L. FEDERAL TAX EXEMPTION OF PREPAID HEALTH CARE PLANS AFTER IRC 501(M)

by
Leah D. Embry Thompson and Robert K. Kolbe

1. Introduction

Few economic issues are of more interest to the American public today than the costs of medical care and how best to meet them. According to the Washington Post, April 29, 1991, at A.5, personal expenditures on health in the United States increased to 12.2 percent of the gross national product in 1990, totaling $666 billion. The competition for the medical care coverage dollar has become a lot tougher. Thus, health care organizations are changing their operations to successfully compete to secure those medical care dollars.

Prepaid health care plans are voluntary plans which provide individuals (or groups) with a vehicle to prepay medical expenses. The individual (or group) pays a fixed fee with the understanding that when the need for hospitalization or other medical services arises the prepaid health care plan will either cover the costs or provide the needed services. In the Tax Reform Act of 1986, Congress decided it was time to take a look at the propriety of the continuing exemption for prepaid health care plans under IRC 501(c)(3) and (4). Specifically, Congress took a look at the tax exemption afforded Blue Cross/Blue Shield (hereinafter the Blues) and other service benefit plans. Congress looked at how these organizations had operated historically, and considered whether they were continuing to operate in the same manner today. Congress determined that although the Blues and plans similar to them historically operated in a manner that furthered community benefit and social welfare, these plans had evolved to the point where many of the characteristics that distinguished them from the commercial insurance carriers were no longer apparent. Therefore, there was no longer any justification for the continuing exemption for service benefit plans if their primary purpose was providing medical insurance indistinguishable from that provided by commercial carriers. It was Congress' look at the Blues' exemption that served as the impetus for the enactment of IRC 501(m).

The potential impact of IRC 501(m) was discussed in the CPE for 1988, Developments In The Health Care Field: A Story of Dramatic Change, at 22. That article focused on the potential impact of IRC 501(m) in relation to the health maintenance organization (HMO). This article will supplement the 1988 article by

taking a look at the prepaid health care plans so that we may understand why Congress concluded that the Blues, and plans similar to them, were no longer promoting social welfare, and how this impacts upon prepaid health care plans applying for exemption today.

This article consists of three parts. The first part is an analytical description of the history of prepaid health care plans. Admittedly, this part will appear to be an analytical description of the Blues. This is unavoidable because in the past, the Service has based the exemption qualification of other prepaid health care plans on their similarity to the Blues. The second part consists of a step-by-step analysis a specialist might apply in determining whether IRC 501(m) should influence the prepaid health care plan's qualification for exemption. The last part will consider, by way of interpretation of recent G.C.M.s issued by the Service, the continuing evolution of the HMO exception under IRC 501(m). Before we can appreciate the influence IRC 501(m) may have in the determination of the tax-exempt status of a prepaid health care plan, we must take a look back so that we may appreciate why Congress felt the need to enact IRC 501(m).

2. Historical Perspective

A. Exemption of Prepaid Health Care Plans Under IRC 501(c)(4) Prior to the Enactment of IRC 501(m).

Background

IRC 501(c)(4) provides for the exemption from federal income tax of civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare or local associations of employees, the membership of which is limited to the employees of a designated person or persons in a particular municipality and the net earnings of which are devoted exclusively to charitable, educational, or recreational purposes.

The largest of the early plans, a predecessor to the Blues, was created by Dr. Justin Ford Kimball, executive vice-president of Baylor University in Texas. In an effort to resolve the problem of numerous unpaid medical bills of teachers, Dr. Kimball established the Baylor Plan. The Baylor Plan enrolled teachers who prepaid 50 cents a month for 21 days of semi-private hospitalization at the Baylor University Hospital. "Prepayment and Hospital," Bulletin of the American Hospital Association, as cited in S. Law, Blue Cross: What Went Wrong? (1974) at 7. (hereinafter Law).

The Baylor Plan, along with other early prepaid health care programs, began to run into problems with state insurance regulators. Some regulators ruled that the plans were subject to insurance regulation while other regulators found that the plans were service contracts, and therefore, not subject to the legal requirements of insurance. H. Becker, ed. Financing Hospital Care in the United States (1955) at 7 and R. Rorem, Non-Profit Hospital Service Plans, (1940) at 29, as cited in Law, supra at 7.

To eliminate the problems with the insurance regulators, the American Hospital Association ("AHA") and local hospital organizations sought special enabling legislation in various state legislatures that would treat prepaid health care plans differently from insurance companies. The AHA promulgated seven standards which should characterize group hospitalization plans. The standards were (1) emphasis on public welfare, (2) limitation to hospital services, (3) freedom of choice of hospital and physician by subscriber, (4) nonprofit sponsorship, (5) compliance with legal requirements (6) economic soundness, and (7) dignified and ethical administration. See J. McGovern, "Federal Tax Exemption of Prepaid Health Care Plans," The Tax Adviser, Vol. 7 (1976) at 7.

AHA and others acquired the special enabling legislation they sought which bestowed the following privileges on the proposed prepaid health care plans: exemption from the general insurance laws of the state; status as a charitable and benevolent organization; exemption from the obligation of maintaining the reserves required of commercial insurers; and tax exemption. Most states have enacted special legislation for these prepaid health care plans. The justification offered for the special legislation was the promise of service to the community, and particularly to low-income families. See Law, supra at 7.

1. Service Benefit Plans

The predecessor of IRC 501(c)(4) simply required that a civic league or organization not be organized for profit, but operated exclusively for the promotion of social welfare. See section 2.G(a) of the Revenue Act of 1913. Therefore, the early plans may have technically met the statutory criteria for exemption. It has been argued that the Service uses IRC 501(c)(4) to exempt organizations that, although providing some benefit to the community, failed to meet the requirements of IRC 501(c)(3). Further, while an organization exempt under IRC 501(c)(4) of the Code does not pay taxes, contributions made to it are not deductible by the contributor as they are in the case of organizations exempt under IRC 501(c)(3).

Because of the limited effect of exemption under IRC 501(c)(4), it has been suggested that the Service has been more liberal in granting exemption to organizations, which are not exactly charitable but at the same time should not be taxed. Law, supra at 9-10.

During the creation of the early prepaid health care plans, many commercial carriers did not believe that medical care coverage could satisfy the requirements for an insurable hazard, and that any coverage provided would not be "insurance." Law, supra at 11. To be classified as insurance, it has been customarily held that an insurance hazard should embody the following features: (1) there should be a large and homogeneous group of risks; (2) the potential loss should be definite and measurable; (3) the loss should be fortuitous, unexpected, and uncontrolled; (4) the loss should be serious in nature; and (5) risks should be widely disbursed and not subject to catastrophic loss. The insurance industry was wary of hospitalization insurance during its early stages because there was a question whether the medical expense hazard could meet the second, third, and fifth principles. R. Eilers, Regulation of Blue Cross and Blue Shield Plans (1963) at 13.

One of the most celebrated early service benefit plans is Blue Cross. Blue Cross was the creation of the American Hospital Association in direct response to the need of medical care during the Great Depression. During the 1920s there was growing recognition of the need for some mechanism by which middle income people could finance extraordinary costs of hospitalization. Hospital insurance was virtually nonexistent. T. Richardson, "The Origin and Development Group Hospitalization in the United States, 1890-1940," 20 University of Missouri Studies, No. 3, at 15-18 (1945) as cited in Law, supra at 6. During a speech in October 1927, the president of the American Hospital Association described the organization's "ultimate objective" as:

> providing hospitalization for the great bulk of people of moderate means . . . [who are] confronted with the necessity of amassing a debt or the alternative of casting aside all pride and accepting the provisions that are intended for the poor . . . . Let us keep in mind the raison d'etre of our existence, vis .. the provision of hospitalization for the patient of moderate means, consisting of 80 per cent of the entire population. The wise solution of this great problem will inscribe the name of the American Hospital Association in the hearts of the people for all time. See R. G. Brodrick, M.D., Presidential Address, Bulletin of the American Hospital Association at 25-27.

It was the stated objective of the association's president in 1927, along with the Great Depression, and the need of a stable source of income for hospitals, that

served as an impetus to the early prepaid health care plans. McGovern, supra at 76. The early plans entered the field at a time of real community need, and at a time when commercial insurance companies were not willing to underwrite the cost of hospital care to any material extent. Id.

Early proposals, prior to the creation of prepaid health care plans, offered as a solution to prevent financial crisis resulting from medical costs were limited to educating the public in the need to save for large medical expenses. For example, in the Bulletin of the American Hospital Association, July 1931, at 68,:

> Economic preparedness of the individual in connection with the use of the modern hospital is largely a matter of public education and training ... Practicable and easy plans might well be formulated to encourage use of the item "sickness" in the family budget as actively as the items "Insurance" and even "clothes" for prospective mothers.

In recognition of the fact that the Blue Cross/Blue Shield Plans were operated on a non-profit basis providing health care coverage that was virtually nonexistent in the commercial field, the Internal Revenue Service determined that the Plans were exempt from federal taxation under IRC 501(c)(4). While it was the administrative practice for the Service to recognize Blue Cross/Blue Shield organizations as exempt under IRC 501(c)(4), its rationale and criteria have never been fully articulated. See G.C.M. 39828 (September 30, 1987) n. 8.

2. Health Maintenance Organizations (Group Practice Plans)

The earliest staff model and group model HMOs were recognized as exempt under IRC 501(c)(4) because the Service determined that in all essential respects they were neither subscriber-controlled nor physician-controlled, and either employed physicians under salary or contracted with existing medical groups on a capitation basis for medical services. See G.C.M. 39828, supra. In 1971, the Service extended the rationale for exemption under IRC 501(c)(4) to an organization providing prepaid optometric services, but at the same time began to study the propriety of the continuing exemption of the Blues and similar plans as social welfare organizations. The Service believed that these prepaid health care plans were not primarily engaged in promoting the common good and general welfare of the people of the community. By restricting their services to fee-paying members, they were primarily operated for the private benefit of their members. G.C.M. 34709 (December 7, 1971).

With the passing of each year, more and more plans sought exemption as social welfare organizations because of their similarity to the Blues or other associations. The Service began to look more closely at these prepaid health care plans claiming to be social welfare organizations.

For example, In Rev. Rul. 86-98, 1986-2 C.B. 74, the Service concluded that an individual practice association or foundation for medical care, (i.e., an organization that contracted with an HMO collectively on behalf of otherwise independent physicians) was not operated primarily for the promotion of social welfare because its primary activity was conducting a business similar to organizations that are conducted for profit. This was supported by the fact that the individual practice association did not solicit nonmember input nor did it assume the fees of indigent patients that the HMO agreement did not cover. The Service determined that promoting prepaid medical services provided by its members at fees reasonable to the physician is intended primarily to help the interests of the individual practice association's members, the physicians. Therefore, the individual practice association did not qualify for exemption as a social welfare organization under IRC 501(c)(4).

B. Exemption Under IRC 501(c)(3) for Prepaid Health Care Plans Prior to the Enactment of IRC 501(m).

Very few prepaid health care plans have been able to establish that they qualify for exemption under IRC 501(c)(3). The qualification of a plan under IRC 501(c)(3) is based on its satisfaction of the requirements of IRC 501(c)(3).

IRC 501(c)(3) provides for the exemption from federal income tax of organizations organized and operated exclusively for charitable or educational purposes. Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" is used in IRC 501(c)(3) of the Code in its generally accepted legal sense.

The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that 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. Restatement of Trusts (Second) sec. 368, comments (b) and (c); IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372.2.

A concept that runs throughout all organizations recognized as exempt under IRC 501(c)(3) is the concept of community benefit. In determining whether an organization promoting health is organized and operated for charitable purposes, the "hospital community benefit analysis" formulated in Rev. Rul. 69-545, 1969-2 C.B. 117, is applied. The hospital community benefit analysis states that if a hospital operates an emergency room and provides emergency care to anyone seeking care, it is promoting the health of a class of persons that is broad enough to benefit the community. This is true even though the hospital ordinarily limits admissions to those who can pay the cost of their hospitalization either themselves, or through private health insurance, or with the aid of public programs such as Medicare and Medicaid.

The Service extended the hospital community benefit analysis to health care organizations other than hospitals, reasoning that they were serving many of the same health needs of the community that hospitals have traditionally served, and therefore were promoting health within the meaning of the general law of charity. Rev. Rul. 72-209, 1972-2 C.B. 148.

1. Service Benefit Plans

Typically, the traditional service benefit plan provides medical benefits to subscribers in return for prepaid premiums. It is generally open to all or a large part of the community, and the group served shares the anticipated medical expenses by paying an fixed fee to the plan. The plan does not actually provide health care services but rather acts as an administrative arm that pays doctors and hospitals to provide services.

Though they provide some benefit to the community and, thus, promote social welfare, these plans typically do not qualify for exemption under IRC 501(c)(3). Most of the nonprofit prepaid health care plans have been classified as tax-exempt social welfare organizations under IRC 501(c)(4) since their inception. See McGovern, at 77. Though the rationale underlying exemption under 501(c)(4) as opposed to 501(c)(3) was not recorded for the earliest plans, the reasoning can be gathered from the rationale articulated by the U.S. Supreme Court in Better Bureau of Washington, Inc. v. United States, 326 U.S. 279 (1945).

In Better Business Bureau, the Court stated that an organization is not organized and operated exclusively for charitable purposes unless it serves a public rather than a private interest. Furthermore, an organization will not qualify under IRC 501(c)(3) if it has a single non-charitable purpose that is substantial in nature

regardless of the number or importance of its charitable purposes. Thus, even though the prepaid medical care plans were providing a community benefit, they were also serving the private interests of those individuals designated as subscribers to their medical care plans. This purpose was substantial enough that they did not qualify as charitable organizations under IRC 501(c)(3). Further, it has been argued that service benefit plans were not promoting health in the traditional sense because they did not directly provide medical care, instead they were responsible for the payment of bills received for services rendered.

2. Health Maintenance Organizations (Group Practice Plans)

The second basic form of prepaid health care is the group practice plan, currently known as a health maintenance organization (HMO). Such plans were first implemented on a large scale by the Kaiser Foundation Health Plan on the West Coast over forty years ago. See Note, "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis," 84 Harvard Law Review 909, (1971). These plans generally provide centralized, comprehensive health care services to members who pay a fixed premium. Providers receive a fixed rate of compensation not directly tied to the medical services performed.

As discussed earlier, most HMOs, if recognized as exempt at all, were recognized under IRC 501(c)(4) because of their similarity to the Blues. If an HMO requested exemption under IRC 501(c)(3), it was denied on the basis of the Service's position at that time that the HMO was organized and operated to serve the private interest of its members. In G.C.M 37043, (March 14, 1977), the Service applied the hospital community benefit analysis in determining whether HMOs qualified as charitable organizations under IRC 501(c)(3).

The Service stated that a plan seeking recognition of exemption under IRC 501(c)(3) must establish that it does not provide preferential services or benefits to its members other than those of a purely incidental nature. Further, the Service stated that, to satisfy the requirement under this subsection, a plan must be an entity organized and operated exclusively to serve public rather than private interests. See Reg. 1.501(c)(3)-1(d)(ii).

The fact that the HMOs maintained an open enrollment policy with regard to the availability of participation in the plan did not alter the conclusion that these organizations failed to satisfy the public benefit requirement. The Service concluded that the membership form of operation of the HMO did not satisfy the requirement of promoting health of a sufficiently broad segment of the community.

The Service had to modify its position, at least with respect to the staff-model HMO, after the decision in Sound Health Assn v. Commissioner, 71 T.C. 158 (1978) (hereinafter Sound Health). G.C.M. 39828, (September 30, 1987). The court in Sound Health concluded that the rendering of medical care is a charitable activity and that the tests for determining the exemption of a hospital were relevant to the determination of the exemption qualification of the HMO. The court also applied the community benefit analysis described in Rev. Rul 69-545, but unlike the Service, concluded that Sound Health did satisfy the community benefit requirements.

The court found the Service's argument that preferential treatment of the HMO's members resulted in serving members' private interests to be insignificant because the court perceived that the class of possible members was, as a practical matter, the class of members of the community itself. The court found no absolute barriers to membership. Further, the court reasoned that just as a charitable hospital might restrict treatment, except for emergency cases, to paying patients, so too could the HMO restrict its (non-emergency) health care services to paying members without resulting in preferential treatment or private benefit.

The Service modified its position to the extent that a staff-model HMO having the characteristics of the HMO in Sound Health qualifies for exemption under IRC 501(c)(3). See Rev. Rul 83-157, 1983-2 C.B. 94 (absence of emergency care/room will not, in and of itself, preclude exemption). See further G.C.M. 39829, (August 24, 1990), n. 10. The Service continues to maintain its position that an HMO that arranges for, but does not provide medical services directly, will not qualify for tax exemption under IRC 501(c)(3). The Service's current view with respect to IRC 501(c)(4) exemption of HMOs involves a community benefit analysis that focuses on a number of factors: open enrollment, whether the HMO serves low income, high risk, medically underserved or elderly persons, and whether there is community rating. See, G.C.M. 39829, supra.

3. Impact of IRC 501(m) Upon Prepaid Health Care Plans Described Under IRC 501(c)(3) or (4)

A. Law of IRC 501(m)

IRC 501(m) provides that:

(1) **Denial of tax exemption where providing commercial-type insurance is substantial part of activities**.--An organization described in paragraph (3) or (4) of subsection (c) shall be exempt from tax under subsection (a) only if no substantial part of its activities consists of providing commercial type insurance.

(2) **Other organizations taxed as insurance companies on insurance business**.--In the case of an organization described in paragraph (3) or (4) of subsection (c) which is exempt from tax under section (a) after application of paragraph (1) of this subsection--

(A) the activity of providing commercial insurance shall be treated as an unrelated trade or business (as defined in section 513), and
(B) in lieu of the tax imposed by section 511 with respect to such activity, such organization shall be treated as an insurance company for purposes of applying subchapter L with respect to such activity.

(3) **Commercial-type insurance**.--For purposes of this subsection, the term "commercial-type insurance" shall not include--

(A) insurance provided at substantially below cost to a class of charitable recipients,
(B) incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations,
(C) property or casualty insurance provided (directly or through a organization described in section 414(e)(3)(B)(ii)) by a church or convention or association of churches for such church or convention or association of churches,
(D) providing retirement or welfare benefits (or both) by a church or a convention or association of churches (directly or through an organization described in section 414(e)(3)(A) or 414(e)(3)(B)) of such church or convention or association of churches or the beneficiaries of such employees, and
(E) charitable gift annuities.

(4) **Insurance includes annuities**.--For purposes of this subsection, the issuance of annuity contracts shall be treated as providing insurance.

(5) **Charitable gift annuity**.--For purposes of paragraph (3)(E), the term "charitable gift annuity" means an annuity if--

> (A) a portion of the amount paid in connection with the issuance of the annuity is allowable as a deduction under section 170 or 2055, and
>
> (B) the annuity is described in section 514(c)(5) (determined as if any amount paid in cash in connection with such issuance were property).

B. Reasons for Enactment

The chief reason for the enactment of IRC 501(m) was to subject plans providing health insurance, including the Blues and other service benefit plans, to taxation.

Two major characteristics have distinguished the early prepaid health care plans from most commercial insurance companies: "payment of service benefits to hospitals rather than cash benefits to the individual insured, and the provision of benefits to all members of the community at the same rate rather than higher rates to high risk groups." Law, supra at 11. To support special legislation efforts, hospitals intentionally distinguished the prepaid health care plans from the commercial carriers and corresponding regulation by focusing on these two differences. See McGovern, supra at 77. The direct provision of medical services vs. cash reimbursement distinction was firmly established in the law. See Jordan vs. Group Health Association, 107 F.2d 239 (1939). Court cases have noted the distinction, and generally conclude that the direct provision of medical services does not constitute insurance.

The original AHA standards for the approval of hospital service plans required that member hospitals express their service contracts in terms of services to which subscribers were entitled. See R. Rorem, Non-Profit Hospital Service Plans, as cited in Law, supra at 12. The Blues used an approach very different from insurance companies in servicing their members. The Blues employed "service-type" benefits while insurance companies sold "cash-indemnity" policies. The former entitles a subscriber to a certain number of days in a member hospital with a specific type of accommodation, generally semiprivate, including meals and general nursing service.

The second major distinction between the Blues--as well as plans similar to them--and commercial carriers was the promise of community service evidenced by the community rating system for prepaid health care benefits. Law, supra at 12. Initially, the Blues offered hospital service benefits to all members of the community at uniform rates, while commercial carriers offered more favorable

rates to those groups actuarially less likely to make claims. Low income families and the aged were helped by the community rating since they were considered to be high risk groups. See Eilers, supra at 210-211.

Over the years, however, as a result of competitive pressures, the Blues changed their mode of operation, and in the process have erased the characteristics that at one time distinguished them from commercial insurance carriers. First, the Blues in increasing numbers began to offer subscribers indemnity rather than service contracts. See Herman M. and Anne R. Somers, Doctors, Patients, and Health Insurance (1961), at 304.

Second, most of the Blues have abandoned their commitment to community rating, (on pressure by organized interests for experience rating) and now offer group experience-rated contracts which base the charges for medical care on the risk level of the group. Law, supra at 12. Therefore, the low-income and aged are charged more since they are considered to be high risk groups.

Initially, the group prepaid hospitalization associations did not satisfy the definition of insurance, and this is one of the reasons why they received tax exemption. These plans were viewed as providing medical services and not insuring against economic loss. As the plans evolved, and in order to compete with commercial insurance carriers, they began to shift away from the practices upon which they received tax exemption. The conditions upon which the tax exempt status of the service benefit plans were determined have changed considerably over the years, while commercial carriers have grown to provide comparable levels of medical care coverage. See Tax Reform 1986: A Legislative History of the Tax Reform Act of 1986, Vol. 60, at 70.

As the Blues and other service plans eliminated practices such as open enrollment and community rating, may become more like commercial insurance carriers. This disturbed commercial carriers, who objected to the competitive cost advantage tax exemption afforded the Blues.

In light of these changes, Congress concluded that the Blues' operations paralleled commercial carriers and they, along other service benefit plans, should be placed on the same footing as commercial carriers and subject to taxation.

C. Application/Interpretation of IRC 501(m)

The application of IRC 501(m) is restricted to organizations applying for exemption under IRC 501(c)(3) or 501(c)(4) which are providing "commercial-type insurance" as a substantial part of their activities. Therefore, before consideration is given to any effect IRC 501(m) may have on an application, it must first be determined that the organization satisfies the requirements of IRC 501(c)(3) or (4). We will look in turn at the factors that should be present before an organization will be denied exemption based on the restrictions in IRC 501(m).

The first inquiry is whether the product being provided by the organization is "insurance." For a detailed discussion of the definition of insurance, refer to CPE 1988, supra at 25. We will review the common definition of insurance for our purposes. In Allied Fidelity Corp. v. Commissioner, 66 TC 1068, 1073 (1976), aff'd 572 F.2d 1190 (7th Cir. 1978), cert. denied 439 US. 835 (1978), the Tax Court referred to the definition of insurance as provided by Couch as follows See 1 Couch on Insurance 2d 1:2 (1959):

> The common definition of insurance is an agreement to protect the insured against a direct or indirect economic loss arising from a defined contingency whereby the insurer undertakes no present duty of performance but stands ready to assume the financial burden of any covered loss.

The Supreme Court in Helvering v. LeGierse, 312 US 531 (1941), stated historically two elements are consistently present when defining insurance: risk-shifting and risk distribution. See also Rev. Rul. 68-27, 1968-1 CB 315. In determining whether an organization should be considered an insurance company, the courts have stated that demonstrating that a transaction has risk transference and risk distribution is not enough to prove that the transaction is one of insurance; something more is required. See R. Keeton, Robert, Basic Text on Insurance Law, 1971, at 9-10. In this regard, the courts also look to the "controlling object" of the contract to determine whether the insurance characteristics are the principal elements that give the contract its distinctive character. See, e.g., Transportation Gee. Co. v. Jellins, 29 Cal.2d 242, 174 P.2d. 625 (1946) ("guaranteed maintenance contract" to maintain truck in mechanical repair held not void as an insurance contract since the "controlling object" of the contract was service, not insurance.)

The traditional service benefit plan provides medical benefits to subscribers in return for prepaid premiums. It is sometimes open to the community, and the insured group shares the anticipated medical expense by paying a fixed fee to the organization. The plan does not provide health care services but acts as an

administrative arm which contracts with doctors and hospitals and pays them a stipulated fee for services rendered. See McGovern, supra at 78.

The early prepaid health care plans, legally and technically were not insurance companies, and because they were distinct from insurance companies they were able to be classified as tax-exempt organizations. Id. As previously noted, the special enabling legislation sought by the hospital organizations distinguished the plans from the commercial carriers. Those efforts were supported by the fact that the plans provided for payment of service benefits rather than cash. The distinction between medical services and cash reimbursement is recognized in the law. For example, Couch on Insurance 2d, section 1:2 provides:

> If there is no hazard or peril, as contemplated by an applicable statute which defines the term "insurance" but a mere contract entitles certificate holders to medical services or supplies at free or reduced rates, the contract is not one of insurance.

The Service validated this principle for federal tax purposes by holding that a group practice plan which issues medical service contracts, and furnishes medical services to subscribers, is not an insurance company within the meaning of the Code. See Rev. Rul. 68-27, 1968-1 C.B. 315.

Today most of the Blues offer group experience-rated contracts. See Law, supra notes 62 and 63, at 169. By adopting experience rating, the Blues no longer treated all of the community the same; they provided a product based on the risk rating of the group which is the same product being offered by commercial carriers. Id. Further, as discussed earlier, many of the Blues offered subscribers indemnity rather than service contracts. Because of changes in the operation of the Blues, as well as organizations similar to them, there was no longer any justification for continued tax exemption. The "controlling object" of the health care operations had shifted from the providing of benefits to insuring against economic loss. Therefore, the Blues evolved into commercial insurance carriers.

Congress agreed that although the service benefit plans at one time provided services distinguishable from insurance companies, this is no longer the case. Now the service benefit plans are performing insurance activities which in nature and scope are inherently commercial rather than charitable; hence, tax-exempt status is inappropriate.

For purposes of IRC 501(m) "commercial-type insurance" generally is any insurance of a type provided by commercial insurance companies. Commercial carriers now provide the same prepaid medical insurance as that provided by the Blues. Since it is provided by commercial carriers, this type of prepaid medical coverage is commercial type insurance.

One of the reasons staff-model HMOs continue to enjoy tax-exempt status is that they are providing direct medical care services and the provision of such services is not "insurance", and therefore, would not be commercial-type insurance. Thus, staff-model HMOs are viewed as providing direct medical services, and not insuring against medical losses.

The final inquiry is whether the providing of "commercial-type insurance" is a "substantial" part of the organization's activities. Congress stated that for purposes of definition, no substantial part has the meaning given to it under present law applicable to such organizations. See, e.g., Haswell v. U.S., 500 F.2d 1133 (CT. Cl. 1974); Seasongood v. Comm'r, 1227 F.2d 907 (6th Cir. 1955); see also section 501(h) H.R. REP. No. 99-426, 99th Cong., 2d Sess. 662 (1986), 1986-3 C.B. Vol. 2 664. Whether or not an activity is substantial is determined on the basis of the facts and circumstances of the overall situation. See Better Business Bureau. If the providing of "commercial-type insurance" is a substantial part of the 501(c)(3) or (4) organization's activities, it loses its exemption or is denied exemption as the case may be.

On the other hand, if it is determined that the providing of commercial insurance is not a substantial part of the organization's activities, the insurance activity is treated as an unrelated trade or business under IRC 513. In lieu of the usual tax on unrelated trade or business taxable income, the unrelated trade or business activity is taxed under rules relating to insurance companies in Subchapter L.

4. Exceptions to "Commercial-Type Insurance"

Several exceptions are provided to the definition of commercial-type insurance. Of these exceptions, the one that has received the most attention is the exception applicable to certain health maintenance organizations (HMOs).

Congress stated that IRC 501(m) was not intended to alter the tax-exempt status of health maintenance organizations. HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees

or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). Similarly, an organization that provides supplemental health maintenance organization-type services (such a dental services) is not affected if operated in the same manner as a health maintenance organization. See General Explanation of the Tax Reform Act of 1986, Prepared by the Staff of the Joint Committee on Taxation, H.R. 3838, Pub. L. 99-514, 99th Cong., 2d Sess (1987) "Blue Book," at 585.

Many HMOs continue to meet the test of the historical justification for exemption. Unlike service benefit plans, they are not faced with the cash indemnity vs. medical benefits distinction because the primary purpose of some HMOs is to provide medical care to their members. Also, some of the plans continue to set fees by the community rating method.

Recently, the Service issued several G.C.M.s in an effort to clarify the Service's position in relation to HMOs. Although the Blue Book stated that there were a variety of HMO structures that could be determined tax-exempt, the Service continues to hold that only HMOs that provide medical services, with only incidental insurance attributes, are covered by the IRC 501(m)(3)(B) exception. In all other cases, the insurance aspects outweigh the service aspects. The Service's present position will be discussed in detail in light of the recent G.C.M.s issued in this area.

In G.C.M. 39828, supra the Service concluded that a health maintenance organization that is related to a health care system but performing no direct health care services, is not promoting health nor providing sufficient community benefit so as to qualify for exemption under IRC 501(c)(3) because it did not meet the guidelines for exemption set forth in the Sound Health decision and other criteria employed by the Service. See also Rev. Rul. 69-545, 1969-2 C.B. 117.

The organization anticipated providing medical services under the following rating systems: community rating; community rating by class; experience rating; and adjusted community rating. The organization did not seek qualification under the Health Maintenance Organization Act of 1973 because experience rating is not allowed and adjusted community rating is only allowed for certain groups of enrollees.

In considering exemption of an HMO under IRC 501(c)(3), G.C.M. 39828, supra devised the following test based on Sound Health. The G.C.M. 39828, supra

test consists of a first part considering community benefit generally and a second part considering whether the community-at-large benefits rather than only members. G.C.M. 39828, supra at 8-9. The first part regarding general community benefit is derived from the Sound Health case and the revenue rulings on hospital exemption. The list of factors in the first part is not all-inclusive and the absence of any one factor is not necessarily determinative. This list includes:

> actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by Medicare, Medicaid or other similar assistance programs, emergency room facilities available to the community without regard to their ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health education programs open to the community; health research programs; health care providers who are paid on a fixed fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs. G.C.M. 39828, supra at 7.

The second part of the test is a list of additional factors that must be considered in the membership organization context to determine whether a prepaid health care organization benefits the community as a whole rather than just the members. These relevant factors are:

> membership composed of both groups and individuals where such individuals compose a substantial portion of the membership, an overt program to attract individuals to become members; a community rating system that provides uniform rates for prepaid care; similar rates charged to individuals and groups (with a possible modest initiation fee for individuals); and no substantive age or health barriers to eligibility for either individuals or groups. Id. at 8.

The Service determined that based on the above factors, there was insufficient community benefit. The HMO provided no health care services; the scope of care actually provided will be based on cost and will not be comprehensive; the HMO was not open to the entire community, because based on the rating systems used those who were likely to be of the highest risk (poor and elderly) would have to pay the high rate; the HMO conducted no research or educational programs.

In addition, in G.C.M. 39828, supra the Service determined that based on the following factors, the HMO's primary activity was the providing of commercial-type insurance within the meaning of IRC 501(m). The factors used to make this determination included, but were not limited to: (i) whether a risk within the meaning of LeGierse is being transferred and distributed; (ii) whether, and to what extent, the entity is operating in a manner similar to for-profit insurers or Blue Cross and Blue Shield; (iii) whether, and to what extent, the entity is marketing a product similar to for-profit insurers or Blue Cross and Blue Shield. Although these factors were relevant, no one factor was determinative. What was determinative was whether the insurance aspects of the HMO were minor and subordinate to the provision of health care services. If so, the HMO would not be found to be providing "commercial-type insurance. Cf. People v. California Mutual Assoc., 441 P.2d 97 (Cal. 1968).

The HMO in G.C.M. 39828, supra was a non-staff HMO without fixed expenses, and it did not have any facilities that may limit expenses. The risk that was shifted from the subscribers was assumed by the HMO rather than the ultimate health care provider who would bear the risk in a fixed expense HMO. By assuming this risk, the HMO was operating substantially similar to the Blues and commercial insurance carriers. Since this was the HMO's primary activity, it was precluded from exemption under IRC 501(m).

In G.C.M. 39829, supra the Service clarified and amplified G.C.M. 39828. The applicant was an Individual Practice Association model (IPA-model) HMO. The HMO qualified under the Federal HMO Act.

The HMO provided physician, hospital and other health care services to subscribers, but the HMO does not provide medical services itself. Physicians' services were paid on a capitated basis (provider is compensated on the basis of the number of subscribers the provider is responsible for serving, without regard to the frequency or extent of services actually provided) and represented 1/2 of the total cost of medical services benefits the HMO provided.

The HMO paid capitation for all physician services. Subscribers were locked into HMO-affiliated providers and there were no out-of-plan benefits. Therefore, the HMO's principal activity was providing or arranging for the provision of medical services, to which the provision of health insurance was qualitatively incidental. Therefore, the organization did not have as a substantial part of its activities the provision of commercial-type insurance because it came within the exception in IRC 501(m)(3)(B).

By applying the traditional LeGierse risk shifting and risk distribution analysis, the G.C.M. concludes that a strong argument can be made that today's HMOs provide insurance, even if they do not rise to the level of insurance companies under the Code.

G.C.M. 39829, supra states that many HMOs providing physician care through employees are shifting a risk of loss from the member to the HMO and, to some extent, on the physician employees. See Jordan v. Group Health Assn., supra at 246. Even the Jordan court found risk shifting arising from physician services for the sick or injured. Only the restrictive formulation of the subscriber agreements in that case allowed the court to conclude that no risk was assumed by the HMO. Moreover, HMOs shift the risk of loss from the member to the health care providers when they pay physicians and hospitals on a capitated basis. See T. J. Sullivan, "The Tax Status of Nonprofit HMOs After Section 501(m)," Tax Notes, January 7, 1991, 75, 81 (hereinafter Sullivan). Although most of the risk in the HMO situation is neither assumed nor retained by the HMO, that portion used to pay the cost of medical services rendered by providers who are neither employees nor paid on a capitated or other fixed-cost basis must be retained by the HMO. Id. In many cases, this retention of limited risk is viewed as incidental to the provision of medical care.

G.C.M. 39829, supra states that the criteria in determining whether a HMO's principal activity is providing health care services rather than insurance services is set forth in G.C.M. 39703, which applied IRC 501(m) in a non-HMO context. "Relevant factors identified in the earlier G.C.M. include whether and to what extent an insurance risk is transferred and distributed, whether and to what extent the entity operates in a manner similar to for-profit insurers or Blue Cross/Blue Shield, and whether and to what extent the entity markets a product similar to the product of for-profit insurers or Blue Cross/Blue Shield. However, G.C.M. 39829 lists additional factors that must be considered in the HMO context. These are (1) whether and to what extent the entity provides health care services itself as opposed to merely arranging for them, and (2) whether and to what extent the entity has shifted any risk of loss to the actual service providers through salary or fixed-fee compensation arrangements." Sullivan, supra at 31.

By applying this analysis, it is easy to see that the characteristics in the early HMOs (provisions of care in a centralized setting, and sharing of risk with the providers) are still characteristics that distinguish today's HMOs from insurance companies.

G.C.M. 39829, supra also provides some guidelines regarding the facts and circumstances important to determine whether an organization is exempt under IRC 501(c)(4). The Service's ruling position under IRC 501(c)(4) requires a showing of general community benefit that is less exacting than that required under IRC 501(c)(3). Although a full consideration of the criteria for exemption under IRC 501(c)(4) has not yet been undertaken.

G.C.M. 39829, supra states that the Service's current IRC 501(c)(4) HMO ruling position involves a community benefit analysis that focuses on factors such as: whether membership is open to individuals and small groups; whether the HMO serves the low-income, high-risk medically undeserved, or elderly; whether the premiums are established on a community-rated basis.

In G.C.M. 39830 (August 24, 1990), the Service concluded that a separately-incorporated nonstaff model HMO that is controlled by the exempt parent of a nonprofit health care system, and that does not qualify for recognition of exemption under IRC 501(c)(3) on its own, cannot qualify for exemption as an "integral part" of its exempt parent.

The HMO was controlled by the tax-exempt parent of a reorganized hospital system, and sought to use the activities and characteristics of its affiliated hospital to meet the test. The HMO argued that it should be granted exemption on the basis that it is an integral part of the exempt affiliated hospitals. See Reg. 1.502-1(b) and Sullivan, supra at 79.

G.C.M. 39830, supra concluded that the Service generally respects the integrity of separate legal entities. The HMO, which primarily served its members and not its affiliated hospitals or their patients, was not an integral part of its exempt parent because (1) it did not provide essential services to the parent, and (2) its primary purpose was carrying on an activity that would be an unrelated trade or business if carried on by the parent. See Sullivan, supra at 80.

5. Conclusion

The earliest prepaid health care plans received special state legislation and favorable federal tax treatment because they promised to serve the community, especially low-income families. Arguably, the early fee-for-service plans met the statutory criteria for exemption under the predecessor of IRC 501(c)(4) since they were providing service to the community by providing medical services. Several

years later, and at a time when the Service began to question the propriety of the Blue's exemption, HMOs began to receive exemption based on their similarity to the Blues.

IRC 501(m) was enacted to bring about equity in the insurance and prepaid health care plan field. Congress recognized that although many of the early plans had initially operated to promote the social welfare and community benefit, they changed their mode of operation in the face of competitive pressures from commercial insurers. Therefore, exemption for the Blues and organizations similar to them was no longer justified.

Congress' chief reason for enacting IRC 501(m) was to subject the Blues and plans similar to them to taxation. Congress determined that the Blues and plans similar to them no longer promoted social welfare. To what extent HMOs are affected by IRC 501(m) continues to evolve with the issuance of each G.C.M. on the subject. Congress did include an express exception for HMOs, IRC 501(m)(3)(B), but the intended scope of the exception was not altogether clear. G.C.M. 39829, supra addresses these exceptions in some detail.

After the enactment of IRC 501(m), the Blues and plans similar to them are no longer exempt. Historically, the Blues were used as the yardstick to determine if a prepaid health care plan qualified for exemption under IRC 501(c)(4). Now that the Blues are no longer tax exempt, the standard for exemption under IRC 501(c)(4) is less clear. The discussion in G.C.M. 39829, supra provides that the Service has developed a current ruling position. This position requires a showing of benefit to the community similar to, but less exacting than, that required under Sound Health.

The standard outlined in Sound Health is based on the community benefit analysis formulated in Rev. Rul 69-545. After Sound Health, the Service liberalized its position on IRC 501(c)(3) status, at least with respect to staff model HMOs. However, even after this modification, very few HMOs have been able to meet the exacting standards for exemption under IRC 501(c)(3).

After IRC 501(m), the specialist should make a step-by-step analysis of the applicant to determine if it qualifies for exempt status. The specialist should consider the following factors:

Q.1. Whether the organization should be applying for exemption under IRC 501(c)(3) or (c)(4)?

A.1. During the preliminary screening of the application, the specialist should determine whether the organization has correctly applied under IRC 501(c)(3) or (4) since IRC 501(m) only applies to these two paragraphs of IRC 501(c). If not, the specialist should determine whether the organization may appear to qualify for exemption under another paragraph of IRC 501(c) other than the one under which applied.

Q.2. Whether the product provided is "insurance" as that term is defined in the Code and by other authorities?

A.2. The existence of insurance is indicated by the Helvering v. LeGierse risk-shifting and risk-distributing standard. HMOs typically shift the risk of loss from the subscriber to the HMO and possibly to the health care providers. G.C.M. 39829, supra at 14, 15. The risk of loss results from the possible need to provide costly medical care for subscribers, see id. at 14, and that the cost of this care could exceed the premium income available to pay for it. There is also present an element of risk distribution among all the subscribers. Id. at 15.

Q.3. If it is insurance, is it "commercial-type insurance?"

A.3. In order to determine whether an entity provides "commercial-type insurance," the specialist must determine whether the organization's activities meet the definition of commercial-type insurance and then make sure that the activities are not excluded from the definition of commercial-type insurance by the exceptions listed in IRC 501(m)(3). The key is usually whether the insurance meets the exception to commercial-type insurance described in IRC 501(m)(3)(B). G.C.M. 39829, supra provides both a safe harbor and a facts and circumstances test to determine whether an HMO provides commercial-type insurance.

Under the safe harbor, an HMO operating on one of the common, existing models provides only incidental (and therefore not commercial-type) insurance if the HMO compensates primary care physicians exclusively on a salary, capitation, or other fixed-fee basis, even if the HMO pays other providers on a fee-for-service basis. G.C.M. 39829, supra at 24. These other providers include out-of-area (emergency) providers, referral specialists, and hospitals. See G.C.M. 39829, supra at 25.

If the safe harbor is not met, an HMO must meet a facts and circumstances test requiring that any insurance element in the

HMO's operations is a necessary and normal consequence of the HMO's principal activity of providing health care services. G.C.M. 39829, supra at 23. In other words, the insurance must, on balance, be qualitatively incidental. Id. Where a substantial portion of the risk is shifted to the providers or a substantial portion of the HMO's costs are otherwise fixed, the insurance aspects of the HMO's operations may be considered incidental. Id.

Q.4. Whether the providing of "commercial-type insurance" is a substantial part of the IRC 501(c)(3) or (4) organization's activities?

A.4. Whether or not an activity is substantial is determined on the basis of the facts and circumstances of the overall situation. As a practical matter whether the commercial-type insurance is substantial is usually not an issue because providing the insurance benefit or service typically is the only activity of the organization. There is an exception from commercial-type insurance in IRC 501(m)(3)(B) for incidental health insurance provided by such organizations. It is necessary under this exception for the specialist to determine whether the HMO's principal activity is providing health care services or insurance. See G.C.M. 39829, supra at 20.

If 501(m) does not preclude exemption, the specialist should go on to determine whether the organization meets the Sound Health standards discussed in G.C.M. 39828, supra with respect to an organization applying under IRC 501(c)(3) or the social welfare community benefit standard with respect to exempt status under IRC 501(c)(4). These standards are detailed in section 4. of this article.

With the continuing evolution of HMOs more challenges lie ahead for the specialist attempting to determine whether these organizations qualify for exempt status. Some HMOs, called open-ended HMOs, are presently offering a hybrid product that includes indemnity benefits for services obtained from out-of-plan physicians. The Federal HMO Act was amended to allow qualified HMOs to provide up to 10 percent of basic physician services through physicians not affiliated with the HMO. See Sullivan, supra at 83. Open-ended HMOs allow members to retain a long-standing relationship with a particular private physician and are the fastest growing segment of the HMO industry. Id.

A final example of the challenges that may lie ahead for the specialist is the nonstaff, nongroup practice HMO that pays providers directly not through a separate IPA on a fee-for-service basis, even where subject to a percentage withhold or reduction for overutilization. This situation may be harder than the

typical HMO to distinguish from commercial insurance companies and the Blues. This type of organization may be viewed as primarily providing an insurance-type benefit and not medical services. Therefore, the organization may not fit within the IRC 501(m)(3)(B) exception. See G.C.M. 39829, supra.

With the increasing expenditures on medical care, IRC 501(m) will play an increasing role in the qualification determination of prepaid health care organizations under IRC 501(c)(3) or (4). As the HMOs continue to evolve, they may find themselves in the unenviable position of the Blues.