J. DEVELOPMENTS IN HEALTH CARE

1. Introduction

The health-care field is a multi-billion dollar industry in the United States. At different ends of the spectrum, health care may be motivated by purest altruism or the unalloyed pursuit of profit. It is a charity and a business; it may be animated by religion, compassion, and love, but it survives in a highly competitive area only by sharp management, shrewdness, and an eye for opportunity. Further, it exists now in a state of rapid and continuous change, some of its revolutionary. Governments, at all levels, are deeply involved in the industry, and in the changes. For these reasons and more, the health-care field remains one of the most challenging ones in the work of exempt organizations specialists.

As a quick glance at any of the myriad publications and seminars on medical economics will reveal, the current emphases in the field are cost-containment, risk and service sharing, economies of scale, joint ventures, outreach programs, conversion to for-profit operation, and the like. In this setting, for-profit and nonprofit entities co-exist sometimes uneasily. The unrelated business income tax is one of the means by which the federal government attempts to provide a level playing field for the two without disturbing their unique features and traditional roles in health-care delivery.

This topic updates CPE topics from prior years on health care. It focuses primarily on unrelated business issues, and on conversions from nonprofit to for-profit operation.

2. Recent Publications

In an important unrelated income case, St. Luke's Hospital of Kansas City v. U.S., 494 F. Supp. 85 (W.D. Mo. 1980), a district court considered a teaching hospital that operated a pathology laboratory in which tests were made on specimens received from patients of St. Luke's Hospital's staff doctors in the course of their private practices. The hospital argued that these tests produced only related income because they contributed importantly to one of its exempt purposes, medical education. The court agreed, accepting St. Luke's contention that, by increasing the number of specimens available for study, the outside testing improved the hospital's teaching program. Because this argument was not anticipated and thus contrary data was not secured before the trial, the Service

could not contest the facts and did not appeal. St. Luke's also argued that the "convenience of members" exception of IRC 513(a)(2) applied to except the testing from unrelated business income because the testing was done for the convenience of its staff doctors, who were "members" of the hospital for purposes of the exception. Although the latter argument was not essential to the outcome of the case since the former had already been accepted, the court nevertheless responded in favor of the convenience argument as well.

As was pointed out on page 37 of the 1984 CPE text, the Service has unresolved doubts about the factual basis for the first conclusion, and disagrees with the legal authority for the second.

Rev. Rul. 85-109, 1985-30 I.R.B. 17, places squarely on the record that the Service will not follow that portion of the decision in St. Luke's that held the hospital's testing of referred specimens from private patients of its staff physicians to be not related because of the "convenience" exception. It is the stated position of the Service that staff physicians are neither "members" nor "employees" of the hospital within the meaning of the exception.

Because the unrefuted facts in St. Luke's show that the testing services provide a supply of specimens needed in the hospital's teaching program, Rev. Rul. 85-109 states the Service will follow that part of the decision which holds this activity related. However, it should be noted again that this is a factual determination that should be subject to close scrutiny since it remains our belief that it would be a rare situation where a teaching hospital's in-patients did not supply it with enough testing specimens, including abnormal ones, for it to conduct a thorough medical education program.

Rev. Rul. 85-110, 1985-30 I.R.B. 18, recites and supports the general rule that the providing of laboratory services to nonpatients of a hospital constitutes unrelated trade or business, but it also describes a few unique circumstances that may exist in which these same services may further the exempt function of the hospital and thus may be considered related. For example, in an emergency situation, referral of nonpatient specimens to private laboratory testing facilities may be detrimental to the health of nonpatients suffering from drug overdose or poisoning. In addition, private laboratories may not be available within a reasonable distance from the area served by the hospital or may be unable to conduct tests needed by nonpatients. In these situations, a hospital's testing program would further its exempt function of promoting the health of the community.

A hospital's claim that its testing program is not subject to the unrelated business income tax based on one of the above circumstances should also be closely scrutinized. The unavailability of private laboratory testing facilities in a particular area is a question of fact that is verifiable during an examination. Likewise, claims that commercial labs do not perform certain types of testing can also be confirmed or refuted.

The following are a few additional representative sample rulings that have been issued by the Exempt Organizations Technical Division that deal with the subject of laboratory services provided by hospitals. (Bear in mind that letter rulings, even those that have been released under IRC 6110, may not be used or cited as precedent, but can be helpful to you in analyzing analogous situations and refining your own thinking.)

A. Application of the General Rules

- Rev. Rul. 68-376, 1968-2 C.B. 246: definition of patients

- Letter Ruling 8317003: general discussion of IRS position

- Letter Rulings 8050105; 8131063: laboratory testing of referred specimens of patients of private physicians - unrelated trade or business

- Letter Ruling 8230005: laboratory tests for nonpatients and for patients of exempt hospitals with over 100 beds - unrelated trade or business

B. Exceptions to the General Rules

- Letter Ruling 8305115: laboratory and radiology services by hospital in isolated rural area held related

- Letter Ruling 8417002: rapid turnaround time for testing indicated relatedness

- Letter Ruling 8325007: educational function supported ruling of relatedness

- Letter Ruling 8135016: IRS rejects definition of members in St. Luke's

3. IRC 513(e)

IRC 513(e) provides that the term "unrelated trade or business" does not include a hospital's furnishing of one or more of the services listed in IRC 501(e)(1)(A) to other hospitals if: (1) the services are furnished solely to hospitals with facilities for not more than 100 inpatients; (2) the services would be related if performed by the recipient hospital on its own behalf; and (3) the services are performed at no more than actual cost as defined in that section.

The services listed in IRC 501(e)(1)(A) are:

(1) Data Processing

(2) Purchasing

(3) Warehousing

(4) Billing and Collection

(5) Food

(6) Clinical (added by the Tax Reform Act of 1976)

(7) Industrial Engineering

(8) Laboratory

(9) Printing

(10) Communications

(11) Record Center, and

(12) Personnel Services (including selection, testing, training, and education of personnel)

The services listed in IRC 501(e)(1)(A) are of a nature that would, under most circumstances, be considered unrelated trade or business when provided by an exempt hospital even if provided to another hospital. (However, see the discussion of laboratory services above. Similar rationale might be applied to

clinical services.) IRC 513(e) provides a limited exception to this rule. This exception, however, does not apply to services not listed in IRC 501(e)(1)(A), including laundry services.

If a large hospital provides a permitted service to ten hospitals, only one of which has facilities for more than 100 inpatients, IRC 513(e) has been interpreted as providing that the revenue generated from that particular service to all ten hospitals is not excluded from the unrelated business income tax. Likewise, if the provision of any permitted service violates any one of the strictures of IRC 513(e), then all the income from that particular service is unrelated. This results from the use of the word "solely" in IRC 513(e)(1). Regulations under IRC 513(e) have not been finalized. Proposed regulations, issued December 13, 1982, contain the following example which illustrates the operation of the statute:

> A large metropolitan hospital provides various services to other hospitals. The hospital furnishes a laboratory service to hospitals N and O, a data processing service to hospitals R and S, and a food service to hospitals X and Y. All the hospitals are described in section 170(b)(1)(A)(iii). All the hospitals have facilities to serve not more than 100 inpatients except hospital N. The services are furnished at cost to all hospitals except that hospital R is charged a fee in excess of cost for its use of the data processing service.
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> The laboratory service constitutes unrelated trade or business because it is not provided solely to hospitals having facilities to service not more than 100 inpatients. The data processing service constitutes unrelated trade or business because it is provided at a fee in excess of cost. The food service satisfies all three requirements of paragraph (a) of this section and does not constitute unrelated trade or business.

For purposes of this exception to UBI, the proposed regulation defines "cost" as including straight line depreciation and a reasonable return on the capital goods used to provide the service. Reasonable return is defined as not exceeding annually 1 1/2 times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund during the coinciding months of the hospital's year.

4. Other Unrelated Business Income Issues of Hospitals

The issue of the unrelated business activities of hospitals has been extensively discussed in previous CPE Texts.

The National Office was recently presented with the issue of a teaching and research hospital in a major metropolitan area conducting drug testing performed under agreement with commercial drug companies. See PLR 8230002.

The testing is performed under the supervision of staff physicians, primarily by research and clinical fellows. The results are presented and discussed at departmental and scientific meetings and are also published in medical journals. At least 90% of all drug testing performed for the drug companies is Phase I and Phase II clinical pharmacology work, for which prior Food and Drug Administration approval is required. Phase I studies cover the introduction of a drug for human use with the purpose of determining human toxicity, metabolism, absorption, and other pharmacological action. Phase II covers the initial trials on a limited number of subjects for specific disease control.

The hospital also performs certain Phase III testing. Phase III consists of clinical trial work and provides an assessment of the drug safety, effectiveness, and optimum dosage schedules. Phase III testing generally involves large scale testing performed directly prior to obtaining FDA approval of the drug for marketing.

The hospital's "for-benefit" drug testing includes those studies in which drugs are offered to its patients who have the disease for which eventual commercial use of the particular drug is intended.

The hospital's "not-for-benefit" drug testing includes the remaining drug studies it conducts. Approximately one-half of this work is Phase I and Phase II work performed on volunteers, some of whom are hospital patients receiving care for an unrelated medical reason, to test the metabolic levels and toxicity of the drug. Most of the other half involves the study of the metabolism and action of drugs already on the market.

Section 512(b)(8) provides that, in the computation of unrelated business taxable income, in the case of a college, university, or hospital, there shall be excluded all income derived from research performed for any person, and all deductions directly connected with such income.

Section 1.512(b)-1(f)(4) of the regulations provides that "research" does not include activities of a type ordinarily carried on as an incident to commercial or industrial operations, for example, the ordinary testing or inspection of materials or products.

Rev. Rul. 68-373, 1968-2 C.B. 206, describes a nonprofit organization primarily engaged in testing drugs for commercial pharmaceutical companies. The tests are required in order to meet FDA requirements. The companies select the drugs and use test results in their FDA applications. Test results are also made available for publication in scientific journals. The Service concluded that the clinical testing is an activity ordinarily carried on as an incident to the commercial operations of the drug companies. The testing is therefore not scientific research under section 1.501(c)(3)-1(d)(5)(i) of the regulations. The testing also principally serves the private interest of the drug company rather than the public interest. The organization thus fails to qualify for exemption under IRC 501(c)(3).

Our ruling observed that the hospital's for-benefit and not-for-benefit drug testing must each be given separate consideration. Each kind of testing represents an activity which serves multiple purposes.

In the for-benefit situation, although the testing serves the business purposes of the sponsoring drug company by enabling the manufacturer to meet FDA requirements for marketing, we held in this case that the testing also serves patient care purposes and adds to the body of available scientific knowledge concerning drug use. The testing activity is therefore distinguishable from that described in Rev. Rul. 68-373, based on the relationship to patient needs. The activity is also distinguishable because it is less closely related to the manufacturer's obtaining FDA approval. The for-benefit activity is, therefore, not an incident of the commercial operations of the drug companies.

The hospital's not-for-benefit studies are also not as closely related to FDA final approval as are the studies described in Rev. Rul. 68-373. However, these studies are not directly related to the hospital's patient care purposes. Accordingly, in weighing the private purposes served against the charitable purposes served by the studies, we have concluded that the private purposes outweigh the charitable purposes of the not-for-benefit studies. The not-for-benefit studies are, therefore, unrelated trade or business under IRC 513(a).

The modification provided by IRC 512(b)(8) is not applicable to M's not-for-benefit studies. Because these studies lack the patient care relationship of the for-benefit studies, we have concluded that they should be treated as not being "research" within the meaning of IRC 512(b)(8) but an activity ordinarily carried on as an incident to the drug manufacturer's commercial operations within the meaning of section 1.512(b)-1(f)(4) of the regulations.

A recent newspaper article referred to several situations in which exempt organizations, including hospitals, order drugs in excess of their needs from drug manufacturers at reduced rates. The organizations would then sell the drugs at a profit to another company which resells the drugs. The exempt organization may not receive these drugs directly but may divert shipments from the drug manufacturer directly to the "drug diverter" company for resale. The article refers to a specific financing scheme where the exempt organization sells the drugs at cost and receives a "contribution" to its building fund in the amount of profit from the sale.

The Service's position, that these types of sales transactions are considered UBI, is clear. (See Rev. Ruls. 68-374, 68-375, 68-376, 1968-2 C.B. 242-246 and Rev. Ruls. 85-109, 85-110, 1985-30 I.R.B. 17 (July 29, 1985).) For further information on this subject, see The Wall Street Journal, August 6, 1985.

Following are some additional representative sample rulings relating to pharmacy sales and other potentially unrelated activities conducted by hospitals:

- Rev. Rul. 68-376, 1968-2 C.B. 246: when persons who purchase drugs from hospital pharmacy are considered "patients" for purposes of the convenience rule exception to unrelated trade or business under IRC 513(a)(2)

- Rev. Rul. 68-375, 1968-2 C.B. 245: hospital operating satellite pharmacy in medical office building making sales to private patients of physicians engaged in unrelated business - Not for convenience of hospital patients under IRC 513(a)(2)

- Rev. Rul. 68-374, 1968-2 C.B. 242: occasional sales to patients of doctors maintaining offices in hospital: not regularly carried on - casual sales exception: Reg. Section 1.513-1(c)(2)(ii)

- Letter Ruling 7721030: pharmacy sales to nursing home: related

- Letter Ruling 7729002: pharmacy sales to MD patients: unrelated

- Letter Ruling 7738002: pharmacy sales to employees: related

- Letter Ruling 7739057: pharmacy sales by HMO to members: related

- Letter Ruling 8314002: sale of drugs in rural area: related

- Letter Ruling 8349006: sale of drugs to hospital-based group practice held related under special circumstances

- Letter Ruling 8404077: billing and collecting for hospital-based group practice related under certain circumstances

- IRS Letter Ruling 8407099: malpractice insurance for doctors through subsidiary produced dividend income; not UBI

- IRS Letter Ruling 8402084: management of skilled nursing facility was not unrelated

- IRS Letter Ruling 8411093: income from CAT scans for hospital patients not unrelated business income

- IRS Letter Ruling 8452011: income from sale of silver recovered from x-ray processing and from doctor paging service: related

- Letter Ruling 8301092: operation and management of alcohol treatment center is related

- Letter Ruling 8323074: general physical fitness program is related activity

- Letter Ruling 8305133: temporary operation of patient service facility by hospital educational organization is related

- Letter Ruling 8318089: provision by medical school of utilities to affiliated teaching hospitals is related

- G.C.M. 38987: sale by university of utility services to affiliated teaching hospitals of university's medical school does not constitute unrelated trade or business once such services are provided at a rate substantially below cost and the university foregoes any rights to recoup the subsidies to be earned by the hospital

- IRS Letter Ruling 8338068: operation of mobile CAT scanner for benefit of unrelated health care institutions and their patients held related; application of uniqueness approach

5. Joint Ventures

The subject of joint ventures involving hospitals has been explored in some detail in several earlier CPE articles, and we will not belabor it again here. (See, for example, the extended discussion of joint ventures involving medical office buildings beginning on page 22 of the 1984 CPE.) However, the following observations made by a speaker at a recent seminar of the National Health Lawyers Association are worthy of note:

> "Hospital's role may be structured so that economic return to hospital is in form of tax-exempt, passive income - i.e., rent, interest, or dividends... Note, however, that if the payor of interest or rents is controlled by the hospital, or if the debt rules apply, income may lose its exempt character ... Conceivably, interest and rent may be stated as a percentage of the gross receipts of the payor ... Special considerations apply where exempt organization becomes general partner in partnership with non-exempt persons ... IRS has recently approved such arrangements in limited contexts, but guidelines are unclear ... The safe approach is to insulate the exempt organization by causing a for-profit, taxable sub to become general partner ... If activity of venture is unrelated, exempt status may be lost if such activity, together with other unrelated business, is more than

insubstantial part of total activities ..." (quoted from a talk by Ross Stromberg, Esq., of Hanson, Bridgett, Marcus, Vlahos and Stromberg, San Francisco.)

6. Conversion from NonProfit to For-Profit Status

The 1983 CPE Text, p. 47, included a discussion of the conversion of for-profit organizations to nonprofit status. In the health care area, the opposite is becoming common: some health maintenance organizations and a few hospitals are abandoning their nonprofit status to become profit-making companies. In addition, we are aware of an exempt hospital corporation that sold its assets (the hospital) for cash. Prior to the sale, the hospital was properly classified under IRC 509(a)(1) and 170(b)(1)(A)(iii). The hospital corporation remained in existence, but its only activity became grant-making from its recently acquired endowment.

The reasons for HMO conversions are numerous. At bottom, there is the fact that the federal Government itself now encourages them. Under the 1973 Federal HMO Act, many of the legal and financial restrictions that had theretofore restrained the growth of HMOs were removed, and indeed the Act provided for start-up grants and for loans and loan guarantees for federally qualified HMOs (i.e., HMOs that met numerous standards including relatively open enrollment policies and "community-rated" premiums). A 1981 amendment to the Act made these loans and guarantees available for the first time to for-profit HMOs.

Thus, the growth of the HMO industry was sparked and sustained by federal initiatives and funds through the 1970s; but a continuing supply of capital is needed to keep HMOs competitive and, in accordance with its belief that such financial support should come from the private sector, this administration has phased out direct federal aid. The last federal grants were issued in 1981 and the last loans in 1983.

Nonprofit HMOs have limited options for raising funds. Indeed, the Service's reluctance to grant 501(c)(3) rather than 501(c)(4) status to these organizations in part contributes to their problem. Bond issues may be a partial solution, but are, for a variety of reasons, difficult and risky. For-profit entities, on the other hand, have greater flexibility; they have free access to private capital through the sale of equity interests, and are tapping this source quite successfully. Moreover, equity participation by the doctors, hospitals, employers, and subscribers provides all with a financial stake in cost-effective operations, and stock options enable for-profit HMOs to attract and retain talented personnel.

Consequently, although it was logical in the 1970s for HMOs to organize as nonprofits in order to qualify for federal money, with that source now removed, most new HMOs are organized as for-profits, and many older ones are looking hard at conversion in order to seek private investment and removal of the restraints imposed by nonprofit operation. As of the end of 1984, eighteen HMOs had switched. The federal government has made it clear that it actively supports these conversions. For example, the government has sponsored studies and conferences to promote private investment in HMOs, and there is a "Private Sector Initiatives Division" in the Office of Health Maintenance Organizations within the Department of Health and Human Services.

The conversion of exempt organizations to for-profit status may present difficult questions for the examiner as well as generate ruling requests on the effect of these transactions. See the 1985 CPE Text, p. 139. For example, IRC 501(c)(3) organizations must permanently dedicate their assets for exempt purposes. The conversion process cannot change this principle. Permanent dedication of assets does not apply to IRC 501(c)(4) and the great majority of other exemption categories.

These transactions should be negotiated at arm's length with independent parties. Full value, supported by appraisal, should be paid. No portion of the sales proceeds may inure to the benefit of any private individual.

At present, we are unaware of any IRC 501(c)(3) health maintenance organizations that have converted. According to the Office of Health Maintenance Organizations in the Department of Health and Human Services, the HMO's that have converted were exempt under IRC 501(c)(4). Therefore there are no restrictions, as far as the Internal Revenue Service is concerned, on the assets during such a conversion. There may be state laws governing these transactions.

We have been monitoring litigation involving an exempt hospital corporation that sold its assets to a for-profit hospital corporation. The issue in this case involves the foundation status of the shell of the exempt hospital corporation whose sole remaining asset is cash. After the sale, the organization received no fees for services, one type of support that qualifies an organization as a public charity under IRC 509(a)(2). (The hospital corporation, which no longer operates the hospital, cannot qualify under IRC 509(a)(1) and 170(b)(1)(A)(iii).) However, Regs. 1.509(a)-3(c)(1)(3) provides for a four/five year averaging period for organizations attempting to qualify as a public charity under IRC 509(a)(2). Since

the hospital corporation had large amounts of fee-for-service income prior to the sale, the organization will qualify for IRC 509(a)(2) status, as it satisfies the "normal" support test of IRC 509(a)(2) through the year of sale. It may also qualify for IRC 509(a)(2) for one or two years after the sale because of the large amount of fee-for-service income prior to the sale. At the end of this period, the organization may generate other sources of public support or qualify under another paragraph of IRC 509(a).

The conversion trend is expected to continue in the future; determination and examination personnel should be aware of the problems inherent in these circumstances.