TAX EXEMPT AND
GOVERNMENT ENTITIES
DIVISION

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

Number: **201412018**
Release Date: 3/21/2014

Date: December 11, 2013

UIL: 501.03-00

Contact Person:

Identification Number:

Contact Number:

Employer Identification Number:

Form Required To Be Filed:

Tax Years:

Dear :

This is our final determination that you do not qualify for exemption from Federal income tax as an organization described in Internal Revenue Code section 501(c)(3). Recently, we sent you a letter in response to your application that proposed an adverse determination. The letter explained the facts, law and rationale, and gave you 30 days to file a protest. Since we did not receive a protest within the requisite 30 days, the proposed adverse determination is now final.

Because you do not qualify for exemption as an organization described in Code section 501(c)(3), donors may not deduct contributions to you under Code section 170. You must file Federal income tax returns on the form and for the years listed above within 30 days of this letter, unless you request an extension of time to file. File the returns in accordance with their instructions, and do not send them to this office. Failure to file the returns timely may result in a penalty.

We will make this letter and our proposed adverse determination letter available for public inspection under Code section 6110, after deleting certain identifying information. Please read the enclosed Notice 437, *Notice of Intention to Disclose,* and review the two attached letters that show our proposed deletions. If you disagree with our proposed deletions, follow the instructions in Notice 437. If you agree with our deletions, you do not need to take any further action.

If you have any questions about this letter, please contact the person whose name and telephone number are shown in the heading of this letter. If you have any questions about your Federal income tax status and responsibilities, please contact IRS Customer Service at

1-800-829-1040 or the IRS Customer Service number for businesses, 1-800-829-4933. The IRS Customer Service number for people with hearing impairments is 1-800-829-4059.

Sincerely,

Karen Schiller
Acting Director, Exempt Organizations
Rulings and Agreements

Enclosure
Notice 437
Redacted Proposed Adverse Determination Letter
Redacted Final Adverse Determination Letter

TAX EXEMPT AND
GOVERNMENT ENTITIES
DIVISION

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

Date: 10/30/2013

Contact Person:

Identification Number:

501.03-00

Contact Number:

FAX Number:

Employer Identification Number:

LEGEND:

Organization 1 =
Organization 2 =
System =
Institute =
Foundation =

Dear :

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

FACTS

You were formed as a nonprofit membership corporation under state law. You will be the successor to the planned merger between two related healthcare organizations, Organization 1 and Organization 2.

Organization 1 is a nonprofit membership corporation. Its members consist of persons who hold insurance contracts directly with Organization 1 or through their employer-subscribers. Organization 1 does not have any corporate members. Organization 1 is recognized by the IRS as an organization described in § 501(c)(4) of the Code. It controls, directly and indirectly, a number of exempt and non-exempt organizations, and serves as the parent of a large integrated healthcare system known as System. The organizations in System include healthcare providers, clinics, and hospitals. Organization 1 is governed by a -member board of directors. directors are elected by Organization 1's subscribers or subscribers of plans administered by Organization 1 directors are selected from the directors of Organization 2; and directors are healthcare providers. Organization 1 is licensed to operate an HMO. It offers a number of arranger-type HMO plans to various groups, including small and large employers, individual enrollees, and Medicare and Medicaid beneficiaries. Currently, Organization 1 has approximately enrollees.

Organization 2 is a nonprofit membership corporation. Its members consist of Associate Members (persons holding insurance contracts with Organization 2 or through their employer-subscribers) and one Corporate Member, Organization 1. Organization 2 is recognized by the IRS as an organization described in § 501(c)(3) of the Code. It is governed by a member board of directors. directors are enrollees in Organization 2's HMO plan (or in another plan administered by System); one director is the Chair of the Organization 1 board of directors; and one director is a physician appointed by the president of Organization 2. Organization 2 operates a "staff model" HMO and physician clinics, providing healthcare services directly by its employed healthcare providers through clinics and hospitals that are part of System. Organization 2's enrollees consist of individuals and Medicare beneficiaries.

Organization 1 and Organization 2 plan to merge and transfer to you all of their assets and operations. As a result, you will carry on the activities and HMO plans that Organization 1 and Organization 2 currently carry on as separate organizations. Following the planned merger, you will continue to offer a variety of insurance plans, including traditional HMO plans, plans providing access to out of network providers, tiered network plans, Medicaid, Medicare Cost and Advantage plans, and dental plans. In addition, as a result of the planned merger, you will replace Organization 1 as the parent of System and thereby control the entities comprising the System.

Your bylaws state that you will have one class of members. A member is a contract holder who holds a health maintenance contract with you for medical services, or a contract holder who receives healthcare services through employer-insured contracts that either you or a related organization administer. Thus, a member of the corporation is also an "enrollee" in one of your healthcare plans. (Hereafter, such an individual is referred to as a "Member-Enrollee.")

Your bylaws state that a -person board of directors governs you. of the directors must be Member-Enrollees. Your bylaws expressly state that all such directors must be covered under an HMO contract or insurance contract that either you or a related organization issue, or under an employer-issued contract that either you or a related organization administer. No more than one Member-Enrollee director may be from any one employer group, unless that group exceeds 1/7 of the total enrollment. For each additional 1/7, there may be an additional director from that group, up to a maximum of three. In addition, a Member-Enrollee director cannot be a person:

The other two directors must be healthcare providers, one physician elected by your Medical Board of Governors, and one of your employee-physicians appointed by your president.

As a result of the merger, you expect to have total assets of approximately $ million, of which $ million, or percent, will consist of accumulated surplus. This surplus is not dedicated to any sort of research, charity care, or educational program. You have not described any tax-exempt programs for which you intend to use this surplus.

For the first full year of operation following the merger, you expect that your revenues will be:

	Amount	Percent
Medical and dental premiums		
Medical and dental patient service revenue		
Total operating revenues		
Investment income and rental income		
Management fees		
Total revenues		

For the first full year of operation, you expect that enrollment in your various health plans will be:

	Number	Percent
Major and national accounts		
Large government employer groups		
Small government employer groups		
Middle market		
Small group employers		
Medicaid program plus plans		
Medicare cost and Part D plans		
Individual plans		
Total		

You expect that enrollment in your traditional HMO plans will account for approximately of your subscribers (or percent) and $ million of your $ billion of

revenue (or percent). You estimate that the open access, tiered network, and consumer directed plans will account for approximately of your subscribers (or percent) and $ of your $ of revenue (or percent).

Following the planned merger, you expect to pay approximately $ (or percent of your total expected healthcare expenditures of $) as direct contractual fee for service payments to non-employee healthcare providers for services rendered to enrollees in your plans.

Organization 1 and Organization 2 currently have financial assistance programs under which they serve those unable to pay. Persons checking in to one of the organizations' clinics are provided with an information sheet referring to, among other things, the financial assistance program and may fill out an application. Individuals and families who are at or below the federal poverty level are eligible for completely subsidized care, with decreasing subsidies as income rises up to 300 percent of the federal poverty level. You state that in , under these programs, Organization 1 and Organization 2 together provided a total of approximately $ million in uncompensated care. You state that, after the merger, you will continue to follow these same programs and that you expect to provide the same amounts of uncompensated care as Organization 1 and Organization 2 provided previously. At this same level, these benefits will constitute approximately percent of your expected total revenues.

You state that you will also continue a premium subsidy plan that is currently operated by Organization 1 and Organization 2 for Medicare Advantage plan enrollees who meet certain eligibility criteria. As of January , approximately individuals were enrolled in this plan. At this same level, this enrollment will represent approximately percent of your total expected enrollment.

Currently, Organization 2's physician employees provide some direct clinical teaching to medical students and interns at various healthcare facilities in System, and your dentist employees conduct a small training program by collaborating with a university to provide clinical rotations for two residents each year. After the merger, you will continue these programs. These student medical and dental education programs are conducted principally by Institute, a § 501(c)(3) organization that is currently controlled by Organization 1. Institute provides training for more than medical residents each year and conducts a variety of continuing medical education programs. After the planned merger, Institute will remain a separate organization that you will control.

Currently, Organization 1, through Organization 2, controls Foundation, a § 501(c)(3) organization that focuses primarily on scientific and medical research. Organization 1 and Organization 2 have funded Foundation in the amount of approximately $ per year. Following the planned merger, you will control Foundation and intend to continue to fund it at approximately the same level, which would represent approximately percent of your expected total revenues.

LAW

Section 501(c)(3) of the Code exempts from federal income tax corporations organized and operated exclusively for charitable, educational, scientific, and other purposes, provided that no part of their 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 (regulations) provides that, in order to be exempt as an organization described in section 501(c)(3), an organization must be both organized and operated exclusively for one or more of the purposes specified. If an organization fails to meet either the organizational test or the operational test, it is not exempt.

Section 1.501(c)(3)-1(c)(1) of the regulations provides that an organization will be regarded as "operated exclusively" for one or more exempt purposes only if it engages primarily in activities that accomplish one or more of the exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

In Better Business Bureau of Washington D.C., Inc. v. U.S., 326 U.S. 279 (1945), the Supreme Court held that the presence of a single non-exempt purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly exempt purposes. The Court found that a trade association had an "underlying commercial motive" that distinguished its educational program from that carried out by a university, and therefore, the association did not qualify for exemption.

In BSW Group, Incorporated v. Commissioner, 70 T.C. 352 (1978), the Tax Court considered the qualification for exemption under § 501(c)(3) of an organization formed to provide consulting services for a fee to nonprofit and tax exempt organizations in the areas of health and health delivery systems, housing, vocational skills, and cooperative management. In concluding that the organization did not qualify for exemption, the court noted that:

> *[T]he critical inquiry is whether petitioner's primary purpose for engaging in its sole activity is an exempt purpose, or whether its primary purpose is the nonexempt one of operating a commercial business producing net profits for petitioner. . . . Factors such as the particular manner in which an organization's activities are conducted, the commercial hue of those activities, and the existence and amount of annual or accumulated profits are relevant evidence of a forbidden predominant purpose.*

Id. at 357.

Section 1.501(c)(3)-1(d)(2) of the regulations states, in part, that the term "charitable" in section 501(c)(3) of the Code includes relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; lessening of the burdens of government; and promotion of social welfare by organizations designed to accomplish any of the above purposes. In addition, the promotion of health has long been recognized as a

charitable purpose under common law. See Restatement (Second) of Trusts, §§ 368, 372 (1959).

An organization that promotes health primarily for the benefit of the community as a whole can qualify as charitable. In Rev. Rul. 69-545, 1969-2 C.B. 117, the Service found that a non-profit hospital was described in section 501(c)(3) of the Code when it: (1) provided hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement; (2) operated an emergency room open to all persons; (3) used its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs; (4) was controlled by a board of trustees that was composed of independent civic leaders; and (5) maintained an open medical staff, with privileges available to all qualified physicians.

Three court cases have considered whether an HMO qualifies for exemption under § 501(c)(3): Sound Health Association v. Commissioner, 71 T.C. 158, 177-181 (1978), Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1219 (3d Cir. 1993), and IHC Health Plans Inc. v. Commissioner, 325 F.3d 1188, 1197 (10th Cir. 2003). All three cases applied the "community benefit" standard for tax-exempt hospitals, using the specific factors set forth in Revenue Ruling 69-545.

In Sound Health, the Tax Court determined that an organization qualified under § 501(c)(3) of the Code where it provided HMO services combined with direct healthcare services. The organization provided services to both subscribers and members of the general public and also operated an outpatient clinic that treated all emergency patients, regardless of subscriber status or ability to pay. The court found that these characteristics, which were similar to those identified in the exempt hospital in Rev. Rul. 69-545, showed that it was operated for charitable purposes.

In Geisinger, the court held that a pre-paid healthcare organization that arranges for the provision of healthcare services only for its members benefits its members rather than the community as a whole. Under the community benefit standard, the organization must benefit the community as a whole to establish the charitable purpose of promoting health for purposes of § 501(c)(3).

IHC involved an operator of health maintenance organizations and insurance providers that served approximately one-quarter of Utah's residents and approximately one-half of its Medicaid population. The court held that these organizations, Health Plans, Care, and Group, failed to meet the community benefit standard to qualify for exemption under § 501(c)(3) because their activities were focused on arranging for healthcare services for their members in exchange for a fee. The court said that providing healthcare products or services to all in the community is necessary but not sufficient to meet the community benefit standard. Rather, the organization must provide some additional benefit that likely would not be provided in the community but for the tax exemption, and that this public benefit must be the primary purpose for which the organization operates.

Not every activity that promotes health generally furthers exclusively charitable purposes under § 501(c)(3). For example, a hospital does not primarily further a charitable purpose solely by offering healthcare services to the public in exchange for a fee. See Rev. Rul. 69-545, supra. As IHC noted, "engaging in an activity that promotes health, standing alone, offers an insufficient indicium of an organization's purpose," as "[n]umerous for-profit enterprises offer products or services that promote health." 325 F.3d at 1197. Thus, a health maintenance organization that is operated primarily for the purpose of benefiting its paying subscribers does not qualify for exemption solely because the community also derives health benefits from its activities. See, generally, Geisinger and IHC.

To qualify as an organization described in § 501(c)(3), a healthcare organization must make its services available to all in the community plus provide additional community or public benefits. IHC, 325 F.3d at 1198. The additional benefits must give rise to a strong inference that the public benefit is the primary purpose for which the organization operates. Id. The Court of Appeals in IHC identified five factors drawn from relevant case law to determine whether a healthcare organization is operating primarily for the benefit of the community. These factors are enumerated below along with the IHC court's application of each factor to the facts of that case.

(1) The size of the class eligible to benefit

The Court of Appeals noted that membership was a precondition to the ability of individuals to qualify for healthcare benefits under its plans, and that a large, diverse enrollment is not indicative per se of the organization's purpose. Citing Geisinger, the court stated:

> *"The community benefited is, in fact, limited to those who belong to [the HMO] since the requirement of subscribership remains a condition precedent to any service. Absent any additional indicia of a charitable purpose, this self-imposed precondition suggests that [the HMO] is primarily benefitting itself (and, perhaps, secondarily benefitting the community) by promoting subscribership throughout the areas it serves."*

985 F.2d at 1219. Further, while the absence of a large class of potential beneficiaries may preclude tax-exempt status, its presence standing alone provides little insight into the organization's purpose. Offering products and services to a broad segment of the population is as consistent with self-promotion and profit maximization as it is with any "charitable" purpose.

325 F.3d at 1201.

(2) Free or below-cost products or services

The Tax Court determined that the organizations provided "virtually no free or below-cost health-care services. [Footnote omitted]. All enrollees must pay a premium in order to receive benefits. [Footnote omitted.]" Id. at 1200. Further, the Court did not consider the organization's "adjusted community rating system, which likely allowed its enrollees to obtain medical care at a lower cost than might otherwise have been available. [Citations omitted]," as

evidence of the organizations' purpose. Id. Furthermore the court noted that a minimal degree of free services is inconsequential, stating:

> *As the Eighth Circuit has noted, "a 'charitable' hospital may impose charges or fees for services rendered, and indeed its charity record may be comparatively low depending upon all the facts ... but a serious question is raised where its charitable operation is virtually inconsequential. [Citations omitted.]*

Id., n. 27.

(3) Treatment of persons participating in governmental programs such as Medicare or Medicaid

The organizations provided healthcare services to Medicaid beneficiaries; however, the Court of Appeals noted that:

> *The relevant inquiry, however, is not "whether [petitioner] benefited the community at all ...[but] whether it primarily benefited the community, as an entity must in order to qualify for tax-exempt status." Geisinger I, 985 F.2d at 1219.*

Id. at 1201, n. 29.

(4) Use of surplus funds for research or educational programs

In IHC, none of the organizations conducted research or offered free education programs to the public.

(5) Composition of the board of trustees

Prior to 1996, the bylaws of one of the IHC organizations provided that employer subscribers represented a plurality of the board. In 1996, the organization amended its bylaws to require that a majority of board members be disinterested and broadly representative of the community. The Court of Appeals did not consider the board composition, either before or after the amendment, as a factor. However, it stated that:

> *Even if we were to conclude petitioners' board broadly represents the community, the dearth of actual community benefit in this case rebuts any inference we might otherwise draw.*

Id. at 1201.

In general, maintaining a board that is representative of the community is a significant factor indicating that an organization will be operated for the benefit of the community as a whole, though it is not essential. See Rev. Rul. 69-545, supra; Sound Health; Geisinger; IHC. For example, in Sound Health, the organization's board was elected by its member-subscribers and was found to qualify under § 501(c)(3). However, that organization demonstrated other

significant factors showing that it was operated for the benefit of the community, such as that initially over 2 percent of its patients would be charity care patients. Sound Health, 71 T.C. at 171. The organization in Sound Health also maintained a significant public health program and subsidized dues program. Id. at 166.

ANALYSIS

You do not meet the community benefit standard because you primarily operate to benefit your Member-Enrollees and not the community as a whole. Thus, you are not described in § 501(c)(3) of the Code. You propose to merge a "staff model" HMO described in § 501(c)(3) with a much larger "arranger" HMO described in § 501(c)(4). You will be the successor to the planned merger of the two organizations. Organization 2, the "staff model" HMO, has approximately members, while Organization 1, the "arranger" HMO, has over enrollees. You expect to have total annual healthcare expenditures of $, of which $ billion (or about percent) will consist of direct contractual fee for service payments to non-employee healthcare providers for services rendered to your Member-Enrollees. Therefore, your primary purpose is to operate a § 501(c)(4) arranger HMO, with your direct healthcare services representing a minority of your activities.

The IHC court said, "In this case, we deal with organizations that do not provide health-care services directly. Rather, petitioners furnish group insurance entitling enrollees to services of participating hospitals and physicians." 325 F.3d at 1199. The court reasoned that this is not an inherently charitable activity, and that "the commercial nature of this activity inspire[s] doubt as to the entity's charitable purpose." Id. Although you will also operate a "staff model" component, your § 501(c)(4) arranger activities supply the bulk of your revenue. Therefore, as your primary activity is commercial rather than charitable, you are not operated exclusively for § 501(c)(3) purposes.

Additionally, IHC lists several factors used to determine whether a healthcare organization is operating primarily for the benefit of the community. Based on the information you provided, several of these factors suggest that you do not operate primarily for the benefit of the community. Namely, the size of the class eligible to benefit from your activities is not sufficient, you do not provide sufficient free or below-cost services, and you do not use your substantial surplus funds to provide meaningful research and educational programs. Each factor is analyzed below.

(1) The size of the class eligible to benefit

You are similar to IHC because you limit your healthcare benefits only to persons who are enrolled in one of your plans, a precondition of which is the payment of the required premiums. Although you provide healthcare benefits to some under your financial assistance policy, these benefits are minimal in relation to the total premiums you receive.

(2) Free or below-cost products or services

Your financial assistance program is expected to result in about $ of uncompensated care, which is minimal in relation to your expected operating revenues of $ billion, representing only about percent of revenues. In addition, your premium subsidy plan for Medicare Advantage plan enrollees is minimal, serving only persons out of your expected total enrollees, or less than . These programs are unlike the programs described in Sound Health, where significant indicia of community benefit outweighed the negative factor that its board was elected by its member-subscribers.

(3) Use of surplus funds for research or educational programs

You do not use ample surplus funds for research or educational programs to further a § 501(c)(3) purpose. For example, Foundation, a related organization in System that you will control as a result of the proposed merger, will continue to conduct scientific and medical research. You intend to continue to fund this organization in the same amount as your two predecessors, about $ per year. At this level, your expected funding will represent only percent of your expected total revenues of $.

In addition, as a result of the merger, you expect to have an accumulated surplus of $ million, which will represent about percent of your total assets. This surplus is not dedicated to any sort of research, charity care, or educational program. You have not described any tax-exempt programs for which you intend to use this surplus. Maintaining a large surplus such as this is contrary to one of the factors in the community benefit standard established in Rev. Rul. 69-545, supra. See IHC, 325 F.3d at 1196.

Therefore, you will not operate for the primary purpose of providing healthcare services for the benefit of the community. Rather, the evidence shows that you will be controlled by, and operate primarily for the benefit of, your Member-Enrollees. Consequently, you do not qualify as an organization described in § 501(c)(3).

CONCLUSION

For the reasons set forth above, you do not qualify for exemption as an organization described in § 501(c)(3) of the Code and you must file federal income tax returns.

You have the right to file a protest if you believe this determination is incorrect. To protest, you must submit a statement of your views and fully explain your reasoning. You must submit the statement, signed by one of your officers, within 30 days from the date of this letter. We will consider your statement and decide if the information affects our determination.

Your protest statement should be accompanied by the following declaration:

Under penalties of perjury, I declare that I have examined this protest statement, including accompanying documents, and, to the best of my knowledge and belief, the statement contains all the relevant facts, and such facts are true, correct, and complete.

You also have a right to request a conference to discuss your protest. This request should be made when you file your protest statement. An attorney, certified public accountant, or an individual enrolled to practice before the Internal Revenue Service may represent you. If you want representation during the conference procedures, you must file a proper power of attorney, Form 2848, *Power of Attorney and Declaration of Representative,* if you have not already done so. For more information about representation, see Publication 947, *Practice before the IRS and Power of Attorney.* All forms and publications mentioned in this letter can be found at www.irs.gov, Forms and Publications.

If you do not file a protest within 30 days, you will not be able to file a suit for declaratory judgment in court because the Internal Revenue Service (IRS) will consider the failure to protest as a failure to exhaust available administrative remedies. Code § 7428(b)(2) provides, in part, that a declaratory judgment or decree 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 all of the administrative remedies available to it within the IRS.

If you do not intend to protest this determination, you do not need to take any further action. If we do not hear from you within 30 days, we will issue a final adverse determination letter. That letter will provide information about filing tax returns and other matters.

Please send your protest statement, Form 2848 and any supporting documents to this address:

You may also fax your statement using the fax number shown in the heading of this letter. If you fax your statement, please call the person identified in the heading of this letter to confirm that he or she received your fax.

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

Thank you for your cooperation. We have sent a copy of this letter to your representative as indicated in your power of attorney.

Sincerely,

Karen Schiller,
Acting Director,
Exempt Organizations
Rulings & Agreements