APPEALS

INDUSTRY SPECIALIZATION PROGRAM

COORDINATED ISSUE PAPER

INDUSTRY:	**PHARMACEUTICAL**
ISSUE:	**ACCRUAL OF MEDICAID REBATE LIABILITY**
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UIL NO.:	**461.01-10**
FACTUAL/LEGAL ISSUE:	**LEGAL**

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Effective Date: OCT 01 2001

Accrual of Medicaid Rebate Liability

Statement of Issue

Should a pharmaceutical manufacturer ("Manufacturer"), in accordance with a national agreement between the Manufacturer and the United States Secretary of Health and Human Services ("HHS"), who is acting on behalf of the States, be allowed to accrue and deduct its Medicaid rebate liability prior to actual payment?

Examination Division's Position

The Examination Division's position in its coordinated issue paper ("CIP") is that the Manufacturer (the taxpayer) may not accrue its liability for Medicaid rebates until the taxable year in which it pays the rebate. The CIP is based on the position that the Manufacturer's rebate liability is not fixed since all events have not occurred to establish liability for payment and the liability is not fixed until the year the quarterly claim for reimbursement, the utilization report, is sent by the State.

Where a taxpayer's obligation to pay expenses is based on a contract, here the rebate agreement, the terms of the contract are relevant in determining what event fixes the right to its income and liabilities. See, e.g. *United States v. General Dynamics Corp.,* 481 U.S. 239 (1987); *Lucas v. North Texas Lumber* Co., 281 U.S. 11 (1930); *Decision, Inc. v. Commissioner,* 47 T.C. 58 (1966); *Estate of G.A.E. Kohler v. Commissioner,* 37 B.T.A. 1019 (1938). As discussed below, the position taken in the CIP requires reexamination.

Industry Position

The position of the pharmaceutical industry is that a Manufacturer's liability for a Medicaid rebate becomes fixed at the time a covered drug is dispensed to a Medicaid beneficiary because the Manufacturer is then legally obligated to pay the rebate. After that time, the possibility that the pharmacy will not submit a claim and the State will fail to invoice a Manufacturer are "remote and speculative." See *United States v. Hughes Properties, Inc.,* 476 U.S. 593 (1986). Thus, these possibilities cannot prevent the Manufacturer's rebate liability from being fixed under the all-events test.

The industry argues that when a covered drug is dispensed to a Medicaid beneficiary it starts the following chain of events that are all required to be performed under the Medicaid law:

- The pharmacy files a reimbursement claim with the State.

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- The State is obligated to reimburse the pharmacy.
- The Manufacturer is required to provide the Health Care Financing Administration ("HCFA") with pricing information. [1]
- The State submits a utilization report to the Manufacturer.
- The Manufacturer is obligated to pay a rebate to the State.

The industry contends that, after dispensing a covered drug without charge to a Medicaid beneficiary, a pharmacy has a formidable economic incentive to file a reimbursement claim with the State Medicaid Agency. To date, the industry has not provided data on the number of claims submitted by pharmacies that are sustained or rejected by the State Medicaid agencies.

Factual Background

The Omnibus Budget Reconciliation Act of 1990, Public Law No.101-508, established the Medicaid Drug Rebate Program, for drugs dispensed on or after January 1, 1991. It enables Medicaid to achieve savings in drug expenditures and increases Medicaid beneficiaries' access to prescription drugs. Prior to this program many States had restrictive Medicaid formularies which offered one drug per therapeutic class based on cost-effectiveness. Under the new program all prescription drugs whose Manufacturers executed rebate agreements must be on a State's formulary.

The Medicaid rebate program was implemented through a complex partnership among HHS, State Medicaid Agencies, and the Manufacturers. Every Manufacturer participating in the program must enter into a rebate agreement with HHS, who is acting on behalf of the States. HHS delegated authority to operate this program to HCFA. Section II of the rebate agreement requires that every Manufacturer agree to the following conditions:

- To calculate and make a rebate payment to each State for the Manufacturer's covered outpatient drugs paid for by the State during a quarter.

[1] On June 14, 2001, the Health Care Financing Administration was renamed the Centers for Medicare and Medicaid Services (CMS). CMS continues administration of the Medicaid Program.

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- To continue to make a rebate payment on all of its covered outpatient drugs for as long as an agreement is in force and State Medicaid utilization information reports that payment was made for that drug.

Thirty days after the last day of each calendar quarter the Manufacturer must report to HCFA its average manufacturer price ("AMP") and best price ("BP"). The AMP and BP are defined in sections 1396r-8(k)(1) and 1396r-8(c)(2)(B), respectively, of Title 42 of the United States Code as follows:

- AMP -the total net sales by the Manufacturer during a calendar quarter for a covered outpatient drug sold to wholesalers, who distribute to the retail pharmacy class of trade, divided by the number of units sold. It excludes free goods.

- BP -the lowest price made available by the Manufacturer to any wholesaler, retailer, nonprofit entity, or governmental entity. It includes cash discounts, free goods, volume discounts, and other rebates.

It is not possible to compute the AMP and BP prior to the end of a quarter because they are based on all of the Manufacturer's sales during that calendar quarter. HCFA uses this pricing information to compute the unit rebate amount ("URA") in its administrative oversight role and for confidentiality concerns, even though Manufacturers might be capable of computing the URA. It then supplies the URA to the States within forty-five days after the end of each calendar quarter.

Each State compiles Medicaid utilization data based on the total number of units of each dosage form and strength of the Manufacturer's covered outpatient drug the State reimbursed during a calendar quarter. Medicaid utilization data is based on claims paid by the States; not on drugs dispensed during the calendar quarter. The URA times the number of units utilized during the quarter equals the amount of the rebate due from the Manufacturer for a covered drug product. Each State then submits its utilization report to the Manufacturer sixty days after the end of each calendar quarter. The rebate payment by the Manufacturer is then due thirty-eight days after the State mails its utilization report.

Legal Analysis

An allowable deduction or credit is taken in the taxable year determined by the taxpayer's method of accounting used in computing its taxable income. I.R.C. section 461(a). Under an accrual method of accounting, three requirements (or prongs) must be met in order to accrue a liability:

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- All-events have occurred which fix the liability.
- The amount of the liability can be determined with reasonable accuracy.
- Economic performance has occurred with respect to the liability.

Treas. Reg. § 1.461-1(a)(2).

Section 461(h)(1) provides that, in determining whether an amount has been incurred during any taxable year, the all-events test is not met any earlier than when economic performance occurs. Pursuant to Treas. Reg. § 1.461-4(g)(1), effective for taxable years beginning after December 31, 1991, economic performance occurs for rebates when payment is made to the person to whom the liability is owed. However, under section 461(h)(3), there is an exception for accrual method taxpayers with recurring items. A liability is treated as incurred during the taxable year, notwithstanding section 461(h)(1), if:

- The all-events test is met during the taxable year (without regard to economic performance).
- Economic performance for such item occurs on or before the earlier of the date the taxpayer files a timely return (including extensions) or eight and one-half months after the end of the taxable year.
- The liability is recurring.
- The accrual during the taxable year when the all-events test is met (without regard to economic performance) results in a better match with its income.

Therefore, economic performance or the third prong of Treas. Reg. § 1.461-1 (a)(2) can be satisfied under the recurring item exception of section 461(h)(3). This occurs when the liability becomes fixed in Year 1 and payment of the liability in Year 2 is on or before the earlier of the taxpayer filing a timely return or eight and one-ha If months after the end of the taxable year. The Medicaid rebate is a recurring liability and the matching requirement is deemed satisfied under Treas. Reg. § 1.461-5(b)(5)(ii). Therefore, if the liability is fixed and can be determined with reasonable accuracy prior to the end of the tax year, the recurring item exception to economic performance is available to Manufacturers.

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The legal issue in dispute is at what point the liability becomes fixed and satisfies the first prong of the all-events test. A State obtains rebate payments only after submitting a utilization report to the Manufacturer, who is then required to make the payment within thirty-eight days. Therefore, the CIP concludes the filing of the report is not a mere technicality based on *United States v. General Dynamics Gorp.,* 481 U.S. 239 (1987).

In *General Dynamics,* the Court concluded that the taxpayer, a self-insurer of its employees' medical expenses, could not deduct reserve accounts reflecting liabilities for medical care provided during the year to employees who had not filed claims for reimbursement during the year. The Supreme Court held that:

- The last event necessary to fix the liability was not the receipt of medical care by covered individuals, but the filing of properly documented claim forms.

- The filing of a claim was a condition precedent to the taxpayer's liability.

- The filing of the claim was necessary because a taxpayer cannot deduct an estimate of an anticipated expense, regardless of how statistically certain, if it is based on events that have not occurred by the close of the taxable year.

- Notwithstanding the Claims Court's factual conclusion that the processing of claims was ministerial, the filing of a claim was necessary to create liability as a matter of law.

The Court noted that the taxpayer's ability to make a reasonable estimate of its liability based on actuarial data did not alone justify a deduction. It stated, "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." Id. at 244. Thus, the filing of the claim by the employee was not a "mere technically," and the failure to file a claim does not represent the type of "extremely remote and speculative possibility" that existed in *Hughes Properties.* See *United States v. Hughes Properties, Inc.,* 476 U.S. 593 (1986).

In *Burnham Gorp. v. Commissioner,* 90T.C. 953 (1988), *aff'd,* 878 F.2d 86 (2nd Cir. 1989), the Tax Court stated that the purpose of the first requirement of the all-events test is to insure that a taxpayer will not take a deduction for expenditures that might never occur. The Tax Court also described a very fine but real distinction between a condition precedent and a condition subsequent as:

- Condition precedent- a contingency that prevents a liability from being fixed and the liability does not in fact arise until the condition is satisfied.

- Condition subsequent -a contingency that may terminate an already fixed liability, subject only to a condition which may cut off liability in the future.

See *Burnham* at 955.

The court relied on Wien *Consolidated Airlines, Inc. v. Commissioner,* 60 T.C. 13 (1973), *aff'd,* 528 F.2d 735 (9th Cir. 1976); and *World Airways, Inc. v. Commissioner,* 62 T.C. 786 (1974), *aff'd,* 564 F.2d 886 (9th Cir. 1977) for support. In *Burnham,* the Tax Court also dismissed the argument that *Wien* is distinguishable from *Burnham* because the liability in *Wien* was fixed by statute rather than by contract. It failed to see any distinction of importance since the settlement obligation in *Burnham* is enforceable and gives rise to a legal obligation no less definite than the statutory obligation in *Wien.*

The CIP concludes that the terms of the contract are relevant in determining what events fix the taxpayer's liability. Even if the Manufacturer is able to make a reasonable estimate of its rebate liability and satisfy the second prong of the all-events test, the first prong, fixing the liability, does not occur until the Manufacturer receives the State utilization report. The CIP also concludes that the filing of the report is not a mere technicality. The Manufacturer will not pay amounts for which a State never submits a utilization report. Thus, under the CIP analysis, most Manufacturers will not meet the recurring item exception of section 461(h)(3) for their fourth quarter rebate liability. Manufacturers will not receive the State utilization report for these fourth quarter amounts by the end of their taxable year and, therefore, the Manufacturer's liability for such rebates is not yet fixed under the all-events test.

The CIP further contends that a change from deducting the rebate liability prior to the year of payment to deducting the liability in the year of payment, for Manufacturers who do not qualify for the recurring item exception, is a change in accounting method. Therefore, sections 446 and 481 are applicable. The industry has not disputed the change in accounting method conclusion. However, it relies on *General Dynamics* and *Hughes Properties* as the decisions that establish the criteria to determine when a liability is fixed, i.e. the degree of likelihood the anticipated liability may be avoided. The industry contends that if avoidance is an "extremely remote and speculative possibility" then the liability may be accrued.

In *Hughes Properties* an accrual method casino operator deducted the amount guaranteed for payment on its progressive slot machines. The Service denied the deduction claiming the jackpot payoff could only be deducted when paid because the winning handle pull was the last event necessary to satisfy the all-events test.

However, a Nevada regulation for progressive slot machines prohibited reducing the payoff without paying the jackpot. Therefore, the taxpayer argued the last event creating the liability was the last play of the jackpot machine before the end of the fiscal year.

In *Hughes Properties* the Court stated, "That an extremely remote and speculative possibility existed that the jackpot might never be won, did not change the fact that, as a matter of state law, respondent had a fixed liability for the jackpot which it could not escape." See *Hughes* at 601. The Court concluded that the effect of the Gaming Commission's regulation was to fix the taxpayer's liability when the obligation was recorded on the slot machine meter and that any uncertainties regarding the identity of the winning gambler or the timing of the winning pull were insufficient to render the jackpot liability contingent. The Court stated that the risk that the jackpot may never be won because the taxpayer may go out of business or go into bankruptcy exists for every business and it does not prevent accrual. The Court further stated that the first prong focuses only on contingencies that impact the fact of the liability, not the amount or timing of the liability.

In *Gold Coast Hotel & Casino, et al. v. United States,* 158 F.3d 484 (9th Cir. 1998), the Ninth Circuit reviewed the issue of when an accrual method casino may deduct the value of slot club points won by a club member in the year the member accumulated the minimum number of points necessary to redeem a prize. Under Nevada law, the taxpayer's liability became unconditional when a member accumulated 1,200 points. The Service argued that because not all club members redeem their points, the liability could not be considered fixed until the points are redeemed. The Service also argued that the taxpayer had not estimated its liability with reasonable certainty since an analysis of their data suggested that only sixty-nine percent of slot club points are actually redeemed.

The Court disagreed with both of the Service's arguments. It concluded that the redemption of points was a technicality and nothing more than a demand for payment of an uncontested liability. It further concluded that the second prong of the all-events test only requires that the amount of the liability be determined with reasonable accuracy. The percentage of the liability that would be discharged by the payment is not relevant.

The industry contends that since *General Dynamics* did not overrule *Hughes Properties* both cases must be used to fix the critical determination of when the fact of liability is established. The industry concludes that although contract terms are relevant in determining which events may have an effect on the timing of an item of income or expense, the point at which it becomes fixed depends on the remoteness of such contractual events. See, e.g., *Daly v. Commissioner,* 227 F.2d 724 (9th Cir. 1955).

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The industry argues the substance rather than the form of the legal liability controls the timing for the accrual of both income and expense items. It notes that since the decision in *General Dynamics,* both deduction and income accrual cases have supported the conclusion and reiterated a long -standing principle. A taxpayer's obligation or right to receive income is not fixed for purposes of the all-events test if the obligation or right is contingent upon certain actions unless the probability of such actions not occurring is remote.

The industry relies on *Doyle, Dane, Bernbach, Inc. v. Commissioner,* 79 T.C. 101 (1982) where the taxpayer's right to a refund of state taxes did not accrue until approved by state authorities because approval was not a mechanical act. The Court stated that the mere existence of a contingency is not sufficient to prevent accrual, it must be of sufficient magnitude. The industry also relies on *Spitzer Columbus, Inc. v. Commissioner,* T.C. Memo 1995-397, where there was more than a remote possibility that consumers would not redeem their coupons for cash. Only sixty percent of the coupons were approved by the attorney general through a meaningful review process.

The industry argues that with a Medicaid rebate, it is unlikely that any similar contingencies will prevent accrual. It is unlikely that the State will ever fail to bill the Manufacturer for the rebate due and unlikely that the pharmacy will ever fail to bill the State for its reimbursement. The industry concludes that the likelihood a Manufacturer will avoid liability with respect to Medicaid rebates is an "extremely remote and speculative possibility." To date, the industry has not demonstrated this assertion.

Both court cases and Service rulings have held that in certain circumstances, even where the taxpayer was required to submit documentation as a condition of payment, these requirements were purely ministerial acts that did not affect the right to payment. In Rev. Rul. 98-39, 1998-33 I.R.B. 4, the Service held that a manufacturer's liability with respect to cooperative advertising accrues when the advertising is performed, not when the bill for that advertising is received. In the cooperative advertising scenario, a manufacturer makes a written offer to pay a specified amount to a retailer who:

- purchases the manufacturer's product in Year 1,
- advertises that product within a specified time frame in Year 1, and
- then satisfies all requirements of the offer with respect to the format and content of the advertising, including the discount on the purchase of the manufacturer's product.

In order to secure payment, the retailer must submit a claim form and proof of performance within ninety days after the date of the advertising. The manufacturer is

able to make a reasonable estimate of its liability to the retailer for services performed in Year 1.

Under these facts, the Service determined that the all-events test is met when the performance required under the contract, the advertising in Year 1, occurred even though proof of performance is not submitted until Year 2. Economic performance with respect to the manufacturer's liability occurred in Year 1 when the retailer performed the cooperative advertising services. The Service also noted that in some cases, such as *General Dynamics,* the requirement that a claim be filed is a condition precedent that delays satisfaction of the all-events test. However, in the cooperative advertising issue, a requirement that the retailer furnish proof of performance to the manufacturer is a mere technicality and not a condition precedent necessary to fix the manufacturer's liability under section 461.

The industry argues that the receipt of the State's utilization report is a ministerial act and no different from the retailers' submission of a claim form to the manufacturer in Year 2 for the cooperative advertising issue. The industry concludes, therefore, that the Medicaid rebate liability becomes fixed when the Manufacturer's product is dispensed. No data supporting this claim has been submitted.

We agree with the CIP that the form and contract terms in the Medicaid rebate agreement are relevant in determining which events have an effect on the timing of the rebate liability. The Tax Court determined that where a taxpayer's obligations are set forth in a written agreement the terms of the agreement are relevant in determining the events that fix the taxpayer's obligation to pay. See *Decision, Inc. v. Commissioner,* 47 T.C. 58 (1966).

Under the rebate agreement, the Manufacturer does not have an obligation to make a rebate payment at the time a drug is dispensed by a pharmacist to a Medicaid recipient. Rather, the Manufacturer is only required to make a rebate payment for drugs paid for by the State Medicaid Agency (i.e., reimbursed by the State to the pharmacy) during a calendar quarter. In addition, the reimbursement by the State Medicaid Agency to the pharmacy is not a ministerial act. Unlike *Gold Coast Hotel & Casino,* but similar to *General Dynamics,* the Medicaid rebate liability does involve third parties necessitating "proof of their right to payment." In light of the rationale of Rev. Rul. 98-39, it is likely that the fact of liability is established no later than the time the State Medicaid agency reimburses the pharmacy.

Documentation secured from HCFA indicates approval by a State of claims reimbursed to pharmacies is not a mechanical act and can be very confusing. For example, sales to HMOs, for drugs dispensed under a captive rate, are included in computing a Manufacturer's BP, but are not included in computing the AMP and they are not eligible

for a Medicaid rebate. However, sales to HMOs, where drugs are dispensed under fee-for-service, are included in computing the BP and eligible for a Medicaid rebate, but they are not included in computing the AMP. Direct sales to hospitals are not included in the AMP computation, but are included in the BP computation and do qualify for a rebate if the drug is used in the outpatient pharmacy and the hospital bills Medicaid for reimbursement for dispensing the outpatient drug. Otherwise, hospital sales do not qualify for a rebate even if the covered drug is dispensed to a Medicaid patient.

A Manufacturer's sale of a covered drug is available for a rebate and included in computing the AMP and BP, except for sales to wholesalers that can be identified with adequate documentation as subsequently sold to any of the excluded sales categories. The following are examples of sales not included in computing the Manufacturer's AMP, BP, and Medicaid rebate:

- Public Health Service ("PHS") covered entities
- State-funded only pharmacy assistance programs
- Veteran's Administration and/or Department of Defense excluded sales Federal supply schedules sales
- Sales to other Manufacturers who repackage and/or relabel under the purchaser's national drug code ("NDC").

A State may reject a pharmacy's claim for many reasons, including the drug dispensed is not on the approved list, NDC errors on the claim, unit field errors, and units of measure errors. See "Medicaid Rebates: Taming the 800 pound Gorilla," Leifer and McCann, *Pharmaceutical Executive,* April 1996, 76-80. This is one of the reasons why some States, such as Massachusetts, have laws that mandate a thirty-day review period before any pharmacy claim is reimbursed. However, no data has been offered revealing the percentage of pharmacy claims sustained or rejected by State Medicaid agencies or the degree of rejection for noncompliance with ministerial items that can easily be remedied.

Many States have encountered problems reconciling rebate amounts due with Manufacturers. Reconciliation problems occur for several reasons, including:

- Claims billing problems with pharmacies that are not detected by system edits, including different use of unit types by pharmacies.

- Manufacturers' attempts to verify Medicaid utilization data using non-Medicaid specific proprietary data sources.

- Drug coding errors made as prescriptions are filled.

According to HCFA, the controlling event for a Medicaid rebate is when the State reimburses the pharmacy for a covered drug, not when the covered drug is dispensed. HCFA views Medicaid as a dynamic, moving target consisting of a very fluid population. It is a State program where each State has different policies, legislation, and operating procedures. There are constant changes in the medical needs of the beneficiary pool, State and Federal requirements, beneficiary's personal life, economic climate, and unemployment level of the region and the nation. States can and do waive different groups in and out of Medicaid depending upon their budget constraints. For example, Nevada included the Children's Initiative Program in Medicaid during the middle of one year.

In *Chrysler Corp., et al. v. Commissioner,* T.C. Memo. 2000-283, the Tax Court held that a liability, for purposes of the first prong of the all-events test, for Chrysler's estimated warranty expense for vehicles sold during the year was not met when the car was sold to a dealer. Relying on *Hughes Properties,* Chrysler argued that the last event necessary to fix its warranty liability was the sale of a vehicle to a dealer. Chrysler also argued that if a liability is fixed by statute, it is fixed under the first prong of the all-events test. Upon the Service's motion for summary judgment, the Court disagreed with Chrysler. It held that even if a liability is fixed by statute that alone is not sufficient to satisfy the first prong of the all-events test.

The industry also argued that the payment of the Medicaid rebate should be viewed as a reduction of gross receipts (and, therefore, gross income) and not a deductible expense under section 162. This issue was not addressed in the CIP and, therefore, is not part of this Appeals Settlement Guideline.

The industry agrees that the calculation of the amount of the Medicaid rebate due does hinge upon future events, such as the AMP and BP in the quarters in which the States reimburse the pharmacy, but argues that the Manufacturer becomes obligated as of the dispense date. The industry states that the amount of the rebate to be paid by the Manufacturer is the greater of:

- a percentage fixed by statute (15.1 percent of the AMP for rebate periods beginning after December 31, 1995);

- the difference between the AMP and the BP for the strength and dosage of the drug.

Therefore, the industry concludes that since the Manufacturer is required by federal law to provide a rebate of 15.1 percent or greater, the rebate is a fixed liability and there is no possibility that it can be avoided. Future events, such as the AMP and BP, will not change the fact of liability and will only impact the amount of liability.

The industry also argues that under the second prong of the all-events test taxpayers can reasonably estimate the amount of liability based upon future events since it is explicitly a more flexible standard. The industry relies on *Burnham Corp* wherein the Second Circuit stated, "the all-events test does not require that the amount of liability be known with certainty. The second prong of the test makes clear that the amount only need be known with reasonable accuracy," See 878 F .2d 86, 88. After discussing several other cases and a ruling, the industry concludes that the second prong is met because the estimates Manufacturers must make for Medicaid rebates relate only to what their prices will be one quarter after the taxable year ends.

This conclusion is not accurate because the AMP and BP are not the only information necessary at the end of the quarter for HCFA to compute the URA. Further, the rebate amount is not just the greater of a stated percentage fixed by statute versus the difference between the AMP and the BP as portrayed by the industry. For example, if a product is in the category of non-innovator, multiple source ("N") such as one from a generic manufacturer, the URA is eleven percent of the AMP for January l' 1994 and subsequent. Prior to January 1, 1994, the URA was ten percent of the AMP for category N products. If the product category is a single source ("S") or innovator, multiple source ("I"), the URA is calculated by using the quarterly AMP and BP, baseline AMP, and CPI-U values.

While the S or I calculation is the same today as it was at the start of the program, the difficulty of this calculation is in where the values come from and what values are used, or not used as in the cap values. For 1991 there was a cap applied to the basic rebate of twenty-five percent of AMP, and for 1992 the cap was fifty percent of AMP. In 1993, the cap was removed and replaced with a CPI-U creep computation to account for cost of living increases. Based on the market date of the product, there are different sets of baseline values to use for the CPI-U creep calculation. It is now necessary to compute both a basic rebate and the additional rebate in order to determine the URA for every S or I product sold.

In addition, according to HCFA quarterly rebate liabilities cannot be estimated based on historical trends. HCFA contends that estimates are not possible due to the dynamics of Medicaid, changes in the beneficiary pool, and variations in eligibility and operating

procedures of the State programs. Each State has its own system to process Medicaid rebates with some using third parties. States could agree to give utilization report data to a Manufacturer before the sixty days required by law. However, it would not be reliable and would include hospitals or other purchases that do not qualify. It would very likely include many errors since it has not been subject to edits, which is why some States mandate up to a forty-five day review period before reimbursing the pharmacy.

The point of sale systems of some pharmacies today can identify Medicaid reimbursements owed to them, but very few for the earlier years of the Medicaid rebate program. This system, however, is before State edits and reviews. The HCFA also notes that the Manufacturers disputed seventy percent of all rebates for the years 1991 through 1994 and for 1992 the estimated cumulative uncollected rebate liability from Manufacturers was $1,352,339,367.

However, as indicated by the industry, the courts have been flexible in their interpretation of the reasonable estimate prong of the all-events test. For example, in both *Kaiser Steel Corp.* and *Crescent Wharf* & *Warehouse* Co., the Ninth Circuit allowed the taxpayers to accrue deductions for amounts based on estimates of facts unknown at the end of the taxable period. See *Kaiser Steel Corp. v. United States,* 717 F.2d 1304 (9th Cir. 1983); *Crescent Wharf& Warehouse* Co. *v. Commissioner,* 518 F.2d 772 (9th Cir. 1975). Thus, in some situations, taxpayers may be able to make reasonably accurate determinations of the amount of the liability even if all the facts relating to the calculation are not known or knowable by the end of the taxable year. Yet in *Robbins Tire* & *Rubber* Co. *v. Commissioner,* 52 T.C. 420 (1969), the Tax Court determined conditions subsequent can affect the amount of a liability and can prevent it from being determinable with reasonable accuracy.

The position of the CIP results in a change in method of accounting under section 446 since it changes the taxable year in which income is reported and involves timing. See Rev. Proc. 97-27, 1997-1 C.B. 680. In the absence of an agreement between the taxpayer and the Commissioner, the section 481(a) adjustment is generally taken completely into account in the year of the change, but subject to section 481(b).

Settlement Position

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