

Audit Technique Guide – Health Maintenance Organizations

Introduction

In our audits of HMOs, we strive to determine whether the organization:

- Qualifies for exemption under either IRC Section 501(c)(3) or IRC Section 501(c)(4) and
- Is precluded from qualifying for exemption by IRC Section 501(m)(1).

We also determine whether any part of the organization's activities is subject to tax under IRC Section 501(m)(2).

Activities of HMOs

HMOs directly provide or arrange health care services to enrollees on a prepaid basis typically through a managed care arrangement. A managed care arrangement describes an HMO that uses its employed and/or contracted primary care providers as "gatekeepers." Enrollees may choose a primary care provider or have one provided to them. Enrollees must obtain a referral from the primary care provider to use:

- inpatient or outpatient hospital services
- specialist physician services
- ancillary health care services.

Direct Provider. A direct provider HMO provides health care services to its enrollees mainly by its employed health care providers at facilities the HMO either owns or leases. This arrangement is sometimes referred to as a "staff model" HMO. An HMO's services may consist of only primary care or may also include:

- specialists
- hospitalization - inpatient and outpatient
- mental health care
- vision care
- dental care

Arranger. An arranger HMO arranges for health care services to its enrollees mainly through a network of contracted health care providers at the providers' own facilities. An arranger HMO's services may consist of arranging for only primary care or may also include:

- specialists
- hospitalization - inpatient and outpatient
- mental health care
- vision care
- dental care

An HMO may permit enrollees to obtain health care services from providers who aren't employed or contracted by the HMO. These benefits, referred to as "point-of-service

benefits,” may be available to enrollees within the HMO’s service area or limited to emergency situations in which the enrollee is out of the HMO’s service area.

An HMO may also engage in other activities, such as:

- Providing whole or partial subsidies of premiums for persons who can’t afford to pay the established premium
- Health care education programs
- Health research programs

To reduce its risk of loss associated with providing or arranging health care services to its enrollees, an HMO may purchase insurance from an insurance company, a state or local government agency, or from another organization in the HMO’s health care system. This is referred to as “stop loss insurance.”

An HMO employs or contracts with physicians, other health care professionals, hospitals, or clinics. Under these contracts, the providers agree to provide health care services to the HMO’s enrollees.

Physicians within the HMO Structure

An HMO’s physician may work for the HMO, or the HMO may use independent physicians in private practice who contract with the HMO, or both. The following describes various physician arrangements:

- Physicians in private practice normally receive a non-exclusive contract.
- Contracted physicians may practice individually, in a group of several physicians, or as an individual practice association (IPA).
- An HMO may employ or contract with primary care physicians, specialists, or both.
- An HMO may employ or contract with other health care professionals, such as osteopaths, registered nurses, nurse practitioners, physician assistants, psychologists, or social workers.

HMO Contracts with Hospitals and Enrollment in an HMO

An HMO may contract with hospitals and clinics to provide enrollees inpatient and/or outpatient health care services. The contracted hospitals and clinics may be related to the HMO (for example, if the companies were owned by the same parent corporation) or they may be independent.

An HMO may offer enrollment to certain groups, such as private employer groups, state or local government employer groups, insurance companies, other HMOs, Medicaid beneficiaries, Medicare beneficiaries, or individuals unaffiliated with any group.

HMO Premiums

An HMO determines its premiums using various methods, such as a community rating method or an experience rating method. For HMOs that enroll Medicaid and Medicare beneficiaries, the government program generally sets the premiums.

- Community Rating. HMOs normally determine premiums without considering the group's or enrollee's use of services. All groups or enrollees pay the same premium regardless of the health care services they require. An HMO may use an adjusted community rating method under which the premiums remain the same for all groups or enrollees in a particular class.
- Experience Rating. Premiums vary based on use of services. Groups or enrollees who require more health care services pay higher premiums.
- Medicaid and Medicare. State Medicaid agencies generally establish the premiums for enrolled Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) determine the premiums they pay for enrolled Medicare beneficiaries.

HMO Governance

An HMO's governing body, such as its board of directors, may consist of independent members of the community. In addition, the following entities may control an HMO:

- One or more IRC Section 501(c)(3) organizations, such as hospitals. These organizations may be related.
- One or more HMOs, which may be either a for-profit entity or a tax-exempt organization under IRC Section 501(c)(3) or Section 501(c)(4)
- Physicians, either individually or as part of a group or IPA.
- Enrollees in the HMO.

HMOs Qualifying for Exemption under IRC Section 501(c)(3)

- To qualify for exemption as an organization described in IRC Section 501(c)(3), an HMO must be organized and operated exclusively for one or more exempt purposes.
- An HMO is organized exclusively for one or more exempt purposes if it satisfies the organizational test in Treas. Reg. 1.501(c)(3)-1(b).
- An HMO operates exclusively for one or more exempt purposes if it satisfies the operational test in Treas. Reg. 1.501(c)(3)-1(c).
- While the promotion of health is considered an exempt purpose, not every activity that promotes health supports tax exemption.

CITATION	HOLDING
<u>Rev. Rul. 69-545, 1969 2 C.B.117</u>	<p>Ruling has two examples to demonstrate when a nonprofit hospital does and does not promote the health of a class of persons that is broad enough to benefit the community, and therefore, operates to serve a public interest rather than a private benefit, which qualifies for exemption under IRC Section 501(c)(3). Ruling describes factors that indicate that the use and control of a hospital are for the public or community benefit, such as: operating an emergency open to all persons regardless of ability to pay and providing hospital services to those in the community able to pay either directly or through third party reimbursement, using its surplus funds to improve quality of patient care and to advance its medical education and research programs, and resting control with a board composed of independent community leaders and not for the private benefit of the individuals exercising control through a board.</p>
<p><i>Federation Pharmacy Services, Inc. v Commissioner</i>, 72 TC 687 (1979), aff'd, 625 F.2d 804 (8th Cir. 1980)</p>	<p>Court held that, while selling prescription pharmaceuticals to elderly persons at a discount promotes health, the pharmacy didn't qualify for recognition of exemption under IRC Section 501(c)(3) on that basis alone. Because the pharmacy operated for a substantial commercial purpose, it did not qualify for exemption under IRC Section 501(c)(3).</p>

No part of net earnings may inure to the benefit of private shareholders or individuals. See Treas. Reg. 1.501(c)(3)-1(c)(2).

Direct Provider of Health Care Services May Further an Exempt Purpose

- An HMO may accomplish the promotion of health in a charitable manner by the direct provision of health care services, but it depends upon the facts and circumstances. The HMO must still meet all the other requirements of IRC Section 501(c)(3).

- An HMO that operates exclusively as a direct provider of health care services accomplishes the charitable promotion of health if it operates in a manner that primarily benefits the community as a whole, and not a select group.

Note: An HMO that is required to be licensed, registered or otherwise recognized under state law as a hospital must also comply with IRC Section 501(r) to be exempt under IRC Section 501(c)(3).

CITATION	HOLDING
<p style="text-align: center;"><i>Sound Health Association v Commissioner, 71 TC 158, acq. 1981 2 C.B. 2.</i></p>	<p>Court stated that when the potential class of members “is so broad, benefit to the membership is benefit to the community.” Because the HMO’s outpatient clinic provided emergency care regardless of ability to pay and membership, which was open to the community, Court held there was no substantial private benefit and the HMO was operated for an exempt charitable purpose as required under IRC Section 501(c)(3).</p>

‘Arranger’ of Health Care Services May Further an Exempt Purpose

Under certain circumstances, an HMO may accomplish the promotion of health in a charitable manner by arranging for the provision of health care services. The HMO must still meet all the other requirements of IRC Section 501(c)(3).

In determining whether an arranger HMO qualifies for tax-exempt status under IRC Section 501(c)(3), we must examine all its circumstances, concentrating on whether the HMO benefits the community as a whole in addition to its subscribers. See *Geisinger Health Plan v. Commissioner*, below.

An arranger HMO must make its services available to all in the community plus provide additional community or public benefits. The additional public benefit must be enough to strongly suggest that the public benefit is the primary purpose for which the organization operates. Consider the entire circumstances when you decide. See *IHC Health Plans v. Commissioner*, below.

CITATION	HOLDING
<i>Geisinger Health Plan v. Commissioner</i> , 985 F.2d 1210 (3d Cir. 1993), reversing 62 T.C.M. (CCH) 1656 (1991)	The court found that arranging for the provision of medical services only to the HMO's enrollees is not necessarily charitable, particularly where the HMO subsidized only a small number of enrollees.
<i>IHC Health Plans, Inc. v. Commissioner</i> , 325 F.3d 1188 (10th Cir. 2003, aff'g T.C. Memo 2001-246.	Some of the factors the court considered included the provision of free or below cost products or services, the existence of research or educational programs, the size of the class eligible for benefits, and the composition of the board of trustees.

Medicaid HMOs

A Medicaid HMO is an HMO that arranges health care services for its enrollees. Enrollees consist exclusively of people who are:

- Eligible for Medicaid or a comparable state program.
- Have special health care needs.

A Medicaid HMO promotes community health if it also actively engages in programs that provide health care services to enrollees, such as:

- Educational programs regarding the benefits available
- Counseling and assistance in making the transition to managed care
- Preventive health care programs
- Coordinating health care services among providers
- Facilitating access to the plan's providers

HMOs as an Integral Part of the Health Care System

An HMO that arranges for the provision of health care services and is part of an IRC Section 501(c)(3) health care system may qualify for exemption under IRC Section 501(c)(3) as an integral part of the health care system. See Treas. Reg. 1.502-1(b).

To qualify as an integral part, an HMO must be financially and structurally controlled by either:

- One organization in the health care system already exempt under IRC Section 501(c)(3).
- Two or more organizations in the health care system already exempt under IRC Section 501(c)(3) and related to each other through common control.

An HMO must perform an essential function of one or more related IRC Section 501(c)(3) organizations in the health care system. When the controlling organizations are hospitals, the HMO must serve only the patients of these hospitals. So, the HMO's enrollees must include patients of the related exempt hospitals. See *Geisinger Health Plan v. Commissioner* and *IHC Health Plans v. Commissioner*, below.

Case law on HMO integral part exemption includes:

CITATION	HOLDING
<i>Geisinger Health Plan v. Commissioner</i> , 100 TC 394 (1993)	HMO failed to meet the integral part doctrine because its operations weren't substantially and closely related to furthering the purposes of the related exempt hospital.
<i>IHC Health Plans v. Commissioner</i> , 325 F.3d 1188 (10th Cir. 2003)	HMO failed to meet the integral part doctrine because its operations were not substantially and closely related to furthering the purposes of the related exempt hospital.

Published rulings on integral part exemption or substantially related activities include:

CITATION	HOLDING
Rev. Rul. 78-41 , 1978-1, C.B. 148	A hospital trust fund used to satisfy malpractice claims operates as an integral part of a hospital tax-exempt under IRC Section 501(c)(3), and therefore, itself operates exclusively for charitable purposes.
Rev. Rul. 68-374 , 1968-2 C.B. 242	Pharmaceutical sales activity from a hospital to the public is unrelated trade or business because no substantial causal relationship exists between the hospital's exempt purposes and the activity.
Rev. Rul. 68-375 , 1968-2 C.B. 245	Pharmaceutical sales activity from a hospital to private patients of physicians is unrelated trade or business because the activity is not substantially related to the exercise or performance of the hospital's exempt functions.
Rev. Rul. 68-376 , 1968-2, C.B. 246	Pharmaceutical sales activity from a hospital to patients of the hospital is not unrelated trade or business because patients receive services that are an integral part of the hospital's exempt function.

HMOs Qualifying for Exemption under IRC Section 501(c)(4)

- 1) To qualify for exemption as an organization described in IRC Section 501(c)(4), an HMO must not be organized for profit and must operate exclusively for the promotion of social welfare.
- 2) An HMO operates exclusively for the promotion of social welfare if it's primarily engaged in promoting in some way the common good and general welfare of the people of the community. See Treas. Reg. 1.501(c)(4)-1(a)(2).
- 3) If an HMO doesn't qualify for exemption under IRC Section 501(c)(3), it may qualify for exemption under IRC Section 501(c)(4).
- 4) An organization that arranges to provide limited vision care services for its enrollees for a fee did not qualify for exemption under IRC Section 501(c)(4) as a social welfare organization. See *Vision Service Plan v. United States*, below.

CITATION	HOLDING
<i>Vision Service Plan, Inc. v. United States</i> , 265 Fed. Appx. 650 (9 th Cir. 2008); <i>aff'g mem.</i> 2005 U.S. Dist. LEXIS 38812 (E.D. Cal., 2005); <i>cert. denied</i> , 555 U.S. 1097 (2009).	The appellate court held that although the plan offered some public benefit, the plan wasn't operated exclusively for the promotion of social welfare because it did not primarily engage in promoting the common good and general welfare of the community. The plan's own articles of incorporation stated that the primary purpose of the corporation was to establish a fund from payments by subscribers to defray and assume the costs of vision care for those subscribers. This was a purpose that benefited the plan's subscribers rather than the general welfare of the community.
Rev. Rul. 86-98 , 1986-2 C.B. 74	An IPA that negotiates with HMOs for the provision of medical services on behalf of its member physicians and administers claims for its members isn't exempt under IRC Section 501(c)(4) because it primarily benefits its member physicians rather than the community as a whole.

HMOs and Commercial Insurance – IRC Section 501(m)(1)

An HMO that satisfies the requirements for exemption under IRC Section 501(c)(3) or IRC Section 501(c)(4) isn't exempt if a substantial part of its activities consists of providing commercial-type insurance. See IRC Section 501(m)(1).

To determine whether the entity provides commercial type insurance, determine whether the organization's activities meet the definition of commercial type insurance

and then make sure that those activities aren't excluded from the definition of commercial type insurance by the exceptions listed in IRC Section 501(m)(3).

Court cases on the definition of commercial type insurance include:

CITATION	HOLDING
<i>Paratransit Insurance Corporation v. Commissioner</i> , 102 T.C. 745, 754 (1994)	"[T]he term 'commercial-type insurance,' as used in [IRC] Section 501(m), encompasses every type of insurance that can be purchased in the commercial market."
<i>Florida Hospital Trust Fund v. Commissioner</i> , 103 T.C. 140, 158 (1994), aff'd on other grounds, 71 F.3d 808, 812 (11 th Cir. 1996)	The term "commercial-type insurance" under IRC Section 501(m) means insurance "normally offered by commercial insurers."
<i>Non-Profits' Insurance Alliance of California v. United States</i> , 32 Fed. Cl. 277, 284 (1994)	Court compared the organization's activities to commercial insurance companies and found they were "commercial in nature."

Statutory Exceptions to Commercial Insurance

Certain HMO activities should **not** be considered as providing commercial-type insurance:

- An HMO that provides insurance at substantially below cost to a class of charitable recipients. See IRC Section 501(m)(3)(A).
- An HMO that provides incidental health insurance of a kind customarily provided by HMOs. See IRC Section 501(m)(3)(B).

HMOs and Unrelated Trade or Business

If an HMO satisfies the requirements for exemption under IRC Section 501(c)(3) or IRC Section 501(c)(4) and is not precluded by IRC Section 501(m) from qualifying for exemption, then IRC Section 501(m)(2)(A) treats the activity of providing commercial-type insurance as an unrelated trade or business. However, instead of the HMO being subject to unrelated business income tax (UBIT) on the activity, IRC Section 501(m)(2)(B) treats an HMO as an insurance company to apply subchapter L to that activity. Therefore, the activity is treated as an unrelated trade or business, but the organization is subject to the tax applied to an insurance company instead of UBIT.