
Chapter 2

What is Insurance?

This chapter addresses:

- The definition of insurance under the Federal income tax law, including the impact of the risk-shifting, risk-distribution, and other requirements of insurance;
- The application of these and other requirements of insurance in various contexts including captive insurance arrangements; and
- Commercial-type insurance under section 501(m).

Part I: Introduction

(a) Background

Whether a contract issued by an insurance company qualifies as insurance fundamentally influences the tax treatment of the insurer, policyholders, and beneficiaries. The definition of insurance company, for example, depends directly on the status of the contracts that a company issues because an insurance company is a “company more than half of the business of which during the taxable year is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.”¹ A trade or business cannot deduct a payment for coverage as an insurance premium under section 162(a) unless the payment relates to an insurance transaction.² A beneficiary of a life insurance policy can exclude proceeds of the policy if the contract qualifies as life insurance and

¹ Section 816(a) (flush language). The definition of insurance company under section 816(a) is addressed on pages 67-68.

² Treas. reg. section 1.162-1(a).

the payments are made by reason of the death of the insured.³ Although it generally is clear whether a given transaction qualifies as insurance, the status of a transaction is unclear or subject to dispute between taxpayers and the government in certain contexts.⁴

(b) *Helvering v. Le Gierse*

The Internal Revenue Code does not define “insurance.”⁵ The Tax Court stated that “[i]nsurance risk is involved when an insured faces some loss-producing hazard (not an investment risk), and an insurer accepts a payment, called a premium, as consideration for agreeing to perform some act if and when that hazard occurs.”⁶ The Supreme Court stated in *Helvering v. Le Gierse*,⁷ the landmark case involving the definition of insurance, that “[h]istorically and commonly insurance involves risk-shifting and risk-distributing.”⁸

Le Gierse, the beneficiary of her mother’s insurance policy, was an executor of her mother’s estate and attempted to exclude the proceeds of the insurance policy from Federal estate tax. Le Gierse’s mother acquired a single premium life insurance policy with a death benefit of \$25,000, for \$22,946, at age 80. Her mother did not have to take a physical examination or answer questions that a woman applicant for life insurance generally had to answer. Her mother also acquired an annuity that would make periodic payments for as long she lived for consideration of \$4,179. The acquisition of the insurance policy and annuity were linked because the insurance company would not issue the insurance contract without also issuing an

3 Section 101(a). A beneficiary can exclude only the portion of the proceeds determined under section 7702(g)(2) if the contract qualifies as a life insurance contract under applicable law but does not qualify as a life insurance contract for Federal income tax purposes under section 7702.

4 Compare section 7702, which determines whether a contract that qualifies as a life insurance contract under applicable law is a life insurance contract for Federal tax purposes. Life insurance contracts include qualified accelerated death benefit riders, other than riders that are long-term care insurance contracts under section 7702B, under section 818(g).

5 See *Sears, Roebuck & Co. v. Comr.*, 972 F.2d 858 at 861 (7th Cir. 1992).

6 *Black Hills Corp. v. Comr.*, 101 T.C. at 182, revised on reconsideration, 102 T.C. 505 (1994), *aff’d*. 73 F.3d 799 (8th Cir. 1996).

7 312 U.S. 531 (1941).

8 *Id.* at 539.

annuity. The insurance policy and annuity were treated as separate contracts in all other formal respects. The insurance policy incorporated the usual characteristics of that type of contract.

The Court concluded that the two contracts must be considered together. The life insurance and annuity contracts involved opposite risks and, in combination, offset each other. The arrangement therefore did not involve insurance.⁹

(c) Economics of insurance coverage

The risk-shifting and distribution requirements highlighted in *Le Gierse* (and addressed below) reflect the economics of insurance coverage. Insurance premiums for one year of coverage, for example, exceed the expected cost of coverage (which equals the cost of a claim times the probability that a valid claim will be made) because the premiums have to cover the cost of claims paid and other costs, including administrative costs incurred by the insurer. Insureds are willing to pay this amount to transfer the risk of incurring a sizable financial loss that would arise if the covered contingency in fact occurs.

The insurer benefits by pooling a given risk with numerous other assumed risks. The expected value of the losses incurred by the insurer, per dollar of premium income, remains unchanged as a life insurer provides life insurance coverage to an increasing number of (equally situated) insureds. The actual losses assumed by the insurer may differ from expected losses so that an insurer's total losses may exceed its expectations.¹⁰ The spread of the risk of loss (or possibility that the insurer will incur a very large loss) per premium dollar decreases, however, as more insureds are covered, as a result of the statistical law of large numbers. Consequently, the loss incurred per premium dollar gets increasingly more predictable as the insurer covers a larger number of insureds. The Seventh Circuit described the law of large numbers as follows,¹¹

9 *Id.* at 540-542.

10 Insureds also assume the risk that investment yields on amounts held will be too low. (This factor is especially important if insurers hold significant amounts to cover long-term risks, such as for whole life insurance, because the cumulative effect of an incorrect estimate of an assumed interest rate can be significant for a long-term contract). In addition, insurers assume the risk that expenses, other than claims, will exceed expectations.

11 *See Sears, Roebuck & Co. v. Com'r*, 972 F.2d 858 at 862-863 (7th Cir. 1992).

One thousand persons at age 30 pay \$450 each for a one-year policy with a death benefit of \$200,000. In a normal year two of these persons will die, so the insurer expects to receive \$450,000 and disperse \$400,000. Of course, more may die in a given year than the actuarial tables predict. But as the size of the pool increases the law of large numbers takes over, and the ratio of actual to expected loss converges on one. The absolute size of the expected variance [spread] increases, but the ratio decreases.

Insurers determine the expected value of losses per premium dollar (400/450 in the Seventh Circuit's example) and the spread (riskiness) of actual/expected losses incurred using actuarial principles. Insurance coverage involving more than one period also involves risk-shifting and distribution although the analysis is more complex than that examined above.

(d) Risk shifting and distribution and other factors

The primary factors that the Service and courts examine to determine whether a transaction is insurance are whether the policyholder transfers insurance risks to a separate entity (risk-shifting) and whether such entity spreads the risks with risks transferred by others (risk-distribution). The Service and courts also attempt to determine whether the transaction has other characteristics traditionally associated with insurance. Whether a given factor is present or required for a given transaction to qualify as insurance for tax purposes is not always definitively clear and a source of considerable contention between insurers and the government in certain contexts.

Risk-shifting—Risk-shifting involves one party “shifting its risk of loss to another.”¹² The Joint Committee on Taxation stated¹³ that the,

12 *Black Hills Corp. v. Com'r.*, 101 T.C. 173, 182 (1993), *revised on reconsideration* 102 T.C. 505 (1994), *aff'd.* 73 F.3d 799 (8th Cir. 1996).

13 Joint Committee on Taxation, *Tax Reform Proposals: Taxation of Insurance Products and Companies* (JCS-41-85), (Sept. 20, 1985) at 60. [Hereinafter cited as *Tax Reform Proposals*].

concept of risk-shifting refers to the fact that a risk of loss is shifted from the individual insured to the insurer (and the insurance pool managed by the insurer). For example, under a fire insurance policy, the property owner's risk of loss from a fire (and the resulting damage costs) is shifted from the owner to the insurance company to the extent that the insurance proceeds from the contract will reimburse the owner for that loss.

Risk distribution—Risk distribution (or sharing), “involves the party onto whom risk is shifted distributing a portion of that risk among others.”¹⁴ The Joint Committee on Taxation stated¹⁵ that the,

concept of risk-distribution . . . relies on the law of large numbers. That is, within a group of a large number of individual insureds who share a similar type of risk of loss, only a certain number will actually suffer the loss within any defined period of time. When a loss is suffered by any insured, each individual insured makes a contribution through the payment of premiums toward indemnifying the loss suffered.

The underlying facts and circumstances influence whether there is sufficient risk distribution in a given transaction. In Technical Advice Memorandum 200323026,¹⁶ a parent company and operating subsidiaries made payments to a related foreign captive for pollution liability coverage. Approximately two thirds of the coverage was for one of the operating subsidiaries, which “operated a small number of plants, most of which engaged in the same operations and used and stored the same chemicals.”¹⁷ The Service concluded that “only limited” risk distribution was present. It distinguished the Tax Court's holding in *The Harper Group v. Commis-*

¹⁴ *Black Hills Corp. v. Com'r*, 101 T.C. at 182, *revised on reconsideration* 102 T.C. 505 (1994), *aff'd*. 73 F.3d 799 (8th Cir. 1996).

¹⁵ See *Tax Reform Proposals*, note 13 at 60-61.

¹⁶ Feb. 7, 2003. This technical advice is addressed at notes 98-103 and accompanying text.

¹⁷ *Id.* at 9.

sioner,¹⁸ in which payments to an insurance captive qualified as deductible insurance premiums although as much as 71 per cent of the premiums were for related party risks. In *The Harper Group* the 71 per cent covered more than one related policyholder and the coverage involved “an extensive variety of cargo shipments throughout the world by a variety of means and vessels.”¹⁹ In contrast, “two thirds of the premiums in the present case represent the pollution liability of a single insured with similar operations in a handful of locations.”²⁰

Is risk shifting a requirement of insurance?—The Service and courts generally require that to qualify as insurance an arrangement must shift and distribute covered risks and satisfy certain other requirements. The Seventh Circuit stated in *Sears, Roebuck & Co. v. Commissioner*,²¹ however, that risk shifting and distribution are not required by statute and that it is a “blunder” to treat a phrase in an opinion as if it were statutory language.²² It questioned the need to shift risk for corporate coverage to qualify as insurance for tax purposes.²³

Other factors—Risk shifting and distribution are not the only factors that courts examine to determine whether a transaction or contract qualifies as insurance. In a series of cases involving wholly owned insurance companies, the Tax Court examined whether a transaction involves the presence of an insurance risk, and whether it involves “commonly accepted notions of insurance,” in addition to whether the insurance risk, if present, is shifted and distributed.²⁴

Impact of nontraditional factors—The U.S. Supreme Court stated that it is not necessary for insurance coverage to incorporate traditional

18 96 T.C. 45 (1991).

19 TAM 200323026 (Feb. 7, 2003) at 9.

20 *Id.*

21 972 F.2d 858 (7th Cir. 1992).

22 *Id.* at 861.

23 *Id.* at 862-864. These issues are addressed at notes 144-148 and accompanying text.

24 See *Sears, Roebuck & Co. v. Com'r.*, 96 T.C. 61, 101 (1991), *aff'd. on this issue, rev'd. in part* 972 F.2d 858 (7th Cir. 1992), which is addressed at notes 136-149 and accompanying text.

characteristics of an insurance contract for the coverage to qualify as insurance for tax purposes. It held in *Haynes v. United States*²⁵ that coverage provided by a telephone company qualified as health insurance although the “employees paid no fixed periodic premiums, there was no definite fund created to assure payment of the disability benefits, and the amount and duration of the benefits varied with the length of service.”²⁶ The Court stated that payment of fixed premiums at regular intervals and the presence of a definite fund are not required for coverage to qualify as insurance. The Court concluded that there is nothing in the statute or legislative history that limits health insurance to the characteristics of a normal insurance contract.²⁷

Part II: Self-Insurance and Captive Insurers

(a) Background

A company may not be able to acquire needed coverage from commercial insurers, or may only be able to acquire it at great cost. The company (or group of companies) may respond by setting amounts aside and “self-insuring” to cover these risks. Payments for such coverage are not deductible as insurance premiums. As an alternative, a company or group of companies may establish a “captive” insurance company to address their insurance goals. Whether coverage from a captive is insurance has been an especially contentious issue. The Service’s view of the tax treatment, however, has been evolving toward standards that reflect much of the case law.

(b) Self-insurance

Tax treatment of self-insurance “premiums”—Amounts set aside as reserves for self-insurance coverage are not deductible. The taxpayer in Revenue Ruling 69-512²⁸ self-insured to cover fire losses because it otherwise was unable to obtain needed coverage. The Service ruled (with-

25 353 U.S. 81 (1956).

26 *Id.* at 83-84.

27 *Id.*

28 1969-2 C.B. 24.

out detailed elaboration) that the amounts set aside as a self-insurance reserves were not ordinary and necessary expenses deductible under section 162.²⁹

Self-insurance premiums are not deductible if they are paid to a separate fund or an irrevocable trust. In *Spring Canyon Coal Co. v. Commissioner*³⁰ a coal mining and two other companies established a self-insurance fund and paid premiums equal to the amount that would be paid to a state insurance fund. An independent agent administered the fund for the three companies but did not commingle their funds. The fund covered compensation, medical, and other benefits under the state's Workmen's Compensation Act as well as incidental administration costs.

The Tenth Circuit concluded that the amounts set aside were reserves for contingent losses akin to reserves set aside by insurance companies. It held that amounts set aside to cover contingent liabilities by companies other than insurance companies were not deductible, however.³¹ The company could deduct incurred expenses when it paid injured workmen but it was "not entitled to deduct as an expense a sum of money which it might have expended for insurance premiums, but did not."³²

In *Steere Tank Lines, Inc. v. United States*³³ a transporter of petroleum products was required to "show evidence of financial responsibility" for the payment of accident claims. It entered into an agreement with an insurance company, Tri-State, which provided Steere Tank Lines with an evidence of financial responsibility bond. Steere Tank Lines agreed to indemnify the insurer for all claims that it had to cover and made two premium payments each year. One premium, which compensated Tri-State for providing the evidence of financial responsibility, was non-refundable. The other premium was allocated to a contract premium account. Tri-State returned the excess of the amounts paid into the fund over the amounts it paid for claims and administration after six years (the maximum statute of limitations period for tort claims). The Fifth Circuit held that the amounts paid into the contract premium account were not deductible until a covered liability became fixed, concluding that the arrangement with

29 *Id.*

30 43 F.2d 78 (10th Cir. 1930), *cert. denied* 284 U.S. 654 (1931).

31 *Id.* at 80.

32 *Id.*

33 577 F.2d 279 (5th Cir. 1978), *cert. denied* 440 U.S. 946 (1979).

Tri-State was not insurance. There was no risk-shifting because Steere Tank Lines “was obligated to pay all risks.”³⁴

In *Anesthesia Service Medical Group, Inc. v. Commissioner*³⁵ a professional corporation made contributions to an irrevocable trust created to cover medical malpractice claims against its employees. The Tax Court and Ninth Circuit held that the contributions were not deductible premium payments. The Ninth Circuit reasoned that the payments “created a capital asset inuring to its continued benefit.”³⁶ The courts were not persuaded by the medical group’s contention that liability was shifted from the employees, not the corporation. The Ninth Circuit noted that the medical group was liable for the tortious acts of its employees that were committed within the scope of their employment under the doctrine of *respondeat superior*.³⁷

The accrual of benefit obligations—The Supreme Court addressed the timing of the deduction of medical payments of an accrual basis non-insurer that self-insured certain medical care coverage in *United States v. General Dynamics Corp.*³⁸ General Dynamics paid medical claims out of its own funds but employed private carriers to administer the plan, instead of continuing its purchase of insurance from others. It set up a reserve to cover its liability for medical care received by employees.

General Dynamics argued that it could deduct certain amounts set aside as reserves as accrued expenses. The Court of Claims held that the amount set aside satisfied the all events test because the medical services were rendered and the amount of liability could be established with reasonable accuracy.³⁹ The Supreme Court held, however, that General

34 *Id.* at 280.

35 85 T.C. 1031 (1985), *aff’d*. 825 F.2d 241 (9th Cir. 1987).

36 *Id.* at 243.

37 *Id.* at 242. *But compare*, Rev. Rul. 92-93, 1992-2 C.B. 45, in which group-term life coverage obtained by a company for its employees from its insurance subsidiary qualified as life insurance. This ruling is addressed at notes 158-161 and accompanying text.

38 481 U.S. 239 (1987).

39 773 F.2d 1224, 125-1226 (Ct.Cl. 1985).

Dynamics was liable to pay for covered medical services only if properly documented claims were filed.⁴⁰

The Court concluded that although General Dynamics could make a reasonable estimate of the amount of liability for claims that would be filed for medical care received during the applicable period, estimated claims were not intended to fall within the all events test. Otherwise, Congress would not have needed to provide an explicit provision that insurance companies could deduct reserves for incurred but unreported claims.⁴¹

(c) Captive insurers: historic background

Whether coverage of risks of affiliated companies qualifies as “insurance” for Federal income tax purposes has been a source of considerable contention between the Service and taxpayers. Before it issued Revenue Ruling 2001-31,⁴² the Service’s position was that coverage of an affiliate’s risks is not insurance. It applied an “economic family theory” in Revenue Ruling 77-316,⁴³ which provided that,⁴⁴

the insuring parent corporation and its domestic subsidiaries, and the wholly owned “insurance” subsidiary, though separate corporate entities, represent one economic family with the result that those who bear the ultimate economic burden of loss are the same persons who suffer the loss.

In Revenue Ruling 77-316, the Service applied its economic family theory in the following three situations,

1. A foreign wholly owned captive insurer provided fire and other casualty insurance coverage for its parent and its parent’s domes-

40 481 U.S. at 244.

41 *Id.* at 245-247.

42 2001-1 C.B. 1348, *amplified in* Rev. Ruls. 2002-89 and 2002-90. Rev. Rul 2001-31 is addressed at notes 48-50 and accompanying text.

43 1977-2 C.B. 53, *clarified and amplified in* Rev. Rul. 88-72, 1988-2 C.B. 31, *declared obsolete in* Rev. Rul 2001-31. Rev. Rul. 2001-31, 2001-1 C.B. 1348, *amplified in* Rev. Ruls. 2002-89 and 2002-90, is addressed at notes 48-50 and accompanying text.

44 1977-2 C.B. at 54.

tic subsidiaries. The parent and its subsidiaries paid premiums at commercial rates to the captive for the coverage.

2. A parent and its domestic subsidiaries paid casualty insurance premiums to an unrelated domestic insurance company, which immediately reinsured 95 percent of the risks to a foreign “insurance” subsidiary that was wholly owned by the parent. The unrelated insurer remained the primary insurer and there were no collateral agreements between the unrelated insurer and the parent company or the other subsidiaries.
3. A parent and its domestic subsidiaries paid casualty insurance premiums to the parent’s wholly owned “insurance” subsidiary, which reinsured 90 percent of the coverage of the risks to an unrelated insurance company.

The Service ruled that the premiums paid in each situation were not deductible (but for amounts addressed below) because “there was no economic shifting or distributing of risks of loss with respect to the risks carried or retained” by the “insurance” subsidiary. It concluded in each case that the “insurance agreement” was “designed to obtain a deduction by indirect means that would be denied if sought directly.”⁴⁵

The Service allowed the parent and its (non-insurance) subsidiaries to deduct only premiums paid for risks that were ultimately borne by an unrelated insurer. Consequently, the parent and subsidiaries could deduct no premium in situation one. They could deduct premiums only for five percent of the risks retained by the unrelated insurer in situation two, and the 90 percent ceded to the unrelated insurer in situation three.

The Service recognized that each parent and its subsidiaries, including the wholly owned “insurance” subsidiaries, were separate corporate entities, reflecting the Supreme Court’s holding in *Moline Properties, Inc. v. Commissioner*.⁴⁶ It applied its economic family theory, however, and concluded that “those who bear the ultimate economic burden of loss are the same persons who suffer the loss.”⁴⁷ The parent retained “practical control” in each situation.

45 1977-2 C.B. at 55.

46 319 U.S. 436 (1943).

47 1977-2 C.B. at 54.

(d) The Service no longer follows the economic family theory

The Service concluded in Revenue Ruling 2001-31⁴⁸ that it “will no longer invoke the economic family theory with respect to captive insurance transactions.”⁴⁹ It reasoned that no court addressing captive insurance transactions has fully accepted the economic family theory⁵⁰ as provided in Revenue Ruling 77-316.

Whether a transaction qualifies as insurance depends on the underlying facts and circumstances. Relevant factors include the amount of related (and unrelated) party risks, the capitalization of a captive and whether related parties provide guaranties or other financial enhancements. The impact of salient factors is addressed below.

(e) No unrelated risks transferred in parent-subsidiary arrangements

In general—The Service and courts hold that coverage by a captive subsidiary of its parent’s risks is not insurance if it only covers risks of related parties. Humana, Inc. and a wholly owned Netherlands Antilles company established Health Care Indemnity, Inc. (HCI) to cover risks of Humana and other HCI subsidiaries (“sister corporations”), in *Humana, Inc. v. Commissioner*.⁵¹ The Sixth Circuit examined the impact of the “insurance” transactions on the insured’s assets in both parent-subsidiary and brother-sister arrangements. It concluded that risk-shifting was lacking in the parent-subsidiary transactions because the risk of loss never left the parent. It reasoned that a captive’s stock is an asset of its parent so that a loss suffered by the captive decreases the value of the parent’s assets.⁵²

Indirect arrangements—The Ninth Circuit held that the taxpayers could not deduct “insurance premiums” attributable to coverage provided by unrelated insurers that was reinsured with the taxpayers’ insurance

48 2001-1 C.B. 1348, *amplified in* Rev. Ruls. 2002-89 and 2002-90.

49 *Id.*

50 *Id.*

51 88 T.C. 197 (1987), *aff’d. in part rev’d. in part* 881 F.2d 247 (6th Cir. 1989).

52 *Id.* at 253. The tax treatment of brother-sister transactions is addressed at notes 71-80 and accompanying text.

subsidiaries in *Carnation v. Commissioner*⁵³ and *Clougherty Packing Co. v. Commissioner*.⁵⁴ The captives only covered related-party risks in each case.

In *Carnation*, a processor and seller of foods and grocery products incorporated Three Flowers Assurance Co., Ltd., a wholly owned (Bermuda) subsidiary, to insure and reinsure multiple-line risks. Carnation acquired insurance coverage from American Home Assurance Co., an unrelated insurance company, which agreed to reinsure 90 percent of the risks with Three Flowers. Three Flowers covered only Carnation and its subsidiaries. American Home paid 90 percent of Carnation's premiums to Three Flowers, which paid American Home a five percent commission on net premiums ceded, and reimbursed its premium taxes.

American Home was concerned that Three Flower's would not be able to cover the reinsured losses so Carnation agreed to capitalize Three Flowers with up to \$3 million at its (Carnation's) election or Three Flowers's request.⁵⁵ The Service allowed a deduction only for ten percent of the premium, which related to the coverage that was not ceded to Three Flowers. The Commissioner argued that the reinsurance was an indirect form of self-insurance and that such payments were within Carnation's practical control.⁵⁶

The Tax Court held that 90 percent of the premiums paid by Carnation to American Home was not deductible. Citing *Le Gierse*, the court concluded that an insurance risk was not present because the capitalization of Three Flowers with up to \$3 million "on demand" neutralized the risks that American Home reinsured with Three Flowers.⁵⁷ The Ninth Circuit concluded that the agreements among the parties were interdependent. That American Home refused to enter into a reinsurance arrangement unless Carnation agreed to capitalize Three Flowers was the key factor. The court also indicated that the Service's second situation in Revenue Ruling 77-316, in which "an insurance subsidiary" reinsured a portion of its parent's risks, supported its conclusion that the agreements neutral-

53 71 T.C. 400 (1978), *aff'd*. 640 F.2d 1010 (9th Cir. 1981), *cert. denied* 454 U.S. 965 (1981).

54 84 T.C. 948 (1985), *aff'd*. 811 F.2d 1297 (9th Cir. 1987).

55 71 T.C. 404; 811 F.2d at 1013.

56 *Id.* at 405.

57 *Id.* at 409. *Le Gierse* is addressed at notes 5-9. The impact of guarantees and various financial enhancements is addressed at notes 81-97 and accompanying text.

ized the risk-shifting from Carnation to the extent that risk was reinsured by Three Flowers.⁵⁸

In *Clougherty Packing*, a slaughtering and meat processing company self-insured a portion of its workers' compensation risks and obtained excess liability insurance for the remaining coverage from 1971-1977. It subsequently terminated its self-insurance arrangement and created Lombardy Insurance Corporation, a captive insurance company, which it capitalized for \$1 million.

Clougherty purchased workers compensation coverage from Fremont Indemnity Co., an unrelated insurance company. Fremont reinsured the first \$100,000 of each claim with Lombardy and ceded 92 percent of Clougherty's premiums. Fremont charged Clougherty an additional five percent of its premiums as a fee for providing a captive insurer program. Fremont remained liable if Lombardy became insolvent or otherwise defaulted. Lombardy's only business was reinsuring Clougherty.⁵⁹

Clougherty distinguished its transaction from that in *Carnation*. It argued that Carnation's agreement to capitalize its reinsurance subsidiary with \$3,000,000 on demand neutralized "any risk shifting in *Carnation* and the absence of any such agreement requires [the court to] reach an opposite result in this case."⁶⁰ The Ninth Circuit, however, denied 92 percent of the deduction for Clougherty's premium payments. It reasoned that Clougherty's net worth decreased when Lombardy paid a claim because it decreased the value of Clougherty's stock. The court stated that a claim decreased Clougherty's assets to the same extent that it would if it self-insured in the "ordinary sense."⁶¹

Clougherty argued that Revenue Ruling 77-316 was inconsistent with the Supreme Court's conclusion in *Moline Properties*⁶² that one must recognize affiliated companies as separate companies. The Ninth Circuit responded that *Moline Properties* does not require the Commissioner to

58 640 F.2d at 1013. Rev. Rul 77-316 is addressed at note 45 and accompanying text. Rev. Rul. 77-316, however, was declared obsolete by Rev. Rul. 2001-31, 2001-1 C.B. 1348. See notes 48-50 and accompanying text.

59 811 F.2d. at 1299.

60 *Id.* at 1303.

61 *Id.* at 1305.

62 319 U.S. 436 (1943).

ignore the impact of a loss on its assets “merely because the asset happens to be stock in a subsidiary.”⁶³

(f) Brother-sister transactions

Humana—In *Humana, Inc. v. Commissioner*,⁶⁴ the Sixth Circuit concluded that risk-shifting was present in the brother-sister transactions because the insured did not own stock of the insurance subsidiary so that a loss covered by the insurer did not influence the insured’s net worth. The court also concluded, without detailed elaboration, that risk-distribution was present. It stated, “we see no reason why there would not be risk distribution in the instant case where the captive insures several separate corporations within an affiliated group and losses can be spread among the several distinct corporate entities.”⁶⁵

HCA and Kidde Industries—The Tax Court, in *Hospital Corporation of America et. al. v. Commissioner*,⁶⁶ (*HCA*), and the Court of Federal Claims, in *Kidde Industries, Inc. v. United States*,⁶⁷ (*Kidde*), applied the “balance sheet” approach to determine whether risk-shifting was present in the taxpayers’ captive insurance arrangements.

HCA involved the tax treatment of a captive insurance arrangement whose facts, “with a few significant differences, . . . [were] strikingly similar to the facts presented in *Humana*[,]”⁶⁸ *HCA* created a wholly owned (captive) subsidiary, Parthenon, which provided a wide range of insurance coverages for its parent, HCA, and its sister corporations. The Tax Court used the balance sheet approach applied by the Sixth Circuit in *Humana* to determine whether HCA and its affiliates shifted their risks to Parthenon. It concluded that HCA did not shift its risks to Parthenon but that the sister affiliates did (but for certain workers compensation cover-

63 811 F.2d at 1307.

64 88 T.C. 197 (1987), *aff’d. in part rev’d. in part* 881 F.2d 247 (6th Cir. 1989).

65 *Id.* at 257.

66 74 T.C.M. 1020 (1997), *aff’d. on another issue* 348 F.3d 136 (6th Cir. 2003), *cert. denied subnom. HCA & Subsidiaries v. Comr.* 543 U.S. 813 (2004).

67 40 Fed.Cl. 42 (1997).

68 74 T.C.M. at 1038 (1997), *aff’d. on another issue* 348 F.3d 136 (6th Cir. 2003), *cert. denied subnom. HCA & Subsidiaries v. Comr.* 543 U.S. 813 (2004).

age subject to an indemnification agreement, which is addressed in the analysis of the impact of guarantees).⁶⁹

Kidde was a “broad-based, decentralized conglomerate with 15 separate divisions and 100 wholly owned subsidiaries” in 1977-1978, the years before the court. Before 1977, Travelers provided workers compensation, automobile and general liability (including products liability) coverage. Travelers would not renew Kidde’s products liability coverage for 1977. Kidde could only obtain such coverage at extremely high rates. It established Kidde Insurance Company Limited (KIC), a Bermuda captive, on December 22, 1976, to provide workers compensation, automobile, and general liability (including products liability) coverage for Kidde’s divisions and operating subsidiaries. Kidde and its operating subsidiaries obtained insurance coverage from an unrelated primary insurer that “transferred” specified portions of the risk to KIC.

The U.S. Court of Federal Claims denied the deduction of premiums attributable to the coverage for KIC’s parent (that is, Kidde’s divisions). Applying the balance sheet approach, the court concluded that Kidde did not shift its risk of loss to its captive when the captive paid a loss. Paying the loss decreased the value of the parent’s holdings of the captive’s stock so the parent realized the economic impact of the loss.

The court allowed Kidde to deduct premiums attributable to coverage of its subsidiaries after May 31, 1978. A loss paid by the captive did not decrease the value of a subsidiary’s assets so that the subsidiary could transfer the risk of loss to the captive. The court concluded that risk was not transferred before June 1, 1978 as a result of the impact of an indemnity agreement between Kidde and the primary insurer.⁷⁰

The Service’s position on brother-sister arrangements—Prior to issuing Revenue Ruling 2001-31⁷¹ the Service held that coverage in brother-sister arrangements was not insurance under its economic family theory.⁷² In Field Service Advice 200125005,⁷³ and Field Service Advice

69 See notes 92-95 and accompanying text.

70 40 Fed.Cl. at 48-50.

71 2001-1 C.B. 1348, *amplified in* Rev. Ruls. 2002-89 and 2002-90. Rev. Rul. 2001-31 is addressed at notes 48-50 and accompanying text.

72 The economic family theory, articulated in Rev. Rul. 77-316, 1977-2 C.B. 53, is addressed at notes 43-44 and accompanying text.

73 Jan. 25, 2001.

200125009,⁷⁴ however, the Service's National office recommended that the Service concede the deduction of premiums paid by an operating subsidiary to a sister insurance captive. It concluded in Field Service Advice 200125005 that contesting the deduction of these premiums raised substantial litigation hazards, noting that the Service lost on the "brother/sister" issue in *Humana* and *Kidde Industries*. Factors "such as 'hold harmless' agreements to unrelated insurers or anyone else" were not present. The Service conceded that "[n]o court, in addressing a captive insurance transaction, has fully accepted the economic family theory set forth in Rev. Rul. 77-316."⁷⁵ In addition, the taxpayer provided some support that it had a valid business reason for creating the captive.⁷⁶

In Revenue Ruling 2002-90,⁷⁷ a domestic holding company created a wholly-owned subsidiary to provide insurance coverage for 12 domestic operating subsidiaries that provided professional services. The operating subsidiaries provided the same "general categories of professional services." Each subsidiary operated on a decentralized basis in a separate state. None of the operating subsidiaries had coverage for less than 5 percent nor more than 15 percent of the total risks covered by the insurance subsidiary. In total the subsidiaries had "a significant volume of independent, homogeneous risks."⁷⁸

The insurance subsidiary was licensed in each of the 12 states in which the operating subsidiaries did business. The holding company pro-

74 March 12, 2001.

75 *Id.* at 3.

76 *Id.* at 5. Cf. TAM 200149003 (Aug. 6, 2001) in which a parent company created an insurance subsidiary to help meet the workers' compensation needs of certain operating subsidiaries when the workers' compensation market became volatile, the availability of coverage unpredictable, and premium costs inconsistent. The Service concluded that the insurance subsidiary qualified as an insurance company, reasoning that the insurance subsidiary assumed and distributed a "large number of homogeneous independent [workers' compensation] risks among its insureds." *Id.* at 7. It was created, "at least in part, [in response to] significant disruptions in the price to be paid to unrelated insurers for workers' compensation coverage" in its state. *Id.* It issued a separate policy to each of the operating subsidiaries. Furthermore, it was adequately capitalized and its "premium to surplus ratio was strong." *Id.* In addition, "there were no parental or related party guarantees (in any form) propping up" the insurance subsidiary. *Id.*

77 2002-2 C.B. 985, *amplifying* Rev. Rul. 2001-31, 2001-1 C.B. 1348. Rev. Rul. 2001-31 is addressed at notes 48-50 and accompanying text.

78 *Id.*

vided adequate capital to its insurance subsidiary but there was no parental guarantee and there were no related party guarantees. The insurance subsidiary loaned no funds to its parent or the operating subsidiaries.

The Service concluded that the insurance subsidiary provided insurance to the operating subsidiaries. It reasoned that the operating subsidiaries' professional liability risks were shifted to the insurance subsidiary. The premiums paid were arms-length and were "pooled such that a loss by one operating subsidiary [was] borne, in substantial part, by the premiums paid by others."⁷⁹ In addition, the insurance and operating subsidiaries "conduct[ed] themselves in all respects as would unrelated parties to a traditional insurance relationship, and [the insurance subsidiary] was regulated as an insurance company in each state where it did business."⁸⁰

(g) Impact of undercapitalizations, guarantees and other financial enhancements

In general—The capitalization of a captive or the use of a guarantee or other financial enhancements can influence whether a transaction is insurance. The Tax Court's conclusion in *Carnation*⁸¹ that the transaction between Carnation and its captive, Three Flowers, was not insurance was influenced by American Home's refusal to enter into the transaction without Carnation's agreement to capitalize Three Flowers with up to \$3 million.⁸²

In *Humana*, the Sixth Circuit indicated that the undercapitalization of the foreign captive combined with the capitalization agreement running to the captive in *Carnation*, the indemnification agreement in *Stearns-Roger*,⁸³ and the undercapitalization of the captive in *Beech Aircraft*,⁸⁴

79 *Id.* at 986.

80 *Id.* at 986.

81 71 T.C. 400 (1978), *aff'd*. 640 F.2d 1010 (9th Cir. 1981), *cert. denied* 454 U.S. 965 (1981).

82 71 T.C. at 409. *See* notes 55-56.

83 577 F.Supp. 833 (D.Colo. 1984), *aff'd*. 774 F.2d 414 (10th Cir. 1985).

84 797 F.2d 920 (10th Cir. 1986).

were sufficient factors to find a lack of risk-shifting.⁸⁵ The Sixth Circuit also addressed the impact of an undercapitalization and/or economic enhancements on the characterization of a captive insurance arrangement in *Malone & Hyde v. Commissioner*.⁸⁶

Malone & Hyde—Malone & Hyde, a company in the wholesale food business, obtained automobile, worker’s compensation, and general liability coverage for its divisions and subsidiaries from Northwestern National Insurance Company, an unrelated casualty insurer. Northwestern reinsured specified amounts of this coverage with Eastland Insurance, Ltd., a Bermuda captive, and a wholly owned subsidiary of Malone & Hyde. Eastland provided Northwestern with an irrevocable letter of credit of \$250,000 (later increased to \$600,000) to cover any unpaid amounts under the reinsurance agreement. Eastland did not reinsure any risks of unrelated parties during the years at issue. Malone & Hyde also entered into a hold-harmless agreement with Northwestern, which provided that Northwestern would be held harmless and defended with regard to any third-party claim that might arise if Eastland defaulted on its obligations as reinsurer.

Malone & Hyde argued that premiums paid to cover risks transferred from sister corporations were deductible under principles addressed in *Humana*. The Commissioner argued that the facts of *Malone & Hyde* were distinguishable from those of *Humana* because the transaction in *Malone & Hyde* included hold-harmless agreements and letters of credit. The Tax Court concluded that the agreements reflected “reasonable, cautious business practices in dealing with a new customer and a new reinsurer” and that Eastland was a valid insurance company. Eastland was adequately capitalized under Bermuda law. The insurance agreements with Northwestern and the reinsurance agreement with Eastland resulted from arms-length negotiations and were evidenced by written policies and endorsements. In addition, “Eastland operated as a separate and viable entity, financially capable of meeting its obligations. In sum, the arrangements among Malone & Hyde, its subsidiaries, Northwestern, and Eastland constituted insurance in the commonly accepted sense.”⁸⁷ The

⁸⁵ 881 F.2d at 254 nt. 2 (6th Cir. 1989). *See also* the Sixth Circuit’s opinion in *Malone & Hyde* at 62 F.3d at 841-842.

⁸⁶ 66 T.C.M. 1551 (1993), *rev’d*. 62 F.3d 835 (6th Cir. 1995).

⁸⁷ *Id.* at 1562.

Tax Court distinguished its holdings in *Carnation* and *Clougherty* stating that “[w]e found in *Carnation*, and further articulated in *Clougherty*, that the capitalization agreement was not a critical factor in the outcome of the case, but only one of several factors to be considered in determining whether or not the requisite risk shifting was present.”⁸⁸

The Sixth Circuit reversed the Tax Court’s decision, concluding that insurance was lacking because the ultimate risk remained with Malone & Hyde under the hold-harmless agreements.⁸⁹ It distinguished *Humana*, stating that Humana established the captive to address the loss of insurance coverage, a legitimate business concern, and its captive was not a sham. The captive was fully capitalized, domestically incorporated, established without any guarantees from its parent, and acted in a straightforward manner.⁹⁰ The court stated,⁹¹

[w]hen the entire scheme involves either undercapitalization or indemnification of the primary insurer by the taxpayer claiming the deduction, or both, these facts alone disqualify the premium payments from being treated as ordinary and necessary business expenses to the extent such payments are ceded by the primary insurer to the captive insurance subsidiary.

In *HCA*,⁹² the Tax Court applied the principles of *Malone & Hyde*⁹³ and concluded that risk shifting was absent with respect to workers compensation obligations covered by the captive as a reinsurer to the “extent and during the time” that HCA agreed to indemnify the primary insurer against nonperformance of the captive.⁹⁴ However, the impact of the indemnification agreement was not sufficient for the court to conclude that the transactions between the captive and its sister corporations were not

88 *Id.* at 1559.

89 62 F.3d at 843.

90 *Id.* at 842-843.

91 *Id.* at 842-843.

92 74 T.C.M. 1020 (1997), *aff’d. on another issue* 348 F.3d 136 (6th Cir. 2003), *cert. denied subnom. HCA & Subsidiaries v. Comr.* 543 U.S. 813 (2004).

93 66 T.C.M. 1551 (1993), *rev’d.* 62 F.3d 835 (6th Cir. 1995).

94 74 T.C.M. at 1039 nt. 13 (1997), *aff’d. on another issue* 348 F.3d 136 (6th Cir. 2003), *cert. denied subnom. HCA & Subsidiaries v. Comr.* 543 U.S. 813 (2004).

bona-fide. The court reasoned, in part, that the agreement only applied to one type of coverage, which was not the primary coverage provided by the captive.⁹⁵

In *Kidde*,⁹⁶ the Court of Federal Claims concluded that risk was not transferred to the captive before June 1, 1978 under a captive insurance arrangement (described in the section above). *Kidde* remained ultimately responsible for the underlying losses as a result of the impact of an indemnity agreement with the primary insurer, which was in effect while the parties worked out the details of the captive insurance agreement.

The court concluded that the indemnity agreement was not meant to be a long-term commitment because retaining the ultimate responsibility for the covered losses would be fundamentally inconsistent with the existence of a true insurance relationship. The court found that the agreement terminated as of May 31, 1978 because by that date the captive's assets and a letter of credit from a major U.S. bank were sufficient to ensure that the captive would be able to protect the primary insurer's interests.⁹⁷

Inadequate capitalization—The “insurance” subsidiary of the foreign parent of a domestic holding company covered pollution liabilities with respect to (1) manufacturing by five operating subsidiaries of the holding company and (2) certain real estate owned by the holding company and used by two of the holding company's operating subsidiaries in Technical Advice Memorandum 200323026.⁹⁸ The foreign parent, incorporated in Country R, created the insurance subsidiary under the laws of another foreign country, Country S.

The insurance subsidiary was capitalized with \$500x, although an independent consultant performed a feasibility study and recommended that the initial capitalization should be \$10,000x. Premiums for the first year totaled \$1000x, including \$620x from one of the subsidiaries. By June 30 of “Year 4” the shareholder's equity grew to \$2,822x.⁹⁹ The insurance subsidiary issued six policies, each of which covered liability of up to

95 *Id.* at 1039.

96 40 Fed.Cl. 42 (1997).

97 *Id.* at 58-59. *Kidde*, however, could deduct payments covering risks of its operating subsidiaries to the insurance subsidiary for the period after May 31, 1978. *Id.* at 67.

98 Feb. 7, 2003.

99 *Id.* at 8.

\$10,000x per pollution incident and an aggregate of up to \$10,000x. The amount of premiums varied considerably among the insureds. For the period July 1 of Year 3 to June 30 of Year 4, more than two thirds of the premiums were paid by Operating Subsidiary 3.

The Service concluded that insurance was not present because the captive was not adequately capitalized. The capitalization was only one-twentieth of the amount recommended in a feasibility study and liability on a single incident that equaled the \$10,000x per incident limit would far exceed the captive's equity, premium and investment income combined.¹⁰⁰

That the capitalization was sufficient to obtain a charter in Country S and to satisfy a "specific tax rule" of Country R were not sufficient to demonstrate that it was adequately capitalized for United States Federal income tax purposes. In contrast, the Service noted that although one potential insurance loss could substantially exceed the capitalization, many states "limit the amount of loss to which an insurer may be exposed on any one risk to ten percent of the insurer's surplus."¹⁰¹ The Service also concluded that sufficient risk distribution was lacking.¹⁰²

In addition, the Service concluded that the insurance arrangement among the parties was too informal. The policies for "Year 2" and "Year 3," for example, were not formally executed until "Year 4." The taxpayers "assert[ed] that there were oral contracts in the meantime."¹⁰³

(h) Coverage of other "related" entities

An individual, Fred Lennon, wholly owned Crawford Fitting, a manufacturer of valves and fittings, in *Crawford Fitting Company v. United States*.¹⁰⁴ He also owned at least 50 percent of four regional warehouses and held varying interests in other companies that provided services and/or parts to the manufacturers. Crawford, other manufacturers of valves and fittings, various companies that provided parts and services for the manufacturers and the regional warehouses obtained coverage from Con-

¹⁰⁰ *Id.* at 8.

¹⁰¹ *Id.*

¹⁰² The Service's reasoning is addressed at notes 16-20 and accompanying text.

¹⁰³ *Id.*

¹⁰⁴ 606 F.Supp. 136 (N.D. Ohio 1985).

stance, which was created under the Colorado Captive Insurance Company Act. Constance retained a specified portion of the covered risk and reinsured the remaining coverage with an unrelated reinsurer.

The warehouses owned 80 percent of Constance. Crawford employees and lawyers owned the remaining 20 percent. Members of Lennon's family held the interests in the warehouses that Lennon did not directly hold. Consequently, Lennon had a significant economic stake in both Crawford Fitting and Constance.

The government argued that the portion of Crawford's premium that was attributable to the retained coverage was a "reserve for self-insurance."¹⁰⁵ It asserted that the risk of loss remained in Crawford's economic group.¹⁰⁶

The District Court for the Northern District of Ohio, however, held that Crawford's premiums were deductible reasoning that Constance was "legitimately organized to enable Crawford to secure insurance at a reasonable price, without substantial limitations on the types and amounts of risk . . . in return for the payment of legitimate premiums."¹⁰⁷ Constance was adequately capitalized. Further, Crawford did not own stock in Constance or any of the warehouses that owned stock in Constance. The premiums were "actuarially based" and proportional to the risks covered.¹⁰⁸ Risk distribution was present because the insureds included numerous entities that were not affiliated with Crawford.¹⁰⁹ Crawford therefore shifted the risk of loss from its economic family to Constance and Constance distributed the risks of the insureds.¹¹⁰

(i) Coverage by an unrelated company

An arrangement in which an unrelated company assumes risks from only one company does not qualify as insurance. In Revenue Ruling 2005-40,¹¹¹ situation 1, a courier transport company that owned and operated

105 *Id.* at 141.

106 *Id.*

107 *Id.* at 145.

108 *Id.* at 147.

109 *Id.*

110 *Id.* at 148

111 2005-27 I.R.B. 4.

a fleet of vehicles paid a premium to an unrelated company to assume the risks of loss arising from the use of the vehicles in its business. The premium was an arms-length amount determined “according to customary insurance industry rating formulas” and the assuming company held enough capital to fulfill its obligations under the agreement.¹¹²

There were no guarantees nor loans of premiums back to the courier transport company. The courier transport company was not obligated to pay additional premiums if the actual risks exceeded the premiums paid and it was not entitled to a refund if the actual losses were less than the premiums paid in any period. The parties conducted themselves in a manner that was “consistent with the standards applicable to an insurance arrangement between unrelated parties,”¹¹³ except that the recipient of the premiums assumed risks only from the courier transport company. The Service concluded that the arrangement did not qualify as insurance reasoning that although the “arrangement may shift the risks of [the courier transport company], the risks [were] not distributed among other insureds or policyholders.”¹¹⁴

The facts were the same in situation 2, except that in addition to assuming the risks of the courier transport company the unrelated company assumed risks from another fleet owner that conducted a courier transport business. The second fleet owner was unrelated to the first. The amounts earned and risks transferred from the second fleet owner constituted 10 percent of the total earnings of and risks borne by the assuming company. The Service concluded that the arrangement between the original courier transport company and the assuming company did not qualify as insurance because there was an “insufficient pool of other premiums to distribute [the courier original transport company’s] risk.”¹¹⁵

In situation 3 the courier transport business was conducted through 12 wholly owned limited liability companies (LLCs). Each LLC transfers risks and pays a specified premium to an unrelated company. The premium paid by each LLC was an arms length amount determined “according to customary insurance industry rating formulas” and the assuming company held enough capital to fulfill its obligations under the agreement.

112 *Id.*

113 *Id.*

114 *Id.* at 5.

115 *Id.* at 5-6.

There were no guarantees nor loans of premiums back to a given LLC. The LLC would not be obligated to pay additional premiums if the actual risks exceeded the premiums paid and it was not entitled to a refund if the actual losses were less than the premiums paid in any period. The parties conducted themselves in a manner that was “consistent with the standards applicable to an insurance arrangement between unrelated parties,” except that the recipient of the premiums only assumed risks from the LLCs.

Each of the LLCs was a “disregarded entity” under regulation section 301.7701-3, and therefore treated as branches or divisions of the LLCs’ owner. The Service concluded that the arrangements did not qualify as insurance because it covered the risks of only one entity, the LLCs’ owner.¹¹⁶

In situation 4, each LLC elected to be treated as an association. The Service concluded that the arrangement between each LLC and the unrelated assuming company was insurance, because each LLC transferred risks to the assuming company and distributed the risks with those of the other LLCs.¹¹⁷

(j) Significant unrelated risks

Historic Background—In Revenue Ruling 88-72,¹¹⁸ a wholly owned subsidiary of the taxpayer insured risks of unrelated parties as well as risks of its parent and other affiliates. The coverage of the related risks represented a small fraction of its total insurance business. The Service ruled that the coverage of its parent’s and other affiliates’ risks did not qualify as insurance because the economic risk of loss had not shifted.¹¹⁹ The risk of loss did not shift because the parent continued to have an economic stake in whether it or the subsidiary incurred a loss. The parent and its subsidiaries therefore could not deduct premiums paid to their life insurance affiliate. The Service declared Revenue Ruling 88-72 obsolete

116 *Id. Cf.* situation 1 of the ruling in which all of the risks covered were from the courier transport company, which is addressed at notes 111-114 and accompanying text.

117 *Id.* at 6.

118 1988-2 C.B. 31, *clarified in* Rev. Rul. 89-61, 1989-1 C.B. 75, *declared obsolete in* Rev. Rul. 2001-31, 2001-1 C.B. 1348.

119 *Id.* at 32.

in Revenue Ruling 2001-31, in which the Service disavowed its “economic family theory.”¹²⁰

The Service’s position—The Service addresses two situations in which a wholly-owned subsidiary “insured” the professional liability risks of its parent, either directly or through reinsurance, as well as “homogeneous” similar risks of unrelated parties, in Revenue Ruling 2002-89.¹²¹ In each situation, the amounts that the parent pays its subsidiary “are established according to customary industry rating formulas. In all respects, the parties conduct themselves consistently with the standards applicable to an insurance arrangement between unrelated parties.”¹²² The subsidiary “may perform all necessary administrative tasks, or it may outsource those tasks at prevailing commercial market rates.”¹²³ In addition, the parent does not provide any guarantee regarding the subsidiary’s performance, the subsidiary does not make a loan to its parent, and all funds and records of the parent and subsidiary are maintained separately.

In situation 1, the premiums and risks assumed from the parent were 90 percent of the subsidiary’s total risks for its taxable year. The Service concluded that the arrangement in this situation was not insurance for Federal income tax purposes. The requisite risk shifting and distribution were not present because such a large portion of the premiums and risks were from the parent. The parent’s payments to its subsidiary therefore were not deductible as “insurance premiums” under section 162.¹²⁴

In situation 2, the premiums and risks assumed from the parent were less than 50 percent of the subsidiary’s total risks assumed for its taxable year. The Service concluded that the arrangement was insurance so that the parent’s payments to its subsidiary were deductible as insurance premiums under section 162.¹²⁵

120 2001-1 C.B. 1348, *amplified in* Rev. Ruls. 2002-89 and 2002-90. Rev. Rul. 2001-31 is addressed at notes 48-50 and accompanying text.

121 2002-2 C.B. 984.

122 *Id.*

123 *Id.*

124 *Id.* at 984-985.

125 *Id.* at 985.

Court pronouncements—The Tax Court concluded (in dicta) in *Gulf Oil*¹²⁶ that coverage of a company’s risks is insurance if an “insurance subsidiary” covers a sufficient amount of unrelated risks. It stated that premiums of an affiliated group,¹²⁷

will no longer cover anticipated losses of all of the insureds [if a sufficient proportion of premiums are paid by unrelated parties because] the members of the affiliated group must necessarily anticipate relying on the premiums of the unrelated insureds in the event that they are ‘the unfortunate few’ and suffer more than their proportionate share of anticipated losses.

Only two percent of the premiums paid to the insurance subsidiary in the years before the court in *Gulf Oil* were from unrelated insureds, which the Tax Court considered *de minimis*.¹²⁸ The Tax Court “declined” to indicate the amount of premiums for unrelated risks that would be sufficient for affiliated group premiums to qualify as insurance premiums. It stated, however, that “if at least 50 percent are unrelated, we cannot believe that sufficient risk would not be present.”¹²⁹

The Tax Court rejected the “economic family” theory espoused by the Service in Revenue Ruling 77-316. Although the economic family approach would have reached the same result that the Tax Court reached in the case before it, the Service’s approach “would have foreclosed a wholly owned captive from ever being considered a separate insurance company.”¹³⁰ The court stated that “[w]e specifically reserved any discussion of the tax consequences of payments to captives with unrelated owners and/or unrelated insureds.”¹³¹ Courts have respected arrangements in which the unrelated risks covered by captive insurers involved 52 to 74 percent

126 89 T.C. 1010 (1987), *aff’d*, 914 F.2d 396 (3rd Cir. 1990).

127 *Id.* at 1027.

128 *Id.* at 1027-1028.

129 *Id.* at 1027 nt. 13.

130 *Id.* at 1024. The Service stated that it would not follow the *Gulf* court’s rejection of the economic family concept in Rev. Rul. 88-72, 1988-2 C.B. 31, *clarified in* Rev. Rul. 89-61, 1989-1 C.B. 75. The Service, however, subsequently disavowed its economic family concept in Rev. Rul. 2001-31, 2001-1 C.B. 1348. *See notes* 48-50 and accompanying text.

131 89 T.C. at 1024-1025.

of the written insurance covered in *AMERCO v. Commissioner*,¹³² 29 to 33 percent in *The Harper Group v. Commissioner*,¹³³ and 44 to 66 percent in *Ocean Drilling & Exploration Co. v. United States*.¹³⁴

(k) Sears

Background—The Service argued in *Sears, Roebuck & Co. v. Commissioner*,¹³⁵ that the coverage of Sears’s risks by Allstate, a wholly owned subsidiary, did not qualify as insurance. This coverage represented less than one-percent of Allstate’s total business and the business was conducted in an arm’s length manner.¹³⁶

The Tax Court—The Tax Court indicated that whether a transaction qualifies as insurance depends on the underlying facts and circumstances. After applying the following three sets of factors the court concluded that Allstate’s coverage of Sears’s risks constituted insurance,

- (1) **Allstate covered claims that arose from insurance risks.** The court contrasted the coverage with arrangements involving investment risks. It focused on the “nature of the losses covered by the policies and the designated responsibility for payment of those losses.”¹³⁷ The impact on Sears’s “ultimate profit or loss from Allstate’s operations [was] not significant to the analysis of whether the contractual arrangements deal with insurance risks;”¹³⁸
- (2) **The policies shifted and distributed the risks.** The risks were shifted to Allstate, which “was a separate, viable entity, financially

132 979 F.2d at 164 (9th Cir. 1992).

133 979 F.2d at 1342 (9th Cir. 1992). *But compare* TAM 200323026 (Feb. 7, 2003) in which risk distribution was considered to be lacking where two-thirds of the total coverage was for one entity. *See* notes 16-20 and accompanying text.

134 988 F.2d 1135 at 1152-1153 (Fed. Cir. 1993).

135 96 T.C. 61 (1991), *aff’d. on this issue rev’d. in part* 972 F.2d 858 (7th Cir. 1992).

136 972 F.2d at 860.

137 96 T.C. at 100.

138 *Id.*

capable of meeting its obligations.”¹³⁹ In addition, Allstate was not formed or operated to self-insure Sears. The policies were sold under the same terms, and in the same context as sales to unrelated third parties. The court stated that risk distribution is the “spreading of loss among the participants in an insurance program.”¹⁴⁰ Such spreading arises from the pooling of risks among unrelated insureds, which “increases the reliability in establishing premiums and estimating appropriate reserves;”¹⁴¹ and,

- (3) **The transactions reflected commonly accepted notions of insurance.** The court concluded that the arrangement was characterized as insurance with regards to all non-tax purposes.¹⁴²

The Seventh Circuit—The Seventh Circuit affirmed the Tax Court’s holding that the transaction between Sears and Allstate qualified as insurance. However, instead of asking “ ‘[w]hat is the definition of insurance?[,]’ ” the court examined whether “there [was] adequate reason to recharacterize the transaction[.]”¹⁴³

The appellate court indicated that the Internal Revenue Code does not define insurance and that in *Le Gierse* the Supreme Court “mentions the combination of risk shifting and risk distribution.”¹⁴⁴ The court added, however, that it would be a “blunder to treat “a phrase in an opinion as if it were statutory language[.]”¹⁴⁵ The Supreme Court “was not writing a definition for all seasons and had no reason to, as the holding of *Le Gierse* is only that paying the ‘underwriter’ more than it promises to return in the event of a casualty is not insurance by any standard.”¹⁴⁶

The Seventh Circuit recognized that a loss incurred by Sears and covered by Allstate would have less financial impact on Sears than a loss

139 *Id.*

140 *Id.* at 101.

141 *Id.*

142 *Id.*

143 972 F.2d at 864

144 *Id.* at 861.

145 *Id.*

146 *Id.*

incurred Sears but covered by an independent insurer. However, the court questioned whether risk-shifting is necessarily a requisite of insurance. It reasoned, in part,¹⁴⁷

[i]f retrospectively rated policies, called ‘insurance’ by both issuers and regulators, are insurance for tax purposes—and the Commissioner’s lawyer conceded for purposes of this case that they are—then it is impossible to see how risk shifting can be a *sine qua non* of ‘insurance.’

Individuals and corporations pay premiums to insurers for different purposes, in the court’s view. Individuals acquire insurance coverage to protect their wealth and future income or to provide income replacement or a substitute for bequests to their heirs. Corporations, such as Sears, acquire insurance to spread the cost of casualties more evenly over time and to benefit from an insurance company’s expertise and ability to provide highly specialized insurance-related services. Corporations buy “loss-evaluation and loss-administration services, at which insurers have a comparative advantage, more than they buy loss distribution.”¹⁴⁸

The court was satisfied that the transaction had sufficient characteristics of insurance to preclude a recharacterization. It increased Allstate’s insurance pool, which reduced Allstate’s ratio of expected to actual losses. It allocated the administrative work on claims to Allstate employees, who had a “comparative advantage” at those tasks. The court stated that the transaction placed,¹⁴⁹

Sears’s risks in a larger pool, performing one of the standard insurance functions in a way that a captive does not. More: Allstate furnishes Sears with the same hedging and administration services it furnishes to all other customers. It establishes reserves, pays state taxes, participates

147 *Id.* at 862. The Seventh Circuit’s implicit view that a retrospectively rated policy cannot involve risk-shifting is flawed. The Service concluded that the retrospective rated arrangement in Revenue Ruling 83-66, 1983-1 C.B. 43, involved risk-shifting, for example. *See* notes 189-191 and accompanying text. Notwithstanding the court’s view regarding the significance of risk-shifting, Allstate clearly assumed risks that Sears transferred in the underlying transaction.

148 *Id.* at 862.

149 *Id.* at 863.

in state risk-sharing pools (for insolvent insurers), and so on, just as it would if Sears were an unrelated company.

Although Sears could deduct its premiums paid to Allstate because the underlying transaction qualified as insurance, the deduction was offset on Sears's consolidated return as premium income of Allstate. Significantly, however, Allstate could deduct reserves established when Sears incurred a covered loss because the coverage qualified as insurance. This tax treatment reflects the underlying economics because Allstate could deduct reserve increases that it had to establish when Sears incurred a loss covered by Allstate.

(I) Economic substance and arms length income allocations

In *United Parcel Service of America, Inc. v. Commissioner*,¹⁵⁰ the Tax Court concluded that a captive arrangement that UPS created to cover damage or loss to packages it collected and shipped for its customers was a sham. In the transaction, UPS was liable for the first \$100 of loss from damage or loss to packages it collected and shipped for its customers. A customer could purchase additional coverage from UPS by paying 25 cents per \$100 of additional liability.

UPS created and capitalized OPL, a Bermuda based captive, late in 1983. On December 31, 1983, UPS distributed shares of OPL to its shareholders, which were current and former employees as well as families, trusts and estates of former employees. The distributions were taxable dividends to the shareholders. UPS retained a small portion of the OPL shares.

UPS restructured its excess value charge program beginning 1984. It transferred excess value amounts, less claims paid in excess of \$100, each month to NUF, a wholly owned subsidiary of AIG and a domestic insurance company. NUF reinsured the EVC coverage with OPL. NUF retained a \$1 million fronting service fee for agreeing to reinsure the coverage to OPL.

UPS continued the functions and activities related to the EVC coverage and remained liable for the damage or loss of packages up to the lesser of \$100 or their declared value. UPS did not charge NUF or OPL for the extensive services that it provided with respect to the EVCs.

150 78 T.C.M. 262 (1999), *rev'd. and rem'd.* 254 F.3d 1014 (11th Cir. 2001).

UPS argued that it restructured the EVC arrangement for bona fide non-tax business considerations. UPS indicated that in 1983 it was concerned that continuing to receive the EVC income could be illegal under the insurance law of various states. The Tax Court, however, concluded that if UPS believed that it had to divest itself of a highly profitable business because of concerns that it was pursuing illegal activities it would have scrutinized the merit of its concerns more carefully than it did.¹⁵¹

The Tax Court examined the amount that UPS paid to transfer the coverage in the reinsurance because the lack of an arms length price is an indicator that an arrangement is a sham, according to the court. The court concluded that UPS did not pay an arms length amount because it could have obtained the coverage elsewhere for considerably less than it paid. It held that UPS earned the excess value charges it received from its customers for the excess value coverage and denied the deduction under section 162 for amounts paid to NUF. In addition, the court added interest, and imposed severe penalties.¹⁵²

The Eleventh Circuit reversed and remanded the Tax Court's decision.¹⁵³ The appellate court concluded that the EVC transfer had both economic effect and a business purpose. The arrangement had economic effect because there was a genuine insurance policy between UPS and National Union. The court stated that although "the odds of losing money on the policy were slim, National Union had assumed liability for the losses of UPS's excess-value shipper's, again a genuine obligation."¹⁵⁴ The reinsurance did not "completely foreclose the risk of loss because reinsurance treaties, like all agreements, are susceptible to default."¹⁵⁵

The court concluded that "altering the form of an existing, bona fide business" to do the job in a more tax effective way is a genuine business purpose. A business purpose is present if a taxpayer chooses among alternative ways to acquire capital and applies the most tax-effective manner, for example. In UPS, there was a "real business that served the genuine

151 *Id.* at 283.

152 *Id.* at 293, 294 and 295

153 254 F.3d 1014 (11th Cir. 2001).

154 *Id.* at 1018.

155 *Id.*

need for customers to enjoy loss coverage and for UPS to lower its liability exposure.”¹⁵⁶

The Eleventh Circuit remanded the case to the Tax Court to address the Service’s alternative argument that section 482 or 845 should apply to reallocate the amount of income (or other items) transferred to National Union to reflect an arms length transaction.¹⁵⁷

(m) Premiums paid to cover others’ risks

A company may pay premiums to a related insurer to cover other persons’ risks. In Revenue Ruling 92-93,¹⁵⁸ a manufacturer paid premiums to a subsidiary insurance company for group-term life insurance coverage for its employees. The Service concluded that the arrangement was not self-insurance because the manufacturer did not incur the underlying economic risk of loss.¹⁵⁹ The economic benefit was enjoyed by the employees, not the employer, which could not be the beneficiary under the contract. The arrangement, in effect, was a form of compensation for the taxpayer’s employees, who benefited from the life insurance coverage.¹⁶⁰ The Service ruled that similar principles would apply to the acquisition of accident and health insurance, including waiver of premium coverage upon disability that was provided by an employer for its employees.¹⁶¹

The Service applied similar principles in Revenue Ruling 92-94¹⁶² to a nonlife insurance company that “charges itself an amount representing premiums for its liability to pay insurance or annuity benefits for its employees.”¹⁶³ It held that the arrangement was not self-insurance because

156 *Id.* at 1020.

157 *Id.*

158 1992-2 C.B. 45.

159 *Id.*

160 *Id.* at 46. The deduction depended, in part, on the reasonableness of the aggregate compensation provided to the employees.

161 *Id.* at 46. The Service indicated that it would not follow the *Gulf* decision to the “extent that it denies a deduction for amounts a parent corporation pays to shift risks of unrelated employees and their beneficiaries to the parent’s wholly owned insurance subsidiary.” *Id.*

162 1992-2 C.B. 144.

163 *Id.* at 145.

it shifted employees' risks to an insurance company. The amount that the insurer charged itself represented additional gross premiums written.¹⁶⁴

(n) Insurance pools and “group captives”

Risk shifting and distribution may be present if an insurance company is owned by numerous unrelated companies and the insurer only covers members of that group. Indeed, in the extreme, a mutual insurer can be viewed as a group captive because the insurer provides coverage only for its owners. In Revenue Ruling 78-338,¹⁶⁵ the Service concluded that a foreign insurance company owned by 31 unrelated (shareholder) corporations qualified as an insurance company. No shareholder had a controlling interest in the company and no shareholder's individual coverage exceeded five percent of the total insured risks. The arrangement satisfied the risk shifting and distribution requirements because the shareholder-insureds were unrelated and the economic risk of loss could be distributed among the shareholders that comprised the insured group.¹⁶⁶

The Service applied the principles of Revenue Ruling 78-338 in Letter Ruling 9642028,¹⁶⁷ in which an assessable mutual insurance company was owned by 34 mutual funds and two foreign companies that operated in a “manner intended to qualify as a regulated investment company [under the Internal Revenue Code].”¹⁶⁸ Each fund was a money market fund that invested in short-term securities. Although each of the 36 funds was a “Name X” mutual fund, none of the funds was controlled by the parent company of the Name X consolidated group. No single investor directly or indirectly beneficially owned as much as one percent of the aggregate value of the stock of all of the funds.

The funds proposed to establish a mutual assessable insurance company to insure against default risks on the assets held by each of the funds. The insurer would cover losses on insurable assets arising from the non-payment of principal or interest, and other specified financial risks.

¹⁶⁴ *Id.* Cf. Treas. reg. section 1.809-4(a)(1)(i), which provides similar treatment for life insurers.

¹⁶⁵ 1978-2 C.B. 107.

¹⁶⁶ *Id.* at 108. The status of insurance pools as insurers and related tax issues are addressed at pages 68-70.

¹⁶⁷ March 20, 1996.

¹⁶⁸ *Id.*

The Service concluded, in effect, that the coverage can qualify as insurance and the premiums paid to the insurer may be deductible as insurance premiums, although the insurer had no owners other than the 36 funds. More funds transferred risks under the arrangement than the 31 corporations that transferred their risks in Revenue Ruling 78-338.

In Revenue Ruling 2002-91,¹⁶⁹ a group of unrelated businesses in an industry that faced significant liability hazards and were required by regulators to maintain adequate liability coverage could not obtain affordable insurance from commercial insurers as a result of significant losses from unusually severe loss events. The taxpayer and a significant number of other businesses in the industry formed a group captive to provide insurance liability coverage for certain risks.

The group captive provided coverage only for the taxpayer and other members. No member owned more than 15 percent of the group captive and no member held more than 15 percent of any corporate governance issue. The group captive was adequately capitalized and its operations were independent of the operations of each of its members.

The premiums that the group captive charged were determined using actuarial techniques and were based, in part, on commercial rates for similar coverage. The group captive pooled premiums from its members and no member had to pay additional premiums if its losses in any period exceeded the premiums that it paid. No member received a refund if its losses were lower than its premiums.

The Service concluded that the contracts issued by the group captive to each of the members, including the taxpayer, were insurance contracts because,

- each member faced true insurable hazards and was required to maintain general liability coverage to operate in its industry;
- each member was unable to obtain affordable insurance coverage from commercial insurers “due to the occurrence of unusually severe loss events;”
- there was a real possibility that a member could realize losses that exceeded the premiums that it paid and no member was reimbursed for premiums that exceeded its losses; and,
- the taxpayer and other members were unrelated.

169 2002-2 C.B. 991.

A professional corporation that employed 10 physicians and 15 registered nurses made non-assessable premium payments to a mutual insurance exchange, in Revenue Ruling 80-120.¹⁷⁰ The exchange was formed and qualified under state law to provide medical professional liability coverage to all physicians and medical professional corporations that were licensed to practice in the state and maintained at least 50 percent of their practice in the state. It insured more than 5000 physicians and several professional corporations. The Service ruled that the payments were deductible as premiums under section 162 because the company covered a sufficient number of policyholders, no one policyholder owned a controlling interest in the exchange, and the policies were non-assessable.¹⁷¹

(o) Further guidance requested

The Service indicated in Notice 2005-49¹⁷² that further guidance is needed, and requested comments, with respect to “the standards for determining whether an arrangement constitutes insurance” for Federal income tax purposes.¹⁷³ It stated,¹⁷⁴

[t]he Service and the Treasury Department are aware that further guidance is needed in this area and request comments on issues that should be addressed. In particular, comments are requested regarding (1) the factors to be taken into account in determining whether a cell captive arrangement constitutes insurance and, if so, the mechanics of any applicable federal tax elections; (2) circumstances under which the qualification of an arrangement between related parties as insurance may be affected by a loan back of amounts paid as “premiums;” (3) the relevance of homogeneity in determining whether risks are adequately distributed for an arrangement to qualify as insurance, and (4) federal income tax issues raised by transactions involving finite risk.

170 1980-1 C.B. 41.

171 *Id.* at 42.

172 2005-2 C.B. 14.

173 *Id.*

174 *Id.*

(p) Ruling requests

In Revenue Procedure 2002-75, the Service indicated that,¹⁷⁵

[w]e will now consider ruling requests regarding the proper tax treatment of a captive insurance company. However, some questions are arising in the context of a captive ruling request are so inherently factual (within the meaning of section 4.02(1) of Rev. Proc. 2002-3) that contact should be made with the appropriate Service function prior to the preparation of such request to determine whether the Service will issue the requested ruling. . . . Inquiries regarding whether the Service considers a proposed captive transaction so inherently factual that it cannot rule, should be directed to Chief, Branch 4, Office of the Associate Chief Counsel (Financial Institutions & Products) at (202) 622-3970 (not a toll-free call).

Part III: Characterization of Other Arrangements and Contracts**(a) Reciprocal flood insurance exchange arrangements**

A contract carrier corporation that hauled automobiles from an automobile assembly plant leased land on which it stored the autos and other equipment in Revenue Ruling 60-275.¹⁷⁶ The land was bound by a river and therefore exposed stored property and leasehold improvements to flood damage. Under an agreement with a “reciprocal flood insurance exchange,” the company and others subject to flood risk made annual payments for a specified period for flood insurance coverage. The company acquired \$150x of coverage underwritten over a ten-year period, of which \$15x (ten percent) became effective when the policy was issued and delivered. The company’s property subject to flood loss equaled \$500x.

The exchange credited one percent of the initial premium to its general reserve fund, which was used to cover certain administrative expenses and losses exceeding the catastrophe loss account. The remainder was

175 2002-2 C.B. 997.

176 1960-2 C.B. 43.

allocated to the catastrophe loss account. This account was charged with a pro-rata share of losses occurring during the year and for incurred reinsurance costs, for each subscriber. The company could withdraw amounts credited to its catastrophe loss account after the end of the current policy year, but could not withdraw amounts credited to the general reserve fund (although subscribers shared in the net balance of the general reserve fund, if any, if the exchange terminated).

Net earnings (determined after a fee to an attorney-in-fact), if any, were credited to subscribers' individual surplus accounts. A subscriber could elect to apply the unencumbered balance of its account to an annual premium deposit or withdraw it. Subscribers' risks were divided into classes or grouped in accordance with the nature of the business's flood hazard, location, and flood district. A subscriber's catastrophe loss account was decreased by a pro-rata share of the adjusted losses incurred by similarly classified subscribers.

The Service concluded that risk shifting was not present in the reciprocal flood insurance arrangement. A major flood would probably affect all properties in a particular flood basin so that there was little likelihood that the subscribers would share any risk.¹⁷⁷ Proceeds received in the event of flood damage would, in effect, be a return of the subscriber's own money because each subscriber was substantially underinsured.

The non-withdrawable one percent of the premium deposit that was credited to the general reserve fund was for a fixed liability, which was deductible as an insurance expense.¹⁷⁸ The Service ruled that an annual premium deposit to the exchange was a nondeductible contingent deposit to the extent that it was withdrawable by the company.¹⁷⁹ Earnings from the investment of the funds were taxable when they were credited to an annual premium deposit or became withdrawable.¹⁸⁰

¹⁷⁷ *Id.* at 45-46.

¹⁷⁸ *Id.* at 46.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

(b) Retroactive insurance

A casualty insurance company provided \$30x coverage to an insured in Revenue Ruling 89-96.¹⁸¹ The insured incurred a liability of an unascertained amount as a result of a catastrophe in June 1987 although the underlying facts indicated that the total liability would exceed \$130x. The insured subsequently paid \$50x to obtain \$100x of additional insurance, increasing the coverage for the catastrophe to \$130x. The insurer increased its unpaid losses by \$100x and deducted the (discounted) present value of the \$100x increase in coverage as losses incurred.

The Service ruled that the retroactive arrangement did not qualify as insurance. Risk-shifting was lacking because the catastrophe covered by the contract already occurred. The Service stated that establishing a loss for \$100x indicated that the insurer expected to have to pay the additional \$100x of coverage. The taxpayer incurred the risk that payments on the contract would be made earlier than expected and that the investment yield for the period from the date that the premium was received until the date the claim was paid would be less than expected, which are investment risks.¹⁸²

(c) Retrospective insurance

Many insurance policies provide for retrospective premium adjustments at the end of the coverage period. The Tax Court stated in *Sears*,¹⁸³

[t]he premium under a retrospectively rated policy is set using the loss data generated over the year in which the policy is in force. The retrospectively rated insured typically pays a deposit at the beginning of the year. At the end of the year, the insured receives a refund if loss experience has been favorable and may have to pay an additional premium if loss experience is unfavorable.

181 1989-2 C.B. 114.

182 *Id.* at 115. Compare the risk involved in *Le Gierse*, which is addressed at notes 7-9.

183 96 T.C. 61, 66-67 (1991), *aff'd.*, *in part*, *rev'd. in part* 972 F.2d 858 (7th Cir. 1992). *Sears* is addressed at notes 135-149 and accompanying text.

There are usually limits on the amount of the additional premium that must be paid.

Retrospective rating is designed, in part, to adjust after the fact for errors made in the estimation of the pure premium. In addition, large insureds need insurance protection primarily for large losses, rather than for small deviations of losses from expected losses. In a retrospective rated plan, risk loading compensates the insurance company for bearing losses greater than the upper limit or maximum of the plan.

A retrospectively rated arrangement should qualify as insurance, at least in part, if it transfers a sufficient amount of insurance risk that is distributed with risks of others and satisfies the other requirements of insurance. In Technical Advice Memorandum 8637003,¹⁸⁴ the Service bifurcated retrospective arrangements between a manufacturer and an unrelated insurer into insurance and noninsurance components. Under a retrospective endorsement for certain contracts, premiums for the contracts equaled the premium for insurance that was not retrospectively rated plus a retrospective premium. The size of the premiums was determined by a complex set of rules, based on administrative costs, profits as well as certain risks that the insurer assumed.

The retrospective premiums were determined six months after the coverage period and annually thereafter until all claims were satisfied or until the taxpayer and the insurance company agreed to a final retrospective premium.¹⁸⁵ One of the factors that influenced the retrospective premium after the first determination date was the actual loss payments made by the insurer.¹⁸⁶

The Service bifurcated the taxpayer's premium payments into a deductible insurance component and a non-deductible "reserve for losses" component. It indicated that, "no risk of loss [was] shifted or distributed by the taxpayer to the extent that the amount payable by taxpayer to the insurance company is based on the actual losses of taxpayer during the period covered by the arrangement"¹⁸⁷ so that the taxpayer could not deduct the component of premium payments based on such losses.¹⁸⁸

184 May 23, 1986.

185 *Id.* at 4.

186 *Id.*

187 *Id.* at 8.

188 *Id.* at 9.

The Service distinguished the retrospective rated contracts from retrospectively rated contracts addressed in Revenue Ruling 83-66,¹⁸⁹ in which a medical malpractice insurance policy provided a retrospective rate credit refund if the insurer's overall loss experience was not as great as it projected.¹⁹⁰ The retrospective credits in the 1983 ruling were based on the insurance company's experience whereas the amounts ultimately payable by the manufacturer in the technical advice were based, in part, on its own loss experience for its policy year.¹⁹¹

In *Sears*, the Seventh Circuit questioned whether risk shifting is necessary for a transaction to qualify as insurance, in part, because retrospective rated plans qualify as insurance. The court stated,¹⁹²

[i]f retrospective rated policies, called insurance by both insurers and regulators, are insurance for tax purposes—and the Commissioner's lawyer concedes for purposes of this case that they are—then it is impossible to see how risk shifting can be a *sine qua non* of insurance.

The Seventh Circuit's implicit position that a retrospective rated plan necessarily lacks risk-shifting is flawed. The Service concluded in Revenue Ruling 83-66¹⁹³ that the retrospective rated plan addressed in the ruling involved risk-shifting. The Service, however, may scrutinize arrangements, including retrospective rate plans, that do not appear to satisfy the requirements of insurance.¹⁹⁴ The Service may bifurcate a transaction that

189 1983-1 C.B. 43.

190 That the contracts qualified as insurance was one of the underlying facts of the ruling. The ruling addressed whether a policyholder could currently deduct the entire premium although a portion might be refunded. The Service ruled that it could, in part, because the "mere expectancy that a refund may be forthcoming . . . did not create an asset in the hands of the [policyholder]." *Id.* at 44-45.

191 TAM 8637003 (May 23, 1986) at 8.

192 972 F.2d 858 at 862 (7th Cir. 1978).

193 1983-1 C.B. 43.

194 A retrospective rated plan may be suspect if it appears to involve the transfer of little or no insurance risk. *Cf.* Notice 2005-49, 2005-27 I.R.B. 14, the Service indicated that more guidance is needed in transactions that involve the transfer of "finite risk." *Also compare* the tax treatment of "finite reinsurance" on pages 120-121.

includes an insurance component and a non-insurance component such as the transaction addressed in Technical Advice Memorandum 8637003.¹⁹⁵

(d) Bail and surety bonds

The Tax Court and Seventh Circuit held that bail bonds are not insurance contracts in *Allied Fidelity Corp. v. Commissioner*.¹⁹⁶ The Tax Court stated,¹⁹⁷

[i]n common understanding, an insurance contract is an agreement to protect the insured (or a third-party beneficiary) against a direct or indirect economic loss arising from a defined contingency. The insurer undertakes no present duty of performance but stands ready to assume the financial burden of any covered loss. In contrast, the principal obligation of the bail surety is to produce the defendant at trial.

The Service concluded in Revenue Ruling 68-101,¹⁹⁸ that bail bonds are not insurance contracts because they do not involve a monetary loss shifted and assumed by an accused or court.¹⁹⁹

Surety bonds, however, can qualify as insurance contracts. “A surety is one who has agreed (in writing) to answer for the debt, default, or miscarriage of another.”²⁰⁰ Surety bonds involve three parties. “The bond is the joint and several obligation of the *principal* and the *surety* in favor of the *obligee* named in the bond.”²⁰¹ The Service concluded that the surety bonds at issue in General Counsel Memorandum 39,154²⁰² qualified as insurance because the taxpayer, a surety, agreed to protect the obligee

195 May 23, 1986. TAM 8637003 is addressed at notes 184-191 and accompanying text.

196 66 T.C. 1068, 1074 (1976), *aff'd*. 572 F.2d 1190 (7th Cir. 1978).

197 66 T.C. at 1074 (citing Couch, *Insurance 2d.*, section 1.2 (1959)).

198 1968-1 C.B. 319.

199 *Id.* at 321.

200 See S. Huebner, K. Black, Jr., and B. Webb, *Property and Liability Insurance* (4th ed.) (1996) pg. 308.

201 *Id.*

202 March 1, 1984.

from the economic risk of loss arising from a default by the principal. The Service concluded that a risk of loss was present although the surety has a right of indemnity against a defaulting principal.

The Service distinguished the characterization of the surety bonds from that of the bail bonds in *Allied Fidelity*. It stated that the surety did not assume a duty to perform, but “stands ready to assume the financial burden of any covered loss.”²⁰³ A bail bond, however, involves the duty to produce a defendant at trial so that it resembles a contract to perform a service.²⁰⁴

(e) Warranty & extended service contracts

The Service addressed whether certain vehicle service agreements (VSAs) that provided coverage for the mechanical breakdown of certain new and used motor vehicles were insurance contracts or prepaid service contracts in Letter Ruling 200509005.²⁰⁵ A company proposed to issue contracts that would provide coverage that exceeded the amount provided by a manufacturer or a guarantee provided by a repairer. Salesmen at motor vehicle dealerships, acting as agents for the company, would sell the contracts, retain a portion of the sales price as a commission, and remit the remainder to the company.

The company paid fees to a third party administrator with expertise in adjudicating mechanical breakdown claims, and to a licensed insurance company that would indemnify purchasers of the vehicle service agreements if the company defaulted. The company allocated the remaining proceeds to a custodial account in its name as reserves, which were used to pay claims under the vehicle service agreements. The company did not manufacture, sell or service the motor vehicles covered by the agreements.

The Service concluded that the vehicle service agreements were insurance contracts. It stated,²⁰⁶

203 *Id.*

204 *Id.* The Tax Court quoted extensively from *Allied Fidelity*, 66 T.C. at 1074 (1976), *aff'd*, 572 F.2d 1190 (7th Cir. 1978).

205 Nov. 17, 2004.

206 *Id.* at 4. The Service also concluded that the company qualified as an insurance company. *See* pages 71-72.

[u]nlike prepaid service contracts, the VSAs are aleatory contracts under which Company, for a fixed price, is obligated to indemnify the purchaser of the VSA for economic loss not covered by warranties provided by a manufacturer, arising from the mechanical breakdown of, and repair expense to, a purchased motor vehicle. Thus, the VSAs are not prepaid service contracts because Company's liability is limited to indemnifying the VSA contractholder for losses in the event a mechanical breakdown occurs. Company does not provide any repair services itself. Further, by accepting a large number of risks, Company has distributed the risk of loss under the VSAs so as to make the average loss more predictable.

A company sold home warranty contracts under which it agreed to make specified repairs or replace covered systems and appliances for purchasers or sellers of previously-owned homes, in Technical Advice Memorandum 9416001.²⁰⁷ The company, which was unrelated to any builder or real estate company, did not directly repair or replace a failed system or appliance under the home warranty contracts. Repairs were made by a network of independent contractors and technicians. Upon each visit from a contractor or technician, the contractholder paid a "trade call fee" and the taxpayer paid any excess. The contracts were noncancellable and nonrefundable.

The Service concluded that the contracts qualified as insurance. The company assumed the contractholder's risk of loss from the failure of any covered system or appliance during the contract period and distributed the risk by accepting a large number of risks. The contracts therefore satisfied the risk shifting and distribution requirements of insurance.

The Service distinguished its holding in Revenue Ruling 68-27,²⁰⁸ in which it ruled that medical service contracts issued by a health maintenance organization that provided services directly to subscribers were not insurance contracts. The company in the technical advice did not provide services performed by its salaried employees but contracted with independent contractors and technicians.

²⁰⁷ June 17, 1993.

²⁰⁸ 1968-1 C.B. 315. This ruling is addressed at pages 70-71

In Letter Ruling 9727014²⁰⁹ the Service concluded that warranty supplements that covered repairs to a product after the manufacturer's warranty expired qualified as insurance contracts. The warranty supplements generally covered repairs made necessary by the failure of major systems or components of the product arising from defects in materials or workmanship but not from accidents or normal wear and tear.

Customers of the product could purchase the warranty supplement coverage from the taxpayer, which was the product's exclusive United States distributor. The selling dealer was the taxpayer's agent and the primary provider of repairs. Participating dealers collected premiums charged for the coverage and transmitted them, less a commission, to the taxpayer. The taxpayer was the sole obligor under the contracts.

The taxpayer proposed the creation of Newco1, whose sole or predominant business would be to issue and administer the warranty supplement program. It also proposed to create Newco2, which would provide indemnification coverage for Newco1.

The Service concluded that the warranty supplements qualified as insurance contracts. Risk shifting was present because Newco1 would be obligated to indemnify a contractholder for the economic loss arising from a failure under a covered system. In addition, the risk was distributed because Newco1 would accept numerous risks.

In contrast, Service officials concluded that "express limited warranties" that a manufacturer of consumer goods provided to consumers for its products did not qualify as insurance in ILM 200628018.²¹⁰ Under this type of warranty a "manufacturer/seller is obligated to repair or replace a defective product if the defect occurs during a specified period of time. The consumers bear no risk related to any defect in the product during the warranty period."²¹¹ Many manufacturers provide such warranties, at least in part, to satisfy legal requirements to provide products that are merchantable and fit for a given purpose.²¹²

The manufacturer "argued that the express limited warranties it provides to consumers should be considered insurance contracts purchased

209 April 2, 1997.

210 Feb. 13, 2006.

211 *Id.* at 3.

212 *Id.*

by the consumers when they buy [the manufacturers's] products.”²¹³ The Service officials, however, concluded that the risks covered by the warranties were business risks reflected in the price of its goods sold, not insurance risks.

“The limited express warranty covers the goods sold for defects that likely existed in the goods at the time of sale. [The manufacturer] does not separately sell this limited express warranty—the manufacturer’s limited express warranty cannot stand on its own.”²¹⁴ The Service officials reasoned in part that “[a] warranty that covers the goods sold for defects that likely existed in the goods at the time of sale is not insurance in the commonly accepted sense.”²¹⁵

Part IV: Commercial-Type Insurance: Section 501(m)

(a) Background

An organization described in section 501(c)(3) or 501(c)(4) can be tax-exempt “only if no substantial part of its activities consists of providing commercial-type insurance,” under section 501(m). When it enacted section 501(m) as part of the Tax Reform Act of 1986, Congress was concerned that certain tax-exempt organizations that provided types of insurance coverage that taxable insurance companies also provided benefited from an unfair tax-based competitive advantage. The Ways and Means Committee Report for the Tax Reform Act of 1986 stated that the committee was,²¹⁶

concerned that exempt charitable and social welfare organizations that engage in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax[-]exempt status is inappropriate. The committee believes that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations.

²¹³ *Id.* at 2.

²¹⁴ *Id.* at 4.

²¹⁵ *Id.*

²¹⁶ H.R. Rep. No. 426, 99th Cong. 1 Sess., pg. 664 (Dec. 7, 1985).

In Notice 2003-31,²¹⁷ the Service indicated that it intends to issue proposed regulations providing guidance under section 501(m).

A commercial-type insurance activity of an organization that remains tax-exempt because only an insubstantial part of its activities consist of providing commercial-type insurance is treated as an “unrelated trade or business” under section 501(m)(2)(A). Such organization is “treated as an insurance company for purposes of applying subchapter L with respect to such activity.”²¹⁸

Section 501(m)(3) provides certain exclusions from commercial-type insurance, including “incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations,” under section 501(m)(3)(B). This exclusion has been very controversial and is addressed in detail below.²¹⁹

(b) Insurance pools

The Tax Court, in *Florida Hospital Trust Fund, et. al. v. Commissioner*²²⁰ and *Paratransit Ins. Corp. v. Commissioner*,²²¹ and the United States Court of Federal Claims, in *Nonprofits' Insurance Alliance of California v. United States*,²²² addressed whether insurance pools provided commercial-type insurance, and therefore were not tax-exempt entities under section 501(m). The courts examined whether the type of coverage provided by the pools was provided by for-profit commercial insurers, and whether the pools were subject to one of the exceptions to section 501(m). The courts concluded that each of the insurance pools provided commercial-type insurance and therefore were not tax-exempt.²²³

217 2003-1 C.B. 948.

218 Section 501(m)(2)(B). For an example of an activity that, in the Service's view, is taxed under subchapter L as a result of section 501(m)(2) see notes 247-248 and accompanying text.

219 See notes 224-252 and accompanying text.

220 103 T.C. 140 (1994), *aff'd*. 71 F.3d 808 (11th Cir. 1996).

221 102 T.C. 745 (1994)

222 32 Fed.Cl. 277 (1994).

223 These cases are examined in E. Burstein, “Insurance Pools Provide Commercial-Type Insurance in Recent Cases,” 9 *Insurance Tax Review* 359 (March 1995).

(c) Incidental health insurance provided by an HMO

Background—An individual who pays a fixed fee to a Health Maintenance Organization (HMO) obtains health insurance coverage as well as access to health care. The Service stated in Technical Advice Memorandum 200033046,²²⁴

[w]hen individuals enroll in an HMO and directly or indirectly pay the HMO fixed premiums, the HMO agrees that it will furnish health care services to treat their injuries and illnesses. Under this arrangement, enrollees protect themselves against the risk that they would suffer economic loss from having to pay for health care services that are necessary because of injuries and illnesses. By enrolling in an HMO, individuals shift their risk of economic loss to the HMO.

Commercial-type insurance does not include “incidental health insurance provided by an [HMO] of a kind customarily provided by such organizations,” under section 501(m)(3)(B).²²⁵ That is, an HMO that is described in section 501(c)(3) or 501(c)(4) does not lose its tax-exempt status under section 501(m) if providing health care is its principal activity and the health insurance that it provides is incidental to such principal activity.

In Notice 2003-31,²²⁶ the Service indicated that it seeks comments regarding the exception for incidental health insurance provided by HMOs under section 501(m)(3)(B), specifically requesting, *inter alia*, comments on,²²⁷

what factors or criteria the Service should consider in determining whether a health maintenance organization’s ‘principal activity’ is providing health care[,] the factors or criteria the Service should consider in determining whether the health insurance a health maintenance organization provides is ‘incidental to the organization’s

224 TAM 200033046 (April 27, 2000) at 5.

225 Section 501(m)(3)(B).

226 2003-1 C.B. 948.

227 *Id.*

principal activity of providing health care' [and] how this exception should be applied to a health maintenance organization that does not provide 'health care to its members predominantly at its own facility through the use of health care professionals and other workers employed by the organization.'

When does an HMO provide incidental health insurance?—

Whether an HMO is considered to provide incidental health insurance depends on the underlying facts and circumstances. The Service stated that to conclude that the HMO is providing incidental health insurance it,²²⁸

must be satisfied on the basis of all the facts and circumstances that any insurance element is a necessary and normal consequence of the HMO's principal activity [of providing health care services]. In many cases, this inquiry will be subsumed within the analysis of whether the insurance aspects of the HMO's activities predominate.

The Service addressed the relevant factors in General Counsel Memorandum 39,829²²⁹ and Technical Advice Memorandum 200033046.²³⁰ In General Counsel Memorandum 39,829, the Service concluded that Congress applied the word "incidental" primarily in its qualitative sense,²³¹ indicating that language in the legislative history of the Tax Reform Act of 1986 supports this view. The Ways and Means Committee Report stated that commercial-type insurance excludes "health insurance provided by a health maintenance organization that is customarily provided by such organization and is incidental to the organization's principal activity of providing health care."²³²

In the Service's view, the primary factor that supports a conclusion that an HMO qualifies for the incidental health insurance exception is whether the HMO transfers all or a substantial amount of its financial risk

228 *Id.* at 23.

229 August 24, 1990.

230 April 27, 2000.

231 G.C.M. 39,829 (Aug. 24, 1990) at 22.

232 H.R. Rep. 426, 99th Cong. 1st Sess., pg. 665 (Dec. 7, 1985).

for “excessive utilization” of health care services to health care providers. The “best example of an HMO providing only incidental insurance would be one which has transferred substantially all of the risk to providers or that has fixed the costs in providing care.”²³³ Consequently, HMOs that qualify under section 501(m)(3)(B) include,²³⁴

an HMO operating under one of the common existing models that (1) compensates primary care physicians exclusively on a salary, capitation, or other fixed-fee basis, and (2) shifts to those physicians (or to HMO-affiliated specialists and hospitals) substantially all of the risk of excess utilization of specialists and hospitals, principally provides health care and provides only incidental health insurance.

The Service also concluded that,²³⁵

absent unusual facts^[236], an HMO operating on one of the common, existing models that compensates primary care physicians exclusively on a salary, capitation or other fixed-fee basis principally provides health care and provides only incidental health insurance, even though the HMO pays other providers on a fee-for-service basis. . . . Other HMOs must be evaluated against the above standard on the totality of their facts and circumstances.

Other factors can influence whether an HMO qualifies under section 501(m)(3)(B), such as the withholding of a significant portion of fees “otherwise payable” to providers. In Technical Advice Memorandum 200033046²³⁷ the Service stated that,²³⁸

233 G.C.M. 39,829 (Aug. 24, 1990) at 22.

234 *Id.* at 23.

235 *Id.* at 24.

236 Unusual facts include cases in which “providing or arranging for the provision of primary care is not a significant part of the HMO’s activities, or the HMO does not use a gatekeeper approach.” *Id.* at 24 nt. 24.

237 April 27, 2000.

238 *Id.* at 6.

an HMO that pays its contracted health care providers almost exclusively fees-for-service under a fee schedule that represents a meaningful discount from the physicians' usual and customary charges (discounted fee-for-service) and withholds from these payments a significant percent of these fees otherwise payable, pending compliance with periodic budget or utilization standards, transfers to these providers, in effect, a substantial portion of the financial risk associated with its obligation to furnish health care to its enrollees.

An HMO does not transfer a financial risk to health care providers by paying discounted fees if there is no withhold, however. The Service stated that accepting discounted fees in return for being assured of having a flow patients is a common commercial practice for service providers.²³⁹

Applying these standards—The Service concluded that an IPA-model HMO retained its tax-exempt status after the effective date of section 501(m) in General Counsel Memorandum 39,829.²⁴⁰ The HMO arranged for the health care of subscribers by contracting with physicians who practiced independently and paid them on a capitated basis. It also paid about half its direct costs to hospitals on a fee-for-service basis, which resembled payments by a commercial insurer for hospitalization coverage.

The Service reasoned that the HMO “was organized and operated as a traditional IPA-model HMO that arranged for the provision of care to its subscribers by contracting with selected physicians who practice independently.”²⁴¹ It shifted its “risk associated with the demand for all physician services . . . to the providers.” Providing the health insurance, including the hospital benefits was “qualitatively incidental” to the HMO’s principal activity of providing or arranging for the provision of services,²⁴² although about half of its payments were for hospitalization provided in a manner that resembled hospitalization provided by commercial insurance

239 *Id.*

240 August 24, 1990.

241 *Id.* at 24.

242 *Id.*

companies.²⁴³ “[H]ow an HMO pays its primary care physicians ordinarily is entitled to greater weight than how it pays out of area (emergency) providers, referral specialists, or hospitals.”²⁴⁴

In Tax Advice Memorandum 200033046,²⁴⁵ an IPA model HMO described in section 501(c)(4) offered two medical plans to subscribers. Under plan A subscribers could use only in-network primary care physicians or physicians authorized by an in-network primary care physician (except for emergencies). Physicians were compensated on a capitated basis. The Service concluded that commercial-type insurance was not present because a substantial amount of the financial risk was transferred to the primary care physician.²⁴⁶

Plan B included a point-of-service option. Subscribers could use any physician including an out-of-network physician. The Service concluded that insurance was present under plan B because “the physicians are on a fee-for-service basis while [the HMO] retains [the] financial risk to furnish medical services.”²⁴⁷ Plan B, however, represented an insubstantial part of the HMO’s total activities. Consequently, although the provision of services under plan B was commercial-type insurance, it was an insubstantial part of the HMO’s activities so that it was subject to unrelated business income tax, which was calculated under subchapter L.²⁴⁸

Impact of Rush Prudential—The Service may have to reconsider its views regarding the impact of a transfer of substantial risks to providers on the tax treatment of HMOs under section 501(m) in response to the Supreme Court’s 2002 decision in *Rush Prudential HMO, Inc. v. Moran*.²⁴⁹ Rush, an HMO, denied Moran’s request to cover the cost of a medical procedure that Rush considered to be unnecessary. Moran responded by making a written demand for an independent medical review of her claim under the Illinois HMO Act. Rush refused the review, and argued that

²⁴³ *Id.* at 25.

²⁴⁴ *Id.*

²⁴⁵ April 27, 2000.

²⁴⁶ *Id.* at 7.

²⁴⁷ *Id.*

²⁴⁸ Section 501(m)(2).

²⁴⁹ 536 U.S. 355 (2002).

Moran's state law suit to compel compliance with the Illinois HMO Act was preempted by ERISA.

The Supreme Court affirmed the Seventh Circuit's decision that the Illinois HMO law was not preempted by ERISA.²⁵⁰ While ERISA "broadly" preempted state laws related to employee benefit plans, state laws that "regulat[e] insurance" are not preempted. The Court reasoned, in part, that HMOs are insurers in addition to service providers. It disagreed with Rush's argument that "an HMO is no longer an insurer when it arranges to limit its exposure, as when an HMO arranges for capitated contracts to compensate its affiliated physicians with a set fee for each HMO patient regardless of the treatment provided."²⁵¹

The Court, in effect, viewed an HMO in this type of arrangement as the primary insurer in a reinsurance arrangement and indicated that "a reinsurance contract does not take the primary insurer out of the insurance business[.]"²⁵² *Rush* disavows the distinction that the Service stresses in determining whether an HMO is providing incidental insurance under section 501(m) (3) (B) (although the dispute in *Rush* does not involve the treatment of HMOs under section 501(m)).

(d) Other exceptions

Commercial-type insurance under section 501(m) does not include the provision of insurance provided at substantially below cost to a class of charitable recipients under section 501(m) (3) (A). Other exceptions include,

- property/casualty coverage and/or retirement or welfare benefits provided by a church or church association for such church or church association;²⁵³
- charitable gift annuities.²⁵⁴

250 *Id.* at 387.

251 *Id.* at 371.

252 *Id.*

253 Sections 501(m) (3) (C) and 501(m) (3) (D).

254 Section 501(m) (3) (E).

Congress narrowed the scope of section 501(m) by adding section 501(n) as part of the Small Business Job Protection Act of 1996.²⁵⁵ Section 501(m) does not apply to qualified charitable risk pools under section 501(n) (1) (A). A charitable risk pool must,

- be organized and operated solely to pool insurable risks of its members (other than risks related to medical malpractice) and to provide information to its members regarding risk management and control;
- consist exclusively of members that are tax-exempt organizations described in section 501(c) (3);
- be organized as a non-profit organization under state law and exempt from state income tax;
- obtain at least \$1,000,000 in startup capital from non-member charitable organizations;
- be controlled by a board of directors elected by its members and provide in organizational documents that members must be tax-exempt and satisfy other rules.

Congress added section 501(n) because it “believed that providing tax-exempt status to not-for-profit risk pools whose members are exclusively tax-exempt charitable organizations, and which obtain significant capital from nonmember charitable organizations, helps make liability insurance more affordable to charitable organizations.”²⁵⁶

255 Pub. L. 104-188, section 1114(a), 110 Stat. 1755, 1759-1760 (Aug. 20, 1996).

256 Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 104th Congress*, pg. 69 (JCS-12-6), Dec. 18, 1996.