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DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

Contact Person: [redacted]
ID Number: [redacted]
Telephone Number: [redacted]

[redacted]

MAY 04 1999

Employer Identification Number: [redacted]

Dear Applicant:

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 name [redacted] as a nonprofit corporation under the [redacted] Nonprofit Corporation Code and as a provider sponsored health care corporation under the [redacted] Health Care Plan Act. On [redacted] pursuant to [redacted] law, the Commissioner of the [redacted] Insurance Department approved your Application for a Charter.

On [redacted] you filed Form 1024, requesting recognition of exemption under section 501(c)(4) of the Code.

On [redacted] you amended your Charter to change your name to [redacted] and to make other changes in anticipation of filing an application for recognition of exemption under section 501(c)(3) of the Code.

On [redacted] you submitted a letter withdrawing Form 1024 and filed Form 1023, requesting recognition of exemption under section 501(c)(3) of the Code rather than under section 501(c)(4).

According to your amended Charter, you were formed for the purpose of operating as a provider sponsored health care corporation. Your Charter provides that you are a membership corporation. According to your Bylaws, your sole member is [redacted] (the "System"), an organization that is exempt under section 501(c)(3) of the Code.

The System is an integrated health care delivery system comprised of three hospitals, a home health agency, three nursing homes, an assisted living center, a college of nursing, an ambulatory surgery center and related health care entities.

[redacted]

Article 17 of your amended Charter provides that in the event of your dissolution or final liquidation, your net assets will be distributed to the System, provided that it is then tax-exempt under section 501(c)(3) of the Code; but if not, then to your successor corporation, provided that it then qualifies as a governmental unit under section 170(c) or is tax-exempt under section 501(c)(3) or section 501(c)(4); or, then to a nonprofit corporation or corporations having similar aims and objectives as yours, provided that it then qualifies as a governmental unit under section 170(c) or is tax-exempt under section 501(c)(3) or section 501(c)(4).

Article 18 of your amended Charter provides, in part, that you will not engage in any political activity prohibited to an organization exempt under section 501(c)(4) of the Code, and that you will not carry on any activities not permitted to be carried on by a corporation that is exempt under section 501(c)(4).

In a letter dated [redacted] you represented that following receipt of a determination letter stating that you have been recognized as exempt under section 501(c)(3) of the Code, you would further amend Article 17 of your amended Charter to delete all references to section 501(c)(4) and would further amend Article 18 to change the references from section 501(c)(4) to section 501(c)(3).

In your [redacted] you also represented that your Board of Directors will adopt a conflicts of interest policy that conforms to the sample policy we previously sent you.

The Health Care Financing Administration ("HCFA") of the U.S. Department of Health and Human Services has approved the System to participate in Medicare Choices Demonstration, a program to provide health care services to Medicare beneficiaries. The goal of this project is to test new managed care delivery systems in areas of the country which have a fairly high penetration of commercial managed care but which have little of no penetration of Medicare managed care. As a result, the System formed your organization as a provider sponsored health care corporation under Georgia law.

You have been licensed by the [redacted] Department as a provider sponsored health care corporation under [redacted] law. Under this license, you may operate in four [redacted] counties located in the [redacted] area. As a provider sponsored health care corporation, you are not limited by statute or by regulation to enroll only Medicare beneficiaries. However, since you do not have a contract with the [redacted] Department of Medical Assistance, you may not enroll Medicaid beneficiaries.

On [redacted] you entered into a three-year contract with HCFA to participate in Medicare Choices Demonstration. You enrolled your first members effective [redacted] HCFA pays you fees on a capitated basis.

Under your plan, called "Medicare Secure Choice," you arrange for the provision of health care services to your enrolled Medicare beneficiaries. Under your plan, your enrollees are entitled to receive health care services that exceed the health care services Medicare beneficiaries generally receive under traditional Medicare fee-for-service arrangements, including vision screenings and pharmaceutical benefits. In addition, through your "Secure Health Trac" program and newsletters, you arrange for the provision of health care education to your enrollees, including preventive health information, health education and wellness programs, and a personal and confidential in-home clinical health assessment by a registered nurse. Under this program, you also arrange for the enrollees to receive information and answers to questions regarding a particular diagnosis, advance

[redacted]

directives and locating a primary care physician. You also arrange for enrollees to receive information on community health programs, such as health fairs and seminars. Further, you arrange for enrollees to receive three telephone contacts after their clinical assessment visit to answer questions and to check on the enrollees' well being.

[redacted] is one of the organizations in the System. It is a non-profit non-exempt corporation of which the System is the sole member. [redacted] operates a network of health care providers consisting of providers that are part of the System as well as independent providers that are unrelated to the System. [redacted] has approximately [redacted] provider agreements with hospitals, physician organizations and ancillary health care providers. Under these agreements, the providers agree to provide health care services for your enrollees.

Effective January 1, [redacted] you and [redacted] entered into a Network Access Agreement. Under this agreement, [redacted] network providers agree to participate in your Medicare program and to provide health care services for your enrollees.

Under the Network Access Agreement, you compensate [redacted] network providers directly. The method by which you compensate these providers depends upon the terms of the particular provider agreement between [redacted] and each provider. For [redacted] and [redacted] the total compensation you will pay to your providers is expected to be as follows:

	(000s Omitted)	
Primary Care Providers	$[redacted]	$[redacted]
Specialists	[redacted]	[redacted]
Hospitals	[redacted]	[redacted]
Ancillary Health Care Providers	[redacted]	[redacted]
Totals	$[redacted]	$[redacted]

For [redacted] and [redacted] you expect to pay your primary care providers under the following compensation methods:

	(000s Omitted)	
Capitated Fees	$[redacted] 15.4%	$[redacted] 33.1%
Fee-for-service based on Medicare RBRVS*	[redacted] 84.6%	[redacted] 66.9%
Totals	$[redacted] 100.0%	$[redacted] 100.0%

* Plus $[redacted] per member per month for care management services.

The HCFA regulations require that whenever a physician is placed at "Substantial Financial Risk," as defined in these regulations, either you or the physician is required either to purchase stop-loss insurance coverage or to show that the enrollee panel serviced by the physician who is at Substantial Financial Risk is sufficiently large to spread the risk so that stop-loss insurance is not required. None of your contracted physicians are at Substantial Financial Risk under these regulations. Therefore, you are not required to purchase stop-loss insurance. However, as a prudent business measure, you have purchased stop-loss insurance from an independent insurance company. The principal terms of this stop-loss insurance are:

[redacted]

	Hospitals	Physicians
Deductible (per person per year)	$[redacted]	$[redacted]
Co-insurance (in excess of above deductible)	90%	90%
Maximum coverage (per person per year, in excess of above deductible and co-insurance)	$1 million	$1 million

LAW

Section 501(c)(3)

Promotion of Health

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.

Rev. Rul. 69-545, 1969-2 C.B. 117, established the community benefit standard as the basis for the federal income tax exemption of a hospital. This revenue ruling held that a hospital satisfies the community benefit standard if it promotes the health of a class of persons broad enough to benefit the community as a whole and it does not unduly benefit private individuals in achieving that objective.

In Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993) ("Geisinger II"), rev'g 62 T.C.M. (CCH) 1656 (1991), an HMO that was part of a large health care system arranged for the provision of health care services only for its enrollees. The Third Circuit held that the HMO did not qualify for exemption under section 501(c)(3) ()(3) of the Code because my merely arranging for health care services for its members, the HMO primarily benefited its members, not the community as a whole. The court held that such an organization must meet a "flexible community benefit test based on a variety of indicia." Thus, to qualify for exemption under section 501(c)(3), the HMO must benefit the community as a whole in addition to its members.

[redacted]

The promotion of health includes activities other than the direct provision of patient care. For example, Rev. Rul. 75-197, 1975-1 C.B. 156, holds 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 IRC 501(c)(3). By facilitating the donation of organs that 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. 77-69, 1977-1 C.B. 143, describes an organization 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 concludes that by establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the HSA is promoting the health of the residents of the area in which it functioned. Therefore, the HSA qualifies for exemption under IRC 501(c)(3) on the basis that it promoted health.

Rev. Rul. 81-28, 1981-1 C.B. 328, holds 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 IRC 501(c)(3) 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.

Relief of the Poor and Distressed

Reg. 1.501(c)(3)-1(d)(2) provides that the term "charitable" includes relief of the poor and distressed. The Service has long held that poor and distressed beneficiaries must be needy, in the sense that they cannot afford the necessities of life.

For example, shelter is considered to be one of the necessities of life. Rev. Rul. 67-138, 1967-1 C.B. 129; Rev. Rul. 70-585, 1970-2 C.B. 115; and Rev. Rul. 76-408, 1976-2 C.B. 145, refer to the needs of housing recipients and to their inability to secure adequate housing under all the facts and circumstances to determine whether they are poor and distressed. The existence of a national housing policy to maintain a commitment to provide decent, safe, and sanitary housing for every American family is reflected in several federal housing acts. However, not all beneficiaries of these housing acts are necessarily poor and distressed within the meaning of Reg. 1.501(c)(3)-1(d)(2). See generally, Rev. Proc. 96-32, 1996-1 C.B. 717.

The Service has also recognized that providing relief of the distress of the elderly or physically handicapped is an exempt purpose. See Rev. Rul. 72-124, 1972-1 C.B. 145; Rev. Rul. 79-18, 1979-1 C.B. 194; and Rev. Rul. 79-19, 1979-1 C.B. 195. An organization may further a charitable purpose by meeting the special needs of the elderly or physically handicapped.

In Rev. Rul. 72-124, an organization operated a home for the aged that provided housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, useful, and independent lives. The revenue ruling stated:

> . . . [I]t is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in the sense that they have special needs because of their advanced years.

[redacted]

This revenue ruling also stated that:

> [A]n organization, otherwise qualified for charitable status under section 501(c)(3) of the Code, which devotes its resources to the operation of a home for the aged will qualify for charitable status for purposes of Federal tax law, if it operates in a manner designed to satisfy the three primary needs of aged persons. These are the need for housing, the need for health care, and the need for financial security.

With regard to the need for health care, Rev. Rul. 72-124 stated:

> The need for health care will generally be satisfied if the organization either directly provides some form of health care, or in the alternative, maintains some continuing arrangement with other organizations, facilities, or health personnel, designed to maintain the physical, and if necessary, mental well-being of its residents.

Thus, the elderly may be considered a class of persons who have special health care needs. Indeed, Congress has recognized the special health care needs of the elderly by enacting the Medicare program for persons age 65 and over. For example, Rev. Rul. 75-198, 1975-1 C.B. 157, held that an organization that established a service center providing information, referral, and counseling services relating to health, housing, finances, education and employment, as well as a facility for specialized recreation for a particular community's senior citizens, who need not become members to obtain the services or participate in the activities, qualified for exemption under section 501(c)(3) of the Code. The organization relieved the distress of aged persons by providing them with specialized recreational activities and by counseling them concerning such primary needs as health care, housing, financial security, education and employment.

Similarly, Rev. Rul. 81-61, 1981-1 C.B. 355, held that the operation of a beauty shop and a barber shop by a section 501(c)(3) senior citizens' center for use by senior citizens was not an unrelated trade or business. The services of the employees of this organization were directed towards meeting the needs of senior citizens, may of whom have physical impairments resulting in a limited ability to travel, and who are unable to meet fully their own personal grooming needs. This revenue ruling held that providing senior citizens, many of whom have physical impairments result in a limited ability to travel, with the services of beauticians and barbers in a place convenient for them to reach is an activity that contributes importantly to the achievement of the organization's charitable purpose.

But as with the federal housing acts referred to in Rev. Proc. 96-32, supra, not all elderly persons, even if they qualify for Medicare, necessarily have special health care needs. Thus, not all services provided to the elderly further a tax-exempt purpose. Rev. Rul. 81-62, 1981-1 C.B. 355, held that the sale of heavy duty appliances, such as dishwashers, by a section 501(c)(3) senior citizens' center to senior citizens was an unrelated trade or business. Unlike the personal grooming services described in Rev. Rul. 81-61, the sale of heavy duty appliances by the senior citizens' center does not significantly relieve a form of distress that aged persons suffer. Unlike personal grooming services, appliances need not be purchased in person, but may be obtained by phone or mail or by someone acting on behalf of the purchaser. Also in contrast with personal grooming services, heavy duty appliances are usually not purchased on a continual basis, but rather are only occasional purchases. Therefore, Rev. Rul. 81-62 concluded that the sale of heavy duty

[redacted]

appliances by the senior citizens' center generally spares aged persons only an infrequent inconvenience and does not contribute importantly to the center's exempt purpose.

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 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 deny 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.
>
> . . . .
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> [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).

[redacted]

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 under takes 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

[redacted]

> 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 Paratransit, 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/
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> 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 amount all of its members.

[redacted]

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 offers 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).

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.

The Tax Court held that the Trust Funds, rather than their hospital members, provided the insurance. The Trust Funds were formed to provide a means by which their member hospitals can join together as a group to insure against professional liability (malpractice) and workers' compensation claims. The Trust Funds, rather than their hospital members, provide the services essential to the administration of the insurance programs. The fact that the Trust Funds adjust member premiums to reflect actual, as opposed to projected, loss experience assures that the Trust Funds will operate on a break even basis and serves 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:

[redacted]

> 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)

You enroll only Medicare beneficiaries, generally persons who are 65 years of age or older. Through your affiliate, [redacted], you arrange for the provision of health care services for these individuals by a network of health care providers. You also ensure that these individuals obtain access to appropriate health care services.

You have not established that your enrollees consist of persons who could not otherwise obtain health insurance due to their medical history or current medical condition. Nor have you established that you provide subsidies to enrollees who cannot afford to pay the Medicare premiums.

The promotion of health as a charitable activity includes activities other than the direct provision of patient care. See Rev. Rul. 75-197, supra; Rev. Rul. 77-69, supra; Rev. Rul. 81-28, supra; However, such activities must benefit the community as a whole. See Rev. Rul. 69-545, supra. In the case of an HMO that arranges for the provision of health care services for its enrollees, such activities must benefit the community as a whole in addition to its enrollees. Geisinger II, supra. By arranging for the provision of health care for persons who are 65 years of age or older, but without performing charitable activities with respect to these persons, such as the types of services described above, you do not promote the health of the community as a whole.

Depending on the circumstances, elderly persons may be considered as a group of persons who are considered as having special health care needs. But not all elderly persons necessarily have special health care needs or are necessarily poor and distressed within the meaning of Reg. 1.501(c)(3)-1(d)(2). See Rev. Rul. 75-198, supra; Rev. Rul. 81-61, supra; Rev. Rul. 81-62, supra. Although Medicare benefits are available only to persons who are 65 years of age or older, not all Medicare beneficiaries have special health care needs. Further, you have not established that your enrollees, consisting solely of Medicare beneficiaries, have special health care needs or are otherwise poor and distressed within the meaning of Reg. 1.501(c)(3)-1(d)(2).

Therefore, since you are not operated for the charitable purposes of promoting the health of the community or providing relief to the poor and distressed, you do not qualify for exemption under section 501(c)(3) of the Code.

Section 501(m)

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

Under the law, a contract of insurance generally has two elements: (1) risk shifting (or risk transfer) by persons who are at risk of sustaining an economic loss (also referred to as the assumption of risk), and (2) risk distribution among such persons. See, e.g., Rev. Rul. 68-27, supra; and Helvering v. LaGierse, supra.

When individuals enroll in a non-staff model HMO and pay the HMO fixed premiums, the HMO agrees that its contracted health care providers will provide health care services to treat the enrollees' injuries and illnesses. Under this arrangement, the enrollees protect themselves against

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the risk that they would incur economic loss from having to pay for health care services that may be required as a result of injuries or illnesses. Therefore, this arrangement constitutes a contract of insurance.

Similarly, when Medicare beneficiaries enroll in a non-staff model HMO, to which HCFA pays fixed premiums, the HMO agrees that its contracted health care providers will provide health care services to treat the enrollees' injuries and illnesses. Under this arrangement, HCFA protects itself against the risk that it would incur economic loss from having to pay for health care services, on a fee-for-service basis, that may be required as a result of injuries or illnesses. Therefore, this arrangement also constitutes a contract of insurance.

By requiring Medicare beneficiaries to enroll in an HMO, HCFA recognizes the possibility that it may sustain economic loss if it had to pay for necessary health care services for these individuals on a fee-for-service basis. Thus, HCFA shifts the risk of this economic loss to the HMO. When the HMO enrolls a large number of such individuals, the HMO distributes this risk of loss among all of its enrollees.

Therefore, a non-staff model HMO's arrangement with its enrollees, or with a third party payor, such as HCFA, constitutes a contract of insurance and the HMO is considered as providing insurance. Thus, the arrangement you have with HCFA, constitutes a contract of insurance.

According to the legislative history of section 501(m) of the Code, the term "commercial-type" insurance, for purposes of section 501(m), is any type of insurance generally provided by commercial insurance companies. You have contracted with HCFA to arrange for the provision of health care services to the Medicare beneficiaries who enroll in your plan. Other organizations also offer prepaid health care services to their enrollees, including Medicare beneficiaries. These services are generally available commercially and HCFA could purchase these services from these organizations.

Therefore, based on the legislative history of section 501(m) of the Code and the interpretation of section 501(m) by the Tax Court in Paratransit, supra, and in Florida Hospital Trust Fund, supra, it is concluded that the insurance services you provide to your enrollees, on behalf of HCFA, are "commercial-type" insurance within the meaning of section 501(m).

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

When individuals enroll in an HMO and 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.

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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 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.

You do not operate as a staff model HMO. Instead, you contract with independent physicians to provide medical services to your enrollees. Under Rev. Rul. 68-27, supra, and Jordan, supra, the contract with your enrollees to arrange for the provision of health care services in return for a fixed fee constitutes a contract of insurance.

For [redacted] and [redacted] you expect to pay 84.6 percent and 66.9 percent, respectively, of your total [redacted] compensation to physicians who provide primary care services at the rate of 110 percent of the Medicare fee schedule (RBRVS). Since the Medicare RBRVS fee schedule is generally considered to be substantially below reasonable and customary fees, your fees are considered to substantially discounted. However, you do not withhold any portion of these payments.

Under this discounted fee-for-service compensation arrangement with participating physicians, you have not transferred to these physicians a substantial portion of your financial risk associated with your obligation to furnish medical services to your enrollees. Therefore, you retain the financial risk associated with your obligation to furnish medical services to your enrollees. This financial risk constitutes a contract of insurance. See Rev. Rul. 68-27.

[redacted]

Therefore, you compensate a substantial portion of your [redacted] under an arrangement that does not result in your shifting to these providers a substantial portion of your risk of your financial risk associated with your obligation to furnish medical services to your enrollees.

Your purchase of stop-loss insurance limits only a minor portion of your financial risk associated with your obligation to furnish medical services to your enrollees. Under the terms of your stop-loss arrangement, you still retain a substantial financial risk associated with your obligation to furnish medical services to your enrollees. This arrangement is distinguishable from one where an HMO pays physicians fixed compensation. By paying physicians fixed compensation, an HMO transfers to the physicians substantially all of its financial risk associated with its obligation to furnish health care services to its enrollees.

Therefore, a substantial portion of your activities consists of providing health insurance to your enrollees. Since this health insurance is the same type of health insurance as that which is offered by commercial insurance companies, it is "commercial-type" insurance under section 501(m)(1) of the Code. Even though you otherwise qualify for exemption under section 501(c)(3) of the Code, you are precluded from qualifying for exemption by section 501(m)(1).

In summary, taking into account all the facts and circumstances relating to your operations, including the method by which you compensate your [redacted] to provide health care services for your enrollees, and your purchase of stop-loss insurance, it is concluded that you have shifted to third parties, your [redacted] and the insurance company, only an incidental portion of your financial risk associated with your obligation to furnish medical services for your enrollees in the event of illness or injury. Therefore, since your have retained a substantial portion of this risk, a substantial portion of your activities is comprised of providing commercial-type insurance.

As a result, even if you qualified for exemption under section 501(c)(3) of the Code, section 501(m)(1) would preclude you from so qualifying.

CONCLUSION

Accordingly, 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 Practices 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 judgement 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.

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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).

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]
OP: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] and [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