANY-1 reimburses the Taxpayers for medical expense, the total value of all of the Taxpayers' assets, which include their COMPANY-1 membership interests, decreases by the amount of the medical expenses. Because the Taxpayers are not, in substance, shifting risk from themselves, their $$$$$-per-month payments to their wholly-owned COMPANY-1 are not payments for "insurance" under § 31A-1-301(87)(a)(i).

Subsection (a)(ii) of § 31A-1-301(87) (2016) further defines "insurance" as follows in part:

> "Insurance" means: . . . an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

The Taxpayers' arrangement with their COMPANY-1 does not "distribut[e] a risk or risks among a group of persons that includes the person seeking to distribute that person's risk." The COMPANY-1 is a "person" that is **not** seeking to distribute the COMPANY-1's risk; the COMPANY-1 has no risk of incurring its own medical expenses. The COMPANY-1 is not among the "group of persons" described in Subsection (a)(ii). Therefore, the Taxpayers are not distributing their risk among a group that includes themselves and the COMPANY-1, for purposes of Subsection (a)(ii). Thus, their $$$$$-per-month payments to their wholly-owned COMPANY-1 are not payments for "insurance" under § 31A-1-301(87)(a)(ii).

Lastly, Subsections (b)(i)-(iii) of § 31A-1-301(87) (2016) defines "insurance" to include the following specific arrangements:

> "Insurance" includes:
> (i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;
> (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and
> (iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

The COMPANY-1 plan does not meet Subsection (b)(i) because the COMPANY-1 plan does not, in substance, shift risk from the Taxpayers, as explained in the prior paragraphs of this order. The COMPANY-1 plan does not meet Subsection (b)(ii) because the COMPANY-1 plan is not a contract of guaranty or suretyship. The COMPANY-1 plan does not meet Subsection (b)(iii) because, under the LLP plan, the risk rests upon the Taxpayers, who created the COMPANY-1 plan.

Because the COMPANY-1 plan does not meet any of the subsections of § 31A-1-301(87) (2016), the COMPANY-1 plan did not provide "insurance." Because the COMPANY-1 plan did not provide "insurance," the COMPANY-1 plan is not a "health benefit plan" as the term is defined is in § 31A-1-301(76)(a) (2016). The COMPANY-1 plan is likewise not a "health benefit plan" under § 59-10-1023(1)(d)(i). The Taxpayers have not paid "insurance offered under a health benefit plan" as required by § 59-10-1023(2)(a)(i)(A); thus, they do not qualify for the Credit for the 2016 tax year.[5]

Analysis for the 2017 Tax Year

As explained below, the Taxpayers also do not qualify for the Credit for the 2017 tax year. For 2017, § 31A-1-301(77)(b) (2017) defines "health benefit plan" as excluding coverage under specifically described types of insurance. The COMPANY-1 plan is not excluded by § 31A-1-301(77)(b) (2017)

[5] Based on the above analysis, it is unnecessary to address for the 2016 tax year, the issue of whether the COMPANY-1 plan was "equivalent self-insurance," as the term is used in § 59-1-1023(1)(d)(ii). However, the issue of "equivalent self-insurance" is addressed later in this order, for the 2017 tax year.

from possibly being a health benefit plan. Subsection 31A-1-301(77)(a) (2017) further defines "health benefit plan" as follows:[6]

> "Health benefit plan" means, except as provided in Subsection (77)(b), a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care.

The above definition uses the term "health carrier"; however, that term is not defined by statute or rule.[7] The Taxpayer asserted that the COMPANY-1 met the definition of "health carrier" because the COMPANY-1 provided protection against economic loss from medical expenses for the Taxpayers and their son. The Taxpayer asserted that "health carrier" is not limited to companies registered with the Utah Insurance Department. The Taxpayer asserted that businesses with their own insurance plans that directly insure only their own employees are, likewise, "health carriers" who are not required to register. The Division did not argue at the Initial Hearing that the COMPANY-1 was not a "health carrier." This order will assume that the COMPANY-1 met the definition of "health carrier" for the 2017 tax year. Thus, the COMPANY-1 plan meets the definition of "health benefit plan" as defined in § 31A-1-301(77) (2017).[8]

To be a "health benefit plan" for purposes of the 2017 Credit, the COMPANY-1 plan must not only meet the definition of "health benefit plan" found in § 31A-1-301(77) (2017) but also must meet the definition of "health benefit plan" found in § 59-10-1023(1)(d), which defines "health benefit plan" to exclude "equivalent self-insurance." "Self-insurance" is defined in § 31A-1-301(161) (2017) as follows:

> (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.
> (b) Except as provided in this Subsection (161), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.
> (c) "Self-insurance" includes:

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[6] "Health care" is defined by § 31A-1-301(78) (2017) but is not at issue.

[7] "Health carrier" is defined by The Individual Market Health Insurance Coverage Model Act prepared by the National Association of Insurance Commissioners ("NAIC"), which act defines "Health carrier" as follows:

> "Carrier" or "health carrier" means any entity licensed, or required to be licensed, by the Department of Insurance that offers health benefit plans covering eligible individuals pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

However, the Utah Legislature did not adopt this definition for "health carrier." Additionally, "carrier(s)" is used multiple times in Utah Administrative Code R428-13, which requires Utah carriers to report certain information unless an exemption applies. However, this administrative rule also does not define "carrier." The administrative rule of R428-13 was "promulgated under authority granted by Title 26, Chapter 33a, Utah Code." *See* R428-13-1. Title 26, Chapter 33a is the Utah Health Data Authority Act, which does not define or use "carrier."

[8] If the Legislature or Utah Insurance Department further define "health carrier" or "carrier" by statute or rule, then this order's conclusions about "health carrier" and "health benefit plan" for the 2017 tax year could change.

(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and
(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk that is related to the relationship or employment.

(d) "Self-insurance" does not include an arrangement with an independent contractor.

The COMPANY-1 plan shows an arrangement under which the Taxpayers spread their own risks by a systematic plan, to different assets they own and control. Thus, the Taxpayers' arrangement with the COMPANY-1 plan meets Subsection (a), and the Taxpayer's arrangement will be found to be self-insurance unless it is excluded from the definition by Subsection (b) or (d). The Taxpayers' arrangement with the COMPANY-1 plan is not an arrangement under which the Taxpayers and the COMPANY-1 spread their risks among themselves. The COMPANY-1 has no risk of incurring its own medical expenses; it has no risk of medical expenses to share with the Taxpayers. Furthermore, the Taxpayers did not reduce their own risk through the COMPANY-1 plan; the Taxpayers' medical expenses reduce the total value for all of the Taxpayers' assets by the amount of the medical expenses, regardless of any reimbursement by the COMPANY-1. Thus, the Taxpayers' arrangement with the COMPANY-1 plan is not excluded from the definition of "self-insurance" through Subsection (b). The COMPANY-1 is not independent of the Taxpayers; instead, it is wholly owned and controlled by the Taxpayers. Thus, the Taxpayers' arrangement with the COMPANY-1 plan is not excluded from the definition of "self-insurance" through Subsection (d). Because the Taxpayers' arrangement meets Subsection (a) and is not excluded by Subsection (b) or (d), the Taxpayers' arrangement is "self-insurance" for the 2017 tax year. Applying § 59-10-1023(1)(d)(ii), the COMPANY-1 plan was not a "health benefit plan" for purposes of the 2017 Credit. Therefore, for 2017, the Taxpayers have not paid insurance offered under a "health benefit plan" as required by § 59-10-1023(2)(a)(i)(A), and they do not qualify for the Credit for the 2017 tax year.[9]

The Taxpayers asked the Commission to allow them a credit or offset to income for the $$$$$-per-month payments they reported as income if the Credits for the 2016 and 2017 tax years are disallowed. The Taxpayers, though, have not shown they are entitled to a credit or offset. In general, if an audited taxpayer amends federal and state tax returns and the IRS accepts a lower federal adjusted gross income, then that taxpayer may contact the Division and request that the Division adjust the taxpayer's state figures to be consistent with the federal ones. The Division will then review the taxpayer's request and determine the changes that are appropriate. The Taxpayers may, likewise, choose

[9] Because the COMPANY-1 plan is not a "health benefit plan" for the 2017 tax year, this order does not analyze whether the $$$$$-per-month payments would be "insurance" for that year. However, the issue of "insurance" is addressed earlier in this order, for the 2016 tax year.

to amend their federal and state returns for themselves and for their COMPANY-1 to treat the $$$$$-per-month payments differently if they think they incorrectly reported the taxability of those payments. If the IRS accepts the revised federal income amounts, then the Taxpayers may contact the Division and request that the Division review and revise the Taxpayers' state income amounts to be consistent with the federal ones.

The Notices of Deficiency reflects amounts owing. The Taxpayers may contact the Taxpayer Services Division at (801)297-7703 to make payment arrangements.

Aimee Nielson-Larios
Administrative Law Judge

DECISION AND ORDER

Based on the foregoing, the Commission sustains in full the Division's audit assessments for the 2016 and 2017 tax years. It is so ordered.

This decision does not limit a party's right to a Formal Hearing. However, this Decision and Order will become the Final Decision and Order of the Commission unless any party to this case files a written request within thirty (30) days of the date of this decision to proceed to a Formal Hearing. Such a request shall be mailed, or emailed, to the address listed below and must include the Petitioner's name, address, and appeal number:

Utah State Tax Commission
Appeals Division
210 North 1950 West
Salt Lake City, Utah 84134

or emailed to:
taxappeals@utah.gov

Failure to request a Formal Hearing will preclude any further appeal rights in this matter.

DATED this _____day of _____, 2020.

John L. Valentine
Commission Chair

Michael J. Cragun
Commissioner

Rebecca L. Rockwell
Commissioner

Lawrence C. Walters
Commissioner

Notice of Payment Requirement: Any balance due as a result of this order must be paid within thirty (30) days of the date of this order, or a late payment penalty could be applied.