APR 2 7 2000

200033046

INTERNAL REVENUE SERVICE

NATIONAL OFFICE TECHNICAL ADVICE MEMORANDUM

No Third Party Contact: OP:E:EO:T1

SIN#: 501.04-02, 513.00-00

Taxpayer's Name:

Taxpayer's Address:

Employer Identification Number:

Years Involved:

Date of Conference:

LEGEND:

X –
Y –
A -
B –

ISSUES:

1. Whether the provision of services under Plan B where the medical providers are compensated on either a discounted fee-for-service basis with no withholds or under a point of service arrangement is commercial-type insurance as described in section 501(m)(3) of the Code.

2. Whether the provision of services under Plan B is an insubstantial part of X's activities and would be subject to unrelated business income tax.

3. Whether the unrelated business income tax would be calculated under subchapter L rather than section 511.

FACTS:

X is a licensed IPA model HMO recognized as an organization described in section 501(c)(4). X arranges for comprehensive preventive and therapeutic health care services, on a prepaid basis, to subscribing individuals and groups.

X arranges for the delivery of health care services to its subscribers through agreements with independent health care providers who form a network

of contracted providers working in private offices and with hospitals within designated service areas.

X offers its subscribers a choice of two medical plans when choosing their medical benefits.

> The A plan provides that subscribers utilize only an in-network primary care physician or physicians authorized by an in-network primary care physician. Subscribers are only responsible for a preset co-payment for each physician office visit. No claim forms are submitted. If an emergency situation arises, care may be provided by an out-of-network physician without authorization from the subscriber's in-network primary care physician.
>
> The B plan contains a point of service (POS) option and is administered by Y, a taxable affiliate of X. Under Plan B, subscribers can utilize any physician, either in network or out-of-network. The POS option can also be used in emergency situations where the member is out of the service area. However, the subscriber is subject to a co-payment based on the total physician charges if an unauthorized, out-of-network physician is selected.

The number of subscribers enrolled in Plan A makes it the predominant plan offered by X. The number of subscribers in Plan B is insignificant compared to X's total health plan subscribers.

The physicians are compensated by X based upon the type of plan that the subscriber purchased. If the subscriber is enrolled in Plan A, then the physician is compensated on a capitated basis. If the in-network physician sees individuals enrolled in Plan B, then the physician is paid 70 percent of the in-network charges with no withhold feature. Out-of-network physicians providing services to Plan B enrollees receive 100 percent of their typical charges, a portion of which is paid by the enrollees as a co-payment.

X shares the income/loss on Plan B with Y. The risk sharing with Y is 50 percent of the income or loss and is capped at 5 percent of the premium revenue.

X originally reported as UBI only premiums received from Plan B. X's return was subsequently amended to include as UBI premiums stemming from Plan B relating to out-of-network primary care physicians for non-authorized services. X's return was amended a second time to exclude from UBI the total premiums received from Plan B.

LAW:

Section 501(m)(1) of the Code provides that an organization described in section 501(c)(4) shall be exempt only if no substantial part of its activities consists of providing commercial-type insurance. Consequently, where an organization's activities resemble those of commercial insurers, section 501(m) would serve to deny exemption under section 501(c)(4).

Section 501(m)(2) of the Code provides that a section 501(c)(3) or (4) organization that provides commercial-type insurance as an insubstantial part of its activities shall treat the activity as an unrelated trade or business (as defined in section 513), and in lieu of the tax imposed by section 511 with respect to such activity shall treat the organization as an insurance company for purposes of applying subchapter L with respect to that activity.

Section 501(m)(3)(B) of the Code provides that commercial-type insurance does not include "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations."

The legislative history of section 501(m) of the Code provides that commercial-type insurance generally is any insurance of a type provided by commercial insurance companies.

Commercial-type insurance does not include arrangements that are not treated as insurance in the absence of a sufficient risk shifting and risk distribution for the arrangement to constitute insurance. See Helvering v. Legierse, 312 U.S. 531 (1941).

In reporting on technical corrections to section 501(m) of the Code that were made in the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), the Conference Committee stated:

> The provision relating to organizations engaging in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations. HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians. The conference committee clarifies that, in addition to the general exemption for HMOs, organizations that provide supplemental HMO type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization.

Rev. Rul. 68-27, 1968-1 C.B. 315, concludes that an organization that issued medical service contracts to groups or individuals and furnished direct

medical services to the subscribers by means of a salaried staff of medical personnel was held not to be an insurance company. In this revenue ruling, a medical clinic employed a staff of salaried physicians, nurses and technicians to provide a major portion of the contracted medical services. In the event the clinic had to treat a patient with an illness or injury, the revenue ruling concluded that any risk the clinic incurred was predominately a normal business risk. The clinic's costs for its medical providers was fixed because the clinic paid its providers a salary. As a result, if a patient were to suffer a serious illness or injury, the clinic would not incur any substantial additional costs. Thus, the clinic's economic risk was fixed regardless of the presence or extent of any illness or injury.

In Jordan, Superintendent of Insurance v. Group Health Association, 107 F.2d 239 (1939), the U.S. Court of Appeals for the District of Columbia held that an HMO was not an insurance company. In this case, the HMO did not employ salaried physicians to provide medical services but paid contracted physicians a "fixed annual compensation, paid in monthly installments, not specific fees for each treatment or case."

Neither the Internal Revenue Code nor the Income Tax Regulations define the term insurance contract. Rev. Rul. 68-27, supra, citing Jordan, defined an insurance contract as one that:

> 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.

Case law has defined an insurance contract as a contract whereby for an adequate consideration one party under takes to indemnify another against loss from certain specific contingencies or perils. It is contractual security against anticipated loss. Epmeier v. U.S., 199 F.2d 508, 509-510 (7th Cir. 1952). See also SEC v. Variable Life Annuity Life Ins. Co., 359 U.S. 65, 71 (1959); Group Life & Health Ins. Co v. Royal Drug Co, 440 U.S. 205, 211 (1979); and Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 127 (1982).

Moreover, case law has established that risk shifting and risk distribution are the fundamental characteristics of a contract of insurance. Helvering v. LeGierse, supra. In this case, the Supreme Court stated that "historically and commonly insurance involves risk-shifting and risk-distributing." 312 U.S. at 539.

Finally, the risk transferred must be a risk of economic loss. 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 insurer. Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976); aff'd, 572 F.2d 1190 (7th Cir. 1978), cert. den., 439 U.S. 835 (1978). In this case, the Court of Appeals stated:

290

> The 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 (1955). 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).

Risk shifting occurs when a person facing the possibility of an economic loss transfers some or all of the financial consequences of the loss to the insurer. Rev. Rul. 88-72, 1988-2 C.B. 31, clarified by Rev. Rul. 89-61, 1989-1 C.B. 75.

RATIONALE:

Under section 501(m)(1) of the Code, an organization that otherwise qualifies for exemption under section 501(c)(3) or section 501(c)(4) is precluded from qualifying for exemption if a substantial part of its activities consists of providing commercial-type insurance. If the provision of commercial-type insurance is an insubstantial part of an organization's activities, then section 501(m)(2) provides that the activity is from an unrelated trade or business and tax shall be calculated under subchapter L of the Code relating to insurance companies.

When individuals enroll in an HMO and directly or indirectly pay the HMO fixed premiums, the HMO agrees that it will furnish health care services to treat their injuries and illnesses. Under this arrangement, enrollees protect themselves against the risk that they would suffer economic loss from having to pay for health care services that are necessary because of injuries and illnesses. By enrolling in an HMO, individuals shift their risk of economic loss to the HMO.

For an HMO that operates on a staff model basis, the HMO assumes the financial risk associated with furnishing medical services. Since a staff model HMO pays physicians on a salaried basis, it does not incur additional fees when its employed physicians treat its enrollees. Therefore, the risk the HMO assumes is predominately a normal business risk of an organization engaged in furnishing medical services on a fixed-price basis, rather than an insurance risk. Rev. Rul. 68-27, supra.

On the other hand, a non-staff model HMO that does not pay its health care providers on a fixed-price basis assumes a financial risk that is greater than a normal business risk associated with its obligation to furnish medical services to its enrollees. Therefore, this obligation constitutes a contract of insurance.

An HMO that compensates its non-employee health care providers on a fixed fee basis is treated the same as a staff model HMO that pays its health care providers on a salaried basis because the HMO has transferred to its health care providers a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. The remaining risk is only the normal business risk associated with operating the HMO.

For example, an HMO that pays its contracted health care providers almost exclusively on fixed monthly fees based on the number of enrollees (capitated fees), transfers to these providers a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO.

Similarly, an HMO that pays its contracted health care providers almost exclusively fees-for-service under a fee schedule that represents a meaningful discount from the physicians' usual and customary charges (discounted fee-for-service) and withholds from these payments a significant percent of the fees otherwise payable, pending compliance with periodic budget or utilization standards, transfers to these providers, in effect, a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO.

On the other hand, when an HMO pays its contracted providers on a fee-for-service basis that is not discounted and where no significant portion of the fees has been withheld, the HMO does not transfer to these providers its financial risk associated with its obligation to furnish medical services to its enrollees. Thus, the HMO retains the financial risk associated with its obligation to furnish medical services to its enrollees. The financial risk constitutes a contract of insurance. A discounted fee arrangement, even if the discount is meaningful, without a significant withhold does not transfer financial risk to providers. In return for accepting discounted fees, the providers are assured a flow of patients from the HMO. It is a common commercial practice for vendors of goods or providers of services to accept lower prices or fees in return for greater sales.

The health care providers are compensated based upon the type of plan purchased by an enrollee. If a physician sees an enrollee who is a subscriber of the A plan, then the physician is compensated by capitated fees. If a physician

sees an enrollee of Plan B, then the in-network physician is paid on a discounted fee-for-service with no withhold and the out-of-network physician is paid at 100 percent of his or her typical charges.

Under the A plan, a substantial amount of the financial risk associated with X's obligation to arrange for the provision of health care services to its enrollees is being shifted to the primary care providers. The provision of services by the health care providers on a capitated basis shifts a substantial portion of risk to the health care providers because they have to provide the medical care without receiving additional funds. But, X retains substantial financial risk associated with Plan B, because the physicians are on a fee-for-service basis while it retains financial risk to furnish medical services. Therefore, the provision of services under the A policy would not be commercial-type insurance as described in section 501(m)(1), but the provision of medical services under Plan B would be commercial-type insurance.

X has argued that the proceeds from the sale of the POS policies satisfy the exception to section 501(m)(3)(B) because the POS product is incidental health insurance customarily provided by a health maintenance organization. The section 501(m)(3)(B) exception would not be applicable since the legislative history of section 501(m)(3)(B) does not include the point of service provisions as examples of the type of insurance that would satisfy this exception. Only dental and vision services are mentioned in the Conference Committee Report on TAMRA.

Even though Plan B is commercial-type insurance for purposes of section 501(m)(3), it is not a substantial part of X's activities since it is an insubstantial portion of X's total activities. Therefore, under section 501(m)(2) of the Code all income from Plan B would be from an unrelated trade or business and tax liability will be calculated in accordance with the provisions set forth in subchapter L.

CONCLUSION:

1. The provision of services under Plan B where the medical providers are compensated on either a discounted fee-for-service basis with no withhold or under a point of service arrangement is commercial-type insurance as described in section 501(m)(3) of the Code.

2. The provision of services under Plan B is an insubstantial part of X's activities and would be subject to unrelated business income tax.

3. The unrelated business income tax would be calculated under subchapter L rather than section 511.

A copy of the technical advice memorandum is to be given to X. Section 6110(j)(3) of the Code provides that it may not be used or cited as precedent

-END-