BACKGROUND AND PRESENT LAW RELATING TO QUALIFIED NONPROFIT HEALTH INSURANCE ISSUERS ESTABLISHED PURSUANT TO SECTION 1322 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Scheduled for a Public Hearing
Before the
SENATE COMMITTEE ON FINANCE
on January 21, 2016

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

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INTRODUCTION AND SUMMARY

The Committee on Finance of the United States Senate has scheduled a public hearing on January 21, 2016, on qualified nonprofit health insurance issuers (sometimes referred to as "healthcare co-ops") established pursuant to section 1322 of the Patient Protection and Affordable Care Act. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides background and a description of present law relating to the tax treatment of such organizations.

[1] This document may be cited as follows: *Joint Committee on Taxation, Present Law Relating to Qualified Nonprofit Health Insurance Issuers Established Pursuant to Section 1322 of the Patient Protection and Affordable Care Act* (JCX-2-16), January 19, 2016. This document can also be found on the Joint Committee on Taxation website at www.jct.gov.

I. BACKGROUND AND PRESENT LAW RELATING TO QUALIFIED NONPROFIT HEALTH INSURANCE ISSUERS

Background

Section 1322 of the Patient Protection and Affordable Care Act ("PPACA")[2] authorized funding for, and directed the Secretary of Health and Human Services ("HHS") to establish, the Consumer Operated and Oriented Plan (the "CO-OP program") to foster the creation of nonprofit, member-run health insurance issuers that offer qualified health plans in the individual and small group markets in certain States. Under section 501(c)(29), as enacted under PPACA, a health insurer that receives a grant or loan under the CO-OP program generally qualifies for exemption from Federal income tax for periods during which the organization is in compliance with the requirements of the CO-OP program and with the terms of any such grant or loan agreement to which the organization is a party.

Present Law

Taxation of insurance companies

Taxation of stock and mutual companies providing health insurance

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Both mutual insurance companies and stock insurance companies are subject to Federal income tax under these rules. Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property and casualty insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[3]

Life insurance companies

A life insurance company, whether stock or mutual, is taxed at regular corporate rates on its life insurance company taxable income ("LICTI"). LICTI is life insurance gross income reduced by life insurance deductions.[4] Life insurance gross income is the sum of (1) premiums,

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[2] Pub. L. No. 111-148 (March 23, 2010). Many provisions of PPACA were amended by the Health Care and Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152 (March 30, 2010). PPACA and HCERA are often referred to collectively as the "Affordable Care Act" or the "ACA."

[3] Sec. 816(a).

[4] Sec. 801.

(2) decreases in reserves, and (3) other amounts generally includible by a taxpayer in gross income. Methods for determining reserves for Federal income tax purposes generally are based on reserves prescribed by the National Association of Insurance Commissioners for purposes of financial reporting under State regulatory rules.

Because deductible reserves might be viewed as being funded proportionately out of taxable and tax-exempt income, the net increase and net decrease in reserves are computed by reducing the ending balance of the reserve items by a portion of tax-exempt interest (known as a proration rule).[5] Similarly, a life insurance company is allowed a dividends-received deduction for intercorporate dividends from nonaffiliates only in proportion to the company's share of such dividends.[6]

Property and casualty insurance companies

The taxable income of a property and casualty insurance company is determined as the sum of the amount earned from underwriting income and from investment income (as well as gains and other income items), reduced by allowable deductions.[7] For this purpose, underwriting income and investment income are computed on the basis of the underwriting and investment exhibit of the annual statement approved by the National Association of Insurance Commissioners.[8]

Underwriting income means premiums earned during the taxable year less losses incurred and expenses incurred.[9] Losses incurred include certain unpaid losses (reported losses that have not been paid, estimates of losses incurred but not reported, resisted claims, and unpaid loss adjustment expenses). Present law limits the deduction for unpaid losses to the amount of discounted unpaid losses, which are discounted using prescribed discount periods and a prescribed interest rate, to take account partially of the time value of money.[10] Any net decrease in the amount of unpaid losses results in income inclusion, and the amount included is computed on a discounted basis.

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[5] Secs. 807(b)(2)(B) and (b)(1)(B).

[6] Secs. 805(a)(4), 812. Fully deductible dividends from affiliates are excluded from the application of this proration formula (so long as such dividends are not themselves distributions from tax-exempt interest or from dividend income that would not be fully deductible if received directly by the taxpayer). In addition, the proration rule includes in prorated amounts the increase for the taxable year in policy cash values of life insurance policies and annuity and endowment contracts owned by the company (the inside buildup on which is not taxed).

[7] Sec. 832.

[8] Sec. 832(b)(1)(A).

[9] Sec. 832(b)(3). In determining premiums earned, the company deducts from gross premiums the increase in unearned premiums for the year (sec. 832(b)(4)(B)). The company is required to reduce the deduction for increases in unearned premiums by 20 percent, reflecting the matching of deferred expenses to deferred income.

[10] Sec. 846.

In calculating its reserve for losses incurred, a proration rule requires that a property and casualty insurance company must reduce the amount of losses incurred by 15 percent of (1) the insurer's tax-exempt interest, (2) the deductible portion of dividends received (with special rules for dividends from affiliates), and (3) the increase for the taxable year in the cash value of life insurance, endowment, or annuity contracts the company owns.[11] This rule reflects the fact that reserves are generally funded in part from tax-exempt interest, from wholly or partially deductible dividends, or from other untaxed amounts.

Tax exemption for certain organizations

In general

Section 501(a) generally provides for exemption from Federal income tax for certain organizations. These organizations include: (1) qualified pension, profit sharing, and stock bonus plans described in section 401(a); (2) religious and apostolic organizations described in section 501(d); and (3) organizations described in section 501(c). Sections 501(c) describes 29 different categories of exempt organizations, including: charitable organizations (section 501(c)(3)); social welfare organizations (section 501(c)(4)); labor, agricultural, and horticultural organizations (section 501(c)(5)); professional associations (section 501(c)(6)); and social clubs (section 501(c)(7)).[12]

Insurance organizations described in section 501(c)

Although most organizations that engage principally in insurance activities are not exempt from Federal income tax, certain organizations that engage in insurance activities are described in section 501(c) and exempt from tax under section 501(a). Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of

[11] Sec. 832(b)(5).

[12] Certain organizations that operate on a cooperative basis are taxed under special rules set forth in Subchapter T of the Code. The two principal criteria for determining whether an entity is operating on a cooperative basis are: (1) ownership of the cooperative by persons who patronize the cooperative (*e.g.*, the farmer members of a cooperative formed to market the farmers' produce); and (2) return of earnings to patrons in proportion to their patronage. In general, cooperative members are those who participate in the management of the cooperative and who share in patronage capital. For Federal income tax purposes, a cooperative that is taxed under the Subchapter T rules generally computes its income as if it were a taxable corporation, with one exception -- the cooperative may deduct from its taxable income distributions of patronage dividends. In general, patronage dividends are the profits of the cooperative that are rebated to its patrons pursuant to a preexisting obligation of the cooperative to do so. Certain farmers' cooperatives described in section 521 are authorized to deduct not only patronage dividends from patronage sources, but also dividends on capital stock and certain distributions to patrons from nonpatronage sources.

Separate from the Subchapter T rules, the Code provides tax exemption for certain cooperatives. Section 501(c)(12), for example, provides that certain rural electric and telephone cooperative are exempt from tax under section 501(a), provided that 85 percent or more of the cooperative's income consists of amounts collected from members for the sole purpose of meeting losses or expenses, and certain other requirements are met.

life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals.[13] Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

Certain section 501(c)(3) organizations

Certain health maintenance organizations (HMOs) have been held to qualify for tax exemption as charitable organizations described in section 501(c)(3). In *Sound Health Association v. Commissioner*,[14] the Tax Court held that a staff model HMO qualified as a charitable organization. A staff model HMO generally employs its own physicians and staff and serves its subscribers at its own facilities. The court concluded that the HMO satisfied the section 501(c)(3) community benefit standard, as its membership was open to almost all members of the community. Although membership was limited to persons who had the money to pay the fixed premiums, the court held that this was not disqualifying, because the HMO had a subsidized premium program for persons of lesser means to be funded through donations and Medicare and Medicaid payments. The HMO also operated an emergency room open to all persons regardless of income. The court rejected the government's contention that the HMO conferred primarily a private benefit to its subscribers, stating that when the potential membership is such a broad segment of the community, benefit to the membership is benefit to the community.

In *Geisinger Health Plan v. Commissioner*,[15] the court applied the section 501(c)(3) community benefit standard to an individual practice association (IPA) model HMO. In the IPA model, health care generally is provided by physicians practicing independently in their own offices, with the IPA usually contracting on behalf of the physicians with the HMO. Reversing a Tax Court decision, the court held that the HMO did not qualify as charitable because the community benefit standard requires that an HMO be an actual provider of health care rather than merely an arranger or deliverer of health care, which is how the court viewed the IPA model in that case.

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[13] When section 501(c)(26) was enacted in 1996, the House Ways and Means Committee, in reporting out the bill, stated as its reasons for change: "The Committee believes that eliminating the uncertainty concerning the eligibility of certain State health insurance risk pools for tax-exempt status will assist States in providing medical care coverage for their uninsured high-risk residents." H.R. Rep. No. 104-496, Part I, "Health Coverage Availability and Affordability Act of 1996," 104th Cong., 2d Sess., March 25, 1996, 124. See also Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 104th Congress* (JCS-12-96), December 18, 1996, p. 351.

[14] 71 T.C. 158 (1978), *acq.* 1981-2 C.B. 2.

[15] 985 F.2d 1210 (3rd Cir. 1993), *rev'g* T.C. Memo. 1991-649.

More recently, in *IHC Health Plans, Inc. v. Commissioner*,[16] the court ruled that three affiliated HMOs did not operate primarily for the benefit of the community they served. The organizations in the case did not provide health care directly, but provided group insurance that could be used at both affiliated and non-affiliated providers. The court found that the organizations primarily performed a risk-bearing function and provided virtually no free or below-cost health care services. In denying charitable status, the court held that a health-care provider must make its services available to all in the community plus provide additional community or public benefits.[17] The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates.[18]

Certain organizations providing commercial-type insurance

Section 501(m) provides that an organization may not be exempt from tax under section 501(c)(3) (generally, charitable organizations) or section 501(c)(4) (social welfare organizations) unless no substantial part of its activities consists of providing commercial-type insurance. For this purpose, commercial-type insurance excludes, among other things: (1) insurance provided at substantially below cost to a class of charitable recipients; and (2) incidental health insurance provided by an HMO of a kind customarily provided by such organizations.

When section 501(m) was enacted in 1986, the following reasons for the provision were stated: "The committee is concerned that exempt charitable and social welfare organizations that engaged in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax-exempt status is inappropriate. The committee believes that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations. The committee further believes that the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial. In addition, the availability of tax-exempt status . . . has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States. Other tax-exempt charitable and social welfare organizations engaged in insurance activities also have a competitive advantage over commercial insurers who do not have tax-exempt status."[19]

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[16] 325 F.3d 1188 (10th Cir. 2003).

[17] *Ibid.* at 1198.

[18] *Ibid.*

[19] H.R. Rep. No. 99-426, "Tax Reform Act of 1985," Report of the Committee on Ways and Means, 99th Cong., 1st Sess., December 7, 1985, 664. See also Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986* (JCS-10-87), May 4, 1987, p. 584.

Unrelated business income tax

Most organizations that are exempt from tax under section 501(a) are subject to the unrelated business income tax rules of sections 511 through 515. The unrelated business income tax generally applies to income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions. Certain types of income are specifically exempt from the unrelated business income tax, such as dividends, interest, royalties, and certain rents, unless derived from debt-financed property or from certain 50-percent controlled subsidiaries.

Qualified nonprofit health insurance issuers

The Consumer Operated and Oriented Plan

As stated above, section 1322 of PPACA authorizes $6 billion in funding[20] for, and instructs the Secretary of HHS to establish, the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans. Federal funds are to be distributed as loans to assist with start-up costs and grants to assist in meeting State solvency requirements.

The Secretary of HHS must require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary of HHS requiring the recipient of funds to meet and continue to meet any requirement for being treated as a qualified nonprofit health insurance issuer, and any requirements to receive the loan or grant. The agreement must prohibit the use of loan or grant funds for carrying on propaganda or otherwise attempting to influence legislation or for marketing.

If the Secretary of HHS determines that a grant or loan recipient failed to meet the requirements described in the preceding paragraph, and failed to correct such failure within a reasonable period from when the person first knew (or reasonably should have known) of such failure, then such person must repay the Secretary of HHS an amount equal to 110 percent of the aggregate amount of the loans and grants received under the program, plus interest on such amount for the period during which the loans or grants were outstanding. The Secretary of HHS must notify the Secretary of the Treasury of any determination of a failure that results in the termination of the grantee's Federal tax-exempt status.

On December 31, 2011, the Centers for Medicare and Medicaid Services ("CMS"), which is part of HHS, issued final regulations implementing the CO-OP program.[21]

[20] Funding for the CO-OP program subsequently was reduced to $2.4 billion.

[21] 76 C.F.R. 77392.

Requirements for qualified nonprofit health insurance issuers

Section 1322 of PPACA defines a qualified nonprofit health insurance issuer as an organization that meets the following requirements:

1. The organization is organized as a nonprofit, member corporation under State law;

2. Substantially all of its activities consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans;

3. None of the organization, a related entity, or a predecessor of either was a health insurance issuer as of July 16, 2009;

4. The organization is not sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision;

5. Governance of the organization is subject to a majority vote of its members;

6. The organization's governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;

7. The organization must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to its members, in accordance with regulations to be promulgated by the Secretary of HHS;

8. Any profits made must be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members;

9. The organization meets all other requirements that other issuers of qualified health plans are required to meet in any State in which it offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, rules on network adequacy, rate and form filing rules, and any applicable State premium assessments. Additionally, the organization must coordinate with certain other State insurance reforms under PPACA; and

10. The organization does not offer a health plan in a State until that State has in effect (or the Secretary of HHS has implemented for the State), the market reforms required by part A of title XXVII of the Public Health Service Act ("PHSA"), as amended by PPACA.

Tax exemption for qualified nonprofit health insurance issuers

Under section 501(c)(29), as enacted in PPACA, an organization receiving a grant or loan under the program qualifies for exemption from Federal income tax under section 501(a) of the Code with respect to periods during which the organization is in compliance with the above-described requirements of the CO-OP program and with the terms of any CO-OP program grant or loan agreement to which such organization is a party.[22] Such organizations are subject to

[22] Sec. 501(c)(29)(A).

organizational and operational requirements applicable to certain other section 501(c) organizations, including the prohibitions on private inurement and political activities, the limitation on lobbying activities, taxation of excess benefit transactions (section 4958), and taxation of unrelated business taxable income under section 511.[23]

CO-OP program participants are required to file an application for exempt status with the IRS in such manner as the Secretary of the Treasury may require.[24] Treasury regulations provide that an organization may be recognized as an organization described in section 501(c)(29) as of a date prior to the date of an organization's application for exemption if the application complies with requirements prescribed by the Commissioner of the IRS and the organization's purposes and activities prior to submitting the application were consistent with the requirements for exempt status.[25] Consistent with the Treasury regulations, IRS guidance provides that exemption under section 501(c)(29) is usually effective as of the later of the date of the organization's formation or March 23, 2010 (the date of enactment of PPACA) if: (1) the organization's purposes and activities prior to the date of issuance of the determination letter or ruling were consistent with the requirements for exemption; and (2) the organization submits a substantially completed application within 15 months of the date of its fully executed grant or loan agreement with CMS.[26] IRS guidance requires that an organization seeking recognition of exemption under section 501(c)(29) submit a letter application (rather than a form application) together with Form 8718 (User Fee for Exempt Organization Determination Letter Request), and include the appropriate user fee.[27]

A qualified nonprofit health insurance issuer claiming exempt status under section 501(c)(29) that has filed or intends to file an application for exemption must file an annual information return (Form 990, Return of Organization Exempt from Income Tax) with the IRS.[28] Such an organization is required to disclose on its annual information return the amount of reserves required by each State in which it operates and the amount of reserves on hand.[29]

If a qualified nonprofit health insurance issuer does not apply for exempt status or loses its exempt status, it may be subject to Federal income taxation. If a taxable issuer qualifies as an

[23] Sec. 501(c)(29)(B)(ii)-(iv).

[24] Sec. 501(c)(29)(B)(i).

[25] Treas. Reg. sec. 1.501(c)(29)-1(b).

[26] Rev. Proc. 2015-17, sec. 5, 2015-7 I.R.B. 593, February 17, 2015.

[27] *Ibid*., sec. 4.

[28] See IRS Notice 2011-23, sec. 8.

[29] Sec. 6033(m).

insurance company for Federal income tax purposes, it will be taxed under the rules of subchapter L of the Code, as described above.[30]

[30] See IRS Notice 2011-23, sec. 3.