DESCRIPTION AND ANALYSIS OF PROVISIONS IN THE HEALTH SECURITY ACT (H.R. 3600) RELATING TO THE TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES AND RELATED ORGANIZATIONS

Scheduled for a Hearing

Before the

SUBCOMMITTEE ON SELECT REVENUE MEASURES

of the

HOUSE COMMITTEE ON WAYS AND MEANS

on December 14, 1993

Prepared by the Staff

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JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The Subcommittee on Select Revenue Measure of the House Committee on Ways and Means has scheduled public hearings on selected tax provisions in the Administration's proposed Health Security Act (H.R. 3600). The first of these hearings is scheduled for December 14, 1993, and will focus on the tax treatment of health care organizations. Additional days of hearings on other tax provisions will be announced at a later date.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law and a description and analysis of the provisions of H.R. 3600 relating to the tax treatment of health care organizations and related organizations (subtitle F of Title VII of the bill).

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[1] This document may be cited as follows: Joint Committee on Taxation, Description and Analysis of Provisions in the Health Security Act (H.R. 3600) Relating to the Tax Treatment of Organizations Providing Health Care Services and Related Organizations (JCX-15-93), December 13, 1993.

DESCRIPTION AND ANALYSIS OF PROVISIONS

Tax Treatment of Organizations Providing Health Care Services and Related Organizations (secs. 7601-7603 of the bill and secs. 501, 509 and 833 of the Code)

Background and Present Law

Tax-exempt organizations generally

Code section 501(a) provides that certain organizations listed in sections 501(c) and (d) are exempt from Federal income tax. Among the organizations listed in section 501(c) are those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual (sec. 501(c)(3)), and civic leagues and organizations not organized for profit which are operated exclusively for the promotion of social welfare (section 501(c)(4)).

Charitable organizations described in section 501(c)(3) are classified either as public charities or private foundations. In general, an organization will be classified as a public charity if it (1) receives significant support (generally more than one third) in the form of contributions from the general public or (2) is a church, school or hospital. In addition, section 509(a)(3) provides that public charities include certain "support" organizations which are organized and operated exclusively to benefit one or more specified public or publicly supported charitable organizations. Public charities are not subject to the special rules applicable to private foundations, such as a prohibition against self-dealing and tax on net investment income, and contributions to public charities are subject to more liberal deduction rules than are contributions to private foundations.

Charitable organizations exempt under section 501(c)(3) receive four major tax benefits: (1) exemption from Federal income tax; (2) ability to accept tax-deductible contributions; (3) ability to benefit from tax-exempt financing; and (4) exemption from certain State and local taxes.[2] In contrast, social welfare organizations exempt from Federal income tax under section 501(c)(4) cannot accept tax-deductible contributions or use tax-exempt financing, and generally are not exempt from State

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[2] The extent to which an organization is eligible for exemption from State and local taxes depends on the laws of the local jurisdiction; while local exemption is frequently conditioned upon Federal exempt status, it does not flow automatically from such status.

and local taxes.

Hospitals as tax-exempt entities

Although Code section 501(c)(3) does not specifically mention furnishing medical care and operating a not-for-profit hospital, such activities have long been considered to further charitable purposes.[3] However, the mere provision of not-for-profit medical care is not, by itself, sufficient to allow an organization to qualify for exemption under section 501(c)(3). Rather, an organization must demonstrate that its activities are targeted to a charitable class. The precise nature of that charitable class has been and continues to be a source of controversy.

In 1956, the Internal Revenue Service (IRS) issued Revenue Ruling 56-185, 1956-1 C.B. 202, setting forth the conditions that a not-for-profit hospital must satisfy to qualify for recognition as a tax-exempt charitable organization under section 501(c)(3). The IRS ruled that a hospital would be exempt if it met the following four conditions: (1) it must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick; (2) it must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay; (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual (this last requirement merely restated a restriction generally applicable to all organizations under section 501(c)(3)).

With respect to the "financial ability" requirement, the IRS noted that:

> The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the

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[3] Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may also qualify for exemption as "educational organizations" because they are organized and operated primarily for medical education purposes.

> expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Three years after publication of Revenue Ruling 56-185, the Treasury Department significantly revised its regulations interpreting section 501(c)(3). The amended regulations provided that:

> The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions.[4]

Relying upon the amended regulations, the IRS issued Revenue Ruling 69-545, 1969-2 C.B. 117, which considered whether two nonprofit hospitals qualified for Federal tax exemption. In establishing the so-called "community benefit" standard, the IRS noted that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." The IRS specifically modified Revenue Ruling 56-185 to eliminate the requirement relating to caring for patients without charge or at rates below cost.

The "community benefit" standard, which remains the principal standard applied by the IRS today, focuses on a number of factors which indicate that the operation of a hospital benefits the community rather than serving private interests. In Revenue Ruling 69-545, the IRS determined that the standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement.[5] The hospital

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[4] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[5] In Rev. Rul. 83-157, 1983-2 C.B. 94, the IRS clarified that the operation of an emergency room was not a prerequisite for hospital exemption, if a State health planning agency made an independent determination that the operation of an emergency room would be unnecessary and duplicative, and provided that other factors set forth in Rev. Rul. 69-545 were present indicating that

also had a board of directors drawn from the community, an open medical staff policy, treated persons paying their bills with the aid of public programs (such as Medicare and Medicaid), and applied any surplus receipts to improving facilities, equipment, patient care, and medical training, education and research.

The community benefit standard was challenged in a class action by various health and welfare organizations and several private citizens on the grounds that it failed adequately to identify a charitable class. In Eastern Kentucky Welfare Rights Organization v. Simon, 370 F. Supp. 325, 338 (D.D.C. 1973), a Federal District Court sustained the challenge, and concluded that Congress intended to restrict the term charitable to its narrow sense of relief of the poor. The United States Court of Appeals reversed the District Court, however, and upheld the IRS' broader interpretation of "charitable" reflected in Revenue Ruling 69-545.[6] The Court of Appeals explained that the term "charitable" is "capable of a definition far broader than merely the relief of the poor." The Court also noted that the community benefit standard did not supplant the "financial ability" requirement of Revenue Ruling 56-185, but rather represented an alternative method whereby a not-for-profit hospital could qualify as a tax-exempt charitable organization.

Health maintenance organizations (HMOs) as tax-exempt entities

The same community benefit standard for determining whether a hospital is a tax-exempt charitable organization applies in determining whether a health maintenance organization ("HMO") qualifies for tax-exempt status under section 501(c)(3). In this context, the IRS has developed a fairly comprehensive list of characteristics that distinguish tax-exempt charitable HMOs from other HMOs. Although an HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section 501(c)(3), its activities must generally satisfy a community benefit standard similar to, but less exacting than, that imposed on charitable HMOs.[7]

In general, HMOs represent one form of managed health care delivery organization. Although there is case law regarding the

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the hospital promoted the health of a class of persons broad enough to benefit the community.

[6] Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976).

[7] See GCM 39829 (August 30, 1990) which reviews the IRS' position regarding HMOs and considers the extent to which HMOs customarily act as providers of health services or insurance.

tax treatment of HMOs, the Code does not define an HMO.[8] In general, HMOs have structured their delivery of medical care in accordance with four basic models: (1) a "staff model" HMO employs its own doctors and staff and serves its members at its own central location; (2) a "group model" HMO contracts with an existing group of physicians to perform services at the HMO's central location; (3) an "IPA model" HMO contracts with physicians, often through an individual practice association ("IPA"), to provide care to HMO members at the physicians' own offices; and (4) a "network model" HMO provides care to its members through a network of independent medical groups.[9]

The IRS initially took the position that, while HMOs could qualify for tax-exempt status as social welfare organizations under section 501(c)(4), they could not qualify as charitable organizations under section 501(c)(3) because the preferential treatment provided to members/subscribers represented private, rather than public, benefit. However, the United States Tax Court rejected this position in Sound Health Association v. Commissioner, 71 T.C. 158 (1978). The Court held that the programs and facilities of the staff model HMO benefited the community because its membership class was so open as to be practically unlimited; where possible membership is so broad, benefit to the membership constitutes benefit to the community.

In response to the Sound Health Association decision, the IRS issued several GCMs identifying certain factors which differentiate HMOs exempt under section 501(c)(3) from other HMOs.[10] In GCM 39828 (August 30, 1990), for example, the IRS stated that the characteristics of an HMO eligible for tax-

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[8] Both State and Federal law regulate the operation of HMOs. For Federal purposes, the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, codified as amended at 42 U.S.C. 300e - 300e17, defines a health maintenance organization and prescribes the manner in which such organizations must be organized and provide health services to be qualified under the Act and eligible for certain Federal developmental loans, grants and guarantees. In GCM 39829, the IRS suggested that an HMO's qualification under the Act could be considered as evidence of community benefit, noting that the Act imposes requirements in the areas of quality assurance, community rating and continuation of coverage that tend to suggest that the HMO's operations would benefit the community.

[9] See GCM 39829 (August 30, 1990).

[10] Although general counsel memoranda may not be relied upon as precedent, these documents are made public under section 6110 of the Code and may be indicative of the IRS' position on particular issues.

exemption under section 501(c)(3) include: actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by Medicare, Medicaid or other similar assistance programs; emergency room facilities available to the community without regard to their ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health research programs; health care providers who are paid on a fixed-fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs. The IRS noted, however, that these factors are not all-inclusive, nor is the absence of any one determinative of the lack of a charitable operation.[11]

More recently, in Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993), the Court of Appeals for the Third Circuit applied the factors set forth in Sound Health Association and held that Geisinger Health Plan (GHP), a network model HMO, did not qualify for tax-exempt status under section 501(c)(3) because its activities did not primarily benefit the community. GHP did not provide any health services directly, but contracted to provide health services with other health care providers (which typically were other entities related to GHP). In addition, the Court noted that operating a subsidized dues program for 35 otherwise medically underserved individuals did not benefit the community sufficiently to overcome GHP's primary purpose of providing benefits only to its members.[12]

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[11] See, e.g., GCM 38735 (May 29, 1981) (concluding that staff model HMOs that have truly open membership, directly provide services to members and nonmembers, maintain an open emergency room, and treat patients regardless of ability to pay may be exempt under section 501(c)(3)); and GCM 39057 (Nov. 9, 1983) (ruling that an IPA model HMO which arranged for health care services through an affiliated, physician-owned IPA that controlled the HMO does not qualify for exemption under section 501(c)(3)). In GCM 39057, the IRS explicitly expressed no opinion as to whether the HMO in question could qualify for exemption under section 501(c)(4).

[12] The Court of Appeals remanded the case to the Tax Court for a determination of whether GHP could qualify for 501(c)(3) status as an "integral part" of an exempt organization. The integral part theory set forth in Treas. Reg. sec. 1.502-1(b) provides generally that an organization is entitled to exemption as an integral part of a tax-exempt affiliate if its activities are carried out under the supervision or control of an exempt organization and could be carried out by the exempt organization without constituting an unrelated trade or business. The Tax Court noted that a taxpayer may qualify for exemption under the integral

HMOs as taxable entities

In fact, the majority of HMOs are not organized as tax-exempt entities. At the beginning of 1990, there were 575 HMOs nationwide, approximately two-thirds of which were organized and operated as taxable, for-profit businesses.[13] The primary issue for such taxable HMOs concerns their ability to deduct additions to reserves established out of premium payments to cover accrued liabilities (so-called "incurred but not reported" or "IBNR" claims). In general, accrual method taxpayers are not entitled to deduct expenses until all events necessary to fix and determine the taxpayer's obligation have occurred (the "all events" test). In addition, section 461(h) imposes an economic performance requirement which, in general, postpones deductions until payment.

Property and casualty insurance companies are entitled to deduct IBNR reserves without regard to the "all events" test or the economic performance requirement. Such reserve deductions are, however, subject to certain limitations. For example, reserve deductions by an insurance company must be discounted on a pre-tax basis to take account partially of the time value of money, and unearned premium reserve deductions must be reduced by 20 percent.[14] Thus, the tax treatment of a taxable HMO depends largely on the extent to which it qualifies as an insurance company.[15]

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part theory if the taxpayer performs an essential service directly to its affiliates, but not if it provides such services to unrelated organizations. Alternatively, the taxpayer may provide services on behalf of its exempt affiliates directly to the class of charitable beneficiaries of such affiliates. The Tax Court concluded GHP did not qualify for tax-exempt status under the integral part theory. Geisinger Health Plan v. Commissioner, 100 T.C. No. 26, filed May 3, 1993.

[13] See, T.J. Sullivan, "The Tax Status of Nonprofit HMOs After Section 501(m)", Tax Notes, January 7, 1991.

[14] Present law also provides that property and casualty insurance companies are eligible for exemption from Federal income tax if their net written premiums or direct written premiums (whichever is greater) do not exceed $350,000; and further provides that a company with such premiums in excess of $350,000 but less than $1.2 million may elect to be taxed only on taxable investment income (and thus, generally to exclude underwriting income from tax) (sec. 501(c)(15)).

[15] Under Treas. Reg. sec. 1.801-3(a), to constitute an "insurance company," a company must be one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsurance of risks underwritten by

Insurance activities of tax-exempt organizations

Under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance. Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies, subject to certain exceptions. For example, commercial-type insurance does not include insurance provided at substantially below cost to a class of charitable recipients. In addition, section 501(m)(3)(B) provides that commercial-type insurance does not include incidental health insurance provided by an HMO, of a kind customarily provided by an HMO.[16]

Special rules applicable to certain taxable insurance companies

When section 501(m) was enacted in 1986, special rules were added to benefit certain organizations that no longer qualified as tax-exempt organizations and became subject to tax as insurance companies under subchapter L. Section 833, enacted concurrently with section 501(m), provides special relief for Blue Cross and Blue Shield organizations existing on August 16, 1986, which were exempt from tax for their last taxable year beginning before January 1, 1987, and which have experienced no material change in their structure or operations since August 16, 1986. In addition, section 833 provides special relief for certain other organizations, substantially all of the activities of which involve the provision of health insurance, that meet certain community-service-related requirements.[17]

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insurance companies.

[16] See GCM 39829 (August 30, 1990) for a discussion of the legislative history of the enactment of section 501(m) and the HMO exception in section 501(m)(3)(B).

[17] These community service requirements are: (1) substantially all the activities of the organization involve providing health insurance; (2) at least 10 percent of the health insurance is provided to individuals and small groups (not taking into account medicare supplemental coverage); (3) the organization provides continuous full-year open enrollment (including conversions) for individuals and small groups; (4) the policies covering individuals provide full coverage of pre-existing conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is without regard to age, income, or employment status of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

Section 833 provides three special rules for organizations within its scope. First, eligible organizations are treated as stock insurance companies. Second, section 833 exempts eligible organizations from the rule (referred to above) that is generally applicable to property and casualty insurance companies, requiring a 20-percent reduction in the amount a company can deduct for any increase in unearned premium reserves.[18] Thus, eligible organizations are not required to reduce the deduction for increases in unearned premium reserves. Third, eligible organizations are entitled to claim a special deduction with respect to their health business in an amount equal to 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

The transition rules in section 833 provide that no adjustment was to be made on account of a change in such an organization's method of accounting for its first taxable year beginning after that date. The transition rules also provide that, for purposes of determining gain or loss, the adjusted basis of any asset of such an organization held on the first day of the taxable year beginning after December 31, 1986, was treated as equal to its fair market value as of such day. Rules were also provided to limit adjustments to surplus that could affect the amount of the special deduction, and to treat reserve weakening after August 16, 1986, as occurring in the organization's first year as a taxable organization.[19]

Description of Provisions

Tax-exempt status of hospitals, HMOs, certain parent organizations and regional alliances

The bill would establish certain new requirements applicable to nonprofit health care providers (hospitals and HMOs) seeking

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[18] The 20-percent reduction requirement was added by the 1986 Act, effective for taxable years beginning after December 31, 1986. The 1986 Act also required the inclusion in income ratably, over the ensuing six-year period, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1987. The inclusion was required at the rate of 3-1/3 percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1986.

[19] Because increases in reserves are generally deductible by a taxable insurer, a reduction in reserves (so-called "reserve weakening") immediately prior to the time a tax-exempt organization becomes a taxable insurer could allow the organization to claim a bigger deduction than it would otherwise be entitled to after it becomes taxable.

to qualify as tax-exempt charitable organizations under section 501(c)(3).

In particular, the bill would amend the Code specifically to require that, in order for the provision of health care services to constitute a charitable activity for purposes of section 501(c)(3), the organization providing such services must periodically assess the health care needs of its community and develop a plan to meet those needs. Such assessment and plan development must take place at least annually and must include the participation of community representatives.

In addition, the bill would provide that an HMO seeking tax-exempt status under section 501(c)(3) must furnish health care services to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

The bill would further provide that organizations which serve as parent holding companies for hospitals or medical research organizations constitute public charities rather than private foundations. Thus, the bill would add to the list of organizations described in section 509(a) any organization which is organized and operated for the benefit of, and which directly or indirectly controls, (1) a hospital, the principal purpose or function of which is the provision of medical or hospital care or medical education or medical research; or (2) a medical research organization if such organization is directly engaged in the continuous active conduct of medical research in conjunction with a hospital and, during the calendar year in which the contribution is made, such organization is committed to spend such contribution for medical research not later than the beginning of the fifth calendar year beginning after the date such contribution is made.

Finally, section 7603 of the bill would add the to-be-established regional alliances described in section 1301 of the bill to the list of tax-exempt organizations set forth in Code section 501(c).

Effective date.--The provisions regarding the definition of charitable activities of medical service providers and HMOs would be effective January 1, 1995. The provision regarding the exempt status of regional alliances would apply to taxable years beginning after the date of enactment, and the provision regarding the treatment of parent organizations of health care providers would take effect on the date of enactment.

Insurance activities of tax-exempt organizations

Under the bill, health insurance provided by an HMO would be treated as commercial-type insurance if such insurance relates to

care which is not provided pursuant to a pre-existing arrangement between the HMO and a health care provider (other than emergency care provided to a member of such organization at a location outside such member's area of residence). Under this rule, commercial-type insurance would include plans under which an HMO member can select any health-care provider, the HMO pays a portion of the costs of such provider, and the member is obligated to pay the remaining portion. Such arrangements are commonly referred to as providing "point of service" or "fee-for-service" benefits (i.e., the member decides which medical provider to use at the point at which service is required). However, the provision of emergency care, even if on a point of service basis, to HMO members outside their area of residence would not constitute commercial-type insurance.

The bill would specifically identify four types of health insurance provided by an HMO that would not be treated as commercial-type insurance and, thus, would not jeopardize the organization's tax-exempt status. Such non-commercial-type health insurance coverages generally address emergency situations and situations in which a health care provider has a pre-existing relationship with an HMO whereby the HMO exerts control over either the fee charged by the service provider or the member's use of such provider's services.

First, insurance relating to care provided by an HMO to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such HMO would not constitute commercial-type insurance. Such arrangements are characteristic of "staff model" or "group model" HMOs which hire health care providers (as employees or independent contractors) to provide services to members on an exclusive basis.

Second, insurance relating to primary care provided by a health care professional to a member of an HMO on a basis under which the amount paid to such professional does not vary with the amount of care provided to such member would not constitute commercial-type insurance. This rule addresses situations in which an HMO pays health care providers on a "fixed" or "capitated" basis for primary care services rendered to members. Although such fees may be based on the number of members served by such provider, they may not be based on the extent of services provided to a member.

Third, insurance which relates to the provision of services other than primary care, if provided pursuant to a pre-existing arrangement with an HMO, would not be commercial-type insurance. This exception is intended to address situations in which an HMO member is referred by his or her primary care provider to a specialist who is a member of an HMO's so-called "provider network," even if the amount paid to the specialist varies with

the amount of care provided. Unlike the "point of service" situation described above, the HMO in these cases, rather than the member, controls the decision regarding the appropriate health care provider.

Fourth, insurance relating to emergency care provided to a member of an HMO at a location outside such member's area of residence would not constitute commercial-type insurance. This exception would apply, for example, when an HMO reimburses health care providers for the provision of emergency care to HMO members, outside of their area of residence, irrespective of whether such providers have a pre-existing arrangement with the HMO.

Effective date.--These provisions would be effective on the date of enactment.

Definition of taxable property and casualty insurance companies

In general, the bill would redefine the scope of organizations treated as taxable property and casualty insurance companies. Under the bill, any organization that is not tax-exempt, is not a life insurance company, and whose primary and predominant business activity during the taxable year falls in one of three categories, would be treated as a property and casualty insurance company. The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements to provide or arrange for the provision of health care services in exchange for fixed payments or premiums that do not vary depending on the amount of health care services provided. The bill would modify the "primary and predominant" requirement in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts would be treated as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

Effective date.--This provision would be effective for taxable years beginning after December 31, 1996.

Special rules applicable to certain taxable insurance companies

The bill would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organizations and other eligible organizations, and would provide transition rules for organizations that become subject to section 833 after the effective date (generally, taxable years beginning after December 31, 1996). The provision would treat such organizations as insurance companies, but would not specify that such

organizations be treated as stock companies.

The bill would repeal the special exception to the 20-percent reduction with respect to unearned premium reserves. The bill would require inclusion in income ratably, over a six-year period following the effective date, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1997. The inclusion would be required at the rate of 3-1/3 percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1996.

The bill would also repeal the special deduction for 25 percent of claims. A special phase-out rule would apply to an organization that meets the community-service-related requirements of present law for each of its taxable years beginning in 1995 and 1996. For such organizations, the deduction would be phased out at a specified rate over the organization's first two years following the effective date; 67 percent of the otherwise allowable amount of the special deduction would be allowed for such an organization's taxable year beginning in 1997, and 33 percent would be allowed for its taxable year beginning in 1998. As under present law, the deduction would not be allowable during the phase-out period in determining the organization's alternative minimum taxable income.

The bill would provide transition rules for organizations that become subject to section 833, as amended, after the effective date (generally, taxable years beginning after December 31, 1996). For an organization that is not tax-exempt for its last taxable year beginning before January 1, 1997 (and is taxed other than under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996), the amendments to section 833 would be treated as a change in method of accounting, and all adjustments required to be taken into account under section 481 would be taken into account in one taxable year, i.e., the company's first taxable year beginning after December 31, 1996. No special transition rule would apply to organizations that treat themselves as subject to tax under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996.

For an organization that is tax-exempt for its last taxable year beginning before January 1, 1997, no adjustment would be taken into account under section 481 or any other provision for the company's first taxable year beginning after December 31, 1996, on account of a change in method of accounting required by the amendments to section 833. In addition, for purposes of determining gain or loss, the adjusted basis of any asset held by such an organization on the first day of its first taxable year beginning after December 31, 1996, would be deemed equal to the

fair market value of the asset on that date.

The bill would also specify that the above amendments do not affect the adjusted basis of any asset determined under the transition rule provided for existing Blue Cross and Blue Shield organizations in the 1986 Act (i.e., generally, that basis equalled fair market value as of the first day of the organization's taxable year beginning after December 31, 1986). In addition, the bill would eliminate the requirement that existing Blue Cross and Blue Shield organizations not experience any material change in their operations or structure to be eligible for the basis adjustment, and would further provide that, on January 1, 1997, such basis adjustment is made permanent.

Effective date.--These provisions would generally be effective for taxable years beginning after December 31, 1996, subject to the special income inclusion rule (with respect to the repeal of the 20 percent reduction), the phase-out rule for certain organizations (with respect to the repeal of the special deduction for 25 percent of claims), and the transition rules described above.

Discussion of Issues

Tax-exempt status of certain organizations

In general, tax exemption is a form of subsidy administered through the tax system (sometimes referred to as a "tax expenditure"). It is granted to, among other organizations, certain private organizations that conduct activities which Congress deems to further worthy public objectives.

As a threshold matter, it is important to assess whether the subsidization of the operation of hospitals and HMOs, as well as regional health alliances, through tax expenditures, rather than through direct outlays or other means of finance, is appropriate. In general, such subsidization means that the true cost of such activities appears understated in relation to the cost of other goods and services because they do not appear as outlays in budget reporting. In addition, such tax expenditures are not subject to the annual appropriations process.

The desirability of tax exemption also must be evaluated in the context of the overall health care proposal. As described above, under present law, the provision of medical care and operation of a nonprofit hospital in a manner that satisfies the "community benefit" standard is considered to further "charitable" objectives. Although this community benefit standard evolved in response to the expanded Federal role in health care financing through programs such as Medicare and Medicaid, payment for medical care remained largely the province

of the private sector.

The system of universal health care coverage envisioned under the bill represents a significant quantitative, and perhaps also qualitative, expansion of Federal participation in financing health care. Accordingly, it may be appropriate to reexamine the circumstances under which the provision of medical care would constitute a charitable function in such a system. Presumably, teaching institutions could continue to be eligible for tax exemption as educational organizations. However, if all Americans have access to health care, what other, if any, activities distinguish a nonprofit from a for-profit health care provider? For example, would nonprofit hospitals provide charity care where gaps exist in the system of universal coverage?

These questions are particularly apt in light of the significant financial benefits for which charitable organizations are eligible. It is not clear, for example, that allowing such organizations continued access to tax-exempt financing is appropriate in a system in which the Federal Government provides considerable direct subsidies (for example, the Federal payments to alliances outlined in Title IX, Subtitle B of the bill). With respect to regional and corporate health alliances, section 7902 of the bill would provide that regional and corporate health alliances be treated as private businesses that are not eligible for tax-exempt financing. This raises the further question of why such alliances should be treated differently than other medical service providers exempt under section 501(c)(3).

Finally, it is not clear whether the community needs assessment and plan development requirements set forth in the bill are intended to replace or supplement present-law standards for exemption. In addition, the scope of organizations subject to the requirements is unclear. The bill states that the requirements apply to hospitals, HMOs and "other entities providing health care services." A wide variety of organizations exempt under section 501(c)(3) provide an equally wide range of health care services. For example, a half-way house for alcoholics, a blood bank, a childbirth education organization, a clinic to aid drug victims, an organization that provides home health care, homes for the elderly, and nursing homes all have qualified for exemption under section 501(c)(3). Do the community needs assessment and plan development requirements apply to all of these organizations, as well as to hospitals and HMOs?

Insurance activities of tax-exempt organizations

Similarly, it may be appropriate to reexamine the characterization of certain forms of insurance provided by HMOs as commercial- or non-commercial-type insurance. The bill generally appears to codify positions developed by the IRS with

respect to various payment arrangements established by HMOs under a health care system very different from the one proposed in the bill.

In addition, the provisions regarding characterizing insurance arrangements as commercial or non-commercial appear somewhat inconsistent with other provisions of the proposed health plan. For example, the bill would characterize "point of service" or "fee-for-service" plans offered by HMOs as commercial-type insurance. However, section 1402(d) of the bill would require certain health plans (e.g., those that offer enrollees the lower cost sharing schedule described in section 1132 of the bill) to offer fee-for-service coverage. If participants elect such coverage to the extent that it constitutes a substantial portion of such HMO's activities, the HMO could lose its tax-exempt status.

Definition of taxable property and casualty insurance companies

The bill would expand the definition of taxable property and casualty insurance companies to include organizations that are not tax-exempt, are not life insurance companies, and that meet one of three tests. The first is insurance or reinsurance of accident and health risks (a traditional activity of insurance companies). The second is operation as an HMO, and the third appears to encompass arrangements similar to those which an HMO might enter into, whether or not it purports to be an HMO (i.e., arrangements to receive fixed payments as consideration for providing or arranging to provide health care services, regardless of the amount of health care services provided). Thus, the bill would treat taxable HMOs and taxable organizations that operate like HMOs as property and casualty insurance companies.

However, it is not self-evident that all taxable HMOs should be taxed as property and casualty insurance companies. The underlying presumption appears to be that if an HMO is not tax-exempt, its activities involve the provision of insurance services as opposed to medical services. This presumption is based on what traditionally has been a key distinction between HMOs and hospitals; HMOs deliver prepaid benefits whereas hospitals are paid on a fee-for-service basis.

Several issues are raised in determining whether a taxable HMO (for example, an HMO that is not tax-exempt because it is organized on a for-profit basis) sufficiently resembles a property and casualty insurance company to be taxed as one. One is whether deductions for reserves are appropriate to the operation of an organization that directly provides medical care.

A central issue in determining whether an HMO should be taxed as a property and casualty insurer is the method of

accounting for premium payments received. In general, property and casualty insurance companies are entitled to deduct increases in reserves which affect premium income. Organizations that are not insurance companies, by contrast, are not entitled to deduct increases in reserves but rather, generally account for deductions in accordance with the all events test and the rules for determining when economic performance has occurred. The allowance of a deduction for Federal income tax purposes with respect to reserves of property and casualty insurance companies generally reflects the fact that payments (premium income) are generally received in a taxable year earlier than the year in which the loss is incurred or paid.

If an HMO receives payments that resemble the premiums received by insurance companies in these respects, it appears appropriate to tax them under the regime applicable to property and casualty insurance companies. On the other hand, if an HMO receives prepayments for medical services it directly provides, reserve deductions are arguably inappropriate, and the organization should not be treated as a property and casualty insurance company. Because the manner of organization and operation of HMOs varies and may change rapidly with business trends, consideration should be given to whether one rule is appropriate for all taxable HMOs. On the other hand, it may not be administratively feasible to distinguish among types of payments received by HMOs.

With respect to treatment of reserves, some taxable HMOs take the position that they are subject to taxation as property and casualty insurance companies. Others, however, may take the position that, although they may be subject to State regulation and financial reporting requirements as insurance companies, they are not taxable as property and casualty insurers. Such organizations nevertheless may claim tax deductions for reserves on the theory that the risk of loss has shifted to them. These organizations may argue that, because they are not taxable as property and casualty insurers, they are not subject to the limitations on reserve deductions imposed on property and casualty insurance companies. Thus, as a practical matter, the regime prescribed under the bill may represent a significant change only for taxable HMOs that take the position that they are not taxable as property and casualty companies.

An additional issue relates to the operation of the property and casualty company tax regime. Treating HMOs as property and casualty insurers could be criticized on the ground that the present-law regime for taxing such entities is flawed in certain respects. For example, present law provides for a pre-tax method of discounting loss reserves of property and casualty insurance companies which only partially takes account of the time value of money. It is arguable whether taxpayers not explicitly subject to this regime should be made explicitly subject to it without

addressing its failure to take account fully of the time value of money. Further, some might assert that the regime of complete or partial tax exemption for small property and casualty companies may not be appropriate for HMOs that fail to qualify for tax-exempt status under 501(c)(3) or 501(c)(4).

As a technical drafting matter, the statutory structure set forth in the bill appears redundant in defining both criteria for tax-exempt status and criteria for taxable status. Rather than simply characterizing all organizations that are not tax-exempt as taxable, the bill would set forth one standard for tax exemption and another, different, standard for taxability. Conceivably, some organizations could fail to meet either set of criteria. In addition, the taxability standards themselves could be criticized as vague. Because neither present law nor the bill defines an HMO, the second standard ("operating as an HMO") is difficult to apply at best.

The bill would also require that the three enumerated activities constitute the primary and predominant business activity of an organization. This standard is similar to a rule set forth in Treasury regulations that describes an insurance company as one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies, and has been variously interpreted in judicial decisions. While the bill does state that administering accident and health insurance contracts is treated as part of the activity of issuing accident and health insurance contracts or reinsuring accident and health risks (for an organization that has issuing such contracts or reinsuring such risks as a material business activity), the bill would not specify the nature and amount of other activities that a company may conduct and still be treated as a property and casualty insurance company. Because this standard does not provide a bright-line test, without further clarification, it could be criticized as an inadequate basis for determining the tax status of an organization.

Finally, because the effective date of this provision would be deferred until taxable years beginning after 1996, additional rules may be needed to forestall opportunities for manipulation of accounting items for organizations that become taxable under the bill (or whose accounting method is changed) and, thus, become subject to the provision. For example, the bill does not contain a rule comparable to that provided in the Tax Reform Act of 1986 (the "1986 Act") to limit reserve weakening by organizations immediately prior to the point at which they become taxable.

Special rules applicable to certain taxable insurance companies

Some might argue that the present-law special rules under Code section 833 (enacted in 1986) for Blue Cross and Blue Shield organizations that became taxable was intended merely to ease the transition from tax-exempt to taxable status and should now be repealed. It could be argued that sufficient time has elapsed since the 1986 Act changed the tax status of these organizations for them to adjust to operation as taxable entities, and that repeal of the special deduction, as provided by the bill, is now appropriate. Others might assert that this purpose was not stated in the legislative history, and, in fact, the provision was not temporary when enacted.