

Office of Chief Counsel  
Internal Revenue Service  
**Memorandum**

Release Number: **20101502F**

Release Date: 4/16/10

CC:LM:F:BOS:  
POSTU-144536-09

UILC: 833.02-00

date: February 04, 2010

to: Technical Advisor, Health & Blue Cross Blue Shield (BC/BS) Insurance  
(Internal Revenue Service, LMSB, Rothschild, WI)  
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from: Associate Area Counsel, Boston, MA  
(Large & Mid-Size Business)

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subject: I.R.C. § 833(b) Special Deduction

This Chief Counsel Advice responds to your request for assistance. This advice may not be used or cited as precedent.

LEGEND

Taxpayer =  
Taxpayer State =  
Program X =  
Program Y =  
Program Z =  
Program Card =  
Year 1 =  
Year 2 =  
Year 3 =  
Year 4 =  
Year 5 =  
Year 6 =

## ISSUE

In determining "claims incurred" and "liabilities incurred . . . under cost-plus contracts" for purposes of the special deduction described in I.R.C. § 833(b), may a BCBS organization include only claims and liabilities that it processes as a "Home" plan with respect to its own subscribers, or may it also include claims and liabilities that it processes as a "Host" plan with respect to subscribers of other BCBS plans, which reimburse the Host plan for the expenditures made "plus" a processing fee.

## CONCLUSION

The special deduction applies only to claims and liabilities with respect to subscribers of the plan claiming the deduction and does not include claims and liabilities with respect to subscribers of other plans. In computing the special deduction described in section 833(b), a "Host" plan may include only claims and liabilities of its own subscribers and not claims and liabilities of subscribers of other BCBS plans for which it is reimbursed by the "Home" plans of those subscribers.

NOTE: The claims for refund in this case include three arrangements, described as "Program Y," "Program Z" and "Program X." The Taxpayer's Protest acknowledges that claim payments under the Program X arrangements are the most significant, and the arguments in the Protest are generally addressed to those arrangements. There are numerous factual issues regarding all three arrangements which are not within the purpose of Chief Counsel Advice, and no concession is being made by the omission of those issues from this memorandum.

## FACTS

The Taxpayer is "an existing Blue Cross or Blue Shield organization" within the meaning of I.R.C. §833(c)(2), and therefore eligible to claim the special deduction provided by section 833(a)(2).

The Taxpayer filed claims for refund for the taxable years Year 1 and Year 2, stating that it had identified three arrangements that should have been included in the special deduction but were not. The claims describe these arrangements as "Program Y," "Program Z," and "Program X." The greatest portion of the claimed deductions is attributable to "Program X" transactions, where the Taxpayer processes claims as a "Host" plan with respect to subscribers of other BCBS plans.

While the claims were being examined, the Taxpayer filed requests for affirmative adjustments on similar grounds for the taxable years Year 3, Year 4, and Year 5. The claims have been disallowed.

The Taxpayer filed a Protest which alleged as follows:

*Taxpayer's Annual Statement Reporting* -- As part of the Year 6 audit of Taxpayer's statutory financial statements, Taxpayer's auditors required Taxpayer to classify its Program Y (described below) and Program X programs as ASC/Cost-Plus and to disclose the claims paid in Footnote 15 of its Audited Statutory Financial Statements. . . . The auditors required this correction because the Program X obligations meet the basic definition of an ASC/Cost-plus plan in SAP 47, in that they require Taxpayer to pay medical claims out of its own bank account before it is reimbursed. To repeat, under a Cost-plus contract, the administrator pays a medical claim (the **cost**) out of its own bank account, and then receives reimbursement of the cost, **plus** a fee for the recovery of its expenses and for profit.

*Taxpayer's Refund Claims* -- The required correction to its Annual Statement reporting for Year 6 prompted Taxpayer to identify three programs that should have been included in the special deduction formula and file refund claims in open years reporting its entitlement to a special deduction. These were the Program X and the Program Y and the Program Z arrangements discussed below. The Program X claim payments are by far the most significant. [Protest, pages 10-11, boldface and italics in original.]

The Blue Cross and Blue Shield Association (BCBSA). The Blue Cross and Blue Shield names and symbols are controlled by the Blue Cross and Blue Shield Association (BCBSA). At the time section 833 was enacted, the BCBSA licensing agreements limited use of the names and symbols to each plan's service territory and granted exclusive use within that territory.

At the time section 833 was enacted, the membership standards of the BCBSA included a requirement that the plan must be organized as a not-for-profit entity. In addition, "the plan must participate effectively and efficiently in each national program adopted by the member plans." Central Benefits Mutual Insurance Co. v. Blue Cross and Blue Shield Association, 711 F. Supp. 1423, 1426 (S.D. Ohio 1989). See also, General Accounting Office, Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight, GAO/HEHS-94-71 (April 1994), page 29: "A plan must participate in national programs that provide portability of membership between Blues plans and ease claims processing for customers that receive benefits outside of its service area." (Emphasis added.)

BCBSA National Programs. The operations of each BCBS organization are restricted to its license territory, yet its subscribers may require services while outside that territory. In addition, employers with a headquarters in the territory of one BCBS plan may have employees in multiples territories of other BCBS plans.

To facilitate coverage in multiple territories, the BCBSA coordinates "National Programs." The BCBS plan issuing a policy or contract is described as the "Home" plan, operating within its "home" territory. If a subscriber requires services outside that territory, the BCBS plan operating in that territory is described as the "Host" plan.

In general, if a BCBS organization is acting as a "Host" plan, it collects the initial claims data and forwards it to the Home plan for a determination whether the claim is covered by the policy issued by the Home plan. The Host plan does not make any determination regarding the scope of coverage or the subscriber's eligibility for coverage.

The Home plan evaluates the data submitted by the Host plan, determines whether or how much of the claim is allowable, and advises the Host plan of its determination. The Host plan then makes payment to the service provider and submits a claim to the Home plan for reimbursement.

All of the financial transactions between the Host plan and the Home plan are carried out through a BCBSA entity which nets and automatically settles inter-licensee financial obligations arising from claims handled through these inter-plan programs. These net settlements are made on a daily basis by direct access to each plan's bank accounts.

Thus, in one sense two BCBS plans do make "payments" with respect to an out-of-territory claim. Initially the Host plan "pays" the claim submitted by the service provider, but eventually the Home plan "pays" the claim by reimbursing the Host plan. Ultimately, however, only one BCBS plan -- the Home plan -- is responsible for the payment of the claim, and ultimately the claim is only paid once -- by the Home plan.

## LAW AND ANALYSIS

Section 833 represents a stage in the evolution of Blue Cross and Blue Shield (BCBS) organizations, which began during the Depression as community-based non-profit organizations providing funding for health care and now rank among the largest health insurance companies on the New York stock exchange.

Background on the special deduction. On December 7, 1985, the House Committee on Ways and Means released a report on a bill entitled "Tax Reform Act of 1985," H.R. 3838, 99th Cong. (1985). The Report expressed concern "that exempt charitable and social welfare organizations that engage in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax-exempt status is inappropriate. The committee believes that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations." H.R. Rep. No. 99-426 at 664 (1985). See also, Staff of the

Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986 at 584 (1987).

On October 25, 1985, before the House bill was passed, the Chairman of the Subcommittee on Health of the Committee on Ways and Means requested that the General Accounting Office examine the potential impact on the availability of health insurance that would result from taxing BCBS plans. On July 11, 1986, after the House bill had been passed but before the final statute was enacted, the General Accounting Office transmitted a report to the Chairman entitled Health Insurance: Comparing Blue Cross and Blue Shield Plans With Commercial Insurers, GAO/HRD-86-10 (July 1986). In preparing the report, GAO obtained information from the BCBSA and a draft of the report was furnished to the Association for comment. The BCBSA objected to the proposed legislation and contended that the plans' current exemption was warranted for several reasons. The first reason was "The plans are nonprofit community service organizations that finance health care for individuals and small groups who could not obtain health insurance elsewhere." 1986 GAO Report, page 9.

The Tax Reform Act of 1986, Pub. L. 99-514 (October 22, 1986), represents a compromise between Congressional concerns that the tax-exempt status of BCBS organizations provided an unfair competitive advantage, and the relative disadvantages inherent in the operating structure of the BCBS system, where the BCBS license required that each member plan be organized on a non-profit basis and restricted the operations of each member plan to a specific territory.

The 1986 Act added I.R.C. § 501(m), which effectively ended tax exempt treatment for BCBS organizations by allowing tax exemption to an organization "only if no substantial part of its activities consists of providing commercial-type insurance." At the same time, the 1986 Act added section 833, which provides generally that BCBS organizations are taxable in the same manner as stock insurance companies. However, section 833 itself includes modifications of this treatment, while the Act includes special transitional rules.

Among the modifications from full taxation included in section 833 is the "special deduction" allowed by section 833(a)(2) and defined in section 833(b)(1). As originally enacted, section 833(b)(1) provided as follows:

- (1) In general. -- Except as provided in paragraph (2), the deduction determined under this subsection for any taxable year is the excess (if any) of --
  - (A) 25 percent of the sum of --
    - (i) the claims incurred during the taxable year, and
    - (ii) the expenses incurred during the taxable year in connection

with the administration, adjustment, or settlement of claims,  
over

- (B) the adjusted surplus as of the beginning of the taxable year.
- (2) Limitation. -- The deduction determined under paragraph (1) for any taxable year shall not exceed taxable income for such taxable year (determined without regard to such deduction).

In 1997 section 833(b)(1)(A) was amended by adding to subparagraph (i) the phrase "and liabilities incurred during the taxable year under cost-plus contracts" and by adding to subparagraph (ii) the phrase "or in connection with the administration of cost-plus contracts." Taxpayer Relief Act of 1997, Pub. L. 105-334, section 1604 (August 5, 1997). These 1997 amendments are retroactive to the effective date of the original 1986 legislation.

The term "adjusted surplus" is defined in section 833(b)(3), along with related definitions of "adjusted taxable income" and "adjusted net operating loss," and "net exempt income." There is no statutory definition of the terms "claims incurred" or "liabilities incurred during the taxable year under cost-plus contracts."

On August 29, 1986, while the Act was still pending, the Joint Committee released a report "Summary of Conference Agreement on H.R. 3838 (Tax Reform Act of 1986)" which described the special deduction as follows:

In the case of certain existing tax-exempt organizations providing health insurance, the agreement provides that these organizations are . . . allowed a deduction for regular tax purposes (not to exceed taxable income) equal to one quarter of the year's annual claims and administration expenses less prior year's surplus.

(Emphasis added.) A similar description was included in a 1992 Senate Print: "The special deduction exempts from the regular 34-percent corporate tax enough taxable income each year to maintain reserves equal to 25 percent of the year's health-related payouts (three month's worth)." S. Prt. 102-119, 102d Cong. 2d Sess. 184 (1992). (Emphasis added.)

The concept of "three months" of payouts did not originate with the 1986 Tax Reform Act. The membership standards of the BCBSA require a plan to "maintain adequate financial resources to protect the interests of its subscribers." Central Benefits Mutual Insurance Co. at 1426; 1994 GAO Report at 29. At one time, the reserves standard for Blue Cross specifically required "A Plan's reserves . . . shall be sufficient at least to meet hospital and operating expenses for a period of three months." The standard for Blue Shield also required "A Plan's reserves . . . shall be sufficient to meet medical/surgical and operating expenses for a period of three months." Robert D.

Eilers, Regulation of Blue Cross and Blue Shield Plans (1963), pages 251-252. See also NAIC Proceedings 1969-1 page 290, describing similar standards at that period. See also, Robert Cunningham III and Robert M. Cunningham, Jr., The Blues: A History of the Blue Cross and Blue Shield System (1997), page 215 ("The section created a tailor-made deduction for those Plans with reserves worth less than three months of premium income.")

In summary, at the time section 833 was enacted, BCBS organizations were required by their licenses and membership standards to be organized on a nonprofit basis and were limited by their licenses to specific territories. As nonprofit organizations they did not have access to investor capital sources available to stock insurance companies. While section 501(m) removed the competitive advantage of tax exemption, the special deduction provided by section 833(b) facilitated the accumulation of surplus by BCBS organizations which at that time remained nonprofit on the state level.

**I. Whether claims and liabilities that the Taxpayer processes as a "Host" plan with respect to subscribers of other BCBS plans may be considered "claims incurred" and "liabilities incurred . . . under cost-plus contracts" for purposes of the special deduction described in I.R.C. § 833(b)?**

This is a fairly straightforward issue that may be resolved by a consideration of the background, legislative history, and statutory purpose of section 833 and the special deduction. The Taxpayer's Protest addresses the question more obliquely, arguing that "The RBC [Risk-Based Capital] instruction makes it clear that the NAIC considers Program X-type arrangements as ASC/Cost-plus contracts." Protest, page 10.

We do not believe that it is necessary for purposes of this case to determine a precise definition of "cost-plus" within the meaning of section 833(b), because the Taxpayer's Program X arrangements do not satisfy the minimal definitional requirement -- the "cost" is not a liability incurred by the Taxpayer. We believe the issue can be decided by a simple analysis of the statute. However, due to the significance of this issue we will address the Taxpayer's NAIC arguments under a separate heading.

The primary issue in this case raises three questions:

May multiple Blue Cross and Blue Shield organizations include the same claim or liability in the computation of their special deductions under section 833(b)?

Where multiple Blue Cross and Blue Shield plans are involved in the administration of a claim, which plan may include the claim in the computation of its special deduction under section 833(b)?

May the Taxpayer include BCBS Program X arrangements in the computation of its special deduction under section 833(b)?

**A. May multiple Blue Cross and Blue Shield organizations include the same claim or liability in the computation of their special deductions under section 833(b)?**

The background and legislative history of section 833 are fairly straightforward and consistent with the history and legal and economic status of BCBS organizations at the time of enactment of section 833: The purpose of the special deduction is to allow geographically restricted, nonprofit organizations to accumulate a working level of surplus, measured by the annual volume of their claims.

The legislative history and statutory purpose of section 833 are inconsistent with multiple deductions by multiple BCBS plans with respect to the same provider claim. "Surplus" or "reserves" are only needed for one payment of a claim, not for each transfer of funds between BCBS plans during the claim administration process.

**B. Where multiple Blue Cross and Blue Shield plans are involved in the administration of a claim, which plan may include the claim in the computation of its special deduction under section 833(b)?**

The legislative history and statutory purpose of section 833 are directed at a single entity, the entity subject to tax under section 833. It is claims of that entity that may be includible in the special deduction.

Where a statute allows a deduction for an item "paid or incurred," the deduction is only allowable to the person or entity incurring the liability that is being paid. Where the special deduction under section 833(b) is based upon "claims incurred" and "liabilities incurred," it can only refer to claims and liabilities of the party claiming the special deduction.

One ground stated in the Revenue Agent's Report for disallowance of the Taxpayer's claims is that allowance of the claims would "result in a double deduction," because "both the Control/Home Plan and Host Plan ([Taxpayer]) would be including the same claim in its special deduction." RAR, Government's Position, 2. The Taxpayer's Protest makes the highly technical argument that "a 'double deduction' would not occur because two separate taxpayers are involved. The courts have held that a double deduction is prohibited only if it involves the same taxpayer, and not two separate taxpayers." Protest, page 17.

The Revenue Agent's Report was using the phrase "double deduction" to describe a factual situation where two taxpayers are claiming a deduction based upon the same transaction. It is a fundamental principle of federal income taxation that when a statute allows a deduction for an item that is "paid or incurred," it is only allowable to the person incurring the liability that is being paid. Griffin v. Commissioner, 7 B.T.A. 1094 (1927) (petitioner paid interest expense of a corporation); Colston v. Commissioner, 21 B.T.A. 396 (1930), aff'd sub nom. Colston v. Burnet, 59 F. 2d 867

(D.C. Cir. 1932), cert denied, 287 U.S. 640 (1932) (husband paid taxes and interest on property owned by wife). Similarly, to be entitled to a deduction for a casualty loss under section 165, the taxpayer must have been the owner of the property when the loss was sustained. Draper v. Commissioner, 15 T.C. 135 (1950) (Parents filing joint returns are not entitled to a deduction for a casualty loss to personal property owned by their adult daughter, notwithstanding the fact that the daughter was still dependent on her parents for support).

Deductions depend upon legislative grace. New Colonial Ice Co. v. Helvering, 292 U.S. 435, 440 (1934). In Simon v. Commissioner, 36 B.T.A 184 (1937), a corporate officer entered into an agreement to pay interest on behalf of the corporation and claimed a deduction for the amount paid. The Board found that the indebtedness was solely that of the corporation, and the interest which the taxpayer undertook to pay "was not interest on his indebtedness, and properly speaking may not as to him be called interest at all." Id. at 185-186. The Board of Tax Appeals sustained the disallowance of the deduction:

Congress meant to provide a deduction not of any payment that a taxpayer may choose to label interest, but only of such as is interest in truth. Baltimore & Ohio Railroad Co. v. Commissioner, 78 Fed. (2d) 460. It used the term in its ordinary meaning. Old Colony Railroad Co. v. Commissioner, 284 U.S. 552; Corbett Investment Co. v. Helvering, 75 Fed. (2d) 525. The assumption by a third person to pay an obligor's interest directly to the obligee may be a gift or support and maintenance, Colston v. Burnet, 59 Fed. (2d) 867; certiorari denied, 287 U.S. 640; or alimony, Longyear v. Helvering, 77 Fed. (2d) 116; or rent, Charles R. Holden, 27 B.T.A. 530; or the purchase price of assets, Automatic Sprinkler Co. of America, 27 B.T.A. 160, deductible or not, as the case may be. But since the statute expressly classifies the deductions which are allowable, it is important that the classification be kept clear and not be clouded by specious use of its terms. [36 B.T.A. at 186.]

In the present case, the Taxpayer has created its own definition of cost-plus, which requires only that "the 'cost' must be paid under an arrangement in which the insurance company is a party to the obligation to make a payment." Protest, page 13, emphasis added. The Taxpayer's watered-down definition eliminates any requirement that the Taxpayer be a party to the contract with the subscriber. According to the Taxpayer, it does not need to incur a liability to the subscriber, it only needs to be "a party to the obligation." In the words of the Board of Tax Appeals, Congress did not mean to provide the special deduction for any payment that a taxpayer may choose to label "cost-plus." In order to qualify for the special deduction, a taxpayer must not merely be "a party to the obligation," it must actually be the party that is liable to the subscriber for the payment of the claim.

**C. May the Taxpayer include BCBS Program X arrangements in the computation of its special deduction under section 833(b)?**

It is not necessary for purposes of this case to determine a precise definition of "cost-plus" within the meaning of section 833(b), because the Taxpayer's Program X arrangements do not satisfy the minimal definitional requirement -- the "cost" is not a liability incurred by the Taxpayer. Under the Program X arrangements that are at issue in this case, the only BCBS plan that is a party to the arrangement with the policyholder and the subscribers is the "Home" plan. The Home plan is the plan that makes the determination whether a claim is allowable. If the services are provided within the territory of the Home plan, the provider submits the claim to the Home plan and the Home plan pays the claim. If the services are provided outside the territory of the Home plan, the provider submits the claim to its local plan, which is considered the "Host" plan. The Host plan collects the data for the claim and submits it to the Home plan, but the Home plan is the entity that determines whether the claim is allowable. The Host plan does not make any payment to a provider until the Home plan makes its determination and advises the Host plan of the result.

If a claim is disallowed, the provider would look to the subscriber, who has received services but has not made any payment. If the subscriber feels the claim was wrongly disallowed, the subscriber would look to the Home plan. The Host plan never "incurs" a liability. It is merely satisfying a liability incurred by the Home plan.

Materials submitted by the Taxpayer with respect to its Program Y arrangements are consistent with this description. The Taxpayer submitted a copy of a form contract between the Taxpayer and an employer group. One of the provisions in the contract described situations involving "Providers Outside the State of Taxpayer State." The sample agreement provides that such claims will be processed under the "Program Card" program. The sample agreement explains that "when members receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), [Taxpayer] will remain responsible to Employer for fulfilling [Taxpayer] contract obligations. However, the Host Blue will only be responsible, in accordance with applicable Program Card Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers." (Emphasis added.) Similar provisions are included in the form contracts for the Program Z arrangements. In other words, the Home plan is the only party with any liability to the policyholder or subscribers and the agreement confirms it, while absolving the Host plan of any concurrent responsibility. The Host plan "will only be responsible for contracting with its participating providers and handling all interaction with its participating providers."

**II. May BCBS Program X arrangements be considered "cost-plus" arrangements for purposes of the special deduction?**

We believe the Taxpayer's claims should be disallowed for the reasons stated above. However, considering the significance of the issue, the balance of this memorandum will address the Taxpayer's NAIC arguments.

Ultimately we conclude there is no merit to the Taxpayer's NAIC arguments. However, as noted at the beginning of this memorandum, there are numerous factual issues regarding all three arrangements described in the claims for refund. Those factual issues provide independent grounds for disallowing the claims. We do not address the factual issues in this memorandum because they are generally not within the purpose of Chef Counsel Advice. No concession is intended by their omission and no inference should be drawn.

The Protest alleges that the Taxpayer's refund claims were "prompted" by an internal audit of the Taxpayer's NAIC Annual Statements. It is not clear whether the audit recommended the reclassification of only the Taxpayer's Program X activity, or if it also included the so-called "Program Y" arrangements. In any event, for Federal Income Tax purposes the Taxpayer has reclassified both of those arrangements, along with its "Program Z" arrangements. But any justification for that reclassification originated with the Taxpayer's treatment of these transactions on its NAIC Annual Statements. Accordingly, the Taxpayer's argument is principally based upon the Accounting Practices and Procedures of the NAIC and the NAIC's Risk-Based Capital (RBC) standards.

The Taxpayer's NAIC-based arguments depend on three dubious links. First, that "Administrative Services Contracts" (ASC) as described in the NAIC's Accounting Practices and Procedures should be considered "cost-plus" contracts for purposes of section 833(b). Second, that the NAIC's Risk-Based Capital rules equate ASC and "Fee-for service" arrangements. And third, that the NAIC's Risk-Based Capital rules consider "Program X-type" arrangements as Fee-for service. According to the Taxpayer:

"Program X-type" arrangements = Fee-for service = ASC = Cost-plus.

It should be emphasized that the "special deduction" under I.R.C. § 833(b) is solely a creation of the Internal Revenue Code, for the purpose of allowing nonprofit Blue Cross and Blue Shield organizations to accumulate "surplus" equal to one-quarter of their annual claims payments. There is no comparable item in the NAIC Annual Statement, or in the NAIC Risk-Based Capital Report.

With respect to items of income, expenses, and reserves the NAIC Annual Statement includes many items that are comparable to items shown on the Federal Income Tax Return. With respect to the section 833(b) special deduction there is none. The Taxpayer's attempt to equate ASC arrangements under the NAIC, and cost-plus arrangements under the I.R.C., is at best inconclusive.

The Taxpayer's Risk-Based Capital Report argument depends on a line-item description for a particular risk factor. The RBC instructions show that the items included on that line are separate items. The fact that they are assigned the same risk factor does not mean they are same type of arrangements. The Taxpayer's attempt to equate Fee-for service under the NAIC, and ASC under the NAIC, is generally irrelevant.

**"Cost-plus" and the NAIC.** This is not the first time a dispute has arisen over the meaning of the phrase "cost-plus." The NAIC has addressed the issue in three contexts: NAIC Annual Statement reporting; BCBS financial reporting; and risk-based capital standards.

When Blue Cross and Blue Shield plans began in the 1930's, they offered one community rate. All subscribers, both in groups and individuals, paid a uniform rate regardless of individual health status. General Accounting Office, Health Insurance: Comparing Blue Cross and Blue Shield Plans With Commercial Insurers GAO/HRD-86-110 (July 1986), page 17. When coverage is sold to a particular group, the "experience" of that group may be different from the community as a whole. Accordingly, commercial insurance companies began offering "experience-rated" policies, where premiums are based wholly or partially on the group's health experience. Id. at 17. In the 1950's, Blue Cross and Blue Shield plans began offering their own experience-rated products, which they called "cost-plus" since the subscription rates were based on the group's total claims, plus an administrative charge. Robert Cunningham III and Robert M. Cunningham, Jr., The Blues: A History of the Blue Cross and Blue Shield System (1997), pages 97-101.

**a. NAIC Annual Statement Instructions.** In September, 1983, the NAIC's Accounting Practices and Procedures Task Force appointed a study group to "review, define and suggest accounting and reporting procedures for Administrative Services Only/Cost-Plus and related business as it concerns accident and health benefits." NAIC Proc. 1986-1 page 187. The study was not directed specifically at BCBS organizations but considered ASO/Cost-Plus arrangements generally.

Research done by the study group or members of the group confirmed that there are no consistent definitions for such terms as "cost-plus." Nor is there consistency in the classification of funding arrangements. Accounting varies from company to company. [Emphasis added.]

Rather than attempting to resolve the "infinite variations in labeling" for arrangements that were self-funded or partially self-funded, the Study Group proposed that each arrangement be divided into "insured" components and "uninsured" components.

For example, the insurance charge contained in a "Cost-Plus/Stop Loss" agreement would be considered insurance premiums and be reported in the same manner as category 1 plans [i.e., "Insured" plans]. Administrative fees,

claim reimbursements, and fees relating to the use of insurer funds would be deemed to fall into category 2 [i.e., "Uninsured-administrative services only" plans] and reported accordingly. [Id. at 188.]

The Study Group proposed changes to the Instructions to the Annual Statement which included the following:

12. "Uninsured accident and health plans" are defined as those plans in which there is no risk to the insurer. For purposes of these instructions, the following definition applies:

"The definition of 'risk to the insurer' for the purpose of classifying funding arrangements is the possibility of liability to the insurer due to claims under accident and health plans."

Uninsured accident and health plans include amounts attributable to the uninsured portion of partially insured or "combination" plans. Such plans may include, but are not limited to, plans described as "minimum premium," "cost-plus/stop-loss" or other similar names. . . .

Amounts related to such uninsured plans must not be reported in premiums, claims, or the aggregate reserve. . . . [Id. at 200.]

The accounting practices and procedures of the NAIC continued to evolve and "Uninsured Plans" were further discussed in Statutory Issue Paper No. 47 (SIP 47) (June 23, 1998) and Statutory Accounting Principles No. 47 (SAP 47) (January 1, 2001). These materials will be discussed below in response to the Taxpayer's argument.

In summary, the NAIC did not attempt to define "cost-plus" arrangements and rejected any classification based on the label attached to any particular arrangement. Instead, the NAIC determined that arrangements should be classified as "insured" or "uninsured," and a "partially insured" or "combination" arrangement should be broken into components which would then be classified as insured or uninsured.

**b. BCBS Financial Reporting.** "Cost-plus" issues arose again following the announcement in October, 1990, by the West Virginia insurance commissioner that BCBS of West Virginia was insolvent. This drew the attention of Congress and of the National Association of Insurance Commissioners. In June, 1991, the NAIC formed a "Special Committee on Blue Cross Plans," which, among other things, was charged with "development of improved financial reporting"; "evaluation of needed consumer protections -- like guaranty funds"; and "the role of the Blue Cross Blue Shield Association in Plan governance, national accounts, and financial matters." NAIC Proc. 1991-2, page 60; 1994-4, page 85. Meanwhile on the Congressional level the Chairman of the Permanent Subcommittee on Investigations, Committee on

Governmental Affairs, requested the General Accounting Office to study the BCBS plans and the BCBS Association. In 1994 the GAO issued a report, Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight, GAO/HEHS-94-71 (April 1994). The 1994 GAO report reflected the lack of understanding about the internal arrangements of BCBS plans at that time:

The revelation that several Blues plans were in poor financial condition prompted fundamental questions about all Blues plans because of the large number of Americans they insure. Are the plans run by a single corporate headquarters, or do they each operate as an independent business? How do Blues plans differ from commercial health insurers? How many Blues plans are in financial trouble and why? What are the responsibilities of the Blues Association when plans have financial problems? [Id. at 2.]

The NAIC Special Committee on Blue Cross Plans found that the organization and regulation of BCBS plans varied significantly from state to state. In many states, BCBS plans were not subject to the general laws and regulations governing commercial insurers. The special statutes governing BCBS plans differed considerably, especially in the areas of financial standards and the level of regulatory authority provided to regulators. NAIC Proc. 1993-1, page 152. Similarly, the 1994 GAO report found that "Blues plans differ considerably in organization, operations, and regulation." 1994 GAO Report, p 34.

In December, 1994, the NAIC Special Committee on Blue Cross Plans issued its final report. During this same period, the NAIC was developing "risk-based capital" (RBC) standards for insurance companies. The NAIC Special Committee on Blue Cross Plans considered risk-based capital standards for BCBS plans but recommended that the standards should be developed by the specific subcommittee that was working on risk-based capital initiatives. NAIC Proc. 1992-2, page 160, 1993-3, page 11. In its final report the Special Committee on Blue Cross Plans repeated its recommendation that "development of risk-based capital standards for health carriers specifically include standards for Blue Plans" and noted that the Blue Cross Blue Shield Association had been developing its own risk-based capital mechanisms in order to monitor its members. NAIC Proc. 1994-4, p 85.

The final report indicated the Committee had reviewed how BCBS national accounts are handled, noting that a written description of these programs had been provided by the Blue Cross Blue Shield Association.

The final report indicated that the Committee had considered recommending the development of a separate Annual Statement form for BCBS plans but instead a "Financial Reporting Working Group" was formed which developed "financial reporting supplements and instructions" for obtaining additional information from Blue Cross/Blue Shield Plans. Id. at 85, 86. The Working Group indicated that "The supplement was largely modeled after filings already required of Plans, primarily internal filings required

of Plans by the Blue Cross/Blue Shield Association." NAIC Proc. 1994-4, page 86. The supplement had three parts:

1. Statement of Operations By Line of Business - Statutory Basis
2. Non-Underwritten Health Benefit Programs - Benefit Payments
3. Interrogatory

The first part of the supplement, showing lines of business, included the following:

- Individual
- Group Community
- Experience
- Cost Plus
- National
- FEP [Federal Employee Plan]
- ASO
- Other

The second part of the supplement, regarding "Non-Underwritten Health Benefit Programs," listed the following:

1. Administrative Services Only Accounts
2. National Accounts and FEP
3. Inter-Plan Bank/Reciprocity
4. Medicare
5. Medicaid
6. CHAMPUS
7. Other Non-Underwritten

The "Definitions" for the supplement distinguished between "Underwritten Lines" and "Nonunderwritten Lines." Both "Underwritten Lines" and "Nonunderwritten Lines" had categories regarding "administrative service" arrangements and "national accounts."

The description for administrative service arrangements for "Underwritten Lines" was as follows:

Cost Plus/Administrative Services Only  
Experience rated groups for which premiums are fully determined retrospectively. Typically the plan pays the benefits and bills the account for the cost of benefits and normal retention items. The plan issues a Blue Cross & Blue Shield identification card, pays the benefits from its bank account, and uses its contractual payment arrangements with providers in the administration of the contract. Often these accounts select aggregate and individual stop loss features for which the cost of coverage is included as part of retention or other

separate charge. This coverage is often purchased by accounts maintaining employee health benefit plans they believe qualify for the ERISA preemption.

In comparison, administrative service arrangements for "Nonunderwritten Lines" were described as follows:

ASO: Administrative Services Only. Self-insured groups where the group is at risk. The plan only provides administrative services, the subscriber identification cards do not include the Blue Cross and/or Blue Shield trade names or trademarks, and the benefits are paid using the group's bank account.

Note that at this time, 1994, the Financial Reporting Working Group is distinguishing between administrative service arrangements that are underwritten, and administrative service arrangements that are not underwritten. The Working Group uses the phrase "ASO" in describing both types of arrangements, although the full label for the underwritten arrangements is "Cost Plus/Administrative Service Only." In contrast, the only term used for the non-underwritten arrangements is "ASO."

The Working Group report also included descriptions for "National Account" arrangements that are underwritten, and arrangements that are not underwritten.

Underwritten National Accounts are described as follows:

National Accounts: A group that has employees located in two or more plan service areas and meets all of the following criteria: (1) is administered by more than one plan; (2) has a control plan and one or more participating plans; (3) uses an inter-plan reporting system; and (4) is periodically settled among plans by use of the equalization process. FEP is excluded from this definition. [There is a separate description for underwritten FEP. Nonunderwritten FEP is included in the description of nonunderwritten National Accounts, below.]

For "Nonunderwritten Lines," the description for National Accounts is as follows:

Serviced National Accounts and REP [sic, FEP]: Benefits paid by "service" plans on National Accounts and FEP. Service plans perform all functions associated with National Accounts and FEP except the risk assumption function. The amount of FEP reported under this account category is immaterial.

In summary, it appears that the "cost-plus" arrangements that were offered by BCBS plans in the early 1990's were underwritten, experience-rated or retrospectively-rated products, characterized by the issuance of a BCBS card, the use of funds from the plan's bank account, and the use of the plan's contractual payment arrangements with providers. The NAIC distinguished these underwritten "cost-plus" arrangements from "administrative services only" arrangements. The NAIC also distinguished underwritten "cost-plus" arrangements from underwritten and nonunderwritten "National Accounts

arrangements. No type of National Accounts arrangement was ever considered "cost-plus."

**c. Risk-Based Capital standards.** "Risk-Based Capital" issues are not unique to BCBS organizations and RBC standards were being developed during the same period that the Special Committee on Blue Cross Plans was conducting its study. As noted above, the Special Committee recommended that the risk-based capital standards that the NAIC was developing for health carriers should specifically include standards for BCBS plans.

The Blue Cross Blue Shield Association "observed, with great interest" the NAIC work on risk-based capital, which "led BCBSA to create a team to develop a proposed formula that could be used by the NAIC as a starting point in developing a health RBC formula." NAIC Proc. 1993-4, pages 518, 519. In October, 1993, the BCBSA presented its proposed formula to the NAIC.

The proposal by the BCBSA noted that the NAIC's formula for life and health insurers:

does not specifically consider risk characteristics of large portions of Plans' revenue base (and probably of other health carriers'), including Administrative Services Contracts (ASC), Cost-Plus and Federal Employee Health Benefits Program (FEHBP) lines of business. While these lines constitute risk business, the risk to the health entity is less than most other types of prospectively rated business because revenue from these products is retrospectively determined. [NAIC Proc., 1993-4 at 519-520.]

\* \* \*

Major characteristics of ASC/Cost-Plus business include: issuance of carrier ID cards and membership materials, access to participating providers and associated discounts, if any, conversion coverage rights for subscribers, and retrospectively determined revenue.

\* \* \*

To the extent self-funded groups utilizing ASC/Cost-Plus products, are unable to fund their claim obligations, the carriers, no longer acting solely as administrators as in ASO arrangements, are at risk for fulfilling claims obligations in the event the group is unable to meet its revenue funding obligation.

Although ASC/Cost-Plus arrangements are at risk, the carrier's risk is substantially less than traditional health insurance because the risk of trend variation has been transferred to the group via the retrospectively determined revenue. [Id. at 520.]

The BCBSA proposal recommended a separate category for "ASC/Cost-Plus", with a risk factor of 0.5%. The BCBSA did not include any category for "national accounts" arrangements and did not show any risk factor for national accounts. Id. at 523.

The NAIC continued to work on its RBC standards after the Special Committee on Blue Cross Plans issued its final report in 1994. The current RBC standards will be discussed below as part of the response to the Taxpayer's argument.

In summary, in the context of NAIC Annual Statement reporting, when the NAIC first considered "cost-plus" type arrangements, it rejected any analysis based on the label of the arrangement and instead determined that arrangements should be classified as "insured" or "uninsured," even to the point of breaking an arrangement into components and classifying each component as insured or uninsured.

In the context of BCBS financial reporting, the NAIC initially used the phrase "cost-plus" to describe an arrangement that was classified as insured. The arrangement included the following features:

"Experience rated groups for which premiums are fully determined retrospectively."

"Typically the plan pays the benefits and bills the account for the cost of benefits and normal retention items."

"The plan issues a Blue Cross & Blue Shield identification card, pays the benefits from its bank account, and uses its contractual payment arrangements with providers in the administration of the contract."

"Often these accounts select aggregate and individual stop loss features for which the cost of coverage is included as part of retention or other separate charge."

The description used by the NAIC for BCBS financial reporting is similar to the description used by the BCBSA in its risk-based capital formula, where it described the major characteristics of ASC/Cost-Plus business to include:

"issuance of carrier ID cards and membership materials"

"access to participating providers and associated discounts, if any"

"retrospectively determined revenue."

**"Cost-plus" -- the Taxpayer's definition.** In its Protest, the Taxpayer acknowledges that Congress did not define the term "cost-plus contract" when it

amended section 833 in 1997. The Protest asserts "the term has a well-understood meaning in the insurance industry." Protest, page 13. However, rather than citing any industry definition, the Taxpayer offers its own version of the term:

Cost-plus contracts have three essential features. First, the "cost" must be paid under an arrangement in which the insurance company is a party to the obligation to make a payment. By contrast, "cost" is not involved under an ASO plan because the participant is the only party that pays or funds the obligation. Second, in the context of I.R.C. § 833(b) the "cost" must relate to health-related claim payments (other than those that are underwritten and qualify as insurance). The third feature of cost-plus contracts is that the insurance company receives reimbursement for the claims, "plus" a fee to cover any expenses and profit. Taxpayer's Program X plans satisfy each of these criteria and are commonly understood to be cost-plus arrangements.

**"Cost-plus" -- the Taxpayer's references to NAIC accounting materials.** As noted above, the Taxpayer's refund claims were prompted by an internal audit of the Taxpayer's NAIC Annual Statements. Accordingly, the Taxpayer's argument is principally based upon the Accounting Practices and Procedures of the NAIC and the NAIC's Risk-Based Capital standards.

The Taxpayer argues that the Accounting Practices and Procedures of the NAIC distinguish between Administrative Services Only (ASO) arrangements and Administrative Services Contracts (ASC), and that the "Health Risk Based Capital" instructions make a similar distinction. Ultimately, the Taxpayer's argument is based upon the line description of a "form template" used in the NAIC's Risk-Based Capital Report:

The section also includes a separate line requiring a charge of one percent applied to "Medical costs paid through ASC arrangements (Including Fee-for-service received from other health entities." This RBC instruction makes it clear that the NAIC considers Program X-type arrangements as ASC-Cost-plus contracts. [Protest, pages 9-10.]

Contrary to the Taxpayer's assertion, ("This RBC instructions makes it clear . . .") neither the line entry nor the instructions make any reference to "Program X" arrangements. The RBC materials will be discussed under a later heading.

The Taxpayer's distinction between ASO and ASC is based upon the NAIC's Statement of Statutory Account Principles No. 47 (SAP 47) (January 1, 2001), which is quoted in the Protest as follows:

***Under an ASO plan***, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, but only after the reporting entity has received

funds from the uninsured plan sponsor that are adequate to fully cover the claim payments. ***Under an ASC plan***, the reporting entity pays claims from its own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor. [Protest, page 8, boldface and italics in the Protest, not in the original.]

SAP 47 is entitled "Uninsured Plans" and is based on Statutory Issue Paper No. 47 (SIP 47), also entitled "Uninsured Plans," which was finalized June 23, 1998. The material quoted in the Protest first appeared in SIP 47, in the following paragraph:

For purposes of this issue paper, uninsured accident and health plans, including HMO administered plans, and uninsured property and casualty plans (collectively referred to as uninsured plans) are defined as plans for which a reporting entity as an administrator, performs administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. In the case of uninsured accident and health plans, the administrator may arrange for the provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self insured) bears all of the insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. The administrator, however, may be subject to credit risk with regard to the risk bearing entity. An uninsured accident and health plan may be either an ASO [Administrative Services Only] plan or an ASC [Administrative Services Contract] plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, but only after the reporting entity has received funds from the uninsured plan sponsor that are adequate to fully cover the claim payments. Under an ASC plan, the reporting entity pays claims from its own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor. No arrangement where the reporting entity receives a capitated payment for providing medical services to a third party shall qualify as an insured plan.

SAP 47 uses the same language, with the difference that the first sentence refers to "this statement" rather than "this issue paper."

SIP 47 was issued by the NAIC to "provide guidance on the recording and reporting of transactions related to uninsured plans"; SAP 47 "establishes statutory accounting principles for all uninsured plans." SIP 47, par. 1; SAP 47, par. 1. SAP 47 provides:

5. The administrator's statement of operations shall exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of uninsured ASO or uninsured ASC plans. . . .

11. . . . Administrators shall not record aggregate reserves, claim/loss reserves, or liabilities (except for Medicare or similarly structured cost based reimbursement contracts) for any other claim costs paid by the administrator on behalf of uninsured plans. [Emphasis added.]

SIP 47 and SAP 47 represent the further development of the principles set forth in the 1986 changes to the Annual Statement instructions, described above, regarding "insured" and "uninsured" arrangements. While the Taxpayer's quotation from SAP 47 describes differences between ASO arrangements and ASC arrangements, both of the arrangements described in SAP 47 are considered "uninsured." Note that the emphasis of the NAIC has been on whether arrangements are insured or uninsured, rather than on the label used by the parties to the arrangement. Thus, the Financial Reporting Working Group of the Special Committee on Blue Cross Plans had used the phrase "Cost Plus/ASO" to describe an arrangement that was considered "underwritten." The BCBSA used the phrase "Cost Plus/ASC" to describe a similar arrangement in its risk-based capital formula. Both of those arrangements had multiple features that are not included in the description of an "ASC" in SAP 47. The most that can be derived from SAP 47 is that it describes an ASC which is not fundamentally distinguishable from an ASO and in fact SAP 47 treats both arrangements as uninsured. It cannot be concluded from SAP 47 that any arrangement that might be described as an ASC must therefore be considered a "cost -plus" arrangement.

**"Cost-plus" -- TAM 9803003.** As noted above, the original version of section 833 only referred to "claims incurred" and did not include the language "liabilities incurred . . . under cost-plus contracts." The Protest notes that "examining agents interpreted the term 'claims incurred' to include only claims incurred under insurance policies," referring to a case pending "shortly before the 1997 Relief Act." Protest, page 15.

It is probably more accurate to say that agents interpreted the term "claims incurred" to refer to claims under insured arrangements, since the phrase "claims incurred" in the health insurance industry is the equivalent of "losses incurred" for property and casualty insurers. In general, the NAIC is only concerned with insurance activities. Insurers are only required to maintain loss reserves with respect to insurance transactions. Accordingly, the statute's use of the phrase "claims incurred" implies insured transactions, since that is the phrase used in the insurance industry for transactions that are treated as insured transactions on the NAIC Annual Statement. The phrase "claims incurred" is not a broad generic term that includes claims of any kind.

It should be noted that during this same time period -- shortly before the 1997 Relief Act -- the NAIC was considering "guidance on the recording and reporting of transactions related to uninsured plans." (SIP 47.) To the extent the NAIC was considering excluding such transactions from Annual Statement reserves, it would be

reasonable to conclude that such items should not be included in the section 833(b) special deduction. If an item was not considered a "claim incurred" for Annual Statement purposes, it should not be considered a "claim incurred" for purposes of section 833(b).

As the Protest points out, section 833 was amended in 1997, retroactively, to include the phrase "liabilities incurred . . . under cost-plus contracts." See Taxpayer Relief Act of 1997, Pub. L. 105-334, section 1604 (August 5, 1997). Shortly thereafter, as the Protest points out, the IRS issued a Technical Advice Memorandum concluding that "cost-plus" contracts are included in claims incurred under section 833(b)(1)(A)(i). TAM 9803003 (September 26, 1997).

Technical Advice Memoranda are not precedent, I.R.C. § 6110(k)(3), although courts have noted that they "do reveal the interpretation put upon the statute by the agency charged with the responsibility of administering the revenue laws." Hanover Bank v. Commissioner, 369 U.S. 672, 686 (1962). See Rowan Cos. v. United States, 452 U.S. 247, 261 n.17 (1981); Estate of Cristofani v. Commissioner, 97 T.C. 74, 84 n.5 (1991). A request for technical advice involves both the IRS and the taxpayer and the taxpayer has input into the facts presented in the request. See Rev. Proc. 97-2, 1997-1 C.B. 486, Section 8. Accordingly, while the TAM cited by the Taxpayer in the present case may not be cited as legal precedent, the facts recited in the TAM are an indication of the type of transactions that were considered "cost-plus" by BCBS organizations at the time of the amendment of section 833.

The Protest does not quote the TAM. The facts, as stated in the TAM, are as follows:

Taxpayer, an "existing Blue Cross or Blue Shield organization" within the meaning of section 833(c)(2), is under examination by the Service for Year 1 and Year 2. For those years, Taxpayer paid claims and established claims reserves with respect to a variety of health benefit products. These products included (1) prepaid service benefit contracts that represent Taxpayer's traditional insurance products, and (2) cost-plus contracts which differ from the traditional product in the manner in which they are financed. Taxpayer also performed services pursuant to administrative services only contracts.

Note that the Taxpayer in the TAM established claims reserves for "traditional insurance products" and for "cost-plus contracts." Accordingly, at that time taxpayers were treating "cost-plus" arrangements as insured business. The Taxpayer in the TAM also entered into "administrative services only" contracts but apparently did not include these arrangements in its reserves.

The TAM distinguishes the "cost-plus" contracts based on "the manner in which they are financed." Specifically, the TAM notes:

Taxpayer's duties under a cost-plus contract include: (1) establishing a membership record for the group members; (2) providing identification cards and applications to subscribers; (3) receiving applications for late entrants and underwriting such applications in accordance with standard underwriting guidelines; (4) providing managed benefit services; (5) receiving claims and processing payments in accordance with the plan's terms; (6) administering subrogation, reimbursement, and coordination of benefits, with subrogation recoveries being shared proportionately among Taxpayer and the group (Taxpayer receives recoveries allocable to stop-loss coverage); (7) paying claims from Taxpayer's bank account; (8) providing members a conversion policy when application is timely made upon termination of enrollment; (9) paying claims in excess of the stop-loss amount set forth in the contract; and (10) a variety of other reporting and servicing duties.

In return, Taxpayer is paid the following amounts under the cost-plus contracts: (1) the amount of benefit payments, or claims, paid by Taxpayer for subscribers; (2) administrative fees for services provided by Taxpayer; (3) fees for conversion coverage costs; (4) stop-loss insurance amounts; (5) various taxes, licenses, and fees; and certain programming charges related to the particular programming requirements. Taxpayer bills the group for the administrative fees, conversion costs, and stop-loss premium on a regular basis.

The TAM describes the Taxpayer's method of computing the special deduction as follows:

The deduction was computed taking into account W dollars of liabilities incurred under cost-plus contracts in Year 1, and X dollars in Year 2. No amounts were included for administrative services only contracts in computing the special deduction.

Finally, the TAM notes the 1997 amendment of section 833 that added "cost-plus contracts" to the computation of the special deduction and concludes:

Because the contracts in question are cost-plus contracts, the liabilities incurred during the taxable year under these contracts are included in claims incurred under section 833(b)(1)(A)(i) in determining the special deduction under section 833(b).

It should be emphasized that the "cost-plus" contracts described in the TAM are very similar to the underwritten "Cost Plus/Administrative Services Only" arrangements described in the 1994 financial reporting supplement for BCBS plans prepared by the Financial Reporting Working Group of the Special Committee on Blue Cross Plans, and in the description of ASC/Cost Plus arrangements by the BCBSA in its risk-based capital formula. In all three cases, the plan issues an identification card, subscribers receive services directly from health-care providers without making any payment, the

plan pays the providers from plan funds, and the plan then bills the account for the cost of benefits. Note also that both the cost-plus arrangement described by the Financial Reporting Working Group and by the TAM included a stop-loss feature, while both the arrangement described by the Working Group and by the BCBSA were experience-rated. Both the arrangement described by the BCBSA and by the TAM allowed subscribers to convert from group to individual coverage.

Finally, note that the Taxpayer in the TAM established claims reserves for its "cost-plus contracts" but not for its ASO arrangements, and that the Taxpayer in the TAM did include its "cost-plus" business in computing the section 833(b) deduction, but did not include ASO contracts.

In summary, the NAIC first used the phrase "Cost-Plus/ASO" in 1994 to describe "underwritten" cost-plus arrangements, as opposed to arrangements that were considered nonunderwritten, which were described by the single term "ASO." During this same period, the BCBSA used the phrase "ASC/Cost-Plus" to describe an arrangement similar to the NAIC's "Cost-Plus/ASO" arrangement, and the BCBSA similarly contrasted its "ASC/Cost-Plus" with "ASO arrangements."

Presently, the NAIC uses the terms "ASO" and "ASC" to describe two types of arrangements that are considered "uninsured." To the extent the term "ASC" was at one time used to describe a "cost-plus" arrangement, it was used by the BCBSA to describe an arrangement that was considered insurance at the time. Accordingly, the fact that the NAIC now uses the term "ASC" to describe an arrangement that is considered uninsured does not mean that such an arrangement should be considered "cost-plus."

**NAIC Risk-Based Capital Rules.** Current NAIC Risk-Based Capital materials regarding ASO and ASC arrangements generally follow the descriptions of the NAIC accounting materials. There is no definition or discussion of "National Account" arrangements or "National Account-type" arrangements and no inference can be drawn from the RBC line entry description for "Fee-for service" items.

"Risk-based capital (RBC)" is described by the NAIC as "a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile." National Association of Insurance Commissioners, Risk-Based Capital Forecasting, Health, 2008 (2008 NAIC Health, Risk-Based Capital Report, Including Overview and Instructions for Companies, as of December 31, 2008), page i. It should be emphasized that, unlike the NAIC Annual Statement and the Federal Income Tax Return, Risk-Based Capital is not concerned with the determination of income in any way.

The NAIC's RBC Report distinguishes five categories of risk: Asset Risk - Affiliates; Asset Risk - Other; Underwriting Risk; Credit Risk; and Business Risk. Id. "Premium" in the Underwriting Risk category "does not include receipts under

administrative services only (ASO) contracts; or administrative services contracts (ASC); or any nonunderwritten business." Page 17.

The risks associated with ASO and ASC arrangements are reported as "Business Risk" under the subcategory "Non-Underwritten and Limited Risk." Thus, the RBC Report is consistent with the NAIC accounting materials in the sense that ASO and ASC arrangements are treated as uninsured.

As the Protest notes, the risk charge required by the RBC Report for the administrative expenses of both ASO and ASC arrangements is the same, 2%. A different risk charge is required for ASC claims payments, 1%, which reflects the risk that the administrative expenses for the ASC arrangement will be "insufficient to absorb the full outlay required and for the recovery of ASC claims payments." Page 30.

The Taxpayer's argument regarding Program X arrangements is based principally on the following line entry for the Business Risk section of the RBC Report:

	Factor
(10) Medical costs paid through ASC arrangements (Including Fee-for service received from other health entities)	0.010

The risk charge for this line is 1%. From this the Protest concludes "This RBC instruction makes it clear that the NAIC considers Program X-type arrangements as ASC/Cost-plus contracts." Page 10.

However, there is no description or definition in the RBC Report instructions regarding Program X or Program X-type arrangements. Nor is there any definition of "Fee-for service received from other health entities." It should be noted the instructions discuss ASO and ASC arrangements in the first three paragraphs of the "Non-Underwritten and Limited Risk" subcategory, but a separate fourth paragraph reads in full:

The RBC requirement for fee-for service revenue received from other reporting entities is also 1 percent.

In other words, while the line entry combines ASC claims payments with Fee-for service received from other health entities, in the instructions they are treated as two separate items.

There is nothing in the paragraphs describing ASO and ASC arrangements that "makes it clear" that the NAIC considers Fee-for service revenue arrangements as ASC/Cost-plus arrangements. It is true the RBC Report requires the same risk charge of 1% for ASC claims payments and for Fee-for service revenue. But by the Taxpayer's logic, ASC expenses should be excluded from the special deduction because they are subject to the same risk charge of 2% as ASO expenses.

The RBC Report instructions and line entry description add nothing, prove nothing, and are no more relevant or conclusive than the NAIC accounting materials.

**Summary.** We believe that an objective review of the treatment of "cost-plus" arrangements by the NAIC, by the BCBSA, and by the IRS, establishes that much more is required than being a mere "party to the obligation to make a payment." The only feature that the NAIC's current description of "Administrative Services Contracts" (ASC) has in common with arrangements that have been considered "cost-plus," is the fact that "the reporting entity pays claims from its own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor." But, in the NAIC accounting materials, an ASO arrangement may also pay claims out of the administrator's own bank accounts. The only difference between an ASO arrangement and an ASC arrangement, from the perspective of the NAIC, is the timing of the transfer of funds from the policyholder to the BCBS plan. In an ASO arrangement, the BCBS plan receives the funds before it makes a payment from its account. In an ASC arrangement, the BCBS plan does not receive funds from the policyholder until after it has paid the claim. The NAIC does not consider this difference significant and treats both arrangements as uninsured. We do not believe that this single feature is sufficient to classify an Administrative Services Contract as a "cost-plus" contract for purposes of section 833(b).

NAIC accounting materials may have some relevance in the sense that the NAIC Annual Statement and the Federal Income Tax Return both include a determination of income. But the NAIC's Risk-Based Capital Rules serve a completely different purpose: "measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations." The fact that separate items on the RBC Report are subject to the same risk charge does not establish that they are legally-equivalent arrangements, with the same legal responsibilities.

This writing may contain privileged information. Any unauthorized disclosure of this writing may undermine our ability to protect the privileged information. If disclosure is determined to be necessary, please contact this office for our views.

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