# D. UPDATE ON HEALTH CARE

**by**
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## 1. Introduction

In the past year, no major revenue rulings have been issued in the areas of unrelated business income, health maintenance organizations and IRC 4958 (intermediate sanctions). Nevertheless, we have considered several fact situations that illustrate the application of some of the rules affecting these areas.

## 2. Unrelated Business Income

### A. Convenience of the Patient Exception

IRC 513(a)(2) provides that an unrelated trade or business does not include any trade or business which is carried on by an IRC 501(c)(3) organization or by certain state colleges and universities primarily for the convenience of its members, students, patients, officers, or employees.

This exception was considered in PLR 200016023 (1/21/00). In this private letter ruling, the issue was whether the rental income one hospital received from another hospital was unrelated business income under IRC 513(a) or debt-financed income under IRC 514(a).

University Hospital was a large tax-exempt teaching hospital located in a large urban area. For many years, University Hospital had teaching relationships with several other hospitals in the same city (the University Hospital Teaching System). One of the hospitals in the University Hospital Teaching System was Specialty Hospital, a large, independent, IRC 501(c)(3) urban hospital devoted to the treatment of certain disorders.

General Hospital, a large, tax-exempt, acute care and teaching hospital located immediately adjacent to Specialty Hospital, was also part of the University Hospital Teaching System. Rehab Hospital, an IRC 501(c)(3) rehabilitation hospital, was also part of University Hospital's Teaching System. Rehab Hospital and General Hospital have the same corporate member. University Hospital, Specialty Hospital and General Hospital are structurally unrelated to each other.

Due to advances in medical technology, Specialty Hospital improved its ability to provide health care services on an outpatient basis. As a result, Specialty Hospital developed excess inpatient capacity in its main facility. Specialty Hospital sought to use this excess capacity in a manner that would further its charitable purpose of providing

health care to the community, consistent with its position as a participant in the University Hospital Teaching System.

As a result, Specialty Hospital leased this excess capacity to Rehab Hospital at fair market value. Rehab Hospital used the leased space (the Rehab Hospital Unit) as a 15-bed inpatient unit of a rehabilitation or long-term care hospital providing post-acute medical care or rehabilitation services. The Rehab Hospital Unit was operated as a separate unit of Rehab Hospital under Rehab Hospital's hospital license, and persons treated at the Rehab Hospital Unit were admitted as Rehab Hospital patients. Although the patients of Specialty Hospital transferred to Rehab Hospital would be admitted to the Rehab Hospital Unit, no beds were set aside in advance for Specialty Hospital's patients and Specialty Hospital's patients did not receive any preference in admission.

Because the Rehab Hospital Unit was located within Specialty Hospital's facility, the number of patients Specialty Hospital discharged to Rehab Hospital could increase, since the proximity and convenience of the Rehab Hospital Unit for Specialty Hospital's physicians would facilitate the continuity of care of Specialty Hospital's patients. Specialty Hospital's patients, who would otherwise have remained at Specialty Hospital for longer periods, would instead be discharged from Specialty Hospital to Rehab Hospital's Unit. This transfer from the sick bed environment of an inpatient unit to a continuing care, rehabilitation unit is desirable for patient care and is encouraged by health care insurers. In essence, the location of the Rehab Hospital Unit within Specialty Hospital's facility would serve in part as Specialty Hospital's rehabilitation facility, relieving Specialty Hospital of the need to fund and operate its own rehabilitation facility. In addition, patients discharged from General Hospital to the Rehab Hospital Unit would also benefit from the rehabilitation services located in the adjacent Specialty Hospital.

By Specialty Hospital leasing unused excess inpatient capacity to Rehab Hospital to provide post-acute medical care or rehabilitation services, Specialty Hospital used this otherwise dormant space to further its charitable purpose of providing health care to the community. By Specialty Hospital providing a convenient rehabilitation facility to which its patients may be discharged as needed, Specialty Hospital furthered its charitable purpose without the need to fund and operate its own rehabilitation facility. Therefore, to the extent that this leased space was used for treating Specialty Hospital's own patients, leasing the space to Rehab Hospital was not an unrelated trade or business activity because the space was used for the convenience of Specialty Hospital's patients.

Based on these facts, the Service ruled that Specialty Hospital's leasing activity was not an unrelated trade or business under IRC 513(a) or an activity utilizing debt-financed property under IRC 514(a).

B. Substantially Related

IRC 513(a) provides that the conduct by a tax-exempt organization of a trade or business which is not substantially related to the organization's exercise or performance of its tax-exempt purpose is an unrelated trade or business. This principle was considered in PLR 9837031 (6/15/98) in the context of a large integrated health care delivery system.

This private letter ruling involved a large integrated health care delivery system (System). The members of System included a parent organization (Parent), a hospital (Hospital), a teaching hospital (Medical Center), and a clinic (Clinic), all of which were tax-exempt under IRC 501(c)(3). The System also included a health maintenance organization (HMO), which was tax-exempt under IRC 501(c)(4).

HMO contracted with Clinic for Clinic to provide physician services to HMO's enrollees in return for the payment of capitated fees. Clinic employed staff physicians and contracted with independent physicians. Clinic paid its employed physicians a salary plus incentives, paid its contracted primary care physicians capitated fees and paid its contracted specialists fees-for-service.

On these facts, the Service ruled that the capitated payments Clinic received from HMO for the provision of physician services to HMO's enrollees, whether performed by Clinic's employed or contracted physicians, were not unrelated business income to Clinic. Clinic's exempt purposes included the provision of heath care services to the community. The provision of health care services by Clinic's employed and contracted physicians to HMO's enrollees, in return for the receipt of fees from HMO, was substantially related to Clinic's exempt purposes.

This private letter ruling considered the substantially related principle in another context, involving the provision of various ancillary health care services. In this private letter ruling, Hospital, Medical Center and Clinic, as part of their overall provision of health care services to the community, each provided certain ancillary health care services, including:

(1) Radiology services, such as magnetic resonance imaging (MRI),

(2) Respiratory, speech and physical therapy,

(3) Occupational and industrial medicine,

(4) Home health and hospice services, and

(5) Case management services.

Hospital, Medical Center and Clinic provided these ancillary health care services through their professional health care employees, consisting of registered nurses, medical technicians and skilled therapists. They provided these ancillary health care services in three different settings:

(1) On Hospital's and Medical Center's respective hospital campuses to patients of Hospital, Medical Center and to patients of other medical institutions in the System,

(2) On Hospital's and Medical Center's respective hospital campuses to persons who were not patients of Hospital, Medical Center, Clinic or of any other medical institution in the System, and

(3) At locations away from Hospital and Medical Center's campus at medical institutions that were not part of the System, or at employer locations.

On these facts, the Service concluded that the provision of professional ancillary health care services by the professional health care employees of Hospital, Medical Center and Clinic furthered their respective exempt purposes, even though some of the patients who received these services were registered at non-System medical institutions and even though some of the health care services were performed at non-System medical institutions or at employer locations. Therefore, the Service ruled that the provision of these services was substantially related to Hospital's, Medical Center's and Clinic's exempt purposes.

C. Laboratory Testing Services

An issue that frequently arises in the health care context is whether the performance of laboratory testing services by a hospital is an unrelated business activity. The key element in analyzing this issue is the convenience of the patient exception in IRC 513(a)(2), previously discussed. Two significant revenue rulings in this area are Rev. Rul. 68-376, 1968-2 C.B. 246, and Rev. Rul. 85-110, 1985-2 C.B. 166. Rev. Rul. 68-376 described six factual situations where it was determined whether a person was a patient of the hospital for purposes of IRC 513(a)(2). Rev. Rul. 85-110 concluded that the hospital's performance of diagnostic laboratory testing on specimens received from the private office patients of a hospital's staff physicians and from patients of a medical clinic that was unrelated to the hospital was an unrelated trade or business because there was no substantial causal relationship between the achievement of the hospital's tax-exempt purpose and the provision of diagnostic laboratory testing services to non-patients

of the hospital. This revenue ruling also concluded that the hospital's provision of diagnostic laboratory testing services on specimens from persons who are not the hospital's patients is not an activity carried on primarily for the convenience of its patients under IRC 513(a)(2).

The most significant case in this area is St. Luke's Hospital of Kansas City. v. United States, 494 F.Supp. 85 (W.D. Mo. 1980) (St. Luke's). In this case, the District Court held that the performance of diagnostic laboratory testing services by an IRC 501(c)(3) teaching hospital on specimens obtained from individuals who were not patients of the hospital, which were needed for the conduct of the hospital's teaching activities, was not an unrelated trade or business activity where the testing services contributed importantly and substantially to the hospital's teaching program. (In Rev. Rul. 85-109, 1985-2 C.B. 165, the Service announced that it would follow this part of the St. Luke's decision.)

Treas. Reg. 1.513-1(d)(3) provides that in determining whether activities contribute importantly to the accomplishment of an exempt purpose, the size and extent of the activities have to be considered in relation to the nature and extent of the exempt function which they purport to serve. Thus, an important fact in St. Luke's and in Rev. Rul. 85-109 was that the diagnostic laboratory testing program was relatively small in size compared to the other activities of the pathology department, and business was not actively solicited through advertising or otherwise.

Several private letter rulings have considered whether a hospital's performance of laboratory testing services was an unrelated trade or business.

In PLR 9837031, Hospital, Medical Center and Clinic performed laboratory testing services on specimens obtained from the following six sources:

(1) Specimens from Hospital's and Medical Center's inpatients.

(2) Specimens sent to the laboratory by Clinic's non-employee contracted physicians, in connection with physician services they provided to HMO enrollees.

(3) Specimens sent to the laboratory by Clinic's employee physicians.

(4) Specimens from the private patients of Clinic's non-employee contracted physicians, in connection with physician services they provided to these patients who were not HMO enrollees.

(5) Specimens from the private patients of Clinic's non-employee contracted physicians who were members of Medical Center's medical staff, in connection with physician services they provided to these patients.

(6) Specimens from the private patients of physicians who were not affiliated with System, in connection with physician services they provided to these patients.

The specimens from sources (4), (5) and (6) were obtained by the laboratory in two ways. Under the more common method, individuals presented themselves at Hospital, Medical Center or Clinic to have the specimens obtained in person (such as by drawing blood, collecting a urine sample, or taking a culture or tissue sample). Under the less common method, physicians obtained specimens from their patients at locations other than Hospital, Medical Center or Clinic, such as the physicians' private offices, and the physicians sent the specimens to Hospital, Medical Center or Clinic to perform the laboratory services at that facility.

Source (1). In PLR 9837031, the Service ruled that the laboratory services performed on specimens obtained from Hospital's and Medical Center's inpatients were performed within the rationale of Rev. Rul. 68-376, 1968-2 C.B. 246. Therefore, the income earned by Hospital, Medical Center and Clinic from performing these laboratory testing services was not income from an unrelated trade or business.

Source (2). PLR 200025059 (3/22/00) involved the same facts as in PLR 9837031. In addition to providing health care to the community, Hospital, Medical Center and Clinic also provided education to medical professionals. Specifically, Hospital and Medical Center engaged in a number of continuing education, residency and fellowship programs and operated a school that trained medical technologists. Hospital also engaged in significant medical education and research activities. In addition, Clinic conducted research and educational activities with Hospital, and Clinic conducted continuing medical education programs in conjunction with Hospital, Medical Center and HMO.

The collection of specimens from all sources, including from Clinic's non-employee contracted physicians, was instrumental to the educational components of Hospital, Medical Center and Clinic in training medical students, interns and residents of Hospital's medical education programs. Hospital's and Medical Center's residency and fellowship programs in certain medical specialties as well as the school for medical technologists rely on the collection and testing of these specimens. The greater number of specimens, the greater number of tests the students are able to perform and the more likely they are to encounter a greater number of cultures that test positive, often providing a more beneficial learning experience. Because Clinic's non-employee contracted

physicians typically treated patients who resided throughout a relatively broad geographic area, the collected specimens generally included a wide sampling of disease strains, a situation that would not be possible without these physicians providing the specimens.

Based on St. Luke's and Rev. Rul. 85-109, PLR 200025059 concluded that the testing of specimens sent to Hospital's Medical Center's and Clinic's laboratories by Clinic's non-employee contracted physicians, in connection with physician services they provided to HMO enrollees, contributed importantly to the educational purposes of Hospital, Medical Center and Clinic because the testing of specimens was utilized in the education of medical students, residents and interns. Therefore, the income earned by Hospital, Medical Center and Clinic from performing these laboratory testing services was not income from an unrelated trade or business.

Source (3). In PLR 9837031, the Service ruled that the income earned by Hospital, Medical Center and Clinic from the performance of laboratory testing services on specimens obtained by physicians employed by Clinic was derived from activities undertaken for the convenience of Clinic's employee-physicians, within the meaning of IRC 513(a)(2). Therefore, the income earned by Hospital, Medical Center and Clinic from performing these laboratory testing services was not income from an unrelated trade or business.

Sources (4), (5) and (6). In PLR 9837031, the Service ruled that when an individual presented oneself in person at the laboratory site of the Hospital, Medical Center or Clinic to provide a specimen, the individual is considered to be a patient of that particular facility, even though the individual is also the patient of a physician in private practice who is not employed or contracted by the Hospital, Medical Center or Clinic. Therefore, the income earned by Hospital, Medical Center and Clinic from performing these laboratory testing services was not income from an unrelated trade or business.

Although not part of the private letter ruling, where the Hospital, Medical Center and Clinic performed laboratory services on specimens sent to the laboratory by non-employee or non-contracted private physicians who obtained specimens at sites other than the Hospital, Medical Center or Clinic, such as the physicians' private offices, the Hospital, Medical Center and Clinic correctly treated this activity as an unrelated trade or business.

The performance of laboratory testing services was also the subject of PLR 9851054 (9/25/98), but under a different set of circumstances. In this private letter ruling, four unrelated IRC 501(c)(3) hospitals were the members of L, an IRC 501(c)(3) organization, and L was the sole member of R, also an IRC 501(c)(3) hospital. (These five hospitals

are collectively referred to as the Patron Hospitals.) In order to provide laboratory services for their respective patients, the Patron Hospitals consolidated their laboratory operations by forming S, a stock corporation that was recognized as tax-exempt under IRC 501(e). The laboratory services consisted of analyzing and testing certain specimens obtained from the human body. S derived its income from performing laboratory services for Patron Hospitals' patients who presented themselves at the Patron Hospitals' draw sites.

Three of the Patron Hospitals formed a limited liability company (LLC). (These three hospitals are collectively referred to as the LLC Hospitals.) LLC derived its income from performing laboratory services for individuals who did not present themselves at the draw sites.

The laboratory operations for both S and LLC were conducted at a centralized laboratory which was owned by S and LLC as tenants-in-common (the Central Lab). Under an Allocation Agreement between S and LLC, all personnel required to operate the Central Lab were employed by LLC. A wholly-owned for-profit subsidiary of one of the Patron Hospitals (Management Company) managed the Central Lab's operations in return for a fixed monthly management fee. Management Company paid the Central Lab's payroll costs from an LLC payroll account that was funded by Central Lab's revenues. In addition, Management Company paid Central Lab's operating expenses from Central Lab's revenues.

The Patron Hospitals obtained specimens at various draw sites, located at the Patron Hospitals and at places owned or leased by a Patron Hospital. The personnel at these draw sites were employed by a respective Patron Hospital and consisted of phlebotomists and medically-trained support staff. The personnel at these draw sites drew and collected specimens and forwarded them to the Central Lab for analysis and testing. The Central Lab's employees performed the appropriate analysis and testing on these specimens using the Central Lab's facilities. Under the Allocation Agreement, the Central Lab's revenue from specimens received from the Patron Hospital draw sites was specifically identified and tracked to S.

Specimens drawn and collected at other than the Patron Hospital draw sites were done by persons who were not Patron Hospital employees, who forwarded the specimens to the Central Lab for analysis and testing. The Central Lab's employees performed the appropriate analysis and testing on these specimens using the Central Lab's facilities. Under the Allocation Agreement, the Central Lab's revenue from specimens received from these other draw sites was specifically identified and tracked to LLC.

Under the Allocation Agreement, the Central Lab's expenses, including payroll costs, operating expenses and management fees, were allocated to S and LLC based on their respective percentages of the number of specimens received from the Patron Hospital draw sites and from the other draw sites.

In this private letter ruling, the Service ruled that the net income S earned from the Central Lab performing analysis and testing services on specimens obtained at the Patron Hospital draw sites by Patron Hospital professional medical employees was not unrelated business income. Persons from whom specimens were drawn or collected at Patron Hospital facilities by Patron Hospital employees were considered patients of a Patron Hospital because the specimens were obtained at a Patron Hospital facility under the direction and supervision of medical professionals employed by a Patron Hospital. As a result, the Central Lab was performing analysis and testing of these patients' specimens primarily for their convenience, within the meaning of IRC 513(a)(2).

Although not discussed in the private letter ruling, the net income LLC earned from the Central Lab performing analysis and testing services on specimens obtained at the other draw sites by persons who were not Patron Hospital employees was unrelated business income.

D. Smoking Cessation Program

Treas. Reg. 1.513-1(d)(2) provides that a trade or business is substantially related to tax-exempt purposes only where the conduct of the business activities has a substantial causal relationship to the achievement of tax-exempt purposes. This regulation also states that for the conduct of a trade or business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes. Treas. Reg. 1.501(c)(3)-1(d)(1)(i) provides that education is a tax-exempt purpose under IRC 501(c)(3). In addition, Treas. Reg. 1.501(c)(4)-1(a) provides that promoting social welfare is a tax-exempt purpose under IRC 501(c)(4).

In PLR 9837031, HMO had been a leader in the use of tobacco cessation patient care in the managed care setting. HMO's research helped to demonstrate conclusively that a nurse-led program in counseling and nicotine replacement therapy was safe and effective. This led to the establishment of a tobacco cessation and prevention program for System, which resulted in a successful smoking cessation rate after the first year.

The success of the tobacco cessation and prevention program was due to the involvement of the nurses trained in the individual assessment of patient motivation. These nurses, who were generally Clinic's employees, provided counseling to patients to overcome barriers in discontinuing the use of tobacco. The nurses were trained in the indications and contraindications to the use of nicotine replacement therapy. When necessary, physicians also assisted in prescribing the nicotine replacement therapy. The nurses followed up with patients for four to six weeks, providing face-to-face visits every two weeks. When the nicotine replacement therapy was provided under the direction of a trained nurse, HMO's pharmacy benefit covered its cost. Additional follow-up was provided for up to one year, including the performance of an exit carbon monoxide breath test to gauge success. The involvement of nurses in the ongoing counseling and support of the patients' activities was unique in the field of smoking cessation programs.

Clinic and HMO planned to build on the success of their initial research by expanding the availability of their tobacco cessation and prevention program. HMO would provide experienced, certified tobacco cessation counselors to train nurses in organizations outside System to use the same approach that has proven successful at HMO. The initial training program would last one day and would include a training manual and a written certification examination developed and tested in System. A follow-up visit would be made to the organization by HMO's personnel to assist with program development and to complete the certification process for counselors. Clinic and HMO would continue to sponsor the shared data base using Clinic's initial research to assist with quality assurance and to track the success of the program.

Clinic and HMO provided the tobacco cessation and prevention program outside of System to other managed care organizations and to insurance companies, employers and to other providers in a manner that would effectively replicate the program. Clinic and HMO charged fees at a level that would encourage broad-based nationwide participation by these entities.

In this private letter ruling, the Service concluded that under these circumstances, Clinic's and HMO's provision of tobacco cessation and prevention services furthered Clinic's educational purposes and HMO's social welfare purposes by providing affordable training, seminars and program material necessary to instruct or train individuals for the purpose of improving their capabilities. Therefore, the Service ruled that the income Clinic and HMO earned from providing these services was not unrelated business income.

E. UBIT Cost Allocation Method

Treas. Reg. 1.512(a)-1 provides that unrelated business taxable income is the gross income derived from any unrelated trade or business regularly carried on, less allowable deductions directly connected with the carrying on of such trade or business, subject to certain modifications.

In the request for ruling, which eventually was issued as PLR 9837031, the taxpayer requested a ruling that the particular cost allocation method Hospital, Medical Center and Clinic used in accounting for the provision of laboratory testing services (discussed above) and ancillary health care services (also discussed above) that produce unrelated business income was reasonable under Treas. Reg. 1.512(a)-1.

The predecessor of section 8.01 of Rev. Proc. 2000-4, 2000 I.R.B. 115, 128, states:

> The Service ordinarily will not issue a letter ruling or determination letter in certain areas because of the factual nature of the problem involved or because of other reasons. The Service may decline to issue a ruling or a determination letter when appropriate in the interest of sound tax administration or on other grounds whenever warranted by the facts or circumstances of a particular case.

Due to the inherently factual nature of the question presented, the Service declined to issue this requested ruling, based on the predecessor of section 8.01 of Rev. Proc. 2000-4.

3. Health Maintenance Organization (HMOs)

A. IRC 501(m)

IRC 501(m)(1) provides that an organization that may otherwise qualify for exemption under IRC 501(c)(3) or IRC 501(c)(4) may be tax-exempt only if no substantial part of its activities consists of providing commercial-type insurance. IRC 501(m)(2) provides that if an organization satisfies IRC 501(m)(1), any activity of the organization consisting of providing commercial-type insurance is treated as an unrelated trade or business that is subject to tax under subchapter L of the Code as an insurance company, rather than under IRC 511.

In PLR 200033046 (4/27/00), a technical advice memorandum (TAM), the Service considered whether an IRC 501(c)(4) health maintenance organization (HMO) with a

point-of-service program provided commercial-type insurance within the meaning of IRC 501(m)(1). In this TAM, HMO arranged, on a prepaid basis, for the provision of comprehensive preventive and therapeutic health care services to its enrollees. HMO's enrollees consisted of individuals and employer groups. HMO obtained the health care services for its enrollees by contracting with a network of independent physicians and with hospitals within designated service areas.

HMO offered its enrollees a choice of two plans when choosing their benefits:

Under Plan A, an enrollee could obtain health care services only from a network primary care physician or from a network specialist following prior authorization by the network primary care provider. In the event of an emergency, however, an enrollee could obtain health care services from a network or non-network specialist without prior authorization from a network primary care physician.

Plan B was a point-of-service (POS) program under which an enrollee could utilize a network or a non-network physician whom the enrollee chose. The POS program was administered by Y, a non-exempt affiliate of HMO. In the event of an emergency, an enrollee could obtain health care services from a network or non-network specialist without prior authorization from a primary care physician.

Based on the number of enrollees, Plan A was HMO's predominant plan and Plan B was insignificant.

HMO compensated its contracted primary care physicians for medical services based on the type of plan that the enrollee selected. HMO paid a network primary care physician who treated a Plan A enrollee on a capitated fee basis. HMO paid a network primary care physician who treated a Plan B enrollee 70 percent of the predetermined network fee-for-service charges. HMO paid non-network primary care physicians who treated Plan B enrollees 100 percent of their standard charges, a portion of which was paid by the enrollees as a co-payment. Thus, a network primary care physician who provided medical services to a Plan A enrollee was paid a different fee for providing the identical medical services to a Plan B enrollee. HMO did not withhold any amounts from the payments it made to any of the physicians.

Under this TAM, HMO's cost of arranging primary health care services for each Plan A enrollee was fixed regardless of the extent of primary care services the primary care physician provided to the Plan A enrollee. In other words, HMO's cost of arranging primary medical care services for each Plan A enrollee did not vary based on the extent of primary care services a network physician provided to the Plan A enrollee. Therefore, HMO shifted to its network primary care physicians a substantial portion of its risk of

loss associated with arranging primary health care services for its Plan A enrollees, and HMO retained only a normal business risk. See Rev. Rul. 68-27, 1968-1 C.B. 315. As a result, HMO's activities with respect to its Plan A enrollees did not consist of providing commercial-type insurance within the meaning of IRC 501(m)(1).

On the other hand, HMO's cost of arranging primary health care services for each Plan B enrollee was not fixed, but varied based on the extent of primary care services the primary care physician provided to the Plan B enrollee. Since HMO paid primary care physicians who treated Plan B enrollees on a fee-for-service basis, HMO bore the risk of loss associated with the cost of providing additional primary care services a Plan B enrollee may require. Therefore, HMO retained rather than shifted to these primary care physicians its risk of loss associated with arranging primary health care services for its Plan B enrollees. As a result, HMO's activities with respect to its Plan B enrollees consisted of providing commercial-type insurance within the meaning of IRC 501(m)(1).

Since HMO's activities of providing commercial-type insurance for its Plan B enrollees was not substantial in relation to its total activities, under IRC 501(m)(1), these activities would not affect HMO's exemption. However, under IRC 501(m)(2), the net income HMO earned from providing commercial-type insurance for its Plan B enrollees would be subject to unrelated business income tax, but HMO's liability for unrelated business income tax would be calculated under subchapter L of the Code, rather than under IRC 511.

The conclusions in this TAM are consistent with the guidelines for examiners included in 7.8.1 IRM, Exempt Organizations Examinations Guidelines Handbook, Chapter 27, Health Maintenance Organizations.

B. Medicaid-Only HMOs

The article at 1999 CPE 67 discussed whether HMOs that arrange for the provision of health care services exclusively to Medicaid beneficiaries qualify for exemption under IRC 501(c)(3). As stated in that article, a Medicaid-only HMO that qualifies for exemption under IRC 501(c)(3) must also satisfy the requirements of IRC 501(m)(1).

In examining HMOs, examiners should first determine whether the HMO meets the examination guidelines in IRM 7.8.1, Chapter 27 for exemption under IRC 501(c)(3) or under IRC 501(c)(4). If the HMO meets these guidelines, the examiner should then consider whether the HMO also satisfies the examination guidelines for IRC 501(m).

IRM 7.8.1, Chapter 27 identifies several IRC 501(m)(1) issues that apply to HMOs that qualify for exemption under IRC 501(c)(3) or IRC 501(c)(4).

i. Physician Compensation Method

7.8.1 IRM 27.10.1 states that one factor demonstrating that an HMO's activities do not consist of providing commercial-type insurance is that the HMO has shifted a significant portion of its risk of loss to its primary care providers. See Rev. Rul. 68-27, 1968-1 C.B. 315. An example of such risk shifting is an HMO compensating its contracted primary care providers on a capitated fee basis. Another example is an HMO compensating its contracted primary care providers on a fee-for-service basis, using the Medicaid-approved fee schedule, and withholding a substantial portion of the fees paid.

A Medicaid-only HMO that meets the IRM examination guidelines for exemption under IRC 501(c)(3) or IRC 501(c)(4), and that compensates its contracted primary care providers using the Medicaid-approved fee schedule, but does not withhold a substantial portion of the fees paid, does not satisfy the examination guidelines for IRC 501(m).

Under these circumstances, an HMO may argue that it satisfies IRC 501(m) because it has shifted a significant portion of its risk of loss under a stop-loss insurance arrangement or a deficit sharing arrangement.

ii. Stop-Loss Insurance

7.8.1 IRM 27.10.2(1) states:

> An HMO that compensates providers using a fee-for-service arrangement may obtain stop-loss insurance from an unrelated party to protect itself from a portion of the financial risk associated with operating the HMO. Whether a stop-loss insurance arrangement obtained by an HMO shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.

To minimize its risk of loss, a Medicaid-only HMO may purchase stop-loss insurance from an unrelated insurance company. In some cases, the HMO's Medicaid agreement with the state requires that the HMO purchase stop-loss insurance. In other cases, the state itself provides the stop-loss insurance to the HMO, and may even charge the HMO a premium for this insurance in the form of a reduction in the capitated fees it pays to the HMO. Generally, under a stop-loss insurance arrangement, if the total annual medical expenses the HMO incurs on behalf of an enrollee exceed a certain amount, the insurer will absorb all or a portion of these excess expenses. In some cases, the insurer

imposes a maximum on the amount it will pay, or covers only certain types of medical expenses, such as in-patient hospital care. (For example, a stop-loss arrangement may provide that if the HMO's total in-patient hospital expenses for an enrollee exceed $50,000 per year, the insurance company would absorb 80% of this excess, but would pay no more than $100,000 per enrollee per year.) In these situations, the HMO may argue that under this arrangement, it has shifted substantial risk of loss to the insurer.

Treas. Reg. 1.801-3(a)(1) states:

> The term insurance company means a company whose primary and predominant business activity during the taxable year is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.

When a Medicaid HMO contracts with a state to arrange for the provision of health care services to its Medicaid beneficiary enrollees, the HMO is primarily liable to arrange and pay for the provision of these services to its enrollees, notwithstanding that the HMO has purchased stop-loss insurance. Where it has been determined that an HMO is providing health insurance for its enrollees, under Treas. Reg. 1.801-3(a)(1), its predominant activity is issuing an insurance contract to the state. The fact that the HMO has obtained an insurance contract from a third party insurer (or from the state itself) that would indemnify the HMO for a portion of the losses it might sustain in performing its Medicaid contract with the state does not alter the fact that the HMO is primarily engaged in the business of insurance.

Even if an HMO with a stop-loss arrangement were considered to have shifted a portion of its risk of loss to an insurance company, the HMO would have to establish that the portion of the risk it shifted was substantial, within the meaning of IRC 501(m)(1), in relation to its total risk of loss, or conversely, that the portion of the risk of loss it retained was insubstantial.

iii. Deficit Sharing

7.8.1 IRM 27.10.2(2) states:

> An HMO that compensates providers using a fee-for-service arrangement may enter into an arrangement with the providers for the providers to share a portion of the HMO's operating losses. Whether a deficit sharing arrangement that an HMO has with its providers shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.

a. An HMO that has a deficit sharing arrangement with a related organization does not shift a significant portion of its risk of loss because the related organization is part of the HMO's economic family. See Rev. Rul. 77-316, 1977-2 C.B. 53; Rev. Rul. 78-338, 1978-2 C.B. 107.

The economic family concept was also applied in a case involving the deductibility of premiums paid to a foreign captive insurance company. In Malone & Hyde, Inc. and Subsidiaries v. Commissioner, 62 F.3d 835 (6th Cir. 1995), the court of appeals held the contractual arrangement between a parent corporation and its foreign subsidiary was not insurance where no shifting of the economic risk of loss had occurred.

When an integrated health care delivery system forms an HMO, and when a group of hospitals which are structurally unrelated to each other form an HMO, the member hospitals are usually the HMO's principal, if not exclusive, providers of inpatient and outpatient hospital services to the HMO's enrollees. Under a deficit sharing arrangement between the member hospitals and the HMO, the member hospitals agree to bear a portion of the HMO's operating losses. If an HMO enters into a deficit sharing arrangement with member hospitals that are structurally related to each other, the HMO does not shift a substantial portion of its risk of loss because it has not shifted its risk of loss outside its economic family. On the other hand, if an HMO enters into a deficit sharing arrangement with member hospitals that are not structurally related to each other, and the hospitals are jointly and severally liable for all of the HMO's operating losses, not just the losses attributable to services the HMO performed for the patients of the particular hospital, an argument can be made that the HMO has shifted a substantial portion of its risk of loss to these unrelated hospitals.

iv. Commercial-Type Insurance

HMOs that qualify for exemption under either IRC 501(c)(3) or IRC 501(c)(4) but which fail to satisfy the IRM examination guidelines in Chapter 27 may argue that although they may provide insurance, they do not provide commercial-type insurance within the meaning of IRC 501(m)(1).

In Paratransit Insurance Corporation v. Commissioner, 102 T.C. 745 (1994) and in Florida Hospital Trust Fund, et al. v. Commissioner, 103 T.C. 140 (1994), aff'd on other grounds, 71 F.3d 808, 812 (11th Cir. 1996), the Tax Court held that commercial insurance is insurance that is generally available commercially. Paratransit states that to be commercial-type insurance, the insurance does not have to be generally available to the public.

Medicaid-only HMOs may argue that even if they are considered as providing insurance, this insurance is not commercial-type insurance, within the meaning of IRC 501(m). They may argue that health insurance to Medicaid beneficiaries is not generally available commercially because virtually no insurance companies in the community offer health insurance solely to a Medicaid population, and if they do, it is generally not affordable.

This argument assumes that the Medicaid beneficiaries are the purchasers of health care insurance, rather than the state. Although a Medicaid beneficiary may select a particular provider from among a panel of providers to be his or her primary care provider, he or she does not purchase the insurance or pay for the insurance. Instead, the state solicits bids from health care organizations to arrange for the provision of health care services to Medicaid beneficiaries in selected areas of the state. The state contracts with the organization and compensates the organization, usually on a capitated fee basis. Usually, there are a number of health care insurance companies, integrated health care systems or other health care consortiums that may offer to sell these health care insurance services to the state, even though this health care insurance is not available for purchase by the individual Medicaid beneficiaries themselves. Thus, if the health care services these organizations provide is considered as insurance, it is generally available commercially to the purchaser of the insurance. On this basis, under Paratransit and Florida Hospital Trust Fund, if the health care services offered by a Medicaid-only HMO are treated as insurance, this insurance would be commercial-type insurance within the meaning of IRC 501(m)(1).

4. Section 4958 (Intermediate Sanctions)

A. Pending Litigation

A group of cases, collectively referred to as the Sta-Home Health Agency cases, are currently pending in the U.S. Tax Court. These cases involve eleven separate petitions.[1] In these cases, the Service imposed excise taxes under IRC 4958 on disqualified persons and organization managers and revoked the exemption of three IRC 501(c)(3) organizations.

In the late 1970's, Mr. Vic Caracci and his wife formed three non-profit corporations to perform home health care services for homebound patients in central Mississippi. The Service recognized these organizations as tax-exempt under IRC 501(c)(3).

[1] Docket Nos. 14711-99X, 17333-99, 17334-99, 17335-99, 17336-99X, 17337-99, 17338-99, 17339-99X, 17340-99, 17341-99, and 17342-99.

Mr. and Mrs. Caracci's children later became involved in operating these organizations. Mrs. Caracci, a son and daughter, were each a member of the board of directors and a principal officer of each organization.

On October 1, 1995, the Board of Directors of each of the three organizations caused the organizations to transfer their assets and liabilities to three Subchapter S Corporations. Collectively, the Caraccis owned all of the voting stock of the S Corporations. The S Corporations continued the home health care activities of the former organizations. The organizations received no consideration from the S Corporations for the transfer of their assets other than the assumption of their liabilities.

The appraiser for the Caraccis determined that as October 1, 1995, each organization's liabilities exceeded the fair market value of its assets, so that the value of the net assets of each organization was less than zero. The Service, on the other hand, determined that the fair market value of each organization's assets substantially exceeded its liabilities, so that the value of the net assets of each organization was significantly more than zero.

The Service contended that each of the Caraccis, directly or indirectly, was a disqualified person within the meaning of IRC 4958(f)(1)(A) and IRC 4958(f)(1)(B). The Service contended that the transfers by the organizations of their net assets to the S Corporations were for less than adequate consideration because the liabilities assumed were substantially more than the value of the assets transferred. Since each of the Caraccis was a shareholder of each of the S Corporations, the increase in the value of their shares that resulted from the transfers was an excess benefit transaction between each organization and each of the Caraccis within the meaning of IRC 4958(c)(1).

The Service also contended that each of the S Corporations was indirectly a disqualified person within the meaning of IRC 4958(f)(1)(C). Since the transfers by the organizations of their net assets to the S Corporations were for less than adequate consideration, the additional economic benefit the S Corporations received was an excess benefit transaction between the organizations and the S Corporations within the meaning of IRC 4958(c)(1).

As a result, the Service asserted that, under IRC 4958(a)(1), the 25 percent first tier excise tax applied to each of the excess benefit transactions. Thus, each of the Caraccis and each of the S Corporations were jointly and severally liable for the 25 percent first tier excise tax based on the amount of excess benefit they each received.

As of the date the statutory notices were issued, none of the excess benefit transactions had been corrected within the meaning of IRC 4958(f)(6). Therefore, under

IRC 4958(b), the Service asserted that the 200 percent second tier excise tax also applied to each of the excess benefit transactions. Thus, each of the Caraccis and each of the S Corporations were jointly and severally liable for this excise tax also.

In addition, the Service contended that Mrs. Caracci, a son and daughter were each an organization manager within the meaning of IRC 4958(f)(2). The Service also contended that each individual participated in each excess benefit transaction knowing that each was an excess benefit transaction, and that each individual's participation was willful and not due to reasonable cause within the meaning of IRC 4958(a)(2). As a result, the Service asserted that, under IRC 4958(a)(2), the 10 percent excise tax applied to the participation by each organization manager in each excess benefit transaction. Thus, each of these individuals was jointly and severally liable for this excise tax, but not to exceed $10,000 for each act of participation by each individual.

In the statutory notices of deficiency, the Service asserted that when the organizations transferred their net assets to the S Corporations for less than adequate consideration, this was a substantial activity that was not in furtherance of an exempt purpose and therefore violated the operational test of Treas. Reg. 1.501(c)(3)-1(c)(1).

The Service also asserted that these transfers indirectly enriched each of the Caraccis by increasing the value of their stock in each of the S Corporations. As a result, the organizations conferred private inurement on each of the Caraccis, in violation of the proscription against private inurement in Treas. Reg. 1.501(c)(3)-1(c)(3) and in violation of the proscription against impermissible private benefit in Treas. Reg. 1.501(c)(3)-1(d)(1)(ii). Furthermore, by impermissibly benefiting private interests, the tax-exempt organizations no longer promoted health in a charitable manner by benefiting the community.

For these reasons, the Service revoked the IRC 501(c)(3) exemption of each of the three organizations.

B. Internal Revenue Manual

On November 4, 1999, Chapter 28 (Taxes on Excess Benefit Transactions) was added to 7.8.1 Internal Revenue Manual (IRM), the Exempt Organizations Guidelines Handbook. This chapter discusses several procedural aspects involving the application of IRC 4958, including:

i. When excess benefit transactions occur,

ii. The period of limitations for IRC 4958 excise taxes,

iii. Whether excess benefit transactions have been corrected, and

iv. When IRC 4958 excise taxes should be abated.

Chapter 28 also includes guidelines on completing Form 872 (Consent to Extend the Time to Assess Tax) for purposes of extending the period of assessment for IRC 4958 excise taxes.

In addition, Chapter 28 includes the reminder that Exempt Organizations Area Managers are required to request technical advice in all cases in which an excise tax under IRC 4958 is being proposed and in all IRC 4958 cases being considered for resolution by a closing agreement.

Examining agents are encouraged to use these guidelines in connection with all matters involving IRC 4958.