H. EVOLUTION OF THE HEALTH CARE FIELD

by
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1. Introduction

"'What you are seeing today is the IRS looking at [tax-exempt] ... hospitals and seeing them for what they are -- big businesses,' said James J. McGovern, Associate Chief Counsel (Employee Benefits and Exempt Organizations) on April 11. Speaking at the spring meeting of the ABA Business Law Section in Orlando, Fla., to the Committee on Nonprofit Organizations, McGovern explained that the Service is reacting to 'a very changed segment of the nonprofit sector, to a very different universe than what existed just ten years ago.'" Tax Notes Today, Wednesday, April 22, 1992. 92TNT086.

During the last decade, the way non-profit hospitals operate has changed in two fundamental ways. In order to survive in a competitive and evolving environment, non-profit hospitals have expanded into broader commercial activities and have taken on more businesslike attitudes and strategies. Many hospitals make extensive use of taxable subsidiaries and joint ventures with physician groups and other non-profit and for-profit entities. Catalysts for the transformation include reduced federal funding, deregulation, cost containment efforts by employers and private insurers, and increased competition among health care providers.

These changes - and the attention they have attracted from the public, from advocacy groups, state and federal agencies including IRS, and from legislatures - have made the health care industry one of the hottest areas in exempt organizations law. This article will focus on some of the most widely felt and discussed issues in exempt organizations law currently facing the health care industry and the Service.

2. Hospital Charitable Activity

A. Background

The furnishing of hospital care or the operation of a non-profit hospital are not specifically mentioned in IRC 501(c)(3). However, they have long been recognized as activities in furtherance of charitable purposes described in IRC 501(c)(3), so long as certain conditions are met.

The idea of a "charitable" hospital had its origin in the 19th century (or before) when non-profit hospitals were institutions primarily engaged in providing free care for the poor. This view was carried over into the early tax law. While the term "charitable" has never been defined statutorily, the tax regulations in effect prior to 1959 interpreted the term in the then commonly accepted narrow sense of aid to the poor and suffering. In Rev. Rul. 56-185, 1956-1 C.B. 202, the Service first announced a formal position on what was required for a hospital to be recognized as a tax exempt charitable organization under IRC 501(c)(3). The revenue ruling applied this conventionally narrow concept of charitability. The ruling established as an absolute requirement for exemption that a hospital admit and treat patients who are unable to pay, either without charge or at rates below cost. Since this uncompensated care had to be provided to the extent of the hospital's financial ability, this requirement became known as the "financial ability standard."

The financial ability standard, being somewhat subjective, did not prove easy to administer. Indeed, the ruling was criticized during congressional hearings for its imprecise standards regarding the extent to which a hospital must accept patients who are unable to pay in order to retain its exempt status. See H.R. Rep. No. 413, 91st Cong., 1st Sess. pt. I, at 43 (1969).

A few years after publication of Rev. Rul. 56-185, the regulations interpreting IRC 501(c)(3) were significantly revised. These 1959 regulations adopted a broader concept of charity than had prevailed in the past, and provided that the term "charitable must be interpreted in its generally accepted legal sense." Reg. 1.501(c)(3)-1(d)(2). Thus, the term is not limited to relief of the poor, but encompasses also broader concepts of community benefit and public interest.

In light of the revised regulations, the perceived difficulties in administering and complying with Rev. Rul. 56-185, and the need to promote rules consistent with health policy developments that were revolutionizing the financial aspects of nonprofit hospital operations (particularly the enactment in 1965 of Medicare and Medicaid), the Service revised its hospital exemption standards in 1969. Rev. Rul. 69-545, 1969-2 C.B. 117, is a watershed ruling that modified Rev. Rul. 56-185 by removing the financial ability standard and substituting a new test, known as the "community benefit standard." Interpreting the term charitable in its general legal sense, based on the common law of charitable trusts, Rev. Rul. 69-545 recognizes that the promotion of health, in and of itself, can be a charitable purpose, at least where the community as a whole is benefitted.

In explaining why an explicit level of charity care is no longer required, the ruling states that the "promotion of health ... is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community."

The community benefit standard, which remains the standard applied by the Service today, focuses on a number of factors indicating that the operation of a hospital benefits the community as a whole. Rev. Rul. 69-545 states that a charitable hospital will meet the community's needs, and thus qualify for exemption, where it operates a full-time emergency room open to all persons, without regard to ability to pay, and provides hospital care in non-emergency situations for all persons able to pay the cost thereof, either by themselves, or through third-party reimbursement, such as private health insurance, or with the aid of public programs such as Medicare.[1] The hospital also has to have a board of directors drawn from the community, an open medical staff, and must apply any surplus to improving facilities, equipment, patient care, and medical training, education, and research. The ruling expressly acknowledges that the hospital found to qualify ordinarily refers non-emergency patients who cannot meet the financial requirements for admission to another hospital in the community that does serve indigents.

In 1983, the Service applied the community benefit standard to a hospital identical to the one found qualified in Rev. Rul. 69-545 but for the fact that it did not operate an emergency room. Rev. Rul. 83-157, 1983-2 C.B. 94, was based on the fact that a state health planning agency made an independent determination that the operation of an emergency room would be unnecessary and duplicative. In essence, the state agency would not allow another emergency room to be established in the community. In that narrowly defined circumstance, or in the case of specialty hospitals offering care limited to conditions unlikely to necessitate emergency care, the ruling allows that other factors may be weighed in determining whether the hospital promotes the health of a class of persons broad enough to benefit the entire community.

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[1]While only Medicare is expressly mentioned, the Service has consistently interpreted and applied the statement as including Medicaid as well.

It should be noted that the conclusion in Rev. Rul. 83-157 was based on the factual premise that a state agency determined independently that there was no community need for additional emergency room services. In the case of a typical non-profit acute care hospital, the Service regards the operation of an emergency room, as well as participation in the Medicare and Medicaid programs, as the two most important factors demonstrating community benefit.

Not long after Rev. Rul. 69-545 was published, various health and welfare organizations and several private citizens, alleging indigence and inability to pay for hospital services, filed a class action suit challenging the validity of Rev. Rul. 69-545. The District Court sustained the challenge, and concluded that Congress intended to restrict the term charitable to its narrow sense of relief of the poor. Eastern Kentucky Welfare Rights Org. v. Shultz, 370 F. Supp. 325, 338 (D.D.C. 1973).

The Court of Appeals reversed the District Court, however, and upheld the broader interpretation of charitable taken in Rev. Rul. 69-545. Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976). The Court of Appeals deemed the term "charitable" as capable of a definition far broader than merely the relief of the poor. The Court explained that the "financial ability" standard of Rev. Rul. 56-185 was not overruled but was merely supplemented by an alternative method whereby a not-for-profit hospital could qualify as a tax exempt charitable organization. The Court postulated that the definition of charity should be broad enough to accommodate the changing economic, social and technological needs and values of society. Eastern Ky. Welfare Rights, supra. at 128.

(Upon appeal, the Supreme Court ruled that the plaintiffs, Eastern Kentucky Welfare Rights Organization, et al., suffered no injury in fact and lacked standing to bring the suit. Simon v. Eastern Ky. Welfare Rights Org., supra. at 26. By ruling thus, the Court made Rev. Rul. 69-545 virtually unassailable by those having the inclination and wherewithal to challenge it. This could partially account for the fact that Rev. Rul. 69-545 has stood for 23 years. Because the Supreme Court never addressed the merits, the D.C. Circuit opinion remains the leading judicial precedent. See, for example, Lugo v. Simon, 453 F. Supp. 677 (N.D. Ohio 1978).)

The provision of uncompensated care by nonprofit hospitals has recently been scrutinized by certain state courts with regard to exemption from state and local taxes. In 1985, the Utah Supreme Court looked carefully at state law standards for hospitals to be treated as charitable, and concluded that, in Utah, the element of gift to the

community (through, for example, free services for the poor) is essential. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985). In reaching its conclusion, the court was convinced that traditional assumptions bear little relationship to the economy of what it called the "medical-industrial complex." The opinion carefully outlined the changing hospital economic environment, and noted the eroding distinction between for-profit and non-profit hospitals.

Likewise, in School District of the City of Erie v. Hamot Medical Center, 602 A.2d 407 (Pa.Commw.Ct. 1992), the Pennsylvania Commonwealth Court recently affirmed the denial of a charitable exemption for a Pennsylvania hospital, finding the trial court correct in its assessment that Hamot was not a "purely public charity". The court found that, unlike the hospital in the case cited by Hamot as controlling, West Allegheny Hospital v. Board of Property Assessment, 500 Pa. 236, 455 A.2d 1170 (1982), Hamot did not have an open admissions policy. Regardless of its non-discriminatory admissions policy, there was no evidence showing that Hamot provided non-emergency services to persons it knows cannot pay for them. Further, Hamot aggressively pursued collection from non-paying patients. Hamot Medical Center at 413.

In addition, Hamot did not meet four of the five criteria set forth in Hospital Utilization Project v. Commonwealth, 507 Pa. 1, 487 A.2d 1306 (1985), the case cited by the trial court. Although Hamot did relieve the government of some of its burden, it failed to advance a charitable purpose, to donate or render gratuitously a substantial portion of its services, to benefit a substantial and indefinite class of persons who are legitimate subjects of charity, or to operate entirely free from private profit motive. Hamot Medical Center, at 414.

Another Pennsylvania case receiving much publicity is HealthEast, Inc., No. 1988-1297, (Court of Common Pleas, Lehigh County, Orphans' Court Div., slip op. July 12, 1990). The Board of Assessment Appeals of Lehigh County revoked the tax exempt status of the Allentown Hospital and Lehigh Valley Hospital Center, known together as HealthEast. The Orphans' Court Division decided that an accounting of the stewardship of those and the other general hospitals located within Lehigh County should be conducted pursuant to the authority of Pennsylvania Rule of Judicial Administration. As a result, an initial audit was conducted by the court, with another one to be conducted. The conclusion of the court from the first audit was that HealthEast should be warned that it had become too powerful and controlling. The court noted changes needed to be made in the ways that HealthEast administers the properties committed to it for charitable purposes. However, the court did not find that HealthEast's exemption should be revoked, specifically stating that the actual

delivery of health care to its patients is not an issue, and that no abuse of discretion by the Trustees could be found.

The Vermont Supreme Court recently affirmed a lower court decision upholding a hospital's exemption against a challenge by local property tax authorities, but stated that the key inquiry in determining qualification for exemption under Vermont law is whether the hospital made care available to all, regardless of ability to pay. The hospital at issue did. Such an "open door" policy, the court stated, accords with settled state law regarding charitable trusts and leads to the conclusion that the hospital is primarily used for charitable purposes. Medical Center Hospital of Vermont v. Burlington, 152 Vt. 611, 566 A.2d 1352 (1989).

B. Congressional Attention

Like some of the state courts, several Congressional committees have expressed concern about whether nonprofit hospitals are providing enough charity care to justify their tax exemption, especially given the number of Americans without health insurance and the value of tax exemption to non-profit hospitals. Some members of Congress have, in particular, questioned the appropriateness of the community benefit standard and current enforcement of that standard.

In response to concerns that charitable hospitals might be devoting insufficient resources to the indigent, the U.S. General Accounting Office (GAO) undertook a broad study of charitable hospitals' activities. In its May 30, 1990, report, "Non-Profit Hospitals: Better Standards Needed for Tax Exemption," GAO found a weak link between tax exempt status and the provision of charitable activities for the poor or underserved, and wide variation in the amounts of uncompensated care provided. It recommended that, if Congress wished to encourage non-profit hospitals to provide charity care to the poor and underserved, it should consider revising the criteria for exemption.

On July 10, 1991, during the first session of the 102d Congress, the House Ways and Means Committee held a hearing on the tax exempt status of hospitals with a particular focus on two bills proposing to establish explicit new charity care standards to replace the community benefit standard. One bill, H.R. 790, is sponsored by Representative Roybal, Chairman of the House Select Committee on Aging. H.R. 790 provides that an organization which operates a non-profit hospital would not be exempt from federal income tax unless the hospital (1) has an open-door policy toward Medicare and Medicaid patients and serves in a nondiscriminatory manner a reasonable number of such patients, and (2) provides in a nondiscriminatory manner

sufficient qualified charity care and sufficient qualified community benefits. Sufficient charity care is defined as at least 50 percent of the value of the hospital's tax exempt status for the year.

Representative Donnelly introduced a similar bill. Rep. Donnelly's bill, H.R. 1374, provides that an organization would not be exempt from federal income tax if a substantial part of its activities consists of operating a "nonqualified hospital". In order to avoid classification as a "nonqualified hospital," a hospital would have to satisfy the following three basic requirements designed to ensure that the hospital provides (1) adequate emergency services, (2) service to Medicaid patients, and (3) charity care or other community benefits. First, the Donnelly bill would require a full-time emergency room open to all without regard to ability to pay and would recognized the overlap of COBRA violations with this requirement. Second, it would require nondiscriminatory provision of care to Medicaid patients. In these two regards, H.R. 1374 is essentially a codification of Rev. Rul. 69-545. However, the Donnelly bill goes on to add a requirement that a hospital devote at least five percent of its gross revenues to the provision of charity care, or meet other proposed standards providing evidence of community benefit, as outlined in the bill.

Both the Department of Treasury and the Service testified at the July hearing. Treasury defended the community benefit standard, stating it believes that it is a more appropriate standard for evaluating the tax status of hospitals than the "charity care" standards of the legislative proposals, which focus more directly on providing uncompensated care. Treasury did not oppose those portions of H.R. 1374 that codify present law. Both Treasury and the Service raised a need for intermediate sanctions for violations of tax exempt status as opposed to the present sole sanction of revocation. At the time this article was prepared, there had been no further action on any of these proposals.

3. Hospital-Physician Relationships

Among the most notable developments in the health care field are those involving relations between hospitals and physicians. New economic relationships are being forged between the two as a result of economic, competitive and regulatory pressures. Where these affiliations allow physicians to share assets which would otherwise belong to the hospital, important tax issues are raised.

A hospital's ability to generate needed revenues depends heavily on its relations with its medical staff. Patients bring revenues to hospitals, but they rarely decide for themselves when or where to obtain care. For that, they rely upon

physicians. Doctors determine when, how long, how intensively, and in what environment to treat patients. They order the laboratory tests, x-rays, pharmaceuticals, and surgery that determine the short-term institutional costs of treatment. Some of hospitals' most intense competitive efforts have focused on attracting, retaining, and motivating physicians to bring in business.

Hospitals traditionally attracted physicians by offering modern treatment facilities, a prestigious reputation, or the latest medical equipment. Increasingly, however, recruitment and retention efforts are shifting toward complex financial arrangements through which the physicians can share in the hospital revenues resulting from their patient referrals. These arrangements include joint ventures between hospitals and physicians, recruiting incentives, and hospital purchases of physician practices.

Whenever a charitable organization engages in new or unusual financial transactions with private parties, the arrangements must be evaluated in light of applicable tax law and other legal standards. One key principle of IRC 501(c)(3) exemption is that no part of the net earnings of a charitable organization can inure to the benefit of a private shareholder or individual. Another key principle, espoused in Reg. 1.501(c)(3)-1(d)(1), is that an entity is not organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest. Some of the new hospital-physician economic arrangements may not withstand a strict application of these "prohibited inurement" and "private benefit" standards.

A. Hospital-Physician Joint Ventures

1. G.C.M. 39862

G.C.M. 39862 (November 22, 1991) has been described as "sophisticated," and "probably one of the most important position statements for tax exempt hospitals in the last decade." Bromberg, "IRS Announces New Position on Hospital-Physician Joint Ventures," The Exempt Organizations Tax Review (Jan. 1992).

G.C.M. 39862 reviews and reconsiders three private letter rulings which approved specific hospital-physician joint ventures involving a sale of part of the hospitals' net revenue streams. The net revenue stream earned during a defined period of time from the operation of an existing hospital department such as the outpatient surgery department was sold to a joint venture between the hospital or a subsidiary and members of the hospital's medical staff. The price was determined by discounting an appraised value of the future revenue stream that was being sold to present value

using an appropriate discount rate. The hospitals continued to own and operate the departments, with only the hospital's anticipated revenues involved in the sale. After the sale, the physician-investors would have a financial incentive to refer more patients to that department of the hospital so that net revenues would grow. G.C.M. 39862 concludes that a hospital entering into such a transaction jeopardizes its tax exempt status for the following reasons: (1) the transaction causes the hospital's net earnings to inure to the benefit of private individuals; (2) the private benefit stemming from such a transaction cannot be considered incidental to the public benefits achieved; and (3) such a transaction may violate federal law. The G.C.M. concludes that each of the three previously issued private letter rulings should be revoked, and that any other existing rulings that conflict with the conclusion should be modified or revoked.

Inurement. G.C.M. 39862 restates the Service's position that all physicians on the medical staff of a hospital, whether serving as employees, as independent contractors, or as persons with a close professional working association with the hospital, have a personal and private interest in the activities of the hospital and are "insiders" subject to the inurement proscription. See G.C.M. 39498 (Jan. 28, 1986). G.C.M. 39862 explains that the physicians have applied for and been granted privileges to admit and treat their private patients at the hospital. They are bound by the medical staff bylaws, which may be viewed as a constructive contract between them and the hospital. Individually, and as a group, they largely control the flow of patients to and from the hospital and patients' utilization of hospital services while there. Some may serve other roles at the hospital, such as that of part-time employee, department head, Board member, etc. Moreover, once the arrangements at issue commenced, each physician-investor became a joint venture partner of the hospital or affiliate, which further suggests a presumed ability to influence the activities of the hospital.

The G.C.M.'s analysis begins with asking what the hospital gets in return for the benefit conferred on the physician-investors. It concludes that there appears to be little accomplished that directly furthers the hospitals' charitable purposes of promoting health. It points out that "[n]o expansion of health care resources results; no new provider is created. No improvement in treatment modalities or reduction in costs is foreseeable." G.C.M. 39862 at 12. Rather, the G.C.M. perceives the transactions as a means for hospitals to retain and reward members of their medical staffs, to attract their admissions and referrals, and to pre-empt the physicians from investing in or creating a competing provider.

The G.C.M. analyzes the transactions as investments rather than compensation arrangements, and finds that they constituted little more than the gift or sale to medical staff physicians of a proprietary interest in the net profits of a hospital, creating a result that is indistinguishable from paying dividends on stock. Thus, the arrangements violate the inurement proscription of IRC 501(c)(3) because profit distributions are made to persons having a personal and private interest in the activities of the organization and are made out of the net earnings of the organization. The G.C.M. sets forth a per se rule that an exempt hospital's participation in an investment arrangement that provides insiders a proprietary interest in the hospital's net earnings constitutes prohibited inurement, regardless of any theoretical, potential, or even demonstrable economic benefit to the hospital. (This is not, however, to suggest that a hospital cannot have a suitably structured incentive compensation plan for employees in which profits may be a factor. See discussion below.)

Benefitting Private Interests more than Incidentally. G.C.M. 39862 notes that, should a particular physician-investor be deemed, for whatever reason, not to be subject to or not to have violated the inurement prohibition, the Service would still apply a private benefit analysis to his or her financial relations with the hospital. It concludes that the benefits received by the physicians-investors in the arrangements exceeded the bounds of permissible private benefit and therefore jeopardized the tax exempt status of the participating hospitals.

The G.C.M. recognizes that, while there is an unavoidable degree of private benefit in the basic use by private practice physicians of hospital facilities to provide services for which they are compensated, that degree of benefit is regarded as incidental to the overwhelming public benefit resulting from having the combined resources of the hospital and its professional staff available to serve the public. However, the G.C.M. judges the additional private benefits conferred on the staff physician-investors in the income stream joint ventures as direct, substantial, and clearly not incidental, either qualitatively or quantitatively, to any public benefit arising from the transactions. The G.C.M. emphasizes that "... even though exemption of the entire organization may be at stake, the private benefit conferred by an activity or arrangement is balanced only against the public benefit conferred by that activity or arrangement, not the overall good accomplished by the organization." (Emphasis added.) G.C.M. 39862 at 17.

G.C.M. 39862 considers the expected public benefit - enhanced hospital financial health or greater efficiency achieved through improved utilization of their facilities - as bearing only a tenuous relationship to the hospitals' charitable purposes of promoting the health of the community. The G.C.M. observes that obtaining

referrals or avoiding new competition may improve the competitive position of an individual hospital, but that is not necessarily the same as benefiting the community.

The discussion above has focused principally on the sales of the revenues streams involved in the arrangements. The joint venture aspect, in and of itself, will be highlighted in the Partnership Article of this CPE text.

Violation of Federal Law. As a matter of general trust law, engaging in conduct or arrangements that violate laws cannot be in furtherance of a charitable organization's purpose. Because nearly all IRC 501(c)(3) hospitals participate in the Medicare and Medicaid Programs, they are subject to the referral prohibitions of the Medicare and Medicaid Fraud and Abuse law, commonly referred to as the Anti-Kickback Statute (discussed in greater detail below). Where a tax exempt hospital engages in activities or arrangements that violate the anti-kickback statute, its exemption may be jeopardized.

The G.C.M. looks to a publication called Special Fraud Alert - Joint Venture Arrangements, released by the Office of the Inspector General of the Department of Health and Human Services in April, 1989, which helps to identify joint ventures that are abusive and illegal. The Fraud Alert includes as examples of questionable features the choosing of investors because they are in a position to make referrals; requiring investors to divest their ownership interest if they cease to practice in the service area, move, become disabled or retire; and having investment interests that are nontransferable. G.C.M. 39862 indicates that each of these features was present to some degree in the three net revenue stream joint ventures.

The Fraud Alert also indicates that the structure of a joint venture is suspect where it is merely a shell, that is, where one party is already involved in the activity that is the subject of the venture, and continues to undertake most or all of the activities. This characteristic is also found in the three net revenue stream joint ventures. Finally, the Fraud Alert states that questions will be raised when the amount of capital invested by the physicians may be disproportionately small and the returns on investments may be disproportionately large, or when the investors may be paid extraordinary returns compared with the risk involved. G.C.M. 39862 does not reach any conclusion on this point because all the facts necessary were not available. The G.C.M. also does not reach a conclusion on the overall illegality question. Generally, the Service has indicated a reluctance to apply a non-tax statute where the courts and the administrative agencies responsible for administering it have not yet spoken to its application to a particular activity or arrangement.

Nevertheless, the net revenue stream joint ventures were viewed in the G.C.M. as shams with no true downside risk on the physician-limited partners, and tremendous upside potential. Aside from the purely legal considerations, these arrangements may be harmful to the public for a number of reasons. Physicians may refer patients for unnecessary services or refer them for necessary services in an unnecessarily costly setting. Medicare and Medicaid Program costs would be increased, honest competition undercut, and hospital resources drained away from charitable activities. In addition, physicians may not refer indigent or Medicaid patients to the facility once they have an interest in its financial performance, further limiting access to services for those patients. These potential harms seem directly inconsistent with the notion of community benefit.

Henceforth, specialists should pay added attention to the possibility that hospital-physician financial arrangements, including all types of joint ownership or operation arrangements, may have among their purposes an intent to induce or reward referrals. G.C.M. 39862 modifies G.C.M. 39732 (Nov. 4, 1987) to the extent that it can be read to suggest that a hospital can further its exempt purposes by inducing or rewarding patient referrals or that paying physicians "reasonable compensation" for referrals is permissible.

2. Announcement 92-70.

On May 18, 1992, the Service announced that, for a limited time, it will consider resolution of tax exemption issues arising from gross or net revenue stream joint ventures of hospitals and their medical staffs if the hospitals terminate the arrangements without further private benefit to the physician-investors.

According to Announcement 92-70, 1992-19 I.R.B. 89, some hospitals described in IRC 501(c)(3) may face the loss of their tax exemptions because of certain partnerships or joint ventures entered into with staff or related physicians. The typical transaction has involved the hospital's sale of a gross or net revenue stream from certain of its activities to the joint venture. The Announcement notes that examples of such a transaction and how it may jeopardize exemption may be found in G.C.M. 39862.

The Announcement states that if a hospital intends to rescind such a transaction and wants to enter into a closing agreement or other arrangement with the Service regarding the transaction's tax consequences, which includes undoing the original transaction, the Service will review requests for such treatment made on or before September 1, 1992. The Announcement warns that, after September 1, such

transactions will be treated by the Service as subject to the usual procedures governing tax consequences, including considering revocation of participating hospitals' tax exemptions.

B. Unreasonable Compensation and Other Forms of Inurement

It is well established that paying reasonable salaries to managers, officers, or other employees, despite their insider status, does not constitute inurement of net earnings to the recipient and does not defeat exemption of an otherwise exempt organization. On the other hand, excessive and therefore unreasonable compensation for goods or services can result in a finding of prohibited inurement. Determining what is reasonable compensation involves analyzing all relevant facts and circumstances. Factors to consider include the extent to which the agreed-upon compensation results from arm's length negotiation between the parties and, closely related, the extent to which the party receiving the compensation is in a position to exert control over the exempt organization.

1. Physician Recruitment

Hospital recruitment of physicians is an area ripe for unreasonable compensation issues or other forms of inurement. In an effort to attract private practice physicians to their service areas, hospitals reportedly are offering them guaranteed private practice incomes, below market loans, reduced or free office rent, subsidized management, consulting, and billing services, and opportunities to participate in joint ventures with the hospital or an affiliate. Guidance in this area is relatively sparse. In Rev. Rul. 73-313, 1973-2 C.B. 174, the Service approved an arrangement in which members of a community (not a hospital seeking referrals) banded together to construct a medical facility and used a below market rental arrangement to attract the first physician to a previously unserved, isolated, rural area. In G.C.M. 39498 (January 28, 1986), the Office of Chief Counsel applied a reasonable compensation analysis to a proposed hospital agreement to guarantee a physician's private practice income as a means of recruiting. G.C.M. 39862 observes that medical staff physicians typically do not become hospital employees or contractors paid by the hospital. G.C.M. 39862 at 9-11. Thus, one may need to go beyond a standard compensation-for-services analysis and look to whether any recruiting expenditure benefits the community or otherwise directly furthers the hospital's exempt purposes.

Careful consideration should be given to whether an expenditure to recruit a physician is in furtherance of exempt purposes by (1) benefiting the community while

(2) conferring no prohibited inurement and only incidental private benefit. Fraud and abuse implications could come into play, especially if physicians are required to refer patients to the hospital or if economic benefits provided to the doctors are intended to induce referrals rather than, for example, to improve the resources available in the community.

2. Incentive Compensation Arrangements

The Service has abandoned an early view that certain incentive compensation arrangements necessarily result in a loss of exemption. Today, the Service's position is that the entire compensation arrangement must be reviewed to ensure that it is the result of arm's length bargaining and that it is reasonable in amount. The Service's current position is reflected in a private letter ruling dealing with incentive compensation released by the Service in December, 1990.

LTR 91-12-006 (Dec. 20, 1990) ruled that the proposed incentive compensation plan would not affect the exempt status of the subject hospital. The information submitted indicated the following favorable factors: the participation of all employees; the development of multi-level standards for increased productivity and cost efficiency, as well as for the quality of health care provided; the various levels of independent review; the operation of a quality assurance program; the relatedness of the plan's employee distribution to the services performed; the review of total compensation paid by independent auditors of incentive payments; and the limitations established to safeguard against possible abuses. The ruling concluded that these factors prevented distributions to employees that exceed reasonable compensation for services performed and indicated that the plan would be furthering the hospital's exempt purposes without serving the private interests of the employees more than incidentally.

When physicians are involved, an incentive compensation plan could have as its purpose rewarding them for certain behaviors beneficial to health care in the community, such as proper coding of patient diagnoses, efficient care delivery, and timely completion of records. However, it may also include payments which allow physicians to share in hospital profits achieved through unwarranted early discharges or reduced utilization of ancillary hospital services. Certain physician incentive arrangements may also serve as a disguised mechanism to reward a physician for referrals.

3. Purchasing Physician Practices

Hospitals may seek to purchase a physician's practice. By doing so, the hospital may improve its market share, assure a continued referral base, and preempt another hospital that might acquire the practice. Hospitals gain guaranteed access to the physician's patients, while physicians often receive a substantial cash payment, and, if they continue practicing medicine as a hospital employee or contractor, enjoy an assured income and relief from the business aspects of practice. Purchase by a hospital of a physician's practice at more than fair market value can result in prohibited inurement. Valuation issues are likely to predominate and be determinative. Also, the selling physicians may continue to provide professional services to their former patients as employees or contractors of the hospital. Compensation of a physician employee based on a percentage of the net profits of the physician's hospital practice or at a level in excess of the fair market value of his services could also result in prohibited inurement.

The purchase of a physician practice can have fraud and abuse implications as well if the form or amount of the payment suggests it is intended to induce or reward the referral of business. Two examples of potential disguised referral fees would be above market rates of compensation being paid the physician who continues to operate the practice, and periodic hospital payments for an option to buy the practice where no sale is really contemplated.

C. Hospital Revocation.

The Service will look carefully at every aspect of a hospital's dealings with its medical and administrative staff and its directors as evidenced by a technical advice recently issued that recommends to a key district revocation of exempt status on inurement grounds. TAM 91-30-002 (Aug. 5, 1991) involves a situation where the hospital was sold to a new organization owned by members of the hospital's board of directors; the directors essentially sold the hospital to themselves for $6.3 million followed closely by a resale to a for-profit hospital chain for about $30 million, a nearly five-fold gain. As part of its examination of the organization, the Service determined that the original valuation report prepared by the organization's appraiser, which valued the hospital at between $3.5 and $4.3 million, was not an appropriate appraisal report to use as a basis for valuing the assets that were transferred to the new corporation. The Service determined that the fair market value at the time of the sale was instead about $24 million. Recommendation for revocation was based on the sale of the hospital to insiders for less than fair market value. As of this writing, the Tax Court has already rendered a decision on procedural questions regarding a suit for declaratory judgment in this case, and the substantive issue is pending in that venue. Anclote Psychiatric Center, Inc. v. Commissioner, 98 T.C. No. 28 (1992).

4. Influence of Medicare Law on Hospital Tax Exemption

A. Relationship between IRS and HHS

In the past, administration of federal tax law by the Service, and administration of federal health law by the Department of Health and Human Services (HHS), progressed essentially independently of each other. Now, however, coordination is developing between the Service and several functions within HHS, including that organization's Office of Inspector General, which may affect the criteria for establishing and maintaining exempt status for hospitals.

While the tax and health laws are different, the overall thrust in some areas is similar. The Service is currently focusing on areas such as whether a hospital emergency room is open to the public, whether Medicaid patients are treated in a nondiscriminatory fashion, and whether a community benefit results from joint venture arrangements. These Service concerns are similar to HHS concerns stemming from COBRA and the anti-kickback statute. Recognizing a commonality of interests, IRS and HHS staff are now working together to better understand and more effectively pursue these issues.

This coordination and greater understanding is reflected in the Service's recent recognition that compliance with charitable trust law and the community benefit standard includes a requirement of compliance with federal anti-patient dumping standards and the anti-kickback provisions of the Medicare-Medicaid Fraud and Abuse statutes. The cooperation is also revealed in the analysis in GCM 39862, discussed earlier.

1. Relevant Federal Health Care Statutes

The federal health care statutes which are the chief subjects of the ongoing discussions between IRS and HHS are (1) the "anti-kickback" provisions, enacted in 1972 as part of the Medicare-Medicaid Fraud and Abuse sections of the Social Security Act and codified 42 U.S.C. sec. 1320a-7b(b), and (2) the "patient dumping" provisions of the Emergency Medical Treatment and Active Labor Act, first enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and codified at 42 U.S.C. sec. 1395dd.

Anti-Kickback Statute. The anti-kickback statute basically prohibits payments for referrals. The anti-kickback statute states as follows:

> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
>
> > (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare or Medicaid], or
> >
> > (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [Medicare or Medicaid] ...
>
> (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person --
>
> > (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare or Medicaid], or
> >
> > (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [Medicare or Medicaid],
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Section 1128(b) of the Social Security Act, as amended, 42 U.S.C. sec. 1320a-7b(b) (West Supp. 1990).

Final regulations, issued by HHS on July 29, 1991, specify certain payment practices that will not be subject to criminal prosecution under the anti-kickback law and will not provide a basis for civil exclusion from either the Medicare or Medicaid programs. These very detailed and specific "safe-harbor" regulations address such matters as investment interests, personal services and management contracts, equipment and space rental agreements, sale of physician practices to another physician, referral services, warranties, discounts, bona fide employees and group purchasing organizations. 42 C.F.R. sec. 1001.952 (1991).

Patient Dumping Law. The COBRA patient dumping law is designed to extend certain protections to all persons seeking emergency hospital care, regardless of whether those persons are Medicare beneficiaries, and regardless of their ability to pay. Its provisions apply to all hospitals that participate in the Medicare program (which nearly all hospitals do).

The anti-dumping provisions require that each Medicare participating hospital that maintains an emergency room must provide, within its level of capabilities, an appropriate medical screening examination to each patient presenting him/herself at the emergency room for treatment. They further require that a patient presenting him/herself at a hospital with an emergency medical condition must receive treatment until stabilized or appropriately transferred. Specific restrictions are placed on a hospital that attempts to transfer a patient prior to stabilization, and on the appropriate means of transfer generally. Sanctions for violation of the anti-dumping statute include (but are not limited to) civil money penalties and suspension or termination of a hospital's Medicare provider status.

2. Significance of the Relationship

Through the improved interagency coordination noted above, the Service now has a better appreciation and understanding of the Medicare/Medicaid laws enforced by HHS. The agency has sent a clear signal that the standards for exemption as a charitable hospital include compliance with the anti-dumping law and with the anti-kickback statute. See, for example, the Service's July 10, 1991 testimony to the Ways and Means Committee, the discussion in Part III of GCM 39862, and the new EO Hospital Audit Guidelines, MT 7(10)69-38 (Mar. 27, 1992) discussed below.

Hospitals must recognize that, under the Service's current view of the law, there is a distinct risk that their tax exempt status may be placed in jeopardy by conduct that violates the anti-dumping or anti-kickback provisions. It may well be inconsistent with IRC 501(c)(3) to continue recognizing tax exempt status for a hospital which has, for example, been sanctioned for excluding individuals from its emergency room for economic reasons or which has been convicted of paying kickbacks for patient referrals. Accordingly, the Service has added "patient dumping" and "anti-kickback" compliance concerns to the list of items that field agents are to consider when examining compliance of a tax exempt hospital with the requirements of IRC 501(c)(3). For example, agents are instructed to investigate the extent to which "radio triage," explained below, may be practiced by the hospital to avoid providing emergency care to indigents.

Patient dumping is a term used to describe denial of treatment to patients in an emergency medical condition or women in active labor, often by transferring them in an unstabilized condition to another hospital, such as a city or county hospital, that serves indigents. One apparent reason for such dumping is the hospital's attempt to avoid providing treatment to uninsured individuals or those unable to pay. Triage is a medical term for classifying patients according to the severity of their illness so that the sickest can be treated first. "Radio triage," however, refers to the less benign practice reported in some communities of assessing a patient's financial condition (e.g., insurance) by radio while enroute to a hospital, so that indigents can be directed elsewhere before they actually arrive at the emergency room and, thus, before the COBRA requirements technically apply. Personal interviews with ambulance drivers and social workers can help agents determine the extent to which this takes place.

Appreciation of the Medicare law may also affect Service enforcement in the area of hospital-physician recruitment incentives. The Service traditionally has focused on the compensation aspects of such arrangements. However, the Service is now more sensitive to the need to consider the extent to which such arrangements intentionally include payments to induce or reward patient referrals, and the extent to which they benefit the community.

Clearly, these matters are important to the Service's exempt organizations audit function. However, tax law specialists working rulings cases also must be cognizant of the need to consider anti-kickback issues that might be implicit in any rulings request submitted by a tax exempt hospital or affiliate. Hospital assertions that the arrangements in question, which may provide physicians with financial incentives to refer patients, are a positive or necessary way to further the hospital's charitable purposes should be scrutinized closely in the light of the foregoing discussion and the relevant documents cited therein. It is advisable to ask the organization to specify in detail the precise manner in which the proposed arrangement furthers the hospital's exempt purpose of promoting the health of the community. Arguments that the community benefits when the hospital's utilization or its bottom line is improved should no longer be accepted at face value; arrangements that merely shift costs to another health care provider or institution, or that improve the efficiency of one hospital at the expense of another or of some government body, should not be recognized as serving charitable purposes. Likewise, applications for exemption from hospitals or their affiliates, whether handled in the National Office or in the field, should be required to address those issues directly and to focus on complying with the Service's heightened awareness of hospital-physician economic relationships and the hospital community benefit standard.

B. Calculation of Medicare Cost Allocations in UBI

A recent G.C.M. demonstrates in another fashion the Service's growing familiarity with and attention to healthcare law. G.C.M. 39843 (April 5, 1991) considered the issue of whether automatically converting cost allocations from the hospital's Medicare cost report into tax deductions creates an accurate calculation of net unrelated business income tax liability. The G.C.M. concluded that the only expenses that may be deducted for purposes of calculating net unrelated business income tax liability connected with a trade or business are those that are otherwise defined as deductible under the Code and that bear a "proximate and primary relationship" to the carrying on of the unrelated trade or business. According to the G.C.M., simply applying Medicare costs as deductions may not be appropriate under either of those requirements and often will fail to determine accurately unrelated business taxable income. Specialists may need to look behind the numbers reported by the hospital to ensure that they meet the standards set forth in G.C.M. 39843.

5. Hospital Audits

The complex arrangements and other changes undertaken by tax exempt hospitals in response to the economic, competitive, and regulatory pressures, along with the Service's increased awareness of health issues and coordination with HHS, have led to a major hospital examination effort including such developments as new examination guidelines for auditing hospital systems, a tax exempt healthcare industry specialization program, a coordinated exam program, and an IRS Technical TV training videotape, Auditing Tax Exempt Hospital Systems (Wash., D.C. 1990), and companion publication Auditing Tax Exempt Hospital Systems - User Guide, Document 7656 (Sept. 1990). Through the new coordinated examination program, industry specialization program, and audit guidelines, the National Office has made clear its desire to obtain a better idea of what is actually happening in the tax exempt hospital community today. Through on-site assistance and formal requests for technical advice, the National Office hopes to be in a position to make available additional guidance and to encourage voluntary compliance for everyone in the tax exempt hospital field.

A. Coordinated Examination Program ("CEP")

A Coordinated Examination Program for hospitals and hospital systems was deemed necessary due to their increasingly business-like structure. As complex systems with multiple entities - some for-profit, some tax exempt - these

organizations present more opportunities to pay unreasonable compensation through multiple salary payments and pension plans and to hide other abuses.

Coordinated exams involve EP/EO revenue agents and other specialist revenue agents, as needed, including actuarial examiners, engineer revenue agents, excise tax revenue agents, international examiners, computer audit specialists, income tax revenue agents, and economists. Each key district has a coordinated examination procedures coordinator. The discussion of coordinated exam procedures for EP/EO is in IRM 7(10)(18)0, Examination Handbook. It lists some criteria defining a coordinated examination and some of the factors that go into the selection of particular organizations for audit.

A CEP has already been under way in all seven key districts. Although the goal was to accomplish 14 coordinated examinations of tax exempt hospitals and/or hospital systems, in the 1992 fiscal year, 21 examinations were under way in the latter part of that year.

The IRS Technical TV training videotape, Auditing Tax Exempt Hospital Systems (Wash., D.C., 1990) and the companion publication Auditing Tax Exempt Hospital Systems - User Guide, Document 7576 (Sept. 1990), were designed to introduce the concept of large case, coordinated exempt organization examinations in a specific context. The video supports the large case hospital system audit efforts by presenting a discussion of the need for these examinations, the challenges they present, and the resources available to assist EO specialists in completing them. Officials from several Service and Chief Counsel functions examined how large case principles were used in a Dallas-based pilot hospital system examination conducted in 1990, and commented on how their functions relate to the coordinated examination approach.

The videotape also refers to IDRs (Information Document Requests). IDRs are used from the start of an examination to request documents from the taxpayer. IDRs are now asking for, among other items, copies of physician recruitment plans, guaranteed income agreements, loan agreements, joint venture agreements, and deferred compensation arrangements.

The User Guide presents in printed form the background, resources, research materials and other helpful information to support the video presentation. A sanitized IDR from a hospital system audit that can be used as an example is included in the User Guide.

B. Health Care Industry Specialization Program ("ISP")

An Exempt Organizations Health Care Industry Specialization Program (ISP) was established in 1991. It is centered around an ISP team consisting of the EO health care industry specialist, the National Office EO ISP Coordinator, representatives from the Associate Chief Counsel (EB/EO), a representative from EO Technical Division at the National Office, and two ISP Counsels from District Counsel staff. Examination Division also has a Health Care ISP. The Exam team works with the EO team providing comprehensive coverage of the industry and coordination with respect to overlapping issues.

The role of the EO Health Care ISP will primarily revolve around coordinating selected issues common to the health care industry, and assisting in resolving those issues uniformly and consistently among all industry taxpayers. The ISP will establish a channel of communication and promote the accumulation of knowledge necessary for better identification and development of issues. This will be accomplished through the preparation of position papers. The ISP will also prepare periodic digests, prepare a report on the industry, determine industry identified cases, prepare "Alert" memorandums regarding industry practices, conduct industry conferences and be a source of support and communication for all field personnel engaged in the examination of health care organizations.

The ISP should result in improved examination by the Service of health care organizations. For a more detailed description of the EP/EO Industry Specialization Program see IRM 7(10)(17)0, Examination Handbook.

C. Hospital Audit Guidelines

The Service's more disciplined approach toward non-profit hospitals that may be misusing their tax exempt status for private gain was manifested most recently in the release of detailed new examination guidelines for field auditors, published in MT 7(10)69-38 (Mar. 27, 1992). The guidelines reflect the Service's increasing sophistication in the healthcare field, and include certain issues that may help encourage compliance with the tax law as well as the anti-dumping and anti-kickback provisions discussed earlier.

Under the new guidelines, auditors are advised to evaluate the factors listed in Rev. Rul. 69-545, to determine if a hospital meets the community benefit standard. Community benefit factors for auditors to examine include (1) emergency room criterion, with greater emphasis on conducting firsthand interviews, looking for

posted signs regarding ER availability, and determining whether deposits are required from uninsured patients; (2) ability-to-pay factor, including hospital admissions practices, Medicare/Medicaid admissions and charity care; (3) open medical staff standard, looking at meeting minutes and credential criteria; and (4) governing board element, to determine the extent to which the Board is composed of independent civic leaders and the extent to which a hospital that is part of a multi-entity system complies with appropriate corporate formality requirements.

The new procedures are also aimed at uncovering a number of hybrid business arrangements that the Service believes were potentially created to confer non-incidental private benefits on doctors or hospital administrators. Under the new guidelines, examiners and specialists are directed to give particular attention to a hospital's outside business relationships and to arrangements with doctors and other staff. Some of the issues highlighted include the following:

(1) being alert for any loan agreement at less than prevailing interest rates;

(2) scrutinizing any business arrangements under which hospitals finance the construction of medical buildings owned by staff doctors on favorable financial terms that may result in inurement or more than incidental private benefit;

(3) scrutinizing contracts and leases entered into by hospitals and examining minutes of board meetings, looking for conflicts of interest;

(4) looking at recruitment incentives used by hospitals or other types of transactions that could reflect inurement or private benefit; and

(5) paying increased attention to specialized financial arrangements within hospitals to ensure that hospital earnings from a specific department are not inuring to the benefit of private doctors, either directly or via joint business ventures.

The new guidelines replace the old general descriptions of practices that may violate tax exemption criteria with new detailed suggestions of where and how auditors should look for suspect practices. For instance, they urge auditors to (1) personally interview ambulance drivers to determine if a hospital regularly refuses to accept indigent patients, (2) determine whether the proportion of services provided to Medicaid patients squares with the proportion of Medicaid recipients in a hospital's service area, and (3) interview emergency room staff, social workers, and physicians about emergency room policies and practices. The guidelines also recommend that examiners contact government agencies, such as HHS, for possible COBRA violations and Medicaid agencies to determine the number of beneficiaries in the area.

6. Employment Taxes

An important item in exempt hospital audits is employment tax issues. In 1989, exempt organization agents were given primary responsibility for verifying the employment tax liability of the organizations they examine. Employment tax is a big dollar issue, particularly pertinent for large employers, including hospitals.

Frequently in the hospital setting, as elsewhere, there are disputes as to whether workers are employees or independent contractors. While doctors are often considered independent contractors, the new hospital audit guidelines note that in some cases their status is more like regular employees whose income should be subject to employer withholding taxes.

Another area of contention has been the student nurse exception cited in IRC 3121(b)(13). Under IRC 3121(b)(13), service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law is a form of employment exempted from FICA tax. The Service's interpretation of this Code provision is expressed in Rev. Rul. 85-74, 1985-1 C.B. 331.

Rev. Rul. 85-74 concluded that an individual must satisfy three requirements to qualify for the student nurse exception: (1) the employment must be substantially less than full-time; (2) the total amount of earnings must be nominal; and (3) the only services performed for the employer must be incidental parts of the student training toward a degree that will qualify the individual to practice as a nurse or in a specialized area of nursing. Some hospitals, on the other hand, wanted to substantially expand that definition to include in the meaning of "student nurse" anyone who is both a student of nursing and performs nursing related duties, whether or not the nursing duties relate to the training of that person.

The Service's position in Rev. Rul. 85-74 has now been upheld in a recently decided employment tax case, Johnson City Medical Center Hospital v. U.S., 783 F. Supp. 1048 (E.D. Tenn. 1992). In this case, Johnson City Medical Center sought to obtain refunds, based on the student nurse exception, of FICA taxes paid in each tax quarter of 1985 and 1986. The nurses at issue did not meet the criteria of Rev. Rul. 85-74. The court found that the services were not incidental parts of the student nurses' training for a degree because they were sporadic and seemingly unconnected to any type of pattern or plan, and the amount of earnings was not nominal because

student nurses were compensated the same as other employees who worked the same number of hours. As a result, the court held that, pursuant to Rev. Rul. 85-74, the services of the student nurses are not exempted from employment under IRC 3121(b)(13) of the Code. The hospital's claim was dismissed.

For a more in-depth discussion of employment tax, see the Employment Tax Article in the 1992 EO CPE Text.

7. Managed Care Organizations

One of the most challenging issues in the health care field is the tax treatment of nonprofit managed care organizations. These include Health Maintenance Organizations (HMOs), Individual Practice Associations (IPAs), and Preferred Provider Organizations (PPOs). Chief Counsel recently issued three significant G.C.M.'s that dealt with HMO topics. These G.C.M.s and the effect of IRC 501(m) on HMOs was discussed in the 1992 EO CPE text beginning on page 258.

A. Background on HMO's

HMO's come in four varieties. There is the "staff model," in which care is provided in a central location by physicians and others working as salaried employees of the HMO; the "group model," in which care is again provided in a central location, this time by physicians practicing in an existing group practice that contracts with the HMO; the "IPA model," the most common, in which care is provided by physicians practicing individually in their own offices, usually contracting with the HMO through an intervening individual practice association; and the "network model," in which care is provided by a network of groups and physicians practicing independently. An HMO may operate in a manner that combines two or more of these characteristics, in which case it is called a "mixed model."

It is important to note the distinction between an IPA-model HMO and the individual practice association itself. The IPA is usually a separate, related or unrelated, physician-controlled entity. As discussed below, IPA's are usually not exempt because they are viewed as being operated primarily to benefit their physician members.

To qualify under IRC 501(c)(3), an HMO must meet the Sound Health test. This is a test based on the Tax Court case Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978), acq., 1981-2 C.B. 2. The Service's chief argument in Sound Health was that the organization existed primarily to serve the private interests of its

members, rather than the community as a whole. The Tax Court disagreed. It found that because this HMO's membership was so open and unrestricted, any benefit to the members was benefit to the community. The court went on to apply the hospital community benefit test of Rev. Rul. 69-545 to the Sound Health HMO. The Service has acquiesced in this case and thus applies that same analysis to HMO applicants seeking exemption under IRC 501(c)(3). The Sound Health test is a facts and circumstances test, but a rather restrictive one, incorporating 14 points that characterize an IRC 501(c)(3) qualifying HMO. See pertinent articles in the EO CPE Texts for 1979-1982 for a comprehensive background.

Chief Counsel has issued three recent G.C.M.s that make clear that the Service will continue to rely on the Sound Health test for exemption under IRC 501(c)(3) for HMOs. G.C.M. 39828 (August 30, 1990) applies the test to two non-staff model HMOs and finds that they do not qualify because there is insufficient community benefit. G.C.M. 39829 (August 30, 1990) carefully reviews the Service's position on all types of HMOs. It acknowledges that the Sound Health test is difficult for most HMOs to meet.

In G.C.M. 39830 (August 30, 1990), Chief Counsel concluded that a separately incorporated non-staff model HMO that is controlled by the exempt parent of a healthcare system and that does not meet the Sound Health test on its own can not turn around and qualify under IRC 501(c)(3) as an integral part of its tax exempt parent. The subject HMO wanted to take advantage of the charitable activities provided by other corporations that were part of the hospital system. It did not have an emergency room of its own but it wanted to rely on the emergency rooms of the hospitals that were brother-sister subsidiaries of the same system parent. Chief Counsel determined that the HMO did not meet the criteria to be considered an integral part of the hospitals or to merit an exception to the well-established principle that the Service will respect corporate separateness. (Counsel notes dryly that accepting the HMO's view could require the Service to attribute the noncharitable characteristics of the for-profit subsidiaries in that system to the HMO as well.)

The organization argued in favor of a derivative theory of exemption based on a concept of attribution culled from language in regulations under IRC 502 that refers to a subsidiary that is exempt "on the ground that its activities are an integral part of the activities of the parent." Counsel concluded that Reg. 1.502-1(b) does not provide a separate route to exemption. IRC 502 bars exemption for feeder organizations, and Reg. 1.502-1(b) simply provides examples of certain subsidiary organizations not subject to that bar. To be an integral part of an exempt parent under existing precedents, a subsidiary's activities must be ones that would not be an unrelated trade

or business if performed by the parent. Equally important, there is a threshold requirement that the subsidiary provide essential services to the exempt parent or related exempt entities, or to employees, patients, or students of the parent.

G.C.M. 39830 reasoned that operating a non-staff model HMO, such as the subject HMO, would not be substantially related to furthering an exempt hospital's charitable purposes because non-staff model HMOs primarily serve their own members who are drawn from the general public and are not patients of the hospitals in question. These are not persons who are viewed as related to the tax exempt hospital. The G.C.M. does suggest that the same analysis might not apply to a staff model HMO operated by a hospital system. In that situation the HMO itself directly provides medical services to patients, which may be sufficient to transform them into patients of the hospital under the rationale of Rev. Rul. 68-374, 1968-2 C.B. 242 (circumstances in which an exempt hospital derives unrelated business taxable income from the sale of pharmaceutical supplies to the general public); Rev. Rul. 68-375, 1968-2 C.B. 245 (sale of pharmaceutical supplies by an exempt hospital to private patients of physicians with offices in a hospital-owned medical building constitutes unrelated business; and Rev. Rul. 68-376, 1968-2 C.B. 246 (situations in which persons who purchase pharmaceutical supplies from an exempt hospital are considered "patients" of the hospital for purposes of determining whether the hospital is engaged in unrelated business). Moreover, a staff model HMO, the G.C.M. noted, may be able to qualify under the Sound Health test on its own.

B. Recent HMO Litigation

The Tax Court recently issued a memorandum decision that appears critical of the Service's application of the Sound Health test in determining the IRC 501(c)(3) status of non-staff model HMOs. In Geisinger Health Plan v. Commissioner, T.C.Memo 1991-649 (1991), the Tax Court held that a hospital-affiliated, non-staff model HMO could be granted exemption under IRC 501(c)(3). The court determined that the HMO was incorporated primarily to provide or ensure the provision of medical services and operated for public, rather than private, interests. It decided that the Service's determination that the Health Plan was not operated for the benefit of the community was erroneous. Although the HMO served mostly large employer groups and medically screened its individual members, those were not substantial restrictions according to the court. The court concluded that, as operated, the Health Plan's membership was practically unlimited, and the benefit to its membership was benefit to the community.

The decision does not rely entirely on the Sound Health test, which was derived from the only other case that considered the issue, but instead looks to the HMO's purpose of promoting health. The Service believes that Geisinger should not have been given charitable status on that basis because it was not engaged in the types of activities that demonstrate charitability under the Sound Health test or Rev. Rul. 69-545. The Sound Health standards are admittedly difficult for many modern HMOs (i.e., non-staff model HMOs) to meet. This is because the Sound Health case compared HMOs to hospitals which themselves must meet certain standards to demonstrate charitability. It should be remembered that most HMOs still qualify as social welfare organizations exempt under IRC 501(c)(4) notwithstanding their inability to meet the stricter IRC 501(c)(3) test. At this time, the Service is still considering whether to appeal Geisinger.

C. IPAs and PPOs

A few years ago there was much controversy over whether IPA's should be considered tax exempt. Rev. Rul. 86-98, 1986-2 C.B. 74, settled the question by concluding that the typical physician-controlled IPA generally will not qualify for exemption because it is viewed as operated primarily to benefit the physician members. In fact, if the physician-controlled IPA itself controls the IPA-model HMO with which it contracts, the HMO may not qualify for exemption. G.C.M. 39763 (October 13, 1988) was read by some to suggest that certain IPA-type organizations could qualify under IRC 501(c)(4). However, the G.C.M. involved extremely unusual, narrow facts and it does not state any new rule. Chief Counsel made this clear in a footnote to G.C.M. 39799 (October 25, 1989).

G.C.M. 39799 sets forth Service thinking regarding PPOs. It concludes that the typical provider-sponsored PPO, one that is sponsored, for example, by a hospital and a group of physicians practicing there, probably would not qualify due to excessive benefit accruing to the sponsoring physicians. The G.C.M. suggested that most PPOs would be subject to the same analysis as IPAs under Rev. Rul. 86-98.

8. Conclusion

Hospitals and the health care field in general, will no doubt remain in the forefront as a hot EO topic. The industry continues to evolve rapidly with new and complex organizational structures and arrangements. The Service, through its increased dialogue with other agencies such as HHS, its intensified audit program and guidelines, its ISPs and CEPs, and its improved understanding of hospital operations, industry trends, economic pressures, and intentions, hopes to keep up with this

critical and challenging area. Our goal is to ensure that exempt hospitals and other providers in the non-profit health care field remain charitable and continue to focus primarily on benefiting the community rather than private interests.

Epiloque

In a speech to hospital trustees on June 6, 1992, Richard J. Davidson, president of the American Hospital Association, said that during the 1980's hospitals had moved far afield from their primary mission of providing community care. Hospitals tried to put each other out of business, he noted. "We're not in business to be a business," Davidson said, urging a return to "high ideals" in hospital care. (Quoted in The Washington Post, June 9, 1992 (Health).) To that, the Service can only add, "Amen."