

August 25, 2003

VIA ELECTRONIC MAIL

TO: tege.501m@irs.gov

Internal Revenue Service
Attn: T:EO:RA:T:1 (Notice 2003-31)
P.O. Box 7604
Ben Franklin Station
Washington D.C., 20044

RE: Notice 2003-31
Comments Regarding § 501(m) of the Internal Revenue Code

Dear Sir/Madam:

This letter responds to Internal Revenue Service Notice 2003-31 and the request for comments on certain regulations to be proposed jointly by the Internal Revenue Service (“IRS”) and Treasury Department. Those regulations are intended to provide guidance under § 501(m) of the Internal Revenue Code of 1986, as amended (the “Code”), that will define the term “commercial-type insurance.” The regulations also are intended to address how § 501(m) applies to organizations described in § 501(c)(3) and § 501(c)(4), including health maintenance organizations (“HMOs”).

The comments set forth below are submitted on behalf of the Substantive Law Committee of the Health Law Section of the State Bar of Michigan. The Substantive Law Committee is actively involved in matters of importance concerning the regulation of health care organizations. Members of the Committee include both attorneys in private practice and in-house counsel who spend significant amounts of their professional time representing and advising organizations engaged in the financing and delivery of health care, including health maintenance organizations, preferred provider organizations and other managed care entities, Blue Cross and Blue Shield of Michigan and commercial health insurers. Members of the Committee have extensive experience representing for profit and both exempt and non-exempt nonprofit health care organizations. The comments set forth below are submitted on behalf of a work group of the Substantive Law Committee of the Health Care Law Section of the State Bar of Michigan. These comments do not necessarily reflect the views of the entire Subcommittee, the Council of the Section or Section members at large. The Committee is grateful for the opportunity to submit the following comments.

I. Factors Indicative of “Commercial-Type Insurance”

A. Functional Difference Between HMOs and Commercial-Type Insurance

As a preliminary matter, it is important to note that HMO coverage is inherently distinguishable from commercial-type insurance since HMO coverage combines health care financing with care management functions, while commercial-type insurance offers purely a health care financing mechanism without any care management functions. Through the use of utilization management, care coordination, contracted providers, primary care physician gatekeepers, and quality assessment and quality management programs, HMOs arrange for, and are involved in the management of, the care which their members receive. None of the foregoing is present with commercial insurance, which is simply a mechanism for reimbursing costs incurred. This inherent difference is why states have regulated HMOs quite differently, and separate and apart, from entities that engage in “commercial type” insurance.

In California, for example, HMOs are licensed and regulated under the Knox-Keene Health Care Service Plan Act which is found in the California Health & Safety Code and not in California’s Insurance Code. Likewise, even though Florida’s HMO licensure act appears within the title regulating insurance, a separate chapter is devoted exclusively to the licensure and regulation of HMOs and prepaid health plans (Chapter 641 of the Florida Statutes). Importantly, provisions of Florida’s insurance code applicable to commercial insurers, including health insurers, are generally inapplicable to HMOs. *See Fla. Stat. Ann. § 641.201.* Along similar lines, Michigan devotes a chapter of its insurance code exclusively to the licensure and regulation of HMOs (Chapter 35, MCLA §§ 500.3500 *et seq.*) which is distinct from the provisions governing health insurers. In fact, to preserve the distinction between HMOs and commercial insurers, Michigan, among other things, prohibits an HMO from using in its “name, contracts, or literature the words ‘insurance,’ ‘casualty,’ ‘surety,’ ‘mutual,’ or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state.” *See MCLA § 500.3505(3).* Finally, the federal government also has accorded HMOs distinct treatment, having established a regulatory scheme specific to federally qualified HMOs. Accordingly, the various state and federal governments already afford disparate treatment to HMOs and commercial insurers.

The involvement of HMOs in arranging for and managing care, and the regulation of HMOs separate and apart from commercial insurers, should be recognized as taking HMOs out of the realm of commercial-type insurance.

B. Risk Shifting to Providers

The IRS has historically limited its focus when determining whether the HMO is engaging in “commercial type insurance” activities. A principal inquiry in this context has been to ask whether the HMO shifts financial risk to its participating provider network. We believe it would be appropriate to broaden the inquiry to consider the full spectrum of best practices and trends within the HMO industry.

We are not suggesting that the IRS ignore or neglect the separate rationales for the standards previously imposed and we understand clearly and appreciate fully the reasons for requiring discounted fees apart from withholds. Substantially discounted fees serve to provide a benefit directly to the community since the result presumably is to lower premiums charged to

members. Substantial withholds ensure cost effective management of care and utilization of health care services since the criteria to release the payments are based on factors tied to the organization's goals to succeed financially.

In some cases, however, previous IRS pronouncements have imposed somewhat draconian standards to determine whether an HMO properly shifted financial risk to its providers for purposes of the exemption analysis. For instance, one technical advice memorandum¹ held fee-for-service arrangements to impractical standards when it required both a substantial discounted fee and a substantial withhold component for contracts with each provider group or network. Other important operational aspects of the HMO business, however, were not fully recognized or considered. Importantly, we believe that HMOs can shift the financial risk, or otherwise accomplish the goals sought to be achieved by risk shifting, through means other than, or in addition to, those accepted by the IRS to date. Although this request may require the IRS to consider factors which are not mechanical or quantitative in nature, and may require further examination of the facts and circumstances, its purpose is to ensure that the organization's exempt status is analyzed practically and with a 'real world' perspective.

For example, the rationales favoring discounted fees and withholds often are taken into consideration by HMOs when negotiating contract renewals and amendments with providers. To the extent that a particular provider group managed costs ineffectively or provided poor services, the contract may not be renewed or will be revised with significant restrictions to ensure the delivery of cost effective, high quality health care services prospectively. Thus, the impetus for the provider group to provide appropriate, cost-effective care is not merely the return of limited amounts withheld, but the desire to continue its participation in the HMO's provider network with the opportunity to continue to earn income through that participation.

Further, the HMO market includes variable demographic and economic trends that dictate the availability of significant fee discounts and significant withholds. Depending on the degree of managed care penetration where the HMO does business, the HMO may not be able to obtain certain concessions from its provider network, such as withholds or the acceptance of capitation rates. For instance, in markets on the east and west coasts of the United States capitation and withhold arrangements are common for providers participating with large, national HMOs. By contrast, in Michigan, managed care penetration is fairly low, being approximately twenty percent (20%), and no national HMO with any sizable membership basis exists. As a result, HMOs are not influencing market conditions and are not able to dictate payment arrangements to providers. In addition, the provider community in Michigan is generally risk averse. Consequently, the typical HMO/provider arrangement in Michigan involves payment on a discounted fee for service basis.

At the same time, risk is shifted to providers through member hold harmless provisions and a contractual commitment to continue care to members even if the HMO becomes insolvent. Typically, when a provider contracts with an HMO, the provider is prohibited from billing the HMO member for HMO covered services, by state statute and/or by contractual agreement, even if the HMO fails to pay for the covered services due to insolvency or otherwise. In the commercial insurance context, no similar restriction exists. Similarly, HMO contracted

¹ Technical Advice Memorandum (TAM) 200033046, dated April 27, 2000.

providers are typically committed to providing care to the HMOs members for a period of time beyond which the HMO becomes insolvent. These member hold harmless and continuation of benefits requirements distinguish HMO coverage from commercial-type insurance and are factors which should be considered to determine the presence of risk-shifting and the non-existence of commercial-type insurance.

Another consideration in defining commercial-type insurance, at least for maintaining an organization's exemption, is to view an HMOs compensation arrangements in their entirety rather than on an individual contract by contract basis. The sum of such arrangements may achieve the appropriate financial risk shifting with providers even though any one contract, or group of contracts, by itself, does not. Arguably, examining the details of each contract for mathematical percentages may cause one to lose sight of the HMO's accomplishment of the overall objective.

A broader perspective may allow the IRS to reconcile differences or solve the 'riddles' that arise between the various HMO remuneration methods. For instance, payments to providers under a fixed fee basis, such as capitation or salary arrangements, are presumed to shift the risk to the provider since no additional payments are made for additional services rendered. The rationale is that with these arrangements the HMO shares the additional costs with the providers as a normal business risk. In contrast, under the fee-for-service method the result is that no financial risk shifts to the providers since the HMO is responsible to pay the provider for each and every additional service rendered. However, industry experts fail to understand and need guidance as to why compensation incentives paid to providers for additional services rendered under the fixed fee arrangements seem to be treated as a normal business risk when those payments made to providers for additional services rendered under the fee-for-service arrangement are not.

Finally, should an exempt HMO fall outside the ambit of compliance with the requirements established by the new rules, we request that the IRS consider and provide time for HMOs to re-negotiate existing contracts within a reasonable period as a means to demonstrate their intentions to share the financial risk with their providers. In many cases, not only will contract amendments or new contracts have to be negotiated with numerous providers, but also HMOs will have to obtain regulatory approval with respect to those amendments and new contracts before they can be put to use.

C. Premium/Rate-Setting Methodology

Generally, there are two approaches to ratemaking, which include "experience rating" and "community rating." Under experience rating, the past health care utilization experience of the group to be insured is used to determine the premium to more appropriately capture the cost of the risk specific to each contracting group. This would take into account the group's own history of claims and other expenses in order to determine the premium rates to be charged. There is a distinct advantage to the insurer with experience rating because it adjusts the cost of insurance in a manner that approximates the expected costs of that particular group. Experience rating is a common premium setting methodology used by commercial insurers since it allows the insurer

to establish higher premiums for those groups who have a history of high utilization of health care services.

On the other hand, under community rating, premium rates are based on an allocation of total costs to all the individuals or groups to be insured, without regard to the past experience of any one particular group. In other words, community rating is spread over a large number of people. Individuals and small groups that have a history of high utilization of health care services benefit from community rating since the premium rates established for them cannot be adjusted upward to take into account their unique circumstances. Individuals who expect to need greater amounts of health care services are more likely than others to purchase insurance and typically can obtain coverage at lower rates under a community rating system than under experience rating. As a result, organizations setting premiums under a community rating system may experience adverse selection (i.e., a disproportionate number of insureds who are high utilizers of services).

The type of rate-making utilized by an HMO is a solid factor to use in assessing whether an HMO is committed to its tax exempt purposes. In Michigan, like many states, HMOs are required to use community rating whereas other commercial insurers are allowed to use experience rating. The requirement for HMOs to use community rating is more characteristic of an entity that does not provide “commercial type” insurance. The Michigan statute provides, at MCL 500.3519 that,

- (1) A health maintenance organization contract and the contract's rates, including any deductibles and copayments, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.
- (2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages.
- (3) All health maintenance organization contracts shall include, at a minimum, basic health services.

An HMO in Michigan can only adjust its rates based on sex, age, and other limited classifications as set forth above. For small groups, the ability to adjust rates is even more limited. This limited ability to adjust rates on the basis of broad classifications (as opposed to individual group characteristics and utilization) result in what is known as adjusted community rating, which does not permit rating based upon individual group experience, but allows for adjustments to be made and rate differentials to exist only across large classes of covered persons. Use of community rating should continue to be a factor in determining whether an

HMO is distinct from commercial-type insurance and is providing a community benefit to its members consistent with tax-exempt status.

II. Application of the Exception set forth in § 501(m)(3)(B)

A. Factors/Criteria Determining Whether an HMO's "Principal Activity" is Providing Health Care"

Health maintenance organizations ("HMO'S") have been a vital element in the delivery of health care for the health care industry for many years. HMO's have created and implemented a variety of initiatives to improve quality in pertaining to internal administration, clinical disease management, delivery of program/services, and community outreach. An example of the type of quality initiatives employed by a typical HMO is attached as Exhibit A.

A fundamental concept of managed care is that healthcare is delivered through an integrated system that includes providers and community based programs to deliver and promote quality healthcare services and wellness as opposed to indemnity insurance that reimburses or compensates the insured for amounts paid to cover medical expenses.

Additionally, HMO's typically provide a comprehensive benefit package, and the benefits provided under HMO's are more extensive than those provided by traditional indemnity plans. Under traditional indemnity plans, many of the preventive services such as physical exams, well childcare, prenatal care, and immunizations, weight management and smoking cessation are either not covered or covered at higher out of pocket expenses.

HMO's and health plan associations engage in research and analysis of initiatives in the managed care field related to:

- The appropriate use of health care facilities and services by the public;
- The quality of health care provided to the public;
- The cost of health care services;
- The accessibility and availability of health care facilities and services;
- The geographic distribution of health care facilities and services;
- Making available research and analyses to policy makers, researchers, health care providers, and the general public;
- Disseminating the data and analyses at the minimum cost to the public;
- Developing and presenting educational seminars and programs concerning health care delivery to health care providers and the general public.

Additionally HMO's and health plan associations develop community awareness educational plans pertaining to, but not limited to the following categories:

- Cancer screening;
- Stroke risk factors;
- Diabetes quality of care;
- Smoking cessation; and
- Asthma treatment.

Annually, Michigan HMO's submit their health care practices and community partnership initiatives to the Michigan Association of Health Plans ("MAHP") a partial list of the 2002-2003 initiatives is listed below:

- Clinical Practice Guidelines: Clinical and preventive service guidelines for providers;
- Smoking Cessation Programs;
- Health Hair starts with a Health Body: Developed community awareness to reduce kidney failure among African American women;
- Asthma Care Collaboration: Supports the community by providing educational materials and resources;
- Diabetes Health Fair: Included a seminar, community resources, and educational materials;
- Management of Chronic Conditions;
- Breast Cancer Screening: Collaborated with the American Cancer Society to bring expertise, community and member support for mammograms;
- County Health Plans/Health Access Initiatives for Uninsured and Underinsured;
- Greater Flint Coalition Pharmacy Task Force;
- Antibiotic education presented at local and regional physician meetings;
- Acute Otitis Media community-based health focus program;
- Reaching out to at-risk mothers and infants;
- Dilated eye exam initiative to reduce adverse effects of diabetes; and
- Infant mortality prevention programs in conjunction with the Michigan SIDS program.

In conclusion, as opposed to traditional fee-for-service indemnity plans, HMO's provide health care through the beneficial effects of encouraging disease prevention and wellness realizing that if a health problem is detected early through routine diagnostic screening and community awareness the problem can be more successfully treated.

B. Factors/Criteria Determining Whether Health Insurance Provided by an HMO is "Incidental to the Organization's Principal Activity of Providing Health Care"

Paragraph (3) of section 501 (m) provides that "commercial-type insurance shall not include "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations...." In order then for health insurance provided by an HMO to be excepted from the definition of commercial-type insurance pursuant to section 501 (m) (3) (B), the health insurance must be of a type "customarily" provided by HMOs. Coverage which an HMO is permitted to provide under state or federal law should be deemed health insurance of a type customarily provided by HMOs. In Florida, for example, coverage which an HMO is permitted to provide is recognized as a distinct type of "insurance" by itself, and HMOs are expressly prohibited from providing any type of health insurance other than "health maintenance organization type insurance". See Fla. Stat. Ann. § 641.2107.

Clearly, at a minimum, indemnity-type coverage which HMOs are required to provide under state or federal law should be deemed to be health insurance customarily provided by an HMO. For example, HMOs may be required to cover medically necessary emergency or urgent

care treatment even though received by an HMO member from an out-of-network physician or hospital. Michigan law expressly states that such coverage, as well as coverage for certain other out of network services, is not considered an act of insurance. *See* MCLA § 500.3517.

On the issue of point of service HMO plans, it should be noted that federal law permits federally qualified HMOs to offer a point of service or out-of-plan benefit option. Several states already require licensed HMOs to offer point of service plans. Again, on the basis that they are legally mandated, the point of service option is a type of health insurance customarily provided by HMOs within the meaning of section 501(m)(3)(B).

By its very nature the incidence of HMO members using out-of-network services customarily provided by an HMO is infrequent and not common. Such activity is “incidental”. The 1988 amendments to the federal HMO Act permit up to 10% of basic physician services to be provided by physicians not affiliated with the HMO. Comments found at 58 FR 38174 state that “the 10 percent limitation reflects congressional concern that offering an indemnity-type product would alter the essential character of prepaid HMOs.” Thus it is clear that the type of health insurance coverage customarily offered by an HMO is incidental health insurance coverage as defined by law.

C. Application to an HMO that does not Provide “Health Care to its Members Predominantly at its Own Facility Through the Use of Health Care Professionals and Other Workers Employed by the Organization.”

The relationship between an HMO and its providers is vastly different under state law from the relationship between a commercial insurer and providers who render health care services to the insurer’s insureds. This difference is a function of the nature and purpose of HMOs in assuring continuity of care and an acceptable quality of health care. An HMO must have a special relationship with its provider network if it is to be successful in carrying out its mission. By contrast, the relationship between a commercial insurer and a health care provider merely involves reimbursement for costs incurred.

Michigan law requires HMOs to contract with sufficient numbers of providers to ensure access by their members to appropriate services. An HMO’s contracts with its providers must assure that the HMO will have access to reports or records concerning services provided to its members. Providers who contract with HMOs must agree to cooperate with the HMO’s quality assurance activities.² In addition, provider contracts must be based on the following written standards:

- (a) Standards for maintaining quality health care.
- (b) Standards for controlling health care costs.
- (c) Standards for assuring appropriate utilization of health care services.
- (d) Standards for assuring reasonable levels of access to health care services.
- (e) Other standards considered appropriate by the HMO.³

² MCLA 500.3529(2).

³ MCLA 500.3531(4).

HMOs contract with providers not just for the purpose of setting fees as a commercial insurer would do, but to “develop services that contribute to prevention of disease and disability and to restoration of health.”⁴

“Commercial-type insurance” has been described by the Supreme Court as an arrangement that includes “risk shifting” and “risk distribution.”⁵ Although financially HMOs also involve risk shifting and risk distribution, these qualities are just a small part of what an HMO is about. The essence of a commercial insurer is risk shifting and risk distribution. Without more, an HMO would be a commercial insurer. But that isn’t the case. HMOs must develop partnerships with its providers to carry out the purposes for which they operate. These purposes are carried out whether providers are employed by the HMO or contracted independently. As a result, a distinction should not be made with respect to the application of this exception based purely on whether or not the HMO employs its providers.

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On behalf of the Substantive Law Committee of the Health Law Section of the State Bar of Michigan, [I/we] thank you for your consideration and the opportunity to comment on the proposed regulations concerning § 501(m). Should you desire any additional information, or wish to discuss further any of the comments set forth above, please do not hesitate to contact the undersigned at 248-357-3010.

Respectfully,

Margaret M. Marchak
Vice Chair
Substantive Law Committee
State Bar of Michigan Health Care Law Section

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⁴ MCLA 500.3513(1).

⁵ Helvering v. LeGierse, 312 U.S. 531,539 (1941).

EXHIBIT A

Quality Initiatives Conducted by a typical HMO and not usually seen in a traditional health insurance environment

Purpose:	Initiative
To improve immunization rates in children and adolescents	<ul style="list-style-type: none">• Reminder postcards to the parents of infants and children reminding them of the importance of well care, including immunizations• Letters to parents of infants, children and adolescents with a list of immunizations their child is missing, according to our data.• Send physicians a list of their HealthPlus patients who have not received specific immunizations, according to our data
To improve lead screening rates among children	<ul style="list-style-type: none">• Reminder letters are sent to parents of Medicaid children who have not had a lead test according to our data.• Physicians are sent a list of their HealthPlus patients (Medicaid and Commercial) who have not received a lead test, according to our data• The physicians are provided member mailing labels and a reproducible letter they can utilize if they so choose to contact the member.
To improve mammogram rates among women	<ul style="list-style-type: none">• Reminder post cards to women who have not had a mammogram according to our data• Physicians are sent lists of their HealthPlus patients who have not had a mammogram according to our data• The physicians are provided member mailing labels and a reproducible letter they can utilize if they so choose to contact the member.• Women 40 and older are invited to an educational seminar on women's health issues• Members who have not had a preventive care visit to their PCP are mailed age appropriate health educational material• Reminder phone calls are made to members who have not had a mammogram, according to our data.• Physicians are provided their individual mammogram rates compared to the plan, region, PPG

	and peers
To improve cervical cancer screening rates	<ul style="list-style-type: none"> • Reminder post cards to women who have not had a pap smear according to our data • Physicians are sent lists of their HealthPlus patients who have not had a pap smear according to our data • The physicians are provided member mailing labels and a reproducible letter they can utilize if they so choose to contact the member. • Women 40 and older are invited to an educational seminar on women’s health issues • Members who have not had a preventive care visit to their PCP are mailed age appropriate health educational material • Reminder phone calls are made to members who have not had a mammogram, according to our data. • Physicians are provided their individual pap smear rates compared to the plan, region, PPG and peers.

Purpose:	Initiative
To improve the rate of colon cancer screening	<ul style="list-style-type: none"> • Reminder post cards to members who have not had a colon cancer screening procedure according to our data. • Physicians are sent lists of their HealthPlus patients who have not had a colon cancer screening procedure according to our data • The physicians are provided member mailing labels and a reproducible letter they can utilize if they so choose to contact the member. • Members who have not had a preventive care visit to their PCP are mailed age appropriate health educational material • Physicians are provided their individual colorectal cancer screening rates compared to the plan, region, PPG and peers.
To decrease the number of second heart attacks	<ul style="list-style-type: none"> • Members who have had a heart attack are monitored for the appropriate prescription of beta-blockers and aspirin upon discharge. • Members who have recently been discharged for a heart attack are sent educational materials • Physicians are informed when HealthPlus sends educational information to their patient.
To improve the number of members with a recent cardiac event whose LDL is within the expected range.	<ul style="list-style-type: none"> • Reminder phone calls to members who have had a cardiac event within the last 12 months. • Physicians are mailed a list of their HealthPlus patients who recently experience a cardiac event and their LDL screening dates and levels, If available, according to our data. • The physicians are provided member mailing labels and a reproducible letter they can utilize if they so choose to contact the member
To improve the frequency of LDL screening for members on lipid lowering medications	<ul style="list-style-type: none"> • Reminder letters and brochures to members who have been placed on a lipid lowering drug and have not had an LDL drawn, according to our data. • Physicians are mailed a list of their HealthPlus patients who are on a lipid lowering drug and have not had an LDL drawn recently, according to our data.
To encourage members on antidepressant medications to stay on their medication and discuss an concerns with their physician.	<ul style="list-style-type: none"> • Members who are recently placed on an antidepressant are sent an encouraging letter to remain on their medication and to discuss any concerns with their physician. • Physicians are mailed a list of members who they recently placed on an antidepressant and who did not get a refill when scheduled. • Physicians are provided their individual rates that their members refill their prescriptions as

	scheduled.
To improve follow-up care after a hospital admission for mental illness	<ul style="list-style-type: none"> Members who are discharged from the hospital for a mental illness are called to schedule an appointment with their mental health provider if they do not have a visit scheduled
To encourage early prenatal care	<ul style="list-style-type: none"> Educational information is included in the Medicaid new-member packet about the importance of prenatal care.
To improve the rate of postpartum care following a delivery	<ul style="list-style-type: none"> Educational information is included in the Medicaid and Commercial new-baby packets about the importance of postpartum care. Medicaid members who recently delivered a baby are called to remind them of the importance of postpartum care.

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