Office of Chief Counsel
Internal Revenue Service
memorandum

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subject:

Legend

Taxpayer	=
Individual	=
Entity 1	=
Entity 2	=
Entity 3	=
Entity 4	=
Entity 5	=
Entity 6	=
Administrator	=
State	=
Year 1	=
Year 2	=
Year 3	=
Year 4	=
Year 5	=
A	=
B	=
C	=

This is in response to your request for legal analysis in the cited case.

Issue

Whether the seven 10-year excess loss policies[1] qualify as insurance for Federal income tax purposes.

Summary of Arrangement

Entities 1-6 and Administrator (the "Group Entities") entered into 10-year excess loss policies with Taxpayer in Year 2.[2] The policies are identical apart from the insured Group Entity, policy numbers, and premiums. Entities 1-6 are S-corporations for Federal income tax purposes. Individual owns all the stock of Entities 1-6.

Entities 1-6 provide healthcare services to members of unrelated health maintenance organizations ("HMOs"). HMOs do not purchase these services directly from Entities 1-6. HMOs contract with Administrator to have Entities 1-6 provide healthcare services to the HMOs' members.

Individual also owns all the stock of Administrator. Administrator is a C-corporation. Administrator does not provide healthcare services directly to patients. The HMOs pay Administrator on a capitated, pre-paid monthly basis. The capitation fees cover primary healthcare, hospital, and specialized healthcare services. Administrator pays Entities 1-6 sub-capitation fees. The amount of the sub-capitation fee paid to each of Entities 1-6 depends primarily on the number of HMO members who receive primary healthcare services from each entity. Administrator also contracts with hospitals to provide hospital services to the HMO members, and contracts with specialists to provide specialized healthcare services to the HMOs' members.

Individual owns all of Taxpayer's stock. Taxpayer is a C-corporation. In December of Year 1, Taxpayer incorporated in State. Taxpayer is licensed with the State Division of Insurance ("State DOI") to operate as a pure captive insurance company. In general, under the State captive statute, a pure captive insurer only insures the risks of its parent and affiliated entities or controlled unaffiliated entities.

Taxpayer's initial business plan, filed with the State DOI, stated that Taxpayer would issue workers' compensation and professional liability coverage to the Group Entities. Taxpayer revised its initial business plan, filing a second business plan with the State DOI. The second business plan stated that Taxpayer would issue one-year excess loss policies to the Group Entities. The new policies were in addition to the existing workers' compensation and professional liability coverage described in the initial business plan.

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[1] The use of terms such as policies, insureds, insurer, and premiums are for convenience only and do not imply that there is a genuine insurance arrangement for Federal income tax purposes.

[2] Entities 2 and 3 merged in Year 3.

Taxpayer then revised its business plan again, filing a third business plan with the State DOI. The third business plan stated that Taxpayer would cancel the one-year excess loss policies and issue 10-year excess loss policies to the Group Entities. The plan stated that, "premiums for the policies for all the entities will total A, payable evenly over the 10-year period. The limit of liability for the policies will total B. . . . The expected losses under the policies will total C, which on a discounted [basis] equals the premiums to be paid." C is less than B and greater than A.

The excess loss policies Taxpayer issued to each of the seven Group Entities covered a portion of the Group Entities' costs of providing healthcare services (the "Costs") to the HMO members over 10 years. The 10-year term started in December 31, Year 2, and went through December 31, Year 5. Premiums were due in 10 equal annual installments. Each policy covered one of Group Entity's Costs to the extent they exceeded a specified amount (the attachment point). A Group Entity's Costs that exceeded the attachment point could trigger claims by that Group Entity to Taxpayer.[3] At the time of its execution, each of the policies provided that the attachment point was "$To Be Determined." Therefore, even though the business plan filed with the State DOI stated that the total premiums would equal the discounted amount of expected losses, the premiums for the policies were priced and the policies were executed before Taxpayer and the Group Entities established the attachment point. It is not clear when the attachment point was established, but circumstantial evidence indicates that it happened no earlier than four years into the 10-year policy period.

Taxpayer's potential liability to each Group Entity was also capped under each policy (the "Policy Cap"). The policies limited Taxpayer's liability to each Group Entity to 150 percent of the premiums that each Group Entity paid. There is evidence that when the attachment point was established, the parties fully expected Group Entities' claims to exceed the Policy Cap. Taxpayer later raised the Policy Cap to 170 percent of premiums in an undated policy endorsement. Each Group Entity did not pay additional premiums for the increased Policy Cap. Additionally, there is evidence that the parties expected Group Entities' claims to exceed the newly raised Policy Cap when the Policy Cap was raised. Claims were payable at the end of the 10-year policy term. No claims were made under the policy from its inception through Year 4.[4]

In the aggregate, the Group Entities paid A in premiums over the 10-year policy term. Each Group Entity claimed a deduction for each taxable year under section 162 for premiums paid to Taxpayer.

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[3] There is no indication that Costs covered by the policies represented actual losses to the Group Entities. Furthermore, there is no evidence that claims under the policies were for Costs that exceeded the capitated payments that Group Entities received, whether directly or indirectly, from the HMOs. For purposes of this memorandum, we will assume that claims under the policies represented actual losses to the Group Entities.

[4] Subsequent years have not yet been audited by the Service.

Law

Insurance

Neither the Internal Revenue Code nor the Income Tax Regulations define the terms "insurance" or "insurance contract" for Federal income tax purposes. In Helvering v. Le Gierse, 312 U.S. 531, 539 (1941), the Supreme Court held that "[h]istorically and commonly insurance involves risk shifting and risk distributing." Cases analyzing captive insurance arrangements have described insurance as having the following three elements: (1) an insurance risk; (2) shifting and distribution of that risk; and (3) insurance in its commonly accepted sense. See e.g., AMERCO, Inc. v. Commissioner, 979 F.2d 162, 164-165 (9th Cir. 1992), aff'g 96 T.C. 18 (1991).

Risk shifting occurs if a person facing the possibility of an economic loss transfers some or all of the financial consequences of the potential loss to the insurer, such that the loss does not affect the insured because the insurance payment offsets the loss. Rev. Rul. 2002-89, 2002-2 C.B. 984; Rev. Rul. 2002-90, 2002-2 C.B. 985; Rev. Rul. 2002-91, 2002-2 C.B. 991; Clougherty Packing Co. v. Commissioner, 811 F.2d 1297, 1300 (9th Cir. 1987), aff'g 84 T.C. 948 (1985); Allied Fidelity Corp. v. Commissioner, 572 F.2d 1190, 1193 (7th Cir. 1978), aff'g 66 T.C. 1068 (1976); Cuesta Title Guaranty Co. v. Commissioner, 71 T.C. 278, 286 (1978). For risk shifting to be present, the party that bears the ultimate financial loss must not be the same party that suffers the loss. "If parties structure an apparent insurance transaction so as to effectively eliminate the effect of insurance risk therein, insurance cannot be present." AMERCO, Inc., 96 T.C. at 39.

The risk transferred pursuant to an insurance contract must be a risk of economic loss. Allied Fidelity Corp., 572 F.2d at 1193. Losses that exist at the time of the insurance agreement, or that are so probable or imminent that there is insufficient risk being transferred between the insured and insurer, are not proper subjects of insurance. 1 Couch on Insurance 3d, ¶ 102:8.

For risk to shift, the insurer must be a "viable entity, financially capable of meeting its obligations." AMERCO, Inc., 96 T.C. at 40; Gulf Oil Corp. v. Commissioner, 89 T.C. 1010, 1024 (1987); The Harper Group v. Commissioner, 96 T.C. 45, 59 (1991), aff'd, 979 F.2d 1341 (9th Cir. 1992) (discussing the insurer's financial capacity to pay the insured's claims as part of its risk shifting analysis). In captive cases, the courts have scrutinized the capitalization of the captive for purposes of determining if there was risk shifting. Malone & Hyde, Inc. v. Commissioner, 62 F.3d 835, 839-840 (6th Cir. 1995); Humana, Inc. v. Commissioner, 881 F.2d 247, 253 (6th Cir. 1989); Stearns-Roger Corp. v. United States, 774 F.2d 414, 415 (10th Cir. 1985); Carnation Co. v. Commissioner, 640 F.2d 1010, 1013 (9th Cir. 1981).

In addition, an arrangement must resemble insurance in its commonly accepted sense

to qualify as insurance for Federal income tax purposes. See e.g., AMERCO, Inc. v. Commissioner, 979 F.2d at 165. The determination of whether an arrangement resembles insurance in its commonly accepted sense encompasses a number of factors, including state regulators' definitions of insurance companies and insurance transactions. AMERCO, Inc., 96 T.C. at 42; The Harper Group, 96 T.C. at 60. However, state law definitions are not dispositive for Federal income tax purposes. AMERCO, Inc., 96 T.C. at 42. The capitalization of the insurer, whether premiums were charged as the result of an arm's-length transaction, whether premiums were actuarially determined, and whether the policies were valid and binding are also relevant for purposes of determining whether there is insurance in its commonly accepted sense. See Rev. Rul. 2002-91, 2002-2 C.B. 991; Malone & Hyde, Inc., 62 F.3d at 836; The Harper Group, 96 T.C. at 60; Gulf Oil Corp., 89 T.C. at 1028 n. 15.

Income Tax Accounting

Section 451 provides that the amount of any item of gross income shall be included in gross income for the taxable year in which received by the taxpayer unless such amount is to be properly included in a different period.

Treas. Reg. § 1.451-1(a) provides in part that under an accrual method of accounting, income is includible in gross income when all the events have occurred which fix the right to receive such income and the amount thereof can be determined with reasonable accuracy. All the events that fix the right to receive income occur when the required performance takes place, payment is due, or payment is made, whichever happens first. See Schlude v. Commissioner, 372 U.S. 128 (1963); Rev. Rul. 80-308, 1980-2 C.B. 162.

Treas. Reg. § 1.461-1(a)(2) provides in part that under an accrual method of accounting, a liability is incurred, and is generally taken into account for Federal income tax purposes, in the taxable year in which: (1) all the events have occurred that establish the fact of the liability, (2) the amount of the liability can be determined with reasonable accuracy, and (3) economic performance has occurred with respect to the liability. Uncertainty as to the amount of the liability does not prevent a taxpayer from taking into account that portion of the amount of the liability which can be computed with reasonable accuracy.

Treas. Reg. § 1.461-4(g)(7) provides that, in the case of taxpayer's liability for which economic performance rules are not provided elsewhere, economic performance occurs as the taxpayer makes payments in satisfaction of the liability to the person to whom the liability is owed.

Analysis

As explained below, we conclude that the seven 10-year excess loss policies do not qualify as insurance for Federal income tax purposes. The policies do not shift any risk from the Group Entities to Taxpayer and the arrangement is not insurance in its commonly accepted sense. As a result, Taxpayer accrues income from premiums when they are due or paid, whichever happens first, but does not accrue liabilities from claims until those claims are paid.

Insurance

The economic risk under each policy is that at the end of that 10-year policy period each Group Entity will make claims up to the Policy Cap (i.e., 170 percent of premiums) if the cost of healthcare services it provided over the 10-year period exceeded the attachment point. See Allied Fidelity Corp., 572 F. 2d at 1193. Accordingly, the policies purportedly transferred this risk of economic loss from the Group Entities to Taxpayer. However, the policies effectively shifted no risk because Taxpayer could expect to pay 170 percent of the premiums because the Costs incurred by each Group Entity were clearly expected to exceed the Policy Cap. The effect was to eliminate the transfer of an insurance risk from the Group Entities to Taxpayer because the losses were certain to occur and, in fact, had already been partially incurred at the time the terms of the policies were finalized (i.e.: when the Policy Cap was increased and when the attachment point was set). The attachment point under each policy was not established until at least four years into the 10-year policy period. When the parties finally set the attachment point, they set it at a level where they would have reasonably expected the Costs of each Group Entity to exceed the Policy Cap. See AMERCO, 96 T.C. at 39; 1 Couch on Insurance 3d, ¶ 102:8.

The arrangement between Taxpayer and the Group Entities resembles the situation that the Service considered in Rev. Rul. 89-96, 1989-2 C.B. 114. The Service held that a property and casualty insurance company could not claim a deduction under section 832(b)(5) for "losses incurred" when the casualty event had taken place before the parties entered into the purported insurance contract. The expected amount of losses incurred as a result of the casualty event greatly exceeded the amount covered under the contract. The Service found that the "premium" received, plus the tax benefits to the insurer, plus the expected investment income on those amounts "would exceed its anticipated liability." The Service concluded that because the amount of the casualty loss the insurer could expect to pay was known at the contract's inception, the arrangement lacked the requisite shifting of an insurance risk.

As in Rev. Rul. 89-86, the only risk that Taxpayer assumes is the risk "that the available investment yield between the time of payment of the premiums and the time of payment of the claims will be lower than expected." Rev. Rul. 89-96. The policies were drafted so that the maximum amount recoverable under the contracts (B), which was 150 percent of premiums, would certainly be reached. Therefore, the policies were

effectively designed as guaranteed investment contracts, payable in 10 years, with 1/10 of the principal deposited each year, and with a fixed annual interest rate of 7.25 percent (which is the rate necessary to grow 100 units, deposited in equal installments over 10 years, into 150 units at the end of those 10 years). The Policy Cap was later raised to 170 percent, increasing the Group Entities' potential return on investment. Moreover, if the tax savings of treating the transaction as insurance for Federal income tax purposes were taken into account, the effective promised annual rate of return would be even higher.

The arrangement between Taxpayer and the Group Entities is also similar to the situation in Rev. Rul. 2007-47, 2007-2 C.B. 127, where a domestic corporation was engaged in an inherently harmful activity and was required by law to incur certain mitigation expenses upon the discontinuation of the activity. When the corporation began the activity, it estimated that the present value of its future remediation costs was $150x. It then entered into an arrangement with an insurance company under which it paid the insurance company $150x in exchange for the promise to be reimbursed for its future remediation costs up to a limit of $300x. The Service found that this arrangement was not insurance because, economically, it was merely the corporation's prefunding of its future remediation expenses. The Service reasoned that "the overall risk assumed by [the insurance company] was whether the estimated present value of the cost of performing the measures ($150x) would accrue to exceed the greater of [the corporation]'s costs to perform the required measures or the contract limit of $300x" and that this "risk is akin to the timing and investment risks that Rev. Rul. 89-96 concludes are not insurance risk." As in the situation in Rev. Rul. 2007-47, the overall risk Taxpayer assumed under the policy is an investment risk—namely, the risk that the purported premiums that it received from the Group entities will grow over 10 years by 70 percent, which is all that it promised to pay to the Group entities. This purported insurance risk is no more than the prefunding of future expenses.

Additionally, the premiums could not have been actuarially determined because they were priced before the attachment point above which Taxpayer would provide coverage to the Group Entities was established and the Policy Cap was raised without increasing the premiums paid. It appears that, instead, the parties engineered Taxpayer's potential losses to provide a specific return on investment for Group Entities, which further indicates a lack of insurance in its commonly accepted sense. See Rev. Rul. 2002-91, 2002-2 C.B. 991; Malone & Hyde, Inc., 62 F.3d at 836; The Harper Group, 96 T.C. at 60; Gulf Oil Corp., 89 T.C. at 1028 n. 15. Overall, there was not insurance in its commonly accepted sense.

We conclude, based on all the facts and circumstances, that the policies do not qualify as insurance contracts for Federal income tax purposes because there was a lack of risk shifting and the contracts are not insurance in its commonly accepted sense.

Income Tax Accounting

Taxpayer receives premiums from the Group Entities in exchange for the promise to pay, at the end of the policy period, the excess, if any, of each Group Entity's costs over the attachment point. Taxpayer's right to receive income is fixed when the premiums are due or are paid, whichever happens first. The amount of the premiums is fixed by the contract, and therefore determinable with reasonable accuracy as of the start of the policy period.

Taxpayer is liable for claims under each policy once each Group Entity's costs exceed the attachment point. The amount of that excess can be computed with reasonable accuracy, and any uncertainty regarding the final amount of claims does not prevent Taxpayer from taking into account the amount by which costs have already exceeded the attachment point. Given that the policies at issue are not insurance for Federal income tax purposes, the claims must be considered "other liabilities" under Treas. Reg. § 1.461-4(g)(7). Economic performance therefore occurs as Taxpayer makes payments in satisfaction of the liabilities, which does not occur until the end of the policy periods. Taxpayer's liability for claims therefore does not satisfy all three prongs of the all events test until the claims are paid.

Therefore, we conclude (1) that Taxpayer accrues income from premiums when they are due or paid, whichever happens first, and (2) that Taxpayer does not accrue liabilities from claims until those claims are paid.

Conclusion

For the reasons stated above, the seven 10-year excess loss policies do not qualify as insurance for Federal income tax purposes. As a result, Taxpayer accrues income from premiums when they are due or paid, whichever happens first, but does not accrue liabilities from claims until those claims are paid.

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[redacted]

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