INTERNAL REVENUE SERVICE
NATIONAL OFFICE TECHNICAL ADVICE MEMORANDUM

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CASE-MIS No.: TAM-129839-10

Acting Director, Field Operations

Taxpayer's Name:
Taxpayer's Address:

Taxpayer's Identification No
Year(s) Involved:
Date of Conference:

LEGEND:

Taxpayer =

State A =

Year 1 =

Year 2 =

Year 3 =

This memorandum responds to your request for technical advice dated July 21, 2010.

ISSUE:

Whether for the taxable years Year 2 and Year 3, Taxpayer is subject to the provisions of Part II of Subchapter L of the Internal Revenue Code and thereby taxable as an insurance company for federal income tax purposes.

CONCLUSION(S):

For the years at issue, Taxpayer is subject to the provisions of Part II of Subchapter L of the Internal Revenue Code and thereby taxable as an insurance company for federal income tax purposes.

FACTS:

Taxpayer is a managed health care organization that began operations in May of Year 1. Taxpayer is owned by four health care associations. Taxpayer is licensed in State A as a Health Maintenance Organization ("HMO") and is considered a "Network-Model" HMO. Taxpayer is regulated by State A pursuant to the relevant State A statutory provisions and files an Annual Statement as required by the National Association of Insurance Commissioners (NAIC). The Taxpayer is also subject to periodic examination of its operations by State A's Department of Insurance.

Taxpayer does not directly provide health care to its subscriber members, rather Taxpayer contracts with networks that in turn arrange for the provision of health care services through participating health care providers. Taxpayer's subscribers are both small and large employers, including primary care physicians from a broad network of Physician Hospital Organizations.

Taxpayer has three lines of business and maintains a variety of managed care options among the three lines. The majority of Taxpayer's premium income is derived from its comprehensive hospital and medical line of business. The remaining premium income consists of other unrelated coverage.

Taxpayer offers both HMO benefit and point-of-service benefit plans to its subscriber members. Taxpayer's HMO benefit plan is the most popular health insurance option. The HMO benefit plan allows members and their dependents to choose their own primary care physician, pay a predictable copayment or coinsurance for in-network services, seek in-network specialists without a primary care referral, enroll in certain wellness programs, and benefit from disease and complex case management at no additional cost. In addition, primary care physicians are available to assist members in navigating the health care system. Employers are also able to actively participate in plan design under the Taxpayer's HMO benefit plan.

The Taxpayer's point-of-service benefit plan offers employers and their employees the flexibility of a traditional insurance plan, but with the cost containment feature of a managed care plan. Taxpayer's benefit plan allows members to choose primary care physicians, receive full in-network benefits, including in-network benefits for copayment and coinsurance, and seek in-network primary care physician's assistance in navigating the health care system. Members can see most in-network specialists without a primary

care physician's referral. Members are allowed to access out-of-network providers without a referral, but must pay higher out-of-pocket expenses.

Taxpayer also offers an alternative to their classic HMO and point-of-service plans that includes features of both. Under the alternative plan, members can select either the higher premium preferred provider program or at no additional cost, the HMO network. Members can see most in-network specialists without a primary care physician referral, enroll in certain wellness programs, receive assistance in navigating the healthcare system and receive disease management and complex case management. Health plan benefits under the alternative plan are the same regardless of which network option is chosen. Members and their dependents must select the same network. Employers can actively engage in benefit plan design.

Subscriber groups are most commonly employers and consist of an organization, firm or governmental entity that has contracted with Taxpayer to arrange health care services for its employees, retirees, their spouses and dependents. Subscriber members are most commonly employees and consist of an individual who meets the eligibility requirements for membership in one of Taxpayer's health care plans.

Taxpayer and each employer or subscriber group enter into a subscriber group service contract agreement. This agreement between Taxpayer and the respective employer or subscriber group expresses the agreed upon contractual rights and obligations of all parties involved and describes the costs, procedures, conditions, eligibility, enrollment, covered services, limitations, exclusions and other obligations to which subscriber members are subject under Taxpayer's plans. In exchange for health care services provided under the selected managed care options, Taxpayer received premium income from the subscriber group as provided for by the group service contract agreement. The premium is calculated based upon factors such as the type of benefit plan selected, the age of the member and the number of members enrolled in the plan.

Networks consist of licensed physicians and other healthcare professionals, hospitals, skilled nursing facilities, home health care agencies and other providers of health care services. The networks enter into written agreements with Taxpayer to provide health care services to members of subscriber groups. Taxpayer publishes a "provider directory" containing the names, addresses and phone numbers of all participating providers. Taxpayer does not contract directly with the participating providers. Under these agreements, sometimes referred to as physician network agreements, Taxpayer compensates the network on a monthly basis for the provision of health care services to its members by its health care professionals on a or per person rate. Generally, this is a fixed fee arrangement provided for in the agreement between Taxpayer and the network.

LAW AND ANALYSIS:

I.R.C. § 831(c) provides that the term "insurance company" has the same meaning given to such term by I.R.C. § 816(a). Under I.R.C. § 816(a), the term "insurance company" means "any 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." The determination of whether an arrangement constitutes insurance is made on a yearly basis and thus, each year must be considered independently. See I.R.C. § 816(a); Cardinal Life Insurance Co. v. United States, 300 F.Supp 387, 392 (N.D. Tex. 1968), rev'd on other grounds, 425 F.2d 1328 (5th Cir. 1970).

Neither the Code nor the regulations define the terms "insurance" or "insurance contract." The standard for evaluating whether an arrangement constitutes insurance is set forth in Helvering v. LeGierse, 312 U.S. 531, 539 (1941), in which the Court stated that "historically and commonly insurance involves risk-shifting and risk-distributing" in a transaction "which involve[s] an actual 'insurance risk' at the time the transaction was executed." Insurance has been described as "involv[ing] a contract, whereby, for adequate consideration, one party agrees to indemnify another against loss arising from certain specified contingencies or perils." Epmeir v. United States, 199 F.2d 508, 509-10 (7th Cir. 1952). Insurance is contractual security against possible anticipated loss. Id. Cases analyzing "captive insurance" arrangements have distilled the concept of "insurance" for federal income tax purposes to three elements, applied consistently with principles of federal income taxation: (1) involvement of an insurance risk; (2) shifting and distribution of that risk; and (3) insurance in its commonly accepted sense. See, e.g., AMERCO, Inc. v. Commissioner, 979 F.2d 162, 164-65 (9th Cir. 1992), aff'g 96 T.C. 18 (1991).

The risk transferred must be risk of economic loss. Allied Fidelity Corp. v. Commissioner, 572 F.2d 1190, 1193 (7th Cir. 1978). The risk must contemplate the fortuitous occurrence of a stated contingency, Commissioner v. Treganowan, 183 F.2d 288, 290-91 (2d Cir. 1950), and must not be merely an investment or business risk. LeGierse, 312 U.S. at 542; Rev. Rul. 89-96, 1989-2 C.B. 114.

Risk shifting occurs if a person facing the possibility of an economic loss transfers some or all of the financial consequences of the potential loss to the insurer, such that a loss by the insured does not affect the insured because the loss is offset by a payment from the insurer. See Rev. Rul. 60-275, 1960-2 C.B. 43 (concluding risk shifting not present where subscribers, all subject to the same flood risk, agreed to coverage under a reciprocal flood insurance exchange); see also Clougherty Packing Co. v. Commissioner, 811 F.2d 1297, 1300 (9th Cir. 1987) (holding risk shifting not present where captive covered only related-party risk).

Risk distribution incorporates the statistical phenomenon known as the law of large numbers. The concept of risk distribution "emphasizes the pooling aspect of insurance: that it is the nature of an insurance contract to be part of a larger collection of coverages, combined to distribute risks between insureds." AMERCO and Subsidiaries v. Commissioner, 96 T.C. 18, 41 (1991), aff'd 979 F.2d 162 (9th Cir. 1992). In Treganowan, the court explained that "[b]y diffusing the risks through a mass of separate risk shifting contracts, the insurer casts his lot with the law of averages. The process of risk distribution, therefore, is the very essence of insurance." Treganowan, 183 F.2d at 291 (quoting Note, The New York Stock Exchange Gratuity Fund: Insurance That Isn't Insurance, 59 Yale L.J. 780, 784 (1950)); see also Beech Aircraft Corp. v. United States, 797 F.2d 920, 922 (10th Cir. 1986), (stating risk distribution "means that the party assuming the risk distributes his potential liability, in part, among others"); Ocean Drilling & Exploration Co. v. United States, 988 F.2d 1135, 1153 (Fed. Cir. 1993) (stating "[r]isk distribution involves spreading the risk of loss among policyholders").

Distributing risk allows the insurer to reduce the possibility that a single costly claim will exceed the amount taken in as premiums and set aside for the payment of such a claim. By assuming numerous relatively small, independent risks that occur over time, the insurer smoothes out losses to match more closely its receipt of premiums. Clougherty Packing Co. v. Commissioner, 811 F.2d at 1300. Risk distribution necessarily entails a pooling of premiums, so that a potential insured is not in significant part paying for its own risks. See Humana, Inc. v. Commissioner, 881 F.2d 247, 257 (6th Cir. 1989); see also Steere Tank Lines, Inc. v. United States, 577 F. 2d 279 (5th Cir. 1978) (holding in part that because Plaintiff paid all the "premiums," there was no genuine pooling of premiums). In Perano v. Commissioner, 130 T.C. 93 (2008), the court held that there was no risk distribution among a broad number of individuals where the risk was spread between two individuals.

In Rush Prudential HMO, Inc. v. Moran, the Supreme Court of the United States ruled that the federal Employee Retirement Income Security Act (ERISA) did not preempt an Illinois statute for medical review. 536 U.S. 355 (2002). In its discussion, the Court concludes that HMOs are insurers that provide health care. Id. at 367.

"'The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed.'" Thus, the HMO "'assumes the financial risk of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment….'" Id. The designs of HMOs are far more broad than the "simple truism that all contracts are, in some sense, insurance against future fluctuations in price" primarily because "HMOs actually underwrite and spread risk among their participants[,]" a feature distinctive to insurance and insurance companies. See id.; see also SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65, 73 (1959).

The Court points out that Congress in establishing and defining the phrase "Health Maintenance Organization," intended that HMOs should develop as a novel type of health care delivery system – one that would "bear and manage risk." Rush Prudential, 536 U.S. at 368. In fact, HMOs have taken over much of the business formerly performed by traditional indemnity insurers and most every HMO is regulated as an insurer under state law. See id. at 368-69, 372. As the Rush Prudential Court notes, HMOs have "'grown explosively in the past decade and [are] now the dominant form of health plan coverage for privately insured individuals.'" Id. at 369 (citing GOLD & HURLEY, THE ROLE OF MANAGED CARE "PRODUCTS" IN MANAGED CARE "PLANS," IN CONTEMPORARY MANAGED CARE 47 (M. Gold ed., Health Administration Press 1998).

An HMO does not cease to be 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." Id. at 371. Such capitation contracts "do not relieve the HMO of its obligations to the beneficiary" – accordingly, the "HMO is still bound to provide medical care to its members, and this is so regardless of the ability of physicians or third party insurers to honor their contracts with the HMO." Id. These capitation arrangements are comparable to reinsurance contracts and as such do not take the primary insurer out of the insurance business. In other words, an insurance company does not cease to be subject to risk when it reinsures its business, unless the insured relieves the primary insurer of the risk under an assumption reinsurance contract. It follows that, the elements of health care and insurance inherent in an HMO are inextricably bound such that an HMO cannot "checkmate common sense" by trying to submerge the insurance features beneath an exclusive characterization of the HMO as a provider of health care services. See id. at 370.

The elements of risk shifting and risk distribution are present in the instant case. In exchange for payment of premium, members of the various subscriber groups shift their risk of economic loss to Taxpayer. The members are numerous such that risk distribution is accomplished. The contracts at issue qualify as insurance under the commonly accepted definition of insurance. The fact that Taxpayer pays its provider network on a capitated basis does not shift the risk from Taxpayer to the provider network. Absent a legitimate assumption reinsurance agreement, Taxpayer remains the party responsible to the members of the subscriber group for the provision of health care services in the form of insurance.

The majority of Taxpayer's business is related to its comprehensive hospital and medical line of business for which it contracts with the various network providers under capitation agreements. We have concluded that these arrangements qualify as arrangements of insurance for federal income tax purposes. Therefore, because the majority of Taxpayer's business is related to these arrangements, Taxpayer is subject to the taxing provisions of Subchapter L of the Code and should file as an insurance

company for federal income tax purposes. See I.R.C. §§ 831(c) and 816(a); see also Cardinal Life Insurance Co., 300 F.Supp at 392.

CAVEAT(S):

A copy of this technical advice memorandum is to be given to the taxpayer(s). Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.