25th Annual Health Sciences Tax Conference

Reading the tea leaves for tax-exempt health plans in a post-Vision Service Plan and ACA world

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Today’s agenda

► What qualifies as a tax-exempt Health Maintenance Organization (HMO)?
  ► Pre-Vision Service Plan (VSP) court decisions and Internal Revenue Manual (IRM) guidelines
  ► VSP ruling
  ► Post-VSP IRS guidance

► What Affordable Care Act (ACA) provisions influence HMO operations and restructuring?
  ► Section 9010 fee on health insurance issuers
  ► Transitional Reinsurance Program fee
  ► ACA considerations for HMOs
What qualifies as a tax-exempt HMO?
Pre-VSP decisions – Sound Health Association

► Background:
  ► Sound Health Association (SHA) – nonprofit membership organization
  ► Provided health care services to its members on a prepaid basis
  ► Provided direct health care services through salaried doctors and nurses
  ► Operated clinic and emergency room (ER)
  ► IRS denied SHA Section 501(c)(3) status, but it concluded SHA qualified for Section 501(c)(4) status
  ► SHA sought declaratory relief
Pre-VSP decisions – Sound Health Association

► Outcome: Tax Court analyzed SHA as if it were a hospital
  ► Applied Rev. Rul. 69-545, Community Benefit Test, and noted:
    ► ER open to non-members without regard to whether non-members could pay
    ► Ambulance contractor was directed to bring all emergency cases to its ER regardless of membership status
    ► Clinic treated non-members on a fee-for-service basis
    ► Conducted research to study better ways of delivering health care
    ► Fund for subsidizing persons desiring member status
    ► Courtesy staff open to all qualified physicians
    ► Community-based board of directors
  ► Concluded SHA qualified for Section 501(c)(3) status
Pre-VSP decisions – Sound Health Association

Outcome: IRS adopts SHA’s analysis for 501(c)(3) HMOs in General Counsel Memorandum (GCM) 39828

- Multiple factors to be examined in meeting the community benefit test, including:
  - Provision of health care services/maintenance of facilities/staff
  - Reduced rate care for indigent
  - Care for Medicare/Medicaid beneficiaries
  - ER open to the community without regard to ability to pay
  - Subsidized membership
  - Governed by community-based board of directors
  - Payment of providers on a fixed-fee basis
  - Using surplus to further exempt purposes
  - Individuals comprise substantial portion of membership
  - Overt program to attract individuals
  - Community rating
  - No age or health barriers
Pre-VSP decisions – Sound Health Association

Two other GCMs addressing HMOs issued at same time as GCM 39828 (GCM 39829 and GCM 39830)

- GCM 39829 – With this GCM, IRS intended to clarify and amplify GCM 39828 especially with regard to Section 501(m)
  - Health insurance incidental to an HMO's principal activity of providing health care is excepted from Section 501(m)

- GCM 39830 addressed HMOs seeking Section 501(c)(3) status based on the “integral part doctrine,” which per the GCM requires:
  - Status of a subsidiary to an exempt parent entity (technical legal subsidiary status not required)
  - Subsidiary’s activities are essential services for fulfilling the exempt purposes of the parent and where the activities are a trade or business they would not be an unrelated trade or business if conducted by the parent
Pre-VSP decisions – Geisinger

- Integral part doctrine case:
  - Geisinger Health Plan (GHP) – non-staff model HMO controlled by Geisinger Foundation, a Section 501(c)(3) company
  - One of nine entities comprising the Geisinger Health System with all entities controlled by Geisinger Foundation
  - History:
    - IRS denied GHP’s request for Section 501(c)(3) status and GHP sought a declaratory judgment from the Tax Court
Pre-VSP decisions – Geisinger

► History:

► Tax Court held GHP qualified as Section 501(c)(3) saying there was no substantial limit on the class of persons eligible for membership; GHP is not operated for the private benefit of its subscribers or for commercial purposes; and that whether it is exempt must be determined by examining all the facts and circumstances, not based on the presence or absence of one or more of the factors discussed in Sound Health – IRS appealed.

► 3rd Circuit reversed Tax Court’s decision and determined that the Sound Health test was not satisfied and that GHP benefitted only its subscribers. Tax Court noted GHP itself did not provide health care services, did not ensure non-subscribers have access to health care services or information, and did not conduct research or provide educational programs. Remanded to Tax Court for consideration of integral part argument.
Pre-VSP decisions – Geisinger

► History:
  ► Tax Court on remand held integral part doctrine not satisfied because activities of GHP would be unrelated business if conducted by the parent entity – GHP appealed
  ► 3rd Circuit Holding: Affirmed Tax Court but articulated the integral part test differently:
    ► In addition to the parent/subsidiary-type relationship, the subsidiary must not carry on a trade or business that would be unrelated to the purposes of the exempt parent and the subsidiary’s relationship to the parent must enhance or boost the subsidiary’s own exempt character
Pre-VSP decisions – Geisinger

History:

► 3rd Circuit Holding:
  ► Noted that GHP provided patients to the health system, which arguably allowed the health system to promote health among a broader segment of the community
  ► However, this provision of patients does not enhance GHP’s own promotion of health
  ► GHP serves the same subscribers with or without its association with the health system
  ► Court held that GHP does not receive a boost from its association with the health system

► However, Geisinger did ultimately qualify for 501(c)(4) status
Pre-VSP decisions – IHC Health Plans

► History:
  ► Three HMOs: IHC Health Plans, Inc. (Plans), IHC Care, Inc. (Care) and IHC Group, Inc. (Group)
  ► All three controlled by Intermountain Health Care, Inc., a health care system exempt under Section 501(c)(3)
  ► Plans was granted exemption under Section 501(c)(3) in 1985 but exemption was revoked in 1999
  ► Care applied for exempt status in 1986 and exemption was denied in 1999
  ► Group applied for exempt status in 1991 and exemption was denied in 1999
  ► Tax Court denied exempt status in actions for declaratory relief and cases appealed to 10th Circuit
Pre-VSP decisions – IHC Health Plans

- *IHC Health Plans, Inc. v. Comr.*
  - HMOs did not qualify for exempt status under Section 501(c)(3)
    - No qualification as “stand-alone” entities
    - Community Benefit Test:
      - “[H]ealthcare provider must make its services available to all in the community plus provide additional community or public benefits”
      - Additional public benefit sufficient so that strong inference is created that the public benefit is primary purpose for its operations
    - Factors considered in evaluating sufficient public benefit:
      - No direct provision of health care services (i.e., they were arrangers)
      - No provision of health care services for free or below cost or provision of subsidized premiums
      - Only paying members received health care services
      - No research or free educational programs to the public
      - Care and Group did not offer their plans to the general public – only large employers
Pre-VSP decisions – IHC Health Plans

► *IHC Health Plans, Inc. v. Comr.*
  ► No qualification under the “integral part doctrine”
    ► 80% of IHC’s members received health care services from physicians unrelated to its Section 501(c)(3) parent organization
    ► Use of the unrelated physicians does not further exempt purposes of parent organization
Pre-VSP decisions – IHC Health Plans

Subsequent to the court’s decision, IHC achieved Section 501(c)(4) status and exhibited the following characteristics:

- Just under 50% enrollment from individuals and small groups
- No Medicare and Medicaid at the time
- Used community ratings
- No separate community benefit and below-cost services
- Broad, community-based board
Pre-VSP IRM – 501(c)(3) HMOs

- Examination guidelines for Section 501(c)(3) – similar to a hospital (staff model)
- Medicaid-only HMOs
Pre-VSP IRM – 501(c)(4) HMOs

► Control by community interests rather than by health care providers who can benefit personally from the HMO’s operations (community benefit standard, controlled by a 501(c)(3))

► Open Enrollment – Enrolls more than an insubstantial number of persons who are unable to obtain affordable health care services or health care insurance or who have special health care needs, such as:
  ► Individuals
  ► Small employer groups (50 or fewer employees)
  ► Elderly persons (e.g., Medicare beneficiaries)
  ► Low-income persons (e.g., Medicaid beneficiaries)
  ► Others (e.g., disabled, substance abuse sufferers)

► Premium methodology
  ► Charges affordable premiums (e.g., determined using a “community rating” methodology)
  ► This guideline does not apply to Medicaid beneficiaries
Pre-VSP IRM – 501(m)

► Section 501(m)
  ► If a “substantial part” of an HMO’s activities consists of providing “commercial-type” insurance, it does not qualify under Section 501(c)(3) or Section 501(c)(4)
  ► There are no regulations under Section 501(m)
  ► Several examination guidelines
    ► For example: capitated fees or fees for service that are substantially discounted and subject to substantial withholding
Vision Service Plan, Inc.

Vision Service Plan, Inc. v. U.S.

Background:
- Vision Service Plan, Inc. (VSP) – health plan providing vision services
- Organized as a state law, nonprofit organization and licensed under the California HMO licensing statute
- Contracts with other health plans, employers and political subdivisions to arrange for the provision of vision services and supplies to their members and employees
- VSP Section 501(c)(4) exemption revoked by IRS effective prospectively
- VSP paid tax for its first year as a taxable entity and filed suit for refund
Vision Service Plan, Inc.

- **Vision Service Plan, Inc. v. U.S.**
  - US District Court held for government on motion for summary judgment on two points
    - Point 1 – District Court held it was for-profit because:
      - Court noted that an organization where much of its revenue is devoted to improving its ability to compete commercially is not entitled to exemption
      - Cost-cutting measures like for-profit businesses
      - Portion of bonuses tied to reducing costs
      - Bonuses taken directly from net earnings
      - High broker commissions (calculated based on revenue VSP will receive from the new client) (Note: broker commissions greater than VSP’s charity care expenditures)
      - Executives received substantial salaries and other forms of compensation (executive salaries tied to median market levels making no distinction between nonprofits and for-profits)
Vision Service Plan, Inc.

Vision Service Plan, Inc. v. U.S.

Point 2 – District Court held it was not operated primarily for social welfare because:

- Organization that provides substantially different benefits to the public as compared to its private subscribers was not primarily devoted to social welfare
- VSP not operating for the benefit of the community as a whole, rather it operated for the primary purpose of serving its paying subscribers
Vision Service Plan, Inc.

Why the Court rejected VSP’s position:

► VSP charged for and made profit from its service to small and rural employer groups; thus, servicing these groups does not provide a community benefit

► VSP serviced Medicaid, Medicare and Healthy Families participants, but:
  ► VSP competitively bid for these contracts and the criterion for enrollee to receive service was not being part of a medically underserved population but rather being an employee or member of a paying subscriber
  ► VSP made a profit servicing these groups, and discounts VSP offered to these groups were a small fraction of both net and gross income

► VSP charity care not enough:
  ► Provided free vision care to non-enrollees disaster relief and community outreach and education
  ► However, “even assuming that VSP’s calculations are accurate, $8 million is 24% of VSP’s 2003 net income and an even smaller percentage of VSP’s income”
The Court ignored the community benefit guidelines from the Internal Revenue Manual stating they were inapplicable because VSP is not an HMO. Why?
- Because it does not provide direct medical services
Vision Service Plan, Inc.

**Vision Service Plan, Inc. v. U.S.**

- VSP appealed the summary judgment ruling
  - 9th Cir. Court of Appeals **affirmed**
    - Ignored the community benefit guidelines of Internal Revenue Manual
    - Stated VSP does provide some public benefits but not enough to be considered primarily engaged in the promotion of the common good and general welfare of the community
  - Considered language from articles of incorporation that stated:
    - VSP’s primary purpose is to establish a fund from payments by subscribers to defray and assume the costs of vision care for subscribers
    - Based on such language, the Court held that this is a purpose that benefits VSP’s subscribers rather than the general welfare of the community
Post-VSP and post-ACA

- IRS withdrew prior IRM Examination Guidelines for 501(c)(4) HMOs and issued new IRM that merely refers to VSP decision
- ACA individual mandate and Health Insurance Exchanges impact access to insurance for individuals and small employer subscribers
- So, what HMO activities now qualify as social welfare?
IRS guidance post-VSP and post-ACA: PLR 201451033

► Private Letter Ruling (PLR) 201451033 – The “future exchange participant”
  ► Denial of application for 501(c)(4) status
  ► Applicant was controlled by 501(c)(3) health system, formed to assume the activities of a for-profit HMO
  ► Approximately 70% of subscribers lived in the county served by the hospital system
  ► 89% of subscribers were under employer-provided group plans and 2% of subscribers purchased individual plans, though applicant expected the mix to change as it began offering plans on an Exchange
  ► Social welfare activities were making grants (including to an organization providing subsidies to Exchange policy purchasers), holding wellness events and providing educational materials
IRS guidance post-VSP and post-ACA – PLR 201451033

► IRS found that applicant was operating for the benefit of subscribers, not the community
  ► Applicant did not demonstrate how an increase in individual paying subscribers would further social welfare and indirect subsidies did not further social welfare as applicant would “receive the same premium amounts from low-income individuals and families who qualify for subsidies and those who do not.”
  ► Other social welfare activities were not substantial

► IRS found that application was not an integral part of the health system
  ► System controlled applicant’s operations, but subscribers were free to choose care other than the system’s and the system provided care to the general public, not solely to applicant’s subscribers
IRS guidance post-VSP and post-ACA – PLR 201538027

► PLR 201538027 – “Is it or isn’t it?”
  ► IRS revokes HMO’s 501(c)(3) status, separately recognizes 501(c)(4) status
  ► An arranger HMO that was originally for-profit became a 501(c)(4) and then merged into a 501(c)(3) arranger HMO, which sought to retain 501(c)(3) status
  ► Examination report cites VSP and IHC and asserts that the HMO operates a commercial line of business:
    ► Does not indicate that arranging for Medicaid services is an exempt activity, noting that the state still retains the obligation to provide health care to the poor and has not transferred the obligation
    ► Asserts that the entity does not qualify for either (c)(3) or (c)(4), as “subscribers and their enrollees are the primary beneficiaries of a prepaid [arranger] health plan as opposed to the public at large”
  ► Despite the examination report, entity applied for and was granted (c)(4) status, but the PLR does not discuss why
What ACA provisions influence HMO restructuring?
Section 9010 fee on health insurance issuers

► Annual fee imposed on companies in the business of providing health insurance for US health risks (covered entities)
► Not a tax, though administered by IRS and subject to similar processes
► Effective date: January 1, 2014, for net premiums written for 2013; continues indefinitely
► Total amounts of annual fees specified in legislation
► Payment due September 30 of each fee year
Annual fees to be collected

- Amounts set by statute:
  - 2014 – $8.0 billion
  - 2015 – $11.3 billion
  - 2016 – $11.3 billion
  - 2017 – $13.9 billion
  - 2018 – $14.3 billion
  - After 2019 – indexed to rate of premium growth

- Total fees collected are allocated among covered entities based on market share. Unlike a tax, covered entities will compete to shift fees to one another.

- The annual fee is not tax deductible.
Premiums included in numerator

- First $25 million: disregarded
- Next $25 million to $50 million: 50% included
- More than $50 million: 100% included
- Related entities combined
- Partial exclusion from numerator:
  - 50% of net premiums written for health insurance relating to the exempt activities of certain tax-exempt entities:
    - Section 501(c)(3): charitable, etc.
    - Section 501(c)(4): social welfare
    - Section 501(c)(26): high-risk health insurance pool
    - Section 501(c)(29): Consumer Operated and Oriented Plan (CO-OP)
Covered entity – exceptions

► Employers to the extent they self-insure the health risks of their employees – but an insurance company that sells health insurance is exempt only with regard to its self-insurance for employees
► A governmental entity
► A Voluntary Beneficiary Association (VEBA) (Section 501(c)(9)) established by other than an employer or union to provide health care benefits
► An entity that:
  ► Is nonprofit under state law
  ► Is prohibited from private inurement, lobbying and political campaign activities
  ► Receives more than 80% of its gross revenue from governmental programs (e.g. Medicare, Medicaid, State Children’s Health insurance Program (SCHIP))
Transitional Reinsurance Program fee

► Section 1341 of the ACA created the Transitional Reinsurance Program to temporarily help pay for high-cost enrollees in the individual market
► To fund this program, a three-year fee (TRP fee) is imposed on insurers and certain self-insured group health plans
► Fee is $63 per covered life in 2014, $44 in 2015 and $27 in 2016
► Significant change in scope for 2015 and 2016 years:
  ► For self-insured group health plans, applies only if the plan uses a third-party administrator
Influence on operation and restructuring of HMOs

- Restructuring may reduce the amount of fees paid:
  - Exemption from 9010 tax for certain entities with 80% of revenues from government premiums
  - Reduction in 9010 tax for certain tax-exempt HMOs
  - Exemption from TRP fee if, for the self-insured portion of a group health plan, no third-party administrator (TPA) is used

- ACA has made insurance more accessible, but also disrupted markets, which could raise tax exemption issues:
  - Traditional mix of subscribers may change due to additional options for consumers and providers entering or exiting the market
  - When applying for recognition of exemption post-ACA and VSP, differentiating from for-profit providers may be a challenge
Questions?
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