

Sheltering High Clinical W-2 and K-1 Income Through Direct Working Interest Participation

A White Paper Examining the Statutory Mechanics of IRC Section 263(c) and Section 469(c)(3) for Physicians, Surgeons, and High-Earning Clinical Professionals

WHITE PAPER | TAX STRATEGY | OIL & GAS

Executive Summary

Physicians and surgeons earning $500,000 or more annually in active clinical compensation face a structural problem that conventional financial planning does not solve: the federal tax code reaches its top marginal rate at a relatively low income threshold, and the tax-advantaged retirement vehicles most clinicians already max out were never designed to absorb earnings at this scale. A hospital-employed surgeon drawing a W-2 salary, or a practice partner receiving K-1 distributions from a physician group, typically has no additional qualifying business expense, no depreciable equipment fleet, and no straightforward mechanism to reduce current-year taxable income beyond the ordinary deferral limits that apply to every other employee in the country.

This paper examines a documented statutory framework — not a novel strategy — that allows active clinical income to be offset through direct participation in oil and gas drilling activity. Two provisions of the Internal Revenue Code work together to make this possible.

IRC Section 263(c)

Rooted in Treasury guidance dating to 1916 and codified in the Internal Revenue Code of 1954, allows the holder of a working interest in an oil or gas well to elect to deduct intangible drilling costs in the year incurred rather than capitalizing them over time.

IRC Section 469(c)(3)

The separate provision that determines whether that deduction can actually offset active income such as W-2 wages or K-1 distributions — and it does so **without requiring the material participation hours test** that applies to real estate professional status or most other active-income strategies.

This paper explains how the two provisions interact, what structural conditions must be met for a physician to preserve the active-income offset, what additional layers of the Code a clinician's tax advisor should evaluate before year-end, and what the statute does not shelter a participant from. It closes with a framework for how direct working interest participation is structured when held through an entrepreneurial joint venture rather than a liability-limiting fund vehicle, and a set of questions physicians should raise with their CPA or tax counsel before acting.

Why This Issue Matters

The compression of the physician income tax problem is a function of timing, not magnitude alone. Under IRS Revenue Procedure 2025-32, the top federal marginal rate of **37 percent**, made permanent by the One Big Beautiful Bill Act (OBBBA, signed July 4, 2025), begins above **$640,600** of taxable income for a single filer and **$768,600** for a married couple filing jointly. A surgeon or specialist physician earning $500,000 to $1,000,000 or more in active compensation routinely sits at or above this threshold well before any other income source is considered, and every additional dollar of clinical income, overtime call pay, locum tenens work, or year-end bonus from a practice distribution is taxed at that marginal rate.

The Retirement Vehicle Gap

Conventional tax-deferred savings vehicles were not built to absorb earnings at this level. Per IRS IR-2025-111 (issued November 13, 2025):

$24,500

401(k) Employee Deferral

2026 limit, with a combined employee-and-employer limit of $72,000

$11,250

Super Catch-Up

For participants age 60 to 63 under the new OBBBA provisions

$7,500

IRA Contribution Limit

Roth IRA eligibility phases out entirely for most high-earning physicians

Even a physician who maximizes every available qualified retirement vehicle is sheltering a small fraction of total clinical compensation, and the unsheltered remainder is taxed at the top marginal rate in the year it is earned.

This is the gap that a documented, decades-old provision of the tax code was built to address for working interest holders, long before oil and gas drilling activity had any connection to medicine. The relevance to a physician is not that the statute was written with clinicians in mind. It is that the statute applies to any taxpayer who holds a working interest directly, regardless of profession, and does not require the recipient to spend material participation hours in the underlying activity — which is precisely the obstacle that prevents a physician working clinical hours from using real estate professional status or an active trade or business to accomplish the same goal.

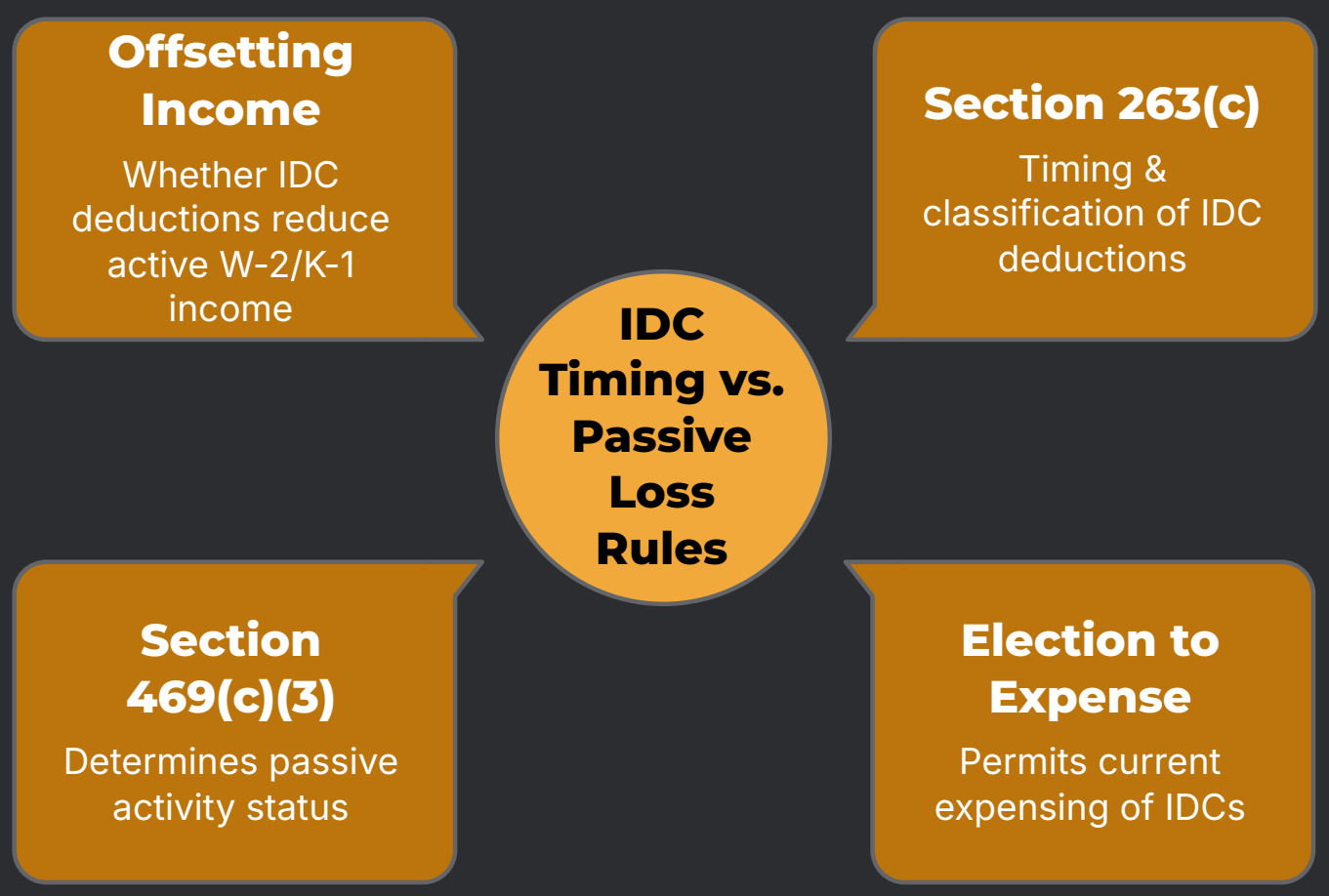
Foundational Concepts: What the Code Actually Says

What an Intangible Drilling Cost Is

Treasury Regulation 1.612-4, issued under IRC Section 263(c), permits the holder of a working interest in an oil or gas property to elect to expense intangible drilling costs (IDC) in the year incurred rather than capitalizing and recovering them over the life of the well. Intangible drilling costs are costs with no salvage value: labor, fuel, drilling mud and chemicals, site preparation, and hauling. Costs for equipment that retains salvage value — such as casing, wellhead equipment, and tanks — are tangible drilling costs (TDC) and are instead capitalized and depreciated, generally over a seven-year schedule under IRC Section 168. Multiple independent industry sources place the typical IDC share of total well cost in a range of roughly **60 to 85 percent**, though the specific split for any given well is a function of its authorization for expenditure (AFE) and depends on the individual well's engineering and completion design. No single percentage applies uniformly to every well or every participant's capital, and the applicable split should be confirmed through the AFE and the participant's own tax advisor rather than assumed from an industry average.

The Distinction Most Explanations Miss

Section 263(c) only governs the **timing and classification** of the deduction, not whether that deduction can offset active income. The provision that actually permits an IDC deduction to reduce W-2 wages, 1099 income, or K-1 distributions is IRC Section 469(c)(3)(A) — the working interest exception to the passive activity loss rules. The statute reads that the term "passive activity" shall not include any working interest in an oil or gas property "which the taxpayer holds directly or through an entity which does not limit the liability of the taxpayer." Critically, this exception carries **no material participation hours requirement**, which is the test that governs real estate professional status and most other active-trade-or-business strategies. A surgeon working a seventy-hour clinical week is not disqualified from this exception on that basis. The exception is disqualified instead by entity structure: holding the interest through a liability-limiting vehicle such as a limited partnership or limited liability company causes the position to revert to passive treatment, at which point losses can generally only offset income the tax code also classifies as passive — not clinical W-2 or K-1 earnings.



The Statutory Stack: Every Layer a Physician's Advisor Must Evaluate

A working interest contribution structured to offset active clinical income sits inside a stack of Code provisions that work together, not a single isolated deduction. A tax advisor evaluating this structure for a physician should walk through each layer.

1 At-Risk Limitation — IRC Section 465

The IDC deduction is capped at the taxpayer's actual economic exposure in the activity. Cash contributed and recourse debt for which the participant is personally liable count toward at-risk basis; nonrecourse debt does not. This differs from the treatment many real estate structures allow, where certain nonrecourse financing can still build basis.

2 Alternative Minimum Tax Treatment — IRC Section 57(a)(2)

Excess intangible drilling costs are an AMT preference item for integrated producers, but Section 57(a)(2)(A) provides that the excess IDC is treated as a preference item only to the extent it exceeds 65 percent of the taxpayer's net income from oil, gas, and geothermal properties for the taxable year. Section 57(a)(2)(E) separately turns this preference off entirely for independent producers, subject to its own ceiling: the resulting reduction in alternative minimum taxable income cannot exceed 40 percent of AMTI computed without regard to the preference. The practical effect is that drilling cost deductions generally cannot reduce a taxpayer's AMTI below 60 percent of pre-deduction income. A physician's advisor needs to model this interaction specifically, not assume the regular-tax deduction carries through dollar for dollar to the AMT calculation.

3 Economic Performance Timing — IRC Section 461(h)

A December capital contribution intended to generate a current-year IDC deduction must satisfy the economic performance rule, which generally requires that drilling activity begin within **90 days** of the tax year's close to qualify for the deduction in that year. This is a timing mechanic, not a loss-limitation mechanic, but it is the single most common reason a year-end contribution fails to produce the deduction a participant expected.

4 Order of Loss Limitations

Four layers apply in sequence before any deduction reaches a physician's Form 1040: basis limitation, then the at-risk rules under Section 465, then the passive activity rules under Section 469 (where the 469(c)(3) working interest exception is evaluated), and finally the excess business loss limitation under Section 461(l), which for the 2026 tax year caps the amount of aggregate business loss an individual can use against nonbusiness income at **$256,000 for a single filer** and **$512,000 for a married couple filing jointly**, with any excess carried forward as a net operating loss. A physician contemplating a large current-year offset should have an advisor model all four layers together, not just the headline IDC percentage.

5 Percentage Depletion — IRC Sections 611 and 613A

Once a well held through a direct working interest begins producing, independent producers may generally claim a **15 percent percentage depletion allowance** against gross income from the property, which continues annually even after the participant's cost basis in the well has been fully recovered. This is a smaller, ongoing benefit distinct from the first-year IDC deduction, relevant to a physician's multi-year tax planning rather than the current-year offset that is this paper's primary focus.

⚠ A physician's advisor needs to model all four loss-limitation layers together against the specific taxpayer's full income picture — not just the headline IDC percentage. The AMT and excess business loss layers mean that a physician's realized current-year benefit is not a flat percentage of capital contributed.

Additional Statutory Considerations

What the Statute Does Not Shelter

A working interest holder who takes an active role consistent with the direct-holding requirement of Section 469(c)(3) can, depending on the specific facts, be exposed to **self-employment tax treatment** on working interest income — a point addressed in *Methvin v. Commissioner* (10th Cir. 2016). This is a separate question from income tax offset and should be reviewed with a tax advisor as part of the same engagement, since the active-income offset and potential self-employment tax exposure arise from related but distinct provisions of the Code.

K-1 Reporting Mechanics

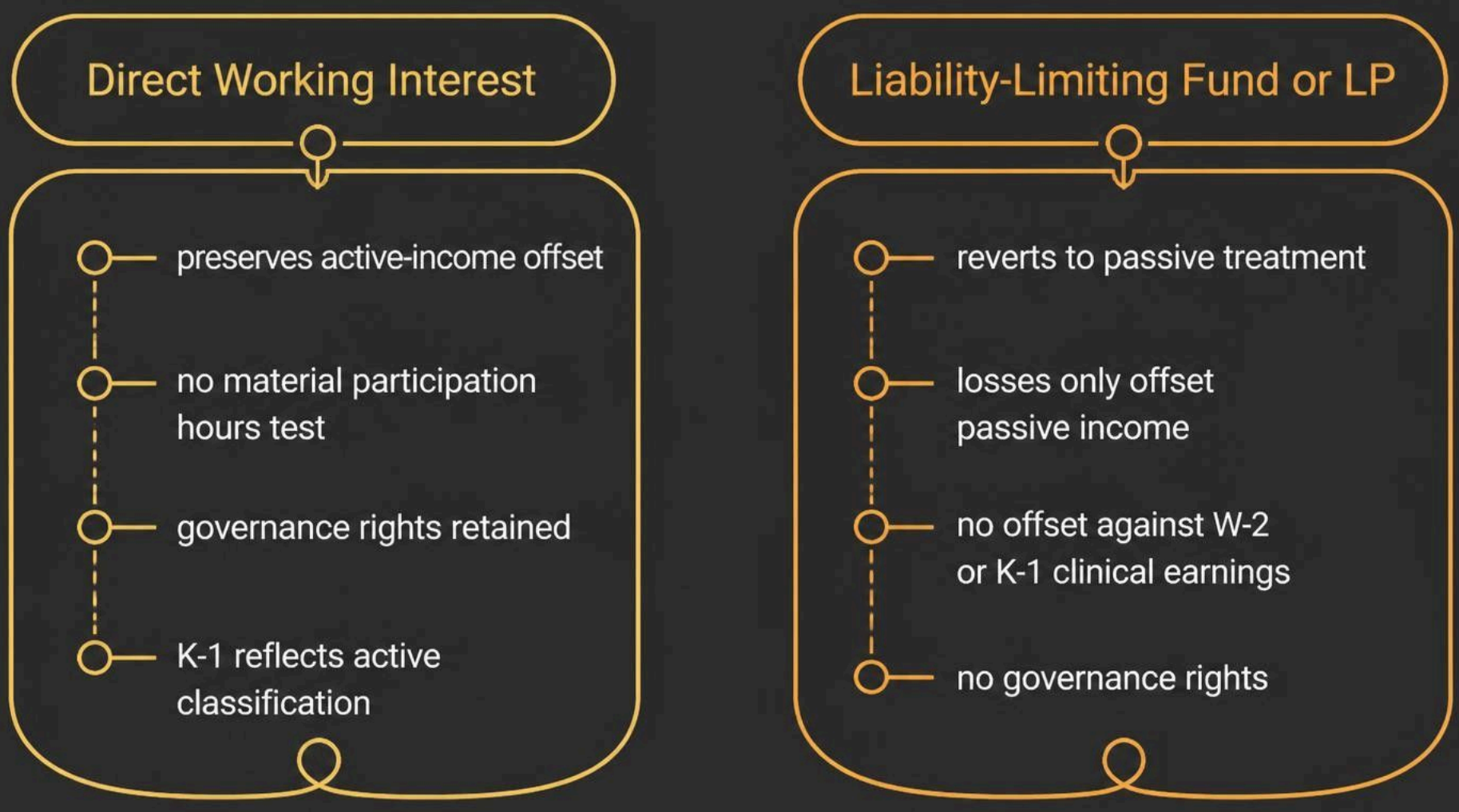
For a physician who is already a K-1 recipient through a practice partnership, the mechanics are familiar. A working interest held directly generates its own K-1, which should reflect **active rather than passive classification** under Section 469 in the relevant boxes — generally Box 1 and the supporting statements tied to Boxes 12, 13, and 20 — giving the participant's accountant a clear basis for the offset against the physician's other active income when the return is prepared.

Market Context: Domestic Drilling Activity

The OBBBA permanently reinstated **100 percent bonus depreciation** under IRC Section 168(k) for qualifying property placed in service after January 19, 2025, which affects the tangible drilling cost portion of a well's cost structure going forward. On the production side, the U.S. Energy Information Administration confirmed that domestic crude oil production set a new record of **13.6 million barrels per day** in 2025, with the Permian Basin alone accounting for roughly 48 percent of that total at 6.6 million barrels per day — an increase of approximately 280,000 barrels per day year over year. This is cited here as market context for domestic drilling activity, not as a projection of returns for any specific well or participant's capital.

How Direct Working Interest Participation Is Structured

The entire active-income offset described above depends on one structural fact: how the working interest is held. This is where an entrepreneurial joint venture structure differs materially from a pooled fund, limited partnership, or limited liability company interest, even when the underlying wells are identical.



Summit Ventures structures physician and surgeon participation around four elements designed to preserve the Section 469(c)(3) exception rather than inadvertently forfeiting it:

1

Direct Assignment of the Working Interest

The physician receives a direct, undivided working interest position, or holds the interest through an entity that does not limit liability, consistent with the statutory requirement. The position is not a share of a pooled fund, a limited partnership unit, or a membership interest in a liability-limiting LLC — any of which would cause the position to revert to passive treatment under the statute.

2

AFE-Documented Cost Allocation

The authorization for expenditure for each well specifies the actual intangible versus tangible cost split for that well, giving the participant's tax advisor a documented, well-specific basis for the IDC election rather than an industry-average assumption.

3

Governance Rights and Operational Transparency

Active JV members retain governance rights into the operating program and receive ongoing reporting on drilling, completion, and production activity, consistent with the active character the statute requires and distinguishing the position from a limited partnership unit that carries no operational governance rights.

4

K-1 Reporting Aligned to Active Classification

Annual K-1 reporting reflects the direct-holding structure, giving the physician's CPA the documentation needed to support active treatment on the individual return.

This structure is directly relevant to why the strategy fits a clinician's actual constraints. A physician cannot realistically log 500 hours of material participation in a side business while maintaining a full clinical schedule, and most do not want to operate a business outside of medicine at all. Because Section 469(c)(3) carries no participation-hours test, and because the entrepreneurial joint venture structure preserves governance rights without requiring day-to-day operational involvement, a physician can hold a working interest position that satisfies the statute's direct-holding requirement without taking on operational responsibilities that would compete with clinical practice.

Recommendations and Implications

For a physician or surgeon evaluating this structure, several implications follow directly from the mechanics above.

Timing of Capital Contribution Is Critical

Because of the Section 461(h) economic performance rule, a contribution made late in December with no drilling activity scheduled within 90 days may not produce the current-year deduction the participant expects. Advisors should confirm well-specific spud timing before year-end commitments are finalized.

Entity Structure Is the Determining Factor

A physician could hold an economically identical working interest through two different legal structures and receive entirely different tax treatment: direct holding preserves the active-income offset, while a liability-limiting fund or LP structure forfeits it and converts the position to passive. This is the single most consequential structural decision in the entire strategy.

Model All Limitation Layers Together

The AMT and excess business loss layers mean that a physician's realized current-year benefit is not a flat percentage of capital contributed. The 65 percent and 40 percent thresholds under Section 57(a)(2), and the $256,000 or $512,000 excess business loss ceiling under Section 461(l), should be modeled against the specific taxpayer's full income picture — not assumed from a generic example.

This Is a Multi-Year Framework

The first-year IDC deduction addresses the immediate income-compression problem, while percentage depletion under Sections 611 and 613A provides a smaller, recurring benefit once wells produce, and the four-layer loss-limitation order remains relevant to each subsequent year's contributions.

Questions for Professional Advisor Discussion

Before acting on any element of this framework, physicians should raise the following questions with their CPA or tax counsel:

01

Marginal Bracket Position

Does my current compensation structure — including W-2 wages and any K-1 distributions from my practice — place me above the 37 percent federal marginal bracket threshold this year, and by how much?

02

Retirement Contribution Capacity

What portion of my retirement contribution capacity is already utilized, and what is my realistic unsheltered income after maximizing qualified retirement vehicles?

03

Documentation for Active Classification

If I hold a working interest directly rather than through a fund or limited partnership, what documentation should I retain to support active classification under Section 469(c)(3) if the position is ever examined?

04

AFE-Confirmed Cost Split

What is the AFE-confirmed intangible versus tangible cost split for the specific well I am evaluating, and who prepared that allocation?

05

AMT and Excess Business Loss Modeling

How would the Section 57(a)(2) AMT preference interaction and the Section 461(l) excess business loss threshold affect my specific projected deduction this year?

06

Economic Performance Timing

Does the well's drilling schedule satisfy the Section 461(h) 90-day economic performance requirement if I contribute capital before year-end?

07

Self-Employment Tax Exposure

Could I be exposed to self-employment tax treatment on any portion of this income given the *Methvin v. Commissioner* precedent, and how should that be modeled alongside the income tax benefit?

08

K-1 and Return Reporting

How should this working interest position be reported on my K-1 and personal return to clearly document the active classification my advisor and I are relying on?

Conclusion & Next Steps

Physicians and surgeons facing compressed timelines before the top marginal bracket applies, and retirement vehicles that cap out far below clinical earnings, are working within real statutory constraints — not a planning gap that better paperwork alone can close. The framework described in this paper — direct working interest participation structured to preserve the Section 469(c)(3) active-income exception — is built on decades-old, well-documented provisions of the Internal Revenue Code rather than an emerging or untested arrangement.

Its value to a specific physician depends entirely on that physician's income composition, entity structure, and the well-specific facts confirmed through the AFE, which is why every element of this paper is presented as mechanics to evaluate with a qualified CPA or tax attorney rather than a guaranteed outcome. Physicians who take the time to understand how Section 263(c) and Section 469(c)(3) interact, and who structure participation to preserve rather than inadvertently forfeit the active-income exception, are positioned to make a more informed decision about whether direct working interest participation belongs in their broader tax and wealth planning.

> The statute applies to any taxpayer who holds a working interest directly, regardless of profession, and does not require the recipient to spend material participation hours in the underlying activity — which is precisely the obstacle that prevents a physician working clinical hours from using real estate professional status or an active trade or business to accomplish the same goal.

Sources and References

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Ready to explore whether direct working interest participation belongs in your tax and wealth planning?

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