DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224 200044039

Date: AUG 03 2000

Contact Person:

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512.00-00

ID Number:

Telephone Number:

T:EO:RA:T4

Employer Identification Number:

LEGEND:

A =
B =
C =
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Dear Sir or Madam:

This is in response to your request for rulings as to the federal income tax consequence of proposed certain global capitation payments entered into by you as described more fully below.

FACTS

You are an organization exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. You have been recognized as a supporting organization under section 509(a)(3) of the Code and serve as the parent of a health care system which includes several tax exempt hospitals, a tax exempt physician clinic, and various other health care related organizations (the System). You do not provide any health care services directly other than in your capacity as a supporting organization to the members of the System.

You have entered into global risk contracting arrangements with certain insurance companies under which you receive payments from the insurance companies and health maintenance organizations (the Insurance Companies) on a percentage of premium, per member per month basis. The Insurance Companies include: A, B, and C. The capitation payments for your fiscal year ended in 1999 represented approximately 15 to 20 percent of the

244

system-wide gross revenue. You contract for and receive these capitation payments on behalf of your affiliated health care providers and certain specialty care physicians.

You do not have a license in the state to operate as an insurance company and the state department of insurance does not regulate you. Therefore, you are not subject to surplus, reserve, or statutory reporting requirements of the state. In addition, the state department of health that has jurisdiction over health maintenance organizations (HMOs) operating within the state with regard to global risk contracting arrangements does not regulate you. Rather, the Insurance Companies that have entered into these contracts with you are licensed as HMOs or insurance companies and operate as such in accordance with the state department of health and department of insurance requirements.

In order to leverage maximum value in the contracting and negotiating process, you prefer to sign the contracts and negotiate with the Insurance Companies directly at your level. In addition, the contracts benefit the System as a whole with appropriate negotiating strength when contracting with physicians. The global nature of these contracts allows the System to provide higher patient care in a more coordinated and integrated fashion.

You, on your own behalf and on behalf of the health care providers, have entered into a global capitation arrangement with A. The arrangement requires the hospitals and physician groups to provide health care services or arrange for the delivery of covered services to A's HMO members.

A has agreed to pay you (on your own behalf and on behalf of affiliated and non-affiliated health care providers) a monthly capitated fee based on a fixed percentage of premium per member per month it receives for the insured individuals (the Members) in exchange for the provision of professional and institutional services by you, your affiliated entities, and certain non-affiliated entities (e.g., specialists not affiliated with you). All of the institutional services (e.g., technical, hospital facility and ancillary services) under the A contract, with the exception of services out of your geographic area or specialization, are provided by entities affiliated with you.

The premium charged by A to individual Members is generally based upon the age, sex and location of the Members as well as other actuarial factors. The State Department of Insurance does not establish the percentage of premium fee paid to you. Rather, the amount results from an arm's length negotiation between A and you. The aggregate percentage of premiums paid by A to you is intended to be sufficient to pay all medical services to be provided by you and your affiliated entities to the Members. This contractual arrangement between the parties is effective for a 5-year term.

You, on your own behalf and on behalf of the health care providers, have entered into a global capitation arrangement with B (referred to as the B Contract). The arrangement provides for you to contract with facilities, providers and ancillary service organizations for the provision of health care services to members covered by B.

B has agreed to pay you a monthly capitated fee based on a fixed percentage of premium per member per month it receives for each of B's Members in exchange for the provision of professional and institutional services by you, your affiliated entities and certain non-affiliated entities (certain specialty services).

The premium charged by B to individual Members is generally based upon the age, sex and location of the Members, as well as other actuarial factors. The percentage of premium fee paid to you is not established by the State Department of Insurance, but results from an arm's-length negotiation between B and you. The premium for the Medicare risk product is established by the Health Care Financing Administration, with an additional premium charged by the HMO depending on the benefit plan selected by the Member.

Through a Master Services Agreement, you immediately assign all contractual rights and percentages of premium received under both the A and B contract agreements to a wholly-owned subsidiary management services organization, D, a taxable, for-profit business corporation. D is the sole member of a limited liability company, E which provides back office management and administration for the providers.

Upon assignment of the A and B contractual rights from you to D, D negotiated capitation rates with each of the providers under the contract. All hospital and physician services are provided by exempt entities within the System, except for out-of-area services and certain physician specialty services not provided within the System. Individual provider agreements, group practice provider agreements, and hospital and ancillary provider agreements evidence these agreements between D and the providers. D directly causes the D providers to accept either capitated payments or other forms of payments as specified in the provider agreements. In only limited circumstances (less than 5 percent of the total primary care and specialty care payments), certain specialists are paid with a discounted fee for service arrangement as opposed to a capitated payment. Discounted fee for service payments are utilized in those areas where the specialties were viewed as having low enough volume that the risk assumed justified payment on a fee-for-service rather than a capitated basis.

D has arranged to accept capitated payments directly from you for the purpose of contracting for the provision of covered healthcare services. D is assigned funds for payment of covered services and administrative services according to the Master Services Agreement with you. D distributes the funds to providers in 3 major financial pools: (a) primary care, (b) specialty care, and (c) hospital/ancillary care. The portion of the total funds allocated to each pool is determined in arm's-length negotiations based on historical and other utilization data and is approved by D's board of directors.

In exchange for payments from D, the affiliated entities carry out the actual provision and delivery of health care services for the individual members. All amounts received under both the A and B Contracts represent payments for services arranged by you and delivered by your affiliated entities and non-affiliated specialists. The payments to you assigned to D and paid to the affiliated organizations and non-affiliated specialists are based on predetermined capitated rate arrangements.

You have agreed to equally share the risk for certain services with A and with B including, pharmacy, transplants, and out of area covered services. You establish a separate budget for all shared risk items and account for these items outside of the individual capitated provider pools.

The D Provider Agreement requires D providers to participate in the Medicaid plan. Neither D nor you retain any financial risk for Medicaid HMO payments. Under the Medicaid program, all providers are paid discounted fee for service at state Medicaid rates directly from the Payor.

Participating primary care physicians collectively receive 100 percent of the funds allocated to the primary care pool. Capitation payments are made to participating primary care providers by applying age, sex, benefit plan and service capability factors to a base rate. The D Board of Directors determines distribution of the primary care pool to the participating primary care providers. Reconciliation of the pool is performed periodically to ensure that all pool funds are distributed to primary care providers.

Participating specialty care providers collectively receive 100 percent of the funds allocated to the specialty care pool less any amount paid to non-participating providers for authorized covered services. The specialty care pool is divided into individual specialty pools each defined as a percentage of the specialty care pool.

D will create a Hospital and Ancillary Incentive Pool to provide a mechanism for the payment of covered services furnished by the hospital, institutional and ancillary providers, as ordered and prescribed by the participating providers. This fund is created as a percentage of the funds available to D providers. Financial surpluses within the fund are shared equally between you and the participating physicians having capitated agreements with D.

The Master Services Agreement assigns the contracts from you to D. The D Participating Provider Agreements reflect subcapitation arrangements between D and all participating providers. These agreements establish the global capitation arrangement. The D Participating Provider Agreements also reflect the payment methodology between D and the subcapitated providers under the primary care and specialty care pools.

D retains less than 5 percent of the overall contractual risk in the capitation arrangements. In other words, 95.37 percent of all funds received under these contracts by D have the capitated risk shifted to the providers. If your related organizations cannot directly or indirectly provide the medical services required by the contracts for the members, you contract with outside providers, including hospitals and physicians, to provide those services. You anticipate that subcontracting for services to providers outside of the System will occur only in situations whereby the care is geographically prohibitive to provide or the services required by the patient are outside of the technical areas of specialization or capabilities of the System. Out of area care will be determined in reference to the System's physical proximity.

D retains a minimal percentage amount of the fees paid by the Insurance Companies to cover oversight, overhead, other general and administrative activities and quality assurance responsibilities. These services are provided by E, which is owned 100 percent by D and include administration of network contracting, capitation reconciliation, periodic reporting, centralized management of shared risk pool operations, and utilization management.

You have entered into a three-way agreement with C and F to provide health care services to C and G insured individuals (the Members) in exchange for a fixed capitation payment (C Contract). F is an unrelated, for-profit physician clinic, and is not an owned entity within your integrated delivery system. The C Contract is not assigned to D. Both F and the providers within your system have accepted separate, agreed upon, negotiated capitation rates based upon a percentage of premium per member per month under the C Contract and a Letter of Agreement between you and F.

For several years before you and F entered into the current three-way C Contract, F exclusively provided professional physician services at one of your exempt affiliated hospitals to the C Members. In addition, the exempt affiliate hospital provided institutional and ancillary services to C Members for several years before the three-way contract. When you entered into negotiations with F to determine the allocation of the C global capitation payment between you and F, the historical experience under the previously contracted arrangements was analyzed. The reimbursement under the previous arrangement was then converted to a percentage of the funds available to the Provider Group.

The percentage of premium fee negotiated under the C Contract resulted from arm's length negotiations between you, F and C. The aggregate percentage of premiums paid by C to the Provider Group is designed to be sufficient to pay all medical services rendered to the Members by the Provider Group.

The global capitation payment received from C is deposited into a joint dual signature bank account between you and F. Distributions are made to both parties under terms and percentages agreed to by the Provider Group in the Letter of Agreement. The percentages and distributions amounts are reviewed annually and developed by the Provider Group in an arm's-length negotiation.

Once the fixed capitation payment is split between you and F, each party to the contract is responsible for providing institutional (you) and professional (F) services to the C Members. You and your affiliated providers bear the risk for the institutional, hospital and ancillary services, and F bears the risk for the professional services. The parties for items such as out of area services, transplants, emergency room physician coverage and certain drugs share some elements of risk. F does not receive any payments in excess of the capitated rates agreed to and accepted under the global capitation arrangement in the event of excess professional utilization or additional incurred costs.

In addition, F makes direct monthly payments to you on behalf of those covered persons in G for F employees. Because the shared capitation ratios are contractually provided for pursuant

to the Letter of Agreement between you and F. F and you each jointly participate in the three-way contract with full assumption of capitation and risk.

You have requested the following rulings:

1. The Capitation Agreements and Subcapitation Agreements, including: (a) the global capitation agreements entered into between you or D and F, G, A, B, and C; (b) the subordinated capitation agreements between you or D and your affiliated providers; and (c) the discounted fee-for-service agreements with unrelated health care providers for services provided outside your geographic area and outside your specialized medical service capabilities will not adversely affect your section 501(c)(3) tax exempt status or your public charity status under section 509(a)(3).

2. The Capitation Agreements and Subcapitation Agreements, including: (a) the global capitation agreements entered into between you or D and F, G, A, B, and C; (b) the subordinated capitation agreements between you or D and your affiliated providers; and (c) the discounted fee-for-service agreements with unrelated health care providers for services provided outside your geographic area and outside your specialized medical service capabilities will not result in unrelated business income under sections 511 through 514 or under section 501(m) to you.

APPLICABLE LAW

Section 501(c)(3) of the Code describes as exempt from federal income tax, as provided under section 501(a), organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

Section 501(m)(1) of the Code provides that an organization described in paragraph (3) or (4) of subsection (c) shall be exempt from tax under subsection (a) only if no substantial part of its activities consists of providing commercial-type insurance.

Section 509(a)(1) of the Code defines the term "private foundation" as an organization described in section 501(c)(3) other than an organization described in section 1709b)(1)(A) (other than in clauses (vii) and (viii)).

Section 170(b)(1)(A)(iii) of the Code refers to an organization whose principal purpose or function is the provision of medical or hospital care.

Section 511(a) of the Code imposes a tax on the unrelated business taxable income of an organization otherwise exempt from federal income tax.

Section 512(a) of the Code defines unrelated business taxable income as the gross income derived by any organization from any unrelated trade or business (as defined in section 513) regularly carried on by it less the deductions allowed by this chapter which are directly

connected with the carrying on of that trade or business.

Section 513(a) of the Code defines an unrelated trade or business as any trade or business the conduct of which is not substantially related to the exercise or performance of the organization's exempt purposes and functions.

Section 1.501(c)(3)-1(c)(1) of the Income Tax Regulations provides that an organization will be regarded as operated exclusively for exempt purposes only if it engages primarily in activities which accomplish exempt purposes.

Section 1.501(c)(3)-1(c)(2) of the regulations provides that an organization is not operated exclusively for 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) defines a private shareholder or individual as a person having a personal and private interest in the activities of the organization.

Section 1.501(c)(3)-1(d)(1) of the regulations provides that an organization is not organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest.

Section 1.501(c)(3)-1(d)(2) of the regulations provides that the term "charitable" is used in section 501(c)(3) of the Code 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).

Section 1.513-1(d)(1) of the regulations provides that gross income derives from unrelated trader or business if the conduct of the trade or business which produces the income is not substantially related to the purposes for which exemption is granted.

Section 1.513-1(d)(2) of the regulations provides that a trade or business is related to exempt purposes only where the conduct of the business activities has a causal relationship to the achievement of exempt purposes; and it is substantially related only if the causal relationship is a substantial one. Thus, for the conduct of a trade or business to be substantially related to purposes for which exemption is granted, the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes.

Rev. Rul. 68-27, 1968-1 C.B. 315, provides that an organization which issues medical service contracts to groups or individuals that repay the contract price at fixed monthly rates is not an insurance company within the meaning of the Code. The organization supplies a medical clinic staffed with salaried physicians, nurses, and technicians to provide a substantial portion of the medical services contracted for, which includes care for the injured or the sick as well as preventive care. Further, the Service determined that although an element of risk exists with respect to the sick or disabled phase of a contract, it is predominantly a normal business risk of an organization engaged in furnishing medical services on a fixed price basis, rather than an insurance risk. As a result of the illness or disablement, the contracting organization generally does not incur any expense other than that which it incurs providing the medical services

through a staff of physicians, nurses and technicians.

In Rev. Rul. 69-383, 1969-2 C.B. 113, the Service examined a hospital that paid a radiologist a fixed percentage of the department's gross billings, adjusted by an allowance for bad debts. The radiologist did not control the organization, the agreement was negotiated at arm's length, and the amount the radiologist received was reasonable in terms of the responsibilities and activities that he assumed under the contract. For these reasons, it was held that the arrangement entered into 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.

Rev. Rul. 69-545, 1969-2 C.B. 117, provides that a nonprofit corporation whose purpose and activity are providing hospital care is promoting health and therefore furthers charitable purposes as provided in section 501(c)(3) of the Code if it meets the community benefit requirements. The community benefit standard focuses on a number of factors indicating the operations of a hospital benefit the community rather than serving private interests.

Rev. Rul. 78-41, 1978-1 C.B. 148, concludes that a trust created by a hospital to accumulate and hold funds to pay malpractice claims against the hospital qualified for exemption under section 501(c)(3) of the Code as an integral part of the hospital. The hospital provided the funds for the trust, and the banker-trustee was required to make payments to claimants at the direction of the hospital. The organization conducted an activity that the hospital could perform itself.

Rev. Rul. 86-98, 1986-1 C.B. 74, describes an IPA that provides health services through written agreements with HMOs. The IPA's stated purpose was to arrange for the delivery of health services through written agreements negotiated with HMOs. Moreover, the IPA's primary activities were to serve as a bargaining agent for its members in dealing with HMOs and to perform the administrative claims services required by the agreements negotiated with the HMOs. The Service found that the IPA was akin to a billing and collection service and a collective bargaining representative negotiating on behalf of its member physicians with HMOs. Hence, the IPA was operating in a manner similar to organizations carried on for profit, and its primary beneficiaries are its member physicians rather than the community as a whole.

In Helvering v. LeGierse, 312 U.S. 531 (1941), the Supreme Court stated that historically two elements are consistently present when defining insurance: risk-shifting and risk distribution.

In Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976), aff'd 572 F.2d 1190 (7th Cir. 1978), the Tax Court referred to the definition of insurance as provided in 1 *Couch on Insurance* 2d 1:2 (1959) as follows:

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

DISCUSSION

Your exempt purpose is the furtherance of the charitable purposes of your exempt subsidiary hospitals and other health care providers through the provision of health care services to the community. The global capitation contracts and subcapitation contracts are essentially medical service contracts for the promotion of the health of the community, as provided under Rev. Rul. 69-545 and Rev. Rul. 78-41.

The A and B contracts do not result in private inurement or other than incidental private benefit. The arrangements and subcapitation rates under the A and Bcontracts are each negotiated at arm's length between all parties. The capitation rates and subcapitation rates are determined based on industry norms and standards for similar services and activities.

The C Contract also does not result in private inurement or other than incidental private benefit. Before you entered into the three-way contract with F and C, F had a substantial, independent relationship with C. In addition, one of your exempt affiliate hospitals also had a separate contractual arrangement to provide institutional services to C Members. You and F developed mutually favorable contract rates and a contracting vehicle to provide physician and hospital services efficiently to the Members insured by C. Consequently, you secured a favorable capitation rate for the System on a long-term basis, with rates agreed to at arm's length.

You negotiated the C Contract for the primary benefit of the System, not for the benefit of F, which historically had a prior contracting relationship with C. In addition, the long-term historic contracting rates negotiated by F as a part of the three-way contract were as good or better than the rates previously being paid to the exempt affiliate hospital under the historic relationship with C.

Under the A and B contracts, the premiums paid to you are allocated to the providers within the System pursuant to subcapitation agreements. Each of the providers within the System receive a fixed capitated fee in exchange for the provision of services under the contracts, resulting in full risk shifting to each of the providers. Under the C contract as well, the total capitated per member per month rate payable and allocated to each of the providers, including F physicians, under the contract is capped and not unlimited. In addition, F and other provider contracts do not control you or have any substantial influence over you in the contracting or capitation rate negotiation activity. As such, similar to the determination in Rev. Rul. 69-383, supra, the contractual arrangements do 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.

The risk pool arrangements incorporated into the global capitation agreements do not result in private inurement or other than incidental private benefit. These arrangements are essential to aligning physician activities with the institutional providers

and are designed to reward the physicians and providers for efficient, cost-effective, quality care.

The global capitation activity is a joint contracting activity designed to facilitate your ability to provide more integrated care within your provider and physician network. However, the joint contracting activity between A, B and the contracting activity between C, you and F, are not joint venture arrangements. The activity does not provide physicians with either an equity interest or ability to share profits or net revenue in any portion of your earnings.

Section 501(m) of the Code deals with both the impact of insurance activities on an organization's tax exemption and, if an organization is eligible for exemption, with the taxation of income derived from its insurance activities. If a substantial part of an organization's activities consists of the provision of commercial-type insurance, then under section 501(m)(1), the organization will not be afforded tax exemption. If the insurance activities do not represent a substantial part of the organization's activities, then the organization is entitled to tax exempt status and the insurance activities will be treated as an unrelated trade or business activity under section 501(m)(2)(A). In addition, this unrelated business income derived by the organization is subject to tax under the insurance company provisions of Subchapter L, rather than the unrelated business income tax provisions of section 511.

You are not providing commercial-type insurance since other organizations or individuals are shifting no risk to you. See Helvering v. LeGierse, supra. By performing the services pursuant to the contracts with the Plans and subcontracts with the Provider Groups on a capitated basis, you are not protecting any other organizations or individuals involved in the programs from economic loss arising from the programs.

Further, you are not providing commercial-type insurance since you are contracting to provide medical services on a capitated basis rather than commercial insurance. See Rev. Rul. 68-27, supra. The negotiated rates shift substantially all of the risk of the contract and the capitation arrangements to the providers (the hospitals, primary care physicians and specialists). Therefore, since you are not providing commercial-type insurance, the provisions of section 501(m) of the Code do not apply to you in this instance.

Your agreement with the Plans to provide necessary medical and hospital care to members enrolled in the Plans is substantially related to your exempt purpose of promoting health. You are distinguishable from the organizations described in Rev. Ruls. 85-110 and 86-98, supra, primarily because you provide direct health care through the primary care physicians employed by your exempt affiliate providers. Further, unlike the organization in Rev. Rul. 86-98, you do not serve as a collective bargaining representative between member physicians and HMOs.

Therefore, you are not conducting an unrelated trade or business through your

contracts with the Plans. See section 1.513-1(d)(1) of the regulations. The contracts with the Plans are substantially related to your tax exempt purpose and do not result in unrelated business income under sections 511 through 513 to you.

CONCLUSION

Accordingly, based on all the facts and circumstances described above, we rule as follows:

1. The Capitation Agreements and Subcapitation Agreements, including: (a) the global capitation agreements entered into between you or D and F, G, A, B, and C; (b) the subordinated capitation agreements between you or D and your affiliated providers; and (c) the discounted fee-for-service agreements with unrelated health care providers for services provided outside your geographic area and outside your specialized medical service capabilities will not adversely affect your section 501(c)(3) tax exempt status or your public charity status under section 509(a)(3).

2. The Capitation Agreements and Subcapitation Agreements, including: (a) the global capitation agreements entered into between you or D and F, G, A, B, and C; (b) the subordinated capitation agreements between you or D and your affiliated providers; and (c) the discounted fee-for-service agreements with unrelated health care providers for services provided outside your geographic area and outside your specialized medical service capabilities will not result in unrelated business income under sections 511 through 514 or under section 501(m) to you.

This ruling is based on the understanding that there will be no material change in the facts upon which it is based. Any changes that may have a bearing on your tax status should be reported to the Service. This ruling does not address the applicability of any section of the Code or regulations to the facts submitted other than with respect to the sections described.

This ruling is directed only to the organization that requested it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

If you have any questions about this ruling, please contact the person whose name and telephone number are shown in the heading of this letter. Because this letter could help resolve future questions about your income tax responsibility, please keep a copy of this ruling in your permanent records.

We have sent a copy of this letter to your authorized representative as indicated in your power of attorney.

Sincerely,

(signed) Marvin Friedlander

Marvin Friedlander
Manager, Exempt Organizations
Technical Group 1

255