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Tax Exemption to Health Maintenance Organizations: What's the Issue and Who Should Decide It

Arthur M. Reginelli

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I. INTRODUCTION

Managed health care systems have been created as an alternative to the fee-for-service method of providing health care. The prototypical example of a managed health care system is the health maintenance organization (HMO). An HMO is a public or private, state-licensed entity organized to provide basic and supplemental health care services to its members via a prepaid financing program. Accordingly, a multitude of health services are provided to members who pay a fixed rate regardless of the frequency, extent, or kind of health care provided.

In our society, where affordable and accessible health care is one of the foremost national concerns, the HMO is consistently viewed as a viable answer...
to our health care troubles. In fact, both political parties have advocated the proliferation and utilization of HMOs in the parties' national health care policies.

As HMOs grow in size and number, so will questions of their operation and treatment under the law, particularly with respect to their treatment under the Internal Revenue Code (the Code). Like many hospitals, some HMOs are organized and operated as nonprofit entities and seek tax exemption under § 501 of the Code. Those HMOs that are exempt under § 501(c)(3) qualify as charitable organizations, and those exempt under § 501(c)(4) qualify as social welfare organizations. Both § 501(c)(3) and § 501(c)(4) organizations are exempt from federal income taxation, but qualification as a § 501(c)(3) organization carries with it many other benefits that make qualification under this provision very desirable.

Since the beginning of the comprehensive federal income tax, many hospitals have enjoyed an exemption from federal taxation as charitable organizations. Although the role of the hospital has evolved over the past century, many hospitals still qualify under § 501(c)(3) as charitable organizations and rely on their tax-exempt status to provide quality health care. This exemption saved hospitals, as a whole, approximately $1.5 billion in federal taxes during fiscal year 1992.

HMOs and hospitals are similar institutions in that they are health care organizations. There are, however, vast differences between hospitals and HMOs, including differences in the way the institutions are organized and differences in the basic services that the institutions provide. Nonetheless, the Internal Revenue Service (the Service), the courts, and Congress have

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4 But see, e.g., Bruce J. Winick, Rethinking the Health Care Delivery Crisis: The Need for a Therapeutic Jurisprudence, 7 J. L. & HEALTH 49 (1992-93)(pointing out that HMOs are also subject to the inflationary problems that have plagued the pay-for-service system supplemented with insurance and Medicare, due to the fact that there are no marginal costs to the consumer, thereby prompting an "all you can eat" approach by the consumer to care from an HMO).


continued to compare and analogize HMOs to hospitals when deciding the tax-exempt status of HMOs. As a result, some HMOs have been precluded from tax exemption based on dissimilarities between their operation and structure and the operation and structure of hospitals.10

The question of tax exemption for HMOs is further complicated because HMOs offer, as part of their services, a form of health care financing. Some have argued that HMOs are simply health insurance companies.11 The 1986 amendments to the Code revoked any tax exemptions given to commercial insurance companies,12 and therefore, classification as a commercial insurance company would be detrimental to an HMO seeking tax exemption.13 Congress, however, exempted from this revocation "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations."14 The Service currently interprets this rule of law favorably for most HMOs with regard to classification as commercial insurers.15 Nevertheless, the fact that members of an HMO assure themselves health care based on prepaid fees to the HMO represents a function that is arguably a type of insurance.16 This fact, coupled with the fact that HMOs are not per se hospitals, has undermined attempts by HMOs to attain tax-exempt status.
Given the similarities between HMOs and both hospitals and insurance companies, the standards that have developed around hospitals and insurance companies are relevant to the issue of tax exemption for HMOs. These standards, however, are not always appropriate. Bottom line, the unanswered question is the policy issue of whether health care management companies should be tax-exempt.

The Service has been willing to grant tax exemptions only to select HMOs meeting specific organizational and operational criteria.\textsuperscript{17} The Service approaches the question of tax exemption for HMOs on a case-by-case basis under a two-tiered analysis.\textsuperscript{18} First, the Service looks to whether an HMO is providing substantially health care services or insurance services.\textsuperscript{19} If the HMO is deemed to be providing substantially an insurance service, it will not be granted any tax exemption.\textsuperscript{20} Second, if the HMO is providing substantially health care services, then the examination moves to the second tier, and the question of tax exemption will be decided in accord with the standards developed for hospitals.\textsuperscript{21} Those HMOs meeting the qualifying criteria adopted for hospitals will qualify as charitable organizations and gain exemption under § 501(c)(3).\textsuperscript{22} Those HMOs that do not meet the standards for exemption that have been adopted for hospitals will be precluded from charitable status and will have to rely on gaining exemption as social welfare organizations pursuant to § 501(c)(4).\textsuperscript{23}

Although judicial review of the Service's position on this matter is sparse, a 1993 Third Circuit opinion has affirmed the Service's philosophy regarding § 501(c)(3) charitable status.\textsuperscript{24} Furthermore, recent health care proposals have adopted the Service's current philosophy regarding exemption of HMOs.\textsuperscript{25} Some commentators have suggested that the current approach regarding tax exemption to HMOs is too limited, precluding worthy institutions of

\footnotesize{\textsuperscript{17} See generally Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3d Cir. 1993).


\textsuperscript{19} Id.

\textsuperscript{20} Id.

\textsuperscript{21} Id.


\textsuperscript{23} Id.

\textsuperscript{24} Geisinger, 985 F.2d 1210.

\textsuperscript{25} See Clinton Administration's proposed Health Security Act, H.R. 3600, 103rd Cong., 1st Sess. (1993); see also Description and Analysis of Provisions in the Health Security Act (H.R. 3600) Relating to the Tax Treatment of Organizations Providing Health Care Services and Related Organizations, 1993: Hearings on H.R. 3600 Before the Subcomm. on Select Revenue Measures of the House Comm. on Ways and Means, 103rd Cong., 1st Sess. 12785 (1993) [hereinafter Health Security Act Description] (prepared by the Staff of the Joint Committee on Taxation).}
exemption, especially as charitable organizations under § 501(c)(3). These commentators suggest that tax exemption is an essential option to those in the health care industry and limiting this option to HMOs will inhibit the growth of nonprofit HMOs and, likewise, inhibit their role in our nation's health care reform. Others, especially those in the health insurance business, have argued that health care institutions should not be exempt, especially HMOs. Their arguments are grounded on the theory that HMOs are simply health care insurers and tax exemption to such organizations creates an uneven playing field, treating similarly situated taxpayers differently.

In light of the expected role HMOs will play in this country's health care reform, the continued debate over the Service's position regarding tax exemption for HMOs, the recent judicial confirmation of the Service's position, and proposals to codify the requirements a tax-exempt HMO must meet, a closer look at HMOs and the questions involving their tax exemption is warranted. Specifically, this note will examine the criteria that hospitals must meet to attain tax-exempt status and will consider the appropriateness of these criteria with respect to HMOs. This will entail a closer look at the Service's current position with respect to HMOs and the case law that has evolved in the hospital and HMO area. Also, this note will examine the law defining insurance providers and consider the arguments that have and will be asserted regarding whether HMOs are simply insurance companies. Finally, this note will conclude with the suggestion that the question of tax exemption for HMOs is purely a policy question that should be viewed apart from hospitals and insurance companies, whereby Congress should simply consider whether tax-exempt managed health care companies are beneficial to our health care system.

II. SIGNIFICANCE OF TAX-EXEMPT STATUS

Section 501(a) of the Code offers complete forgiveness from federal taxation to any of more than twenty categories of organizations. For example, § 501(c)(3) offers tax forgiveness to those organizations which qualify as "charitable." Beyond this federal tax forgiveness, however, those organiza-

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26 See Levine, supra note 10, at 98.
27 Id.
28 See Testimony of Blue Cross Blue Shield, supra note 11.
29 See Neal & Papiewski, supra note 11, at 587.
30 Although an organization may be exempt from taxation under I.R.C. § 501(a) (1995), there is still a tax levied on income that is earned as a result of an unrelated business activity. See I.R.C. § 501(b) (1995); see generally I.R.C. §§ 510-514 (1995).
tions qualifying as "charitable" organizations reap other tax benefits not spelled out under § 501.33

For example, organizations meeting the "charitable" requirements of § 501(c)(3) are also eligible to receive charitable contributions from individual taxpayers under § 170.34 Accordingly, taxpayers who contribute to such charitable organizations may deduct their contributions as allowed pursuant to § 170. Furthermore, organizations qualifying under § 501(c)(3) can benefit from tax-exempt financing by issuing tax-exempt bonds in conjunction with a state or local municipality pursuant to § 103 of the Code.35 With this advantage, such "charitable" organizations can quickly finance expansion and upkeep expenses through bond financing at a lower rate of interest than they could otherwise obtain in the market.36 Finally, many states offer freedom from state and local income taxes to those organizations qualifying as "charitable" under § 501(c)(3).37 Therefore, although § 501(c) offers freedom from federal taxes to a variety of organizations, qualification as a § 501(c)(3) organization is by far the most desirable.

Section 501(c)(4) organizations receive the same forgiveness from federal income taxation under § 501(a) as charitable organizations.38 They cannot, however, benefit from tax-exempt bond financing, receive tax-exempt contributions and often do not receive favorable treatment regarding state and local taxes.39

III. THE HISTORY OF TAX EXEMPTION FOR HOSPITALS

As the reality of federal income taxation took on full steam in the early twentieth century and was finally ratified by the Sixteenth Amendment in 1913, Congress saw the need to exempt certain organizations from income taxation.40 Some commentators have suggested that these exemptions derived from a

33 See generally Health Security Act Description, supra note 25.
36 Because interest received on bonds satisfying the requirements of § 103 is tax-free to the recipient, such bonds can be offered at a significantly lower rate of interest (a rate equal to the after-tax rate of interest on equivalent taxable bonds). Thus, § 103 allows states and municipalities (and certain private entities borrowing through states and municipalities, such as hospitals) to finance their activities at a lower cost.
37 But see, e.g., Utah v. Intermountain Health Care, Inc., 709 P.2d 265 (1985) (holding that tax exemption given to hospitals is inconsistent with the Constitution of the State of Utah, thereby revoking any state and local tax exemptions provided to hospitals under state statutes and ordinances).
39 See Gourevitch, supra note 22, at 1320.
simple sense of heritage or morality.\textsuperscript{41} Others believe tax exemptions were obtained by the persistence and convincing arguments of special interest groups contending that their organizations were not appropriate candidates for taxation.\textsuperscript{42} Others have posited economic arguments for federal tax exemptions, reasoning that if it were not for tax-exempt organizations, the government would have to expend revenue dollars to provide the benefit to the public that the tax-exempt institutions provide.\textsuperscript{43}

Today, § 501 of the Code exempts from taxation a variety of organizations ranging from cemetery companies to horticultural organizations.\textsuperscript{44} Specifically, § 501(c)(3) of the Code exempts "corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes . . . or for the prevention of cruelty to children or animals."\textsuperscript{45}

Hospitals traditionally have been included in the group of charitable organizations escaping federal taxation.\textsuperscript{46} Historically, charities have been organizations that cared for the poor, homeless, or sick in our society. In fact, the word "charity" generally is associated with generosity and benevolence to the poor and needy. Consistent with this understanding of the word charity, nineteenth century and early twentieth century hospitals were often sanctuaries for the poor and sick who could not financially afford a doctor to care for them in their home.\textsuperscript{47} A majority, if not all, of these early hospitals survived financially on income obtained from charitable donations.\textsuperscript{48}

With advancements in medicine and medical techniques during the twentieth century came dramatic changes in the role hospitals played in providing healthcare.\textsuperscript{49} Instead of social welfare institutions, hospitals quickly became large enterprises closely linked with advanced and expensive medical treatment.\textsuperscript{50} As a result, the hospital became the primary location to which the entire community turned for health treatment—rich and poor alike.\textsuperscript{51}

\begin{enumerate}
\item \textsuperscript{41} Id. at 525-26.
\item \textsuperscript{42} Id. at 527.
\item \textsuperscript{43} See HOPKINS, supra note 7, at 37.
\item \textsuperscript{44} See generally, I.R.C. § 501 (1995).
\item \textsuperscript{45} See I.R.C. § 501(c)(3) (1995).
\item \textsuperscript{46} See Utah, 709 P.2d at 270.
\item \textsuperscript{47} Id.
\item \textsuperscript{48} Id.
\item \textsuperscript{49} Id.
\item \textsuperscript{50} 709 P.2d at 270.
\item \textsuperscript{51} See Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978); Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976).\end{enumerate}
This metamorphosis in the structure and function of hospitals invited the Service to rethink the tax-exempt status of hospitals. In 1956, the Service issued Revenue Ruling 56-185 (1956 Revenue Ruling), which set forth four conditions a hospital must meet in order to qualify for tax exemption as a charitable organization. First, a hospital must be organized as a "not-for-profit entity" whose primary goal is to care for the sick. Second, and most significantly, the hospital must be operated, to the extent of its financial ability, for those not able to pay for its services. Third, the hospital must not restrict use of its facilities to a particular group of physicians. Finally, as is specified in the Code, the earnings of a hospital must not inure, directly or indirectly, to the benefit of any private shareholder or individual.

In 1959, however, the Service issued Treasury Regulations laying the groundwork for a much broader interpretation of tax-exempt hospitals. According to these regulations: "[t]he term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions." In other words, the fact that hospitals are not specifically listed in § 501, does not preclude their exemption from federal income tax.

The promulgation of this regulation provoked Revenue Ruling 69-545 in 1969 (1969 Revenue Ruling) whereby the Service discussed the issue of tax-exempt hospitals by way of publishing anonymously the results of two earlier Private Letter Rulings. Each Private Letter Ruling was directed to the

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53 A common misunderstanding of the not-for-profit status is the notion that the organization should not make a profit. The crux of the status, however, depends upon where the profits go if in fact they are made. The profits of a tax-exempt entity cannot inure to the benefit of private shareholders or individuals as defined in Treas. Reg. § 1.501(a)-1, and in most cases the profits are directed back into the organization to further its purpose. In fact, there are strong policy reasons why not-for-profit institutions should be operated to make a profit. Profitable institutions are often marked with quality, efficiency, and sound management. Thus, if a not-for-profit institution is providing a service that the government would have to provide but for the institution, then quality, efficiency and sound management are desirable. Moreover, if the profits and earnings of a not-for-profit institution are funnelled back into the institution, the exempt purpose is directly furthered, eliminating the transfer of funds to Washington and back to the institution via subsidy.


55 Id.

56 Id.

57 Id.


tax-exempt status of a separate hospital. Notably, one of the hospitals failed to render services, to the extent of its financial ability, to those unable to pay for such services. The only "charitable" service the hospital provided was full-time emergency care to those in the community, regardless of their ability to pay. Admission to the hospital, however, was predicated on one's ability to pay, via insurance or some public program such as Medicare. Nevertheless, the Service ruled that this hospital qualified as a tax-exempt entity under § 501.

The Service justified its apparent turnabout by declaring that the term "charitable" could be extended to mean the general promotion of health of a community. In so doing, the Service looked to the fact that the hospital provided emergency service to the entire community, and that the hospital admitted a sufficiently large number of people into the hospital, even though this group was limited to those who could pay.

Following the promulgation of the 1969 Revenue Ruling, various health and welfare organizations and several private citizens brought suit against the Service challenging the validity of the 1969 Revenue Ruling. In Eastern Kentucky Welfare Rights Org. v. Simon, the D.C. Circuit overturned a district court's ruling and upheld the Service's decision to grant a tax exemption even if the requirements of the 1956 Revenue Ruling had not been met, especially where the hospital in question was analogous to the hospitals described in the 1969 Revenue Ruling. The court initially reasoned that, since the Code does not specifically define what is meant by "charitable," the meaning was subject to interpretation.

Given the various interpretations given to the term "charitable," especially in areas of the common law, the court ruled that the

60 Id. at 117-19.
61 Id.
62 Id. at 117.
64 Relying on the RESTATEMENT (SECOND) OF TRUSTS §§ 368 and 372, and IV SCOTT ON TRUSTS (3d ed. 1967) §§ 368 and 372.2, the Service concluded [t]he promotion of health... is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community...
65 Id.
67 506 F.2d 1278.
68 Id. at 1280-81.
term "charitable" could be interpreted as meaning more than the "relief of the poor." With this understanding, the court upheld the Service's ruling that the "promotion of health is a charitable purpose." The court reasoned that changes in the area of health care prompted a more expansive view of the "charitable" status of hospitals that did not focus merely on the care a hospital provides to the poor.

Furthermore, the court considered the fact that the Code was amended in 1969, and that Congress, aware of the 1969 Revenue Ruling, failed to amend the Code to disallow such an interpretation of the term "charitable." In fact, Congress contemplated a provision that would have provided a blanket tax exemption to all institutions "organized and operated exclusively for the providing of hospital care." Regardless of the broad interpretation that this court seemed to give to the word "charitable," and the broad discretion it seemed to bestow on the Service in determining which hospitals qualify for tax exemption, the court clearly relied on the requirement that a hospital provide at least emergency care to the indigent. Thus, some believed that the operation of an emergency room open to the entire community was essential to attaining tax exemption. In 1983, however, the Service issued Revenue Ruling 83-157 (1983 Revenue Ruling), concluding that the operation of an emergency room is not a requirement that need be met to qualify for tax exemption, at least where such services would be duplicative within the community.

Although the issue of whether hospitals should be exempt is not an issue specifically addressed by this note, considering those essential characteristics of a hospital that yield tax exemption is valuable when considering the issue of exemption for HMOs. Particularly, the 1983 Revenue Ruling, concluding that emergency room services are not mandatory where duplicative within a community, serves to better delineate the essence of the hospital exemption. Prior to this ruling, many believed that the determining factor that gave rise to a hospital's tax exemption was the free care offered through its emergency room. With the promulgation of the 1983 Revenue Ruling, however, a question still remains: What is the essential characteristic supporting tax exemption?

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69Id. at 1287-88.
70Id. at 1287-90.
71506 F.2d at 1288-90.
72Id. at 1289.
73Id. at 1289-90 (concluding that Revenue Ruling 69-545 did not overrule Revenue Ruling 56-185 but modified Revenue Ruling 56-185 by offering hospitals an alternative means to provide care to the indigent via an emergency room).
75Id. at 94-95.
76See Eastern Kentucky, 506 F.2d at 1289 (stating that, "to qualify as a tax exempt charitable organization, a hospital must still provide services to indigents").
Obviously it is not the care of the poor or any type of free services rendered. Moreover, even in the case of a hospital that provides free emergency room care, what is the justification for allowing an exclusion of income related to the hospital's major source of revenue, its non-emergency services?

A possible answer to these questions could simply be the fact that a hospital is promoting the health of a community, and this function furthers a charitable purpose. This, however, cannot be the only criterion since "promotion of health" as a charitable purpose expands the field of eligible organizations too broadly; for example, a health club could be tax-exempt since it arguably promotes the health of the community.

A more consistent approach would suggest that the determining factor giving rise to the hospital exemption is the provision of health care. Thus, an institution organized as a not-for-profit organization providing health care services should arguably be entitled to tax-exempt status. In other words, the act of providing health care gives rise to the tax exemption. The absence of an emergency room, on the other hand, appears to preclude tax exemption only in certain situations. An analogy can be drawn to educational institutions, which are specifically exempt under § 501(c)(3). The act of educating is the determinative element that yields the tax exemption, while operating under a discriminatory policy can serve to frustrate the tax exemption. Similarly, the act of providing health care to patients appears to be the determinative factor that gives rise to the tax exemption.

Policy reasons also support this conclusion. A significant reason supporting tax exemption was the underlying economic motivation, whereby, the government would have to perform the service if it were not for the exempt

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77 Allowing tax exemption to institutions not having an emergency room "will further the public's interest because the emergency care offered by a health care provider that is not a hospital usually cannot compare to the emergency care offered by hospitals." Levine, supra note 10, at 93.

78 See supra note 64 and accompanying text. The promotion of health within a community has long been recognized as a charitable purpose.

79 Health care is used here narrowly to refer to a broad range of "hands-on" health care services provided to patients by health care professionals. It is not used to refer to the "arranging of" doctor care, or the like, which arguably is a health care service. For example, a physical given by a doctor is a health care service, but the arranging for the physical and the payment for that physical is not a health care service for purposes of this argument.

80 See Bob Jones Univ. v. United States, 461 U.S. 574 (1983) (holding that a discriminatory admissions policy precludes tax exemption for an institution otherwise worthy of tax exemption as an educational institution).

81 Educational institutions are specifically listed in § 501 of the Code, while hospitals are not. See I.R.C. § 501(c)(3) (1995). As in the case of hospitals, however, the element of charity is not the determinative factor giving rise to the tax-exempt status. The element of education appears to be the determinative factor, above and beyond any form of traditional charity. Likewise, a hospital's exemption should be based on the promotion of the health of the community rather than providing alms and the like to the poor.
organization. Because health care is one of the foremost national concerns, government would be called upon to provide health care absent a private industry. Therefore, a sound argument can be made that dollars earned by organizations providing health care should not be taxed. This would allow profits generated from these tax-exempt organizations to circulate directly back into the organization for the benefit of the organization. The organization is then in a better position to benefit the community by the fact that market pressures and bottom-line profits will be less of a concern, thereby allowing health care or health care management to be the primary concern. This back door subsidy, as some commentators have defined it, eliminates the money transfer through Washington and any red tape associated with such transfer.

IV. HMOs: HEALTH CARE PROVIDER OR INSURANCE COMPANY?

Section 501(m) of the Code, promulgated as a part of the 1986 amendments to the Code, repealed all tax exemptions for "certain organizations providing commercial-type insurance." Exempted, however, from the definition of "commercial-type insurance" is incidental insurance customarily provided by health maintenance organizations. Although this exemption appears to protect HMOs from the § 501(m) tax exemption repeal, the fact that Congress did not define such words as "incidental" and "customarily" leaves many HMOs at the mercy of the Service's discretion. The problem is further exacerbated because the Code does not affirmatively define "commercial-type insurance."

The House Report regarding these amendments indicates that the House intended to safeguard all HMOs that provide health care to their members via staff physicians practicing at a facility owned and operated by the HMO, that is, a staff model HMO. Although the Senate did not confront these questions, the Statement of Managers suggests that a very broad definition of HMO was agreed upon, one that also includes group model and IPA model HMOs.


83 See Hopkins, supra note 7, at 49.


87 Section 501(m)(3) states what "commercial-type insurance" shall not include, but fails to state what "commercial-type insurance" shall include.


Nevertheless, the issue remains ambiguous and ultimately rests with the Service's discretion and judicial review thereof.

The Service's position on the matter can be gleaned from a 1990 IRS General Counsel Memorandum, which sets forth the applicable test for examining the tax status of HMOs. Because Congress did not affirmatively define "commercial-type insurance," the Service chose to focus on the "common meaning of the term." Turning to the common law, the Service pointed out basic elements that define insurance, including risk shifting, risk distribution, and the realization of adverse results on the insurer if the risk becomes payable; that is, the insured collects on the policy as a result of a certain occurrence.

The Service's approach has resulted in favorable tax exemptions to staff model HMOs. The Service has reasoned that the service aspect of staff model HMOs overshadows the insurance attributes of the HMO, thereby qualifying the organization for tax exemption. Nevertheless, the Service has indicated that whether an HMO does or does not own a medical facility or directly employs a group of physicians is not determinative of its status as either a health provider or insurer. Instead, the Service has determined that the most important characteristic is risk control. If an HMO can control its risk, it will...

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91 Id. (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1978)).
92 Id. (citing Helvering v. LeGiere, 312 U.S. 531 (1941)).
93 Id.
95 Id.
96 Id. The Service relied on the definition of insurance set forth in Allied Fidelity Corp. v. Commissioner, 572 F.2d 1190 (7th Cir. 1978). In Allied, the court stated that "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." Id. (citing 1 COUCH ON INSURANCE 2d 1.2 (1959)). Because the insurer will "assume the financial burden of any covered loss," the insurer is accepting a risk as to whether the insured-against event or "defined contingency" will occur. An insurance company or insurer can control this risk in several ways. One way is to control the contingency. This is rarely an option since insured contingencies are often not controllable. For example, an insurer can have little control over whether someone becomes ill, or over the gravity of someone's illness. Another way an insurer can control risk is by placing the risk on another party. For example, an insurer can contract with a group of doctors to care for the primary needs of a group of people. This contract would be for a fixed or lump-sum amount of money. The risk then shifts from the insurer to the group of doctors. The doctors accept the risk speculating that the cost of primary care for the designated insured group is equal to or below the lump-sum payment received. In gambling terms, if the group is healthier than average, the doctors win. If the group needs more service than expected, the doctors lose.
be deemed to be a health care provider rather than insurance provider. If the HMO has little control over its risk, it will be deemed a health care insurer.97

HMOs gain or lose control of risk based on the nature of their contracts with both hospital facilities and health care providers. Those HMOs that are able to "capitate"—or fix—physician expenses, will exercise a degree of control over their risk and most likely will not be deemed an insurer.98 For example, an HMO that controls its risk, or actually has no risk, would operate under a system whereby the HMO contracts with a group of physicians and pays these physicians a fixed amount of money or places a ceiling on the amount of money paid to such physicians. The risk is then placed on the physicians who may have to provide services worth more than the lump-sum payment received. On the other hand, those HMOs that contract with hospitals and physicians on a marginal or usage basis do not control the risk or shift the risk to a third party such as physicians. In this fee-for-service system, the HMO compensates the hospital or physician for each service rendered, and therefore, the HMO bears the risk that the cost of the services that are paid for in a given period will be greater than the amount of the premiums received in that given period.

Some, especially those in the health insurance industry, believe that the Service's stand on this matter is erroneous.99 They assert that HMOs and commercial health care insurers, like Blue Cross/Blue Shield, are in the same business: financing health care via risk distribution and risk transfer, all deriving revenue from premium income.100

Those in the health insurance industry believe the Service's contentions regarding risk control are misdirected for two reasons. First, even if risk is transferred to the physicians under a capitated contract, the HMO is still never entirely relieved of the risk.101 Second, the control of risk applies only to the physician expenses. Hospital facility expenses, however, which usually account for approximately sixty percent of the total care expenses, are rarely fixed.102

HMOs do provide the service of financing health care. This function is one of their stated purposes. To focus exclusively on this function, however, ignores the progressive function of health care management; the arranging for, organizing and managing of health care treatment in furtherance of the goal of providing a more efficient health care system.

97Id. Health insurance companies take on the risk that a group of insured individuals will incur less medical costs than the premiums that the insured individuals paid. Typically, little is done to control risk other than to charge higher premiums to those expected to incur higher costs.


99See Tax Treatment under H.R. 3600, supra note 9.

100Id.

101Id.

102Id.
The first major case in which the Service considered the tax exemption of an HMO involved the Sound Health Association HMO (Sound Health). Shortly after its incorporation, Sound Health applied to the Service for tax-exempt status under § 501(c)(3) of the Code. In disallowing the exemption, the Service took the position that private interests were being benefited rather than public interests as is required under the Treasury Regulations implementing § 501(c)(3). Essentially, the Service argued that public interests were not being served because the structure of the HMO primarily benefited only those members of the community who were members of the HMO.

Sound Health, after exhausting all of its administrative remedies, sought review from the United States Tax Court. In Sound Health Association v. Commissioner, the court held that Sound Health qualified as a charitable organization under § 501(c)(3) of the Code. The court began its analysis by recognizing that hospitals and the like are not specifically listed as tax-exempt organizations, and therefore an HMO, like a hospital, must qualify as a charitable organization to attain tax-exempt status. The court, relying on the Eastern Kentucky decision, looked to the law of charitable trusts and ruled that the promotion of health within a community was a "charitable purpose." Thus, a medical institution that provides medical services could attain charitable status, regardless of whether its services benefited the rich or poor.

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103 Sound Health Ass'n v. Commissioner, 71 T.C. 158, 159-66 (1978), modified by Geisinger v. Commissioner, 985 F.2d 1210 (3d Cir. 1993). Sound Health HMO was incorporated under the laws of Washington. It was organized as a not-for-profit institution; therefore none of the profits it generated would inure to the benefit of any member, director, officer or individual.

104 Id.

105 Id. at 168 (citing Treas. Reg. § 1.501(c)(3)-1(d)(1)(i)).

106 The question of insurance provider versus health care provider was not an issue in this litigation; thus, the Sound Health HMO passed the first tier of the Service's two-tiered test. See Gen. Couns. Mem. 39,828 (Sept. 10, 1990).

107 71 T.C. at 177-86.

108 Id. at 158.

109 Id.

110 See supra notes 62-72 and accompanying text (describing the Eastern Kentucky litigation).

111 Sound Health, 71 T.C. at 178-84.

112 Id. at 177-78.
With this rule of law in mind, the court looked to the services provided by Sound Health. In so doing, the court reasoned that the qualifying criteria applicable to hospitals should be applied to HMOs. Based on the services that the HMO provided, the court concluded that the HMO was tantamount to a hospital, as defined in the Treasury Regulations, and ruled that the Sound Health HMO did provide medical services sufficient to qualify as a charitable entity. Significant in the court's determination was the fact that Sound Health provided a full range of medical services including an outpatient clinic as well as a full-scale emergency room.

Consistent with the law of charitable trusts, the court also recognized the requirement that those benefited by the "promotion of health" should be of a "sufficiently large or indefinite" class so as to constitute a community. The court found this requirement consistent with the requirements under the Treasury Regulations pertaining to § 501(c)(3). Under the Treasury Regulations, the Service indicates that an exempt organization under § 501(c)(3) must be organized and operated for public rather than private interests. Thus, at issue was whether the HMO's membership policy created a group of persons large enough to be considered a community for purposes of a charitable trust.

The court found that the group of persons served by the HMO was sufficiently large to meet this requirement, even though, except in the case of emergency room care, those served by the HMO had to be members. The court reasoned that the number of people who could derive benefits from the HMO was "practically unlimited" since the only barrier to joining the HMO was the monetary fee for joining and retaining membership. The fee, however, did not vary between individuals, and it varied only slightly between individual and group membership. The court also considered the fact that

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113 *Id.* at 178-79.
115 71 T.C. at 179.
116 *Id.* at 184.
117 *Id.* at 181.
119 71 T.C. at 185. Following this decision, the Service issued Revenue Ruling 83-157. Pursuant to this ruling, the lack of an emergency room does not preclude exemption if such services are duplicative within the community. Based on the reasoning set forth in this Revenue Ruling, if Sound Health's emergency room had been duplicative within the community, then, arguably, the emergency room would not be a necessary element to attain tax exemption. See 1983-2 C.B. 94.
120 71 T.C. at 185.
121 Group memberships received a discount on the initial membership fee, but the monthly fees between individual memberships and group membership did not vary. This difference in price resulted primarily from processing fees. 71 T.C. at 169 n. 3.
Sound Health maintained a subsidized membership program. This program, supported by charitable contributions, gave members of the community who were unable to pay an opportunity to join the HMO at a reduced or minimal charge. The court further found that public interests were being served because the HMO had a nondiscriminatory hiring policy whereby all qualified physicians were welcome to join the staff. Thus, even though Sound Health only serviced its members, Sound Health sufficiently demonstrated that public rather than private interests were being served by its open membership policy.

B. The Geisinger Decision

The Service's latest attempt to limit the tax exemption given to HMOs involved the Geisinger Health Plan (hereinafter GHP). GHP is an HMO incorporated under both state and federal law and was part of a larger health organization.

122See I.R.C. § 170 (1995). An organization that qualifies as a charitable organization under § 501(c)(3) may accept contributions that are tax-deductible contributions.

123Sound Health, 71 T.C. at 184.

124A nondiscriminatory hiring policy is significant when weighing public versus private interests. The essence of the prohibition on benefiting private interests is the fear that private shareholders or founders of the organization are the ones being benefited rather than the public or the portion of the public whom the institution is organized to benefit. For example, some hospitals or HMOs may be established, managed, operated, and serviced exclusively by a small group of doctors. Such institutions would fail the tax-exempt requirements when the "interests of charity are sacrificed to the private interests of the founder[s] or [shareholders]," even though the institution may be operated like any other tax-exempt hospital. See Sound Health, 71 T.C. at 186 (quoting EXEMPT ORGANIZATIONS HANDBOOK (3 I.R.M. 7751), Part VII, 382.1(2)).

125In addition to servicing its members, Sound Health also serviced nonmembers in its emergency room. Sound Health notified a local ambulance company to bring all emergency patients to the HMO emergency clinic regardless of membership. See 71 T.C. at 184.

126The court further reasoned that "[t]he main difference between [Sound Health and an exempt hospital] is the time when they [and HMO or hospital] obligate themselves to provide health care services." 71 T.C. at 187. The hospital has the opportunity, except in the emergency situation, to wait until a person needs medical treatment before the decision is made regarding whether the person will be treated. Id. An HMO, however, must make a determination regarding whom it is going to treat at the time of membership rather than when an individual becomes ill. Id. Both the decision of the hospital and the HMO regarding who will be treated are financial decisions based on who can pay the service fee. Id. In either situation, however, the indigent emergency patient will not be denied service. 71 T.C. at 187. See also Levine, supra note 10, at 98. Both hospitals and HMOs serve to promote the health of a community but differ only regarding when payment is made. With HMOs, payment is made in the form of a subscriber fee, but with hospitals, payment is made following the performance of services. Ultimately, this should have no significance in determining community benefit.
care network called the Geisinger System. The Geisinger System was a parent system that consisted of eight other health care entities, all of which were tax-exempt. In 1987, consistent with the status of each constituent member in the system, GHP petitioned the Service for exempt status as a charitable organization under § 501(c)(3).

The Service, relying on the ruling set forth in Sound Health, denied GHP's request on the grounds that GHP did not meet all of the elements set forth in Sound Health. Particularly, the Service relied on the fact that GHP was not organized as a health care provider. Instead, GHP contracted with groups of physicians and other hospitals within the larger Geisinger System to provide health services to its members. The HMO contracted with physicians to provide these services and compensated the physicians based on a flat monthly fee. The hospitals with which the HMO contracted were compensated on a per diem basis for inpatient services, while the outpatient services were charged to the HMO at a discounted rate.

In an attempt to challenge the Service's decision, GHP sought a declaratory judgment from the United States Tax Court. The Tax Court, in Geisinger Health Plan v. Commissioner, overturned the Service's ruling and held that GHP qualified as a charitable organization under § 501(c)(3). The court concluded, as a factual matter, that GHP was organized and operated for the purpose of promoting the health of the community. Additionally, the court found that the group of persons benefited by GHP was sufficient to constitute a community.

In reaching these conclusions, the court relied on the Treasury Regulations, which require tax-exempt organizations to be organized and

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128 Id. at 1656-60.
129 Id.
130 Id. at 158.
131 Geisinger, 62 T.C.M. (CCH) at 1656-60.
132 Id.
133 Id.
134 Id.
135 Geisinger, 62 T.C.M. (CCH) at 1656-60.
136 Id. at 1664.
137 Id. at 1661-64.
138 Id.
139 Geisinger, 62 T.C.M. (CCH) at 1662-64.
operated exclusively for a tax-exempt purpose. As was mentioned, GHP's stated tax-exempt purpose was the promotion of health of the community, a charitable purpose under the common law of trusts and under the Eastern Kentucky decision. To meet the requirement that an entity be organized and operated for a tax-exempt purpose, the Treasury Regulations require an entity to engage primarily in activities that serve its exempt purpose. Aware of this requirement, the Tax Court chose to focus on GHP's exempt purpose rather than the nature of the activities in which GHP engaged. Because GHP promoted the health of the community, its stated purpose, the court concluded that the issue of how it promoted the health of the community was of no significance. Therefore, GHP qualified for exemption even though GHP's primary activity was arranging for health care rather than actually providing hands-on health care.

Also at issue was whether the group of persons benefited by GHP was large enough to constitute a community. Because the Treasury Regulations require that public rather than private interests be served, the Service argued that, by arranging for the health care of only its members, GHP served private interests rather than public interests. The Tax Court, relying on the Sound Health decision, concluded that GHP did serve a sufficiently large class of the community to pass the public/private test. Similar to the reasoning in Sound Health, the Tax Court considering GHP's status reasoned that the lack of significant barriers to membership indicated that the entire community was "eligible" to benefit from GHP through membership. Furthermore, the court considered the fact that GHP had a subsidized membership program, which served to allow membership to those who would otherwise be financially unable to join.

On appeal to the Third Circuit, the appellate court overturned the Tax Court's decision holding that "GHP does not qualify for tax-exempt status . . .

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141 See supra note 64 and accompanying text (describing the law of charitable trusts).
143 Geisinger, 62 T.C.M. (CCH) at 1660.
144 Id. at 1662-64.
146 Geisinger, 62 T.C.M.(CCH) at 1662-63.
147 Id. at 1662.
148 Id.
149 Id. The number of people actually admitted by GHP under the subsidized dues program was thirty-five. Geisinger, 62 T.C.M.(CCH) at 1660. GHP claimed that the subsidized dues program would assist a more significant number of people once financing for the program matured. Id. Moreover, GHP maintained that the success of this program hinged on whether GHP qualified for exempt status, thereby enabling it to receive § 170 contributions (recall that the ability to receive tax-deductible contributions is a benefit of the § 501(c)(3) status). Id.
since it does no more than arrange for ... health care services."

Furthermore, the fact that GHP arranged for the medical care of only its members indicated that it failed to serve a charitable purpose, especially where few members were admitted under the subsidized membership program.

The Third Circuit began its analysis by acknowledging that GHP was not a hospital. The court maintained, however, that hospital precedent was applicable since GHP's stated purpose was the promotion of health. Subsequently, based on its understanding of the law of tax-exempt hospitals, the court concluded that the applicable test was whether GHP "primarily benefited the community."

Relying on this test, the court concluded that the Sound Health court misapplied the law in reasoning that a public interest was served by the fact that the entire community was "eligible" to become a member. The Geisinger court opined that GHP's membership program served to primarily benefit itself, only "secondarily benefiting the community."

The Geisinger court, however, did not overrule the decision set forth in Sound Health. Rather, it modified the ruling by holding that the Sound Health HMO provided "additional indicia of a charitable purpose," thereby allowing it to qualify under § 501(c)(3). Such "additional indicia of a charitable purpose" included Sound Health's full-scale emergency room and outpatient clinic which were open to the entire community.

With regard to GHP's subsidized membership program, the court discredited it as offering no additional indicia of a charitable purpose. The court particularly noted that GHP had only thirty-five subsidized members as opposed to the nearly seventy thousand paying members.

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150 Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1220 (3d Cir. 1993).
151 Id.
152 Id. at 1216.
153 Id. at 1217.
154 985 F.2d at 1218.
155 Id. at 1219.
156 Id. at 1217-20.
157 Id. at 1218.
158 985 F.2d at 1220.
159 Id. GHP argued that Sound Health had subsidized its program only $158.50 at the time it was granted tax exemption. Id. The court, however, opined that Sound Health had benefited the community in other ways via the emergency room and outpatient clinic. Id.
VI. GEISINGER'S EFFECT ON HMOs SEEKING EXEMPTION

Congress has contemplated codifying standards that would delineate HMOs based on their organizational structures and operation.160 Under such a statute, each HMO would be classified and its classification would affect its ability to gain tax exemption.161 The rule of law as set forth in Geisinger would serve as the basis for determining whether HMOs can be charitable organizations pursuant to § 501(c)(3).162 Exemption as a charitable organization would require satisfying the community benefit standard, establishing that the HMO serves public rather than private interests, and assuring that net income does not inure to the benefit of any individual or private shareholder.163 Congress has also contemplated codifying the standards an HMO must meet to gain exemption under § 501(c)(4).164 One commentator has suggested that this standard would involve a community benefit standard that is less demanding than the community benefit standard for § 501(c)(3) organizations.165 Health insurance companies, of which Blue Cross/Blue Shield is a prototypical example, would continue to be precluded from § 501(a) exemption pursuant to § 501(m)(3).166

Since Congress began considering health care reform, much debate has surrounded the issue of tax exemption for HMOs. Advocates at one end of the debate, especially those in the health insurance industry, have argued that all HMOs should be precluded from tax exemption.167 Their arguments are grounded on the premise that HMOs simply offer a form of health insurance and, therefore, they should be treated like other health insurers.168 At the other end of the debate, advocates have argued that a strong tax-exempt health care system is vital to maintaining a quality health care system.169 As one

160See Health Security Act Description, supra note 25.
161See Neal & Papiewski, supra note 11, at 585.
162See Gourevitch, supra note 22, at 1320.
163See supra notes 148-59 and accompanying text (discussing the Third Circuit's decision in Geisinger); see also supra notes 52-65 and accompanying text (discussing the standard that the Service has adopted for considering an HMO's exemption).
164See Gourevitch, supra note 22, at 1319.
165Id.
166Id. at 1321; Blue Cross/Blue Shield Organizations are generally taxed in the same manner that property and casualty insurance companies are taxed, but are "entitled to a special income tax deduction ... enabling them to take a tax deduction, for regular tax but not alternative minimum tax purposes, equal to 25 percent of claims and expenses for the taxable year reduced by the adjusted surplus at the beginning of the year." Id.; see also I.R.C. § 833 (1995).
167See Testimony of Blue Cross Blue Shield, supra note 11.
168Id.
169See Boisture, supra note 82.
commentator has suggested, in a nonprofit health care system, "patients' interests, not profits are paramount."\(^1\)

Current statutory proposals strike a compromise between the opposite ends of the debate, allowing exemption to some HMOs as § 501(c)(3) organizations, and to others as § 501(c)(4) organizations. Similarly, the holding in *Geisinger* falls midway between the opposing views in the debate, allowing tax exemption as charitable organizations to those HMOs that look most like hospitals.

Because any legislation ultimately passed by Congress will have a significant impact on the future of HMOs, a closer look at the reasoning supporting the current proposals is warranted. The *Geisinger* decision currently represents the Service's and the Clinton Administration's standard for considering the status of HMOs as charitable organizations. Congress, prior to codifying this rule of law, should consider the reasoning on which this rule of law is based. Particularly, should HMOs be compared to hospitals when considering their status as charitable organizations pursuant to § 501(c)(3)? Also, does the community benefit standard, as set forth in *Geisinger*, make sense?

The Third Circuit in *Geisinger* based its conclusion on two factors. First, GHP was primarily benefiting itself since only members could obtain its services. Second, GHP lacked any indicia of a charitable purpose, such as the operation of an emergency room open to the public or some type of outpatient service.

These reasons appear to have been guided by two themes. First, the Third Circuit seemed to be swayed significantly by the fact that GHP was not a hospital or similar institution. GHP was simply a health care manager, arranging for the health services of its members through a managed system. The weight given to this fact is evident in the court's concluding statement that "GHP does not qualify . . . since it does no more than arrange for . . . health care."\(^1\) In fact, this reasoning pervaded the opinion, in that the court began its analysis by applying precedent that had related exclusively to the question of tax exemption for hospitals. The fatal impact that this line of reasoning had on GHP's tax exemption manifests itself in the court's observation that GHP lacked an "outpatient service" or simply failed to provide "free care."\(^1\) Both of these criteria are applicable exclusively to institutions that provide hands-on health care treatment. Since GHP was not organized and operated to provide hands-on health care treatment, it was precluded from attaining § 501(c)(3) status once the court began this reasoning. Although HMOs have traditionally been thought of as hybrid hospital-health insurers, they are not exclusively organized and operated in this manner. The impact that *Geisinger* will have on HMOs, therefore, is significant since those not resembling hospitals will be precluded from attaining § 501(c)(3) status.

\(^{170}\)Id. at 785.

\(^{171}\) *Geisinger*, 985 F.2d at 1220.

\(^{172}\)Id.
Second, the court created and applied what appears to be a new community benefit standard. The court ruled that an institution will qualify as a tax-exempt entity if it "primarily benefits the community." This test, however, is clearly distinguishable from the requirements of the Treasury Regulations. The Treasury Regulations require tax-exempt organizations to operate by "engag[ing] primarily in activities which accomplish" a charitable purpose, and this charitable purpose must serve "a public rather than a private interest." The court's application of this "primarily benefits" test proved fatal to GHP's § 501(c)(3) tax-exempt status. This is not surprising, however, since the requirement that an organization primarily benefit the community is almost insurmountable. In fact, if such a test were applied to all § 501(c)(3) organizations, there would be few tax-exempt organizations left. For example, churches and related religious organizations are operated to primarily benefit their members, although the entire community could be eligible for membership. Likewise, educational institutions operate primarily for the benefit of their own students. Educational institutions are also similar to hospitals in that students attending educational institutions pay for the service of education directly or indirectly through some third party payment system such as grants, scholarships or loans. Bottom line: charities primarily benefit the poor; scientific organizations seeking cures for diseases primarily benefit people with those diseases; organizations to prevent cruelty to children or animals primarily benefit children and animals; and hospitals operate primarily to benefit patients who pay for services, either directly or indirectly through some third party payment system such as private insurance, Medicare or Medicaid.

All the institutions mentioned above are tax-exempt because they are organized and operated to engage primarily in activities to further their exempt purpose and to serve public rather than private interests. They do not, however, operate to primarily benefit the community. Arguably, the government, armed forces, law enforcement, and similar institutions are the only organizations that are organized and operated to primarily benefit the community.

Thus, Geisinger seems to be grounded on somewhat shaky ground. Nonetheless, the court may have arrived at the right decision. The decision in Geisinger was directed to the charitable status of HMOs and their tax exemption

\[173\text{Id. at 1217.}\]

\[174\text{See 26 C.F.R. §§ 1.501(c) & (d)(1)(ii) (1959).}\]

\[175\text{The court in Sound Health, 71 T.C. at 185, made a similar argument: If any "preferential treatment" is given to Association members, then it is the preferential treatment common to every charitable organization that benefits the community by benefiting a certain class of individuals. To our knowledge, no charity has ever succeeded in benefiting every member of the community. If to fail to so benefit everyone renders an organization noncharitable, then dire times must lie ahead for this nation's charities.}\]

\[176\text{Id.}\]
under this status. The case was not, however, determinative of the general question of exemption for HMOs under § 501(a). Thus, although an HMO may not meet the requirements of § 501(c)(3) status, exemption as a social welfare organization pursuant to § 501(c)(4) is still a possibility.\textsuperscript{177}

An organization qualifying as a social welfare organization under § 501(c)(4) obtains the same freedom from federal taxation under § 501(a) as a charitable organization qualifying under § 501(c)(3). The major shortcoming of § 501(c)(4) status, however, is the inability to obtain tax-free bond financing. The inability to obtain tax-free bond financing may be significant to HMOs needing to expand their medical facilities as demand for health services increases, but HMOs that do not maintain medical facilities (such as IPA and network model HMOs) should not be affected by this shortcoming. The hospitals or staff model HMOs with which the IPA or network model HMOs contract for services will be able to obtain § 501(c)(3) status under the current law of \textit{Geisinger}. Thus, if Congress decides that HMOs are worthy of tax exemption under § 501(c)(4), the decision in \textit{Geisinger} should not have a major impact on those HMOs unable to gain § 501(c)(3) exemption status.

\textbf{VII. The Next Debate: Exemption as a Social Welfare Organization}

Many HMOs have taken advantage of the § 501(c)(4) status and many others are sure to follow, especially in the wake of the \textit{Geisinger} decision.\textsuperscript{178} This trend will inevitably lead to a debate over whether HMOs deserve to be exempt as social welfare organizations. Rather than argue the similarities and differences between HMOs and hospitals, this debate will most likely center around the differences and similarities between HMOs and insurance companies.

Those in the health insurance industry have argued that any exemption for HMOs will result in treating similarly situated taxpayers differently.\textsuperscript{179} Such arguments are grounded on the contention that the services provided by HMOs, especially IPA and network model HMOs, are tantamount to the services provided by the insurance industry.\textsuperscript{180}

The Service's current position is that HMOs transfer risk to the primary care physicians and, therefore, are distinguishable from health insurance

\textsuperscript{177}See T.J. Sullivan, \textit{The Tax Status of Nonprofit HMOs After Section 501(m)}, 50 TAX NOTES 75,80 (1991)(indicating that the Service's position requires HMOs seeking social welfare status to meet a community benefit standard, one that is less exacting than the standard for charitable status); see also Gen. Couns. Mem. 39,829 (Aug. 24, 1990). The impact that the \textit{Geisinger} decision will have on the application and interpretation of this standard is not presently clear. See Gourevitch, \textit{supra} note 22, at 1319.

\textsuperscript{178}In 1992, only 32.5 percent of all HMOs were exempt as either charitable or social welfare organizations. Robert A. Boisture, \textit{Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs}, 9 EXEMPT ORG. TAX REV. 271, 283 (1994).

\textsuperscript{179}See Testimony of Blue Cross Blue Shield, \textit{supra} note 11.

\textsuperscript{180}Id.
Advocates for the health insurance industry, however, argue that the Service's position is misdirected on two counts. First, insurance advocates contend that HMOs are never fully relieved of risk "unless the insured relieves the insurer of risk." Second, such advocates contend that any risks that may be transferred are simply physician benefits, and non-physician benefits, which comprise a majority of the cost, are not transferred.

The Code at § 501(m)(3) indicates that "incidental health insurance provided by a health maintenance organization" is not considered commercial-type insurance for purposes of § 501(m). Pursuant to § 501(m), an organization, "a substantial part of [whose] activities consists of providing commercial-type insurance," is precluded from exemption under § 501. Without a more precise rule by Congress, the issue of whether IPA or network model HMOs provide incidental health insurance will inevitably come before the courts. Similar to the situation in *Geisinger*, a court will be forced to make a policy decision regarding whether IPA or network model HMOs are worthy of exemption. At the center of the debate will be the issue of whether HMOs are or are not health insurance companies. This debate, like the debate over whether HMOs are or are not hospitals, could continue indefinitely. Thus, it is incumbent upon Congress to decide whether managed care is worthy of exemption. This decision should not be made based on the comparability of hospitals to HMOs or the comparability of health insurance companies to HMOs, but rather the decision should be based on whether tax-exempt HMOs are needed and whether they provide a benefit to our health care system, thereby promoting the health of the community.

The question of whether managed health care systems should be exempt is worthy of direct consideration for several reasons. As our society continually attempts to reform the overall health care system, it is quite clear that health care management, financing, and organization play as important a role as the provision of health care treatment itself. Managed care is not a service that hospitals have traditionally provided and often does not involve hands-on medical treatment. Instead, managed health care is simply a means of controlling the inflationary effects of a pay-for-service system of health care. Although managed health care can assume a variety of structures and operational formats, institutions that provide health care management essentially organize, finance and manage health care delivery in a manner which maximizes efficiency and minimizes cost. The question of whether organizations providing this service should be tax-exempt has never been addressed in this light.


182 See Testimony of Blue Cross Blue Shield, supra note 11.

183 Id.
Managed health care organizations will play an important role in this
country's health care reform. These organizations offer advantages over the
current pay-for-service system, including the ability to control costs.
Exemption from federal income taxation has historically been an option for
hospitals, economically affecting the operation and survival of many hospitals.
Tax exemption could also play a vital role in the proliferation, financing and
operation of many HMOs.

The recent decision in Geisinger has narrowed the opportunity for many
HMOs to gain exemption as charitable organizations. Although the reasoning
of the Geisinger court can be debated, the decision appears to have resulted in
a logical approach to the question of tax exemption for HMOs. Those HMOs
that operate full-scale medical facilities and employ large medical staffs can
gain exemption as charitable organizations and reap the derivative benefits of
this status in order to maintain and grow their medical staffs and facilities.
HMOs that do not operate full-scale medical facilities should still be permitted
to gain exemption as social welfare organizations, a status that does not carry
the derivative benefits of charitable status. An HMO not operating a medical
facility, however, probably does not need the derivative benefits of the
charitable status.

The question of exemption for HMOs will continually be debated as those
in the health care industry compete for market share and seek identical tax
treatment. While Congress is currently considering codifying the holding of
Geisinger, legislators should directly consider the reasons why HMOs should
or should not be taxed. Such a forthright debate would serve to delineate the
requirements for charitable status and the requirements for social welfare
status. In doing so, Congress should consider whether managed health care
systems offer any benefit to the community by strengthening the health care
system. This is clearly a policy question that should be left to the legislature.

ARTHUR M. REGINELLI