Office of Chief Counsel
Internal Revenue Service

memorandum

CC:LM:FSH:BOS:TL-N-2142-01
CWMaurer

date: JUL 07 2001

to: Examination Division, [redacted]

from: Associate Area Counsel(LMSB), Boston, MA

subject: [redacted] Risk Withholds

This refers to a FAX transmittal March 12, 2001, from Revenue Agent [redacted] attaching a copy of a letter dated [redacted], from [redacted], to Revenue Agent Joshi, concerning the provider settlement reserve issue for [redacted]. Among other things, [redacted] asserts that "It appears the IRS positions in the TAM [PLR 9723005] have not been persuasive enough for the majority of Agents or Appeals Officers to pursue the provider settlement reserve issue." (Letter, page 2.) This memorandum should not be cited as precedent.

[redacted]'s letter discusses the following issues:

ISSUES:

1. Whether I.R.C. §§ 404(a) and 404(d) affect the determination of an insurance company's losses incurred and loss adjustment expenses;

2. Whether the issue described in PLR 9723005 is being raised in the examination of non-[redacted] entities, and if the issue is raised -- either in the case of a [redacted] entity, or a non-[redacted] entity -- whether it is pursued after the taxpayer articulates the objections raised by this taxpayer;

3. Whether section 404 applies only to cash-basis and not to accrual-basis payees;

4. Whether for insurance companies section 846 achieves the matching principle of section 404(a).

CONCLUSIONS:

1. Estimated payments for risk withholds and surplus distributions to individual health care providers are considered liabilities incurred in connection with a deferred compensation arrangement, subject to the timing restrictions in I.R.C. §§ 404(a) and 404(d), notwithstanding the provisions of section 832(b) regarding an insurance company's losses incurred and loss adjustment expenses.

2. This issue should be raised in appropriate cases.

3. Section 404 applies both to cash-basis and to accrual-basis payees.

4. Sections 404(a) and 404(d) apply to deferred compensation arrangements, including deferred compensation arrangements where the payor is an insurance company and the amounts have been included in the payor's unpaid claims reserves. The amendment of section 832(b)(5) and the enactment of section 846, which require that an insurance company discount its unpaid loss reserves, do not affect the application of sections 404(a) and 404(d).

FACTS

The examining agent has proposed an "Accrued Medical Incentive Payments" adjustment as follows:

Year	Section 481(a) Adjustment	Current Year Adjustment	Total
[redacted]	$[redacted]	$[redacted]	$[redacted]
	N/A		

This issue has been very well-developed. We have reviewed the examining agent's Notice of Proposed Adjustment, and various materials provided by the taxpayer in response to Information Document Requests. In some instances, the materials provided by the taxpayer do not fully respond to the agent's requests. We have not reviewed the entire file, and accordingly additional information may be included in the file which more fully explains the details of the transactions in issue. At the conclusion of this memorandum we note additional information that may be useful in clarifying these transactions.

The taxpayer, [redacted], owns a health maintenance organization, [redacted].

[redacted] enters into a "Medical Services Agreement" with primary care physicians which provides for three types of payments: a capitation payment, a fee-for-service payment, and a "Value Incentive Program" ("VIP") payment. The capitation payment is a fixed monthly fee, based upon the number of members selecting that physician as their primary care physician, and constitutes payment in full for all services rendered to those members by that physician. Fee-for-service payments are made for services rendered that are not covered by the capitation provisions; for example, services rendered to out-of-state members. The "Value Incentive Program" is a "discretionary program . . . whereby a Primary Care Physician (PCP) may receive in addition to his/her monthly capitation payment, additional amounts based upon financial and quality indices." (Medical Services Agreement, Exhibit 1, Value Incentive Program.) For purposes of these "VIP distributions" the year is divided into two settlement periods, ending [redacted] and [redacted], and the amount available for distribution is determined within [redacted] days of each settlement period and paid within [redacted] days of determination. Accordingly, payments for the [redacted] period may not be made until [redacted] of the following year.

The agreement does not describe how the total amount available for distribution is determined. The agreement indicates that the amount awarded to any particular physician is based upon a "quality index" and a "financial index." The agreement includes a general description of these indices. The "Quality Score" is comprised of the following elements:

	Elements	Points available
A.	Member Satisfaction	
	1. Member satisfaction survey results	0-15
	2. Member Complaints	0-5
B.	Member Access	
	1. Expanded service	
	Scheduled extended hours	0-5
	Saturday appointments available	0-5
	After hours phone answering	0-5
	2. Open Panel	0-5
C.	Member Service	
	1. Appropriateness of Referrals	
	Substantiated complaints by specialists	0-5
	Non-authorized referrals to non-participating providers	0-5
	Emergency Room usage rate	0-5
	2. Ambulatory Review Results	
	Documentation of care	0-10
	Practice Parameter Compliance	0-10
	3. Pharmacy	0-5

D. Other
1. Specific Assistance Requests 0-5
2. Participation in Extra-Curricular Activities 0-5

[Total points available 90]

In most cases, no criteria are specified for determining how points are awarded within any given category. For example, the schedule shows 0-5 points available for "Saturday appointments," but the agreement does not specify how a determination is made to award one point rather than two points, or three, four, or five points.

The complete description of the "Financial Indicators" is as follows:

> Medical cost management is a very important aspect of the PARTICIPATING ENTITY'S practice in an HMO environment. Each PHYSICIAN, and each physician within a PARTICIPATING GROUP, will receive a score based upon his/her ability to manage the medical cost of his or her panel.
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> In calculating Medical Cost Management, indices will be calculated and adjusted by age, sex, peer group, and speciality. Stop loss levels will be utilized to provide financial protections for the PHYSICIAN for catastrophic cases.

The agreement does not include any description of these "Medical Cost Management" indices. The agreement does not indicate how many indices are used, or the elements of the indices, or how the indices are calculated for any particular participant.

Language in the agreement emphasizes the conditional nature of the VIP distributions. The text of the agreement indicates that in addition to capitation payments and fee-for-service payments, a physician "may be eligible" to receive VIP distributions. Exhibit 1 to the agreement describes the VIP program as a "discretionary program . . . whereby a Primary Care Physician (PCP) may receive . . . additional amounts." "This discretionary additional reimbursement on the part of [redacted] is not required under any agreement, and does not create any precedent or expectations regarding future distributions of this type." A participating physician must meet certain criteria "to be eligible for the awarding of the VIP Distribution."

The taxpayer, in its response to IDR #64, "disagrees with the IRS's contention that these programs are discretionary and that therefore there is no legal obligation to make payments and

that such payments are not guaranteed." However, we believe the issue is not so much whether payments will be made, but rather when the payments will be made. It does appear that the agreement with the physician imposes a contractual obligation on [redacted] to make VIP distributions, but the method for calculating those distributions leaves a great deal to [redacted]'s judgment. It appears that [redacted] determines the total amount available for distribution. It appears that [redacted] determines how the total amount will be distributed among the participating physicians. While Exhibit 1 describes the elements that will be taken into account, it appears that [redacted] determines the weight that will be given to each element, and [redacted] determines the number of points awarded to each physician. Once [redacted] determines the total amount available for distribution, it may be under an obligation to distribute the full amount, and once [redacted] determines that factors that will be taken into account in allocating the total amount among the participating physicians, it may be under an obligation to apply those factors consistently, but one of the issues for consideration is when those obligations become fixed to the extent that the participating physician would accrue the income receivable, and when would that physician have sufficient information to make a reasonable estimate of the amount of income.

Background on health care and health insurance. Health care may be funded by a variety of arrangements, ranging from traditional, indemnity insurance arrangements, to non-insurance, pre-paid services arrangements, with a variety of arrangements in between that combine elements of insurance and pre-paid services. In response to IDRs 55 and 56, the taxpayer presented general background on insurance arrangements within the health insurance marketplace. The taxpayer describes three categories of insurance arrangements: "traditional"; "preferred provider organizations" (PPOs); and "health maintenance organizations" (HMOs).

The traditional function of insurance is to provide indemnification for loss. Allied Fidelity Corp., Inc., v. Commissioner, 66 T.C. 1068 (1976). With respect to health care, a traditional, indemnification insurance arrangement reimburses the insured for health care provided by third-parties unrelated to the insurer. The insurer itself does not provide the health care, but merely reimburses the insured for services obtained from others.

The taxpayer's description of insurance arrangements within the health insurance marketplace reflects the evolution of that market, where insurers have become more involved in the provision

of health care, while health care providers have assumed some share of the insurer's risk.

Thus, in a "preferred provider organization" arrangement, the insurer contracts with health care providers for a negotiated fee based on a volume discount concept. The providers accept a lower fee-for-service amount in expectation that the arrangement with the insurer will generate greater volume for the providers. In this situation the insurer is not itself engaged in providing services, nor do the providers assume any risk from the insureds or the insurer.[1]

In the HMO insurance arrangement, the insurer contracts with physicians to become "Primary Care Physicians" (PCPs). Members of the HMO select a physician as their PCP, and that physician provides the majority of medical services required by the member, in return for a fixed monthly "capitation payment." The PCP's capitation fees are based on the number of members that select that physician as their PCP, rather than the amount of services provided by the PCP. Thus, the PCP bears the risk of "overutilization" -- the risk that the services required will exceed the amount anticipated at the time the fees were set. In addition, the member must obtain PCP approval for hospitalization or treatment by a specialist, which the HMO generally pays on a fee-for service basis. The contract between the HMO and the PCP provides for additional payments which are linked to referrals to specialists and hospitals. Thus, the PCP has an incentive to restrict referrals.

The taxpayer's description was limited to insurance arrangements. Health care may also be financed through non-insurance arrangements. For example, Rev. Rul. 68-27, 1968-1 C.B. 315, describes an organization operating a clinic available to members for a prepaid, fixed monthly fee. The ruling

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[1] To the extent the provider agrees to a fixed fee schedule for a fixed period, the provider has assumed some cost risk from the insurer, but this would be considered a business risk, rather than an insurance risk. See, e.g. Group Life & Health Ins. Co. v. Royal Drug Co. Inc., 440 U.S. 205 (1979), where Blue Shield of Texas entered into agreements with pharmacies to provide prescription drugs to Blue Shield members for cost plus $2. The Court held that these arrangements were not the "business of insurance": "The Pharmacy Agreements are thus legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low." Id. at 215.

concludes that such an organization is not an insurance company for purposes of federal income taxes.

While the taxpayer's description of insurance arrangements included a Health Maintenance Organization, there is no single model for an HMO and not all HMOs are considered insurance companies. HMOs are generally classified into one of four models, based largely on the relationships between the HMO and the physicians who actually provide care to its subscribers.

(1) The "staff model" -- care is provided through a staff of physicians (and other health care personnel) employed by the HMO;

(2) The "group model" -- care is provided through physicians who are affiliated in a single group, typically a partnership;

(3) The individual practice association model or "IPA model" -- care is provided by specified physicians practicing independently in their own offices, with the physicians usually contracting with the HMO; and,

(4) The "network model" -- care is provided by a combination of physicians practicing independently and in groups.

See, for example, the description of the different types of HMOs in FSA 1999-1134 (undated).

Private letter rulings and field service advice memoranda may not be used as precedents in the disposition of other cases but may be used as a guide with other research material in formulating a position on an issue. I.R.M. 7.2.10. While the conclusions in the following memoranda are not precedent, they illustrate both the range of HMO structures and also that the tax consequences of any particular structure or transaction require a review of all the facts and not just the label which the taxpayer attaches to that particular HMO arrangement. Thus, in PLR 8424058 (March 13, 1984) it was concluded that an "independent practice association" (IPA) model HMO was not an insurance company for federal income tax purposes. In FSA 1999-1134 (undated) and FSA 200104011 (October 19, 2000), it was concluded that certain managed health care plans were principally prepaid contracts for services and not insurance contracts.

In contrast, in PLR 9412002 (December 17, 1993) it was concluded that an IPA model HMO did qualify as an insurance company.

Classification as an insurance company has significance for federal income tax purposes because the Internal Revenue Code allows specific tax benefits to insurance companies in recognition of the unusual nature of insurance transactions. These unusual features were summarized by the Tax Court in a frequently-quoted passage:

> In commerce generally, expenses come first and income follows. The manufacturer must incur the cost of manufacturing his product before he gets paid for it. . . .
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> In the insurance industry, however, the reverse is true. The policyholder pays the insurance company in advance and the insurance company's costs, which are primarily the payment of claims, come afterwards. If the premiums were to be taxed as received and the deductions allowed only as they later became fixed, the result would be to tax very large sums of money as income when in fact those amounts will never really become income because they will have to be paid out to policyholders and other claimants.
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> The Annual Statement method of accounting relies extensively on the use of estimated amounts which would be improper under general tax accounting. Thus, for example, instead of taking into income all of the premiums received or accrued, casualty insurance companies take into account only the portion of those premiums which are estimated to be "earned." Similarly, the major deductions from income are "losses" and "loss adjustment expenses," which are again estimated amounts. The deduction of these loss and loss adjustment expense items is fundamentally at odds with the "all events" test: the items include amounts for liabilities which are not established, but, on the contrary, vigorously contested; they include, in the case of the loss adjustment items, expenses which will not only be paid in the future, but which are attributable to events which will not even occur until the future, including future overhead. . . .

Bituminous Casualty Corp. v. Commissioner, 57 T.C. 58, 77 (1971). (Similar excerpts are quoted in North Central Life Insurance Company v. Commissioner, 92 T.C. 254, 279-280 (1989); Sears, Roebuck and Co. v. Commissioner, 96 T.C. 61, 86-87 (1991), aff'd, rev'd, and remanded, 972 F.2d 858 (7th Cir. 1992); and Western Casualty and Surety Company v. Commissioner, 571 F.2d 514, 523-524 (10th Cir. 1978) (Barrett, J., dissent).

DISCUSSION

Issues 1. and 2.: Application of section 404 to amounts includible in insurance company loss reserves. The first and second issues under consideration raise the question as to which of two sets of deduction timing rules should apply to the taxpayer's estimated liability for payment of the VIP distributions to providers: the unpaid loss reserve rules of section 832, or the deferred compensation rules of section 404.

We summarized the background material on health insurance because, in the taxpayer's own words "In our response to IDR's 55 and 56 we spent considerable time differentiating traditional fee-for-service insurance from the managed care structure of health insurance." (Memorandum dated [redacted], from [redacted] to [redacted].) Clearly, the section 404 issue would not arise with traditional fee-for-service insurance, because traditional insurers do not enter into cost-sharing and profit-sharing arrangements with service providers. On the other hand, if the taxpayer did not claim to be an insurance company, there would be no question that the amounts in dispute would be considered deferred compensation subject to the rules of sections 404(a) and 404(d). By the taxpayer's own admission, [redacted] has entered into arrangements that are not traditional fee-for-service insurance, and yet -- by virtue of [redacted]'s status as an insurance company -- the taxpayer argues that those arrangements should be entitled to the favored tax treatment of insurance transactions.

The examining agent has proposed the disallowance of the portion of the taxpayer's deduction for losses incurred which reflects the taxpayer's estimate of its liability for medical incentive payments. The position being taken with respect to the proposed adjustment is similar to the position taken in PLR 9723005 (February 6, 1997). As noted above, [redacted] has rejected the reasoning of PLR 9723005, and some discussion of the PLR is necessary in order to respond to [redacted]'s arguments.

a. PLR 9723005. This private letter ruling dealt with an Independent Practice Association (IPA) model HMO which was taxable as an insurance company. The taxpayer entered into fee-for-service agreements with health care providers for two types of payments: risk withhold payments, and surplus distributions. The contractual arrangements described in the PLR are fairly complicated, but in broad general terms the providers would bill the taxpayer for their services at a standard cost rate. The taxpayer would pay [redacted] percent of the amount billed, and would retain the balance in a "risk withhold" account. The taxpayer would later compute the total of all claims incurred during the

calendar year and paid during the year or within 4 months of the close of the year, and would compare the amount paid to the total budget for that category of health care services. If the total claims paid exceeded the budgeted amount, the risk withhold amounts would be paid to the providers only up to the budgeted amount. If the total claims paid were less than the budgeted amount, the full amount of the risk withholds would be paid to the providers. In addition, the providers would receive a "surplus distribution" equal to 50 percent of the excess of the budgeted amount over the total claims paid.

The PLR considered the application of sections 832, 846, and 404 in the context of these profit- and risk-sharing arrangements:

> Unlike a traditional indemnity insurer, however, the HMO stresses the interaction of the specific health plan and the providers of health care, commonly known as managed care. The HMO, by entering into service arrangements with health care providers, seeks to ensure that while the services defined in the benefits package are available when enrollees require them, the payment structure and reimbursement formulas incorporate provisions that discourage the over-utilization of health care services. . . . [T]he HMO seeks to provide affiliated health care providers with financial incentives to control the utilization of health care services. In effect, the HMO gives its affiliated health care providers a financial stake in the health care plan's operation by basing their compensation, to a significant degree, on their ability to hold the usage of health care services to an appropriate level.
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> In this respect, the reimbursement formula established by Taxpayer's Risk Sharing Plan is no different than the performance-based compensation arrangements used in other industries, pursuant to which executives or other key personnel may qualify for additional compensation for current services based on a percentage of the corporation's net earnings or other performance-based criteria.

The PLR concludes that the deduction timing rules in section 404 take precedence over the determination of losses incurred under section 832. The amounts included in taxpayer's incurred but unpaid claims reserves for payment of risk withholds and surplus distributions to individual health care providers are liabilities incurred in connection with a deferred compensation arrangement.

Accordingly, the timing restrictions in sections 404(a) and 404(d) apply to taxpayer's deduction of these amounts.

b. Application of sections 832 and 404 in the present case. As noted above, private letter rulings and field service advice memoranda may not be used as precedents in the disposition of other cases but may be used as a guide with other research material in formulating a position on an issue. I.R.M. 7.2.10. While there are factual differences between the transaction described in PLR 9723005 and the transaction described in the present case, the general legal principles are the same. As we noted above, the taxpayer in the present case is not engaged in a pure, fee-for-service insurance business, but has chosen to enter into various managed care arrangements. The specific purpose of these arrangements is to defer some portion of the amounts paid to the care providers, subject to the overall profitability of the enterprise. The imposition of the deduction timing rules of section 404 is not the result of some statutory preference over the rules of section 832, but reflects the structure of the transaction chosen by the taxpayer.

Where a care provider is unrelated to the taxpayer, and the taxpayer makes payments in satisfaction of services furnished to a policyholder, the payments could be considered losses incurred withing the meaning of section 832. Where the taxpayer enters into a contractual relationship with the care provider under which amounts payable to the provider are not dependent solely upon the amount of services furnished but are limited in some manner to the overall profitablity of the enterprise, then to that extent the payments represent deferred compensation within the meaning of sections 404(a) and 404(d).

Section 832(a) provides that in the case of an insurance company subject to the tax imposed by § 831, the term "taxable income" means the gross income as defined in § 832(b) less the deductions allowed by § 832(c).

Section 832(b)(1) provides in part that the gross income of an insurance company subject to the tax imposed by section 831 equals the sum of the combined amount earned during the taxable year from investment income and from underwriting income; section 832(b)(3) defines "underwriting income" as the premiums earned on insurance contracts during the taxable year less losses incurred and expenses incurred. Section 832(c)(4) provides that in computing the taxable income of an insurance company subject to tax under section 831, a deduction is allowed for losses incurred as defined in section 832(b)(5). Thus, in the context of a traditional health insurance arrangement, where the care provider is unrelated to the insurance company, payments made in

satisfaction of services furnished to a policyholder by the care provider could be considered losses incurred withing the meaning of section 832.

In contrast, section 404(a) imposes limitations as to the amounts deductible in any year with respect to a plan "deferring the receipt of . . . compensation."

Sections 404(a)(1), (2), or (3) set forth rules for contributions to pension trusts, employees' annuities, and stock bonus and profit-sharing trusts. Section 404(a)(5) provides the general rule that if compensation is paid under a plan to which the contributions are not deductible under sections 404(a)(1), (2), or (3), then a deduction is allowable in the taxable year in which an amount attributable to the contribution is includible in the gross income of employees participating in the plan. Section 404(b) provides that if there is no plan, but there is a method or arrangement of compensation which has the effect of a plan deferring the receipt of compensation, section 404(a) shall apply as if there were such a plan.

Section 404(d) extends the general deduction-timing rule of section 404(a) to benefits or compensation paid to nonemployees, by providing that if a plan would be covered by section 404(a) but for the fact that there is no employer-employee relationship, the contributions or compensation shall be deductible for the taxable year in which an amount attributable to the compensation is includible in the gross income of the persons participating in the plan.

Section 1.404(b)-1T, Q&A-1, of the temporary regulations provides, in part, that sections 404(a) and (d) govern the deduction of compensation paid or incurred with respect to compensation and benefit plans, or methods or arrangements, however denominated, which defer the receipt of any amount of compensation or benefit, including fees and other payments. Under sections 404(a) and (b), if otherwise deductible, a contribution paid or incurred with respect to a nonqualified plan, or method or arrangement, is deductible in the taxable year of the employer in which or with which ends the taxable year of the employee in which the amount attributable to the contribution is includible in the gross income of the employee.

Section 1.404(d)-1T explains in more detail the application of sections 404(a), (b), and (d) to deferred benefits or compensation for service providers with respect to which there is no employer-employee relationship. It provides, in part, that section 404(d) governs the deduction of compensation paid or incurred by a payor under a plan, or method or arrangement,

deferring the receipt of compensation for service providers with respect to which there is no employer-employee relationship. In such case, sections 404(a) and (b) and the regulations thereunder apply as if the person providing the services were the employee and the person to whom the services are provided were the employer.

Section 1.404(b)-1T, Q&A-2(a), provides that, for purposes of sections 404(a), (b), or (d), a plan, or method or arrangement, defers the receipt of compensation or benefits to the extent it is one under which an employee receives compensation or benefits more than a brief period of time after the end of the employer's taxable year in which the services creating the right to such compensation or benefits are performed. The determination of whether a plan, or method or arrangement, defers the receipt of compensation or benefits is made separately with respect to each employee and each amount of compensation or benefit.

Section 1.404(b)-1T, Q&A-2(b)(1) provides that a plan, or method or arrangement, is presumed to be one that defers the receipt of compensation for more than a brief period of time after the end of an employer's taxable year to the extent that compensation is received after the 15th day of the third month after the end of the employer's taxable year in which the services are rendered ("the two and one-half month period").

Under § 1.404(b)-1T, Q&A-2(b)(2), the taxpayer may rebut this presumption only by demonstrating that it was impracticable to avoid the deferral of the receipt by an employee of the amount of compensation or benefits beyond the applicable two and one-half month period and that, as of the end of the employer's taxable year, such impracticability was unforeseeable.

Thus, in the context of a managed care arrangement, where the taxpayer enters into a contractual relationship with the care provider under which amounts payable to the provider are not dependent solely upon the amount of services furnished to a policyholder but are limited in some manner to the overall profitablity of the enterprise, then to that extent the payments represent deferred compensation withing the meaning of sections 404(a) and 404(d).

Again, we emphasize that the application of the deduction timing rules of sections 404(a) and (d) arises from the taxpayer's choice of structure for its managed care operations. Section 832 and the rules for "losses incurred" are directed at traditional insurance arrangements, where the care provider is unrelated to the insurance company and the amount paid depends

solely on the services furnished to the policyholder and not on the overall profitability of the enterprise. The taxpayer has chosen to enter into contractual relationships with care providers which have the effect of deferring compensation to the care providers. The deduction timing rules of section 404(a) are broad in scope and are not confined to qualifying pension, profit sharing, and stock bonus plans; these rules are applicable to all compensation arrangements which defer the receipt of compensation by an employee or independent contractor.

The Tax Reform Act of 1984 amended § 404(b)(1) to clarify the broad scope of the deduction timing rules. See H.R. Rep. No. 432, Pt. 2, 98th Cong., 2d Sess. 1283 (1984). The Tax Reform Act of 1986 included a further "clarifying amendment" to the 1984 changes, eliminating references to sections 162 and 212. This amendment clarified that the timing restrictions for deferred compensation arrangements apply to all forms of compensation for services rendered, regardless of the provision under which this compensation would be deductible. The legislative history explained the Congressional intent underlying this statutory change as follows:

> The bill clarifies that the deduction-timing rules for deferred compensation arrangements apply to any plan or method of deferring compensation regardless of the section under which the amounts might otherwise be deductible and that the amount shall be deductible under section 404(a)(5) and shall not otherwise be deductible under any other section. This clarification is necessary to prevent taxpayers from asserting that deferred compensation is attributable to capitalizable compensation expenses and, thereby, accelerate the timing of the deduction of such deferred compensation.

See S. Rep. No. 313, 99th Cong., 2d Sess. 1013 (1986).

Accordingly, even if the estimated liability for payment of risk withholds and surplus distributions could otherwise be considered "losses incurred" under section 832, the deduction timing rules of section 404(a)(5) apply because such payments are considered "deferred compensation."

Issue 3.: Application of section 404 to accrual-basis payees. Section 404(d) extends the general deduction-timing rule of section 404(a) to benefits or compensation paid to nonemployees by providing that if a plan would be covered by section 404(a) but for the fact that there is no employer-employee relationship, the contributions or compensation (if otherwise deductible by the payor under chapter 1 of subtitle A),

shall be deductible for the taxable year in which an amount attributable to the compensation is includible in the gross income of the persons participating in the plan. Where the payee is a cash-basis taxpayer, the compensation would not be includible in gross income until it is received, and, under the rules of section 404 the payor would not be allowed to claim a deduction for the payment until it is received by the payee.

The taxpayer contends that sections 404(a) and 404(d) do not affect the determination of an insurance company's losses incurred and loss adjustment expenses, but if the Service continues to assert that [redacted]'s provider settlement reserves are subject to section 404(a), the taxpayer asserts that the deduction timing rules apply only to cash-basis taxpayers.

There is nothing that limits the application of sections 404(a) and 404(d) to cash-basis payees. Note that the effect of the deduction timing rules is that the timing of the payor's deduction is determined by the timing rules for the payee's income. Even where the payor and the payee are both accrual-basis taxpayers, the payee's rules for accruing income may differ from the payor's rules for accruing a deduction.

Generally under the accrual method income is to be included for the taxable year when all the events have occurred that fix the right to receive the income and the amount of the income can be determined with reasonable accuracy. Treas. Reg. § 1.446-1(c)(1)(ii).

Based on the description of the "Value Incentive Program" set forth in the agreement with the physicians, it appears that the taxpayer exercises considerable judgment in determining the total amount that will be paid for VIP distributions, when that amount will be paid, and how it will be divided among the participating physicians. Much of the information necessary for making these determinations may not be available to the taxpayer as of [redacted]. Much of the determinations seems to be subject to the judgment of the taxpayer. Accordingly, based on the information available, it has not been established that any participating physician would have an enforceable right to any distribution as of [redacted]. See, Emery Kinkead, Inc. v. Commissioner, 35 T.C. 152 (1960). United States v. Safety Car Heating and Lighting Co., 297 U.S. 88 (1936); Continental Tie and Lumber Co. v. United States, 286 U.S. 290 (1932).

Furthermore, even if sufficient information were available to the taxpayer at [redacted], it is unlikely such information would be available to the participating physicians. Accordingly, it has not been established that any participating physician

would be able to estimate the distribution with reasonable accuracy. Continental Tie and Lumber Co. v. United States, supra.

Issue 4.: The impact of section 846. Section 846 provides for the discounting of additions to unpaid loss reserves under section 832. Accordingly, the taxpayer argues that "The objective of Section 404(a) is to match income and expense. This matching principle is achieved for insurance companies by section 846."

The fact that Congress enacted section 846 and amended 832 does not preclude the application of 404 to amounts that might otherwise be deductible under section 832. Clearly, not all items includible in unpaid loss reserves would be considered deferred compensation. In a traditional insurance arrangement, the insured is the payor of compensation to the party that provides services which mitigate the insured's loss. The insurer then reimburses the insured for the payments to the provider. In a traditional insurance arrangement, where there are no compensatory agreements between the insurer and the parties that provide services to the insured, section 404 would not apply. In those cases, section 846 would limit the insurer's deduction for unpaid losses to the discounted value of the amount that ultimately will be paid. Thus, there are situations where section 846 would apply, and section 404 would not be applicable.

On the other hand, in the area of health care and health insurance, arrangements have evolved that blur the distinction between the insurer reimbursing the insured for health care services provided by an unrelated third party, and situations such as the present case, where the insurer participates in providing services to the insured and exercises some control over the timing of the compensation to the party providing those services.

It can be argued that both section 846 and section 404 recognize the significance of the time value of money, but that does not mean that this is the principal purpose of both sections, or that one section applies only when the other does not. The taxpayer asserts that where section 846 applies, section 404 is not necessary; it could as well be argued that section 846 is necessary only where section 404 does not apply. Without going into an analysis of the purposes behind section 404, the fact that it deals with "deferred compensation" suggests that the time value of money is not its sole concern. By definition, a compensation transaction involves two parties, and section 404 achieves symmetry between the deduction by one and the inclusion by the other. While section 846 is concerned with

matching the income and expenses of a single taxpayer, section 404 is concerned with matching income and expenses between taxpayers

Practical issues. In its response to IRR's 55 and 56, the taxpayer suggests that there are "enormous practical problems" in implementing the tax treatment proposed by the examining agent. In his memorandum of [redacted], [redacted] suggests it "will be a challenge" to determine the amounts paid to accrual basis taxpayers.

We do not know the quality of the taxpayer's records, or the capacity of its data-processing functions. Clearly, this could be a difficult undertaking, but it is an undertaking that arises from the particular contractual relationships which this taxpayer has chosen to enter into in carrying on its business. As indicated above, section 404 would generally not apply to amounts included in unpaid loss reserves for traditional insurance transactions.

Furthermore, Section 10.7 of the Participating Physician Group Agreement states:

> Physician Group shall furnish to [redacted] a current list of all physicians who are officers, Physicians, employees, agents, and/or independent contractors of Physician Group categorized by full name, specialty (if applicable), board status (if applicable), hospital affiliation (if applicable) and such other information as [redacted] reasonably requests.

Clearly, the taxpayer has information indicating the parties that receive compensatory payments under the VIP distribution process. While the information currently available may not be sufficient to determine the accounting method of those parties, or the specific amount received by each member of a physician group, that information should be available to the taxpayer. Where the taxpayer has chosen to structure a transaction in a way that makes it difficult to comply with the requirements of the Internal Revenue Code, we believe it would be preferable for the taxpayer to consider modifying the structure of the transaction, rather than seeking exemption from compliance.

ADDITIONAL INFORMATION

As indicated above, some of the material provided by the taxpayer is not completely responsive to the examining agent's requests. We have not reviewed the entire file, and accordingly

additional information may be included in the file which more fully explains the details of the transactions in issue. The following are suggestions of additional facts that may be relevant to this issue:

(b)(5)(AC), (b)(7)a

(b)(5)(AC), (b)(7)a

(b)(5)(AC), (b)(7)a

(b)(5)(AC), (b)(7)a

If you have any questions regarding this memorandum, please call Charles Maurer at (617) 565-7838.

This writing may contain privileged information. Any unauthorized disclosure of this writing may have an adverse effect on privileges, such as the attorney client privilege. If disclosure becomes necessary, please contact this office for our views.

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By: _____
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