P. INTEGRATED DELIVERY SYSTEMS AND HEALTH CARE UPDATE

by
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1. Introduction

This article updates and supplements the 1994 and 1995 articles on integrated delivery systems ("IDSs") and the 1994 article on health care which appear in the Continuing Professional Education Exempt Organizations Technical Instruction Program ("CPE").

The Service is experiencing an increase in technically, legally and factually complex health care issues stemming from the trend toward integration. Applications for recognition of exemption under IRC 501(c)(3) as well as ruling requests are straining the Service's workforce and its ability to respond in a timely manner. Similar demands on examination resources are expected as the 1993-1995 tax years become subject to audit.

To help address the tax exempt health care sector's unique and challenging issues, the Internal Revenue Service Exempt Organizations Division recently dedicated Technical Branch 1 to handle health care cases. Consolidation of the work in Branch 1 ensures consistency in determinations and rulings and allows tax law specialists to become acclimated to the unique questions surrounding health care, and, over the long term, will reduce the average time needed to process cases. Equally important, the Service is increasing its efforts to educate its National Office and field workforce as well as the interested public about issues involving health care. For example, the Service recently published the comprehensive Introduction to the Health Care Industry coursebook.

2. Standards for Determining Exemption Qualification

A. Community Benefit Standard

IRC 501(c)(3) describes, in part, those organizations organized and operated exclusively for charitable purposes, where no part of the net earnings inures to the benefit of any private shareholder or individual. While IRC 501(c)(3) does not expressly address hospitals or health care providers, Rev. Rul. 69-545, 1969-2 C.B. 117, establishes the "community benefit standard," which focuses on a number of factors indicating whether operation of a hospital benefits the

community rather than serving private interests. The revenue ruling states that a hospital, otherwise qualified for tax-exempt status, will meet the community benefit standard where it has a board composed of prominent citizens drawn from the community (as opposed to physicians, administrators, or others with a private interest in the organization); it has a medical staff open to all qualified physicians in the area, consistent with the size and nature of its facilities; it operates a full time emergency room open to all persons without regard to their ability to pay; and it provides hospital care for everyone in the community able to pay the cost thereof, either themselves, through private health insurance, or with the aid of public programs such as Medicare. While the ruling expressly mentions Medicare, the Service has consistently interpreted and applied the phrase "public programs such as Medicare" to include Medicaid.

The Service applies a facts and circumstances test based heavily on Rev. Rul. 69-545, supra, to measure the community benefit of a health care provider organized as an IDS. Each fact and circumstance must be weighed carefully. A Tax Law Specialist working an IDS issue should consider the case in its totality, including weighing individual facts or groupings of facts to determine whether they indicate community benefit, or on the other hand, impermissible private benefit.

B. Private Benefit

An organization cannot be organized or operated exclusively for charitable purposes unless it serves a public rather than a private interest. Thus, to meet the requirements of IRC 501(c)(3), an organization must establish that it is not organized or operated for the benefit of private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests. See Reg. 1.501(c)(3)-1(d)(1)(ii). Private shareholders or individuals are defined as persons having a personal and private interest in the activities of the organization. See Reg. 1.501(a)-1(c).

The private benefit prohibition applies to all physicians, either individually or as part of a medical group that sells assets to a tax exempt organization and all physicians who subsequently perform services for the exempt organization. The selling physicians customarily will be performing services, but doing so on behalf of a new entity, the tax exempt IDS organization. All benefits to the physicians, whether from the sale of assets or from a professional services arrangement, must be balanced against the benefits accruing to the public.

C. Private Inurement

Private inurement generally involves persons who, because of their particular relationship with an organization, have an opportunity to control or influence its activities from the inside. These individuals are generally referred to as "insiders." See American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989). Inurement generally will not be found in the absence of an insider; therefore, an important issue is whether a particular physician is an insider with respect to a hospital or IDS organization.

G.C.M. 39670 (June 17, 1987) indicates that certain key groups of employees of an exempt organization have a significant ability to exert inside influence and, therefore, possess the requisite relationship necessary to find private benefit or inurement. It follows that physicians providing services to or on behalf of a hospital or an IDS organization, as a class, are likely to enjoy considerable influence over the hospital or IDS organization. Thus, potential insider status may require the Service to consider the possibility of inurement as well as private benefit accruing to physician sellers or service providers in any consideration of an IDS organization's exemption. See also G.C.M. 39498 (January 25, 1986), which treats nonemployee physicians as insiders with respect to a hospital.

3. Governance

A. Conflicts of Interest

The Service has expressed concerns about interested party control of IDS organizations through its 80% community board safe harbor. The Service is also concerned about private benefit and inurement issues that may arise because of the relationship between an exempt organization providing IDS services and its physician employees/contractors, Officers, Directors and key employees. In most situations, the best protection for a charitable trust is a well-defined, written policy governing conflicts of interest. This serves to educate affected individuals and limit their activities under appropriate circumstances. Because most IDS organizations include some financially interested individuals on their governing Boards, they may wish to adopt a clear conflicts of interest policy.

While not required, the Service favorably views organizations having policy statements in their by-laws which clearly identify situations where a conflict might

arise. The Service believes Directors of exempt IDS organizations must exercise their powers in good faith and in a manner they believe to be in the organization's best interests. Further, organizations which educate their new Directors, employees, and Officers regarding conflicts of interest and concerns about private benefit and inurement help to eliminate problems arising from lack of knowledge.

An example of a conflicts of interest policy that is viewed favorably by the Service is one that requires that, if the Board of Directors considers entering into any transaction or arrangement with a corporation, entity or individual in which a Director has an interest:

a. the interested Director must disclose the potential conflict of interest to the Board;

b. the Board may ask the interested Director to leave the meeting during discussion of the matter that gives rise to the potential conflict;

c. the interested Director will not vote on the matter that gives rise to the potential conflict;

d. the Board must approve the transaction or arrangement by a majority vote of the Directors present at a meeting that has a quorum, not including the vote of the interested Director; and

e. the Board meeting minutes must state which Directors were present for the discussion and vote, the content of the discussion, and any roll call of the vote.

In addition, if a Director has any interest in a transaction or arrangement that might involve personal financial gain or loss for the Director, in addition to the provisions described above;

f. if appropriate, the Board may appoint a non-interested person or committee to investigate alternatives to the proposed transaction or arrangement;

g. in order to approve the transaction, the Board must first find, by a majority vote of the Directors then in office,

without counting the vote of the interested Director, that the proposed transaction or arrangement is in the IDS organization's best interest and for its own benefit; the proposed transaction is fair and reasonable to the IDS organization; and, after reasonable investigation, the Board has determined that the IDS organization cannot obtain a more advantageous transaction or arrangement with reasonable efforts under the circumstances;

h. the interested Director will not be present for the discussion or vote regarding the transaction or arrangement; and

i. the transaction or arrangement must be approved by a majority vote of the Directors, not including interested Directors.

B. Committees

Most IDS organizations have provisions in their by-laws for the creation and operation of various committees. Normally, an IDS organization will have an Executive Committee, Finance and Planning Committee, and provisions for various other committees or subcommittees. Often these committees have substantial authority to study, create, implement and review charitable and business activities as well as the clinical aspects of the organization's operations. Generally, a committee has either advisory authority or specific powers delegated to it by the Board of Directors.

(1) Delegated Board Authority

In situations where an organization's by-laws grant Board of Directors' powers to a committee or subcommittee, the Service requests that the organization's by-laws state that no more than 20% of its committee members may be physicians who are financially interested or related, directly or indirectly, to any owner, partner, shareholder, or employee of the medical group or other physicians providing services in conjunction with the IDS organization. It should be noted the Service's position allows unlimited physician representation on any committees or sub-committees that have authority over the clinical aspects of the organization's activities. See the 1994 CPE text at page 227 for more information about the 20% safe harbor.

(2) Advisory Committees

Committees which do not have Board of Directors' powers, but are merely advisory in nature may also create concerns for the Service. To understand these issues, some background information may be useful.

The tax-exempt status of IDSs presents several difficult issues. Generally speaking, IDS organizations are created through the purchase of one or more existing private medical practices, where the individual physician(s) become employees or contractors of the IDS organization. These are factually intensive cases with important issues which the Service must address. The benefit to the community from the formation of the IDSs must be carefully weighed against the benefit to the physicians from the sale of their practices and subsequent professional services agreements. Unless there is a significant community benefit, these transactions may benefit the physicians more than insubstantially.

Integration also raises serious concerns for physicians. After integration, physicians face a totally different employment or service environment; there may be a hesitancy to relinquish control of their former medical practice. The Service, on the other hand, is concerned that the community receive a substantial benefit because of the large amount of charitable assets involved in the purchase of physicians' medical practice assets. In contrast, the physicians may believe that, as the former owners of a valuable business, they should continue to exert considerable control. The Service acknowledges this expertise, but seeks to ensure that there is a significant community benefit which, in certain situations, may conflict directly with the interests of the physicians.

Because of the perceived loss of control, physicians often seek to become designated members of committees having substantial day to day operational powers as well as considerable influence over business and charitable programs. In many cases, these committees are the important bodies which weigh all the facts and circumstances in a complicated proposed action. These committees often make recommendations based upon complex fact patterns to the Board of Directors. Typically, the full Board of Directors meets infrequently. Because of workload demands, limited expertise of Board members, and the complexity of issues, the Board often is unable to give detailed attention to every item coming up for a vote. Under certain circumstances, the Service is concerned that the Board will routinely accept the recommendations of committees which have significant control by financially-interested parties.

Because the Service has no accurate tool to measure the real control exercised by physicians or other financially interested individuals who are members of committees, it will under appropriate circumstances apply the 20% safe harbor to committees.

C. Application of the 20% Safe Harbor

The Service has, under certain circumstances, allowed physician representation on the Board of Directors of an IDS organization to exceed 20% where the physicians at issue have no past or present financial interest in the IDS. Also, while in one or two IDS cases the Service may have applied the 20% safe harbor to include salaried managers or administrators of hospital participants, the Service now applies the 20% safe harbor only to physicians selling assets to or providing professional services in conjunction with the IDS organization.

For example, in a particular case involving a 10 person Board of Directors, the Service approved the inclusion of three physicians as members. Two physicians were allowed to have a direct or indirect financial interest in the IDS organization. The third physician did not and could not have any direct or indirect financial interest in the IDS organization. In this situation, the third physician member was an employee of the hospital, the sole corporate member of the IDS organization. Another situation where the safe harbor was allowed to be exceeded was when the third physician on a 10 person Board was retired and had no past or present direct or indirect financial interest in the IDS organization or any acquired physician practice.

In general, any physician selling assets to, employed by, or providing professional services to or on behalf of an IDS organization is "tainted" and can never serve as a "disinterested" physician on an IDS organization's Board of Directors. Also, any physician receiving significant referrals from an IDS organization may be considered financially interested and precluded from being considered a disinterested physician member.

4. Compensation

Compensation issues often arise in IDS organizations, faculty group practice plans, clinics, hospitals converting from for-profit to non-profit status, and joint ventures and partnerships involving exempt organizations, as well as ruling requests regarding these entities. Compensation arrangements often provide

for base salaries, fringe benefits, deferred payments, income guarantees, contingencies to compensation, and incentive bonuses.

In most situations, the Service wants to review certain basic information involving compensation arrangements. Although the compensation arrangements and the accompanying professional services agreement ("PSA") may be included in the file, they are complex and often it is difficult to determine ultimate actual compensation. Thus, the Service often requests more specific information, adding additional time to the rulings process. The following is a reproduction of the typical "compensation" questions the Service asks. It expedites matters if this information is included in the original submission to the Service.

(1) How many physicians do you employ and how many do you contract with for professional services?

a. Please submit a compensation contract for each physician employee. You may black out the physician's name and assign a letter or number to each contract if concerned about privacy issues.

b. For each compensation arrangement please provide the following:

i. A realistic estimate of total projected physician's compensation (including base, bonus, benefits and managed care risk pool withholds or other risk pool participation) for a three year period. (The "estimate" could be for one year of actual operation and two years of projections, depending upon how long you have been operational.) The estimate must be based on the terms contained in the compensation agreement.

ii. A realistic estimate of three years projected gross receipts. (The "estimate" could be for one year of actual operation and two years of projections, depending upon how long you have been operational.) The estimate must be supported by data used in preparing actual or future financial reports or projections.

iii. A statement establishing that the physician's total

compensation is reasonable for the geographic locale and physician specialty. You can establish reasonableness by the use of compensation data for the physician specialty based upon compensation studies produced by local, regional, or national medical associations, the American Hospital Association, the Medical Group Management Association, the Hay Group, or other knowledgeable consultants.

iv. Are there any caps (ceilings) on total compensation?

v. Before total compensation of all physicians (base and benefits minus bonus and risk pool withholds) is determined, how much surplus remains for the exempt organization? After total compensation is determined how much surplus remains? What percentage of surplus do the physicians receive? What percentage does your organization receive?

5. Affiliation Rights

In some situations, the professional services agreement and/or the asset purchase agreement between the exempt IDS organization and its physician employee(s) allows the selling physicians or medical group to have final authority in determining if the IDS can own, operate or affiliate with other medical practices. The Service views this right as inconsistent with exempt status.

An important reason for an IDS organization's exemption is the fact it is a provider of medical services to its total community. Thus, a right to approve affiliation given to the selling physicians can effectively eliminate the IDS organization's ability to add to the provision of its charitable medical services at a new location in the community. Such a provision also confers a substantial private benefit on the selling physicians.

6. Sales of Exempt Hospitals

Horizontal integration, the purchase by or close affiliation of one hospital with another, is occurring at an accelerating pace. The Service is witnessing a large increase in ruling requests in this area.

Generally, rulings involving the sale of IRC 501(c)(3) hospitals fall into three categories. The first involves hospitals which sell their assets and remit the proceeds to an existing IRC 501(c)(3) community trust. As a general rule, so long as fair market value ("FMV") is paid, the transfer of the proceeds to the existing, established community trust poses little chance for abuse. The second category involves situations where a church controlled hospital or a hospital corporation with multiple locations is selling one of several community hospitals. Again, as a general rule, so long as FMV is paid, the Service is likely to approve this type of transaction. The third category is when the proceeds of the sale are transferred to a newly created private foundation ("Foundation") which makes grants to support health related projects in the community. Generally, in each of these three situations the hospital and/or the Foundation requests rulings on the effect of the transaction on its exempt status and, if bonds are involved, the exclusion of bond interest from gross income of the bondholders. In making the exemption determination, the Service considers the following factors.

A. Fair Market Value

Generally, the administrative file accompanying the ruling request must contain an appraisal of the hospital assets being sold. The appraisal should contain the type of information discussed in the 1995 and 1996 CPE texts on the valuation of medical practices. If the appraisal meets the criteria discussed in the CPE articles and the purchase price is at or above the appraised amount, the Service generally will not raise a FMV issue.

B. Funding of Projects

Because the Foundation's source of income typically emanates from the sale and conversion of a **direct** health care provider, the immediate impact on the community from the sale may be a reduction in the amount of charitable medical services available to the community. Therefore, one of the most important positive facts indicating a charitable purpose is the Foundation's support of indigent care and Medicaid services. This is accomplished by the Foundation making grants to all local health care providers for the reimbursement of medical services. The disproportionate payment to the purchaser of the exempt hospital (the "For-profit Hospital"), to the detriment of other community wide providers, is a negative factor.

Another positive fact is when the Foundation's level of monetary commitment to direct medical services is equivalent to what the non-profit

hospital provided in the past. The hospital's average past three years of Medicaid and charity care has been viewed as a good bench mark for the Foundation's future support of direct medical care to the community.

The Service also looks to the hospital's past monetary commitment to local education, testing, and outreach programs as important facts in determining whether sufficient community benefit will be present to offset the loss of the charitable hospital to the community.

Programs which benefit the community in a less immediate fashion, such as research and scientific activities, will also be considered as positive health related projects. However, the Service carefully reviews these expenditures for more than incidental private benefit or inurement. The Service is concerned that the For-profit Hospital, its physicians, and/or its stockholders not receive more than an incidental benefit from the Foundation's grants for research or scientific activities. All such transactions must meet the following criteria: provide for no more than FMV payment for goods and services; and provide for no more than reasonable compensation to financially interested individuals.

C. Side Deals

The Service is very concerned that no Directors, Officers, administrators, committee members, medical staff leaders, key employees or their relatives receive any compensation, consideration or other forms of direct or indirect payments to induce the sale of a charitable hospital to a for-profit interest. Any such payments trigger serious private benefit issues.

D. Limitations on Providers

The Foundation is encouraged to fund any reasonable and worthy charitable health care projects in the community. A positive fact indicating community benefit is a willingness by the Foundation to make grants to all hospitals and health care providers in the community. The Service questions the Foundation's community benefit if it omits or restricts grants for reasonable charitable activities at existing hospitals or other health care organizations which compete with the For-profit Hospital.

E. Faculty Group Practice Plans

The Service understands that IRC 501(c)(3) hospitals associated with or

controlled by university medical schools often do not create charitable foundations which directly fund community programs. Instead, varying portions of the money are likely to go toward the universities' medical schools and their priorities. In these situations, the deans of those medical schools often decide how the funds are expended.

F. A Minority of Financially Interested Directors

The Service recognizes the importance of having representatives of the For-profit Hospital, other hospitals, as well as physician membership on the Foundation's Board. However, the Service believes that such participation should be limited to a minority of the members of the Foundation's Board of Directors. Such limited participation reduces the chance of private benefit and inurement issues resulting from grants, research and scientific projects directed to these entities and individuals. The Foundation's by-laws should clearly establish that the composition of the Board of Directors satisfies this standard.

G. Term Limitations

Another favorable fact is that the Foundation's by-laws provide for the rotation of Board members. Board members of the former non-profit hospital may be reluctant to make grants to former competing hospitals in their community. Term limitations may encourage membership representing varying segments of the community with differing ideas and needs. Term limitations may reduce the effect of prejudices and serve as a deterrent to possible private benefit.

H. Conflicts of Interest Policy

The Foundation's by-laws should contain language which clearly identifies situations where a conflict might arise. Further, its Directors must exercise their powers in good faith and in a manner which they believe to be in Foundation's best interests. Please refer to section 3 of this article for suggested language.

I. Compensation From the Sale

The Service carefully reviews any type or form of consideration passing between "insiders" of the non-profit hospital as a result of the sale. All payments, commissions and other arrangements involving transfers of monies or other consideration must be detailed. The community does not benefit when individuals in authority use their position for private gain or to receive more than reasonable

compensation. The non-profit's Board minutes should reflect any type of compensation flowing from this transaction and provide supporting evidence demonstrating that it is reasonable.

J. Operation as a Private Foundation

Generally, if the Foundation does not implement a fund raising program, it is or will become a private foundation subject to IRC 4941 excise taxes on any direct or indirect acts of self-dealing between it and a disqualified person. Any Foundation Board member, whether representing the community or the For-profit Hospital, its employees, independent contractors, or financially interested medical group, is a "foundation manager" under IRC 4946(d)(3)(B) and is subject to the IRC 4941 rules on self-dealing.

IRC 4941(d)(1) lists six acts involving self-dealing. Directors of the Foundation could be involved in three acts. They could be subject to (1) IRC 4941(d)(1)(A) involving the sale or exchange, or leasing of property between the Foundation and disqualified persons ("DPs"); (2) subsection (C) involving the furnishing of goods, services or facilities between the Foundation and the DP; and (3) subsection (D) involving the payment of compensation by the Foundation to the DP.

If the For-profit Hospital is a substantial contributor to the Foundation, and thus a DP in relation to the Foundation, situations where the Foundation provides goods or services to the For-profit Hospital will raise the question of self-dealing. Further, situations where the Foundation compensates the For-profit Hospital, its physicians or related medical groups for the provision of direct medical services, educational programs or scientific research create self-dealing issues. Thus, the Foundation should be aware that many of its primary exempt charitable functions involve situations where there is a potential for self-dealing in transactions between it and the For-profit Hospital that is a substantial contributor to the Foundation.

7. Problems with Stock Liquidations

In an IDS transaction, the purchasing exempt organization may become a vehicle for conferring private benefit on the sellers when it buys a physician medical practice. In certain situations, a medical practice is comprised of various corporate entities and partnerships. Often the medical practice is a partnership because of favorable tax considerations while assets employed in the operation of

the medical practice are owned by a corporation. The corporation's stockholders usually are limited to the physicians who operate the medical practice or physician controlled partnerships which own all shares in the corporation.

A for-profit medical group operating a medical practice or holding real estate, fixtures and medical equipment through a "C" corporation (or under certain circumstances an "S" corporation) is ultimately subject to double taxation (once at the corporate level and once at the individual level) on the earnings and appreciation that arise while the investment or business is maintained in corporate solution.<$FAn S corporation is generally treated for income tax purposes as a pass-through entity, the income and deductions of which flow through and are taxed at the shareholder level. The corporation pays no corporate level tax and the shareholders pay the tax on the corporate operations roughly in place of the shareholder level tax on distributions, which leaves the shareholders larger after-tax proceeds from corporate profits distributed to the shareholders. However, under IRC 1374, if a C corporation files after 1986 to elect S status, the net unrealized built-in gain in its assets at the time of conversion to S status is subject to a special corporate level tax on any net built-in gains recognized during its first 10 years as an S corporation.> Were an IDS organization to acquire a physician practice or related assets, it could operate the business or assets on a tax-exempt basis. If the IDS organization acquired the assets of a physician practice from the physicians' C corporation, the C corporation would be taxed on any gain it had in those assets (under IRC 1001). Only the after-tax proceeds would be available for distribution to the physician/shareholders, who would also pay the additional individual level of tax (generally under IRC 331 or 301, depending on whether the corporation liquidates). In this case the net proceeds to the shareholders are reduced by both levels of taxation. The results are similar if the C corporation first distributes the practice or assets to the shareholders, who then sell them to the IDS. The corporation recognizes gain on the distribution of assets under IRC 311 or 336 (depending on whether it liquidates) as if sold to them for fair market value, and the shareholders also are taxed on the distribution, generally under IRC 301 or 331.

If instead the IDS organization were to purchase the stock of the corporation, the shareholders would still bear the individual level of tax on their gain, but the corporate level of tax would remain deferred. In that case, the IDS organization would be operating a for-profit subsidiary, which would not make effective use of its ongoing tax exemption. In order to acquire the corporate assets, the IDS organization would have to have the assets distributed to it. That distribution generally triggers the corporate level tax, either under IRC 311 (if the

corporation is not liquidated) or under section 337(b)(2) (if the corporation is liquidated). Section 337(b)(2) denies an exception to the corporate level tax otherwise available on the liquidation of a lower tier wholly-owned corporate subsidiary where the parent corporation is exempt from tax unless, immediately after the distribution, the acquiring corporation uses the property in an unrelated trade or business. In most IDS organizations, this latter exception does not apply because the IDS organization uses the property for an exempt function.

The effect of these provisions is that, for the IDS organization to obtain the assets directly, the same two levels of taxation must be borne as in the direct purchase of the assets. The difference between this transaction and the direct asset purchase is that the corporate level tax is borne while the corporation is owned by the IDS, and does not reduce the proceeds available to the selling shareholders. In an arm's-length purchase, the buyer would pay less for the stock than it would for the net assets because the buyer assumes the burden of the corporate level tax on any previously developed appreciation in the assets. Thus, the IDS organization's failure to make a downward adjustment to the value of the assets confers a private benefit on the selling physician.

A. An Example of the Application of the Law

In 1960, 10 physicians invested $20,000 each ($200,000 in total) in a C corporation to operate a group medical practice, to purchase land, and construct a medical office building. The building was constructed and the medical practice is thriving. In 1994, the physicians decide to become a part of an IDS. The IDS organization wants the corporate assets instead of the stock because of liability concerns and its ability to escape taxation on the profits of the corporation. Assume at that time that the corporation's basis in its assets is $10 million and that it has no liabilities. If it sells its assets to the IDS organization for $60 million, it will be taxed on its gain (35% x $50 million = $17.5 million). That leaves $42.5 million cash that can be distributed to the physician/shareholders in liquidation. They will also pay individual tax on the liquidation (39.6% x $42.5 million = $16.8 million), clearing net about $25.7 million on the sale.

If the IDS organization buys the stock from the physicians, the physicians will be taxed on their gain on the stock, but the corporate level gain will not be triggered. The $17.5 million tax on the built-in gain will be borne by the corporation, either over time through operations or in liquidation, while the corporation is a subsidiary of the IDS. This tax will reduce the IDS organization's return on its purchase. In an arm's-length transaction, this will be reflected in the

amount paid to buy the stock. Failure to reflect that would be a substantial benefit to the physician shareholders.

B. The Potential Adverse Effect on the Charitable Purchaser

An IDS organization may provide benefits to "private individuals," or persons who are not members of a charitable class, provided those benefits are "incidental" both quantitatively and qualitatively. See G.C.M. 37789 (Dec. 18, 1978). To be qualitatively incidental, private benefit must be a necessary concomitant of an activity which benefits the public at large; in other words, the benefit to the public cannot be achieved without necessarily benefitting certain private individuals. Id. at 6. In this situation, the community can receive the same services, without unnecessarily benefiting the seller, if the IDS organization purchases the assets instead of the stock. Thus, the private benefit to the physicians is not a necessary incident of purchasing the medical practice.

To be "quantitatively incidental," any private benefit must be insubstantial "measured in the context of the overall public benefit conferred by the activity." G.C.M. 37789 at 8. Whether private benefit is quantitatively incidental or insubstantial depends on whether the benefits provided are greater than necessary to accomplish the exempt purpose. If a charitable IDS organization pays a corporate tax on behalf of a financially interested party, it may well be considered quantitatively substantial as measured in the context of the overall public benefit to the community. This payment may also be considered a significant negative fact in making a determination of the purchasing organization's community benefit. See Rev. Rul. 69-545, supra.

8. Physician-Hospital Organizations ("PHOs")

A. In General

For a variety of reasons, physicians and hospitals may wish to coordinate some activities without fully integrating their operations. One method of accomplishing this is through the creation of a physician-hospital organization ("PHO"). The PHO typically is controlled jointly by the hospital and the physicians as either owners or members of the organization. The physicians may participate in the PHO either individually or through an individual practice association ("IPA").

A PHO typically owns no facilities or equipment and generally is not itself a

health care provider. The PHO serves instead as a vehicle through which hospitals and physicians jointly market their services to and contract with third party payers, such as managed care plans, insurance companies, and employers. It may also provide some administrative services related to third party payer contracts. The PHO does not exercise control over the operations of the hospital or the physicians, which retain their separate existence.

A PHO generally will not qualify for exemption under IRC 501(c)(3) because negotiating managed care contracts for the member-physicians furthers their private interests more than incidentally. PHOs are likely to be closely analogous to the individual practice associations described in Rev. Rul. 86-98, 1986-2 C.B. 74. Those organizations did not qualify for exemption under the less stringent requirements of social welfare organizations described in IRC 501(c)(4) or business leagues described in IRC 501(c)(6) because of the private benefit provided to the member physicians.

B. Tax-Exempt PHO

Although typical PHOs are unlikely to be recognized as exempt organizations, the Service recently recognized a somewhat unique PHO as an organization described in IRC 501(c)(3). That organization was a PHO formed by the University of Kansas Hospital ("Hospital"), the fourteen faculty group practice associations ("Clinical Practices") affiliated with the University of Kansas Medical Center ("Center"), and the physicians who are members of the faculty and medical staff of the Hospital and professional employees of the Clinical Practices. The Clinical Practices had already been recognized as exempt from federal income tax as organizations described in IRC 501(c)(3). The members of the PHO are the Hospital and the Clinical Practices.

There are eleven Directors on the governing board of the PHO: two Hospital Directors, four Clinical Practice Directors, and five physician Directors. The Hospital Directors are nominated by the Hospital. The Clinical Practice Directors are nominated from the presidents of the Clinical Practices. The physician Directors are nominated by the Executive Committee of the medical staff of the Hospital. Any action taken by the Board requires the approval of the majority of those present, which must include at least one Hospital Director, two Clinical Practice Directors, and two physician Directors. Thus, all Board actions must be approved by at least one of the Hospital Directors and two Clinical Practice Directors.

Unlike most PHOs, which confer substantial private benefit on the participating physicians, this PHO is controlled by the related IRC 501(c)(3) organizations with which it is affiliated. Its mission is not simply to negotiate contracts for the delivery of hospital and medical services, but to supply a continuum of patients with diverse medical problems to the faculty and teaching hospital in order to perform their exempt function of educating the medical students. As a result, this PHO provides essential services to and is operated for the benefit of a group of related tax exempt organizations with which it is affiliated and not for the benefit of private interests. Therefore, this PHO qualifies as an organization described in IRC 501(c)(3).

C. Participation by Tax-Exempt Hospitals in PHOs

PHOs that do not themselves qualify as tax-exempt organizations may nevertheless have tax-exempt hospitals as members. Under certain circumstances, a tax-exempt hospital may participate in a PHO without jeopardizing its exempt status. See the 1995 CPE, at pages 154-157, for additional guidance on this subject. However, the hospital's exempt status will be jeopardized if the participation in the PHO is merely a device to distribute its earnings to the physician participants. The hospital participant is required to ensure that the PHO is structured so that it is not providing impermissible benefits to the physician participants.

Since the PHO in these instances is not a tax-exempt health care organization, it is not required to have a governing body that represents the community. Instead, its governing body may represent the participants. However, the tax-exempt hospital participant should ensure that its interests are adequately represented on the governing body so that the PHO is not operated in a manner that is inconsistent with the hospital's exempt status. This can be accomplished, for example, by the hospital appointing a portion of the governing board commensurate with its investment in the PHO or by otherwise structuring it so the hospital has a veto power over actions of the PHO which may adversely affect its exempt status.

Tax exempt hospital capitalization of a PHO should be commensurate with the benefits expected to be received by the hospital and its community from the hospital's participation in the PHO. All the benefits of participation should be considered. Absolute parity between investment and control may not be required, though the opportunity to control the organization is one of the benefits of participation and may evince a hospital's intention to protect its investment.

Properly structured loans and preferred stock arrangements, where reasonable, may provide some flexibility to the general expectation that capitalization be proportional.