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REV. RUL. 2014-15:
THE REQUIREMENT OF RISK DISTRIBUTION, THE LAW OF UNINTENDED CONSEQUENCES, AND NEW QUESTIONS TO CONSIDER IN FUNDING RETIREE HEALTH BENEFITS

By Terrance F. Richardson and Mark S. Smith

In Rev. Rul. 2014-15,[1] the Internal Revenue Service and Treasury provided both certainty on the use of a captive insurance company to fund retiree health benefits, and a lesson in the law of unintended consequences. Many questions remain, however, for taxpayers who enter into structures similar to that in the ruling.

THE RULING AND ITS ANALYSIS

The facts of the ruling are straightforward and not uncommon. X, a publicly-traded domestic corporation, maintains a single-employer voluntary employees' beneficiary association (a VEBA). X made a contribution to the VEBA to fund health benefits for a large group of named retired employees and their dependents. X deducted the contribution to the extent permitted under sections 419 and 419A of the Internal Revenue Code. As an alternative to self-insuring the benefits, the VEBA entered into a noncancellable accident and health insurance contract with IC, an unrelated commercial insurance company.[2] Neither X nor the VEBA has any legal obligation to provide health benefits to the covered retirees and their dependents; in fact, both may cancel any provided coverage at any time.

In order to control costs, IC entered into a contract (Contract B) with S1, a wholly-owned subsidiary of X, under which it reinsured 100 percent of its obligations under the contract with the VEBA. The reinsurance contract with IC constitutes S1's only business and requires payment of arms'-length premiums. S1 is regulated as an insurance company, and possesses adequate capital to fulfill its obligations under the contract. There are no guarantees that VEBA or X will reimburse S1 with respect to its obligations, nor is any amount of the premium loaned back to the VEBA or to X. In all respects, the parties conduct themselves in an arms'-length manner, except that S1 does not reinsure any other contracts.

The ruling first summarizes the requirements that must be met in order for a contract to be treated as an insurance contract, and for a business entity to be taxed as an insurance company. In particular, the ruling explains that risks that are the subject of the arrangement must be insurance risks and not merely investment or business risks, and that those risks must be shifted from the policyholder to the issuer and distributed, or pooled, such that the law of large numbers may operate.[3] Those requirements were met under the facts in the ruling. This is because the covered retirees' health coverage represented insurance risks, and because Contract B shifted those risks from the retirees to S1. On this point, the analysis of the ruling was made easy because the risks were solely those of the retirees: Neither X nor the VEBA had any obligation to provide the benefits. Under the analysis of the ruling, the requirement of risk distribution was met because the risks under Contract B are distributed among a large number of covered individuals. Because Contract B represents more than half (in fact, all) of S1's business, S1 qualifies as an insurance company under the more-than-half the business test of sections 831(c) and 816(a).

A TENSION THAT WAS NOT THERE

The publication of Rev. Rul. 2014-15 was in response to a request from a law firm that had previously requested a Private Letter Ruling (PLR) to the same effect on behalf of a large corporation.[4] The law firm's request for guidance described a "possible misunderstanding" of existing published rulings that prevented the timely issuance of its requested PLR. The law firm's letter requested a revenue ruling that would distinguish the insurance of employee health from a single company's insurance of its own risks, such as those related to its ownership and leasing of multiple motor vehicles. In short, the letter served up the issue as an arguable inconsistency between two previously-published rulings: Rev. Rul. 92-93 [5] and Rev. Rul. 2005-40.[6]

In Rev. Rul. 92-93, a domestic manufacturing corporation provided life insurance to its active employees under a group-term life insurance contract purchased from its wholly-owned insurance subsidiary. The terms of the contract were customary in the industry, and there was no guarantee of renewal, nor were permanent benefits (such as a cash surrender value) provided. The ruling concludes that although the employer corporation purchased the group-term life insurance from its subsidiary, this fact did not cause the arrangement to be

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"self-insurance" because the economic risk of loss being insured is not a risk of the employer, rather it is a risk—the mortality risk—of the employees. The ruling recites that "[t]he holdings of this revenue ruling also apply to accident and health insurance." The Service applied a similar analysis in Rev. Rul. 92-94 to a nonlife insurance company insuring its own employees, concluding that the company's gross premiums written include amounts the company charged itself with respect to liability for insurance and annuity benefits for the employees. Again, according to the Service, the arrangements were not non-deductible self-insurance because the company's assumption of liabilities shifts the employees' risks to the insurance company.[8]

In Rev. Rul. 2005-40, the Service concluded that an arrangement entered into with a single policyholder cannot qualify as an insurance contract for Federal income tax purposes if the issuer does not enter into contracts with other policyholders. According to the ruling, such an arrangement cannot satisfy the risk distribution requirement regardless of the number of statistically independent risk units that are insured. This position has generated considerable debate. On the one hand, an economist or actuary may reasonably conclude that the requirement of risk distribution is met (and the law of large numbers may operate) with regard to a contract with a single policyholder if that single contract represents a sufficient number of independent underlying risks, such as a fleet of vehicles—or a pool of employees or retirees. On the other hand, the Service is rightfully concerned that a deduction generally is not permitted for the prefunding of future losses that do not otherwise meet the requirements of the all-events test and economic performance. The line between insurance and non-insurance is of broad consequence.

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The Service may not have foreseen some of the corollary issues that resulted from the publication of Rev. Rul. 2005-40. For example, shortly after Rev. Rul. 2005-40 was published, practitioners requested clarification that the position in Rev. Rul. 2005-40 would not be applied to a single reinsurance contract issued by a reinsurer where the reinsurance contract itself represents an entire block of insurance business, with a sufficiently large number of unrelated policyholders and risks.[9] In response, the Service issued Rev. Rul. 2009-26,[10] confirming exactly that. Nor did many practitioners foresee the relatively little weight that the Tax Court would accord the concentration of risks in a relatively small number of policyholders in *Rent-A-Center v. Commissioner*. In that case, the Tax Court concluded that an arrangement qualified as insurance and did not even discuss the number of policyholders, even though according to the Service's brief the related risks that were covered were concentrated in just three policyholders, and two-thirds of the risks related to a single policyholder.[12]

One might view the publication of Rev. Rul. 2014-15 as yet another unintended consequence of Rev. Rul. 2005-40. That is, having concluded categorically that an arrangement pooling a large number of unrelated risks of just one policyholder cannot be insurance, the Service's analysis of insurance qualification must necessarily delve deeper into questions involving whose risk is whose.

Ironically, Rev. Rul. 92-93 and Rev. Rul. 2005-40 need not have been viewed as offering competing analyses of risk distribution. If the Service had interpreted (as do most practitioners) Rev. Rul. 92-93 as looking through to the insured employees as the ultimate policyholders, there was no inconsistency with Rev. Rul. 2005-40 to resolve. Under the analysis of Rev. Rul. 92-93, the insurance contract between the VEBA and IC represented a large group of named retirees and their dependents. The "single insured" position in Rev. Rul. 2005-40 thus was not implicated. Rev. Rul. 2014-15 acknowledges as much by "distinguishing" Rev. Rul. 2005-40.[13]

IMPORTANT QUESTIONS UNANSWERED

At least as important as the questions answered in Rev. Rul. 2014-15 are the questions that remain unaddressed. It is, of course, important that the ruling concluded what is obvious: under the facts presented, S1 qualified as an insurance company for Federal income tax purposes. A company planning a transaction such as that described in the ruling, however, likely needs answers to additional questions, including questions on which the ruling explicitly provides no guidance.

For example:
The contract that S1 issued provides noncancellable accident and health coverage. Under section 816(b) of the Code,

reserves with regard to noncancellable accident and health insurance contracts may be life insurance reserves. Because the contract that S1 issued is its only business, S1 would qualify as a life insurance company, although the ruling does not say so. Does life company qualification mean that the life-nonlife consolidated return limitations apply, and prevent the utilization of S1 losses, if any, for the first five years it is in the group? Are there approaches to avoid this result?

Also, under the facts of the ruling, X is not legally obligated to provide health benefits to its retirees and may cancel coverage at any time. Would the conclusion be different if, instead of retirees, the contract insured the health of active employees and X were obligated to provide coverage such as under a collective bargaining agreement? Would the ruling treat the Affordable Care Act employer mandate as an obligation to provide coverage? Although the risks at issue would still be those of the individuals, arguably the risks could also be viewed as risks of X because the ACA requires the employer to provide coverage or pay a fine for not doing so. The likeliest analogy in that case would likely still be Rev. Rul. 92-93, or perhaps Rev. Rul. 2006-95 (concerning reinsurance), but Rev. Rul. 2014-15 does not address these facts directly.

The ruling addresses only circumstances in which welfare benefits are provided through a VEBA. It does not address other circumstances, such as the provision of welfare benefits other than through a VEBA, or the provision of benefits that might be deferred compensation. In theory, one would expect the same conclusion that S1 is an insurance company if instead the employer contracted with S1 directly (or through a fronting insurer if it were an ERISA benefit[14]) and no VEBA was involved. Different rules, however, govern the timing of deductions for insurance premiums than govern the timing of deductions for deferred compensation.

Another explicit caveat concerns the status of the contract with S1 as a self-insured medical reimbursement plan for purposes of the nondiscrimination rules of section 105(h). The ruling does not give any reason for this caveat, but the fact that it is there suggests that companies should consider the applicability of section 105(h) on their own facts.

And, perhaps most importantly, would the same analysis apply to a medical stop-loss policy as applies to the contract with S1? Presumably, if an employer, either directly or through a VEBA, enters into a medical stop-loss policy with

a captive insurer, one would still look through to the underlying insured employees to determine whether the insurance requirement of risk distribution is met. Medical stop-loss arrangements are common. The ruling's failure to shed light on their treatment does not prevent the issue from coming up in this context and others. Rather, it leaves taxpayers and their advisors to make their best judgment as to how existing judicial authorities should be applied.

The insurance company conclusion in Rev. Rul. 2014-15 provides welcome certainty on the facts of the ruling and is clearly correct, even obvious. The Service and Treasury are no doubt aware there is unfinished business in this area, however. As discussed, the ruling declines to address a number of issues concerning the taxation of employee benefits, and even the ruling's insurance conclusion is limited to the ruling's facts. There may be further guidance. Meanwhile, employers and their advisors are working through corollary issues on a case-by-case basis. ◂

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ENDNOTES

[1] 2014-24 I.R.B. 1095 (June 9, 2014).

[2] The participation of an unrelated insurance company is a condition of an exemption from the Department of Labor from the prohibited transaction provisions of the Employment Retirement Income Security Act of 1974 (ERISA).

[3] The ruling did not discuss the third prong of *AMERCO v. Commissioner*, 96 T.C. 18 (1991), *aff'd* 979 F.2d 162 (9th Cir., 1992), to the effect that an arrangement must constitute insurance in the commonly accepted sense. Presumably this requirement merited no discussion as it is clearly met in the case of health benefits of individuals.

[4] May 11, 2011, letter of Theodore R. Groom in response to Notice 2011-39, 2011-20 I.R.B. 786 (April 16, 2011), Tax Analysts Doc. 2011-11073.

[5] 1992-2 C.B. 45, *modified by* Rev. Rul. 2001-31, 2001-1 C.B. 1348.

[6] 2005-2 C.B. 4.

[7] 1992-2 C.B. 144.

[8] *See also* Rev. Rul. 80-95, 1980-1 C.B. 252, which analyzed a disability policy between a domestic employer and a foreign insurer as a "policy of life, sickness or accident insurance" for purposes of the excise tax imposed by section 4371, even though the insured employees were not directly parties to the contract.

[9] *See, e.g.,* August 26 2005, letter of George W. Craven in response to Notice 2005-49, 2005-2 C.B. 14, Tax Analysts Doc. 2005-19415.

[10] 2009-38 I.R.B. (Sept. 21, 2009).

[11] 142 T.C. 1 (2014).

[12] Opening Brief for Respondent at 50, *Rent-A-Center v. Commissioner*, 142 T.C. 1 (2014) (Nos. 8320-09, 6909-10, 21627-10).

[13] The ruling also distinguishes Rev. Rul. 2002-89, 2002-2 C.B. 984, which concludes that the requirements of risk shifting and risk distribution are not satisfied when a wholly-owned subsidiary's agreement to indemnify the risks of its parent represents 90% of the subsidiary's business.

[14] If the benefit at issue were covered by the Employee Retirement Income Security Act of 1974 (ERISA), the parent company would be required to obtain a prohibited transaction exemption. Provided the parent is not in the business of insurance, a key requirement of such an exemption would be the use of a fronting insurer to contract with the employee benefit plan and reinsure the coverage with the captive.