F. HEALTH CARE ORGANIZATIONS UNDER IRC 501(c)

The 1979 EOATRI contains an extensive discussion of the health care area. This section will update several of the subtopics discussed in the 1979 EOATRI and discuss other issues that have been raised during the past year.

1. Hospitals

Hospitals may qualify for exemption under IRC 501(c)(3). See the 1979 EOATRI at pages 186-191.

During the past year, the Service has been considering the effect on exemption under IRC 501(c)(3) of hospitals that finance the construction of medical office buildings to be owned and used by staff physicians. Revenue rulings on the following three situations may be published.

The first situation involves an IRC 501(c)(3) hospital that contracts with its staff doctors for the construction of a medical building adjacent to the hospital. The land upon which the building is to be constructed is owned by the hospital and will be leased to the doctors, at its fair market rental value. Construction of the building will be paid for and supervised by the doctors; however, the hospital has agreed to lend each doctor an amount not exceeding his or her proportionate cost of the construction at prevailing interest rates. The loans are evidenced by promissory notes and are secured. Upon completion of construction, each doctor will be the owner of a particular portion of the building. We have tentatively concluded that in this situation the hospital's exemption under section 501(c)(3) will not be jeopardized.

In the second situation, a wholly-owned taxable subsidiary of a tax exempt hospital entered into a limited partnership agreement with several doctors on the hospital's medical staff. The subsidiary is the sole general partner. The building will be constructed on land owned by the hospital and will be paid for and supervised by the partnership. The land will be leased to the partnership at less than its fair rental value. The hospital has agreed to loan the partnership sufficient funds to construct the building at prevailing interest rates. The loans are evidenced by promissory notes and are secured.

We have tentatively concluded in the second situation that the hospital will loss its exemption under IRC 501(c)(3) because the lease of the land to the

partnership at less than fair rental value results in inurement of the hospital's net earnings and serves the private interests of the partners.

The third situation is the same as the second situation except that the land will be leased at its fair rental value. Also, the hospital has entered into a second loan agreement with the partnership for a fluctuating amount. Under this agreement, the hospital is committed to making loans to the partnership, at the prevailing interest rate, equal to the partnership's net operating losses. There are no limitations on the amounts the hospital could be required to loan the partnership.

We have tentatively concluded that the hospital would loss its exemption in the third situation. Because the fluctuating loan agreement provides no reasonable limitations on the amounts the hospital could be required to loan the partnership, the hospital might have to adjust its operating policies in order to maintain sufficient reserves to meet its obligations under the loan agreement. Also, by entering into the agreement, the hospital is acting to protect the interests of the limited partners. This purpose, along with the possible resulting changes in its operating policies, creates a conflict of interest that is incompatible with the hospital's being operated exclusively for charitable purposes.

Apparently, hospital financing of the construction of medical office buildings is becoming more common. EO personnel in both determinations and examinations should therefore be on the lookout for this activity and develop the case accordingly.

2. Prepaid Health Plans

(a) HMOs (Health Maintenance Organizations)

An HMO is an organization that provides a wide range of health care services to a defined, enrolled population for a predetermined, prepaid premium. Under the prepayment plan the member is obligated to pay the prescribed premium only and is not subjected to the imposition of additional charges depending on the extent or frequency of the health care services received. Thus, the HMO is at risk, rather than the members, for any costs that exceed its income from the members' premiums.

The Health Maintenance Organization Act of 1973, 42 U.S.C. section 300e et seq., as amended, entitles HMOs that meet the requirements of the Act (qualified HMOs) to receive Federal financial assistance in the form of grants, loans, and

loan guarantees. Generally, a qualified HMO is required under the Act to enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, to have an open enrollment period as defined in the Act during which it will accept additional individuals as members in the order in which they apply regardless of a prior history of poor health, and to determine members' payments on the basis of a community rating system. Under a community rating system, the HMO, with only minor exceptions, may not consider the expected utilization of services of any individual or group but instead sets rates based on the expected utilization of its entire membership. This is in contrast to the experience rating system utilized by commercial insurers, under which members are charged different rates depending on the risk expected for members of a specific group, such as employees of one employer.

The HMO Act recognizes three basic types or models of HMOs. The first is the staff model HMO. It provides hospitalization and physicians' services through its own professional health staff in its centrally located facility. These physicians are paid on a salary or capitation basis. The plan bears all the risk for outpatient services and either directly provides inpatient services or contracts with an insurance company or Blue Cross for these services. These HMOs, which form approximately one-third of all HMOs, are sponsored by universities, hospitals, and physician groups.

The other types of HMOs differ from the staff model HMO in that health care services are provided by third parties, that is, physicians and medical groups who contract with the HMO to provide health care services to HMO members. These types of HMOs generally do not have their own facilities and the services are provided in facilities owned by the third-party providers.

The second type of HMO is the Individual Practice Association (IPA) model HMO. This type of HMO contracts with an IPA which in turn contracts with individual health professionals who provide health care on a free-for-service basis. The IPA is often sponsored by local, county, or state medical societies. As stated above, this type of HMO uses existing facilities of individual providers for providing health care services. Under this plan, the HMO and in some circumstances the physicians bear the risk for inpatient and outpatient services. (This is done through bonus arrangements, encouraged by HEW, that either reward or penalize physicians for factors such as hospital utilization.) Fees generally are set less than the customary fee-for-service rates, but physicians benefit because of prompt payment and access to a guaranteed patient population. Many of these plans are underwritten by Blue Cross.

The third type of HMO is the group practice HMO, which contracts with a medical group composed of health professionals who provide services on a fee-for-service or capitation basis. The medical group is at risk for the providing of care. The extent of the risk depends on the terms of the individual plan.

One of the first HMO-type organizations on which the Service took a position was the Group Health Association, Inc. in Washington, D.C. In G.C.M. 22554, 1941-1 C.B. 243, the Service held that Group Health, an organization formed to provide prepaid medical and hospital services to its members by making the necessary arrangements with hospitals, physicians and other medical providers, was not exempt under section 101(6) of the 1939 Code (the predecessor of IRC 501(c)(3)). Membership was restricted to Civil Service employees who were employed in the Washington area. This position was elaborated on in Hassett v. Associated Hospital Service Corp., 125 F. 2d 611 (1st Cir. 1942). In Hassett the court held that the plaintiff was not operated for charitable purposes and therefore not exempt from employment taxes.

These two precedents reflected the Service position prior to enactment of the HMO Act of 1973. As a result of the HMO Act of 1973, the Service undertook a review of this position. As a result of this review, the Service took the position that HMOs could not qualify for exemption under IRC 501(c)(3) (although they may qualify for exemption under IRC 501(c)(4)) for the following two reasons:

(1) HMOs serve the private interest of their members by providing them with health care on a preferential basis.

(2) The prepayment plan operated by HMOs serves the private interests of the members by providing them with a form of health insurance.

This position was successfully challenged in Sound Health Association v. Commissioner, 71 T.C. 158 (November 13, 1978) which held the petitioner-HMO exempt under section 501(c)(3). The two arguments listed in the preceding paragraph were addressed by the court as follows:

(1) The class of persons eligible for membership, and hence eligible to benefit from the HMO's activities, is practically unlimited. Therefore, the class of possible members of the HMO is, for all practical purposes, the class of members of the community itself, and benefit to the members is benefit to the community.

(2) The risk-spreading feature of the HMO's prepayment plan is a substantial benefit to the members, but since the potential class of membership is so broad, the plan does not serve private interests but rather is serving the benefit of the community.

Finally, the court, analyzing Rev. Rul. 69-545, 1969-2 C.B. 117, found little to distinguish Sound Health from the exempt hospital described therein.

The Service neither appealed nor has yet acquiesced in the Sound Health case. As a result of this case, the Service is reconsidering what its position should be with respect to HMOs. Applications for exemption under IRC 501(c)(3) submitted by HMOs have been suspended pending resolution of this issue.

District offices should continue to refer applications for exemption submitted by HMOs under IRC 501(c) (other than under IRC 501(c)(4)) to the National Office, per IRM 7664.3.

(b) IPAs (Individual Practice Associations)

IPAs are nonprofit organizations composed of health professionals that contract to provide health services to the members of prepaid health care plans on a fee-for-service basis. If the health care plan involved is a federally-qualified HMO, the IPA must fall within the following definition contained in the HMO Act (42 U.S.C. section 300e-1(5)):

The term "individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide -

> (A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and
>
> (B) to the extent feasible (i) for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff, and (ii) for the arrangement and encouragement

of the continuing education of such persons in the field of clinical medicine and related areas.

HMOs are therefore the vehicles for health delivery and IPAs are organizations that represent physicians' interests in dealing with HMOs.

Finalization of the Service position regarding the exemption of IPAs has been postponed pending reconsideration of the Service's position on HMOs (discussed above). Although our resolution of the HMO exemption issue may help to resolve the IPA exemption issue with respect to IPAs that contract with Federally-qualified HMOs, there will remain the problem of how to treat IPAs that contract with other types of prepaid health plans, in particular for-profit prepaid health plans.

3. Home Health Agencies (HHAs)

HHAs are defined in the Social Security Act (42 U.S.C. section 1395x(o)) as organizations primarily engaged in providing skilled nursing services and other therapeutic services to patients in their homes. To be a qualified HHA under the Social Security Act, an organization must either be exempt under IRC 501 or be licensed pursuant to a State law. Rev. Rul. 72-209, 1972-1 C.B. 148, provides that qualified HHAs are exempt under IRC 501(c)(3).

The General Accounting Office (GAO) is studying our administration of HHAs based on allegations that they are controlled by for-profit medical groups. Because of GAO's interest, we have included in the 1980 Program Letter a requirement to examine five percent of them.

GAO, in its Report to the Congress, Home Health Care Services -- Tighter Fiscal Controls Needed (HRD-79-17, May 15, 1979), highlights the following abuse situations that were found to exist in the home health care area:

(a) Inurement of Net Earnings

An HHA claimed costs relating to European trips for its president, treasurer, acting administrator, and their spouses. HHA officials claimed Medicare reimbursement for several other trips, including trips to Boston, New Orleans, and New York. The HHA also claimed expenses for local restaurant charges, flowers for various individuals, a fishing trip and "boat conference," and membership in a local country club.

(b) Leasing Office Space

An HHA rented office space at excessive costs from a company owned by the HHA's C.P.A. firm, which organized the HHA. Also, the HHA rented more space than it needed. The administrator stated that she had no authority to seek other facilities without prior approval from the board of directors, which was controlled by the C.P.A. firm.

(c) Franchising

HHAs are sometimes created by for-profit organizations under agreements that resemble franchise agreements. One such agreement required the HHA to purchase manuals and business forms from the for-profit organization (licensor) and to pay a licensing fee. The licensor had the right to examine the HHA's books. Also, the HHA was prohibited from establishing another health agency within 50 miles should the agreement be terminated, required to comply with minimum performance standards established by the licensor, and could not assign the contract to a new owner without the licensor's consent. The term of the contract was for 35 years. Under the contract, the licensor also supplied the agency with accounting, data processing, and other management services.

(d) Long-Term Contracts

Similar to the franchising arrangements described above, a for-profit organization will organize an HHA and enter into a long-term contract with the HHA to provide accounting, data processing, and other management services. Owners of the for-profit organization also serve on the board of the HHA at the time the contracts are entered into. The agreement may require the HHA to pay a percentage of its monthly gross billings or receipts to the for-profit organization.

(e) Use of HHA Facilities by a For-Profit Organization

In one case noted by GAO, a for-profit organization and the HHA that it had organized were located on the same office building floor and were billed separately for the space they leased. However, the for-profit organization was found to have used the HHA's space to conduct its business. The for-profit organization also charged long distance telephone calls to the HHA.

The issue presented in each of these situations is whether the HHA's net earnings inure to the benefit of private shareholders or individuals, and whether the HHA is operated for the benefit of private interests. Common to all of the above situations is the fact that the HHAs involved are not governed by independent boards. Particularly in those situations where an independent board is not present, the EO specialist should determine whether any abuse-type activities, such as the ones described above, exist.

4. Professional Standards Review Organizations (PSROs)

The PSRO program was established by Congress in 1972 pursuant to Title XI of the Social Security Act, 42 U.S.C. section 1320c et seq., to review the professional activities of physicians and other health care professionals to ensure the efficient delivery of health care services to Medicare and Medicaid beneficiaries. The law also provides PSROs with a number of other functions and responsibilities including the development of regional norms and criteria of diagnosis and care (42 U.S.C. section 1320c-5) in order to foster the reduction of unnecessary medical care.

The Service position is that although PSROs may provide some public benefit, they also serve a business interest by maintaining the professional standards, prestige, and independence of the organized medical profession. See, for example, Rev. Rul. 74-553, 1974-2 C.B. 168, which holds that a non-profit organization formed by members of a state medical association to operate peer review boards for the primary purpose of establishing standards for measuring quality, quantity, and reasonableness of cost of medical care was not exempt under IRC 501(c)(3).

In Virginia Professional Standards Review Foundation et al. v. Michael Blumenthal et al., 79-1 USTC Paragraph 9167 (D.D.C. 1979) the District Court for the District of Columbia rejected the Service's position and held a federally qualified PSRO exempt under IRC 501(c)(3). This case is discussed in detail in the 1979 EOATRI at pages 228-232. The court held the PSRO exempt under IRC 501(c)(3) on the theory that it was a quasi-governmental organization mandated by federal statute as the exclusive method of assuring appropriate quality and utilization of care provided to Medicare and Medicaid patients.

The Service recommended appeal of this case. However, the Solicitor General decided not to appeal. It is uncertain at this time whether we will adopt the position of the court in Virginia PSRO. We are awaiting the decision of the Tax

Court in a similar case, PSRO of Queen's County, Inc., before deciding how to proceed in this area. In the interim, our position continues to be that PSROs do not qualify for exemption under IRC 501(c)(3).

5. Cooperative Hospital Service Organizations

Cooperative hospital service organizations are owned and operated by their member-hospitals to provide services to those hospitals. The hospitals pool their resources to form the cooperative and pay the cooperative a fee designed to cover the cooperative's costs.

In 1967, Congress first turned its attention to the general problem of tax-exempt status for cooperative organizations established by tax-exempt hospitals to supply them certain commercial services. Prior to that time the Service had taken the position that such a cooperative organization constituted a taxable commercial business and not a charitable organization entitled to exemption under IRC 501(c)(3). In 1967, the Senate approved legislation that would treat cooperative organizations established by tax-exempt hospitals to provide them commercial services as charitable organizations entitled to tax exempt status. The House refused to pass such legislation. In 1968, the Senate again adopted legislation that would treat virtually all entities established by tax-exempt hospitals to provide commercial services for them as charitable organizations. In recommending the adoption of the provisions that were added to the Code as IRC 501(e), the House emphasized that only specified service organizations were to be treated as charitable organizations. (Expressly excluded in 1968 and again in 1976 were mutual laundry service organizations, discussed below.) It is the current Service position that cooperative hospital service organizations are not exempt under IRC 501(c)(3) as charitable organizations unless they are specified in IRC 501(e) or unless the cooperative is providing noncommercial services directly in furtherance of charitable purposes, such as health care or education and research.

Further discussion of this topic may be found in the 1979 EOATRI at pages 263-277. Regarding cooperative hospital laundry organizations, the Service continues to maintain the position that these organizations are not exempt under IRC 501(e) or 501(c)(3). We have lost the following two IRC 501(c)(3) declaratory judgment cases involving these types of organizations (in addition to the four cases listed in the 1979 EOATRI at pages 276-277):

1. HCSC - Laundry v. United States, 473 F. Supp. 250, 79-2 U.S.T.C. Paragraph 9532 (E.D. Pa. 1979).

2. Community Hospital Services, Inc. v. United States, 79-1 U.S.T.C. Paragraph 9301 (E.D. Mich. 1979).

We are appealing both of these cases as well as Metropolitan Detroit Area Hospital Services, Inc. v. United States, 78-1 U.S.T.C. Paragraph 9256 (E.D. Mich. 1978) and Hospital Central Services Association v. United States, 77-2 U.S.T.C. Paragraph 9601 (W.D. Wash. 1977) (both referred to in the 1979 EOATRI). We continue to maintain this position because we feel obligated to defend what we believe is the clearly expressed Congressional mandate contained in the legislative history of IRC 501(e).

6. Blue Cross and Blue Shield

Blue Cross and Blue Shield (BC/BS) are insurance programs organized in a nonprofit framework to pay physicians' bills and hospital fees. Since 1937 the Service has recognized these organizations as exempt under IRC 501(c)(4).

There are currently several technical advice cases in the National Office involving the issue of whether BC/BS engages in an unrelated trade or business by contracting with the Department of Health, Education, and Welfare to process Medicare claims submitted by hospitals. Specifically, BC/BS organizations act as agents under the Medicare and Medicaid programs. They pay beneficiaries or providers for health care rendered to the beneficiaries of the programs, adjudicate claims, audit health care providers, assist institutions in qualifying for Medicare reimbursement, conduct statistical and research studies, work with PSROs, etc. BC/BS is reimbursed by the responsible government agency for all costs incurred. For-profit insurance companies also serve as agents under Medicare to perform these services, but to a much lesser extent than BC/BS organizations.

Other UBI issues involve the provision of services by a Blue Cross Plan to a Blue Shield Plan and the provision of hospital benefits by one Blue Cross Plan to subscribers of another Blue Cross Plan on a cost reimbursement basis (commonly referred to as the Inter-Plan Service Benefit Bank).

The Service has not yet decided whether any of these activities constitute an unrelated trade or business. Technical advice should be sought in cases involving these issues.

7. Faculty Compensation Plans (FCPs)

FCPs are created by IRC 501(c)(3) teaching hospitals that are affiliated with universities. These organizations are in essence the incorporation of a department of the hospital and are formed to bill patients for professional services rendered by the department's physicians to be paid by Blue Shield. Under the rules of Blue Shield, the teaching hospital and the university cannot bill Blue Shield for these services. This is because Blue Shield is a payment vehicle for physicians' services.

FCPs may be controlled by their member-physicians, who are entitled to receive a part of the collected fees for their services. The member-physician typically may not earn more than a certain multiple of his or her teaching salary.

The Service position is that FCPs are not exempt under IRC 501(c)(3) because they are operated in a manner essentially equivalent to the private practice of medicine and thus serve the private benefit of their member-physicians. This argument was rejected by the Tax Court in B.H.W. Anesthesia Foundation, Inc. v. Commissioner, 71 T.C. No. 59 (July 24, 1979), which held a FCP exempt under IRC 501(c)(3).

The BHW case was not appealed. However, the Service position continues to be that FCPs are not exempt under IRC 501(c)(3). There are currently two FCP cases docketed in the United States Tax Court that should test the Service position in this area.

8. Shared Services

The term "shared services" refers to the provision of services by a tax-exempt hospital to other tax-exempt hospitals, organizations (both for-profit and nonprofit), and individuals. The two issues raised by this activity are (1) whether the exempt status under IRC 501(c)(3) of the hospital providing the services will be jeopardized, and (2) whether the hospital providing the services will be subject to the unrelated business income tax. Of course, exempt hospitals may provide support services, such as laundry services, exclusively for themselves without any tax liabilities. For example, in Rev. Rul. 78-41, 1978-1 C.B. 148, the Service held that a separate trust which was an integral part of a hospital and set up to fund and otherwise process the hospital's malpractice claims was entitled to exemption under IRC 501(c)(3).

IRC 513(e) allows hospitals to provide the services specified in IRC 501(e) (including clinical and laboratory services) in certain limited situations to other

tax-exempt hospitals without being subject to tax. The question the Service is currently considering is whether a hospital can provide services in situations other than those described in IRC 513(e).

An exempt hospital may provide services to other organizations and to individuals without jeopardizing its exempt status and without being subject to the unrelated business tax if the services provided further an exempt purpose, which in this context is usually the promotion of health. For example, in a private letter ruling, we held that one hospital's provision of physical and respiratory therapy services to patients of another hospital, at cost, did not constitute unrelated business or threaten its exemption. (CCH Private Letter Ruling 7843128, July 31, 1978).

In another letter ruling we held that a hospital's proposal to construct a professional office building on hospital-owned real estate adjacent to it for the purpose of encouraging staff doctors to maintain their private practices near the hospital would not result in unrelated business income or jeopardize exemption where the space would be leased only to staff members at fair market value. (CCH Private Letter Ruling 7825036, March 22, 1978). Also, the Service is considering publishing a revenue ruling holding that a tax-exempt hospital that treats patients of other unrelated hospitals (including both exempt and non-exempt hospitals) is not engaged in an unrelated trade or business, because the treatment of patients is substantially related to the hospital's exempt purposes.

However, if the service provided does not further an exempt purpose, unless section 513(e) applies, the exempt organization providing the service will be subject to the unrelated business tax and may jeopardize its exemption if this activity constitutes more than an insubstantial part of its activities. For example, Rev. Rul. 69-633, 1969-2 C.B. 121, holds that the sale of laundry services by a tax-exempt hospital to other tax-exempt hospitals constitutes unrelated trade or business because the sale of laundry services to other hospitals is not an activity substantially related to the performance of the selling hospital's exempt purposes.

The issue raised most frequently is whether the provision of laboratory services by a tax-exempt hospital to other organizations and to individual physicians constitutes unrelated trade or business. We are currently considering this issue but as yet have not reached a conclusion. In the interim, technical advice should be requested in all UBIT cases involving the provision of laboratory services.

Hospitals will probably expand their shared service activities as a result of regulations promulgated by the Department of Health, Education, and Welfare that encourage this type of activity. EO specialists should therefore be on the lookout for this type of activity and request technical advice in appropriate cases.

9. Miscellaneous

(a) Private hospital room - An organization formed for the purpose of making a private hospital room available to patients who can benefit medically from a private room but who cannot afford the expense of such a room qualifies for exemption under IRC 501(c)(3). Rev. Rul. 79-358, I.R.B. 1979-45, page 9.

(b) The question has been raised as to whether municipal hospitals eligible for the IRC 115 exemption are also able to receive IRC 501(c)(3) status. Municipal hospitals apparently seek exemption under IRC 501(c)(3) for purposes of qualifying for tax free annuities for employees under IRC 403(b).

A municipal hospital, like other state or municipal instrumentalities, may qualify for exemption under IRC 501(c)(3) provided that it is a separate entity and is a clear counterpart of an IRC 501(c)(3) organization. Rev. Rul. 74-15, 1974-1 C.B. 126.