INTERNAL REVENUE SERVICE

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INTERNAL REVENUE SERVICE NATIONAL OFFICE FIELD SERVICE ADVICE

MEMORANDUM FOR DISTRICT COUNSEL, CONNECTICUT-RHODE ISLAND
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FROM: Heather Maloy
Associate Chief Counsel CC:ITA

SUBJECT: Deduction for Expenses Incurred but not Reported

This Field Service Advice responds to your memorandum dated July 25, 2000. Field Service Advice is not binding on Examination or Appeals and is not a final case determination. This document is not to be cited as precedent.

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LEGEND:
A = .
B = .

Year 1 =
Year 2 =
b =
c =
e =
f% =
State A =
g =
h% =

ISSUES

1. Whether A qualifies as an insurance company for purposes of deducting net increases in its loss reserves pursuant to I.R.C. section 832.

2. Whether A, a professional corporation in the business of providing medical services, satisfies the all events test so it is entitled to accrue a deduction for services provided by outside medical specialists for which claims for payment have not been submitted.

CONCLUSIONS

1. Based on the information we have received, it is our position that the managed health care plans offered by A are principally prepaid contracts for services to be rendered in the future and not insurance contracts. Whether A qualifies as an insurance company for tax purposes requires, at a minimum, a determination that A's business involves more insurance business than any other type of business, which is not the case here.

2. Once services are provided, A satisfies the all events test for preauthorized services by outside medical specialists, notwithstanding that claims for payment have not been submitted.

FACTS

A is a professional corporation established in Year 1. It is in the business of providing medical services and has b employees of which approximately c are physicians. Since Year 2, A has been owned by e shareholder physicians and by B, a State A health maintenance organization (HMO).

A derives its income from two sources: (1) 80 percent of its income comes from capitation payments received under a contract with B to provide services to B's members; and (2) 20 percent of its income comes from fee for services to individuals not affiliated with B (i.e. members of other HMOs).

A is an accrual method taxpayer for both book and tax purposes. Capitation payments from B are recorded in income in the month for which coverage is provided. Revenue from fee-for-services patients is recorded in the period in which the services are performed.

A often refers patients to outside specialists, also known as referral physicians. Under its contract with B, A is required to pay for the services provided by the outside specialists. At times A will refer a patient to an outside specialist for a number of visits. On average, only approximately one-third of the visits to outside specialists approved by A are actually used by the patients. If a referral to an outside specialist is made and the patient receives treatment from the outside specialist, the outside specialist must submit a claim form to B in order to receive payment. In general, all claims must be submitted within g days of the date of service. Any claim for payment submitted beyond g days, but within one year of the date of treatment, must be submitted with an explanation as to why the claim was submitted late. Claims submitted beyond one year from the date of treatment are not paid. B can deny a claim for a number of reasons such as: (1) late submission, (2) no referral from the primary care physician, and (3) lack of membership in the plan.

If a claim submitted by an outside specialist is approved by B then it becomes A's liability, subject to the risk/reward clause under which B and A share in the referral expense variance. The charges for outside medical services provided to A's members are recorded by A in the period in which the services are provided. These charges include amounts based on estimates for reported charges as well as estimates for services performed by outside specialists but not reported (IBNR) by the outside specialists to B. The IBNR amount is based on a per member per month actuarially estimated amount. It is not based on the number of referrals outstanding at year-end. A does not know the cost for an outside specialist until a claim is filed because the cost can vary depending on how many times the patient visits the specialist, and whether the specialist orders additional treatment. For the year in issue, A understated its IBNR deduction. Form 886-A, p.3.

A is not regulated and licensed by the state as an insurance company. It does not file an annual statement with the state's insurance department. Nor does it file a non-life insurance tax return (Form 1120-PC) with the Internal Revenue Service. A does not issue any annuity contracts. A does not issue insurance contracts to itself or B or reinsure risks underwritten by other insurance companies.

LAW AND ANALYSIS

1. In order to qualify as an insurance company for purposes of Subchapter L of the Code, A must show that its "primary and predominant" business is the issuing of insurance contracts, which means that the contract must provide for risk shifting, and A deals with this risk by distributing it over many independent risks. In determining whether a managed health care plan is insurance, it is necessary to scrutinize the plan as a whole and not artificially segregate simple components or phases of the plan. Jordan v. Group Health Association, 107 F.2d 239, 245-46 (D.C. Cir. 1939).

Property and casualty insurance companies are taxed in accordance with the provisions of section 831. However, under present law, there is no statutory definition for a property and casualty insurance company. The regulations promulgated under section 831 provide some guidance by referencing the definition set forth in regulations under section 801. Treas. Reg. § 1.831-3(a). That regulation provides that an insurance company is a company "whose primary and predominant business activity during the taxable year is the issuing of insurance or annuity contracts or reinsuring of risks underwritten by insurance companies." Treas. Reg. §1.801-3(a)(1). There is nothing in the regulations or case law that definitively quantifies the standard "primary and predominant business activity."

Neither the Internal Revenue Code nor the regulations thereunder define the terms "insurance" or "insurance contract." The accepted definition of "insurance" for Federal income tax purposes relates back to Helvering v. LeGierse, 312 U.S. 531 (1941), in which the Supreme Court stated, "[h]istorically and commonly insurance involves risk-shifting and risk-distributing." Id. at 539. Case law has defined an insurance contract as "a contract whereby, for an adequate consideration, one party undertakes to indemnify another against loss arising from certain specified contingencies or perils. . . .[I]t is contractual security against possible anticipated loss." Epmeier v. United States, 199 F.2d 508, 509-10 (7th Cir. 1952). In addition, the risk transferred must be risk of economic loss. Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976), aff'd, 572 F.2d 1190 (7th Cir. 1978), cert. denied, 439 U.S. 835 (1978).

Risk-shifting occurs when a person facing the possibility of an economic loss transfers some or all of the financial consequences of the loss to the insurer. If the insured has shifted its risk to the insurer, then a loss by the insured does not affect the insured because the loss is offset by the insurance proceeds. See Rev. Rul. 92-93, 1992-2 C.B. 45 (permitting a parent company to deduct premiums paid to the insurance subsidiary for group-term life insurance on an employee of the parent).

Risk distribution incorporates the statistical phenomenon known as the law of large numbers. Clougherty Packing Co. v. Commissioner, 811 F.2d 1297, 1300 (9th Cir. 1987). When additional statistically independent risk exposures are insured, an insurance company's potential total loss increases, as does the uncertainty regarding

the amount of that loss. As uncertainty regarding the company's total loss increases, however, there is an increase in the predictability of the insurance company's average loss (total loss divided by the number of exposure units). That is, when the sample number increases, the probability density function of the average loss tends to be more concentrated around the mean. Due to this increase in predictability, there is a downward trend in the amount of capital a company needs per risk unit to remain at a given level of solvency. See Rev. Rul. 89-61, 1989-1 C.B. 75.

It is the position of the National Office that managed health care plans, such as those at issue herein, are principally prepaid service contracts, and not insurance contracts because the prerequisite elements of risk shifting and risk distribution do not exist. See Rev. Rul. 68-27. However, assuming arguendo that A's agreement to provide medical services to its members can be construed as an acceptance of the risk that members will be unable to pay for health care service, we would argue that the HMO plans still do not qualify as insurance because (1) that aspect of the health service plan is miniscule in relation to the noninsurance aspects of these plans, and (2) A is providing medical services at reduced costs and not distributing risk. Both points are supported by the Supreme Court's decision in Group Life. According to the Supreme Court, when a company that has accepted risk from its members handles the risk by providing arrangements for the purchase of medical goods and services, there is no "underwriting or spreading of risk," 440 U.S. at 214 (i.e., no risk shifting or distribution), and therefore the arrangement does not qualify as insurance.

The Service has acknowledged in published and private rulings that there are aspects of a prepaid service contract that resemble insurance. However, in each situation, the Service has ruled that the indemnity feature was minor in comparison to the predominant purpose of the health service plan which was the provision of health care services at the lowest possible cost.

For example, in Rev. Rul. 68-27, the Service ruled that an HMO which issued medical service contracts to groups or individuals and furnished direct medical services to subscribers did not qualify as an insurance company for purposes of the Code. Generally, the medical staff provided a major portion of the medical services contracted for by the subscribers. However, when the staff was unable to perform the medical services contracted for because the injury or illness occurred in another geographical area or because a specialist or hospitalization was required, the organization paid the entire cost of such services. A review of the organization's financial operations indicated that a major portion of the HMO's expenses related to the service feature and only a minor portion related to the dollar indemnity feature. Also, the HMO was classified under state law as a health care service contractor. The HMO was not deemed to be engaged in the insurance business and was not subject to state laws relating to insurance companies.

The Service concluded that any risk that existed in the context of a staff model HMO engaged in the rendering of health care services constituted a normal business risk rather than that which it incurred in providing the medical services through a salaried staff of physicians, nurses and technicians. Consequently, the Service ruled that the medical service contract issued by the HMO was not an insurance contract, and the predominant business activity of the organization was not the issuance of insurance contracts.

We would contend that based upon a practical considerations of the functions performed by an HMO, and the methods used by an HMO in performing such functions, an HMO cannot be considered an insurance company. Indeed, we would contend that the principal purpose of an HMO is the rendition of services and that any indemnification aspect resulting from the payment for services rendered by specialists and outside hospitals was incidental to an HMO's purpose of providing and arranging for health care services. In essence, we would contend that the service arrangements A offers are more in the nature of a consumers' cooperative which is concerned principally with getting service rendered to its members and doing so at lower prices made possible by quantity purchasing and economies in operation.

For example, in Jordan v. Group Health Association, 107 F.2d 239 (D.C. Cir. 1939), the court held that a prepaid health service plan was a prepaid contract for service and not an insurance company within the meaning of the District of Columbia Code, D.C. Code 1929, tit. 5, section 179. Group Health was a nonprofit corporation that provided medical services (preventive and curative, surgery and hospitalization) to its members. Group Health did not maintain a staff of full-time salaried physicians to work under its direction, but arranged for medical and surgical services to be rendered by independent practitioners.

The court concluded that Group Health was "in fact and in function a consumer cooperative" which is distinguishable from an insurance or indemnity company. Jordan, 107 F.2d at 247. According to the court, a "cooperative is concerned principally with getting service rendered to its members and doing so at lower prices made possible by quantity purchasing and economies in operation." Id. However, an insurance company is concerned primarily, if not exclusively, with risk, not with provision or distribution of service. Id. The court noted that insurance and cooperatives differed in that cooperatives contracted for the rendering of service on the contingency that it might be needed, while insurance companies merely pay the costs when or after services are actually rendered. Id. at 247-48.

The court in Jordan also noted that if an organization owned, operated and controlled by physicians offered a similar plan to provide service, such plan would not be "insurance" or "indemnity." Jordan, at 248. Although the same element of risk would exist, the plan would be a contract "for service on contingency." Id. The court

indicated that there was no basis for distinguishing between a plan which is controlled, for business purposes, by professionals, and a plan which is controlled by nonmedical professionals. Thus, if the plan is for "service," not "insurance," in the one case, it should not be treated as insurance in the other case. Id.

The Supreme Court in Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1978), relied on Jordan in holding that certain contractual arrangements between Blue Shield and a number of pharmacies were arrangements for the purchase of goods and services and not insurance. Consequently, the Court held that such purchase arrangements did not constitute the "business of insurance," and thus were not exempt from the antitrust laws under Sec. 2(b) of the McCarran-Ferguson Act.

The Court construed the definition of the "business of insurance" by reference to states' treatment and regulation of prepaid health service plans, stating that prepaid health-service plans and corporations organized for the purpose of providing members with medical services were either exempted from state insurance code requirements or were not to "be construed as being engaged in the business of insurance" under state law. Group Life, 440 U.S. at 225.

According to the Court, the contemporary perception of a health-care organization as a prepaid contract for service, rather than insurance, was exemplified by the decision in Jordan. Id. at 227-28. Thus, the Court stated that it is difficult to assume that, contrary to a majority of court decisions, Congress in 1945 understood that advance-payment medical-benefits plans "are the 'business of insurance.'" Id. at 229-30. Consequently, the Court concluded that it is next to impossible to assume that Congress could have thought that agreements (even by insurance companies) which provide for the purchase of goods and services from third parties at a set price are within the meaning of that phrase. Id. at 230.

A's predominant business activity is the provision of services and noninsurance business activities, and A should not qualify as a life insurance company for Federal tax purposes.

2. Section 461(a) provides that the amount of any deduction or credit allowed under
subtitle A shall be taken for the taxable year which is the proper taxable year under the method of accounting used in computing taxable income.

Treas. Reg. § 1.461-1)a)(2) provides that under an accrual method of accounting, a liability if incurred, and generally is taken into account for federal income tax purposes, in the taxable year in which all the events have occurred that establish the fact of the liability, the amount of the liability can be determined with reasonable

accuracy, and economic performance has occurred with respect to the liability.

Section 461(h)(1) provides that in determining whether an amount has been incurred with respect to any item during any taxable year, the all events test shall not be treated as met any earlier than when economic performance with respect to such item occurs. Section 461(h)(2)(A) provides that if the liability of the taxpayer arises out of the providing of services or property to the taxpayer by another person, economic performance occurs as such person provides such services or property. See also Treas. Reg. § 1.461-4(d)(2)(i). Treas. Reg. § 1.461-4(d)(6)(i) provides that services or property provided to a taxpayer includes services or property provided to another person at the direction of the taxpayer.

Section 461(h)(3) (the recurring item exception) provides that, notwithstanding the general rule of section 461(h), an item shall be treated as incurred during an y taxable year if-

(i) the all events test with respect to such item is met during such taxable year,
(ii) economic performance with respect to such item occurs within the shorter of- (i) a reasonable period after the close of such taxable year, or
(ii) 8 ½ months after the close of such taxable,
(iii) such item is recurring in nature and the taxpayer consistently treats items of such kind as incurred in the taxable year in which the requirements of clause (i) are met, and
(iv) either- (i) such item is not a material item, or
(ii) the accrual of such item in the taxable year in which the requirements of clause (i) are met results in a more proper match against income than accruing such item in the taxable year in which economic performance occurs. See also Treas. Reg. § 1.461-5.

Section 461(h)(2)(A) provides that if the liability of the taxpayer arises out of the providing of services or property to the taxpayer by another person, economic performance occurs as such person provides such services or property. See also Treas. Reg. § 1.461-4(d)(2)(i). Treas. Reg. § 1.461-4(d)(6)(i) provides that services or property provided to a taxpayer includes services or property provided to another person at the direction of the taxpayer.

In United States v. General Dynamics Corp., 481 U.S. 239 (1987), employees were required to submit health insurance claims to taxpayer's self-insured health insurance plan in order to receive reimbursement for medical care. While the Court did not challenge the Claims Court's factual conclusion that the processing of the claims was "routine", "clerical," and "ministerial" in nature, Id. at 244 n.4, it held that a claim must be submitted in order for the liability to reimburse employees for medical expenses to be fixed under the all events test. The Court noted that some covered individuals, through oversight, procrastination, confusion over the coverage provided,

or fear of disclosure to the employer of the extent or nature of the services received, might not file claims for reimbursement to which they are plainly entitled. Thus, the Court found the filing of the claim was not a mere technicality, but essential to establishing a fixed liability. Id. at 244.

Rev. Rul. 98-39, 1998-2 C.B. 198 holds that an accrual method manufacturer's liability to pay a retailer for cooperative advertising services is incurred in the year in which the services are performed, even though the retailer does not submit the required claim form until the next year.

The field's position is that A may not deduct an IBNR reserve because the all events test has not been met, and based on United States v. General Dynamics, supra, the medical liability requires a claim form for payment, just as in General Dynamics. The field also believes that A seeks to deduct an actuarial estimate of the claims it expects will be filed in the future, and the last event creating the liability occurs when a specialist submits a claim.

A relies on a revenue ruling and a field service advice to justify its proposed deduction. First, it cites to Rev. Rul. 98-39, supra, in which the Service held that a deduction for cooperative advertising services is permitted once services are performed and if the liability is capable of estimation with reasonable accuracy. The required claim form for payment is ministerial and does not delay accrual of the liability.

FSA, 1999 TNT 127-89 involved HMO's and preauthorized services and permitted a deduction for provided services which could be estimated with accuracy, even though required claim forms had not yet been filed. We note, of course, that Field Service Advice is not binding precedent for anyone under any circumstances.

This case is distinguishable from General Dynamics. Specialists provide specific preauthorized medical services with the understanding that they will be reimbursed by A. There is no reason for the specialists not to seek payment for their services. In this context, the submission of a claim merely verifies that medical services have been provided, and it is the provision of services that establishes the fact of A's liability. Thus, the filing of the claim by a specialist is a ministerial act, not a condition precedent that is necessary to establish A's liability. See Rev. Rul. 98-39, supra.

Section 461(h)(2)(A) provides that if the liability of the taxpayer arises out of the providing of services or property to the taxpayer by another person, economic performance occurs as such person provides such services or property. See also Treas. Reg. § 1.461-4(d)(2)(i). Treas. Reg. § 1.461-4(d)(6)(i) provides that services or property provided to a taxpayer includes services or property provided to another person at the direction of the taxpayer. A refers patients to outside specialists, and

under its contract with B is required to pay for the services provided to patients by the specialists. Thus, A's liability arises out of the providing of medical services and economic performance occurs as the specialists provide medical services. At the time the medical services are provided, the fact of the liability has been established and economic performance has occurred with respect to the liability.

In general, we believe that the rule of law of General Dynamics should be confined to analogous facts involving consumers or patients. Where a claim for payment in which processing is ministerial[1] is required from a business in a commercial transaction, the fixing of the liability is not delayed until the claim is filed. The claim filing itself is ministerial, that is, it is not essential to the process of fixing the liability. This is in contrast to General Dynamics where the claim was essential for the employee to receive reimbursement.

Once medical services have been preauthorized and services are provided, accrual is appropriate if it can be verified that A has made a reasonably accurate estimate of its liability, which is likely. A's estimate may be made in the aggregate, rather than individually, and the estimate may be derived from specific historical data. In that case the method of computing the reserve did not reflect any specific liability to particular employees who received treatment, rather, the employer estimated aggregate liability, claiming it to be the most reasonable method for estimating liability–a method derived from procedures developed by the insurance companies. The court noted that 82.2% of the accrued reserve amount sought to be deducted was subsequently paid, and this percentage is well within the reasonably accurate range accepted by the courts for the purposes of satisfying the second prong of the all events test. General Dynamics, 6 Cl.Ct. at 253, 256 citing Harrold v. Commissioner, 192 F.2d 1002, 1003 (4th Cir. 1951); Denise Coal Co. v. Commissioner, 271 F.2d 930, 936 (3rd Cir. 1959).

As a final point, A has asserted as one of its arguments in this case, its eligibility to use the recurring item exception, but that exception serves to accelerate a deduction when economic performance has not yet been met. Here, we have concluded that the all events test and economic performance occur at the same time, so the recurring item exception is not applicable.

CASE DEVELOPMENT, HAZARDS AND OTHER CONSIDERATIONS

We would argue that, in viewing A's health service plans as a whole, the principal aspect of such plans is the arranging for the provision of services in a manner which minimizes costs and maximizes profits. Although certain aspects of A's activities

[1]The Supreme Court in General Dynamics did not challenge the Claims Court's factual conclusion that the processing of employee's medical claims was "routine", "clerical", and "ministerial in nature." The Claims Court made these findings despite the fact that approximately 10% of claims were rejected by the claims administrators and ultimately were not paid. General Dynamics v. United States, 6 Cl.Ct. 250, 254 (1984).

may resemble insurance, such as purchasing specialist care on a fee-for-service basis, these components are incidental to the predominant business activity. Consequently, because it appears that A's activities involve considerably more noninsurance business than insurance business, we would argue that the primary and predominant business activity is the not the issuance of insurance contracts.

While the Service has previously determined an HMO issues contracts for prepaid medical services, which are not contracts for insurance, PLR 9412002 contains a contrary holding. In that ruling, the Service ruled that independent practice model HMOs qualify as insurance companies for Federal income tax purposes. However, that ruling is distinguishable because in that ruling the HMO was not licensed to practice medicine, filed Form 1120-PC, was regulated by the state's department of insurance, and the premiums were actuarially determined.

With respect to issue two, as discussed supra, it appears that A's methodology for estimating its liability is reasonably (quite) accurate and not subject to challenge.

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