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General Counsel Memorandum

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Memorandum to:

Robert I. Brauer

Assistant Commissioner

(Employee Plans and Exempt Organizations)

Attention:

Director, Exempt Organizations Technical Division

This memorandum further considers issues raised in *** GCM 39828, EE-170-86 (Sept. 30, 1987). It is intended to clarify and amplify the earlier GCM, especially with regard to the effect of section 501(m) on health maintenance organizations. The analysis below stems from our assistance on a ruling request submitted by *** Inc. (“Insurer”) on behalf of its former subsidiary, *** Corporation (hereinafter referred to as ABC Corporation or ABC).

ISSUES

1. Whether ABC Corporation, an IPA-model HMO, was tax exempt on or before December 31, 1986?

2. Whether provision of commercial-type insurance is a substantial part of ADC's activities within the meaning of I.R.C. section 501(m) and, thus, whether ABC has lost its exemption by operation of section 501(m)?

CONCLUSIONS

1. ABC Corporation was exempt under section 501(c)(4) on December 31, 1986. It had received a determination letter from the Service recognizing its exemption in 1978.

2. ABC provides health insurance within the common meaning of that term, but does not, as a substantial part of its activities, provide commercial-type insurance within the meaning of section 501(m). ABC did not lose its exemption by operation of section 501(m). Thus, it was entitled to rely on its determination letter until the first material change in its organization or operation that was inconsistent with exemption under section 501(c)(4).

FACTS

ABC is an Individual Practice Association model (“IPA-model”) health maintenance organization (“HMO”). Prior to the transactions giving rise to its ruling request, ABC was separately incorporated under the *** nonprofit corporations law. ABC was qualified under the federal HMO Act,[1] and was classified as a hospital service plan regulated by the *** Insurance Commissioner. Insurer states that ABC was (until December 31, 1986) recognized as exempt under section 501(c)(4) of the Internal Revenue Code. The file contains a July 31, 1978, determination letter in which the District Director, *** recognized ABC's exemption under section 501(c)(4). It is implicit in Insurer's position that ABC lost its exempt status by operation of section 501(m).[2]

ABC provides physician, hospital, and other health care services to subscribers. Physicians' services paid for on a capitated (i.e., fixed-fee per subscriber) basis represent approximately one-half the total cost of medical service benefits ABC provides. Other payments for care are not capitated. For example, ABC makes payments directly to third party providers each time a covered individual needs hospitalization. These costs are paid either on a fee-for-service basis or a flat rate basis, and vary directly with occurrences.

Insurer is a *** nonprofit corporation that was (until December 31, 1986) exempt under section 501(c)(4). Insurer offered subscribers traditional indemnity products and HMO options; a non- federally qualified, experience-rated HMO operated as part of Insurer, and a federally qualified, community-rated HMO operated by the separate ABC Corporation. Insurer was effectively ABC's parent; Insurer's Board members were the members of ABC, one-fourth of ABC's Board were Insurer Board members, and ABC's assets were to revert upon dissolution to Insurer. Insurer represents that ABC was separately incorporated only to comply with federal HMO qualification requirements.[3]

After the effective date of sections 501(m) and 833, certain transactions were undertaken that changed the form of ABC's organization and ownership. Insurer applied for a ruling on whether ABC qualifies for the favorable tax treatment under section 833. Before such a ruling could be provided, it was necessary to determine whether ABC lost its exemption by reason of section 501(m).

ANALYSIS

Health maintenance organizations issue contracts under which they agree to provide or arrange for a comprehensive set of medical services for subscribers in exchange for periodic payments that do not vary with the extent or type of services provided. HMOs provide medical care to subscribers through selected physicians, hospitals, and other providers who are affiliated with the HMO in one manner or another. Subscribers are “locked in” to the HMO-affiliated providers, and receive no benefits for nonemergency services obtained from outside providers without prior HMO authorization. It is this limitation, along with an increased emphasis on preventive care, that distinguishes HMOs from traditional health care insurance.

Most states have enacted specific acts pursuant to which HMOs are organized or licensed. While these statutes vary, they may be useful, along with other facts and circumstances, in helping the Service to determine whether an organization purporting to be an HMO should be treated as one for tax purposes. Licensure under one of these statutes suggests that an entity is an HMO, while licensure under some other authority in a state having an HMO act suggests otherwise. In addition, the federal government gave the industry a boost with passage of the HMO Act of 1973, which provided voluntary federal qualification standards and developmental financial assistance. Unfortunately, the federal Act is of only limited utility in identifying or defining HMOs because so many have chosen not to seek federal qualification.

There is no single paradigm for an HMO. Rather, they generally are classified into one of four models, based largely on the relationships between the HMO and the physicians who actually provide care to its subscribers:

1. The “staff model,” in which care is provided in a central location by physicians and other health care professionals working as salaried employees of the HMO;

2. The “group model,” in which care is provided in a central location by physicians practicing in an existing group practice;

3. The “network model,” in which care is provided by a network of two or more independent group practices; and

4. The individual practice association model or “IPA-model,” in which care is provided by physicians practicing independently in their own offices, with the physicians usually contracting with the HMO through an IPA.[4] Early HMOs generally were of the staff or group model. The network and IPA-models constitute more recent expansions of the HMO concept, though the IPA-model is by far the most common. While some HMOs today actually are mixtures of the above models, the distinctions in how these types of entities operate can be important.

In most cases, HMOs pay primary care physicians[5] a fixed amount for their services, rather than paying them on the more traditional fee-for-service basis. Some physicians are paid fixed salaries or salaries and bonuses; others are paid a fixed fee per member-subscriber for all needed care during a given period (i.e., a capitated payment[6]). Specialists, hospitals, and out-of-area emergency care providers, on the other hand, often are paid on some type of fee-for-service basis.

It is not possible to establish conclusively, based on the administrative file, whether ABC Corporation would have qualified for recognition of exemption immediately prior to the effective date of section 501(m). Since the case arose based on a ruling request, rather than a determination request, details about ABC's actual operations are sparse. Nevertheless, absent any suggestion that the HMO's organization or operations had undergone a material change, or that the Service's 1978 determination was somehow incorrect, we presume that it would be entitled to rely on its existing determination letter at least until the effective date of section 501(m).

It also should be noted that the Service's position with respect to non-staff model HMOs, especially IPA-model HMOs, was not well developed at the time section 501(m) was enacted. Many of the existing precedents concerned IPAs themselves, rather than IPA-model HMOs. See, e.g., Rev. Rul. 86-98, 1986-2 C.B. 75 (holding that a physician-controlled IPA that contracted with HMOs did not qualify under section 501(c)(4) because it operated primarily to benefit the physicians); *** GCM 38894 , EE-75-78 (Sept. 3, 1982) (same result.) As discussed below, the Service never has determined conclusively that an IPA-model HMO that is not physician-controlled (as opposed to the IPA itself) may not quality for exemption. In fact, largely because of their similarity to then-exempt Blue Cross/Blue Shield organizations, many IPA-model HMOs were recognized as tax exempt social welfare organizations under section 501(c)(4)[7] during the late 1970s and early 1980s. We can assume that this is what happened in the instant case.

Part I of this memorandum explores the Service's position on the exemption of HMOs prior to enactment of section 501(m). Part II considers the effect of section 501(m) on HMOs.

I. EXEMPTION OF HMOs PRIOR TO SECTION 501(m)

The Service's position with respect to HMOs has evolved over the last three decades. In *** GCM 32453, I-17 (Nov. 30, 1962), this Office recommended that an organization that operated essentially as a group model HMO be recognized as exempt under section 501(c)(4) due to its similarity to Blue Cross/Blue Shield plans.[8] The organization was neither subscriber-controlled nor physician- controlled, and contracted with existing medical groups on a capitated basis for medical services. See also *** GCM 34709, I- 3701 (Dec. 7, 1971) (same rationale extended to organization that provided prepaid optometric services).

Fifteen years later, in *** GCM 37043, I-56-75 (Mar. 14, 1977), this Office reviewed a proposed revenue ruling that would have found two nonprofit HMOs entitled to recognition of exemption. We disagreed with the proposed ruling and concluded that the two HMOs were not exempt because they served the private interests of their member-subscribers. Inherent in that position is the belief that an HMO's membership, no matter how open or large, is not sufficiently broad to constitute a charitable class.

The first HMO considered in GCM 37043 was a community-rated staff model HMO that made services available to nonmembers to the extent it had capacity and provided 24-hour emergency care to members and nonmembers at one of its facilities. The second HMO limited provision of care to members and did not maintain 24-hour emergency care. The GCM extended the community benefit analysis the Service applies to hospitals, see Rev. Rul. 69-545, 1969-2 C.B. 117, to staff model HMOs, and found the membership form of HMO coverage to be at odds with exemption. The GCM focussed heavily on the fact that an HMO operates to benefit its paying members to the exclusion of the community as a whole, and on the similarity of an HMO to commercial insurance. It concluded that HMOs and other organizations that provide services exclusively to their fee-paying members do not qualify for exemption under either section 501(c)(3) or (c)(4). No opinion was given on whether HMOs that provide services to nonmembers might qualify under section 501(c)(4). Accord, *** GCM 37018, I-10- 76 (Feb. 25, 1977) prepaid health plan whose membership is limited to the members of one union local primarily benefits member-subscribers and does not qualify under *section 501(c)(4))*. It is worth noting that, by this point, the Service was seriously questioning the continued exemption of Blue Cross/Blue Shield organizations. E.g., *** GCM 36734, I-132-74 (May 19, 1976).

The Service was forced to revise its thinking on the HMO question by the Tax Court decision in Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978), acg., 1981-2 C.B. 2. The court, applying the hospital community benefit analysis of Rev. Rul. 69-545, ruled that the staff model HMO in question was entitled to exemption under section 501(c)(3).[9] The Service raised the same arguments in Sound Health that were made in GCM 37043, but the HMO established unusually strong facts showing community benefit. The court rejected the Service's claim that the organization provided preferential treatment, and thus private benefit, to its members. Instead, the court reasoned, Sound Health's membership class was so open as to be practically unlimited, and no charity ever has been required to benefit every member of the community. 71 T.C. at 185. When possible membership is so broad, observed the court, benefit to the membership IS benefit to the community. 71 T.C. at 190.

As a result of the Tax Court decision, the Service reexamined its position, and a GCM was issued that expressly modified GCM 37043 and announced a new position, at least with respect to staff model HMOs. See Sound Health Ass'n, GCM 38735, EE-9-81 (May 29, 1981). That GCM concluded that HMOs operating in a manner similar to the one in the Sound Health case (i.e., staff model HMOs that have truly open membership, directly provide services to members and nonmembers, maintain an open emergency room, and treat patients regardless of ability to pay) may be exempt under section

501(c)(3).[10] The memorandum sets forth our present view that the provision of prepaid health care services to a class of eligible beneficiaries may constitute the promotion of health in a manner beneficial to the community as a whole if all the facts and circumstances indicate that a sufficiently broad segment of the community is eligible to receive the direct benefits of an organization's health care services and other health related activities. GCM 38735 at 11. Although a draft revenue ruling was included with the GCM, it never was issued.

The next major development in the Service's position on HMOs and related organizations came with the publication of *** GCM 38894, EE-75-78 (Sept. 3, 1982) and Rev. Rul. 86-98, 1986-2 C.B. 75. In GCM 38894, this Office considered whether individual practice associations (i.e., organizations composed of and controlled by health professionals that contract with HMOs and insurers to provide health care services to beneficiaries on a fee-for-service basis) qualified for exemption under section 501(c)(4). It is important to note that GCM 38894 dealt only with the IPAs themselves, not IPA- model HMOs, which usually are separate related or unrelated organizations. We concluded that the IPAs do not qualify under section 501(c)(4) because their primary activity is conducting a business similar to organizations operated for profit and because they primarily benefit their physician members.

Rev. Rul. 86-98 represents formal publication of the position developed in GCM 38894 with respect to IPAs. That ruling holds that an IPA that arranges for its member physicians to perform services for HMOs, accepts payments on a capitated basis, and pays its members on a fee-for-service basis subject to a 15 percent withhold does not qualify under section 501(c)(4). Its rationale is that the IPA operates in a manner similar to organizations operated for profit and its primary beneficiaries are its member physicians. It has been suggested that Rev. Rul. 86-98 may have affected ABC's exemption, but that is not the case. Like GCM 38894, the revenue ruling is limited in scope to the qualification of the IPA itself, and has no direct bearing on IPA-model HMOs.[11]

A year later, this Office did reach the issue of whether an IPA- model HMO could qualify under section 501(c)(3). In *** GCM 39057, EE-101-81 (Nov. 9, 1983) we determined that a federally qualified HMO that arranges for (but does not directly provide) health care services through an affiliated IPA not qualify under section 501(c)(3). Extrapolating from the Tax Court's reasoning in Sound Health, the GCM expressly extended the Rev. Rul. 69-545 hospital community benefit analysis to non-staff model HMOs. Unlike Sound Health Association, the HMO in question did not directly benefit a sufficiently broad segment of the community to qualify. Moreover, the GCM found that the HMO primarily served the private interests of the IPA and the physicians who control it rather than the community as a whole, and that this private benefit was more than incidental. Note, however, (1) that the HMO in this case, while separately incorporated, was controlled by the physician-owned IPA with which it contracted, and (2) that we did not consider whether the organization would have qualified under section 501(c)(4). Whether an IPA-model HMO that is NOT controlled by physicians or other nonexempt providers could qualify under section 501(c)(4) is a very different question on which the Service has not published any formal guidance.[12]

In summary, the Service's position on the tax exemption of HMOs prior to enactment of section 501(m) evolved in a somewhat piecemeal fashion and never has been clearly or comprehensively articulated in a formal publication. This is important to note because some HMO advocates argue that the Congress expressly or implicitly took notice of the Service's position when enacting section 501(m), while others argue only that the Service's treatment of HMOs should be the same as immediately before enactment of section 501(m).

This being said, a few things are clear. First, since Sound Health and the GCMs extending its applicability, the test for exemption under section 501(c)(3) has been straightforward, if somewhat difficult for most HMOs to meet. The standard for exemption under section 501(c)(4) is less clear, particularly now that Blue Cross/Blue Shield organizations no longer are exempt. Presumably, qualification as an organization operated exclusively for the promotion of social welfare requires a showing of benefit to the community similar to, but less exacting than, that required under Sound Health.

The Service's current section 501(c)(4) HMO ruling position involves a community benefit analysis that focuses on factors such as whether membership is open to individuals and small groups (taking into consideration any examination requirements, coverage limitations, and conversion rights), whether the HMO serves low income, high risk, medically underserved, or elderly persons, and whether premiums are established on a community-rated basis. These factors are important, especially given the historical linkage between the Service's position on HMOs and its position on Blue Cross/Blue Shield. Representatives of your office have suggested that we prepare a full consideration of the criteria for HMOs to be recognized as exempt under section 501(c)(4), and we would be happy to prepare one in an appropriate case. The fact that the instant case stems from a ruling request and that the taxpayer already has a determination letter makes it inappropriate to do so here.[13]

Second, as a practical matter, there always have been important differences in the Service's treatment of different types of HMOs. Staff model HMOs able to demonstrate sufficient community benefit have attained section 501(c)(3) status. Other staff model and group model HMOs were recognized as exempt under section 501(c)(4), if only because of their similarity to Blue Cross/Blue Shield organizations. Some IPA-model HMOs that were not operated primarily for the convenience of their participating physicians were recognized as exempt under section 501(c)(4); others were denied because of private benefit. Rather than applying a facile test based on the type of model, the Service always has looked carefully at how the organization is organized and operated. At present, all HMO applications are sent to the National Office for processing. I.R.M. section 7664.31(1).

Finally, HMOs themselves have evolved in response to changing economic and regulatory environments, and will continue to do so. The Service has observed movement away from the staff and group models toward HMOs that have no facilities or staff and that have complicated risk sharing arrangements with health care providers. The HMO Amendments of 1988 will allow federally qualified HMOs to provide up to 10 percent of basic physician services through physicians not affiliated with the HMO, further blurring the distinction between HMOs and commercial health insurers. Answers pertaining to today's HMOs may not apply equally to organizations calling themselves HMOs in the future.

In light of the Service's position and the fact that ABC received a favorable determination letter in 1978, we believe that ABC was exempt under section 501(c)(4) on December 31, 1986, the effective date of section 501(m) with respect to that organization.

II. SECTION 501(m) AND THE PROVISION OF INSURANCE

Section 501(m) was added to the Code by section 1012 of the Tax Reform Act of 1986, Pub. L. No. 99-514 (Oct. 22, 1986). That section states that an organization described in section 501(c)(3) or (c)(4) may be exempt under section 501(a) “only if no substantial part of its activities consists of providing commercial-type insurance.” Section 1012 of the Tax Reform Act also added section 833 to the Code. Under section 833, certain Blue Cross and Blue Shield organizations and other health insurers are

afforded special treatment under subchapter L of the Code. Both provisions are effective for taxable years beginning after December 31, 1986.

We note at the outset that the Congress' chief purpose in enacting section 501(m) was to subject Blue Cross/Blue Shield organizations previously exempt under section 501(c)(4) to taxation. The Congress determined that, despite an early history of fulfilling important societal needs, these organizations had become identical to contemporary commercial insurers. Section 501(m) was intended to take away the unfair competitive advantage of tax exemption, placing the Blues and other exempt organizations engaged in insurance activities on a level playing field with commercial insurers. See Staff of the Joint Comm. on Taxation, 100th Cong., 1st Sess., General Explanation of the Tax Reform Act of 1986 (Comm. Print 1987) at 583. It is sometimes difficult to determine, however, which other types of organizations are barred by section 501(m) from being exempt.

In *** GCM 39703, EE-56-86 (Feb. 26, 1988), we stated that it is necessary to make two findings to determine that section 501(m) precludes exemption for a particular entity. First, the entity must be found to provide “commercial-type insurance.” Second, provision of commercial-type insurance must be found to constitute a substantial part of the entity's activities. Whether an entity provides commercial-type insurance within the meaning of the statute ordinarily will be based on the all the facts and circumstances of any given case.

Whether HMOs are affected by section 501(m) is an issue that has generated particular controversy since the 1986 Act. HMO advocates argue that HMOs provide services, not insurance. Moreover, section 501(m)(3)(B) states that the term commercial-type insurance shall not include “incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations.” Determining the intended scope of the exception requires a detailed analysis of the express terms of section 501(m)(3)(B) and the general legislative history of section 501(m).

A useful point of departure is to consider whether various types of HMOs in fact provide insurance and what the Congress meant when it used the terms commercial-type insurance and incidental health insurance. The Congress did not define “commercial-type insurance" in the statute. The Report of the House Committee on Ways and Means, however, states that “...commercial-type insurance generally is any insurance of a type provided by commercial insurance companies.” H.R. Rep. No. 426, 99th Cong. 1st. Sess. 665 (1985). Because the statute was intended to reach Blue Cross/Blue Shield organizations, it is self-evident that health insurance is included within the meaning of commercial-type insurance.

Existing precedent concerning the definition of insurance in other areas of the tax law is relevant, though not necessarily controlling, in determining what constitutes commercial-type insurance under section 501(m). In examining existing authorities, one finds as many definitions of what constitutes insurance as purposes for which the definition is relevant. See Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068, 1073 (1976), aff'd, 572 F.2d 1190 (7th Cir.), cert. denied, 439 U.S. 835 (1978). Two elements of the definition, however, are relied upon consistently. These were set out by the Supreme Court in Helvering v. LeGierse, 312 U.S. 531 (1941), when it stated “[h]istorically and commonly insurance involves risk-shifting and risk-distributing." 312 U.S. at 539. See also Staff of the Joint Committee on Taxation, 100th Cong., 1st Sess., General Explanation of the Tax Reform Act of 1986 585-586 (Comm. Print 1987) (“commercial-type insurance does not include arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance)”).

In Allied Fidelity, 572 F.2d at 1190, a case concerning whether an entity was properly classified as an insurance company under former section 831, the court provided the following definition of insurance:

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

Existing authorities are inconclusive regarding whether the various types of modern HMOs provide insurance.[14] Long before the Tax Reform Act of 1986, the Service considered whether an organization that operated like a staff model HMO qualified as an insurance company under the Code. In Rev. Rul. 68-27, 1968-1 C.B. 315, considered by this Office *** GCM 33144, I-1619 (Dec. 2, 1965), the Service found that an organization that issues medical service contracts to groups or individuals and furnishes direct medical services to subscribers by means of a salaried staff is not an insurance company within the meaning of the Code. The ruling is based on the finding of no insurance contract -- that is, no element of shifting or assuming the risk of loss of the insured -- present in the organization's activities. Instead, the ruling states that the only risk present is that inherent in any normal business engaged in furnishing medical services on a fixed-price basis.

Rev. Rul. 68-27 is often cited, somewhat inexactly, as establishing that HMOs do not provide insurance. While Rev. Rul. 68-27 does suggest that STAFF MODEL HMOs predominantly provide services rather than insurance, it should be noted that the ruling turned on the definition of the term “insurance company” in Treas. Reg. 1.801- 3(a) which is not the same as the term “providing commercial-type insurance.” In any event, the ruling is limited to organizations that directly provide services through a salaried staff, and thus generally would cover staff model HMOs only. Compare *** GCM 37043, I-56-75 (Mar. 14, 1977) (effect of HMO prepayment feature is to provide a form of insurance for member-subscribers) WITH Sound Health Ass'n, GCM 38735, EE:9-81 (May 29, 1981) (staff model HMOs' provision of prepaid medical services to prevent or treat illness should not be characterized as the provision of insurance).

Rev. Rul. 68-27 follows Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939), the seminal case concerning the insurance aspects of HMOs. That case found an early HMO[15] that furnished services in its own facility through contracts with individual physicians who received a fixed annual compensation was not engaged in the business of insurance. The Jordan court regarded the arrangement as in the nature of a contract between Group Health and its subscribers for medical services on a contingency rather than as a contract for insurance. Examining the HMO's obligations to its members separately, the court found that the preventive care component was not insurance because its incidence was predictable, so no risk was involved. It found that the physician care component was not insurance because the physicians were paid a fixed compensation and (unlike modern HMOs) Group Health was not obligated to provide services or see that they were provided; but only to use its best efforts to arrange for care. 107 F.2d at 243. This was risk, said the court, but it was not shifted to or assumed by Group Health on the facts of that case. Id. at 246. The limited hospital benefit, provided by arrangement with independent hospitals, was dismissed as incidental. Id. at 244. The court characterized Group Health as a consumer cooperative whose primary function is the

quantity purchase of medical services despite the presence of “an incidental element of risk distribution or assumption." Id. at 247.

Notwithstanding these early precedents, a strong argument can be made that many of today's HMOs provide insurance, even if they do not rise to the level of insurance companies under the Code. HMOs providing physician care through employees shift a risk of loss (i.e., the need for costly medical care) from the subscriber to the HMO and, to some extent, on to the physician employees.[16] Those HMOs paying physicians and hospitals on a capitated basis thereby shift the risk from the subscriber to the providers. In either case, there is also present an element of risk distribution among all the subscribers. Also, while most of the risk typically either is not assumed or not retained by the HMO, a portion of the risk is retained by the HMO for the cost of services rendered by providers who are neither employees nor paid on a capitated or other fixed-cost basis. See, e.g., GCM 37043 (MODIFIED in this regard by GCM 38735).

At the same time, it is apparent that at least some HMOs' primary activities are providing health services. Any insurance element is a necessary concomitant to the provision of theoretically unlimited services for a fixed, prepaid fee. This argument is particularly strong with respect to staff model HMOs, because they directly provide physician services through employees. In GCM 38735, this Office formally acknowledged that, where a staff model HMO's salaried physicians and secondary health care service providers are paid a fixed compensation that does not vary with the nature or frequency of services performed during a contract period, its provision of prepaid medical services should not be characterized as the provision of insurance. While not expressly stated in the GCM, this conclusion was based on a finding that such HMOs primarily provide services rather than indemnity.

Attempting to reconcile these two arguments, provision of insurance versus provision of services, is not easy. Both are present to a greater or lesser degree in each of the common types of HMOs. A close reading of the Jordan decision shows that the D.C. Circuit identified a useful framework for resolving the issue 50 years ago. Noting the difficulty of distinguishing contracts to render services on the happening of a contingency from true contracts of insurance, the panel suggested that the distinction should turn on which object or purpose underlying the contract is paramount. 107 F.2d at 248. In the modern HMO context, this would require, in effect, balancing the service aspects of the organization's activities against the insurance aspects of its activities. Interestingly, despite the limited relevance of the Jordan facts to today's more varied types of HMOs, the approach used to decide the case remains workable, and helps explain the approach taken by the Congress in crafting an HMO exception from section 501(m).

LEGISLATIVE HISTORY OF SECTION 501(m)

The best way to fathom the intent underlying the section 501(m)(3)(B) exception for incidental health insurance provided by HMOs is to work chronologically through section 501(m)'s legislative history. The Ways and Means Committee Report, H.R. Rep. No. 426, 99th Cong., 1st Sess. 665 (Dec. 17, 1985), which first considered the bill ultimately enacted as the Tax Reform Act of 1986, describes the HMO exception from section 501(m) as follows:

Commercial-type insurance also does not include health insurance provided by a health maintenance organization that is of a kind customarily provided by such organizations 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. Similarly, organizations that provide supplemental health maintenance organization-type services (such as dental services) would not be affected if they operate in the same manner as a health maintenance organization.

Clearly, the Committee intended to extend protection only to HMOs whose PRINCIPAL ACTIVITY is providing health care. Also, any health insurance provided must be INCIDENTAL to that principal activity. This raised the issue of what types of HMOs should be excepted. Many HMOs, including IPA-model HMOs, arrange for but do not directly provide care. It would seem difficult at first blush to conclude that their principal activity is providing health care. Moreover, the second sentence quoted above seems to confirm that the Committee intended to exclude only HMOs that provide care at their own facilities through the efforts of employees (i.e., only staff model HMOs). This suggests that even the typical group model HMO would not benefit from the exception.

The Senate bill contained no counterpart to the provisions in question. Accordingly, the Finance Committee Report, S. Rep. No. 313, 99th Cong., 1st Sess. (May 29, 1986), sheds no light on the scope of section 501(m).

The 1986 Act, as adopted, contains the language from the House bill. The Conference Committee Report, H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-346 (Sept. 18, 1986) notes that the conference agreement follows the House bill with modifications, and states:

The conference agreement does not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

This language apparently was intended as a substitute for the middle sentence in the above-quoted excerpt from the House Report (i.e., describing staff model HMOs). In describing the House bill, the Conference Report repeats only the first and last sentences in the above-quoted excerpt from the House Report. Its less restrictive description of the bill's effect on HMOs follows under the heading “Conference Agreement”.

While it could be clearer, this substituted language evinces an intent on the part of the conference managers that section 501(m) not affect the tax status of any of the common, existing types of HMOs, be they staff, group, network, or IPA-model, so long as their principal activity is providing health care and any insurance provided is incidental.[17] Some difficulties remain. The report states that the conference agreement does not alter “the tax-exempt status” of HMOs, yet it is not clear that all common, existing types of HMOs qualified for recognition of exemption under then-current law. The report also describes HMOs as “providing” physician services in a variety of settings including through contracts with individual physicians on an individual practice basis. This seems to refer to IPA-model HMOs, yet the Service's past treatment of these organizations was based in part on the fact that they arrange for, but do not themselves provide physician services.

The intended scope of the HMO exception from section 501(m) was clouded somewhat by the description in the General Explanation of the Tax Reform Act of 1986, prepared by the Staff of the Joint Comm. on Taxation, 100th Cong., 1st Sess. 583-586 (May 4, 1987). In blending together the above-quoted language from the House Report and the Conference Report, the staff explanation appears to return to the more narrow formulation of the exception (i.e., for staff model HMOs only).

In response to these continuing questions, the Congress revisited the issue in the legislative history of the Technical and Miscellaneous Revenue Act of 1988 (“TAMRA”), Pub. L. No. 100-647, (Nov. 10, 1988). While the Act itself made only a minor change to section 501(m) that is not relevant here, both the House and Senate reports on the proposed technical amendments commented once again on the exception for HMOs. H.R. Rep. No. 795, 100th Cong., 2d Sess. 114- 115 (1988); S. Rep. No. 445, 100th Cong., 2d Sess. 120-121 (1988). Under the heading “Present Law,” both reports state:

Commercial-type insurance also does not include health insurance provided by a health maintenance organization (i.e., any health maintenance organization, tax-exempt under prior law, which is substantially the same as a Federally chartered health maintenance organization), if such health insurance is of a kind customarily provided by such organizations and is incidental to the organization's principal activity of providing health care.

Under the heading “Explanation of Provision”, both reports state that organizations providing 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 an HMO. However, only the Senate Report goes on to say that HMOs provide services in a variety of settings, adding a sentence identical to that in the 1986 Act Conference Report. This further fueled the uncertainty over what types of HMOs the Congress intended to exclude from section 501(m).

The TAMRA Conference Report, H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. 11-9 (1988), notes that, with respect to insurance, the conference agreement follows the Senate bill with a clarification. The “clarification” is as follows:

Under the 1986 Act, the provision relating to organizations engaged in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). The conference agreement clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organization-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.

Despite all the purported clarifications, questions surrounding the intended scope of the HMO exception remain. Mere recitation of the fact that HMOs provide services in a variety of settings implies, but does not clearly state, that all common types of HMOs should be unaffected by the provision. At one point in the process, legislators suggested they intended favorably treating only federally qualified[18] and similar HMOs; at another only staff model HMOs. Nonetheless, substitution in the TAMRA Conference Report of language similar to that used in the 1986 Act Conference Report implies a rejection of the “tax-exempt under prior law ...substantially the same as a Federally chartered health maintenance organization” standard in the TAMRA House and Senate Reports and a reaffirmation of the 1986 Act Conference Report “variety of practice settings” position.

On the whole, we believe the legislative history must be read in light of Jordan and other existing precedents to mean only that section 501(m) was not intended to deny exemption to an HMO whose principal activity is providing health care services in the same manner as one of the common, existing types of HMOs solely because it also provides incidental health insurance.[19] We do not read the legislative history to mean that any organization styled as an HMO will never be found to provide

commercial-type insurance within the meaning of the statute. Where an HMO's principal activity is not providing health care or where, notwithstanding that its principal activity is providing health care, it provides insurance that is not incidental to that activity, the organization may be found to provide commercial-type insurance. However, statements in both Conference Reports make clear that the determination of whether an HMO qualifies for the section 501(m)(3)(B) exception should be based on all the facts and circumstances surrounding its operations, and not solely on whether it operates on the staff, group, network, or IPA-model. Of course, the tax status of HMOs that qualify for the exception should continue to be determined under the principles discussed in Part I of this memorandum.

In determining whether an HMO's principal activity is providing health care services or, instead, is providing insurance, an analysis similar to that set forth in GCM 39703, supra, must be made. Relevant factors identified in the GCM include whether and to what extent an insurance risk is transferred and distributed, whether and to what extent the entity operates in a manner similar to for-profit insurers or Blue Cross/Blue Shield, and whether and to what extent the entity markets a product similar to the product of for-profit insurers or Blue Cross/Blue Shield. Additional factors that must be considered in the HMO context, however, are whether and to what extent the entity provides health care services directly and whether and to what extent the entity has shifted any risk of loss to the service providers through salary or fixed-fee compensation arrangements. See Jordan; Rev. Rul. 68-27.[20]

Drawing on Jordan, Rev. Rul. 68-27, GCM 38735, and the statements in the legislative history, one might easily conclude that HMOs that directly provide prepaid medical care in their own facilities through salaried physicians and secondary health care providers paid a fixed compensation have as their principal activity providing health care, not insurance. The same is basically true of HMOs that contract on a fixed cost basis with an existing medical group practice for provision of services in a centralized group setting. On the other hand, distinguishing HMOs that arrange for the provision of services by physicians practicing individually from Blue Cross/Blue Shield and commercial insurers is difficult, particularly since both types of entities seemingly compete for the same subscribers.

Focussing on other traditionally unique characteristics of HMOs may offer some help. Unlike indemnity insurers, HMOs are required by the federal HMO Act and many state laws to undertake substantial utilization review and quality assurance activities. They are responsible for managing all aspects of covered care provided to subscribers through such mechanisms as pretreatment certifications, notifications, and financial incentives for cost containment. However, even these traditional distinctions are disappearing as more HMOs respond to consumer demand for freedom to choose providers and physician demand to incorporate their existing individual practices instead of requiring a group practice pattern. At the same time, commercial insurers are adopting HMO-like managed care characteristics in an effort to control costs.[21]

*** GCM 36734, I-132-74 (May 19, 1976), this Office distinguished staff model and other fixed-cost HMOs from typical Blue Cross/Blue Shield plans when we determined that the latter were providing insurance. In an addendum to the GCM, we found that the HMOs provided direct health care services, a type of business not engaged in by insurance companies under the Code. in contrast, Blue Cross and Blue Shield did not attempt to provide services themselves, but instead contracted with providers on a cash indemnity basis. This distinction was deemed important since the plans 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 to the actual amount of premiums collected. Because Blue Cross/Blue Shield assumed the risk that the charges they contracted to pay might exceed the premiums collected,

we found that they were providing insurance within the meaning of the Code. Thus, the fact that an HMO employs its own staff and operates its own facilities, or otherwise fixes its costs by shifting a substantial portion of the risk to providers, may be the only practical way to distinguish it from commercial insurers or Blue Cross/Blue Shield.

In a staff model HMO, a subscriber purchases the right to receive all needed medical services from a small designated group of HMO employees and other providers affiliated with the HMO, not the right to be indemnified for medical costs wherever incurred. Moreover, much of the risk assumed by the HMO is shared by the salaried physicians and other providers because their workload may vary while their salary is fixed. The same may be true to a somewhat lesser degree for other models of HMOs, including IPA-model HMOs, where they pay providers on a capitated or other fixed-fee basis.[22]

The Congress made clear in section 501(m)(3)(B) and the legislative history that only health insurance that is incidental to an HMO's principal activity of providing health care is excepted from section 501(m). The term “incidental” has meaning. in both a qualitative and quantitative sense. See *** GCM 37789, EE-66-78 (Dec. 13, 1978) (construing the term in the private benefit context).

Used qualitatively, the term means that something happens as a result of or concomitant to something more important. Congress may have used the term qualitatively, recognizing that HMOs, by accepting an obligation to provide all of a subscriber's needed medical services for a filed, prepaid fee, provide insurance. If so, the Congress implicitly recognized that, under certain circumstances, this insurance element may be considered a necessary concomitant to or normal consequence of, and thus incidental to, the HMO's primary function of providing health services.

Used quantitatively, the term means secondary, minor, or relatively insubstantial. The Congress may have used the term quantitatively, recognizing that most HMOs are unable to directly provide 100 percent of the services they make available to subscribers. Most HMOs cover out of area emergency services and certain referral specialist services in much the some manner as indemnity insurers. Others provide ancillary benefits such as vision or dental care in a manner similar to insurers. If using the term quantitatively, the Congress may have meant only that those pure insurance functions may be considered incidental when viewed in the context of the HMO's primary activity of providing care.

In light of our overall reading of the legislative history discussed above, and the fact that incidental was used several times to describe the risk shifting and distribution in the Jordan case, we believe that the Congress used the term in section 501(m)(3)(B) primarily in its qualitative sense. This conclusion is buttressed by the context in which the term appears in the 1986 Act House Report, supra, (“incidental to the organization's principal activity”) and by the fact that the pure insurance activities described above as quantitatively incidental may also under proper circumstances be considered qualitatively incidental to an HMO's principal activity of providing care.

Accordingly, before determining that health insurance provided by an HMO whose principal activity is providing services qualifies for the exception in section 501(m)(3)(B), the Service must be satisfied on the basis of all the facts and circumstances that any insurance element is a necessary and normal consequence of the HMO's principal activity. In many cases, this inquiry will be subsumed within the analysis of whether the insurance aspects or service aspects of the HMO's activities predominate.

The best example of an HMO providing only incidental insurance would be one which has transferred substantially all of the risk to providers or that has fixed the costs it incurs in providing care. We believe that an HMO operating on one of the common, existing models that (1) compensates primary care

physicians exclusively on a salary, capitation, or other fixed-fee basis, and (2) shifts to those physicians (or to HMO-affiliated specialists and hospitals) substantially all of the risk of excess utilization of specialists and hospitals, principally provides health care and provides only incidental health insurance. Such HMOs qualify for the section 501(m)(3)(B) exception.

Other HMOs must be examined on a case by case basis, taking into consideration their risk sharing arrangements with primary care physicians, specialists, hospitals, and other providers. Where a substantial portion of the risk is shifted to the providers, or a substantial portion of the HMO's costs are otherwise fixed, the insurance aspects of the HMO's operations may be considered incidental.

It is important to note that, while salary or capitation arrangements fixing an HMO's costs or transferring its risk for primary care were customary at the time section 501(m) was enacted, arrangements regarding specialists and hospital care were more varied. Nevertheless, most HMOs rely on a primary care case management or “gatekeeper” approach that places on the primary care physicians responsibility for controlling specialist and hospital utilization, whether or not they actually are placed at financial risk for those services. Because HMOs customarily place so much emphasis on controlling utilization through their primary care physicians, and because arrangements with specialists and hospitals are so varied, we believe arrangements with primary care physicians ordinarily should be accorded greater weight in this determination than those with specialists or hospitals.[23]

Accordingly we believe that, absent unusual facts, an HMO operating on one of the common, existing models that compensates primary care physicians exclusively on a salary, capitation, or other fixed-fee basis principally provides health care and provides only incidental health insurance, even though the HMO pays other providers on a fee-for-service basis.[24] In the usual case, these HMOs, too, will qualify for the section 501(m)(3)(B) exception. Other HMOs must be evaluated against the above standard based on the totality of their facts and circumstances.

Finally, we note that, for incidental health insurance to qualify for the exception, it also must be “of a kind customarily provided by” HMOs. Section 501(m)(3)(B). This suggests that the Congress did not intend to exclude from the reach of section 501(m) many of the new hybrid organizations being developed that, while formally called HMOs, closely resemble indemnity insurers or other types of health care providers in operation. For example, “point-of- service plans” or “open-ended HMOs” (i.e., those allowing subscribers to obtain nonemergency services from providers who are not affiliated with the HMO without a referral) cannot be said to provide only insurance customarily provided by HMOs. The out of plan benefits these organizations offer are provided on a true indemnity basis. Moreover, these organizations do not share the fundamental HMO characteristic that subscribers must obtain services from providers affiliated with the HMO (i.e., the lock in). If this type of activity is substantial, the organization providing it is precluded from exemption by section 501(m). If it is not substantial, it must be treated as an unrelated trade or business subject to the special taxation provisions of section 501(m)(2).

Applying this analysis to the case at hand, we believe that ABC retained its tax exemption after the effective date of section 501(m). The organization was organized and operated as a traditional IPA-model HMO that arranged for the provision of care to its subscribers by contracting with selected physicians who practice independently. It paid its primary care physicians for all physician services on a capitated basis, thus shifting the risk associated with demand for all physician services (both primary care and specialists) to the providers. Absent unusual circumstances, its activities fall within the section 501(m)(3)(B) exception.

This case is slightly unusual; ABC wants to have its exemption revoked by operation of section 501(m) . Accordingly, it argues that it paid hospitals on a fee-for-service basis, thereby assuming and retaining a significant insurance risk. It states that only about half its direct costs are for physician services, while the other half are for hospital services. The latter coverage, it claims, is provided in much the same manner as hospitalization provided by commercial insurers. While admitting that its capitated physician services are not insurance, it argues that the hospitalization is insurance, and is substantial, so that section 501(m) applies.

While the amount of premiums or expenditures allocable to capitated or fixed cost benefits on the one hand, and insurance-like benefits on the other is certainly a fact to be considered, we recommend against applying a simple percentage test. The better approach is to determine whether the organization is truly an HMO, and, if so, to evaluate its purposes and activities based on all the facts and circumstances. As noted above, we believe that how an HMO pays its primary care physicians ordinarily is entitled to greater weight than how it pays out of area (emergency) providers, referral specialists, or hospitals.

Here, ABC pays capitation for ALL physician services. Subscribers are locked in to HMO-affiliated providers and there are no out of plan benefits. Nothing in the administrative file indicates that ABC is in any material respect not a typical IPA-model HMO. On balance, we believe ABC can fairly be said to have as its principal activity providing or arranging for the provision of services, to which its provision of health insurance, including hospital benefits, is qualitatively incidental. Thus, it does not have as a substantial part of its activities the provision of commercial-type insurance because it falls within the exception in section 501(m)(3)(B). Section 501(m) does not prevent it from being exempt.

In summary, to determine whether an organization seeking tax exemption as an HMO can qualify, the Service must make two determinations. As a threshold, it must determine whether section 501(m) prohibits exemption. If section 501(m) does not prevent exemption, the Service must go on to determine whether the organization meets the Sound Health test for exemption under section 501(c)(3) or the social welfare organization community benefit test for exemption under section 501(c)(4). Only the first part of this analysis needs to be applied in this case. It is unnecessary to consider whether ABC would meet the Service's current standards for exemption as a social welfare organization. Since ABC did not lose its exemption by operation of section 501(m), it was entitled to rely on its 1978 determination letter until the occurrence of the first material change in its organization or operations that was inconsistent with its exempt status.

James J. McGovern

Assistant Chief Counsel

By: James L. Brokaw

Chief, Branch 5

Office of the Assistant Chief Counsel

(Employee Benefits and Exempt Organizations)

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[1] Health Maintenance Organization Act of 1973, Pub. L. No. 93- 222, codified as amended at 42 U.S.C. sections 300e - 300e-17 (hereinafter cited as HMO Act).

[2] ABC is a calendar year taxpayer. Sections 501(m) and 833 are effective for the first taxable year beginning after December 31, 1986 (see below). Thus, taxpayer has taken the position that it is subject to these provisions as of January 1, 1987.

[3] The HMO Amendments of 1988, Pub. L. No. 100-517 (Oct. 24, 1988), eliminated the requirement that a federally qualified HMO be organized as a separate entity.

[4] Note the distinction between the IPA-model HMO and the individual practice association (IPA) itself. Most IPA-model HMOs contract with physicians through an IPA, which is usually a separate, related or unrelated, physician-controlled entity. A few IPA-model HMOs contract directly with individual physicians. These are termed “direct contract” HMOs. See generally E. Wagner, Types of Managed Health Care Organizations, in P. Kongstvedt, ed., The Managed Health Care Handbook (1989); Group Health Ass'n of America, HMO Industry Profile (vol. 1, 1989).

[5] As used herein, “primary care physicians” refers to the physicians who provide to an HMO's subscribers basic medical services including preventive care and routine medical treatments for illnesses and injuries.

[6] As used herein, the term “capitation” or “capitated payment” refers to the practice of compensating providers on the basis of the number of subscribers the provider is responsible for serving, without regard to the frequency or extent of services actually provided. The Group Health Ass'n of America reported in a November 1987 Research Brief that capitation is the predominant basis used to compensate primary care physicians in all but staff model HMOs, where salary is common.

[7] Generally, section 501(c)(4) exempts entities primarily engaged in promoting the common good and general welfare of the people of the community and not primarily carrying on a business with the general public in a manner similar to organizations operated for profit. Reg. section 1.501(c)(4)-1.

[8] Interestingly, despite longstanding administrative practice, the historical rationale and legal criteria for recognizing Blue Cross/Blue Shield organizations as described in section 501(c)(4) have never been fully articulated. See GCM 34709 (Service has in past used section 501(c)(4) to exempt organizations that, although worthy, failed to meet particular requirements of section 501(c)(3), especially prepaid medical service organizations); McGovern, Federal Tax Exemption of Prepaid Health Care Plans, The Tax Advisor (Feb. 1976). Nevertheless, it is clear that open enrollment and community-rating were among the socially beneficial characteristics these plans possessed in their early years.

[9] Interestingly, the Service had recognized Sound Health as exempt under section 501(c)(4), but the taxpayer still brought a declaratory judgment action regarding its status under section 501(c)(3). The desire for exemption under section 501(c)(3) rather than (c)(4) underlies a number of recent cases. Since HMOs presumably benefit little from deductible contributions, the reasons for desiring (c)(3) status probably relate more to interorganizational funding transfers, property tax exemptions, access to tax exempt financing, and preferential postal rates.

[10] The GCM, in conjunction with the Sound Health opinion and Rev. Rul. 69-545, sets forth a number of factors indicating community benefit. Some practitioners have suggested that the Service requires an HMO to meet each of fourteen factors or tests to qualify under this analysis. See, e.g., Minutes, American Bar Ass'n, Section on Tax'n, Exempt Org'ns Committee Meeting, (Feb. 10, 1989). We believe applicants should be judged on the basis of whether they operate exclusively to benefit the community based on all the facts and circumstances. The presence or absence of any one factor is not necessarily determinative.

[11] *** GCM 39763, EE-120-87 (May 26, 1988), which is limited to the extremely narrow facts set forth therein, *** in no way changes the analysis of typical IPA-type organizations under Rev. Rul. 86-98. ***

[12] Such an HMO might be entirely independent or, for example, be sponsored by an insurance company or controlled exclusively by a tax exempt hospital.

[13] Nevertheless, in keeping with the facts and circumstances nature of such an analysis, we believe the Service would be justified in considering as evidence suggesting community benefit the fact that an HMO is federally qualified within the meaning of the federal HMO Act. While subject to change, the Act presently imposes requirements in the areas of quality assurance, community rating, and continuation of coverage that tend to suggest that the HMO's operations would benefit the community. Similarly, the Service might accept as evidence of community benefit the fact that an HMO has a Medicare risk sharing contract. However, the absence of federal qualification or a risk sharing contract, in itself, should create no negative inference.

[14] E.g., compare Family Health Services, Inc., 104 Bankr. 279 (Bankr. C.D. Cal. 1989) (finding Maxicare's Wisconsin HMO subsidiary was not a “domestic insurance company” within the meaning of federal bankruptcy law, despite classification as an insurance company under state law, because it primarily provides services) with Beacon Health, Inc., 105 Bankr. 178 (Bankr. D.N.H. 1989) (distinguishing Maxicare proceedings and holding that an HMO is a domestic insurance company under similar facts).

[15] At the time of the Jordan decision, Group Health Association was structured in a manner roughly similar to a staff model HMO, except that its physicians were individual independent contractors who worked full- or part-time at Group Health's clinic. See 107 F.2d at 242. Note that the term “HMO” did not come into use until the early 1970s. Prototypes were referred to as clinics, prepaid group practices, and medical foundations.

[16] See Jordan, 107 F.2d at 246. Even the Jordan court found risk shifting arising from physician services for the sick or injured. Only the uniquely restrictive formulation of the subscriber agreements in that case allowed the court to conclude that no risk was assumed by the HMO. Id. at 239, 246. See also Id. at 248 n.30 (distinguishing burial associations because the obligation assumed is a definite and binding one to supply the service). In this regard, Jordan is easily distinguishable on its facts from today's HMOs. See Neal, The Tax Status of Nonprofit HMOs, in HealthSpan (Feb. 1989) (limitations on HMO obligations to provide services to members have all but disappeared since Jordan). See also 42 U.S.C. section 300e(c)(2), requiring federally qualified HMOs to assume full financial risk on a prospective basis for the provision of basic health services.

[17] Discussing which of the common, existing types of HMOs the Congress intended to exclude will not end the controversy. See Neal, supra note 16, “The IRS will find it difficult to determine which organizations should benefit from the favorable Congressional intent as the distinctions between HMOs and other types of health benefits providers, including preferred provider organizations, becomes increasingly blurred....it is likely that Congress will have to address this issue again.”

[18] While the reports say “Federally chartered”, we assume the term to mean federally qualified within the meaning of 42 U.S.C. section 300e-9(d). Many HMOs are not federally qualified.

[19] By using the term HMO in the statute and legislative history, we believe the Congress intended to limit the exception to HMOs as they were commonly structured and existing at the time of the 1986 Act. See United States v. Cambridge Loan and Building Co., 278 U.S. 55 (1928) (Congress presumed to use terms according to legal significance at time of enactment); 1 J. Mertens, Law of Federal Taxation section 3.25 (1982) (descriptive trade term usually given its special meaning as of time act was passed).

[20] It has been suggested that Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, reh. denied, 441 U.S. 917 (1979) stands for the proposition that, in determining whether an arrangement constitutes insurance, only the relationship between insurer and insured is relevant. Under this analysis, an HMO's relationship with its providers would be irrelevant. We do not agree. In Royal Drug, the Supreme Court found that a Blue Shield plan's contracts with pharmacies were not the business of insurance within the meaning of the McCarran-Ferguson Act exemption from federal antitrust law because the contracts do not involve underwriting or spreading of the risk. See 440 U.S. at 213. An HMO's contracts with its providers typically do involve shifting and spreading the risk and are the main way an HMO preserves its reliability in the absence of

large insurance-type reserves.

[21] See generally, InterStudy, From HMO Movement to Managed Care Industry (June 1988). This blurring of distinctions has led a number of recent commentators to question the continued utility of descriptive labels such as HMO. Id.; Monahan and Willis, Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment? 18 Stetson L. Rev. 353 (1989); see note 17, supra.

[22] On the other hand, nonstaff, nongroup practice HMOs that pay providers on a fee-for-service basis, even where subject to a percentage withhold or reduction for overutilization, are much harder to distinguish from commercial insurance companies and Blue Cross/Blue Shield. We express no opinion at this time on whether these latter organizations primarily provide services or an insurance-type benefit or on whether they fit within the section 501(m)(3)(B) exception.

[23] Since nearly all HMOs provide out of area (emergency) services on an indemnity basis, these services ordinarily should be accorded little weight.

[24] Unusual facts would include cases where, for example, providing or arranging for the provision of primary care is not a significant part of the HMO's activities, or the HMO does not use a gatekeeper approach.
