Internal Revenue Service
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Department of the Treasury
Washington, DC 20224

Contact Person: [redacted]
Telephone Number: [redacted]
In Reference to: OP:E:EO:T:1:[redacted]
Date: DEC 10 1998

Employer Identification Number: [redacted]

Dear Applicant:

We have considered your application for recognition of exemption from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3). Based on the information submitted, we have concluded that you do not qualify for exemption under that section. The basis for our conclusion is set forth below.

FACTS

You were incorporated on [redacted] as a membership corporation. [redacted], filed [redacted], states that your purposes include providing or arranging for the provision of mental health services to individuals with serious mental illness on a prepaid capitated basis to an enrolled population substantially comprised of persons eligible to receive benefits under Medicaid. [redacted] also provides that no part of your earnings shall inure to the benefit of any private individual; that you are organized and operated exclusively for charitable purposes; and that upon dissolution, your net assets shall be distributed to fulfill your charitable purposes or to organizations exempt under section 501(c)(3) of the Code.

According to the Bylaws adopted on [redacted] ("Amended Bylaws"), your members consist of [redacted] and [redacted] specified organizations. All of these organizations are providers of mental health care services. All but one of these organizations are exempt under section 501(c)(3) of the Code. The one non-exempt organization, [redacted] is a non-profit corporation whose [redacted] members are all health care providers exempt under section 501(c)(3) of the Code.

[redacted]

Your Amended Bylaws (adopted [redacted]) provide that your Board of Directors consists of not less than ten individuals. Each of your members is entitled to nominate a candidate for Director. Each member is entitled to vote for [redacted], so long as she is a member, and for each of the other candidates. Candidates are elected by a two-thirds vote of the members. [redacted] of your Amended Bylaws provide for various standing committees, including an Executive Committee. In addition, the Board may authorize the establishment of special committees of the Board. On [redacted] your Board of Directors adopted a substantial conflicts of interest policy.

In the first few months of [redacted], you expect to obtain a certificate of authority from [redacted] to operate a [redacted]. At the same time, you expect to contract with [redacted] to arrange for the provision of various mental health care services to Medicaid beneficiaries who suffer from serious mental illnesses. Under this contract, [redacted] will compensate you on a prepaid capitated basis. You expect to begin enrollment in the spring of [redacted].

You expect that under the contract with [redacted], [redacted] will provide you with stop-loss insurance. You expect that [redacted] will withhold from the capitated payments it makes to you [redacted] percent of these payments as a "premium" for this insurance. In return, the State will bear the costs associated with you providing [redacted] percent of the inpatient expenses with respect to an individual enrollee in excess of $[redacted] per enrollee per year.

Your enrollees will be able to receive all covered outpatient services without a referral from, or pre-authorization by, a primary care provider. Enrollees will also be permitted to access the least intensive level of rehabilitation services without a prior authorization or referral. However, access to medium or high intensity rehabilitation services requires your approval.

You are the sole member of [redacted] ("[redacted]"), a [redacted] nonprofit corporation whose application for exemption under section 501(c)(3) of the Code is currently pending.

[redacted] ([redacted]) is a [redacted] business corporation. [redacted] shareholders and your members are identical. You have no direct ownership interest in [redacted]. To date, [redacted] has not issued any shares of stock and has not entered into any contracts. [redacted]

[redacted]

purpose is to engage in the provision of management and consulting services to other provider networks, and to provide ongoing management support. It is contemplated that [redacted] will enter into contracts with certain of your member organizations to provide grant writing services unrelated to your activities or to [redacted] activities.

Providers

You intend to arrange for the provision of mental health care services to your enrollees by contracting principally with institutional mental health care providers. These institutional providers will consist of your member organizations as well as non-member organizations. You also intend to contract with individual mental health care providers.

You expect that the compensation you will pay to your providers will consist of the following:

Institutional providers	
Outpatient services	
Capitated fees*	[redacted]
Inpatient services	
Case rate	[redacted]
Fees-for-service (per diem)	[redacted]
Rehabilitation services	
Capitated fees	[redacted]
Case rate	[redacted]
Total institutional providers	[redacted]
Individual providers	
Reserve pool	[redacted]
Total	[redacted]

* Includes individual providers.

Case rated compensation involves payment of a fixed fee in return for which the provider agrees to deliver all medically necessary services to the patient for a predefined episode of care. In contrast to capitation, case rates are adjusted at the outset and on an ongoing basis to take into account the severity of the member's illness. Thus, the payment of a case rate is contingent upon your assessment of the patient's need for a particular level of service.

You will pay providers of case rated rehabilitation services a monthly case rate payment for each enrollee for whom they have

[redacted]

treatment responsibility. The amount of the case rate payment will depend upon the enrollee's level of need for rehabilitation services as you determine.

Each enrollee will be categorized as requiring either [redacted] rehabilitation services. The amount of the case rate payment will rise with the [redacted] The case rate will cover [redacted] service. If it appears that [redacted] of an enrollee's need for rehabilitation services has changed, providers of rehabilitation services may request a prospective increase in the case rate or you may impose a prospective decrease in the case rate. Any changes would be made on a monthly basis. The case rate, however, will not be adjusted retroactively. It is the responsibility of the provider to develop and deliver a rehabilitation services package that meets the needs of the enrollee and is within your quality, access and case management standards.

You determine rehabilitation services case rates by first estimating the median amount and type of rehabilitation services to be used in a given month by enrollees having [redacted] needs for rehabilitation services. You then multiply the median estimated amount of services for each of these levels of need by the Medicaid fee schedule for each service in the mix. The result is the monthly rehabilitation services case rate for each level of need.

The reserve pool for individual providers will be used for several purposes. You have stated that you do not expect providers to deliver crisis outpatient and rehabilitation services within the fixed capitation or case rate budgets. If an enrollee is in need of crisis services, you will pay supplemental reimbursement to the providers. You have not yet determined whether the form of this reimbursement will be capitation, case rate or fee-for-service. In addition, you will use the reserve pool to cover obligations that exceed budgeted amounts. Finally, if at year-end, there are any surplus funds in the reserve pool, you will distribute the surplus to the providers based on the volume of services the provider delivered to your enrollees during that year.

Management Services Agreement

[redacted] is an unrelated for-profit behavioral managed care company that manages the behavioral service components of commercial and Medicaid health plans throughout the country. [redacted] is owned by [redacted] and

[redacted] a for-profit subsidiary of which you are the sole shareholder, will form a limited liability company (the "LLC") to provide administrative and management services for the operation of your organization. The LLC would then subcontract these services to [redacted] and to [redacted].

Under [redacted] of the draft Management Services Agreement, ("Management Services Agreement"), the LLC will provide you with various services, including network management services (an ongoing capacity and needs assessment of your network of participating providers), credentialing of participating providers, claims administration services (administering the payment of all claims for the provision of covered services to enrollees submitted by providers), member services, clinical management services, financial management services, preparation of reports, providing and maintaining a computerized management information system, administering a utilization management program, administering a quality management program, and implementing personnel programs.

[redacted] the Management Services Agreement provides that during its term, the LLC will be your exclusive provider of these services. Without [redacted] approval, you may not contract with any other party to obtain any of these services. [redacted] provides that this agreement has a [redacted] term. Any renewals are subject to negotiation; however, any renewal will expire at the same time as the Operating Agreement expires. (See discussion below.)

In return for these services, you will pay the LLC certain fees ("Management Fees"). Prior to your operations reaching a break even level, you will pay the LLC $[redacted] per month. Thereafter, you will pay the LLC the sum of:

A. $[redacted] per month (the "Consulting Fees");

B. Fees determined based on a fee-for-service schedule;

C. An amount equal to the costs incurred by [redacted] in performing its services; and

D. An unspecified percentage of your gross capitation revenues, subject to an unspecified annual cap.

In addition, the LLC will be entitled to an unspecified percentage of your operating surplus, subject to an unspecified annual cap. (See [redacted] of [redacted] letter dated [redacted], [redacted].)

[redacted]

You have stated that as part of the process of obtaining a license as [redacted] regulations require [redacted] to review the Management Services Agreement to determine whether the terms of the agreement are reasonable.

LLC Operating Agreement

You and [redacted] intend to enter into an Operating Agreement with respect to the LLC. According to [redacted] the [redacted] draft of the LLC Operating Agreement ("Operating Agreement"), you will make no capital contributions to the LLC but [redacted] will make capital contributions of cash as necessary. [redacted] the Operating Agreement states that [redacted] capital contribution obligation is $[redacted].

[redacted] of the Operating Agreement provides that cash distributions, if any, will be made as follows:

A. [redacted]% to [redacted] until the total management fees and cash distributions to [redacted] equal [redacted] capital contributions plus a [redacted]% annual return on its capital contributions; and

B. [redacted]% to you and [redacted]% to [redacted].

[redacted] the Operating Agreement provides that the agreement will expire on the latest of:

A. [redacted] years after your being operating as [redacted], or

B. The date on which the sum of:

i. The $[redacted] per month Consulting Fees you pay to [redacted] plus

ii. Any cash distributions you make to [redacted]

Equals or exceeds:

iii. [redacted] capital contributions; plus

iv. A [redacted]% annual return on [redacted] capital contributions (less the Management Fees paid under the Management Services Agreement), or

C. The date on which you repay LLC's loan.

[redacted]

The LLC will be managed by its members, [redacted] It will not have a governing body. [redacted] the Operating Agreement provides that all action by the LLC requires your approval, except that certain actions will also require [redacted] approval, including adoption of the operating budget; commencement, acquisition or divestiture of a line of business of another business entity; merger, consolidation, recapitalization, dissolution or combination; amendment or termination of the Management Services Agreement with [redacted]; and incurrence of any indebtedness.

[redacted] the Operating Agreement provides that until one year after the termination of [redacted] or your exercise of your buyout right (as described below), whichever occurs first, [redacted] will not participate in any manner in any [redacted] serving [redacted] including the provision of management or administrative services to [redacted] or as an equity owner of [redacted]

[redacted] the Operating Agreement provides that at any time beginning [redacted] years after you commence operations, you have the right to purchase [redacted] interest in the LLC for the greater of:

A. $[redacted] or

B. An amount equal to:

i. [redacted] capital contributions; plus

ii. [redacted] annual return on [redacted] capital contributions reduced by the $[redacted] per month Consulting Fees you pay to [redacted]

Minus the sum of:

iii. Any cash distributions made to [redacted]; plus

iv. The $[redacted] per month Consulting Fees you pay to [redacted]

[redacted] the Operating Agreement provides that if the LLC is prevented from implementing a plan to correct certain performance problems due to the absence of required regulatory approval or because implementation would violate applicable law or regulation, [redacted] may withdraw as a member of the LLC. However, [redacted] may not withdraw prior to having fulfilled its $[redacted] capital contribution obligation. If [redacted]

[redacted]

withdraws, it would be entitled to receive the same payments as if you purchased [redacted] interest.

Loan

The LLC will loan you approximately $[redacted] for a term of [redacted]. These funds are necessary to satisfy certain reserve and escrow requirements applicable to [redacted] and to finance certain working capital requirements. The interest rate is expected to be approximately [redacted]. The loan will be unsecured and subordinated to your existing bank credit line. It will not be repayable unless you meet certain debt service coverage tests, have a positive net worth and have sufficient cash to satisfy all reserve requirements.

[redacted] the Loan Agreement ("Loan Agreement") between you and the LLC provides that if you need additional funds, the LLC has the first right to provide the additional funds either through a second loan or renegotiation of the terms of the current loan.

You have represented that there is no relationship between the owners, officers and directors of [redacted] or [redacted] and the officers and directors of your organization.

[redacted] the Operating Agreement provides that in the event of a default under the Loan Agreement, [redacted] would have the exclusive authority to determine the LLC's actions with respect to such default, subject to LLC's rights set forth in the Loan Agreement.

You have stated that as part of the process of obtaining a license as [redacted] regulations require t[redacted] to review the Loan Agreement to determine whether the loan should be treated as a liability for purposes of meeting the net worth requirements for [redacted]

CEO Compensation

As of [redacted] your organization, M[redacted] entered into an Executive Employment Agreement ("Employment Agreement") with [redacted]. The Employment Agreement is for a term of [redacted] years plus unlimited one-year renewals. Under this agreement, [redacted] will serve as [redacted] and [redacted] of your organization, [redacted] and [redacted]. In such capacity, [redacted] will have the various duties and responsibilities that are specified in [redacted] the Employment Agreement.

[redacted]

According to the Employment Agreement, [redacted] compensation consists of the following components:

A. Base Salary

Year	Amount
[redacted]	$[redacted]
[redacted]	$[redacted]
[redacted]	[redacted]

B. Special Needs Plan Bonus

If before [redacted], you enter into a contract with, or obtain all necessary licenses from [redacted] or [redacted] to operate a [redacted], you will pay [redacted] a bonus of $[redacted].

C. Covered Lives Bonus

If at the end of any calendar month, you achieve the following levels of enrollment, [redacted] annual base salary will be revised as follows, as of the beginning of the following month.

End of Month Enrollment	Revised Annual Base Salary
[redacted]	$[redacted]
[redacted]	$[redacted]
[redacted]	$[redacted]

However, if enrollment falls below the above levels at the end of any [redacted] period, [redacted] base salary will be reduced based on the lower enrollment level, as of the beginning of the following month.

D. Surplus Bonus

If you obtain a [redacted], and for any fiscal year you have a surplus (i.e., revenues exceed related expenses), you will pay [redacted] a bonus of [redacted] of the surplus. However, the combined amounts you may pay to [redacted] as [redacted] and [redacted] may not exceed $[redacted] per year for [redacted] and may not exceed $[redacted] for the duration of the Employment Agreement, including any extensions. In addition,

[redacted] the Employment [redacted]:

> However, upon Executive's exhaustion of the $[redacted] provided for in this [redacted], the Board of Directors can, in its discretion, consider providing Executive with additional surplus bonus compensation.

E. Other Bonus Compensation

[redacted] the Employment Agreement provides:

> Executive and Company [i.e., your organization, [redacted] and [redacted] agree and understand that the Company may pursue, during the term of this Agreement, other activities unrelated to the [redacted]. If Executive's other such activities result, during the term of this agreement, in additional revenue and significant Surplus to the Company, then the Board of Directors in its discretion will consider providing Executive with additional bonus compensation.

F. Equity Purchase Options

[redacted] the Employment Agreement provides that if equity in a for-profit venture is issued to you or to [redacted] would be entitled to purchase equity for $[redacted] on the same terms as you and [redacted] and in the same average amount that is issued to you and to [redacted].

You have submitted a memorandum describing the deliberations of the Executive/Compensation Committee (the "E/C Committee") of your Board of Directors in connection with the negotiation of the Employment Agreement with [redacted]. (See [redacted]) This memorandum states that none of the members of the E/C Committee had any relationship to [redacted] or were subject to [redacted]; that the E/C Committee and [redacted] were each represented by separate counsel, that the E/C Committee engaged independent consultants to structure the compensation arrangement; and that [redacted] was never a party to Board of Directors deliberations with respect to the terms of the Employment Agreement.

[redacted]

You have stated that as part of the process of obtaining a license as [redacted], regulations do not require the [redacted] to review employment or compensation agreements. The one exception is for contracts that exceed [redacted] percent of the organization's assets. Since this is not the case with the Employment Agreement, it is not expected that the [redacted] will review this document.

LAW

Section 501(c)(3)

A. Promotion of Health

Section 501(c)(3) of the Code provides for the exemption from federal income tax of organizations organized and operated exclusively for charitable, scientific or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(a)(1) of the Income Tax Regulations provides that in order for an organization to be exempt as one described in section 501(c)(3) of the Code, it must be both organized and operated exclusively for one or more exempt purposes. Under section 1.501(c)(3)-1(d)(1)(i)(b) of the regulations, an exempt purpose includes a charitable purpose.

Section 1.501(c)(3)-1(d)(2) of the regulations provides that the term "charitable" is used in Code section 501(c)(3) in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose. See Restatement (Second) of Trusts, sections 368, 372 (1959); 4A Scott and Fratcher, The Law of Trusts, sections 368, 372 (4th ed. 1989); Rev. Rul. 69-545, 1969-2 C.B. 117.

The promotion of health includes activities other than the direct provision of patient care. For example, Rev. Rul. 75-197, 1975-1 C.B. 156, holds that a nonprofit organization that operates a free computerized donor authorization retrieval system to facilitate transplantation of body organs upon a donor's death qualifies for exemption under IRC 501(c)(3). By facilitating the donation of organs that will be used to save lives, it is serving the health needs of the community and therefore is promoting health within the meaning of the general law of charity.

Rev. Rul. 77-69, 1977-1 C.B. 143, describes an organization formed as a Health Systems Agency (HSA) under the National Health Planning and Resources Development Act of 1974. As an HSA, the organization's primary responsibility was the provision of

[redacted]

effective health planning for a specified geographic area and the promotion of the development within that area of health services, staffing and facilities that met identified needs, reduced inefficiencies and implemented the HSA's health plan. The revenue ruling concludes that by establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the HSA is promoting the health of the residents of the area in which it functioned. Therefore, the HSA qualifies for exemption under IRC 501(c)(3) on the basis that it promoted health.

Rev. Rul. 81-28, 1981-1 C.B. 328, holds that a nonprofit organization that provides housing, transportation and counseling to hospital patients' relatives and friends who travel to the locality to assist and comfort the patients qualifies for exemption under IRC 501(c)(3) because it promotes health by helping to relieve the distress of hospital patients who benefit from the visitation and comfort provided by their relatives and friends.

In Professional Standards Review Organization of Queens County, Inc. v. Commissioner, 74 T.C. 240 (1980), acq. 1980-2 C.B. 2 ("Queens County PSRO"), the Tax Court held that an organization that reviewed the propriety of hospital treatment provided to Medicaid recipients is exempt under IRC 501(c)(3) because it lessened the burdens of government and promoted the health of persons eligible for Medicare and Medicaid.

Rev. Rul. 81-276, 1981-2 C.B. 128, holds that a PSRO qualifies for exemption under IRC 501(c)(3) because it lessens the burdens of government and promotes the health of the beneficiaries of the Medicare and Medicaid programs.

B. Relief of the Poor and Distressed

Reg. 1.501(c)(3)-1(d)(2) provides that the term "charitable" includes relief of the poor and distressed. The Service has long held that poor and distressed beneficiaries must be needy, in the sense that they cannot afford the necessities of life.

For example, shelter is considered to be one of the necessities of life. Rev. Rul. 67-138, 1967-1 C.B. 129; Rev. Rul. 70-585, 1970-2 C.B. 115; and Rev. Rul. 76-408, 1976-2 C.B. 145, hold that the provision of housing for low-income persons accomplishes charitable purposes by relieving the poor and distressed. These revenue rulings refer to the needs of housing recipients and their inability to secure adequate housing to determine whether they are poor and distressed. See also Rev. Proc. 96-32, 1996-1 C.B. 717.

The Service has also recognized that conditions other than poverty may deprive individuals of the ability to satisfy their basic needs. For example, providing relief of the distress of the elderly or physically handicapped is an exempt purpose. See Rev. Rul. 72-124, 1972-1 C.B. 145; Rev. Rul. 79-18, 1979-1 C.B. 194; and Rev. Rul. 79-19, 1979-1 C.B. 195.

In Rev. Rul. 72-124, an organization operated a home for the aged that provided housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, useful, and independent lives. The revenue ruling states:

> . . . [I]t is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in the sense that they have special needs because of their advanced years. For example, it is recognized in the Congressional declaration of objectives, Older Americans Act of 1965, Public Law 89-73, 89th Congress, 42, U.S.C. 3001, that such needs include suitable housing, physical and mental health care, civic, cultural and recreational activities, and an overall environment conducive to dignity and independence, all specially designed to meet the needs of the aged. Satisfaction of these special needs contributes to the prevention and elimination of the causes of the unique forms of "distress" to which the aged, as a class, are highly susceptible and may in the proper context constitute charitable purposes or functions even though direct financial assistance in the sense of relief of poverty may not be involved.

Thus, an organization may further a charitable purpose by meeting either the basic needs of persons who are part of a charitable class or the special needs of persons who have been recognized as requiring specific forms of assistance.

In Rev. Rul. 77-3, 1977-1 C.B. 140, the owner of housing property contracted with the city to lease temporary housing to persons whose residences were destroyed by fire. The Service acknowledged that the provision of free temporary housing to distressed persons in need of adequate housing is a charitable activity. Nevertheless, the lessor did not qualify for exemption under IRC 501(c)(3) because the city, not the lessor, was responsible for providing the free temporary housing to the distressed families. The lessor merely leased the housing property to the city in a commercial manner, similar to

organizations operated for profit, and was not engaged in charitable activities.

On the other hand, if the lessor in this revenue ruling had also undertaken responsibility to provide affordable housing to the fire victims, it would have been comparable to the low-income housing organizations described in Rev. Rul. 67-138, supra; Rev. Rul. 70-585, supra; and Rev. Rul. 76-408, supra. Or, if the lessor had undertaken the responsibility to provide social services to the fire victims to meet their other critical needs, it would have been comparable to the elderly housing organization described in Rev. Rul. 72-124, supra.

C. Private Benefit and Private Inurement

Section 1.501(c)(3)-1(c) of the regulations provides that an organization is not operating exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.

Section 1.501(a)-1(c) of the regulations provides that the words "private shareholder or individual" refer to persons having a personal and private interest in the activities of the organization.

In Rev. Rul. 69-383, 1969-2 C.B. 113, after arm's-length negotiations with a radiologist, a hospital exempt under section 501(c)(3) of the Code contracted with the radiologist to perform all required radiological services in return for a fixed percentage of the radiology department's net billings. The radiologist served as the head of the hospital's department of radiology. The radiologist had no control over, or management authority with respect to, the hospital itself. This revenue ruling pointed out that the radiologist did not control the organization and the agreement was negotiated at arm's-length. In addition, the amount the radiologist received was reasonable in terms of the responsibilities and activities that he assumed under the contract. Therefore, the arrangement between the hospital and the radiologist did not constitute inurement of net earnings to a private individual within the meaning of section 1.501(c)(3)-1(c)(2) of the regulations.

In Lorain Avenue Clinic v. Commissioner, 31 T.C. 141 (1958), the Tax Court held that the presence of a percentage compensation agreement, where such arrangement transforms the principal activity of the organization into a joint venture between it and a group of physicians, destroys the organization's exemption under section 501(c)(3) of the Code.

[redacted]

In Birmingham Business College v. Commissioner, 276 F.2d 476 (5th Cir. 1960), a brother and two sisters established and operated a private business college and shared net proceeds of the school's operations. The Court of Appeals held that the school was an ordinary business enterprise that distributed substantial portions of its net earnings to private individuals.

In Broadway Theatre League of Lynchburg, Virginia, Inc. v. U.S., 293 F.Supp. 346 (W.D. Va. 1968), an organization that promoted an interest in theatrical arts did not jeopardize its tax-exempt status when it hired a third party to perform administrative and management services because the contract was for a reasonable term and provided for reasonable compensation and the organization retained ultimate authority over the activities being managed.

In Harding Hospital, Inc. v. U.S., 505 F.2d 1068 (6th Cir. 1974), a nonprofit hospital with an independent board of directors that contracted with a physician partnership that gave the physicians control over care of the hospital's patients and the stream of income generated by the patients which guaranteed the physicians substantial amounts in payment for various supervisory activities constituted impermissible private benefit.

In est of Hawaii v. Commissioner, 71 T.C. 1067 (1979), aff'd in unpublished opinion, 647 F.2d 170 (9th Cir. 1981), several for-profit organizations exerted significant indirect control of a nonprofit organization through contractual arrangements so that the for-profits were able to use the nonprofit as an "instrument" to further their for-profit purposes even though the for-profits lacked structural control over the nonprofit and the amounts the nonprofit paid to the for profit were reasonable.

In United Cancer Council, Inc., 109 T.C. No. 17 (1997), a professional fundraising organization had extensive authority and control over a section 501(c)(3) organization's fundraising activities and related finances was an "insider" under section 1.501(a)-1(c) of the regulations, who received excessive compensation, which constituted prohibited private inurement under section 1.501(c)(3)-1(c) of the regulations. Therefore, the revocation of the organization's section 501(c)(3) exemption was appropriate.

In Rev. Rul. 98-15, 1998-12 I.R.B. 6, Situation 2 involved a section 501(c)(3) hospital ("D") and a for-profit corporation ("E"), which owned and operated a number of hospitals and provided management services to hospitals that it did not own. D required additional funds and E was interested in providing financing if it could earn a reasonable rate of return.

[redacted]

Therefore, D and E formed a limited liability company ("LLC"). D contributed its hospital assets to the LLC and E contributed assets equal in value to D's contribution. D and E received equal ownership interests in the LLC and each appointed three members to the LLC's governing board. The LLC contracted with a management company that was a wholly-owned subsidiary of E to provide day-to-day management services to the LLC. The management agreement was for a five-year term and was renewable for additional five-year periods at the discretion of the management company. This revenue ruling concluded that because D shared control of the LLC with E, D was not able to initiate programs within the LLC to serve new health needs within the community without the agreement of at least one governing board member appointed by E. As a business enterprise, E would not necessarily give priority to the health needs of the community over the consequences for the LLC's profits. In addition, the management company would have broad discretion over the LLC's activities that may not always be under the governing board's supervision. Therefore, D could not establish that the activities it conducts through the LLC furthered exempt purposes.

In Plumstead Theatre Society, Inc., 74 T.C. 1324 (1980), aff'd, 675 F.2d 244 (9th Cir. 1982), a charitable organization's participation as a general partner in a limited partnership did not jeopardize its exempt status where the limited partners had no control over the organization's operations.

In Housing Pioneers, Inc., 65 T.C.M. (CCH) ¶ 2191 (1993), aff'd, 49 F.3d 1395 (9th Cir. 1995), amended, 58 F.3d 401 (9th Cir. 1995), an organization did not qualify for exemption under section 501(c)(3) of the Code because the activities it performed as a co-general partner in a for-profit limited partnership substantially furthered a non-exempt purpose. The organization served private interests because under the management agreement, its authority as a co-general partner was narrowly circumscribed, it had no management responsibilities and it performed only minor charitable activities.

Section 501(m)

Section 501(m)(1) of the Code provides that an organization described in section 501(c)(3) or 501(c)(4) shall be exempt "only if no substantial part of its activities consists of providing commercial-type insurance." The legislative history indicates that this provision was intended, in part, to bar continued section 501(c)(4) exemption for Blue Cross/Blue Shield organizations, which had enjoyed such status for many years despite being in many respects indistinguishable from commercial health insurers. See H.R. Rep. No. 99-426, 99th Cong., 1st Sess.

662 - 6 (1986); 1986-3 C.B. (Vol. 2) 662 - 6. Consequently, where an organization's activities resemble those of commercial insurers, generally, section 501(m) would serve to preclude exemption under section 501(c)(4).

The legislative history of section 501(m) provides:

> For this purpose [section 501(m)of the Code], commercial-type insurance generally is any insurance of a type provided by commercial insurance companies.
>
> . . . .
>
> [C]ommercial-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).13/
>
> 13/ See Helvering v. LeGierse, 312 U.S. 531 (1941).

Staff of Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, at 585 (Comm. Print 1987). See also, H.R. Rep. No. 99-426, 99th Cong., 1st Sess. 663 - 4 (1986); 1986-3 C.B. (Vol. 2) 663 - 4.

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

> [T]he 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 committee clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organization-type services (such as dental

[redacted]

> or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization.

H.R. Conf. Rep. No. 100-1104, 100th Cong., 2d Sess. II-9 (1988).

In Rev. Rul. 68-27, 1968-1 C.B. 315, an organization that issued medical service contracts to groups or individuals and furnished direct medical services to the subscribers by means of a salaried staff of medical personnel was held not to be an insurance company. In this revenue ruling, a medical clinic employed a staff of salaried physicians, nurses and technicians to provide a major portion of the contracted medical services. In the event the clinic had to treat a patient with an illness or injury, the patient was treated by the clinic's salaried staff, thereby incurring no significant additional costs. The revenue ruling concluded that any risk the clinic incurred was predominantly a normal business risk. The clinic's costs for its medical providers was fixed because the clinic paid its providers a salary. As a result, if a patient were to suffer a serious illness or injury, the clinic would not incur any substantial additional costs. Thus, the clinic's economic risk was fixed regardless of the presence or extent of any illness or injury.

In Jordan, Superintendent of Insurance v. Group Health Association, 107 F.2d 239 (1939) ("Jordan"), the U.S. Court of Appeals for the District of Columbia held that an HMO was not an insurance company. In this case, the HMO did not employ salaried physicians to provide medical services but paid contracted physicians a "fixed annual compensation, paid in monthly installments, not specific fees for each treatment or case." Jordan, at 242, ftnt. 7.

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

> [M]ust involve the element of shifting or assuming the risk of loss of the insured and must, therefore, be a contract under which the insurer is liable for a loss suffered by its insured.

Case law has defined "insurance contract," as a "contract whereby, for an adequate consideration, one party under takes to indemnify another against loss from certain specified contingencies or peril. . . . [I]t is contractual security

[redacted]

against possible anticipated loss." Epmeier v. U.S., 199 F.2d 508, 509-10 (7th Cir. 1952). See also, SEC v. Variable life Annuity Life Ins. Co., 359 U.S. 65, 71 (1959); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979); Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 127 (1982); 1 Couch on Insurance 2d (Rev. ed) Sections 1:2, 1:3 (1984).

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

Finally, the risk transferred must be a risk of economic loss. The risk for which insurance coverage is provided is an insurance risk; that is, it must occur fortuitously and must result in an economic loss to the insurer. Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976); aff'd, 572 F.2d 1190 (7th Cir. 1978); cert. den., 439 U.S. 835 (1978). In this case, the Court of Appeals stated:

> . . . [T]he common definition for insurance is an agreement to protect the insured against a direct or indirect economic loss arising from a defined contingency whereby the insurer undertakes no present duty of performance but stands ready to assume the financial burden of any covered loss. 1 Couch on Insurance 2d 1:2 (1959). As the tax court below noted, an insurance contract contemplates a specified insurable hazard or risk with one party willing, in exchange for the payment of premiums, to agree to sustain economic loss resulting from the occurrence of the risk specified and, another party with an insurable interest in the insurable risk. It is important here to note that one of the essential features of insurance is this assumption of another's risk of economic loss. 1 Couch on Insurance 2d 1:3 (1959).

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

Risk distribution refers to the operation of the statistical phenomenon known as the "law of large numbers." When additional

[redacted] independent risk exposure units are insured, an insurance company's potential total loss increases, as does the uncertainty regarding the amount of that loss. As the uncertainty regarding the company's total loss increases, however, there is an increase in the predictability of the insurance company's average loss. Due to this increase in the predictability of average loss, there is a downward trend in the amount of capital that the company needs per risk unit to remain at a given level of solvency. See Rev. Rul. 89-61, supra.

In Paratransit Insurance Corporation, 102 T.C. 745 (1994), a nonprofit mutual benefit insurance corporation provided automobile liability insurance to its members, all of which were tax-exempt social service organizations that furnished transportation to the elderly, the handicapped and the needy.

In this case, one of the issues was whether the organization provided "commercial-type" insurance within the meaning of section 501(m) of the Code. In this regard, the Tax Court stated:

> It is clear from the passages in the Report of the House Ways and Means Committee that the term "commercial-type insurance", as used in section 501(m), encompasses every type of insurance that can be purchased in the commercial market.16/
>
> 16/ Such insurance, however, obviously does not include self-insurance by a single organization, which is not purchased commercially, and which does not involve risk sharing or risk shifting that is characteristic of true insurance. See Staff of Joint Comm. on Taxation, General Explanation of the Tax Reform Act of 1986 at 583-586 (J. Comm. Print 1987).

102 T.C. at 754.

The Tax Court concluded that the organization provided "commercial-type insurance" within the meaning of section 501(m) of the Code, based on the following factors:

1. The purpose of the insurance pool the organization established was to shift the risk of potential tort liability from each of the individual insured paratransit organizations to Paratransit.

2. The organization diversified the risk of liability for each individual member through the receipt of premiums form multiple member organizations. Thus, Paratransit spread each member's individual risk of tort liability among all of its members.

3. The type of insurance the organization offered to its members, basic automobile liability insurance, was a type of insurance provided by a number of commercial insurance carriers.

4. The organization insured its members in a commercial manner. It offered insurance to its members based not on need or at a uniform charge. Instead, it determined premiums by reference to factors affecting the level of risk, such as total number of vehicles, number of passengers per vehicle, radius of operation, etc. Thus, Paratransit calculated its members' premiums actuarially in precisely the same way that commercial insurers determine premiums for their customers.

In addition, the Tax Court rejected the organization's argument that the phrase "commercial-type insurance" in section 501(m) of the Code was intended to cover only those situations where insurance is offered to the general public. The Tax Court pointed out that the Committee on Ways and Means stated:

> The committee further believes that the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial. [Emphasis added.]
>
> H.R. Rep. No. 99-426 at 664 (1986); 1986-3 (Vol. 2) at 664.

102 T.C. at 755.

The Tax Court pointed out, however, that the Joint Committee on Taxation's General Explanation deleted the phrase "to the general public." See Staff of Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, at 584 (Comm. Print 1987).

The Tax Court also pointed out that if Congress had intended the phrase "commercial-type insurance" in section 501(m) of the Code to apply only to insurance available to the general public it would not have needed to enact the exceptions in section 501(m)(3)(C) (relating to property or casualty insurance provided

by a church or church related organization) and section 501(m)(3)(D) (relating to retirement or welfare benefits provided by a church or church related organization to its employees). See 102 T.C. at 755 - 6.

In Florida Hospital Trust Fund, et al. v. Commissioner, 103 T.C. 140 (1994), several government-run and tax-exempt hospitals created organizations ("Trust Funds") to pool their resources on a group basis to insure against hospital professional liability, excess hospital professional liability and workers' compensation liability. The Tax Court held that a substantial part of the Trust Funds' activities consisted of providing commercial-type insurance within the meaning of section 501(m) of the Code.

The Tax Court held that the Trust Funds, rather than their hospital members, provided the insurance. The Trust Funds were formed to provide a means by which their member hospitals could join together as a group to insure against professional liability (malpractice) and workers' compensation claims. The Trust Funds, rather than their hospital members, provided the services essential to the administration of the insurance programs. The fact that the Trust Funds adjusted member premiums to reflect actual, as opposed to projected, loss experience assured that the Trust Funds would operate on a break even basis and served as a means for the Trust Funds to shift the risk of insurance losses from their individual members to the whole group. The Tax Court stated:

> It is this characteristic, petitioners' ability to shift the risk of loss, that distinguishes petitioners' (the insurers) from their members (the insured). Paratransit Ins. Corp. v. Commissioner, 102 T.C. 745, 754 (1994).

103 T.C. at 157.

In relying on the plain meaning of the phrase "commercial-type insurance," the Tax Court said:

> . . . [W]e understand that Congress intended for section 501(m) to apply to those organizations providing any "type of insurance that can be purchased in the commercial market." Paratransit Insurance Corp. v. Commissioner, supra, at 754. There is no dispute that hospital professional liability and workers' compensation insurance

[redacted]

are normally offered by commercial insurers.

103 T.C. at 158.

Further, in reviewing the legislative history of section 501(m) of the Code, the Tax Court concluded that:

> . . . [T]he report of the House Committee on Ways and Means quoted above reflects Congress' view that organizations engaged in insurance pooling or group self-insurance arrangements (including malpractice insurance) are involved in inherently commercial activities. Congress resolved to deny exempt status to organizations engaged in such activities in order to ensure that such organizations would not enjoy an unfair competitive advantage over their commercial counterparts.

103 T.C. at 160.

The Tax Court also rejected the Trust Funds' contention that the dearth of commercial insurers in the particular market in which the hospitals operated made section 501(m) of the Code inapplicable. The Tax Court stated:

> . . . [W]hether an organization seeking exempt status happens to be competing with a commercial insurer at any particular point in time simply begs the question whether granting exempt status will tend to provide the organization with an unfair competitive advantage over commercial insurers. Focusing on the latter issue, and Congress' obvious desire to provide a level playing field for commercial insurers, we hold that section 501(m) applies to deny petitioners exempt status.

Ibid.

Thus, the Tax Court concluded that the Trust Funds were providing commercial-type insurance within the meaning of section 501(m) of the Code.

[redacted]

RATIONALE

Section 501(c)(3)

Your enrollment is limited to Medicaid beneficiaries. Through contracted providers, you arrange for the provision of mental health care services for these enrollees.

Medicaid beneficiaries, consisting of low-income persons, are a group of persons who are considered as having special health care needs. By enabling Medicaid beneficiaries to obtain mental health care services under a managed care arrangement, you ensure that their special health care needs are met. Promoting the health of Medicaid beneficiaries, low income persons who have special health care needs, promotes the health of the community under Rev. Rul. 69-545, supra; Rev. Rul. 75-197, supra; Rev. Rul. 77-69, supra; and Rev. Rul 81-28, supra. You also satisfy the flexible community benefit standard in Geisinger II, supra; in addition to benefiting your enrollees personally, you benefit the community as a whole by promoting the health of Medicaid beneficiaries who reside in the community.

Your activities are also similar to the activities in Queens County PSRO. See also Rev. Rul. 81-276, supra. In Queens County PSRO, the Tax Court reasoned that a PSRO promotes the health of the community because its activities help ensure that Medicare and Medicaid beneficiaries will receive health care that is medically necessary, thus discouraging the performance of unnecessary medical treatment. Similarly, by enrolling only Medicaid beneficiaries and arranging for the provision of mental health care services for these individuals by a group of health care providers, you enable the federal government to operate the Medicaid program more effectively and more efficiently. This promotes the health of the Medicaid beneficiaries in the community and therefore also promotes the health of the community as a whole.

It is generally acknowledged that many Medicaid beneficiaries have greater mental health care needs than other members of the population, yet many of these individuals are often unable to obtain adequate mental health care services because they are unavailable or they are unavailable at an affordable level. Similarly, elderly individuals comprise a group of persons with special health care needs. The federal statutes expressly recognize the special health care needs of these elderly individuals. Like organizations that provide housing to low-income individuals or that address the special needs of the elderly, such as for housing or physical and mental health (see Rev. Rul. 67-138, Rev. Rul. 70-585, Rev. Rul. 76-408,

[redacted]

Rev. Rul. 72-124; Rev. Rul. 79-18, and Rev. Rul. 79-19), an HMO that enrolls only Medicaid beneficiaries and arranges for the provision of mental health care services to these individuals by a group of health care providers facilitates the provision of health care services to low income individuals, a group having special health care needs. Therefore, your activities accomplish the charitable purpose of providing relief to the poor and distressed.

Private Benefit and Private Inurement

A. [redacted]

Under the Management Services Agreement with [redacted] will provide you with extensive administrative and management services in connection with the operation of your HMO. An exempt organization may enter into a management contract with a private party, giving that party authority to conduct activities on behalf of the organization and to direct the use of the organization's assets, provided that the exempt organization retains ultimate authority over the assets and activities being managed and the terms and conditions of the contract are reasonable, including reasonable compensation and a reasonable term. Broadway Theatre League of Lynchburg, Virginia, Inc. v. U.S., supra. However, if a private party is allowed to control or use the non-profit organization's activities or assets for the benefit of the private party, and the benefit is not incidental to the accomplishment of exempt purposes, the organization will fail to be organized and operated exclusively for exempt purposes. est of Hawaii v. Commissioner, supra; Harding Hospital, Inc. v. U.S., supra.. Where the private party receiving the benefit is an "insider," the benefit constitutes private inurement. United Cancer Council, Inc.. See also sections 1.501(c)(3)-1(c)(1) and 1.501(c)(3)-1(d)(1)(ii) of the regulations.

[redacted] relationship with you is principally that of a vendor of administrative and management services relating to the operation of your HMO. However, [redacted] relationship with you goes beyond that of a mere third-party vendor. Taken together, the Management Services Agreement, the LLC Agreement, and the Loan Agreement give [redacted] substantial power and authority over the operations and activities of your organization. For example, [redacted] of the Operating Agreement provides that all action by the LLC requires your approval, except that certain actions will also require [redacted] approval, including adoption of the operating budget; commencement, acquisition or divestiture of a line of business of another business entity; merger, consolidation, recapitalization,

[redacted]

dissolution or combination; amendment or termination of the Management Services Agreement with [redacted], and incurrance of any indebtedness. Additional examples are: the Management Services Agreement provides that during [redacted], the LLC will be your exclusive provider of these services and without [redacted]'s approval, you may not contract with any other party to obtain any of these services; any renewals of the Management Services Agreement are subject to negotiation, however, any renewal will expire at the same time as the Operating Agreement expires; and, in the event of a default under the Loan Agreement, [redacted] would have the exclusive authority to determine the LLC's actions with respect to such default, subject to LLC's rights set forth in the Loan Agreement.

In substance, your relationship with [redacted], through [redacted] and the LLC is more than that of a purchaser of [redacted] services. Instead, you participate with [redacted] in a joint business endeavor, where [redacted] is both a vendor and an investor. Taken together, the Management Services Agreement, the LLC Agreement and the Loan Agreement give [redacted] rights and powers that are similar to those of a partner in a joint venture, rather than that of merely a vendor of services. For example, part of the compensation you will pay to the LLC for [redacted] services include an unspecified percentage of your gross capitation revenues, subject to an unspecified annual cap, and the LLC will be entitled to an unspecified percentage of your operating surplus, subject to an unspecified annual cap. Any cash distributions from the LLC will be made to [redacted] under a formula so that [redacted] would recover its capital contributions plus a [redacted] percent annual return. In fact, the term of the Operating Agreement depends on whether [redacted] has recovered its investment plus a [redacted]% return and has received repayment of its loan. Furthermore, in addition to your approval of certain major LLC actions, [redacted] approval is also required. [redacted] ability, during the term of the Operating Agreement, to provide management or administrative services to another [redacted] or to own an equity interest in [redacted] is expressly restricted. You have the ability to purchase [redacted] interest in the LLC at a price that is based on [redacted] capital contributions plus a [redacted] percent return on its investment. Finally, if the LLC is prevented from correcting certain performance problems due to the absence of required regulatory approval or because implementation would violate applicable law or regulation, [redacted] may withdraw as a member of the LLC, but not before [redacted] has fulfilled its $[redacted] capital contribution obligation. If [redacted] does withdraw, it would be entitled to receive the same payments as if

[redacted]

you purchased [redacted] interest. These are rights and powers of an investor, not merely a vendor of services.

A section 501(c)(3) organization may form and participate in a partnership, including an LLC treated as a partnership for federal income tax purposes, and meet the operational test of section 1.501(c)(3)-1(c)(1) of the regulations, if participation in the partnership furthers a charitable purpose, and the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purposes and only incidentally for the benefit of the for-profit partners. Plumstead Theatre Society, Inc., supra; Housing Pioneers, Inc., supra; Rev. Rul. 98-15, supra.

Therefore, whether or not your relationship with [redacted] constitutes a partnership, the substantial power and authority [redacted] has over your operations and activities pursuant to the Management Services Agreement, the LLC Agreement, and the Loan Agreement, lead to the conclusion that you are prevented from operating exclusively in furtherance of your exempt purpose and only incidentally for the benefit of [redacted].

B. Chief Executive Officer

As [redacted] of your organization, [redacted] is in a position to exert substantial influence and control over your operations and activities. Therefore, under section 1.501(a)-1(c) of the regulations, [redacted] is a considered as an "insider."

The use of a method of compensation based on a percentage of an exempt organization's income may constitute inurement of net earnings to private individuals. For example, the presence of a percentage compensation agreement will destroy the organization's exemption under section 501(c)(3) of the Code where such arrangement transforms the principal activity of the organization into a joint venture between it and a group of physicians (Lorain Avenue Clinic v. Commissioner, supra), or is merely a device for distributing profits to persons in control (Birmingham Business College v. Commissioner, supra. Since the compensation arrangement with [redacted] includes unspecified percentages of gross revenue and net income with no specified limitations, open-ended discretionary bonuses with no predetermined measurable standards, and equity participation in for-profit businesses, your arrangement with [redacted] resembles a joint venture in which [redacted] shares a portion of your profits. See also Harding Hospital, supra.

[redacted]

Similar to Rev. Rul. 69-383, supra, your negotiations with [redacted] were at arm's length. However, unlike Rev. Rul. 69-383, [redacted], as [redacted], has substantial control over and management authority over your organization, and you have not submitted evidence to establish that the compensation you expect to pay [redacted] under the Employment Agreement is reasonable in terms of [redacted] duties and responsibilities.

Therefore, the compensation arrangement between you and [redacted] constitutes the inurement of net earnings to a private individual in violation of the prohibition in section 1.501(c)(3)-1(c)(2) of the Regulations.

Section 501(m)

Under section 501(m)(1) of the Code, an organization that otherwise qualifies for exemption under section 501(c)(3) or section 501(c)(4) is precluded from exemption if a substantial part of its activities consists of providing commercial-type insurance.

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

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

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

An HMO that compensates its non-employee physicians on a fixed fee basis is treated the same as a staff model HMO that

[redacted]

pays its physicians on a salaried basis because the HMO has transferred to its physicians a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. The remaining risk is only the normal business risk associated with operating the HMO.

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

Similarly, an HMO that pays its contracted physicians almost exclusively fees-for-service under a fee schedule that represents a meaningful discount from the physicians' usual and customary charges ("discounted fee-for-service") and withholds from these payments a significant percent of the fees otherwise payable, pending compliance with periodic budget or utilization standards transfers to these physicians, in effect, a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO. In return for accepting discounted fees, the physicians are assured of a flow of patients from the HMO. It is a common commercial practice for vendors of goods or providers of services to accept lower prices or fees in return for greater sales.

On the other hand, when an HMO pays its contracted physicians on a fee-for-service basis that is not discounted and where no significant portion of the fees has been withheld, the HMO does not transfer to these physicians its financial risk associated with its obligation to furnish medical services to its enrollees. Thus, the HMO retains the financial risk associated with its obligation to furnish medical services to its enrollees. This financial risk constitutes a contract of insurance.

Under Rev. Rul. 68-27, supra, and Jordan, supra, your contract with [redacted] to arrange for the provision of health care services in return for a fixed fee constitutes a contract of insurance. You contract with mental health care providers, primarily institutions, to provide mental health care services to your enrollees. You compensate your providers using a variety of compensation methods, including case rated fees.

[redacted]

Case rated fees include both fixed and variable elements. The fixed element consists of your agreement to pay a provider a certain amount to perform a certain level of mental health care services over a certain period of time. There is also a variable element because the case rated fees you pay may be redetermined on a monthly basis depending on the enrollee's mental health care needs. To the extent that the case rated fees are fixed, you have transferred to the provider the financial risk associated with the performance of mental health care services. However, to the extent of the variable portion of these fees, you retain substantial financial risk associated with your obligation to arrange for the provision of mental health care services to your enrollees.

Your purchase of stop-loss insurance limits only a portion of your financial risk associated with your obligation to furnish mental health care services to your enrollees. Under the terms of your stop-loss arrangement with [redacted], you still retain a substantial financial risk associated with your obligation to arrange for the provision of mental health care services to your enrollees.

Your case rated compensation arrangement with your providers coupled with your purchase of stop-loss insurance is distinguishable from a compensation arrangement where an HMO pays providers a fixed amount of compensation, such as salaries to employed providers or capitated fees to contracted providers. By paying providers fixed compensation, an HMO transfers to the providers substantially all of its financial risk associated with its obligation to furnish health care services to its enrollees.

Since case rated fees represents [redacted] percent of your total provider compensation, and the fixed element of these fees represents a major component of these fees, we conclude that a substantial portion of your activities consists of providing health insurance to your enrollees. Since your activity, arranging for the provision of mental health care services to Medicaid beneficiaries, is the same type of activity engaged in by commercial insurance companies, this insurance is "commercial-type" insurance under section 501(m)(1) of the Code. See Paratransit Insurance Corporation, supra; and Florida Hospital Trust Fund, et al. v. Commissioner, supra.

Therefore, even though you might otherwise qualify for exemption under section 501(c)(3) of the Code, you are precluded from exemption by section 501(m)(1).

[redacted]

CONCLUSION

Accordingly, you do not qualify for exemption as an organization described in section 501(c)(3) of the Code and you must file federal income tax returns.

Contributions to you are not deductible under section 170 of the Code.

You have the right to protest this ruling if you believe it is incorrect. To protest, you should submit a statement of your views, with a full explanation of your reasoning. This statement, signed by one of your officers, must be submitted within 30 days from the date of this letter. You also have a right to a conference in this office after your statement is submitted. You must request the conference, if you want one, when you file your protest statement. If you are to be represented by someone who is not one of your officers, that person will need to file a proper power of attorney and otherwise qualify under our Conference and Practices Requirements.

If you do not protest this ruling in a timely manner, it will be considered by the Internal Revenue Service as a failure to exhaust available administrative remedies. Section 7428(b)(2) of the Code provides, in part, that a declaratory judgement or decree under this section shall not be issued in any proceeding unless the Tax Court, the United States Court of Federal Claims, or the District Court of the United States for the District of Columbia determines that the organization involved has exhausted administrative remedies available to it within the Internal Revenue Service.

If we do not hear from you within 30 days, this ruling will become final and copies will be forwarded to your key district office. Thereafter, any questions about your federal income tax status should be addressed to that office. The appropriate State Officials will be notified of this action in accordance with Code section 6104(c).

When sending additional letters to us with respect to this case, you will expedite their receipt by using the following address:

Internal Revenue Service
[redacted]
OP:E:EO:T:1, Room 6514
1111 Constitution Ave, N.W.
Washington, D.C. 20224

[redacted]

For your convenience, our FAX number is [redacted] or [redacted] address is: [redacted]

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

In accordance with the Power of Attorney currently on file with the Internal Revenue Service, we are sending a copy of this letter to your authorized representatives.

Sincerely,

Marvin Friedlander

Marvin Friedlander
Chief, Exempt Organizations
Technical Branch 1