

Office of Chief Counsel  
Internal Revenue Service

# Memorandum

Release Number: 20165301F

Release Date: 12/30/2016

CC:LB&I:HMP:BOS1:CWMaurer  
POSTF-119944-16

UILC 833.03-02

date: October 13, 2016

to: LB&I Heavy Manufacturing & Pharmaceuticals

from: Associate Area Counsel, Boston

CC:LB&I:F:BOS1

---

subject:

Taxable years and

This refers to a request by Revenue Agent \_\_\_\_\_ for advice regarding claims by the above-named Taxpayer that certain subsidiaries of Taxpayer qualify for taxation as "other organizations" under I.R.C. § 833(c)(3).

## LEGEND

TAXPAYER PARENT =

TAXPAYER =

SECOND TIER SUB =

HEALTH SUB 1 =

HEALTH SUB 2 =

HEALTH SUB 3 =

## ISSUES

1. Is the special tax treatment provided for "other organizations" as described in I.R.C. § 833(c)(3)(A), limited to organizations that were in existence on the effective date of that section, or does it apply to organizations that come into existence after that date?

2. If section 833 does apply to organizations that come into existence after the effective date of the statute:
  - a. Subsection 833(c)(3)(A)(ii) requires that at least 10 percent of the health insurance provided by such organization must be provided to individuals and small groups (not taking into account any medicare supplemental coverage). Does this test include all individuals receiving health care benefits through the organization, or does it exclude individuals receiving benefits under certain government programs that are administered by the organization?
  - b. Subsection 833(c)(3)(A)(v) requires that at least 35 percent of the organization's premiums must be determined on a community rated basis. Does this test include all individuals receiving health care benefits through the organization, or does it exclude individuals receiving benefits under certain government programs that are administered by the organization?
3. If the percentage tests under subsections 833(c)(A)(ii) and (v) do include individuals receiving benefits under certain government programs, does the requirement under subsection 833(c)(3)(A)(v) that premiums must be determined on a "community rated basis" refer to pure community rating, or does it include "adjusted" community rating or community rating "by class"?

**CONCLUSIONS:** Section 833(c)(3) applies to organizations that come into existence after the effective date of the statute. Assuming that Taxpayer is eligible for the special tax treatment provided by section 833, we believe that the tests for qualifying under section 833 do not include coverages under certain government programs. Furthermore, regardless of whether certain government programs are includible in the qualifying tests, we conclude that Taxpayer does not satisfy the community rating test under section 833(c)(3)(A)(v).

## STATEMENT OF FACTS

**General Information.** Taxpayer claims that three of its subsidiaries qualify as "other organizations" entitled to the special tax treatment provided in I.R.C. § 833. The statute will be analyzed further below, but in order to put the facts in context, section 833(c)(3)(A) requires:

(3) Other Organizations -- (A) In General-- An organization meets the requirements of this paragraph for any taxable year if --

(i) substantially all the activities of such organization involve the providing of health insurance,

(ii) at least 10 percent of the health insurance provided by such organization is provided to individuals and small groups (not taking into account any medicare supplemental coverage),

(iii) such organization provides continuous full-year open enrollment (including conversions) for individuals and small groups,

(iv) such organization's policies covering individuals provide full coverage of preexisting conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is provided without regard to age, income, or employment status of individuals under age 65,

(v) at least 35 percent of its premiums are determined on a community rated basis, and

(vi) no part of its net earnings inures to the benefit of any private shareholder or individual.

The issues under consideration were first raised by Taxpayer

. If in fact the subsidiaries qualify for taxation under section 833, they would be allowed to claim "special deductions" as provided under section 833(a)(2). These special deductions would reduce the absorption of net operating losses in earlier periods, with the result that the NOLs could be carried forward to later periods. The total increase in the carryforwards is approximately \$

The following description of Taxpayer's structure and activities is based on the

Taxpayer is a wholly-owned subsidiary of TAXPAYER PARENT, which is exempt from federal income tax under section 501(c)(3) of the Code.

Taxpayer's second tier, for-profit and wholly-owned subsidiary, SECOND TIER SUB, controls 100 percent of the outstanding stock of several domestic corporations taxed as nonlife insurance companies under section 831 of the Code, which include HEALTH SUB 2, and HEALTH SUB 3. SECOND TIER SUB also controls \_\_\_\_\_ percent of the ownership interests of HEALTH SUB 1, which is organized as a nonprofit, nonstock corporation under state law. HEALTH SUB 2, HEALTH SUB 3, and HEALTH SUB 1 (collectively, "TAXPAYER Health Insurers"), are the entities that are under consideration regarding the application of section 833.

HEALTH SUB 2, HEALTH SUB 3, and HEALTH SUB 1, along with SECOND TIER SUB, four other wholly-owned domestic corporations also taxed as nonlife insurance companies, and several other noninsurance corporations, join with Taxpayer (collectively, "Parent Group") in filing a consolidated federal income tax return on Form 1120. The Parent Group reports on a fiscal year . Each of the TAXPAYER Health Insurers has consistently reported its taxable income as part of the Parent Group for every tax year that each of the TAXPAYER Health Insurers has conducted its business operations. According to Taxpayer, all activities of the TAXPAYER Health Insurers are related to the providing of health insurance.

### HEALTH SUB 1

### HEALTH SUB 2

### HEALTH SUB 3

**Qualification for I.R.C. § 833.** In support of its claim that HEALTH SUB 2, HEALTH SUB 3, and HEALTH SUB 1 qualify for taxation as "other organizations" under I.R.C. § 833(c)(3) Taxpayer submitted

At the present time it does not appear that there is any dispute that each of these three entities satisfy the first test (substantially all the activities of such organization involve the providing of health insurance); the third test (open enrollment for individuals and small groups); the fourth test (coverage of preexisting conditions of high-risk individuals, and coverage without regard to age, income, or employment status of individuals under age 65); and the sixth test (no inurement). The issues in dispute regard the applicability of section 833 to organizations that were not in existence at the date the statute took effect, and whether Taxpayer satisfies the second and fifth tests, which require that at least 10 percent of the health insurance provided by such organization is provided to individuals and small groups, and that at least 35 percent of its premiums are determined on a community rated basis. These two tests raise issues whether coverage under certain government programs may be considered at all, and whether such coverages satisfy the "community rating" requirement of section 833.

The schedules show categories based on types of coverage, without specific descriptions of the coverages, and then makes conclusory interpretations of those coverages.

**HEALTH SUB 1.** For purposes of the 10% test, for early years it appears that Taxpayer is relying on coverage for  
In later years, the computations appear to rely on coverages for

For purposes of the 35% test, it appears that Taxpayer is relying on the same coverages, with the difference that the numbers for the 10% test limit the small group items to groups of 2-15 as required by section 833, while the numbers for the 35% test include small groups of up to 50 members.

**HEALTH SUB 2.** For purposes of the 10% test, it appears that items are being included for

For purposes of the 35% test, it appears that Taxpayer is relying on the same coverages up through , with the difference in the numbers for small groups. For through , it appears Taxpayer is including

For through as Taxpayer asserts that 100% of its total enrollment is community rated, which is inconsistent with its determinations for HEALTH SUB 1 and HEALTH SUB 3. In addition, the totals for the columns are incorrect. The columns include significant amounts for but these numbers are not included in the totals.

**HEALTH SUB 3.** For purposes of the 10% test, it appears that items are being included

For purposes of the 35% test, it appears that Taxpayer is relying on the same coverages, with the difference in the numbers for small groups.

### **Background on Blue Cross and Blue Shield (BCBS), Health Maintenance Organizations (HMOs), and Community Rating**

Health care services in the United States are provided and financed through a variety of organizations which in turn reflect different approaches to health care.

- some entities are providers of services, such as hospitals and doctors;
- some entities finance services, such as employers and insurance companies;
- and some entities combine both functions in different ways, such as Blue Cross and Blue Shield organizations, and Health Maintenance Organizations.

Because all these entities are directed at the common problems of providing and financing health care, there are similarities in their operations. Strategies or

practices which are effective for one type of entity are often adopted by others. Because of similarities in the operations of these entities, similar issues have arisen regarding their tax treatment.

**Blue Cross/Blue Shield.** Blue Cross was the first significant effort to organize the provision and financing of health care. The Blue Cross system developed in the 1930's, and eventually evolved into state-by-state networks of hospitals which provided services to their "members" in exchange for regular, pre-paid premiums. Blue Shield developed similar organizations for physician services, and in many states the two organizations combined as Blue Cross and Blue Shield.

Initially the Internal Revenue Service determined that prepaid hospitalization plans did not qualify for exemption under I.R.C. § 501(c)(3) (specific exempt purposes), but did qualify under section 501(c)(4) (social welfare organization). G.C.M. 22554, 1941-1 C.B. 243. However, as plans spread and enrollment shifted to large employer groups and national organizations, the operational distinctions between plans and commercial insurers diminished. This led to reevaluation of the legal status of the plans, both at the state regulatory level, and for federal income tax purposes.

**HMOs.** In the 1970's the federal government encouraged the development of a new type of entity by passage of the Health Maintenance Organization Act of 1973. Various states had enacted legislation for the organization of HMOs. The federal statute established standards for qualifying HMOs, which were then eligible for federal financial assistance. In 1990, General Counsel Memorandum 39829 analyzed the historic tax treatment of HMOs:

Health maintenance organizations issue contracts under which they agree to provide or arrange for a comprehensive set of medical services for subscribers in exchange for periodic payments that do not vary with the extent or type of services provided. HMOs provide medical care to subscribers through selected physicians, hospitals, and other providers who are affiliated with the HMO in one manner or another. Subscribers are 'locked in' to the HMO-affiliated providers, and receive no benefits for nonemergency services obtained from outside providers without prior HMO authorization. It is this limitation, along with an increased emphasis on preventive care, that distinguishes HMOs from traditional health care insurance.

Most states have enacted specific acts pursuant to which HMOs are organized or licensed. While these statutes vary, they may be useful, along with other facts and circumstances, in helping the Service to determine whether an organization purporting to be an HMO should be treated as one for tax purposes. Licensure under one of these statutes suggests that an entity is an HMO, while licensure under some other authority in a state having an HMO act suggests otherwise. In addition, the federal government gave the industry a boost with passage of the HMO Act of 1973, which provided

voluntary federal qualification standards and developmental financial assistance. Unfortunately, the federal Act is of only limited utility in identifying or defining HMOs because so many have chosen not to seek federal qualification. [Page 2.]

\* \* \*

The Service's position with respect to HMOs has evolved over the last three decades. In \* \* \* GCM 32453, l-17 (Nov. 30, 1962), this Office recommended that an organization that operated essentially as a group model HMO be recognized as exempt under section 501(c)(4) due to its similarity to Blue Cross/Blue Shield plans.<sup>8</sup> The organization was neither subscriber-controlled nor physician-controlled, and contracted with existing medical groups on a capitated basis for medical services. See also \* \* \* GCM 34709, l- 3701 (Dec. 7, 1971) (same rationale extended to organization that provided prepaid optometric services).

[<sup>8</sup> Interestingly, despite longstanding administrative practice, the historical rationale and legal criteria for recognizing Blue Cross/Blue Shield organizations as described in section 501(c)(4) have never been fully articulated. See GCM 34709 (Service has in past used section 501(c)(4) to exempt organizations that, although worthy, failed to meet particular requirements of section 501(c)(3), especially prepaid medical service organizations); McGovern, Federal Tax Exemption of Prepaid Health Care Plans, The Tax Advisor (Feb. 1976). Nevertheless, it is clear that open enrollment and community-rating were among the socially beneficial characteristics these plans possessed in their early years.] [Page 3, emphasis added.]

\* \* \*

The Service's current section 501(c)(4) HMO ruling position involves a community benefit analysis that focuses on factors such as whether membership is open to individuals and small groups (taking into consideration any examination requirements, coverage limitations, and conversion rights), whether the HMO serves low income, high risk, medically underserved, or elderly persons, and whether premiums are established on a community-rated basis. These factors are important, especially given the historical linkage between the Service's position on HMOs and its position on Blue Cross/Blue Shield. [Page 5, emphasis added.]

Unlike BCBS organizations, HMOs were not uniformly tax-exempt but might or might not qualify for exemption under either section 501(c)(3) or 501(c)(4). See the discussion in GCM 39829.

**Community Rating -- BCBS.** On December 7, 1985, the House Committee on Ways and Means released a report on a bill entitled "Tax Reform Act of 1985," H.R. 3838, 99th Cong. (1995).

The committee is concerned that exempt charitable and social welfare organizations that engage 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 under present law 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 section 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. [H.R. Rep. No. 99-426 at 664 (1985).]

While legislation was under consideration, the Chairman of the Subcommittee on Health of the Committee on Ways and Means requested that the General Accounting Office examine the potential impact on the availability of health insurance that would result from taxing Blue Cross and Blue Shield plans. On July 11, 1986, the General Accounting Office transmitted a report to the Chairman entitled "Health Insurance: Comparing Blue Cross and Blue Shield Plans With Commercial Insurers," GAO/HRD-86-110 (July 1986).

In describing its "Scope," the GAO Report states:

We focused on the availability of coverage for high-risk individuals under age 65 because practices of the plans and commercial insurers do not differ significantly in other markets -- large groups, where pricing methods are essentially the same, and Medicare supplemental policies, where uniform federal guidelines exist. [Page 10, emphasis added.]

The report includes specific recommendations regarding matters that should be considered by Congress in deciding whether the exemption for Blue Cross and Blue Shield plans is warranted:

If the Congress decides not to continue the current exemptions, but to offer special tax treatment for insurers who provide coverage to high-risk individuals



by amending the tax code, we believe it should establish specific criteria for granting such treatment. The criteria could include such factors as whether an insurer (1) offers continuous open enrollment, (2) fully covers medical services for high-risk conditions, (3) offers coverage to high-risk individuals at the same rates charged to other individual policyholders, and (4) offers coverage without regard to age or employment status. [Pages 3-4, emphasis added.]

The GAO Report discusses the differences between the pricing methods of Blue Cross and Blue Shield plans and commercial insurers on pages 17 and 18:

Over time, the plans' pricing methods have come to resemble those of commercial insurers. Specifically, changes in the plans' use of community rating (defined below) have reduced the subsidy for individuals in general and high-risk individuals in particular.

During the 1930's, when the initial tax exemptions were recognized, the plans offered one community rate. Under this system, all subscribers -- group and individual -- paid a uniform rate regardless of individual health status. Higher risk individuals benefited because their premiums were subsidized by lower risk individuals. Today, the plans experience-rate their large groups (which constitute most of their business) as do commercial companies. Experience-rating means the premiums are based wholly or partially on the group's health experience.

For their individual business, however, the plans continue to use a modified form of community rating. But the extent of the subsidy for individuals is significantly reduced because the large groups are experience-rated. Moreover, the plans further reduce the subsidy of high-risk individuals by establishing different community rates for sub-groups of their individual business. In Maryland and the District of Columbia, for example, we found at least two community rates for (1) healthier individuals accepted for medically underwritten coverage, and (2) sicker individuals accepted for open enrollment coverage. The more the plans use such rating classifications to reflect health experience, the less they differ from those commercial health insurers who charge extra premiums to high-risk individuals. [Emphasis added.]

The Blue Cross and Blue Shield Association reviewed a draft of the GAO Report and submitted comments which were addressed in the final report. Among other things, the Association objected that "the pricing methods of commercial insurers and Blue Cross and Blue Shield plans are substantially different." Page 28. The final Report responded:

As discussed on page 17, both the plans and the commercials experience-rate their large groups, which constitute most of their business. In addition, the plans' use of multiple community rates for individuals and small

groups has, as discussed below and on pages 17 and 18, come to resemble experience-rating. [Emphasis added.]

The Association also stated that "We strongly disagree" with the Report's statement that "Plans and commercial insurers are not significantly different in the . . . Medicare supplementary policy market, where uniform federal guidelines exist." Page 42. The final Report responded:

We did not focus on Medicare supplementary coverage because an association consultant told us that would not be a good basis for comparison since the plans and one commercial insurer dominate the market. Further, as stated on page 10, there are uniform federal guidelines that both the plans and the commercials must adhere to in offering this coverage. . . . [Page 43, emphasis added.]

**Community Rating-- HMOs.** As originally enacted, the HMO Act of 1973 required that a health maintenance organization shall provide basic and supplemental health services to its members for a basic health service payment which, among other things, "is fixed under a community rating system." P.L. 93-222, new section 1301. This term is defined as follows:

(8) the term "community rating system" means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. [New section 1302(8).]

In 1980, the statute was amended to allow "community rating by class." H.R. Rep. No. 208, 97th Cong. 1st Sess., July 29, 1981, p. 812. Under this system, members are divided into classes which "predict the differences in the use of health services by the individuals or families in each class." 42 USC § 300e-1(8)(C)(i)(I). "This new system will provide substantial new flexibility in rate-setting and will allow HMO's to set more competitive rates." H.R. Rep. No. 208, p. 814.

**In summary.** When BCBS organizations were initially recognized as tax exempt, the plans offered one community rate; all subscribers -- group and individual -- paid a uniform rate regardless of individual health status. By 1986, the plans were using experience-rating for large groups, and were using "a modified form of community rating" for individuals "by establishing different community rates for sub-groups of their individual business."

Under the federal HMO Act, qualifying HMOs were initially required to use community rating. In 1980 the act was amended to allow "community rating by class."

**The Tax Reform Act of 1986.** As noted above, in 1985 the House Committee on Ways and Means expressed concern "that exempt charitable and social welfare organizations that engage in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax-exempt status is inappropriate." At that time, these exempt organizations included both Blue Cross and Blue Shield organizations, and certain Health Maintenance Organizations.

The Tax Reform Act of 1986, Pub. L. 99-514 (October 22, 1986) addressed both types of organizations. The Act amended section 501 to allow tax exemption to an organization described in section 501(c)(3) or (4) "only if no substantial part of its activities consists of providing commercial-type insurance." I.R.C. § 501(m)(1). This provision applies generally to any organization providing commercial-type insurance, and thus has the effect of ending tax exempt treatment for Blue Cross and Blue Shield organizations. With respect to HMOs, the statute provides that the term "commercial-type insurance" shall not include "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations." Section 501(m)(3)(B). Accordingly, a tax-exempt HMO would not lose its exemption as long as any health insurance which it provided was "incidental" and "of a kind customarily provided" by HMOs.

While Congress terminated the tax exemption of Blue Cross and Blue Shield plans by enacting section 501(m), at the same time Congress provided special tax treatment for these organizations in newly enacted section 833, entitled "Treatment of Blue Cross and Blue Shield Organizations, Etc." Section 833(a)(1) provides that any organization to which section 833 applies shall be taxable as if it were a stock insurance company. Section 833(a)(2) and (3) provide additional tax benefits, and the text of the Act provides certain transitional benefits.

The first benefit provided by section 833(a)(2) and (b) is a "special deduction" equal to the excess of 25 percent of the claims and expenses incurred during the taxable year, over the adjusted surplus at the beginning of the year. Each year's deduction is limited to the taxable income for that year, and is added to accumulated surplus. The effect of the special deduction was to eliminate ordinary taxable income until the total of the special deductions accumulated to an amount equal to 25% of the losses incurred. After the accumulated deductions equaled 25% of losses incurred, additional deductions would only be allowable to the extent of any increase in the annual losses incurred.

At the time section 833 was enacted, Blue Cross and Blue Shield entities were organized on a non-profit basis at the state level. Such entities did not have shareholders and accordingly had limited capital. The purpose of the special deduction was to allow these entities to accumulate surplus up to an amount equal to 25% of their annual losses incurred. The special deduction is a tax preference item for purposes of the corporate alternative minimum tax. Section 56(c)(3). "The special deduction exempts from the regular 34-percent corporate tax enough taxable income each year to

maintain reserves equal to 25 percent of the year's health-related payouts (three month's worth)." S.Prt. 102-119, 102d Cong. 2d Sess. 184 (1992).

Insurance companies are already allowed to claim a deduction based on 100% of their losses incurred. The special deduction has the effect of allowing a deduction for an additional 25% of losses incurred.

The second tax benefit is provided by section 833(a)(3). Under that provision, organizations to which section 833 applies are not subject to the 20% reduction in the unearned premium reserve which otherwise applies to stock insurance companies under section 832(b)(4)(B) and (C). According to the Conference Report, this exemption was allowed in order to "ease the transition from tax-exempt to taxable status." Conf. Rep. No. 99-841 at II-349, 1986-3 C.B. Vol. 4 349.

The Tax Reform Act itself also included certain transitional benefits for Blue Cross and Blue Shield organizations. No adjustment was required under section 481 for any accounting change for the first taxable year after December 31, 1986, and the adjusted basis of any asset held on the first day after such taxable year was treated as equal to its fair market value. Pub. L. 1012(c)(3)(A)(i) and (ii).

**"Other Organizations" under section 833.** Section 833 is not limited to Blue Cross and Blue Shield organizations. Section 833(c)(1) provides generally that section 833 applies to "any existing Blue Cross or Blue Shield organization," and to "any other organization meeting the requirements of paragraph (3)."

The term "existing Blue Cross or Blue Shield organization" is defined in section 833(c)(2) to mean any Blue Cross or Blue Shield organization if --

- (A) such organization was in existence on August 16, 1986,
- (B) such organization is determined to be exempt from tax for its last taxable year beginning before January 1, 1987, and
- (C) no material change has occurred in the operations of such organization or in its structure after August 16, 1986, and before the close of the taxable year.

Thus, Blue Cross and Blue Shield organizations are incorporated into the statute regardless of differences in their operations from plan to plan. On the other hand, with respect to "any other organization," section 833(c)(3)(A) sets forth specific requirements that an organization must meet in order to qualify for taxation under section 833:

- (i) substantially all the activities of such organization involve the providing of health insurance,

- (ii) at least 10 percent of the health insurance provided by such organization is provided to individuals and small groups (not taking into account any medicare supplemental coverage),
- (iii) such organization provides continuous full-year open enrollment (including conversions) for individuals and small groups,
- (iv) such organization's policies covering individuals provide full coverage of preexisting conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is provided without regard to age, income, or employment status of individuals under age 65,
- (v) at least 35 percent of its premiums are determined on a community rated basis, and
- (vi) no part of its net earnings inures to the benefit of any private shareholder or individual.

The term "small group" is defined in section 833(c)(3)(B) as the lesser of --

- (i) 15 individuals, or
- (ii) the number of individuals required for a small group under applicable State law.

The 1986 GAO Report had found significant diversity in the operations of the plans, and recommended specific criteria if special tax treatment were provided to such organizations. The 1986 Act did not impose these criteria on "existing" Blue Cross or Blue Shield plans. Instead, such organizations were made subject to the special tax treatment of section 833 on a wholesale basis. However, any "other organization" which sought that special tax treatment was required to meet the specific criteria of section 833(c)(3)(A).

## DISCUSSION

### Issue 1:

Is the special treatment provided for "other organizations" as described in subsection 833(c)(3)(A), limited to organizations that were in existence on the effective date of that section, or does it apply to an organization that subsequently comes into existence?

As noted above, the 1986 Act made the provisions of section 833 applicable to "any existing Blue Cross or Blue Shield organization," which was defined, in part, as "any Blue Cross or Blue Shield organization . . . in existence on August 16, 1986." Section 833 provided certain tax benefits to organizations subject to its provisions,

including an exemption from the reduction in the deduction for unearned premiums which applied generally to property and casualty insurance companies. In describing this benefit, the Conference Report stated that the exemption was allowed in order to "ease the transition from tax-exempt to taxable status." Conf. Rep. No. 99-841 at II-349, 1986-3 C.B. Vol. 4 349.

Although the 1986 Conference Report was referring only to the provisions in section 833 dealing with unearned premiums, as time passed the entire statute came to be described as "transitional." In December, 1993, the Joint Committee prepared a report for hearings before the Subcommittee on Select Revenue Measures of the House Committee on Ways and Means, entitled "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 14, 1993). A bill had been proposed that "would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organization and other eligible organizations." JCX-15-93, p. 13. The Joint Committee Report includes a "Discussion of Issues" and states:

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. [JCX-15-93, p. 20.]

In summary, section 833 as enacted applied specifically to Blue Cross and Blue Shield organizations that were in existence on August 16, 1986. Any Blue Cross or Blue Shield organization that came into existence after that date would not be eligible for the special tax treatment provided by section 833, based solely on its status as a Blue Cross or Blue Shield organization.

The legislative history does not include any description of the types of organizations that were intended to be included in the statute under the category of "other organizations." The statute merely includes specific criteria that such organizations must satisfy. Those criteria do not appear to be directed at any specific organizations that were identified during consideration of the statute; instead, they seem to be a catch-all based on the GAO Report, to avoid challenges that the statute unfairly provided tax benefits to Blue Cross and Blue Shield organizations. There is no indication that Congress was attempting to encourage the formation of other organizations, by providing the specific tax benefits of section 833.

Under these circumstances, an argument can be made that section 833 was only intended to apply to "other organizations" which, like existing Blue Cross or Blue Shield organizations, were in existence at the effective date of the statute.

On the other hand, the provisions regarding existing Blue Cross or Blue Shield organizations do include a specific provision requiring that the organization be in existence as of August 16, 1986; section 833(c)(3) regarding "other organizations" does not include such a provision. In addition, in describing the computation of the special deduction, the Conference Report states that for organizations that first become eligible for the deduction in the first taxable year beginning after December 31, 1986 -- which would include all existing Blue Cross or Blue Shield organizations -- "adjusted surplus" shall be determined based on the NAIC Annual Statement for the preceding year. The Report then states:

For organizations that first become eligible for the provision in a later taxable year, the amount of the adjusted surplus for the first year of the deduction is the surplus reported in the annual statement at the close of the preceding year. [Conf. Rep. No. 99-841 at II-348, 1986-3 C.B. Vol. 4 348, emphasis added.]

This language is broad enough to include post-1986 Blue Cross or Blue Shield organizations, but for the explicit language in the statute limiting its application to BCBS organizations in existence on August 16, 1986. Since the language in the Conference Report cannot refer to BCBS organizations, it must be referring to "other" organizations which "become eligible for the provision in a later taxable year." Accordingly, with respect to "other organizations" as described in subsection 833(c)(3)(A), we believe that section 833(c)(3) applies to organizations that come into existence after the effective date of the statute

**Issues 2.a. and 2.b.** If section 833 does apply to organizations that come into existence after the effective date of the statute, such organizations must satisfy each of the six tests set forth in section 833(c)(3)(A). Subsection 833(c)(3)(A)(ii) requires that at least 10 percent of the health insurance provided by such organization is provided to individuals and small groups (not taking into account any medicare supplemental coverage). Subsection 833(c)(3)(A)(v) requires that at least 35 percent of the organization's premiums are determined on a community rated basis.

Do these tests include all individuals receiving health care benefits through the organization, or does it exclude individuals receiving benefits under certain government programs that are administered by the organization?

Again, as noted above the 1986 GAO Report focused on the potential impact on the availability of health insurance that would result from taxing Blue Cross and Blue Shield plans. Specifically, the GAO Report "focused on the availability of coverage for high-risk individual under age 65 because practices of the plans and commercial insurers do not differ significantly in other markets -- large groups, where pricing methods are

essentially the same, and Medicare supplemental policies, where uniform federal guidelines exist." Page 10.

The BCBS Association "strongly disagree[d]" with the Report's finding that there was no significant difference between the plans and commercial insurers in the "Medicare supplementary policy market." The Report considered the Association's objection, and affirmed its finding, because "there are uniform federal guidelines that both the plans and the commercials must adhere to in offering this coverage." Pages 42-43.

As noted above the history of the taxation of BCBS organizations runs parallel with considerations of the taxation of HMOs. The 1986 Act made BCBS organizations taxable, with the special benefits provided by section 833 and the transitional provisions of the Act. HMOs that were tax-exempt at the time of Act could continue to be considered to be exempt, as long as any health insurance which they offered was merely "incidental" and of a kind customarily offered by HMOs.

In this regard, in determining the tax-exempt status of an HMO, the Internal Revenue Manual describes "Premiums" as follows:

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

(a.) **Community rating.** Premiums are determined without regard to the enrollee's utilization of services. All enrollees pay the same premium regardless of the extent of health care services they require. An HMO may use an adjusted community rating method under which the premiums are the same for all enrollees in a particular class.

(b.) **Experience Rating.** Premiums vary based on utilization of services. Enrollees who require more health care services pay higher premiums.

(c.) **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. [IRM 4.76.31.5 - Premiums (08-01-2008), emphasis added.]

In determining whether an HMO qualifies under section 501(c)(3) on the basis that it promotes health or relieves the poor and distressed, IRM 4.76.31.7.3.2 directs agents to consider, among other things, "Premium Methodology." However, "This guideline does not apply to enrollees who are beneficiaries under Medicaid, a comparable state program, beneficiaries under Medicare, or other persons having special health care needs, where a government agency determines the premiums."



Similarly, in determining whether an HMO qualifies under section 501(c)(4) as a social welfare organization, IRM 4.76.31.8.3.3 also directs agents to consider "Premium Methodology" and states that "This guideline does not apply to enrollees who are beneficiaries under Medicaid, a comparable state program, beneficiaries under Medicare, or other persons having special health care needs, where a government agency determines the premiums."

As indicated above, Taxpayer submitted two binders of material which purport to show that each of the three subsidiaries under consideration satisfy each of the six tests set forth in section 833(c)(3)(A). As noted above, for HEALTH SUB 1 for early years ( through ) a substantial amount of its coverage is described as An explanatory schedule states

For later years, HEALTH SUB 1 shows a substantial amount of coverages for

Similarly, HEALTH SUB 2 shows coverages for  
HEALTH SUB 3 shows coverage for

Section 833 was directed at assuring the availability of health insurance for high risk individuals and small groups, where BCBS organizations provided coverage that was not available from commercial insurers. Congress was concerned that "high risk" individuals would not be able to afford insurance at commercial rates that took account of their greater utilization of services. That concern did not extend to persons obtaining coverage under government sponsored programs, where the rates were established by the government and not by the entity that chose to participate in those programs.

Accordingly, we believe that coverages under certain government programs, where the premiums are established by the government and not by the entity that chooses to participate in those programs, should not be included for purposes of both the 10% and 35% tests,

### Issue 3.

If the percentage tests under subsections 833(c)(A)(ii) and (v) do include individuals receiving benefits under certain government programs, does the requirement under subsection 833(c)(3)(A)(v) that premiums be determined on a "community rated basis" refer to pure community rating, or does it include "adjusted" community rating or community rating "by class"?

In 1986, when Congress was initially considering changes in the tax status of BCBS organizations, "community rating" meant "community rating." There were no nuances. The 1986 GAO Report summarized the evolution of the term:

During the 1930's, when the initial tax exemptions were recognized, the plans offered one community rate. Under this system, all subscribers -- group and individual -- paid a uniform rate regardless of individual health status.

However, by the time of the 1986 GAO Report, BCBS organizations had moved away from community rating, and were using a "modified" form which used "different community rates for sub-groups of their individual business." Nevertheless the 1986 Act adopted a strict interpretation of the term. The Conference Report described the special criteria that applied to "other organizations," including "community rating":

Fourth, at least 35 percent of the organization's health insurance premiums are determined on a community-rated basis. This percentage is determined as a percentage of the total number of persons covered on an annual basis. Community rating means that premiums are determined on the basis of the average annual cost of health insurance over the population in the community. [Conf. Rep. No. 99-841 at II-350, 1986-3 C.B. Vol. 4 350.]

It is significant, in interpreting section 833, to emphasize that the GAO Report had identified differences in the application of community rating among BCBS organizations. Rather than imposing any definitional requirement on BCBS organizations, Congress incorporated them into the statute on a wholesale basis. If Congress had intended that "other organizations" could qualify for the special tax treatment provided by section 833 using a relaxed version of community rating, it could have done so.

It is also significant, that the original HMO Act of 1973 had required a strict version of community rating:

(8) the term "community rating system" means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. [New section 1302(8).]

In 1980, the statute was amended to allow "community rating by class," where HMO members are divided into classes which "predict the differences in the use of health services by the individuals or families in each class." Accordingly, prior to the enactment of the Tax Reform Act of 1986, Congress was aware that health care organizations such as BCBS and HMOs were using forms of community ratings that did not conform to the original, "pure" version, yet it did not make allowance for any such "modified" versions in setting forth the requirements for qualifying "other organizations" under section 833(c)(3).

In the present case, the schedules submitted by the Taxpayer in support of its claim that HEALTH SUB 2, HEALTH SUB 3, and HEALTH SUB 1 qualify for taxation as "other organizations" under I.R.C. § 833(c)(3) do not clearly establish that the subsidiaries

were using a "pure" form of community rating. As noted above, the schedules show substantial amounts of coverage for various programs.

Premiums ratings for explanatory schedules indicate that the premiums for The Taxpayer's descriptions of The Taxpayer's

To the extent that the method can be considered some form of "community rating," it seems to be a modified method, or a method by class. Accordingly, we do not believe the Taxpayer's subsidiaries satisfy the community rating test under section 833(c)(3)(A)(v).

## SUMMARY AND CONCLUSION

An argument can be made that section 833 was only intended as a transitional statute. However, there is authority that section 833(c)(3) does include organizations that came into existence after the effective date of the statute.

The statute was directed at preserving health insurance coverage for high risk individuals at affordable rates. Thus the specific criteria for "other organizations" under section 833(c)(3) include percentage requirements for coverage of individuals and small groups; continuous open enrollment for individuals and small groups; coverage for preexisting conditions, and no restrictions for age, income or employment status of persons under age 65; and strict community rating. In this context, the tests for qualifying under section 833 should not include coverages under certain government programs. In those situations, there is no meaningful difference between commercial insurers, BCBS organizations, and "other" organizations attempting to qualify for the special tax benefits provided by section 833. Premiums are established by the government entity that sponsors the particular program being offered. Organizations can choose to participate in the program or not, subject to the terms established by the government entity. There is no need for any special tax incentive for any subset of eligible organizations. If an incentive were necessary to induce organizations to participate in the program, it would be built directly into the program. A program would not be developed based on an assumed tax benefit from the federal government that applied to only some eligible organizations.

Finally, the term "community rating" was well-understood at the time section 833 was enacted. Congress did not indicate any intention of benefiting any group of organizations that were utilizing some modified version of community rating. Congress specifically required that any "other organization" seeking to qualify for the special tax treatment provided by section 833 must use "community rating," without any qualifying or mitigating deviations. While industry usage of community rating has evolved and few organizations may be utilizing that system on the same basis that it was being used in 1986, Congress did not give any indication that the term was meant to have some kind

of evolving, industry-usage meaning. At the time section 833 was enacted, the term had already evolved; there were already differences in its application, which were recognized by qualifying terminology, such as "modified community rating," and "community rating by class." Nevertheless, Congress used the phrase "community rating," in contrast to any kind of qualified term. This selection of the strict term, at a time when more liberal applications were in existence and had been recognized in other legislation, must be accepted at its face meaning.

Accordingly, we believe that section 833(c)(3) applies to organizations that come into existence after the effective date of the statute. We believe that the tests for qualifying under section 833 do not include coverages under certain government programs. And finally, we conclude that Taxpayer does not satisfy the community rating test under section 833(c)(3)(A)(v).

This writing may contain privileged information. Any unauthorized disclosure of this writing may have an adverse effect on privileges, such as attorney client privilege. If disclosure becomes necessary, please contact this office for our views. If we can be of any further assistance, please call Charles Maurer at (617) 565-7838.

---

Charles W. Maurer, Jr.  
Attorney (Boston)  
(Large Business & International)