Internal Revenue Service

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Date: [redacted]

Surname [redacted]

Department of the Treasury

Washington, DC 20224

Contact Person: [redacted]

Telephone Number: [redacted]

In Reference to: [redacted]

Date: JAN 7 1999

Employer Identification Number: [redacted]
Key District: [redacted]

Dear Applicant:

On [redacted], we sent you a letter in which we proposed denying your application for recognition of exemption under section 501(c)(3) of the Internal Revenue Code. On [redacted], you submitted your written protest. Subsequently, you submitted additional information relating to your activities. Based on your protest and the additional information you submitted, we have concluded that our [redacted] letter was incomplete. Therefore, our [redacted] is hereby withdrawn and is superseded by this letter.

We have considered your application for recognition of exemption from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3). Based on the information submitted, we have concluded that you do not qualify for exemption under that section. The basis for our conclusion is set forth below.

FACTS

You were incorporated on [redacted] under the [redacted] as a nonstock membership corporation under the name [redacted] You subsequently amended your Articles of Incorporation to change your name to [redacted] Your amended Articles provide that your purposes include providing health care services through employed and contracted personnel; owning, controlling, and/or operating hospital, medical, clinical, research and nursing facilities; and providing financial, management, advisory and service assistance and support to other health-care related organizations.

Your current members consist of the following hospitals, all of which are exempt from federal income tax under section 501(c)(3) of the Code:

[redacted] operates a separate health maintenance organization. ("HMO").

On [redacted], [redacted] and [redacted] became affiliated through a newly created common parent, [redacted] which is the sole member of both hospitals. Collectively, [redacted] and [redacted] represent approximately [redacted] percent of your membership interests.

You have notified us that negotiations are taking place whereby [redacted] would join this affiliation. If this were to occur, collectively, [redacted] and [redacted] would represent approximately [redacted] percent of your membership interests.

You serve as a component of your four members' strategy to develop a full service, regional non-profit behavioral health care network in [redacted] area. You are primarily engaged in providing outpatient behavioral health care services to employees through employee assistance programs ("EAPs"). You contract with employers to provide a variety of services designed to treat behavioral health and other lifestyle management problems including marriage and family counseling, substance abuse, stress management, anxiety and depression. You also provide a telephone "hotline" staffed with trained counselors; wellness and prevention education programs; consultative services in the development and implementation of a drug-free workplace and other similar programs; provider network development; and utilization management, claims processing and payment for certain client companies. In addition, you provide outpatient services to individuals with mental health and other behavioral problems as part of a network of providers that include your four hospital members and their controlled affiliates.

Your Bylaws provide that your Board of Directors consists of [redacted] Directors, of whom nine are appointed by your members, two are ex-officio voting members and one is a member-at-large. You have represented that at [redacted] meeting of your Board of Directors, you adopted a substantial conflicts of interest policy. You have also represented that currently and at all times in the future, at least a majority of your Board of

[redacted]

Directors will be comprised of independent members of the community.

You are the sole member of two nonprofit corporations formed under [redacted] of the [redacted] and [redacted].

Your activities consist of providing the following services:

1. Behavioral health care EAPs for employees of approximately [redacted] contracted employers. All but one of these employers have more than 100 employees; most have substantially more. For some of these employers, you also provide related pre-certification services, utilization review and claims management services.

2. Behavioral health care services to enrollees of the [redacted] and psychiatric unit administrative services to the behavioral health service departments of two hospitals, [redacted], which are affiliated with two of your member organizations.

3. Behavioral health care services to the general public.

Revenues

Your actual and projected revenues are:

	FYE [redacted]	
Employer Clients	$[redacted]	27.6%
[redacted]		70.7%
General Public		1.4%
Total	$[redacted]	100.0%

	[redacted]	
Employer Clients	$[redacted]	22.2%
[redacted]		77.6%
General Public		0.2%
Total	$[redacted]	100.0%

	FYE [redacted]	
Employer Clients	$[redacted]	20.4%
[redacted]		79.5%
General Public		0.1%
Total	$[redacted]	100.0%

[redacted] of the [redacted] Employer Clients have 100 employees or more. Your Employer Clients include employees of your four member hospitals and their affiliates.

Under all but two of your contracts to provide EAP services to employers, including pre-certification and utilization review and claims management, you are paid on a "retainer fee" basis. (A "retainer fee" is a fee that may or may not change as the number of covered employees changes for an EAP contract, and does not include any adjustment for the number of dependents that are also covered.) For two contracts ([redacted]), your are paid on a fee-for-service basis. For one contract ([redacted]), you are paid on a fixed monthly fee for claims management. Under the contract with the [redacted] you are paid on a capitated fee basis. For the psychiatric unit administrative services that you provide to two affiliates of your members, you receive a fixed management fee.

Your actual and projected revenues consist of the following types:

	Ended [redacted]	FYE [redacted]
Retainer Fees	$[redacted]	$[redacted]
Capitated Fees	[redacted]	[redacted]
Fees-for-service	[redacted]	[redacted]
Total	$[redacted]	$[redacted]

Providers

You provide the services described above through two types of behavioral health care providers:

1. Employee Providers, which are salaried employees who perform services at seven outpatient behavioral clinics that you own and operate.

2. Contracted Providers, consisting of "Allied Providers" and "Subsidiary Physicians." Allied Providers are independent behavioral health care professionals in private practice with whom you contract. Subsidiary Physicians are independent physicians engaged in the private practice of medicine who contract with your two provider subsidiaries, [redacted] and [redacted]

[redacted]

As of [redacted], your providers consisted of:

	Employees	Contracted Providers	Total	Pct.
Psychiatrists/Osteopaths	0	90	90	18.6%
Psychologists	0	90	90	18.6%
Licensed Behavioral Health Care Therapists	35	270	305	62.8%
Totals	35	450	485	100.0%
Percentages	7.2%	92.8%	100.0%	

Psychiatrists/osteopaths perform in-person psychiatric assessments, medication management office visits and attending physicians services for inpatients.

Psychologists perform in-person assessments, outpatient therapy and counseling services and psychological testing.

Licensed behavioral health care therapists ("LBHCTs") provide coverage for incoming telephone calls under your EAPs and provide crisis intervention counseling. LBHCTs whom you employ perform non-emergency patient assessments and triage services by telephone and in person; provide outpatient therapy and counseling services at your [redacted] outpatient clinic locations; and when necessary, perform counseling services to patients by telephone. LBHCTs with whom you contract perform in-person assessments and outpatient therapy/counseling services.

The compensation you paid to these providers was:

	FYE [redacted]	
Employees	$[redacted]	41%
Contracted Providers	[redacted]	59%
Total	$[redacted]	100%

	FYE [redacted]	
Employees	$[redacted]	67%
Contracted Providers	[redacted]	33%
Total	$[redacted]	100%

The Contracted Providers are compensated on a "case rated" basis, which is a fixed payment for a specified level of service that is prepaid for a twelve-month period, regardless of how many times the provider sees the patient during such twelve-month period. Patients may have different levels of service, but each level of services has only one twelve-month prepayment case rate.

[redacted]

Communication

You plan to communicate the availability of your services to the general public through advertisements in the Yellow Pages and through community service announcements on the radio. You are in the process of drafting a proposed charity care policy. You expect that discounted or subsidized fees will be approved by your Board of Directors at the same time the proposed charity care policy is approved. Presently, you do not have a separately identified marketing or community education budget. You plan to present community stress management clinics that would be open to the public, with five to ten percent of the spaces reserved for medically underserved persons. You expect to provide behavioral health care services to Medicare and Medicaid beneficiaries through contracts with affiliates of your members, such as [redacted], community clinics that provide health care services specifically tailored to meet the unique needs of the elderly, and with similar community clinics owned by [redacted] You anticipate that once the [redacted] determines how Medicaid beneficiaries will be served, you will treat Medicaid patients.

LAW

Section 501(c)(3)

Stand Alone Basis for Exemption

Section 501(c)(3) of the Code provides for the exemption from federal income tax of organizations organized and operated exclusively for charitable, scientific or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(a)(1) of the Income Tax Regulations provides that in order for an organization to be exempt as one described in section 501(c)(3) of the Code, it must be both organized and operated exclusively for one or more exempt purposes. Under section 1.501(c)(3)-1(d)(1)(i)(b) of the regulations, an exempt purpose includes a charitable purpose.

Section 1.501(c)(3)-1(d)(2) of the regulations provides that the term "charitable" is used in Code section 501(c)(3) in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose. See Restatement (Second) of Trusts, sections 368, 372 (1959); 4A Scott and Fratcher, The Law of Trusts, sections 368, 372 (4th ed. 1989); Rev. Rul. 69-545, 1969-2 C.B. 117.

[redacted]

Section 1.501(c)(3)-1(b)(1) of the regulations provides that an organization is organized exclusively for one or more exempt purposes only if its articles of organization (a) limit the purposes of such organization to one or more exempt purposes and (b) do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes.

Section 1.501(c)(3)-1(c)(1) of the regulations provides that an organization will be regarded as "operated exclusively" for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3) of the Code. An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

Section 1.501(c)(3)-1(e)(1) of the regulations states that an organization which is organized and operated for the primary purpose of carrying on an unrelated trade or business is not exempt under section 501(c)(3) of the Code.

In Better Business Bureau of Washington, D.C. v. United States, 326 U.S. 279, 283 (1945), the Court stated that "the presence of a single . . . [nonexempt] purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly . . . [exempt] purposes."

In Rev. Rul. 69-545, 1969-2 C.B. 117, the Service established the community benefit standard as the test by which the Service determines whether a hospital is organized and operated for the charitable purpose of promoting health.

Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993), rev'g 62 TCM 1656 (1991) ("Geisinger II"), held that a prepaid health care organization that arranges for the provision of health care services only to its members benefits its members, not the community as a whole and therefore does not promote health in a charitable sense. Under the community benefit standard, the organization must benefit the community as a whole in addition to its members. In concluding that the organization did not qualify for exemption under section 501(c)(3) on the basis of promoting health, the court of appeals stated that an organization must meet a "flexible community benefit test based on a variety of indicia."

Rev. Rul. 75-197, 1975-1 C.B. 156, held that a nonprofit organization that operates a free computerized donor authorization retrieval system to facilitate transplantation of

body organs upon a donor's death qualifies for exemption under section 501(c)(3) of the Code because by facilitating the donation of organs which will be used to save lives, it is serving the health needs of the community and therefore is promoting health within the meaning of the general law of charity.

Rev. Rul. 77-68, 1977-1 C.B. 142, held that a nonprofit organization formed to provide individual psychological and educational evaluations, as well as tutoring and therapy, for children and adolescents with learning disabilities qualified for exemption under section 501(c)(3) of the Code because it both promoted health and advanced education. Because its services are designed to relieve psychological tensions and thereby improve the mental health of the children and adolescents, it promoted health.

In Rev. Rul. 77-69, 1977-1 C.B. 143, an organization was formed as a Health Systems Agency (HSA) under the National Health Planning and Resources Development Act of 1974. As an HSA, the organization's primary responsibility was the provision of effective health planning for a specified geographic area and the promotion of the development within that area of health services, staffing and facilities that met identified needs, reduced inefficiencies and implemented the HSA's health plan. The revenue ruling concluded that by establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the HSA was promoting the health of the residents of the area in which it functioned. Therefore, the HSA qualified for exemption under section 501(c)(3) of the Code on the basis that it promoted health.

Rev. Rul. 81-298, 1981-1 C.B. 328, held that a nonprofit organization that provides housing, transportation and counseling to hospital patients' relatives and friends who travel to the locality to assist and comfort the patients qualifies for exemption under section 501(c)(3) of the Code because it promotes health by helping to relieve the distress of hospital patients who benefit from the visitation and comfort provided by their relatives and friends.

In Professional Standards Review Organization of Queens County, Inc. v. Commissioner, 74 T.C. 240 (1980), acq., 1980-2 C.B. 2 ("Queens County PSRO"), the Tax Court held that an organization that reviewed the propriety of hospital treatment provided to Medicare and Medicaid recipients was exempt under section 501(c)(3) of the Code because it lessened the burdens of government and promoted the health of persons eligible for Medicare and Medicaid.

In Rev. Rul. 81-276, 1981-2 C.B. 128, the Service held that a PSRO qualifies for exemption under section 501(c)(3) of the Code because it lessens the burdens of government and promotes the health of the beneficiaries of the Medicare and Medicaid programs.

Living Faith, Inc. v. Commissioner, 950 F.2d 365 (7th Cir. 1991), involved an organization that operated restaurants and health food stores with the intention of furthering the religious work of the Seventh-Day Adventist Church as a health ministry. However, the Seventh Circuit held that these activities were primarily carried on for the purpose of conducting a commercial business enterprise. Therefore, the organization did not qualify for recognition of exemption under section 501(c)(3) of the Code.

Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. 687 (1979), aff'd, 625 F.2d 804 (8th Cir. 1980), held that while selling prescription pharmaceuticals promotes health, pharmacies cannot qualify for recognition of exemption under section 501(c)(3) on that basis alone.

Integral Part Doctrine

Section 502 of the Code states that an organization operated for the primary purpose of carrying on a trade or business for profit is not tax exempt on the ground that all of its profits are payable to one or more tax-exempt organizations.

Section 1.502-1(b) of the regulations provides that a subsidiary organization of a tax exempt organization may be exempt on the ground that the activities of the subsidiary are an integral part of the exempt activities of the parent organization. However, the subsidiary is not exempt from tax if it is operated for the primary purpose of carrying on a trade or business which would be an unrelated trade or business if regularly carried on by the parent organization.

In Rev. Rul. 78-41, 1978-1 C.B. 148, a trust created by a hospital to accumulate and hold funds to pay malpractice claims against the hospital was determined to be an integral part organization because the hospital exercised significant financial control over the trust. This was because the trustee was required to make payments to claimants at the direction of the hospital, the hospital provided the funds for the trust and the hospital directed where the funds from the trust were to be paid.

Geisinger Health Plan v. Commissioner, 100 T.C. 394 (1993), ("Geisinger III"), aff'd, 30 F.3d 494 (3rd Cir. 1994) ("Geisinger IV"), held that a prepaid health plan did not qualify for

[redacted]

exemption under section 501(c)(3) of the Code based on the integral part doctrine of section 1.502-1(b) of the regulations.

Section 513(a) of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of the purpose or function constituting the basis for its exemption.

Section 513(a)(2) of the Code provides that the term "unrelated trade or business" does not include any trade or business which is carried on, in the case of an organization described in section 501(c)(3), such as a hospital, by the organization primarily for the convenience of its patients.

Section 1.513-1(a) of the regulations defines "unrelated business taxable income" to mean gross income derived by an organization from any unrelated trade or business regularly carried on by it, less directly connected deductions and subject to certain modifications. Therefore, gross income of an exempt organization subject to the tax imposed by section 511 of the Code is includible in the computation of unrelated business taxable income if: (1) it is income from trade or business; (2) such trade or business is regularly carried on by the organization; and (3) the conduct of such trade or business is not substantially related (other than through the production of funds) to the organization's performance of its exempt functions.

Section 1.513-1(b) of the regulations states that the phrase "trade or business" includes activities carried on for the production of income which possess the characteristics of a trade or business within the meaning of section 162 of the Code. Section 1.513-1(c) of the regulations explains that "regularly carried on" has reference to the frequency and continuity with which the activities productive of the income are conducted and the manner in which they are pursued.

Section 1.513-1(d)(1) of the regulations states that the presence of the substantially related requirement necessitates an examination of the relationship between the business activities which generate the particular income in question -- the activities, that is, of producing or distributing the goods or performing the services involved -- and the accomplishment of the organization's exempt purposes.

Section 1.513-1(d)(2) of the regulations states that a trade or business is related to exempt purposes only where the conduct of the business activity has a causal relationship to the

achievement of an exempt purpose, and is substantially related for purposes of section 513, only if the causal relationship is a substantial one. Thus, for the conduct of a trade or business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the production or distribution of the goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes.

Section 1.513-1(d)(4)(i) of the regulations states that gross income derived from charges for the performance of exempt functions does not constitute gross income from the conduct of unrelated trade or business.

Cooperative Hospital Service Organizations

Section 501(e) of the Code provides that a cooperative hospital service organization is treated as if it were exempt under section 501(c)(3) if it performs certain specific service activities enumerated in the statute (e.g., "clinical" services). These services must be performed for two or more exempt hospitals and the organization must allocate or pays, within 8-1/2 months after the end of the year, all net earnings to its members on the basis of the services performed for them. To qualify under section 501(e), the services must be such that if they were performed by an exempt hospital, they would constitute activities in exercising or performing the purpose or function constituting the basis for the hospital's exemption. Therefore, implicit in section 501(e) is the requirement that hospital service organization must also satisfy the community benefit standard of Rev. Rul. 69-545, supra.

Section 1.501(e)-1 of the regulations provides that section 501(e) is the exclusive and controlling section under which a cooperative hospital service organization can qualify as a charitable organization.

In HCSC-Laundry v. U.S., 450 U.S. 1 (1981), the Supreme Court held that a cooperative laundry organization that served exempt organizations could not qualify as exempt under section 501(c)(3) because laundry services is not one of the activities enumerated in section 501(e).

Section 501(m)

Section 501(m)(1) of the Code provides that an organization described in section 501(c)(3) or 501(c)(4) shall be exempt "only if no substantial part of its activities consists of providing commercial-type insurance." The legislative history indicates

[redacted]

that this provision was intended, in part, to bar continued section 501(c)(4) exemption for Blue Cross/Blue Shield organizations, which had enjoyed such status for many years despite being in many respects indistinguishable from commercial health insurers. See H.R. Rep. No. 99-426, 99th Cong., 1st Sess. 662 - 6 (1986); 1986-3 C.B. (Vol. 2) 662 - 6. Consequently, where an organization's activities resemble those of commercial insurers, generally, section 501(m) would serve to preclude exemption under section 501(c)(4).

The legislative history of section 501(m) provides:

> For this purpose [section 501(m) of the Code], commercial-type insurance generally is any insurance of a type provided by commercial insurance companies.
>
> . . . .
>
> [C]ommercial-type insurance does not include arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance).13/

13/ See Helvering v. LeGierse, 312 U.S. 531 (1941).

Staff of Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, at 585 (Comm. Print 1987). See also, H.R. Rep. No. 99-426, 99th Cong., 1st Sess. 663 - 4 (1986); 1986-3 C.B. (Vol. 2) 663 - 4.

In reporting on technical corrections to Section 501(m) of the Code that were made in the Technical and Miscellaneous Revenue Act of 1988 ("TAMRA"), the Conference Committee stated:

> [T]he provision relating to organizations engaged in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). The

> conference committee clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organization-type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization.

H.R. Conf. Rep. No. 100-1104, 100th Cong., 2d Sess. II-9 (1988).

In Rev. Rul. 68-27, 1968-1 C.B. 315, an organization that issued medical service contracts to groups or individuals and furnished direct medical services to the subscribers by means of a salaried staff of medical personnel was held not to be an insurance company. In this revenue ruling, a medical clinic employed a staff of salaried physicians, nurses and technicians to provide a major portion of the contracted medical services. In the event the clinic had to treat a patient with an illness or injury, the patient was treated by the clinic's salaried staff, thereby incurring no significant additional costs. The revenue ruling concluded that any risk the clinic incurred was predominantly a normal business risk. The clinic's costs for its medical providers was fixed because the clinic paid its providers a salary. As a result, if a patient were to suffer a serious illness or injury, the clinic would not incur any substantial additional costs. Thus, the clinic's economic risk was fixed regardless of the presence or extent of any illness or injury.

In Jordan, Superintendent of Insurance v. Group Health Association, 107 F.2d 239 (1939) ("Jordan"), the U.S. Court of Appeals for the District of Columbia held that an HMO was not an insurance company. In this case, the HMO did not employ salaried physicians to provide medical services but paid contracted physicians a "fixed annual compensation, paid in monthly installments, not specific fees for each treatment or case." Jordan, at 242, ftnt. 7.

Neither the Internal Revenue Code nor the regulations define the term "insurance contract." Rev. Rul. 68-27, supra, citing Jordan, supra, defined an insurance contract as one that:

> [M]ust involve the element of shifting or assuming the risk of loss of the insured and must, therefore, be a contract under which the insurer is liable for a loss suffered by its insured.

Case law has defined "insurance contract," as a "contract whereby, for an adequate consideration, one party undertakes to indemnify another against loss from certain specified contingencies or peril. . . . [I]t is contractual security against possible anticipated loss." Epmeier v. U.S., 199 F.2d 508, 509-10 (7th Cir. 1952). See also, SEC v. Variable life Annuity Life Ins. Co., 359 U.S. 65, 71 (1959); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979); Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 127 (1982); 1 Couch on Insurance 2d (Rev. ed.) Sections 1:2, 1:3 (1984).

Moreover, case law has established that risk shifting and risk distribution are the fundamental characteristics of a contract of insurance. Helvering v. LeGierse, supra. In this case, the Supreme Court stated that "[h]istorically and commonly insurance involves risk-shifting and risk-distributing." 312 U.S. at 539.

Finally, the risk transferred must be a risk of economic loss. The risk for which insurance coverage is provided is an insurance risk; that is, it must occur fortuitously and must result in an economic loss to the insurer. Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976); aff'd, 572 F.2d 1190 (7th Cir. 1978); cert. den., 439 U.S. 835 (1978). In this case, the Court of Appeals stated:

> . . . [T]he common definition for insurance is an agreement to protect the insured against a direct or indirect economic loss arising from a defined contingency whereby the insurer undertakes no present duty of performance but stands ready to assume the financial burden of any covered loss. 1 Couch on Insurance 2d 1:2 (1959). As the tax court below noted, an insurance contract contemplates a specified insurable hazard or risk with one party willing, in exchange for the payment of premiums, to agree to sustain economic loss resulting from the occurrence of the risk specified and, another party with an insurable interest in the insurable risk. It is important here to note that one of the essential features of insurance is this assumption of another's risk of economic loss. 1 Couch on Insurance 2d 1:3 (1959).

Risk shifting occurs when a person facing the possibility of an economic loss transfers some or all of the financial

consequences of the loss to the insurer. Rev. Rul. 88-72, 1988-2 C.B. 31, clarified by Rev. Rul. 89-61, 1989-1 C.B. 75.

Risk distribution refers to the operation of the statistical phenomenon known as the "law of large numbers." When additional statistically independent risk exposure units are insured, an insurance company's potential total loss increases, as does the uncertainty regarding the amount of that loss. As the uncertainty regarding the company's total loss increases, however, there is an increase in the predictability of the insurance company's average loss. Due to this increase in the predictability of average loss, there is a downward trend in the amount of capital that the company needs per risk unit to remain at a given level of solvency. See Rev. Rul. 89-61, supra.

In Paratransit Insurance Corporation, 102 T.C. 745 (1994), a nonprofit mutual benefit insurance corporation provided automobile liability insurance to its members, all of which were tax-exempt social service organizations that furnished transportation to the elderly, the handicapped and the needy.

In this case, one of the issues was whether the organization provided "commercial-type" insurance within the meaning of section 501(m) of the Code. In this regard, the Tax Court stated:

> It is clear from the passages in the Report of the House Ways and Means Committee that the term "commercial-type insurance", as used in section 501(m), encompasses every type of insurance that can be purchased in the commercial market.16/
>
> 16/ Such insurance, however, obviously does not include self-insurance by a single organization, which is not purchased commercially, and which does not involve risk sharing or risk shifting that is characteristic of true insurance. See Staff of Joint Comm. on Taxation, General Explanation of the Tax Reform Act of 1986 at 583-586 (J. Comm. Print 1987).

102 T.C. at 754.

The Tax Court concluded that the organization provided "commercial-type insurance" within the meaning of section 501(m) of the Code, based on the following factors:

1. The purpose of the insurance pool the organization established was to shift the risk of potential tort liability from each of the individual insured paratransit organizations to Paratransit.

2. The organization diversified the risk of liability for each individual member through the receipt of premiums form multiple member organizations. Thus, Paratransit spread each member's individual risk of tort liability among all of its members.

3. The type of insurance the organization offered to its members, basic automobile liability insurance, was a type of insurance provided by a number of commercial insurance carriers.

4. The organization insured its members in a commercial manner. It offered insurance to its members based not on need or at a uniform charge. Instead, it determined premiums by reference to factors affecting the level of risk, such as total number of vehicles, number of passengers per vehicle, radius of operation, etc. Thus, Paratransit calculated its members' premiums actuarially in precisely the same way that commercial insurers determine premiums for their customers.

In addition, the Tax Court rejected the organization's argument that the phrase "commercial-type insurance" in section 501(m) of the Code was intended to cover only those situations where insurance is offered to the general public. The Tax Court pointed out that the Committee on Ways and Means stated:

> The committee further believes that the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial. [Emphasis added.]
>
> H.R. Rep. No. 99-426 at 664 (1986); 1986-3 (Vol. 2) at 664.

102 T.C. at 755.

The Tax Court pointed out, however, that the Joint Committee on Taxation's General Explanation deleted the phrase "to the general public." See Staff of Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, at 584 (Comm. Print 1987).

[redacted]

The Tax Court also pointed out that if Congress had intended the phrase "commercial-type insurance" in section 501(m) of the Code to apply only to insurance available to the general public it would not have needed to enact the exceptions in section 501(m)(3)(C) (relating to property or casualty insurance provided by a church or church related organization) and section 501(m)(3)(D) (relating to retirement or welfare benefits provided by a church or church related organization to its employees). See 102 T.C. at 755 - 6.

In Florida Hospital Trust Fund, et al. v. Commissioner, 103 T.C. 140 (1994), several government-run and tax-exempt hospitals created organizations ("Trust Funds") to pool their resources on a group basis to insure against hospital professional liability, excess hospital professional liability and workers' compensation liability. The Tax Court held that a substantial part of the Trust Funds' activities consisted of providing commercial-type insurance within the meaning of section 501(m) of the Code.

[redacted] hospital members, provided the insurance. The Trust Funds were formed to provide a means by which their member hospitals could join together as a group to insure against professional liability (malpractice) and workers' compensation claims. The Trust Funds, rather than their hospital members, provided the services essential to the administration of the insurance programs. The fact that the Trust Funds adjusted member premiums to reflect actual, as opposed to projected, loss experience assured that the Trust Funds would operate on a break even basis and served as a means for the Trust Funds to shift the risk of insurance losses from their individual members to the whole group. The Tax Court stated:

> It is this characteristic, petitioners' ability to shift the risk of loss, that distinguishes petitioners' (the insurers) from their members (the insured). Paratransit Ins. Corp. v. Commissioner, 102 T.C. 745, 754 (1994).

103 T.C. at 157.

In relying on the plain meaning of the phrase "commercial-type insurance," the Tax Court said:

> . . . [W]e understand that Congress intended for section 501(m) to apply to those organizations providing any "type of insurance that can be purchased in the

> commercial market." Paratransit Insurance Corp. v. Commissioner, supra, at 754. There is no dispute that hospital professional liability and workers' compensation insurance are normally offered by commercial insurers.

103 T.C. at 158.

Further, in reviewing the legislative history of section 501(m) of the Code, the Tax Court concluded that:

> . . . [T]he report of the House Committee on Ways and Means quoted above reflects Congress' view that organizations engaged in insurance pooling or group self-insurance arrangements (including malpractice insurance) are involved in inherently commercial activities. Congress resolved to deny exempt status to organizations engaged in such activities in order to ensure that such organizations would not enjoy an unfair competitive advantage over their commercial counterparts.

103 T.C. at 160.

The Tax Court also rejected the Trust Funds' contention that the dearth of commercial insurers in the particular market in which the hospitals operated made section 501(m) of the Code inapplicable. The Tax Court stated:

> . . . [W]hether an organization seeking exempt status happens to be competing with a commercial insurer at any particular point in time simply begs the question whether granting exempt status will tend to provide the organization with an unfair competitive advantage over commercial insurers. Focusing on the latter issue, and Congress' obvious desire to provide a level playing field for commercial insurers, we hold that section 501(m) applies to deny petitioners exempt status.

Ibid.

Thus, the Tax Court concluded that the Trust Funds were providing commercial-type insurance within the meaning of section 501(m) of the Code.

[redacted]

RATIONALE

Section 501(c)(3)

Stand Alone Basis for Exemption

Your activities consist of directly providing, and arranging for the provision of, behavioral health care services for the benefit of employees of large employers (other than [redacted], enrollees in an HMO owned and operated by one of your member organizations (the [redacted]), and the general public. You perform these activities through Contracted Providers and through your employees at your out-patient behavioral clinics. However, your predominant activities consist of arranging for the provision of behavioral health care services through Contracted Providers for the benefit of employees of unrelated large employers and for enrollees in the [redacted]. You do not currently engage in community benefit activities, although you expect to do so some time in the future.

Under the regulations, an organization that is organized and operated exclusively for charitable purposes may qualify for exemption under section 501(c)(3) of the Code. The regulations also provide that an organization will be regarded as "operated exclusively" for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3) of the Code. An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

The promotion of health has long been recognized as a charitable purpose. Whether a hospital promotes health in a charitable manner is determined under the community benefit standard of Rev. Rul. 69-545, supra. This standard focuses on a number of factors to determine whether the hospital benefits the community as a whole rather than private interests. The application of the community benefit standard to exempt hospitals and other exempt health care organizations was sustained in Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1975); and in Sound Health Association v. Commissioner, 71 T.C. 158 (1978), acq., 1981-2 C.B. 2.

The Service and the courts have recognized that the promotion of health includes activities other than the direct provision of patient care. See Rev. Rul. 81-298, supra; Rev. Rul. 81-276, supra; Rev. Rul. 77-69, supra; Rev. Rul. 77-68, supra; Rev. Rul. 75-197, supra; and Queens County PSRO, supra.

[redacted]

However, an organization that merely promotes health, without more, is not entitled to recognition of exemption under section 501(c)(3) of the Code. See Living Faith, Inc. v. Commissioner, supra; and Federation Pharmacy Services, Inc. v. Commissioner, supra.

Arranging for the provision of behavioral health care services through Contracted Providers for the benefit of employees of unrelated large employers are not activities that benefit the community as a whole. Therefore, since you provide no more than incidental benefits to the community as a whole, you do not satisfy the community benefit standard of Rev. Rul. 69-545, supra. Although your activities promote health, you do not promote health in a charitable manner.

In addition, arranging for the provision of behavioral health care services through Contracted Providers for the benefit of enrollees in [redacted] does not benefit the community as a whole. In Geisinger II, supra, the court of appeals held that an HMO did not qualify for exemption under section 501(c)(3) of the Code because arranging for the provision of health care services exclusively for the HMO's members primarily benefited the members, not the community as a whole. Under the community benefit standard, the organization must benefit the community as a whole in addition to its members. In concluding that the HMO did not qualify for exemption under section 501(c)(3) on the basis of promoting health, the court of appeals stated that an organization must meet a "flexible community benefit test based on a variety of indicia."

Because you have not established that a substantial portion of your activities consist of the promotion of health in a charitable manner, you do not operate exclusively for a charitable purpose. See section 1.501(c)(3)-1(c)(1) of the regulations and Better Business Bureau of Washington, D.C. v. United States, supra. Therefore, you do not qualify for exemption under section 501(c)(3) of the Code as a charitable organization on the basis that you promote health.

Integral Part Doctrine

Under section 1.502-1(b) of the regulations, one organization may derive its exemption from a related organization exempt under section 501(c)(3) of the Code if the former organization is an integral part of the exempt organization. To obtain exemption derivatively, two requirements must be met: (1) the two organizations must be "related" and (2) the subordinate entity must perform "essential" services for the parent. Section 1.502-1(b) of the regulations includes the following example of

[redacted]

an organization that is considered as providing essential services: a subsidiary which is operated for the sole purpose of furnishing electric power used by its parent organization, a tax-exempt educational organization, in carrying on its educational activities. See Rev. Rul. 78-41, supra.

(1) Related. Under section 1.502-1(b) of the regulations, a subsidiary organization that is engaged in an activity that would be considered an unrelated trade or business if it were regularly carried on by the exempt parent does not provide an essential service for the parent. The regulations include an example of a subsidiary organization that is operated primarily for the purpose of furnishing electric power to consumers other than its parent organization.

Thus, if the subsidiary organization were owned by several unrelated exempt organizations and operated for the purpose of furnishing electric power to each of them, it would not be exempt because the business would be an unrelated trade or business if regularly carried on by any one of the tax-exempt organizations. For this purpose, organizations are related only if they consist of a parent and one or more of its subsidiaries, or subsidiaries having a common parent. An exempt organization is not related to another exempt organization merely because they both engage in the same type of exempt activities. See section 1.502-1(b) of the regulations.

To the extent that you are controlled by two related exempt organizations, [redacted] and [redacted], you satisfy the relatedness requirement of the regulations. However, since your other members, [redacted] and [redacted], are not structurally related to each other or to [redacted] or [redacted] and [redacted] do not satisfy the relatedness requirement.

(2) Essential Services. A predominant portion of your activities consists of arranging for the provision of behavioral health care services by Contract Providers for the benefit of employees of large employer clients, including your four member organizations, and for enrollees in [redacted]

If [redacted] or [redacted] regularly performed these activities, they would constitute an unrelated trade or business because as previously explained, these activities do not constitute the promotion of health in a charitable manner. In addition, these activities do not contribute importantly to the accomplishment of [redacted] or [redacted] exempt purpose of promoting the health of the community, and thus would not have a substantial causal relationship, as described in section 1.513-1(d)(2) of the regulations, to the achievement of their exempt

[redacted]

purposes. Therefore, for purposes of section 1.502-1(b) of the regulations, these activities would not be considered as essential services.

Further, in Geisinger III, supra, the Tax Court held that a prepaid health plan created by an exempt hospital system was not an integral part of the system because a substantial portion of the enrollees of the plan, approximately 20%, were not patients of the exempt hospitals in the hospital system. The Tax Court reasoned that providing services to such a significant number of nonsystem patients precluded a finding that the plan's activities were devoted to furthering the exempt purposes of the hospitals in the system.

In Geisinger IV, supra, the Third Circuit Court of Appeals affirmed the Tax Court, stating that the integral part doctrine has two requirements: (1) the subordinate organization must not be engaged in activities that would be unrelated trade or business activities if the parent engaged in these activities directly, and (2) the subordinate organization's relationship to the parent must enhance (or "boost") the subsidiary's ability to accomplish charitable purposes to such a degree that the subsidiary could qualify for exemption on its own merits.

The Third Circuit concluded that the prepaid health plan did not receive any boost from its association with the exempt hospitals in the hospital system. The patients the plan provided to the system, i.e., the plan's enrollees, were the same patients that it served without its association with the hospital system. Thus, the court concluded that the plan did not satisfy the integral part test because it was not rendered "more charitable" by virtue of its association with the exempt hospitals in the system.

You have not established that the persons for whom you arrange for the provision of behavioral health care services, i.e., the employees of your large employer clients, the employees of [redacted] and [redacted], and the enrollees in [redacted] are also patients of your related controlling members, [redacted] or [redacted]. Therefore, under Geisinger III, supra, since your activities do not further the exempt purposes of your related controlling members, the integral part doctrine does not apply.

Further, there is no evidence establishing that you received a charitable "boost" from your related controlling members, [redacted] or [redacted]. The patients you provide to [redacted] or [redacted], i.e., the employees of your large employer clients (other than [redacted] or [redacted] employees), are the same persons that you would serve without your association with [redacted]

[redacted]

or [redacted]. Therefore, under Geisinger IV, supra, since you are not rendered "more charitable" by virtue of your association with [redacted] or [redacted] the integral part doctrine does not apply.

As a result, you do not qualify for exemption under section 501(c)(3) of the Code based on the integral part doctrine.

Cooperative Hospital Service Organizations

An organization that provides services for hospitals that are exempt under section 501(c)(3) of the Code may qualify for exemption under section 501(c)(3) if it meets the requirements of Section 501(e). However, the exemption applies only to organizations that provide one or more of the services specifically enumerated in the statute and the regulations, including "clinical" services. Since section 501(e) is the exclusive means by which a hospital service organization may qualify for exemption under section 501(c)(3) (see section 1.501(e)-1 of the regulations and HCSC-Laundry, supra), a hospital service organization providing services other than those specifically enumerated in the statute does not qualify for exemption.

It is doubtful that all of your activities, as described above, are considered as "clinical" services for purposes of section 501(e) of the Code. Furthermore, you do not meet the requirements of section 501(e)(2) regarding allocation or payment of net earnings. Therefore, under section 501(e), you do not qualify as an organization that is treated as exempt under section 501(c)(3).

Section 501(m)

Under section 501(m)(1) of the Code, an organization that otherwise qualifies for exemption under section 501(c)(3) or section 501(c)(4) is precluded from exemption if a substantial part of its activities consists of providing commercial-type insurance.

When individuals enroll in an HMO and directly or indirectly pay the HMO fixed premiums, the HMO agrees that it will furnish health care services to treat their injuries and illnesses. Under this arrangement, enrollees protect themselves against the risk that they would suffer economic loss from having to pay for health care services that are necessary because of injuries or illnesses. By enrolling in an HMO, individuals shift their risk of economic loss to the HMO.

For an HMO that operates on a staff model basis, the HMO assumes the financial risk associated with furnishing medical services. Since a staff model HMO pays physicians on a salaried basis, it does not incur additional fees when its employed physicians treat its enrollees. Therefore, the risk the HMO assumes is predominantly a normal business risk of an organization engaged in furnishing medical services on a fixed-price basis, rather than an insurance risk. Rev. Rul. 68-27, supra.

On the other hand, a non-staff model HMO that does not pay its physicians on a fixed-price basis assumes a financial risk that is greater than a normal business risk associated with its obligation to furnish medical services to its enrollees. Therefore, this obligation constitutes a contract of insurance.

An HMO that compensates its non-employee physicians on a fixed fee basis is treated the same as a staff model HMO that pays its physicians on a salaried basis because the HMO has transferred to its physicians a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. The remaining risk is only the normal business risk associated with operating the HMO.

For example, an HMO that pays its contracted physicians almost exclusively fixed monthly fees based on the number of enrollees ("capitated fees"), transfers to these physicians a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO.

Similarly, an HMO that pays its contracted physicians almost exclusively fees-for-service under a fee schedule that represents a meaningful discount from the physicians' usual and customary charges ("discounted fee-for-service") and withholds from these payments a significant percent of the fees otherwise payable, pending compliance with periodic budget or utilization standards transfers to these physicians, in effect, a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO. In return for accepting discounted fees, the physicians are assured of a flow of patients from the HMO. It is a common commercial practice for vendors of goods or providers of services to accept lower prices or fees in return for greater sales.

On the other hand, when an HMO pays its contracted physicians on a fee-for-service basis that is not discounted and

[redacted]

where no significant portion of the fees has been withheld, the HMO does not transfer to these physicians its financial risk associated with its obligation to furnish medical services to its enrollees. Thus, the HMO retains the financial risk associated with its obligation to furnish medical services to its enrollees. This financial risk constitutes a contract of insurance.

Under Rev. Rul. 68-27, supra, and Jordan, supra, your contracts with large employer clients and the [redacted] to arrange for the provision of behavioral health care services in return for fixed fees constitute contracts of insurance. You provide these services primarily through Contract Providers, whom you compensate using case rated fees.

Case rated fees include both fixed and variable elements. The fixed element consists of the payment to a provider of a certain amount to perform a certain level of behavioral health care services over a certain period of time. There is also a variable element because the case rated fees may be redetermined depending on the patient's behavioral health care needs. To the extent that the case rated fees are fixed, the payor has transferred to the provider the financial risk associated with the performance of behavioral health care services. However, to the extent of the variable portion of these fees, the payor retains substantial financial risk associated with its obligation to arrange for the provision of behavioral health care services to its clients.

Your case rated compensation arrangement with your Contract Providers is distinguishable from a compensation arrangement where a prepaid health care organization pays providers a fixed amount of compensation, such as salaries to employed providers or capitated fees to contracted providers. By paying providers fixed compensation, a prepaid health care organization transfers to the providers substantially all of its financial risk associated with its obligation to furnish health care services to its enrollees.

Since the predominant portion of your revenues represents prepaid fees, case rated compensation comprises a predominant portion of your total provider compensation, and the variable element of these fees represents a major component of these fees, we conclude that a substantial portion of your activities consists of providing health insurance. Since the predominant portion of your activities, arranging, on a prepaid basis, for the provision of behavioral health care services through Contracted Providers for the benefit of employees of unrelated large employers and for enrollees in [redacted] are the same types of activities engaged in by commercial insurance companies,

[redacted]

this insurance is "commercial-type" insurance under section 501(m)(1) of the Code. See Paratransit Insurance Corporation, supra; and Florida Hospital Trust Fund, et al. v. Commissioner, supra.

Therefore, even if you otherwise qualified for exemption under section 501(c)(3) of the Code, you would be precluded from exemption by section 501(m)(1).

CONCLUSION

For the reasons stated above, you do not qualify for exemption as an organization described in section 501(c)(3) of the Code and you must file federal income tax returns.

Contributions to you are not deductible under section 170 of the Code.

You have the right to protest this ruling if you believe it is incorrect. To protest, you should submit a statement of your views, with a full explanation of your reasoning. This statement, signed by one of your officers, must be submitted within 30 days from the date of this letter. You also have a right to a conference in this office after your statement is submitted. You must request the conference, if you want one, when you file your protest statement. If you are to be represented by someone who is not one of your officers, that person will need to file a proper power of attorney and otherwise qualify under our Conference and Practice Requirements.

If you do not protest this ruling in a timely manner, it will be considered by the Internal Revenue Service as a failure to exhaust available administrative remedies. Section 7428(b)(2) of the Code provides, in part, that a declaratory judgment or decree under this section shall not be issued in any proceeding unless the Tax Court, the United States Court of Federal Claims, or the District Court of the United States for the District of Columbia determines that the organization involved has exhausted administrative remedies available to it within the Internal Revenue Service.

If we do not hear from you within 30 days, this ruling will become final and copies will be forwarded to your key district office. Thereafter, any questions about your federal income tax status should be addressed to that office. The appropriate State Officials will be notified of this action in accordance with Code section 6104(c).

[redacted]

When sending additional letters to us with respect to this case, you will expedite their receipt by using the following address:

Internal Revenue Service
[redacted]
CP:E:EO:T:1, Room 6514
1111 Constitution Ave, N.W.
Washington, D.C. 20224

For your convenience, our FAX number is [redacted] or [redacted] E-Mail address is: [redacted]ccmail.irs.gov

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

In accordance with the Power of Attorney currently on file with the Internal Revenue Service, we are sending a copy of this letter to your authorized representative.

Sincerely,
Marvin Friedlander

Marvin Friedlander
Chief, Exempt Organizations
Technical Branch 1