# C. DEVELOPMENTS IN THE HEALTH CARE FIELD: A STORY OF DRAMATIC CHANGE

## 1. Introduction

The rapidly changing economic situation of the past several years has seen dynamic growth in the health care industry. No longer are we dealing with the traditional one-entity hospital. The rising demand for health care and the search to fund ever increasing alternatives to traditional care have resulted in the mammoth growth of multi-organizational hospital systems. The rapid expansion of traditional modes of health care delivery and financing has raised numerous issues regarding the continued exempt status of these entities.

In past years, we have discussed the organizational requirements for continued exemption of multi-organizational health care systems (1987 CPE 31-39). This year's focus is on the operational aspects affecting various entities in the system. In this regard, we have included a discussion of the effects of physician recruitment programs and joint ventures and partnerships on exempt status. Our discussion of developing law in the health care area would, of course, be incomplete without a thorough analysis of the effect of newly-enacted IRC 501(m) on exempt status. Because IRC 501(m) is new and its potential impact severe, it will be the primary focus of this year's CPE text.

## 2. Section 501(m)

Section 501(m) was added to the Code by section 1012 of the Tax Reform Act of 1986, Pub. L. No. 99-514. The section states that an organization described in IRC 501(c)(3) or 501(c)(4) may be exempt from tax under IRC 501(a) only if no substantial part of its activities consists of providing "commercial-type insurance." For purposes of this subsection, the issuance of annuity contracts is treated as providing insurance. IRC 501(m)(4). Section 1012 of the Tax Reform Act of 1986 also added section 833 to the Code. Under IRC 833, certain Blue Cross and Blue Shield entities are given special treatment under subchapter L. This treatment is also available to certain other health-care insurers that are described in IRC 833(c)(3). These sections are effective for taxable years after December 1986.

An HMO is an entity which combines the financing of health care with medical services by arranging specified health care services with selected providers in exchange for a negotiated payment, which is usually fixed without

regard to the frequency or extent of services provided. It is this type of organization that will be most affected by the provisions of IRC 501(m). The Service has been wrestling with the question of whether such entities qualify for tax exemption since as early as 1942. That year the Court upheld the Service's denial of exemption under the predecessor of IRC 501(c)(3) to an HMO. Hassett v. Associated Hospital Services Corporation, 125 F.2d 611 (1st Cir. 1942.)

In 1962 the Service held that an organization operating basically as an HMO was entitled to exemption under IRC 501(c)(4). G.C.M. 32453 (Nov. 30, 1962). Prior to 1978 most prepaid health plans were recognized as exempt under section 501(c)(4).

The Service was forced to revise its thinking in this area by the Tax Court decision in Sound Health Association v. Commissioner, 71 TC 158 (1978), acq., 1981-2 C.B. 2. The Court, in applying the hospital exemption test of Rev. Rul. 69-545, 1969-2 C.B. 117, ruled that a staff model HMO was entitled to exemption under IRC 501(c)(3). See also G.C.M. 38735 (May 29, 1981).

For a discussion of the requirements for exemption under IRC 501(c)(3) under the Sound Health, supra, guidelines, refer to 1982 CPE 1. A short review of our position without regard to IRC 501(m) is appropriate, however, as that section works in conjunction with prior law and to a great extent merely codifies our prior position.

It is possible to distill from the opinion in Sound Health, G.C.M. 38735, and the revenue rulings on the exemption of hospitals, those factors that establish sufficient community benefit to qualify for exemption. Without the existence of these aspects of operation, there is little to differentiate an exempt HMO from a nonexempt HMO. The key factors include: the actual provision of health care 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.

There is an important subset of factors that must be considered where an organization that promotes health is a membership organization. This is required since a membership organization may be more likely to benefit its members rather than the community-at-large. Sound Health and G.C.M. 38375 require, therefore, that the membership be truly open; that is, that there be no meaningful restrictions on membership that would preclude a finding that the entity serves the community as a whole. The relevant factors in this determination include the following: a 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.

An organization whose primary activity is the provision of insurance would have been unlikely to meet the requirements for exemption under IRC 501(c)(3) because it would lack the essential elements of community benefit. With this in mind, let us return to the discussion of IRC 501(m).

It is necessary to make two findings in order to determine that IRC 501(m) precludes tax exempt status for a particular entity. First, the entity must be found to provide "commercial-type insurance." Second, the provision of "commercial-type insurance" must be found to constitute a substantial part of the activities of the entity.

In order to make the first determination, it is necessary to define "commercial-type insurance" for purposes of IRC 501(m). It is clear that Congress did not define the term in the statute. Existing precedent defining insurance for other purposes is not necessarily controlling but is nonetheless helpful in attempting to interpret Congressional intent. Where a federal statute uses the term "insurance" without an accompanying definition, the ordinary and common meaning of the term must be used in conjunction with any guidance to be found in the structure of the particular provision and its legislative history. Group Life & Health Insurance Co., v. Royal Drug Co., 440 US 205, 211 (1978). In IRC 501(m), for example, it is clear that Congress found Blue Cross and Blue Shield to be providing health insurance despite certain case law to the contrary.

In an examination of existing precedent, one finds that there are as many definitions of what constitutes insurance as there are purposes for which the definition is relevant. Two elements of the definition, however, are consistently

relied upon. These elements were set out by the Supreme Court in Helvering v. LeGierse, 312 US 531 (1941), when it stated that "[h]istorically and commonly insurance involves risk-shifting and risk-distributing." 312 US at 539. The risk for which insurance coverage is provided is an insurance risk, that is, it must occur fortuitously and must result in an economic loss to the insured. See Commissioner v. Treganowan, 183 F.2d, 288 (2nd Cir. 1950).

An expanded definition is found in Allied Fidelity Corp. v. Commissioner, 572 F.2d 1190 (7th Cir. 1978):

> ...[T]he common definition for 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. 1 Couch on Insurance 2d 1:2 (1959). As the tax court below noted, an insurance contract contemplates a specified insurable hazard or risk with one party willing, in exchange for the payment of premiums, to agree to sustain economic loss resulting from the occurrence of the risk specified and, another party with an insurable interest in the insurable risk. It is important here to note that one of the essential features of insurance is this assumption of another's risk of economic loss. 1 Couch on Insurance 2d 1:3 (1959).

No precise definition of "commercial-type insurance" is possible. As stated in Royal Drug, supra, the term must be read in light of the purposes for which it was enacted. At a minimum, however, it is apparent that "commercial-type insurance" includes some form of risk-sharing and risk-distribution within the meaning of LeGierse, supra.

Additional indications of Congressional intent as to the meaning of the term may be gleaned from the discussion of HMOs in the legislative history of the provision. In this regard, the statute itself excepts from the definition of commercial-type insurance "...incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations." IRC 501(m)(3)(B). The House Report indicates that the tax-exempt status of certain HMOs is not altered by the statute. Thus, it comments:

> Commercial-type insurance also does not include health insurance provided by a health maintenance organization that is of a kind customarily provided by such organization and is incidental to the organization's principal activity of providing health care. Section 501(m) of the Code, as added by the bill, is not intended to alter the tax-exempt status of an ordinary health maintenance organization that provides health care to its members predominantly at its own facility through the use of health care professionals and other workers employed by the organization. H.R. Rep. No. 426, 99th Cong., 1st Sess. 665 (1985).

The Senate version of the Tax Reform Act contained no counterpart to IRC 501(m). The Statement of Managers, however, in commenting on the conference agreements version of IRC 501(m), makes no explicit distinction between types of HMOs. It states:

> The conference agreement does not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician service 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). H.R. Conf. Rep. No. 841 99th Cong., 2d Sess. II-346 (1986).

It must be noted at this point that the language in the Statement of Managers does not stand for the proposition that any form of HMO may be exempt. We have discussed earlier the requirements for exemption under IRC 501(c)(3).

The references contained in the House and Conference Reports concerning health insurance customarily provided by tax exempt HMOs do not mean that such entities will never be recognized as providing commercial-type insurance within the meaning of IRC 501(m). Rather, each case must be analyzed in light of the existing precedent concerning the definition of insurance in other areas of the Code and in light of the legislative intent behind IRC 501(m). In making the analysis, certain factors must be examined. These include, but are not limited to, the following: whether a risk (LaGierse, supra) is being transferred and distributed;

and to what extent the entity is operating in a manner similar to for-profit insurers or Blue Cross and Blue Shield; and whether, and to what extent, the entity is marketing a product similar to for-profit insurers or the "Blues." No one factor is determinative, rather the service operations of any given HMO must be weighed and balanced against the insurance aspects of their operations. Thus, where a prepaid health care provider is concerned, if the insurance aspects of the entity are minor and subordinate to its provision of health care services the entity will not be found to provide commercial-type insurance. For instance, a staff-model HMO does not normally provide insurance of a type issued by commercial insurance companies. Where staff-model HMO's exist, their service aspects generally dominate the insurance aspects. The distinction for purposes of whether an entity is providing commercial-type insurance is not based solely on whether the entity owns facilities and employs staff. The facts of each case must be examined in their entirety to make such a determination.

While not binding in future cases, it is instructive to examine the prior position of the Service whether prepaid health care providers have been found to be providing insurance under other provisions of the Code. In Rev. Rul. 68-27, 1968-1 C.B. 315, the Service found that the prepaid plan involved in that case did not constitute insurance and that the entity involved was, therefore, not an insurance company. The plan was issued by a clinic providing health care services predominantly through its own facilities and staff. In concluding that the clinic was not an insurance company, Rev. Rul. 68-27 stated:

> An insurance contract must involve the element of shifting or assuming the risk of loss of the insured and must, therefore, be a contract under which the insurer is liable for a loss suffered by its insured. With regard to the preventive phase of the medical service contract...there is no hazard or peril insured against. With respect to the sick or disabled phase of the contract, although an element of risk exists, it is predominantly a normal business risk of an organization engaged in furnishing medical services on a fixed price basis, rather than an insurance risk. As a result of the illness or disablement, the contracting organization generally does not incur any expense other than that which it incurs providing the medical services through a staff of physicians, nurses, and technicians.

In G.C.M. 36734 (May 19, 1976), the Blue Cross and Blue Shield plans were distinguished from staff-model and other fixed expense HMOs. In contrast to such organizations providing direct health care, the Blues contracted with other health care providers on a cash indemnity basis. Thus, the Blues incurred a risk in the insurance sense in that their expenses were not limited to the physicians' salaries, to the cost of operating health facilities, or the actual amount of premiums collected. The Blues incurred the risk that the charges they had contracted to pay might exceed the premiums collected. Therefore, they were found to provide insurance within the meaning of the Code.

Relevant case law also indicates that assumption of the risk is the primary factor in determining whether a prepaid plan is a contract for services or a contract for insurance.

In Associated Hospital Service of Maine v. Mahoney, 212 A2d 712 (Me 1965), the Supreme Court of Maine distinguished a contract from other Blue Cross contracts because the entities providing care under the extended benefits policy were not limited to the plaintiffs' available surplus funds. At the time of the suit, other provider contracts were on a fixed fee basis. The Court stated at 721-722:

> The risk of subscriber's (assured's) being exposed to certain expenses in excess and independent of the basic coverage is assumed by plaintiff-shifted from the subscriber to [Blue Cross]. The payments so promised are not contingent on the existence of adequate surplus... .
>
> Neither the participating hospitals nor participating doctors assume these risks against which the subscriber is so protected. There is no discernable difference between this contract and the conventional health and accident insurance contract.

The above-cited Service rulings and case law all stand for the proposition that a provider of prepaid medical plans assumes no risk in an insurance sense where it has fixed costs. This factor was an essential part of the rationale in California Physician's Service v. Garrison, 28 Cal 2d 771, 172 P2d (1946). In that case, the prepaid medical plan provided care free of charge to the dues-paying members of CPS. The physicians were paid on the basis of services rendered, but were limited to a pro rata share of dues actually collected. The Supreme Court of California found that CPS was not providing insurance. The Court concluded that

... "[t]he business of [CPS] lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk." 172 P2d at 13. The risk, the Court found, was on the physicians who would have to provide the actual service regardless of the occurrence of any contingency. See also Metropolitan Life Insurance Co. v. State Board of Equalization, 32 Cal 3d 649, 652 P2d 426 (Cal. 1982).

The absence of assumption of the risk was also determinative in Prepaid Dental Services, Inc. v. Day, 615 P2d 1271 (Utah 1980). The plaintiff in that case contracted with dentists to provide specific dental care to group enrollees. Dentists were paid on a fixed monthly basis. The amount of payment did not vary with services performed. The Court noted that there was insurance risk involved and that the risk had been spread among the enrollees by use of the premium payments. It found, however, that the dentists bore the financial risk transferred from the enrollees and not the plaintiff. In light of the fact that the plaintiff did not assume the risk, these dental plans were not insurance and consequently not subject to the state's insurance regulations.

A case that is often cited in this area is Jordan v. Group Health Assn., 107 F.2d 239 (DC Cir. 1939). In Jordan, the question concerned whether Group Health Association (GHA) provided insurance. GHA had some of its own health care facilities staffed by independent contractors. The physicians were paid a fixed monthly fee regardless of services rendered. GHA arranged health care for its dues paying members. The doctors and the hospitals used by the members were to look solely to GHA for financial remuneration. The Court found that, on balance, GHA was providing services and not insurance.

This brings us to the second inquiry necessary to determine whether exemption for any particular entity is precluded by IRC 501(m). Does the insurance activity constitute a substantial part of the activities of the prepaid plan? This can only be determined through a case by case analysis carefully balancing the insurance aspects of each plan against the direct health services provided.

Thus, it is necessary to acknowledge that staff-model and other fixed expense HMOs do undertake some insurance risk with respect to expenses outside their control. These expenses include those for care outside the HMO's service area or outside its capabilities. These expenses, provided that they are an insubstantial part of the operations of the HMO, are excluded from the definition of commercial-type insurance under IRC 501(m) as incidental to the HMO's primary activity of providing health care.

At this point in the discussion let us note that the health care industry has been growing rapidly and the HMO market expanding in many ways in recent years. Along with staff-model HMOs, many other options are being offered. Group-model HMOs are those in which the HMO contracts with a group practice to provide services to HMO members. IPA-model HMOs are those in which the HMO contracts with individual physicians or with an individual practice association to provide services to members in the physicians own offices. A network-model HMO is one in which the HMO contracts with group practices to provide services to HMO members. We are also seeing preferred provider organizations (PPOs). A PPO is an arrangement in which participants in an indemnity plan are offered incentives for using the services of selected health care providers. Applications from such organizations will be considered on the totality of their activities to determine whether they are precluded from exemption by IRC 501(m). If not precluded by IRC 501(m), the operations of these organizations will be examined in light of the requirements set forth in Sound Health, supra, to determine whether they qualify for exemption under IRC 501(c)(3).

3. Physician Recruitment and Employee Retention

As noted in 1987 CPE 38-51, exempt hospitals are constantly in competition with the private sector and among themselves to recruit and retain top notch, capable administrators, officers, and doctors to staff their operations, especially in light of the increasing phenomenon of multi-organization hospital systems. Yet exempt hospitals must qualify under the Code provisions and questions arise regarding when various recruitment incentives and employee incentive pay packages are too high to be reasonable, resulting in inurement or private benefit.

G.C.M. 39498 (April 24, 1986) describes a physician recruitment incentive program. The particular program is a two-year guaranteed minimum annual income contract with no obligation to repay any amount of the subsidy out of income earned after the two year contract period. The income to be guaranteed is established by hospital officials who are totally independent of the recruited physicians. The amount is based upon how much the physician could earn during the year and the hospital's need for a physician in that area of specialization at a particular level of experience.

In exchange, the physician is required to perform significant services for the hospital, such as training and emergency room duties. The guaranteed minimum

annual income is offered when needed to help persuade a physician to locate his medical practice in the hospital's service area.

The G.C.M. concludes that such an arrangement raises the issue of reasonable compensation. This issue was discussed extensively in the 1987 CPE text at pp. 39-51. The G.C.M. recognizes that hospitals must offer incentives or inducements to attract qualified physicians. It also affirms the position that exempt hospitals can offer reasonable compensation packages and may do so without violating the requirements for exemption either as respects exclusive operation for exempt purposes or the inurement prohibition. What it does not do is define what will be considered reasonable compensation in operation.

The G.C.M. is careful to point out that the hospital's operation of a physician recruitment program with the added benefit of a guaranteed minimum annual income feature for the first two years is not per se a violation of IRC 501(c)(3). In considering whether such a program violates the inurement proscription, however, reference must be made to any and all additional compensation and incentives to be paid the participating physicians. Thus, the G.C.M. concludes that it is virtually impossible to determine in advance that the payment of any particular subsidy will not result in unreasonable compensation or the serving of private interests.

G.C.M. 39670 (October 14, 1987), addresses the issue of whether the establishment of deferred compensation plans by an organization exempt from tax under IRC 501(c)(3) constitutes prohibited inurement of income.

The G.C.M. describes an organization the purpose of which is to promote the physical and moral welfare of the student body of X University by encouraging participation in healthful exercise, recreation, athletic games and contests, by assisting approved athletic students and by awarding funds in scholarship form. One of the organization's activities was to provide incentives for the various coaching staffs at the University.

The Board of Directors approved and implemented deferred compensation plans for three of the coaches. The plans were designed to induce the individuals to perform services for at least ten years. Under the terms of the plans, the entire amount of deferred compensation became non-forfeitable after 10 years. Although one of the coaches was also an officer and director of the organization, he did not participate in the vote on his compensation.

The University was limited by law to the payment of $60,000 in compensation per year per instructor. Additional compensation for the athletic staff was provided through this organization. The deferred compensation issue was raised during an examination of the organization's books and records. Such examination permitted the conclusion that the overall compensation packages did not represent unreasonable compensation.

G.C.M. 39670, referring to the principles set forth in G.C.M. 39498, supra, concluded that the deferred compensation plans were not inconsistent with exempt status.

Whether the establishment of "profit sharing" incentive compensation plans for hospital employees results in the inurement of the net earnings of the hospitals to the employees or in other private benefit inconsistent with exemption under IRC 501(c)(3) is addressed in G.C.M. 39674 (June 17, 1987), which clarifies G.C.M. 39498. The determination of whether the plan under which any contributions are made is a profit-sharing plan is made without regard to current or accumulated profits of the employer and without regard to whether the employer is a tax-exempt organization. IRC 401(a)(27). In determining that profit sharing plans do not per se violate the proscriptions against private benefit and prohibited inurement, the G.C.M. returns to the principles enunciated in Rev. Rul. 69-383, 1969-2 C.B. 113, and the preceding G.C.M.s.

Rev. Rul. 69-383 considered a hospital that, after arms-length negotiations, entered into an agreement with a hospital-based radiologist to compensate him on the basis of a fixed percentage of the radiology department's gross billings. The radiologist did not have any management authority with respect to the hospital itself, but did have the right to approve the amounts charged by the hospital for radiology services. The amount received by the radiologist under the contract was not excessive when compared with amounts received by other radiologists having similar responsibilities and handling a comparable patient volume at other hospitals. Rev. Rul. 69-383 noted that, under certain circumstances, a method of compensation based on a percentage of income might constitute prohibited inurement or be a device to distribute profits to principals.

Rev. Rul. 69-383 outlines the factors that we will examine in testing whether any compensation plan results in prohibited inurement. Thus a compensation plan of an exempt organization does not result in prohibited inurement if: (1) the compensation plan is not inconsistent with exempt status, such as merely a device to distribute profits to principals or transform the organization's principal activity

into a joint venture, (2) the compensation plan is the result of arms length bargaining and (3) the compensation plan results in reasonable compensation. Whether these criteria are met depends upon the facts and circumstances of each case.

4. Partnerships and Joint Ventures

Joint ventures and partnerships have been favorite financing tools for the expanding health care industry. The problems associated with these forms of enterprise as well as their affect on the exempt status of the hospitals involved have been the subject of several CPE articles in past years. See 1984 CPE 22 and 1981 CPE 1, both of which discuss these tools in connection with the financing of medical office buildings. These situations often raise issues of inurement and private benefit.

Our position in cases involving partnerships and joint ventures among exempt organizations, taxable entities, and private individuals is to scrutinize the facts carefully. By doing so, we can determine whether any conflict of interest exists that would prohibit the exempt organization from operating exclusively for charitable purposes. The mere participation in such an arrangement does not preclude an entity from qualifying for exemption. On the other hand, the use of such entities or wholly-owned subsidiaries will not insulate an exempt organization from the consequences of its actions if the facts establish that it used its control over those entities to benefit private individuals.

G.C.M. 39598 (January 23, 1987) addresses both the issue whether a subsidiary organization itself operates exclusively for charitable purposes and the issue whether the subsidiary's operations jeopardize the exempt status of the parent or of the other entities in the system.

The subsidiary was created within the reorganized hospital system for the purpose of leasing a medical office building adjacent to the hospital. The subsidiary was then to sublease space in the building to physicians on the staff of the hospital for their private practices and to manage the physicians group practice of medicine, including providing nursing, secretarial, billing, collection and recordkeeping services, under a management contract. The reasons provided in support of its initial exemption application were that the activities were designed to prevent the physicians from moving their offices out of the area and away from the hospital.

The office building was owned by a partnership consisting of the physicians on the staff of the hospital. Prior to the creation of the subsidiary, the building was leased directly by this physician-partnership to a second partnership consisting of the same individuals but engaging in the group practice of medicine. The group practice occupied approximately 80 percent of the building. The remainder of the building was unoccupied. Due to financial, organizational, and management difficulties the group practice-partnership approached the hospital for assistance. It was as a result of negotiations that the subsidiary was created and undertook the various duties described.

The subsidiary leased the building under an agreement obligating it not only for a stated monthly rental fee, but also for all expenses incurred in operating and maintaining the building as a medical clinic. It then subleased the building to the group practice for an amount considerably less than that being paid the physician-partnership. As part of the transaction the parties also entered into a management agreement whereby the subsidiary would provide management services to the group practice.

The management agreement provided that the subsidiary would manage the business of the group practice, including, but not limited to, the following: personnel management, purchasing, budgeting, billing, scheduling, accounting, auditing, collections, and systems and marketing matters. For these services, the subsidiary would receive approximately 50 percent of all collections. The remaining amount went directly to the group practice. From the funds retained by the subsidiary were to be paid all operating expenses in connection with the operation of the practice including the rent under the sublease, insurance, maintenance, laundry, printing, collection expenses, auditing, supplies, the cost of the administrator provided by the subsidiary, and an amount calculated on a five-year amortization basis necessary to provide sufficient funds for repayment of the security deposit under the lease. Not paid out of these funds were compensation to partner and associate physicians, professional association dues, individual practice licenses, seminars, meetings, or training. If the share of collections retained was insufficient to cover the expenses, the group practice would assume payment of any excess expenses over $50,000.

It was anticipated that additional income would come from the rental of the 20% of the building unused by the practice. After some efforts to rent this space, it was determined that the remaining space was unsuitable for physicians' offices. No additional tenants were found for the space.

The subsidiary was dissolved in 1985 having absorbed in excess of $700,000 in losses. During the course of examination it could not be determined how funds were transferred from the parent, the hospital, or any other exempt entity in the system to keep the subsidiary afloat. The funds were untraceable.

The result of the complex arrangements described here is that the subsidiary absorbed the financial losses that would have otherwise been realized by the group practice. We can speculate that it was similar losses that brought the physicians to the parent and the hospital seeking help in the first place. Thus, it appears that the arrangement prevented the financial collapse of the practice and served the private interests of the physicians other than incidentally.

Because the subsidiary in this case was one of many inter-connected corporations comprising a multi-organizational system, the G.C.M. also considered what effect, if any, its disqualification would have on the other entities. Whether the activities of a separately incorporated subsidiary may be attributable to a parent was the topic of an article in the 1986 CPE at page 33. It has also been the subject of several G.C.M.s in the past few years.

Most recently, G.C.M. 39326 (January 17, 1985), noted:

For federal income tax purposes, a parent corporation and its subsidiary are separate taxable entities so long as the purposes for which the subsidiary is incorporated are the equivalent of business activities or the subsidiary subsequently carries on business activities. Moline Properties, Inc. v. Commissioner, 319 U.S. 436, 438 (1943); Britt v. United States, 431 F. 2d 227, 234 (5th Cir. 1970). That is where a corporation is organized with the bona fide intention that it will have some real and substantial business function, its existence may not generally be disregarded for tax purposes. Britt, 431 F. 2d at 234. However, where the parent corporation so controls the affairs of the subsidiary that it is merely an instrumentality of the parent, the corporate entity of the subsidiary may be disregarded. Krivo Industrial Supply Co. v. National Distillers and Chemical Corp., 483 F. 2d 1098, 1106 (5th Cir. 1973); 1 W. Fletcher, Cyclopedia of the Law of Private Corporations, Section 43.10 (Perm. ED. 1983).

Relying on this reasoning, and that in earlier G.C.M.s, the G.C.M. concluded that "the activities of the separately incorporated subsidiary cannot ordinarily be attributed to its parent organization unless the facts provide clear and convincing evidence that the subsidiary is in reality an arm, agent or integral part of the parent." G.C.M. 39326, at p.5.

G.C.M. 39598, supra, went further in analyzing the two avenues of inquiry which must be pursued to determine whether the corporate form may be ignored for the purpose of attributing a subsidiary's activities to the parent. The first avenue is the requirement that the subsidiary be organized for some bona fide purpose of its own and not be a mere sham or instrumentality of the parent. The requirement that the subsidiary have a bona fide business purpose should not be construed to require that the subsidiary have an inherently commercial or for-profit activity. The term "business," as used in the context of this test, is not synonymous with trade or business in the sense of requiring a profit motive. Instead, the term business appears to have been carried over from Moline and Britt, supra, which involved for-profit corporations, and in which the determination as to the existence of a business purpose or activity was an appropriate test for requiring substance over form given the factual circumstances of the particular cases.

The second aspect of the test is the requirement that the parent not be so involved in or in control of the day-to-day operations of the subsidiary that the relationship between parent and subsidiary assumes the characteristics of the relationship of principal and agent, i.e., that the parent not be so in control of the affairs of the subsidiary that it is merely an instrumentality of the parent. Control through ownership of stock, or power to appoint the Board of Directors of the subsidiary, will not cause the attribution of the subsidiary's activities to the parent. The extent to which the parent is involved in the day-to-day management of the subsidiary is the factor which must be considered, along with the bona fide and substantial purpose of the subsidiary, in determining whether or not the subsidiary entity is so completely an arm, agent or integral part of the parent that its separate corporate identity is properly disregarded. The doctrine of corporate identity is well established, and the courts, in considering whether or not to disregard it, have articulated a very demanding evidentiary standard requiring clear and convincing evidence of the subsidiary's lack of independent status.

G.C.M. 39598 concluded that there was no evidence to support a conclusion that the parent or the hospital described in the G.C.M. had any control or hand in the day-to-day operations of the subsidiary. The subsidiary was also determined to have a bona fide business purpose. For these reasons, Counsel concluded that the activities of the subsidiary, although jeopardizing its exempt status, could not be attributed to the other entities in the system. Thus, the system survived because of the absence of sufficient facts to overcome the well-established doctrine of corporate separateness.

The organization described in G.C.M. 39598, supra, failed to qualify for exemption for two reasons. First, the activities of the subsidiary organization conferred a substantial private benefit on the physician-partners. Secondly, the funds of the subsidiary inured to the benefit of the physician partners. G.C.M. 39646 (June 30, 1987) clarifies G.C.M. 39598, by pointing out that the decision was based on the facts presented, i.e., no funds could be traced. The G.C.M. notes that where the facts show that funds inured to the benefit of private individuals either directly or through other organizations, exemption will be denied or revoked for both organizations. Where there is inurement of the funds of an exempt organization, and the funds have merely passed through the exempt organization from another exempt organization, the funds will be considered to have come from both organizations for purposes of the inurement proscription, thereby disqualifying both organizations from exemption under IRC 501(c)(3).