THE USE OF CAPTIVE INSURANCE COMPANIES IN THE MEDICAL INDUSTRY

Beckett G. Cantley[1]
Atlanta Law Group

F. Hale Stewart, Esq.[2]
The Law Office of Hale Stewart

The purpose of this article is to provide the managing partner of a medical practice with sufficient information on captive insurance to determine if forming a captive is viable for the firm. The article is split into two parts. The first part explains not only the legal definition of insurance but also an analysis of the IRS' unsuccessful attempts to stop captive insurance company transactions. Part 2 illustrates several key insurance policies a medical practice focused captive could underwrite. At the conclusion, the managing partner should have enough information to know if he or she should investigate the captive insurance company option further.

Part 1: Technical Background

The Legal Definition of Insurance

All insurance transactions must have five factors, starting with a definite risk. Sometimes called the triggering event, a specific incident must occur before the insured can file a claim. For example, fire and lightning trigger coverage under a property policy. Second, the risk must be fortuitous. If the insured is aware of an upcoming incident, he can make adequate preparations to minimize its negative impact, thereby eliminating the need for coverage. Third, the insured must have an insurable interest; he must show that he will be personally hurt when the definite risk occurs. Court's developed this factor in the 19th century, when individuals purchased life insurance on the lives of famous people as a way to gamble on the date of their death. Courts concluded this practice led to economic waste and was therefore against public policy. Fourth, there must be risk shifting which is accomplished through the issuance of a valid insurance policy. The policy "shifts" the risk of loss from the insured (who is no longer responsible for the cost from damages) to the insurer (who will "make the insured whole" with its indemnification payment).

The final factor is risk distribution, which requires a more in-depth explanation, best accomplished through an example. Begin with the risk borne by a single homeowner who does not have property insurance. It is highly unlikely he will have sufficient financial resources to replace his home in the event it is destroyed by a fortuitous event. But if that individual pools his risk with other similarly situated homeowners who live across a geographically diverse area, a key development occurs – the possibility that the insured's funds will return to him as part of the indemnification payment decrease, since all of the insured parties are unlikely to suffer a simultaneous loss. At the same time, it becomes more likely that one insured's funds (and any

[1] Beckett G. Cantley is a partner in the Atlanta Law Group (www.atllawgroup.com). He can be reached for comment at bgcantley@atllawgroup.com and (404) 502-6716.
[2] F. Hale Stewart, Esq. is a partner at The Law Office of Hale Stewart (www.halestewartlaw.com). He can be reached at 823.330.4101 or hale.stewart.esq@gmail.com

earnings thereon while held by the insurer) will ultimately support a payment to another insured who has indeed lost his home. It is this pooling of premiums in the insurance company, resulting in a distribution of the risk of loss (and potential for indemnification) across the entire pool of insured persons that creates insurance.

A Brief History of Captive Insurance and the IRS's Unsuccessful Efforts to Prevent Its Use

Market failure forced the creation of captive insurance. Starting in the mid-1950s, businesses in certain industries, either couldn't find any insurance, could only find very expensive insurance or determined that forming an insurance subsidiary was the best available option. The following fact patterns from captive cases illustrate these scenarios.

In *Ocean Drilling and Exploration Co. v. United States*,[3] the taxpayer's primary business was offshore oil exploration. Because this was a new industry, only a limited number of insurers would provide coverage. Eventually, the cost of insurance became prohibitive, forcing the company to form an insurance subsidiary.

In *Kidde Industries Inc. v. United States*,[4] the company found itself "in the midst of a products liability insurance crisis in which many insurance companies either ceased or significantly restricted their coverage of products liability…. Travelers informed Kidde that it would not renew Kidde's products liability insurance policy for 1977."

In *Malone and Hyde Inc. v. Commissioner*,[5] "[b]y the mid-1970s, the Hyde Insurance Agency found that insurance premiums were increasing each year and certain insurance was not obtainable for some clients."

In *Mobil Oil. Corp. v. United States*,[6] after determining that "the outside insurance purchased by Mobil Overseas was not bought efficiently," the company commissioned an internal report. The Adams Report concluded the methods of Mobil Overseas and its affiliates of insuring against physical damage should be revised. The report states (in part): "Mobil Overseas should . . . [f]orm an insurance affiliate to cover our risks where possible.'');

In *Beech Aircraft Corp. v. United States*,[7] an aircraft manufacturer was sued for product liability. The company's insurance policy granted the insurer complete control of the attorneys used in litigation. Beech tried to remove counsel before trial, but the motion was denied. Beech formed the captive after it lost the case and a $21 million judgment.

Humana v. Commissioner,[8] clearly illustrates the decision-making process that led to captive formation. After being priced out of the liability market, the hospital considered four

---

[3] *Ocean Drilling and Exploration Co. v. United States*, 24 Cl. Ct. 714, 715 (1991).
[4] *Kidde Industries Inc. v. United States*, 40 Fed. Cl. 42 (1977).
[5] *Malone and Hyde Inc. v. C.I.R.*, T.C. Memo. 1989-604.
[6] *Mobil Oil. Corp. v. United States*, 8 Cl. Ct. 555, 556 (1985).
[7] *Beech Aircraft Corp. v. United States*, No. Civ. 82-1369 (D. Kan. July 3, 1984) *aff'd*, 797 F.2d 920 (10th Cir. 1986).
[8] *Humana v. C.I.R.*, 88 T.C. 197 *rev'd in part* 881 F.2d 247 (6th Cir. 1989).

options: (1) going uninsured; (2) forming a reserve; (3) forming an insurance company with other hospitals; and (4) forming a captive. The company rejected the notion of going uninsured because several catastrophic events could potentially bankrupt the company. The board decided against the second option because contributions to a reserve are not deductible. Humana rejected option three because another participating hospital could be in a compromised financial position. The only remaining viable option was forming a captive.

Despite having valid non-tax business reasons to form a captive, the Service aggressively challenged these arrangements. Their reasons were substantive; they argued that a single or affiliated group of companies had an insufficient amount of risk to provide risk distribution as required under federal tax law. Then existing case law provided strong support for their position. The 1941 Supreme Court case *Helvering v. LeGierse* first articulated the risk distribution requirement. This case, however, only stated this element must be present. It provided no in-depth explanation of the term, leaving that to later jurisprudence. By the time taxpayers started to form captives in the mid-1950s, case law had done little to provide detailed guidance for this term. This definitional and substantive vacuum left sufficient legal ambiguity to permit the Service's conclusions.

The Service explained the reasoning behind their opposition to captive insurance in Revenue Ruling 77-316, which outlines three fact patterns: (1) A parent making direct payments to its captive; (2) A parent making payments to a third party insurer who reinsures 90% the parent's risk with the captive; and (3) A parent paying a premium to a captive who reinsures 90% of the risk with a third-party.[9]

The Ruling states that any risk that is contained in the wholly owned insurance subsidiary and is either directly (the first fact pattern, and the 10% in the third fact pattern) or circuitously (the second fact pattern) transferred to the captive subsidiary is not deductible as an insurance premium. However, premiums paid for any risk not contained in the captive (the 10% that remains with the third-party insurer in the second fact pattern, and the 90% transferred to the reinsurer in the third fact pattern) are deductible.

The Service's primary rationale was that the captive was not an insurance company but instead an accounting reserve, which is a "segregation of retained earnings to provide for such payouts as dividends, contingencies, improvements, or retirement of preferred stock."[10] For example, if a company anticipates a tax bill of $50,000, it will create a reserve in that amount, which is then specifically notated on the company's balance sheet. However, because the funds placed into this account are not co-mingled with non-parent funds, there is no risk distribution transforming the transaction into an insurance arrangement. This explains why the Service argued any money retained by the wholly owned insurance company was not an insurance company. Throughout the Service's challenges, they continually asserted that while the transaction had all the outer trappings of insurance, it was in substance an accounting reserve.

Two of the earliest captive cases explain the various arguments used by taxpayers and the Service regarding captive insurance. The taxpayers in *Consume'rs Oil* and *Weber Paper* both

[9] Rev. Rul 77-316, 1977-2 C.B. 52.
[10] Downes and Goodman, *Barron's Finance and Investment Handbook,* Third Edition, 1990, p. 446.

owned property in a flood plain. Commercial insurance was unavailable to either due to recent flooding. Consumer's Oil formed a trust where it was the sole contributor and beneficiary. In contrast, the Weber Paper taxpayers formed an insurance company licensed in Missouri and Kansas which received premiums from numerous, similarly situated taxpayers.

The Service challenged both transactions. The Consumer's Oil court sided with the Service. Here, the fact the funds were placed in a trust and segregated from the company's general accounts was critical. In substance, this transaction was clearly a reserve account. But the *Weber Paper* Court sided with the taxpayers. While the reasoning was thin, the bulk of the decision described the transaction's details. It noted business necessity initiated the transaction, which was followed by the local business community backing and then promoting the plan. The court noted the insurance policy issued by the captive was derived from a standard industry document. The judge analyzed the company's structure, noting the company maintained reserves and that the attorney in fact operated the company as a bona fide insurer. The only logical conclusion to draw from these facts was that taxpayers formed a valid insurance company.

Beginning with the flood plain cases in the 1950s, the Service challenged captives for about 40 years, ending with the UPS appellate decision in 2002. It's possible to divide the timeline into "pre" and "post" *Humana*, which was tried and appealed between 1987-1989. Before *Humana*, the IRS won a majority of its cases for numerous reasons. First, they had a number of years to develop their legal theory, giving them a tactical advantage. Second, courts were analytically unsophisticated; they were far more likely to agree with the Service's arguments with little independent analysis. Third, taxpayer's cases were simplistic. And finally, most of the structures involved transactional structures resembling the *Consumer's Oil* case; taxpayers formed a captive whose only insured was the parent and perhaps a few subsidiaries. Risk distribution was non-existent.

But taxpayers gained transactional and legal sophistication after *Humana*. This began with their trial teams, who put on far more complex cases utilizing stellar expert witnesses, one of which was Nobel Prize winning economist Joseph Stiglitz. In contrast to previous cases, where the taxpayer's primary argument read more like an appellate brief, post-*Humana* cases demonstrated the business reasons underlying the transaction in addition to the substance of the captives. Perhaps most importantly, parent companies began forming captives resembling the *Weber Paper* case above; these captives either had sufficient non-parent risk or underwrote the risks of a large number of parent company subsidiaries, both of which achieved the required level of risk distribution. By the time of the tersely written UPS appellate decision, it was obvious that courts would accept some captive structures if they were formed for legitimate reasons and if they contained a sufficient amount of risk distribution.

In response to their numerous 1990s losses, the IRS issued several Revenue Rulings on captive insurance in 2002. They first stated that, for a captive to be recognized as a valid insurance company, it must receive at least 50% of its revenue and risk from a non-parent, or insure the risk of at least 12 subsidiaries, none accounting for less than 5% nor more than 15% of the total underwritten risk.

The IRS next stated that it would no longer use the "economic family" argument, but instead rely on a facts and circumstances test. Perhaps the best way to conceptualize this requirement is that all captives must comport with the factors of the three-prong *Harper* test: (1) Whether the arrangement involves the existence of an "insurance risk;" (2) Whether there was both risk shifting and risk distribution; and (3) Whether the arrangement was for "insurance" in its commonly accepted sense.[11]

Subsequent releases from the IRS in the form of Chief Counsel Memoranda, Private Letter Rulings and the like indicate the following factors are important in making this determination: whether the captive is subject to state regulation, whether the captive is considered as an insurance company under state law, whether an independent actuary determined the premium levels, whether the captive is adequately capitalized, and whether the underlying documentation supports the transaction as an insurance company. The preceding list is not exhaustive.

Part 2: How a Medical Practice Should Utilize a Captive

To understand how to utilize a captive insurance company, it's important to know a small amount of insurance coverage history. Beginning in the mid-1960s, the plaintiff's bar brought four lines of high profile cases: product's liability, medical malpractice, environmental claims and asbestos losses. Each line eventually ended with large multi-million dollar judgments that forced insurers out of these respective markets. Captives filled this coverage vacuum. To this day, it's very common for all but the largest companies to implement an insurance "tapestry," where they maintain their CGL and property policies while using a captive to underwrite "stochastic" (lower frequency, higher payout) risks that are excluded from their commercially available coverage.

Medical firms are no exception. For a relatively small sum, they can obtain generalized policies for generic business risk. But these policies contain large gaps in coverage for events that could, should they occur, potentially place the firm in financial jeopardy. Some of the more common policy gaps underwritten by medical captives follow.

Cyber Risk

Target's data breach in the winter of 2013 highlighted this risk in the public's mind. According to their March 13, 2015 10-K, it eventually cost the company $145 million. Over the last year, other major companies reporting similar events include JP Morgan, Anthem Health and Home Depot. The total cost of each breach now totals $3.8 million; the average per record cost has also increased from $144 to $154.[12]

Confidentiality adds an additional layer of risk for cyber liability. Suppose a hacker successfully breached a medical practice's computer system. A client could sue the practice not only for the breach of data but also for a breach of confidentiality, potentially placing the doctors' licenses in danger. While there are no cases on point, it's only a matter of time before plaintiff's attorneys start testing this legal theory.

---

[11] *The Harper Group v. C.I.R.*, 96 T.C. 45 (1991), *aff'd* 979 F.2d 1341 (9th Cir. 1992).
[12] Cory Bennett, *Study: Data Breaches Average $3.8 Million*, The Hill May 27, 2015.

At a minimum, a medical practice's captive program should underwrite a cyber-liability policy that provides coverage for:

1. A security breach where hackers obtain confidential client information such as physical and email addresses, social security (or similar) numbers, medical history and other privileged information.

2. Public relations expenses expended by the company to overcome negative publicity related to the event.

3. Loss of income directly related to the event.

4. Extortion threats, where hackers obtain confidential information and then demand payment to not distribute it.

Employment Claims Coverage

This is not a rarely used policy. Over 80% of companies with 500 or more employees have faced these claims.[13] The EEOC reported 88,778 discrimination charges were filed in 2014.[14] The suits are expensive, averaging approximately $125,000 to defend with median payouts of $200,000. Employers lose approximately 66% of these cases.

Several recent cases illustrate the prevalence of these claims in the medical field. A former six-year employee of Valley View Hospital sued the hospital for discrimination.[15] The case took three years to settle. A former employee of a Chicago hospital recently sued her employer for not accommodating an employee with a high-risk pregnancy.[16] Finally, a former MRI technician is suing Baylor for discrimination.[17]

The standard Insurance Services Office ("ISO") employment liability coverage form provides coverage in four separate areas, two of which are especially salient for medical practices. The first of these two areas is demotion (or failure to promote), which includes negative evaluation, reassignment or discipline of your current "employee," or wrongful refusal to employ. The second area is wrongful termination, meaning the actual or constructive termination of an employee in violation or breach of applicable law or public policy, or that is determined to be in violation of a contract or agreement, other than any employment contract or agreement, whether written, oral or implied, which stipulates financial consideration if such financial consideration is due as the result of a breach of the contract.

---

[13] 4-41 New Appleman Insurance Law Practice Guide 41.01.
[14] Top 10 Employment Discrimination Claims, Claims Journal February 5, 2015
[15] Nelson Harvey, Valley View Hospital Faces Racial Discrimination Lawsuit, Aspen Daily News, Monday, January 27, 2014
[16] Roseland Community Hospital Sued By EEOC for Pregnancy Discrimination, Sunday, September 21, 2014, The National Law Review
[17] Alex Wolf, Ex-Baylor MRI Tech Takes Age Bias Suit To Supreme Court, May 12, 2015 Law 360

Legal Liability Coverage

The possible fact patterns utilizing this policy are endless. They can stem from breach of contract, bankruptcy of a counter-party, and suits related to customer complaints. In addition, this policy would allow the doctor or medical practice to hire an attorney before a third party filed suit against the insured, better allowing the practice to prepare for the lawsuit.

The 1981 book "The Business Insurance Handbook," provided three justifications for such coverage:

1. The greater complexity of doing business.
2. The greater sophistication of the public: individuals and competing businesses are legally savvy, meaning they will be more than likely to file claims.
3. The large number of lawyers increases the possibility of frivolous suits.[18]

These policies' standard insuring clauses are written very broadly, usually containing the following language: "We will pay for all expenses for 'legal representation' incurred by the insured expended in defense of a 'suit' and which occurs during the policy period as stated in the declarations." The term "suit" is defined broadly; it includes not only an actual complaint, but also arbitration and mediation. Although most insurance policies cover legal expenses, they typically require specific triggering events. Legal liability coverage fills the gaps.

Commercial Crime/Employee Fidelity Coverage

Unfortunately, employee fraud is fairly common. According to a 2012 report conducted by the Association of Fraud Examiners:

- The typical organization loses 5% of its revenues to fraud each year.
- The median loss in the cases in their study was $140,000. More than one-fifth of these cases caused losses of at least $1 million.
- The frauds lasted an average of 18 months before being detected.
- The smallest organizations suffered the largest losses because they typically employ fewer anti-fraud controls. In addition, fraud affected small businesses disproportionately because they have fewer resources to act as a financial cushion.
- Perpetrators with higher levels of authority tend to cause much larger losses. The median loss among frauds committed by owner/ executives was $573,000, the median loss caused by managers was $180,000, and the median loss caused by employees was $60,000.
- The longer a perpetrator had worked for an organization, the higher fraud losses tended to be. Perpetrators with more than 10 years of experience at the company caused a median loss of $229,000. By comparison, the median loss caused by perpetrators who committed fraud in their first year on the job was only $25,000.

[18] Castle, Cushman and Kensicki, *The Business Insurance Handbook*, Dow-Jones 1981, p. 682.

- Most occupational fraudsters are first-time offenders with clean employment histories.[19]

Several recent cases illustrate fraud problems within the medical industry. The former executive director of St. John's Children's Hospital stole more than $700,000 from the hospital over a 6 1/2-year period.[20] A Michigan nurse was recently convicted for stealing from her patient and then using the funds to gamble.[21] Grady Memorial Hospital Corporation's former payroll director stole nearly half a million dollars from the Atlanta hospital.[22]

The standard ISO commercial crime policy contains the following language:

> 1. Employee Theft: We will pay for loss of or damage to "money," "securities" and "other property" resulting directly from "theft" committed by an "employee," whether identified or not, acting alone or in collusion with other persons. "Theft" is defined as the "unlawful taking" of property, meaning this coverage applies to practically any scenario where an employee has stolen any valuable items.
>
> 2. Forgery Or Alteration: We will pay for loss resulting directly from "forgery" or alteration of checks, drafts, promissory notes, or similar written promises, orders or directions to pay a sum certain in "money" that are: made or drawn by or drawn upon you; or made or drawn by one acting as your agent; or that are purported to have been so made or drawn.

The policies define forgery as, "the signing of the name of another person or organization with intent to deceive." A medical practice's captive program could easily ascribe a broad definition to this clause, allowing it to apply to most hypothetical situations a medical practice could encounter.

Administrative Actions Policy

Doctors are governed by their respective state medical boards, who wield a large amount of regulatory power over the medical industry. In addition, there are other state and federal organizations who have the ability to commence actions against doctors for a large number of potential infractions.

To cover this risk, captives commonly issue administrative actions policies, which cover the costs of "… all losses resulting from or caused by an 'administrative action' that occurs during the policy period. The total calculation of losses will include 'loss of income,' 'remedial measures,' 'legal representation,' and 'public relations expense,' caused by 'negative publicity' if

---

[19] Report to the Nations on Occupational Fraud and Abuse, 2012, Association of Certified Fraud Examiners.
[20] Chris Dettro, Former St. John's Children's Hospital Director Peggy Curtin Pleads Guilty, The State Journal Register, May 21, 2015
[21] Darcie Moran, Nurse Stole Thousands of Dollars from Homebound Ann Arbor Woman, Police Say, Mlive.com June 13, 2015.
[22] Staff Writer, Ex-Grady Hospital Employee Convicted of Embezzlement, 11Alive, December 9, 2014

applicable and provided insured can demonstrate loss." The policy defines an "administrative action" broadly, usually using the following definition: "an 'administrative action' is a formal legal event, proceeding or 'suit' commenced by an 'administrative agency' (which would include the state bar), seeking to formally or informally adjudicate or enforce an administrative code."

Conclusion

For years, the IRS fiercely resisted captive insurance companies on various grounds with overwhelming success. However, both the IRS and the courts now respect captive insurance as a legitimate risk management arrangement. In order to be respected by the IRS and the courts as such, a captive insurance arrangement must meet the legal definition of insurance, including risk shifting and risk distribution. Also, a parent company must have a legitimate, non-tax business purpose for establishing the captive arrangement.

Like many businesses, medical practices can generally benefit from the flexible coverage available through captive insurance company arrangements. As discussed above, four out of five companies with 500 or more employees will face an employment claim of some type, costing on average $125,000 to defend, with a median payout of $200,000, and employers losing these cases twice as often as they win. Similarly, companies lose, on average, approximately 5 per cent of yearly revenue to employee fraud. Also, most companies could benefit from legal liability coverage to fill in the rather large gaps typically present in those companies' current coverage schemes. Medical firms may have a higher degree of exposure to these risks. The perception that such companies have "deep pockets" may make these companies an inviting target for fraudsters and litigious parties.

Moreover, medical practices face various risks for which coverage may be commercially unavailable or unattractive due to prohibitively high premiums or large coverage gaps. For example, they may face heightened risk in the form of cyber threats, due to the highly sensitive nature of the information they accumulate and maintain. Also, they are particularly sensitive to the administrative landscape via their respective state medical boards.

Among other benefits, captive insurance companies offer the flexibility to underwrite these and other commercially reasonable risks. Managing partners interested in exploring advanced strategies to maintain competitiveness and security in today's business environment may contact us for more information.