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Healthcare Organizations and 501(c)(3): Uncertainty in the Post-Geisinger World

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NOTES

HEALTHCARE ORGANIZATIONS AND 501(C)(3): UNCERTAINTY IN THE POST-GEISINGER WORLD

Seth Dewees[†]

I. INTRODUCTION

THE MAJORITY OF HEALTHCARE services traditionally have been provided by nonprofit hospitals and largely funded through the donations of philanthropic organizations. By the mid-1970s, as a result of rising medical costs[1] and increased competition among providers, the traditional structure of healthcare delivery began to erode.[2] Today, the healthcare industry is characterized by "the growth of the prospective payment system, the increased consolidation of insurance and service delivery within prepaid health plans, and the imposition of a variety of regulatory measures."[3]

In particular, new institutions have taken the form of risk-sharing Health Maintenance Organizations (HMOs) and Integrated Delivery Systems (IDSs), which combine professional and management services. While some of these entities are contained within pre-existing hospital structures, state laws and regulations often make it highly impractical, if not impossible, to maintain HMOs within established healthcare organiza-

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1. ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, MEASURING HEALTH CARE 1960-1983: EXPENDITURES, COSTS AND PERFORMANCE 29, 53 (1985) (listing total expenditures and pharmaceutical price indexes for healthcare between 1960 and 1983).

2. *See* Theodore R. Marmor et al., *Nonprofit Organizations and Health Care, in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 221 (Walter W. Powell ed., 1987).

3. *Id.* at 228.

tions.[4] Such laws have resulted in the establishment of HMOs as separate corporate entities within larger healthcare systems.

With the development of freestanding HMOs, several issues have arisen surrounding the exempt status of such organizations under section 501(c)(3) of the Internal Revenue Code. Traditionally, to be exempt from federal income taxation under section 501(c)(3), an entity must be both "organized" and "operated" for one of the purposes enumerated in that section. To facilitate this inquiry, the Internal Revenue Service (IRS) and courts have developed a "community benefit" test along with a corollary "private benefit" test. Thus, in order to gain or retain exemption, an organization must benefit a sufficiently large portion of the population, while providing no significant benefit to any private individual.

In addition to those organizations which themselves provide a community benefit, the IRS and the courts have extended exemption to other "related" entities. Under this test, traditionally known as the "integral part" test, an organization that would otherwise fail the community benefit test could retain exemption as long as that entity engages in activities which, if carried on by its related organization, would not produce unrelated business income.[5] Thus, an organization could operate an exempt subsidiary as long as the subsidiary significantly aided the parent in furtherance of its exempt purposes.

Confusion has surrounded the application of both the "community benefit" and "integral part" tests to newly developed care-providing organizations. Particularly troubling is the tax treatment of Geisinger Health Plan (GHP), an HMO serving a large geographic area in northeastern Pennsylvania. In a series of decisions, first by the IRS, then by the Tax Court, and

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4. *See, e.g.*, PA. STAT. ANN. tit. 40, §§ 1551-1568 (West 1997) (regulating HMOs through the Commonwealth's Departments of Health and Insurance); 28 PA. CODE § 9.96 (1996) (requiring at least one-third of an HMO's board of directors to consist of subscribers of the HMO).

5. *See* Squire v. Students Book Corp., 191 F.2d 1018, 1020 (9th Cir. 1951). The court held that a campus book store and restaurant, operated as a separate corporate entity, was nevertheless exempt, reasoning that "[t]he business enterprise in which taxpayer is engaged obviously bears a close and intimate relationship to the functioning of the College itself." *Id. See also* Rev. Rul. 58-194, 1958-1 C.B. 240 (approving the exemption of a book and supply store as well as a restaurant at a state university since all are designed to benefit the students and faculty and not any private shareholder or individual).

ultimately by the Third Circuit,[6] the Third Circuit held that GHP neither passed the community benefit test nor the integral part test.[7] This litigation has left both scholars and practitioners scratching their heads because the results are inconsistent with both established case law applying the two tests and general public policy rationales which underlie exemption for healthcare providers.

Part II of this Note will discuss the application of the community benefit test to HMOs and IDSs. Using Geisinger Health Plan (GHP) as a paradigm, this part will examine the realities that face healthcare systems that aspire to operate as separately organized entities in light of the GHP decisions. When viewed in conjunction with the Third Circuit's construction of the integral part test, that Court's construction of the "community benefit" element suggests the following: an otherwise exempt organization cannot operate a separately incorporated subsidiary within a larger healthcare network unless that subsidiary duplicates services already provided by other entities within the system. Common sense dictates that such an inefficient and illogical result be scrutinized closely.

Part III will examine both the Tax Court's [hereinafter *Geisinger II* (Tax Ct.)] and the Third Circuit's [hereinafter *Geisinger II* (3rd Cir.)] application of the integral part test in *Geisinger II*. This part will conclude that the position taken by the IRS, which was subsequently upheld by the Tax Court, is internally inconsistent. The apparent implication of the Tax Court's decision is that, in most cases a free-standing HMO, organized by exempt entities within a healthcare network, cannot be exempt, despite the fact that if the HMO operated within one of the exempt entities, that organization would not incur unrelated-business income taxation. The Third Circuit upheld the Tax Court's result but applied a new test for which no precedent can be found. Given its limited application, it is unclear exactly how this test should be construed or whether it will in fact be applied in the future. Regardless of which inte-

6. *See* Geisinger Health Plan v. Commissioner, 62 T.C.M. (CCH) 1656 (1991), *rev'd*, 985 F.2d 1210 (3d Cir. 1993); Geisinger Health Plan v. Commissioner, 100 T.C. 394 (1993), *aff'd*, 30 F.3d 494 (3d Cir. 1994).

7. *See Geisinger*, 985 F.2d at 1210.

gral part test is applied, the result in *Geisinger II* creates a distinction based entirely on form, and not one in substance.

Finally, Part IV of this Note will look briefly at the public policy considerations surrounding exemptions for healthcare organizations. This part will ultimately conclude that the IRS and the courts strayed from these policy considerations with the GHP decisions. In an area of law that is already plagued by a lack of clarity, the *Geisinger* decisions have created a morass of uncertainty which indeed may take years to wade through.

II. APPLICATION OF THE COMMUNITY BENEFIT TEST TO HMOs AND IDSs

A. Charitable Requirements of Section 501(c)(3)

Section 501(c)(3) of the Internal Revenue Code provides exemption from federal income taxation to "[c]orporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes."[8] Because the providing of medical care is not one of the purposes specifically enumerated in the Code, the rendering of medical services must fall under the broad umbrella of "charitable purposes."[9] Federal Regulations make it clear that "charity," as used in section 501(c)(3), is to be construed "in its generally accepted legal sense and is . . . not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."[10] For guidance in determining what is charitable "in its generally accepted legal sense," the courts primarily have looked to charitable trust law.[11]

Throughout the 1800s, hospitals rendered the majority of their services to indigent patients who were unable to pay for care.[12] These hospitals almost completely relied on the philan-

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8. 26 U.S.C. § 501(c)(3) (1994).

9. *See id.*

10. 26 C.F.R. § 1.501(c)(3)-1(d)(2) (1997) (defining "charitable" and providing examples of organizations which qualify as "charitable" under 501(c)(3) of the Code).

11. *See, e.g.*, Sound Health Ass'n v. Commissioner, 71 T.C. 158, 177-78 (1978) (citing Green v. Connally, 330 F. Supp. 1150 (D.D.C. 1971) and Coit v. Green, 404 U.S. 997 (1971)).

12. Marmor, *supra* note 2, at 224 (providing an historical overview of the structure of

thropic donations of religious organizations to support their operations.[13] As such, the traditional functions of hospitals were characterized as "charitable" in the strictest sense of the word.[14]

During the first half of the twentieth century, extraordinary advances in the field of medicine "transformed hospitals from the dumping ground of humanity to the pinnacle establishment of the healthcare delivery system."[15] For example, in the post World War II era, due to the development of governmental subsidies such as Social Security, Medicaid, and Medicare, hospitals became increasingly less reliant on donative support.[16] The IRS was cognizant of the rapidly changing environment of the delivery of medical care, and accordingly, maintained a flexible definition of charity when determining exemption status under section 501(c)(3). In 1956, the IRS issued a Revenue Ruling which defined the required level of free or low-cost care necessary to qualify for exemption as a charity under section 501(c)(3).[17] Although no specific level was delineated, the Ruling made it clear that if an organization had the financial resources to provide free services, it was required to do so.[18]

In 1969, the IRS issued another Revenue Ruling in response to requests for advice concerning the required level of free care.[19] In that Ruling, the IRS once again recognized changing conditions and backed off its 1956 position. Revenue

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healthcare delivery in the United States).

13. *Id.*

14. *See* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 318 (1991) (describing the voluntary hospitals of the nineteenth century as "organized by religious societies, heavily funded by donations, and staffed by doctors who worked without compensation and nurses who worked for room and board as part of their lifetime commitment to a religious order devoted to caring for the poor").

15. *Id.* at 319.

16. *See* Marmor, *supra* note 2, at 226 (describing the growth of public medical facilities and the reduced need for donative financing in the 1960s and 1970s).

17. *See* Rev. Rul. 56-185, 1956-1 C.B. 202 (providing in part that for an organization to be exempt "[i]t must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay").

18. *See id.*

19. *See* Rev. Rul. 69-545, 1969-2 C.B. 117. In this ruling, the IRS used two hypothetical hospitals as examples to illustrate the changing requirements necessary to retain exemption. In light of the examples used, it seems clear that hospitals could serve sufficiently charitable purposes while providing little or no free care.

Ruling 56-185 was expressly modified "to remove therefrom the requirements relating to caring for patients without charge or at rates below cost."[20] In 1973, with Revenue Ruling 73-313, the IRS granted exemption to an organization which built medical facilities in an attempt to induce physicians to practice medicine in a particular area.[21] The IRS reasoned that the complete lack of medical services within the community posed a substantial risk to public health and safety, such that "[p]roviding the physical facility in the manner described bears a clear relationship to lessening of the health hazards resulting from the absence of a local practitioner in the community."[22]

In addition to the positions espoused by the IRS, courts have followed suit in maintaining a flexible definition of "charitable purpose." In *Eastern Kentucky Welfare Rights Organization v. Simon*, the Court examined the validity of Revenue Ruling 69-545 in light of the language of section 501(c)(3).[23] In upholding the validity of the Ruling, the Court heavily relied on changes in the healthcare field. The Court noted that "[t]o continue to base the 'charitable' status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of healthcare."[24]

The first case to rule on the exempt status of an HMO was *Sound Health Association v. Commissioner*.[25] There, the Tax Court again emphasized the flexible construction of "charity" as contemplated by section 501(c)(3).[26] Thus, despite the

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20. *Id.*

21. *See* Rev. Rul. 73-313, 1973-2 C.B. 174. "An organization formed and supported by residents of an isolated rural community to provide a medical building and facilities at reasonable rent to attract a doctor who would provide medical services to the entire community is exempt under section 501(c)(3) of the Code." *Id.*

22. *Id.*

23. 506 F.2d 1278, 1281 (D.C. Cir. 1974).

24. *Id.* at 1288-89. Two major factors underlying the court's holding were the increase in public healthcare and the rise of Medicaid and Medicare along with an increase in coverage by medical and hospital insurance. Such changes led to a decrease in the number of indigents requiring free or below-cost medical care.

25. 71 T.C. 158 (1978).

26. *Id.* at 178. In supporting a broad definition of "charitable purpose," the court stated that:

> [W]hile it is true that in the past Congress and the federal courts have conditioned the hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary

changing environment of healthcare delivery, the IRS and courts alike consistently adapted to meet the changes.

B. Pre-Geisinger Interpretations of HMOs' Fulfillment of the Community Benefit Element

As the nature of healthcare delivery continued to evolve in the second half of the twentieth century, one of the dominant structures to emerge was the HMO. In particular, as the costs of healthcare drastically increased in the 1970s and 1980s, membership in HMOs rose exponentially.[27] The National Health Lawyers Association defines an HMO as "a legal entity that combines the insurance of healthcare with the delivery of healthcare. Specifically, HMOs provide or arrange for the provision of comprehensive healthcare services for a fixed, prepaid charge."[28]

Under section 501(c)(3), an exempt organization must be "organized" for one of the enumerated exempt purposes. Federal Regulations set out the standard for passing the "organizational test."[29] Because healthcare delivery has been widely viewed as having an underlying charitable purpose, HMOs can be "organized" for a charitable purpose if they follow the orga-

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society.

Id.

27. *See* NATIONAL HEALTH LAWYERS ASS'N, INTRODUCTION TO ALTERNATIVE DELIVERY MECHANISMS: HMOS, PPO'S & CMPS 5, 5 (Jeanie M. Johnson ed., 1986) (stating that the number of HMOs increased from approximately thirty in 1970 with a total membership of approximately three million, to four hundred in 1986 with a membership of twenty million).

28. *Id.* Under this definition, four characteristics are essential to the structure of HMOs:

> 1. an organized system of healthcare in a geographic area, generally including the services of physicians whom the HMO employs or contracts with and hospitals which the HMO owns or contracts with; 2. a set of comprehensive basic health benefits, specified by state and/or federal law and regulations; 3. a voluntarily enrolled group of persons; and 4. a predetermined and fixed periodic payment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amount of actual services provided.

Id.

29. *See* 26 C.F.R. § 1.501(c)(3)-1(b)(1)(ii) (1997). The organizational test provides the following:

> [A]n organization is organized exclusively for one or more exempt purposes only if its articles of organization . . . (a) Limit the purposes of such organization to one or more exempt purposes; and (b) Do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in the furtherance of one or more exempt purposes.

Id. § 1.501(c)(3) - 1(b)(1)(i).

nizational procedures set forth in the Regulations. Generally, in organizing HMOs, this has not been a highly litigated issue.

Rather, the primary issues surrounding the exemption of healthcare providers, and specifically HMOs, involve the "operational test." Federal Regulations provide a general definition of organizations which are "operated" in furtherance of an exempt purpose.[30] To pass the operational test, no more than an insubstantial part of an organization's activities may be directed to a purpose other than an exempt purpose enumerated in section 501(c)(3).

As previously discussed in Section II, subsection A, the applicable standard for determining whether a hospital is "operating" in furtherance of an exempt charitable purpose involves some measure of free or low-cost care. Likewise, to aid in applying the operational test, the "community benefit" standard was adopted.[31] This new approach resulted from a recognition that healthcare organizations, while unable to feasibly provide free or low-cost care, were able, nonetheless, to provide significant benefits to society as a whole. Under this standard, the courts began looking at a variety of characteristics in addition to free care when determining the tax status of healthcare organizations.[32]

An initial issue with respect to determining whether HMOs would qualify for the section 501(c)(3) exemption was how the community benefit test would be construed. In *Sound Health Association*, the Court held that the appropriate standard involved the same considerations encompassed in evaluating hospitals.[33] Likewise, under Revenue Ruling 69-545, neither

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30. *See* 26 C.F.R. § 1.501(c)(3)-1(c) (1997) The operational test provides the following:

> [A]n organization will be regarded as 'operated exclusively' for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

Id.

31. *See* Rev. Rul. 69-545, 1969-2 C.B. 117 (providing in part that the relevant inquiry with respect to a hospital's exemption is whether the organization provides services which are "deemed beneficial to the community as a whole . . .").

32. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 184 (1978). Among the factors considered by the court were the open subscribership of the HMO, its operation of an emergency room, its operation of an ambulance company, and a research program designed to help physicians to study ways of improving the delivery of services. *Id.*

33. *Id.* at 178-79 (asserting that because providing medical services is a charitable activity,

hospitals nor HMOs are required to provide free care in order to pass the community benefit test. Finally, in 1983, the IRS issued a Revenue Ruling which relaxed the previous requirement that hospitals operate a public emergency room without consideration of the patients' ability to pay for emergency services.[34] Thus, both the IRS and the courts seemed to apply the community benefit test to HMOs as if they were hospitals.

C. Community Benefit and *Geisinger Health Plan*: A Change in Exempt Status for HMOs

GHP was an HMO, incorporated under the laws of Pennsylvania, which served an open subscribership. GHP was part of a large healthcare network which consisted of a number of related organizations, all under the Geisinger Foundation's control.[35] The system as a whole served twenty-seven counties and a total of 2.1 million people.[36] Geisinger Foundation itself was an exempt organization. Likewise, many of the other members of the Geisinger Network were also exempt.[37] Among the other organizations comprising the Geisinger System were the following: "Geisinger Medical Center, a 569-bed tertiary care regional medical center and teaching hospital; Geisinger Wyoming Valley Medical Center, a 230-bed community hospital; and Geisinger Clinic, a group practice employing more than 400 licensed physicians and conducting an extensive medical research program."[38] GHP provided no medical services itself, but contracted with other members of the Geisinger System to provide services to its subscribers.

"it is reasonable to conclude that the tests applied to determine the status of a hospital are relevant to a determination of the status of an HMO").

34. *See* Rev. Rul. 83-157, 1983-2 C.B. 94 (providing that hospitals are no longer required to operate emergency rooms open to the public without regard to ability to pay if so doing would needlessly duplicate already existing services).

35. *See* Geisinger Health Plan v. Commissioner, 62 T.C.M. (CCH) 1656, 1656 (describing purpose and structure of the Geisinger Health Plan).

36. *Id.*

37. *See* Gen. Couns. Mem. 39,830 (Aug. 30, 1990). Geisinger Foundation also operated three for-profit organizations which were not a part of the medical-care network. *See* Geisinger, 62 T.C.M. (CCH) at 1656.

38. Frederick J. Gerhart & Melissa B. Rasman, *HMO Denied Section 501(c)(3) Status by Third Circuit*, 4 J. TAX EXEMPT ORG. 17 (1993). GHP contracted primarily with these entities to deliver services to its subscribers. *Id.*

The IRS initially denied tax exemption to GHP for a number of reasons. First, in 1990, in a General Counsel Memorandum, the Assistant Commissioner identified the characteristics of *Sound Health* which led to its exempt status.[39] In comparing GHP with the Sound Health facility, GCM 39828 identified several differences between the two which it believed justified the denial of exemption. For example, one important factor, as expressed in the General Counsel Memorandum, was the nature of GHP's membership. "Sound Health and [the Assistant Commissioner] require . . . that the membership be truly open, that is, that there be no meaningful restrictions on membership which would preclude a finding that the entity serves the community as a whole."[40] Though the Assistant Commissioner enumerated this as an essential criterion for exempt status, the General Counsel Memorandum offered little evidence which supported the conclusion that there were substantial barriers to membership in GHP, such that it provided no substantial benefit to the community.[41]

Second, and perhaps the most important rationale underlying the IRS's refusal to grant GHP exemption was the nature of risk-sharing exercised under GHP. The Assistant Commissioner stated that if a plan "is found to be providing 'commercial-type' insurance in more than an insubstantial amount, it will be precluded from 501(c)(3) status."[42] Following a lengthy discussion of case law concerning the definition of "commercial insurance," the IRS concluded that non-staffed HMOs, like GHP, were predominantly in the business of pro-

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39. *See* Gen. Couns. Mem. 39,828 (Aug. 30, 1990). Among the factors emphasized were actual provision of services and maintenance of medical facilities and employees, availability of emergency services, and provision of services to nonmembers on a fee-for- service basis. *Id.*

40. *Id.* The factors relevant in determining whether a membership is sufficiently open so as to provide a substantial benefit to the community as a whole are:

> [A] membership composed of both groups and individuals where such individuals compose a substantial portion of the membership; an overt program to attract individuals to become members; a community rating system that provides uniform rates for prepaid care; similar rates charged to individuals and groups (with a possible modest initiation fee for individuals); and no substantive age or health barriers to eligibility for either individuals or groups.

Id.

41. *See id.* The reasons offered by the IRS for denying exemption on restrictive membership grounds was the insubstantial number of individuals enrolled in the program, and no overt attempt by GHP to improve enrollment in that respect. *Id.*

42. *Id.*

viding insurance. The IRS reasoned that because GHP neither provided direct services nor employed any physicians, it functioned essentially in the same manner as an insurance company. Because the risk was shifted from subscribers to the plan and not to actual care providers, the IRS characterized GHP's activities as "providing 'commercial type' insurance."[43] Though the insurance argument was a determinative factor for denying exempt status, for reasons apparently unarticulated, the IRS later abandoned this argument in the litigation which followed.

After receiving a final negative ruling from the IRS, GHP filed suit against the Commissioner in the Tax Court.[44] Initially, the Court looked at GHP's Articles of Incorporation and determined that the Plan was organized for the purpose of providing healthcare to patients in the geographic area served by the Plan.[45] Next, the Court examined the operations of GHP to determine whether or not the Plan provided a substantial benefit to the community. The Court reversed its earlier finding and held that GHP's membership was essentially open to all groups and individuals within the geographic area served by the Plan.[46] In addition, the Court noted that "individual members and group members were required to pay the same amount to petitioner for the healthcare services that they received, which amount was determined on a community rating system by balancing high-risk members against low-risk members."[47] The Court also emphasized the fact that GHP had adopted a subsidized dues program designed to secure healthcare for those unable to afford membership payments.

In its analysis, the Tax Court relied on the aforementioned factors when it applied the *Sound Health* standard to GHP. In

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43. *Id.*

44. *See* Geisinger Health Plan v. Commissioner, 62 T.C.M. (CCH) 1656 (1991).

45. *Id.* at 1657-58 (noting that GHP's articles of incorporation restricted its activities to those serving its exempt purposes).

46. *Id.* at 1659. The Court noted that in its first nine months of operation, GHP enrolled all but six percent of its individual applicants. Less than one year following the commencement of operations, GHP had enrolled 2,380 individual members, and this number eventually increased to 4,396. *Id.*

47. *Id.* Individual members were required to pay an additional premium not required of group members in order to cover the higher administrative costs associated with individual memberships. *Id.*

construing *Sound Health* the court held that "[i]t was that HMO's particular form of membership organization that most qualified it as an organization providing benefit to the community."[48] Contrary to the position taken by the IRS, the Tax Court did not find the differences between GHP and Sound Health dispositive in determining GHP's tax status. Rather, heavily relying on GHP's open-membership and subsidized dues program, the Court ultimately held that GHP was entitled to exemption.[49]

The IRS appealed the Tax Court's decision to the U.S. Court of Appeals for the Third Circuit. Applying the standards set forth in *Sound Health*, the Court reversed the Tax Court and remanded the case for further proceedings.[50] While not expressly overruling *Sound Health*, the Third Circuit did hold that the Court "ventured too far" in that case.[51] According to the Third Circuit, the *Sound Health* Court accorded disproportionate weight to the subsidized dues program. While the Court did recognize that "no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions,"[52] it chose not to follow the Tax Court's analysis. Instead, it faulted that court for relying too heavily upon a relatively open membership to support its proposition that the HMO provided a benefit to the community as a whole, as opposed to just benefitting its subscribers.[53]

The Third Circuit agreed with the IRS that the factors crucial to the exemption of Sound Health were not present in GHP. In particular, the Court focused on the actual provision of healthcare services, and thus distinguished GHP from Sound Health on the grounds that Sound Health owned its own facilities and employed its own physicians.[54] However, if GHP had

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48. *Id.* at 1662.

49. *Id.* at 1664.

50. *See* Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3d Cir. 1993) (holding that Geisinger Health Plan, standing alone, is not entitled to tax exempt status under 26 U.S.C. § 501(c)(3)).

51. *Id.* at 1219 (holding that the *Sound Health* court applied too loose a standard in determining whether that HMO provided a significant community benefit).

52. *Id.* at 1217.

53. *Id.* at 1216.

54. *See id.* at 1217-18 (stressing the fact that the employees of Sound Health provided services not only to members of the HMO, but also to members of the community at large on an outpatient basis).

performed services paralleling those rendered by Sound Health, it would have been needlessly duplicating services already provided by other entities within the Geisinger System. Ultimately, the Third Circuit reversed the Tax Court and decided that GHP was not entitled to exemption under the community benefit standard. The case was remanded to the Tax Court to determine whether GHP could qualify for exemption under the "integral part" doctrine.

D. Community Benefit After *Geisinger I*

In the wake of *Geisinger I* (both the Tax Court and the Third Circuit decisions), it is difficult to ascertain what factors will be accorded the most weight when applying the community benefit test to HMOs. The construction of community benefit articulated in *Sound Health* is more logical in both its formulation and application than the Third Circuit's construction. While the *Sound Health* Court exhibited some confusion in sorting out the private and community benefit tests, it did recognize the close relationship between open membership and community benefit. If subscribership is open to essentially any member of the community, with no barriers other than financial ones, the benefit which accrues to the membership in effect accrues to the community as well.

While the *Sound Health* Court did recognize the existence of a nominal dues program for those unable to afford membership, the case does not appear to have been decided on that basis.[55] Rather, it appears that *Sound Health* was decided primarily on the basis of open membership. Thus, the standards articulated in that case may present some difficulties in providing guidance for construing community benefit. As discussed below, the *Sound Health* standard may need to be modified to yield a construction of the community benefit test that takes into consideration the appropriate factors.

Given the Third Circuit's position in *Geisinger I*, considerable doubt remains concerning the application of the communi-

55. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 187 (1978) (finding that various services including the subsidized dues program go beyond mere emergency room services that characterize a charitable hospital).

ty benefit test to HMOs. Clearly the Third Circuit rejected the *Sound Health* approach with respect to membership. Although the Third Circuit was unwilling to accept the construction of the Tax Court, it offered little in the way of a definitive test for determining whether an HMO provides a sufficient community benefit.

A common point of both *Geisinger I* decisions was that both the 3rd Circuit and IRS seem to have emphasized the provision of services by the organization itself as essential for acquiring exempt status. However, the relative importance of this element has been called into question by two subsequent IRS Revenue Rulings.[56] First, in 1993, the IRS granted Friendly Hills Health Care Network exempt status. The IRS described Friendly Hills Health Care operations as follows:

> You will provide all assets, personal property, management services, and non-physician support personnel. You will contract with the former Medical Group, which has reorganized into a new Medical Group that no longer owns any of the assets used by the integrated health delivery system, to provide all professional medical services for your enrollees.[57]

In granting the network exemption under section 501(c)(3), the IRS relied heavily on the facts that the network owned some medical facilities, continued to operate an emergency room, and conducted some medical research.[58]

Next, the IRS granted the Facey Medical Foundation exempt status even though the foundation itself only would provide "management services and non-physician support."[59] In granting exemption to this foundation, the IRS emphasized the contractual arrangements between the foundation and care providers which required rendering of free services.[60] In addition, the IRS focused on the Foundation's conducting

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56. *See* Friendly Hills Health Care Network Qualifies for (c)(3) Exemption, 93 TNT 40-113 (Feb. 19, 1993); Facey Med. Found. Qualifies for (c)(3) Exemption, 93 TNT 83-116 (Mar. 31, 1993).

57. 93 TNT 40-113.

58. *Id.*

59. *See* Facey Med. Found. Qualifies for (c)(3) Exemption, 93 TNT 83-116 (Mar. 31, 1993) (noting that the Foundation would provide only management services and non-physician support).

60. *Id.*

"significant programs of clinical research and public health education programs."[61]

In light of the Friendly Hills and Facey exemption Rulings, the direct provision of services is not in and of itself a dispositive factor. While the community benefit standard has always been a flexible one, these Rulings demonstrate that flexibility has given way to complete uncertainty. Hopefully, future case law and Revenue Rulings will clarify the standard.

Presently, as there is little guidance as to the relative weight accorded to each of the determinative factors, it would be wise for the IRS to alleviate the present confusion with some definitive guidance. While undoubtedly the test must be applied on a case-by-case basis, organizations need this guidance to ensure compliance with the community benefit standard.

III. APPLICATION OF THE INTEGRAL PART DOCTRINE[62]

A. Definition

The integral part doctrine is not itself contained in the United States Tax Code. Nevertheless, both the IRS and the courts have recognized that the doctrine:

> [P]rovides a means by which organizations may qualify for exemption vicariously through related organizations, as long as they are engaged in activities which would be exempt if the related organizations engaged in them, and as long as those activities are furthering the exempt purposes of the related organizations.[63]

Federal regulations, applicable to feeder organizations, enumerate the requirements for a subsidiary to maintain exemption under the integral part doctrine.[64] Likewise, this construction has

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61. *Id.*

62. The integral part doctrine permits an organization, that would otherwise fail the community benefit test, to retain exemption as long as that entity engages in activities which, if carried on by its related organization, would not produce unrelated-business income. *See infra* footnotes 63-65 and accompanying text for a comprehensive definition of this doctrine.

63. *See* Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1220 (3rd Cir. 1993) (citing Texas Learning Tech. Group v. Commissioner, 958 F.2d 122, 126 (5th Cir. 1992)).

64. *See* 26 C.F.R. § 1.502-1(b) (1996). This section provides in part that "a subsidiary organization is not exempt from tax if it is operated for the primary purpose of carrying on a trade

been widely adopted by the courts when applying the integral part test.[65]

B. Integral Part Test: The Tax Court's Treatment in *Geisinger II*

Having determined that GHP was not entitled to exemption under the community benefit standard, the Third Circuit remanded the case to the Tax Court for a determination of whether GHP was entitled to exemption as an integral part of the Geisinger System.[66] Following an initial discussion of the functional structure of GHP within the Geisinger System, the Tax Court held that GHP was not entitled to exemption because it did not provide an "essential service" to any of its related organizations.[67] Relying on *Squire v. Students Book Corporation*,[68] *Brundage v. Commissioner*,[69] and *B.H.W. Anesthesia Foundation, Incorporated v. Commissioner*,[70] the Tax Court concluded that in order for the integral part doctrine to be applied successfully to GHP, "the population of subscribers would have to overlap substantially with the patients of the related exempt entities."[71] To make this determination, the

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or business which would be an unrelated trade or business (that is, unrelated to exempt activities) if regularly carried on by the parent organization." *Id.* This regulation also provides examples to illustrate the operation of the integral part doctrine. An organization operated for the sole purpose of providing electric power to its exempt parent *would* be exempt under the doctrine. *Id.* However, if the subsidiary, although related to the exempt parent, had as its primary purpose the provision of electric power to organizations other than the parent, it would *not* qualify for exemption. *Id.*

65. *See* Squire v. Student Book Corp., 191 F.2d 1018, 1019 (9th Cir. 1951) (affirming a trial court's decision that a campus book store should be treated as a tax exempt entity since it bore a close and intimate relationship to the functioning of a tax exempt university); Brundage v. Commissioner, 54 T.C. 1468, 1474 (1970) (applying the integral part test to hold an art museum exempt as part of a city school system); B.H.W. Anesthesia Found., Inc. v. Commissioner, 72 T.C. 681, 685-87 (1979) (holding a non-profit corporation, within a teaching hospital's department of anesthesiology, exempt under the integral part doctrine).

66. *See Geisinger*, 985 F.2d at 1220.

67. *See* Geisinger Health Plan v. Commissioner, 100 T.C. 394, 400 (1993) (discussing the final adverse ruling by the IRS against GHP on the integral part issue). The court reasoned:

> [I]n order to qualify for exemption under the integral part theory, petitioner must perform an essential service either to its affiliates or to the class of direct beneficiaries of the charitable activities of its affiliates (in petitioner's case, its patients), as required by the entities in the legal precedents in this area.

Id. (citations omitted).

68. 191 F.2d at 1018.

69. 54 T.C. at 1474.

70. 72 T.C. at 687.

71. *Geisinger*, 100 T.C. at 404.

Tax Court primarily focused on the prior finding of the Third Circuit that GHP's sole purpose was to serve the interests of its subscribers, the court found little, if any, overlap of beneficiaries among GHP and its related organizations.[72]

While the basis upon which the Tax Court ultimately denied exemption is unclear, the Court did acknowledge the traditional approach to applying the integral part test. Both the IRS and GHP referred to the "question of whether petitioner's activities would constitute an unrelated business if conducted by petitioner's affiliate"[73] as dispositive of the issue of GHP's exemption. Analogizing to cases in which laboratory or pharmacy services were provided to those other than patients of the related entities, the IRS argued that because the subscribers of GHP were not patients of any of the related entities, the activities of GHP would be unrelated if conducted by any of the other members of the Geisinger system.[74] In response, GHP pointed out that if one of the other members of the Geisinger system carried on the activities of GHP, it would in fact be more charitable than the HMO which was granted exemption in *Sound Health*.[75]

The Court did not specifically address the merits of either of these arguments, but rather inquired into the number of services rendered to GHP subscribers outside of the Geisinger System.[76] Concluding that the record could not justify a finding either way with respect to the number of services provided to GHP subscribers by unrelated organizations, the Court held that the commissioner did not err in determining that GHP was not entitled to exemption.[77]

Finally, the Court distinguished this case from those where the issue was whether certain business activities would give rise to unrelated-business income taxation.[78] In cases where the amount of taxable income was at issue, courts have routinely separated different kinds of income to determine what

72. *Id.*
73. *Id.*
74. *Id.*
75. *See generally* Sound Health Ass'n v. Commissioner 71 T.C. 158 (1978).
76. *Geisinger*, 100 T.C. at 405.
77. *Id.* at 406.
78. *Id.*

portion of the net income is subject to unrelated-business income taxation.[79] Income generated from transactions with unrelated entities are subject to the tax, while income resulting from the provision of services to the parent organization are not taxed. However, the *Geisinger II* Court held that in cases where exemption is the primary issue, no accounting can be done to separate services provided to the exempt parent and services provided to unrelated entities.[80] This is a curious position, especially in light of the Court's analysis which in effect attempted to make such an allocation. As will be discussed below, the Tax Court's decision is riddled with confusion and inconsistency.

The most glaring of the problems raised by the Tax Court's decision in *Geisinger II* stems from the Court's failure to recognize the inextricably intertwined purposes of GHP and its related affiliates. For example, the Court relies on prior cases and Revenue Rulings which involve the rendering of laboratory and pharmacy services. In fact, the Court should have distinguished these cases from *Geisinger II* for the following reason: in those cases, if the parent organization carried on the activities of the subsidiary, it would have been simple to distinguish between services rendered to the beneficiaries of the parent and those rendered to unrelated entities. The allocation could have been made because the purpose of providing pharmacy or laboratory services is distinguishable from the direct provision of medical services to patients. In contrast, with GHP, both the purpose of GHP and the other related entities within the system, was to provide medical services. Because the GHP provided medical services to its subscribers by contracting with other entities in the Geisinger System, the subscribers of GHP were indistinguishable from the other patients of that entity if the same activities were carried on by one of the other exempt organizations in the system.

In spite of the IRS's position, it is difficult to imagine that if, in fact, the activities of GHP were conducted by one of the other entities in the System, such activities would give rise to

79. *Id.*
80. *Id.* at 406-07.

unrelated-business income taxation for that organization.[81] GHP presented a compelling argument that if any of the other exempt organizations in the System were carrying on the activities of GHP, that entity would look more charitable than the HMO in *Sound Health.* Part of Sound Health's operations consisted of an HMO very similar to GHP.[82] While in that case Sound Health's exemption was ultimately granted on community benefit grounds and not via the integral part doctrine, there is no evidence which suggests that the HMO portion of Sound Health's operations was subject to unrelated-business income taxation. In fact, the operation of a risk-sharing entity was a substantial part of Sound Health's business. Contrary to the position taken by the IRS and the Tax Court in *Geisinger II*, it seems quite unlikely that the operations of GHP, carried on by any of the exempt organizations in the Geisinger System, would give rise to unrelated-business income taxation.

Was the Tax Court suggesting, by examining the record for evidence of services provided to GHP subscribers by non-Geisinger entities, that if the record had shown no substantial amount of services provided by unrelated entities, GHP would have been entitled to exemption? This approach seems entirely inconsistent with the Court's analysis of GHP's limited class of beneficiaries. If, in fact, there were no overlap between the subscribers of GHP and the patients of the other entities within the system, then under the Court's initial analysis, GHP would fail the integral part test even if one hundred percent of the services to GHP subscribers were provided by other Geisinger organizations.

A final and significant difficulty raised by the Tax Court's decision involves the failure to allocate income. The Court held that because the issue was exemption rather than the amount of taxable income, allocation among different types of income was inappropriate. This approach leads to discrepancies in tax treatment based entirely on form as opposed to substance. Under the Tax Court's analysis in *Geisinger II*, an organization

81. *Id.* at 404.

82. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 167-68 (1978) (describing the IRS's initial denial of exemption due to the limited class of beneficiaries).

loses its exemption when *any part* of its operations would be unrelated if carried on by its exempt affiliates. In contrast, a system which performs the same functions within one of the exempt entities of the system retains its exemption. Related entities are penalized solely for operating the organization as a separate entity. It seems that some assessment regarding the number of services provided to the related organizations is necessary to determine an organization's exemption status.

If some small part of an organization's activities would constitute an unrelated trade or business in the hands of its related exempt affiliates, what would be the result? Under the Tax Court's approach, presumably that organization would not be entitled to exemption. If this were the case, the taxable organization would be required to pay income tax on all of its earnings, including that portion associated with services rendered to its related exempt organizations. Were the parent organization to operate the subsidiary within an exempt organization, it would be required to pay unrelated-business income taxation *only on that portion of income derived from non-exempt activities.*

The result described above favors conducting activities, any part of which might give rise to unrelated-business income taxation, within preexisting exempt organizations. As previously discussed, there are a number of valid reasons why operating such organizations as separate entities might be advantageous or necessary. Furthermore, neither legal precedent nor public policies underlying tax treatment of exempt organizations justify such a distinction.

C. *Geisinger II* Appealed to the Third Circuit: Adding to the Confusion

After the Tax Court denied exemption under the integral part doctrine, GHP again appealed to the Third Circuit.[83] In *Geisinger I* (3rd Cir.), the Court had denied exemption under the community benefit standard and remanded the case to the Tax Court for a determination regarding the integral part doctrine.[84] In so doing, the Third Circuit described the integral part test as follows:

> The integral part doctrine provides a means by which organizations may qualify for exemption vicariously through related organizations, as long as they are engaged in activities which would be exempt if the related organizations engaged in them, and as long as those activities are furthering the exempt purposes of the related organizations.[85]

Despite the Third Circuit's own interpretation of the integral part test in *Geisinger I*, when the case was appealed to the Third Circuit [*Geisinger II* (3rd Cir.)], the Court asserted that it was in no way bound by any previous construction of the integral part doctrine, including its own in *Geisinger I*.[86] The Court departed from the traditional construction of the doctrine and concluded that "we will determine whether GHP is exempt from taxation when examined in the context of its relationship with the other entities in the System, but also based upon its own organizational structure."[87] Thus, the Court fashioned a new, two-pronged integral part test known as the "boost test." Under this new test,

> [A] subsidiary which is not entitled to exempt status on its own may only receive such status as an integral part of its § 501(c)(3) qualified parent [footnote omitted] if (i) it is not carrying on a trade or business which would be an unrelated trade or business (that is, unrelated to exempt activities) if regu-

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83. Geisinger Health Plan v. Commissioner, 30 F.3d 494 (3rd Cir. 1994) [hereinafter *Geisinger II* (3rd Cir.)].

84. *See Geisinger*, 985 F.2d at 1221.

85. *Id.* at 1220.

86. *See* Geisinger, 30 F.3d at 499 (holding that although the traditional analysis was relevant, the unrelated-business test was necessary, but not sufficient, for resolving exemption issues under the integral part doctrine). *Id.*

87. *Id.*

> larly carried on by the parent, and (ii) its relationship to its parent somehow enhances the subsidiary's own exempt character to the point that, when the boost provided by the parent is added to the contribution made by the subsidiary itself, the subsidiary would be entitled to § 501(c)(3) status.[88]

To illustrate the workings of the so-called "boost" test, the Court used the classic example of a power company producing electricity solely supplied to an exempt educational organization.[89] The Court reasoned that although the power company could not be exempt on its own, because the provision of electric power is not a charitable activity, its purpose is transposed into a charitable one by virtue of its relationship with the exempt parent. In effect, the power company receives a "boost" from its exempt parent.[90] In applying this new analysis to the Geisinger System, the Court found that GHP could not meet the requirements of the test's second prong.

> Here, we do not think that GHP receives any 'boost' from its association with the Geisinger System . . . the manner in which GHP interacts with other entities in the System makes clear, its association with those entities does nothing to increase the portion of the community for which GHP promotes health— it serves no more people as a part of the System than it would serve otherwise.[91]

Essentially, the Court determined that although the operation of GHP did allow the System as a whole to reach a wider cross section of the community, the subscribers of GHP would comprise the same fraction of the community whether GHP was associated with the System or contracted through entirely unrelated entities. Finally, it bears notice that, having determined that GHP could not meet the boost requirement, the Court declined to address the unrelated-business issue. It did, however, hint that if another of the exempt organizations within the System undertook the activities of GHP it might not incur unrelated-business income taxation.[92]

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88. *Id.* at 501.
89. *Id.* at 501-02.
90. *Id.*
91. *Id.* at 502.
92. *Id.* at 501. The court stated the following:

As with the Tax Court decision, many uncertainties arise in interpreting the Third Circuit decision in *Geisinger II*. The traditional test applied by the courts is found in the federal regulations pertaining to feeder organizations.[93] In fact, at the Tax Court level, both the IRS and GHP stipulated that the relevant issue was whether the activities of GHP, if carried on by another exempt entity within the Geisinger System, would constitute an unrelated trade or business.[94] However, in the face of federal regulations and generally established case law, the Third Circuit saw fit to fashion its own test.

Given its limited application, it is unclear exactly what the second prong of the "boost" test entails. This "boost" test finds no basis in precedent and makes little if any sense as applied in *Geisinger II*.[95] Additionally, it is unclear what results this test would yield in many of the established cases which embody the integral part doctrine. There is considerable doubt as to whether many of the organizations previously granted exemption under the integral part test would retain exemption under the new standard.[96]

> Whether income received by an HMO operated by an entity which also directly operates a healthcare facility would be deemed unrelated business income was answered in the negative by Sound Health. Nevertheless, this is a complex issue which will probably be further explored by the courts and Congress as the entities which pay for healthcare, and those which provide it, begin to intertwine.

Id.

93. *See* 26 C.F.R. § 1.502-1(b) (1996) (describing the traditional integral part doctrine).

94. *See Geisinger*, 100 T.C. at 404 (including a discussion of revenue rulings and exemptions).

95. *See* Bruce R. Hopkins, *Integral Part Doctrine Held to Embody "Boost" Requirement*, 10 EXEMPT ORG. TAX REV. 784, 785 (1994). The author described the holding of the Third Circuit in the following terms:

> Now we have this foolishness in the form of the 'boost' principle— something heretofore not known as part of the law encompassing the integral part doctrine. Someone just 'invented' this one. There is no precedent whatsoever for this pronouncement— and no need for it either.
>
> This newly discovered 'boost' rule requires that the 'parent' provide a 'boost' to the 'subsidiary.' However, up to this point, if there was any 'boost' occurring, it was the other way around. That the court is amiss in articulating a 'boost' requirement and then getting it backward is evident in the example given in the very regulations it cited as the genesis of the integral part doctrine.

Id.

96. *See id.* at 786.

IV. POST-GEISINGER COMMENTARY: IMPLICATIONS FOR THE FUTURE

A. Impact of the Third Circuit Decisions

The initial significant blunder made by the Third Circuit was abandoning the principles which provided the foundation for the *Sound Health* decision.[97] In that case, the Court had the insight to recognize that a subscribership which is open to essentially any member of the community indeed provides a substantial community benefit. Combined with the fact that GHP had in place a program to subsidize membership among indigent members of the community, GHP's open subscribership was sufficient to constitute a substantial community benefit. The conscious effort by GHP to reduce or eliminate financial barriers to membership is evidence that GHP intended to provide medical services to as much of the community as possible. This approach to community benefit makes far more sense than the convoluted analysis undertaken by the Third Circuit.

Practitioners and scholars alike have questioned the validity of the Third Circuit's approach. Lauren K. McNulty, a partner in the Tax-Exempt Organizations Practice Group of Gardner, Carton and Douglas, a Chicago law firm, commented that "[t]he Third Circuit's opinion in effect shifts the focus of the inquiry from whether the potential pool of subscribers is broad enough to encompass the community to whether the HMO benefits members of the community other than its subscribers."[98] Such an approach makes little sense when compared to the approach taken in *Sound Health*.[99] What portion of the community needs to be served by the HMO to constitute a community benefit? Presumably, if every member of the community were a subscriber, the HMO could not be denied exemption on the basis that it only serves its subscribers and

97. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 181 (1978) (defining substantial community benefit).

98. Lauren K. McNulty, *Recent Geisinger Opinions Address Community Benefit and Integral Part Tests*, 7 EXEMPT ORG. TAX REV. 933, 935 (1993) (discussing how the Geisinger decisions set limitations on and made departures from prior analysis of the integral part theory).

99. *See Sound Health*, 71 T.C. at 158.

not the community as a whole. A more realistic approach is to recognize a benefit to the community if a particular subscribership is essentially open to all members of the community.

While it is still unclear just how much weight each factor is accorded under the Third Circuit approach, presumably, one important factor is the direct provision of medical services. Fred Gerhart, Counsel for GHP, responded to this position by asking "[w]hy should it make any difference whether care is provided by contract or employee?"[100] There seems to be no basis for making such a distinction. Particularly in light of the Third Circuit's position on the integral part doctrine, construction of the community benefit standard becomes increasingly more important for healthcare organizations interested in retaining or acquiring exemption. The IRS and the courts need to closely examine the path upon which they have embarked. Thus, it seems that the community benefit standard, defined by the Third Circuit, is a step in the wrong direction.

Given the Third Circuit's decision in *Geisinger II* and the stated position of the IRS on the integral part issue, a separately incorporated healthcare organization must qualify for exemption essentially on its own merits.[101] While empirically untested, such a position may well have a chilling effect on the development of alternative healthcare organizations. Many organizations find it impractical, if not impossible, to operate an HMO like GHP within preexisting exempt entities, and are likewise, financially unable to operate a separately incorporated, but taxable, affiliate.

Given its novelty and confused foundation, it is unclear whether the integral part test espoused by the Third Circuit is here to stay. If the test is indeed to be widely applied, even

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100. Paul Streckfus, *IRS Wins Geisinger Case on Appeal*, 7 EXEMPT ORG.TAX REV. 357, 358 (1993) (discussing the various reactions of practitioners to the Geisinger decisions). The author also noted Gerhart's position that "no other areas of the tax law make this distinction that the Service is making in the Geisinger case." *Id.*

101. *See* Laverne Woods & Peter N. Grant, *The Third Circuit's Integral Part Test In Geisinger Health Plan: Implications for Integrated Delivery Systems*, 10 EXEMPT ORG. TAX REV. 1351, 1353 (1994) (asserting that "[i]n considering the qualifications of an IDS for tax exemption, the IRS has consistently taken the position that the provider entity must meet the exemption requirements, including satisfaction of the community benefit standard, on its own and without reference to the activities of any exempt affiliate").

more confusion will surround its application. Commentators have expressed their dissatisfaction with the test and its application in *Geisinger II* (3rd Cir.).[102]

There has been some debate among practitioners and scholars as to how much, if at all, the new test has truly altered the traditional integral part analysis. Fred Gerhart called the test "a 'novel' approach."[103] On the other hand, Milt Cerny, an attorney with Caplin and Drysdale, a Washington, D.C. law firm, believes that the Third Circuit's test is consistent with past rulings by the IRS.[104] Cerny also added that "the two-pronged test does not add much to the analysis because it is merely a new way of stating the same test."[105] Cerny construes the test as requiring that "the subsidiary's activities must further the exempt purpose of the parent organization."[106] However, the "boost" necessity set forth by the Third Circuit seems to require just the opposite: that the parent organization somehow "boost" the subsidiary such that the exempt purposes of the parent are imputed to the subsidiary.[107] Douglas Mancino of McDermott, Will, and Emery, a law firm in Los Angeles, was of the opinion that the Third Circuit created an entirely new and inconsistent test.[108]

The end result and ultimate implication of the Third Circuit decision is that systems that want to operate HMOs are faced with a serious dilemma. As a result of state laws and regulations,[109] it is not feasible for organizations to operate such HMOs within the structure of preexisting care organizations. Yet, if they incorporate HMOs as separate entities, the

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102. *See, e.g.*, Hopkins, *supra* note 95, at 785 (discussing the confusion and inconsistency associated with the Third Circuit opinion in *Geisinger II*).

103. Marlis L. Carson, *Geisinger Plan Fails Third Circuit's New 'Integral Part' Test*, 10 EXEMPT ORG. TAX REV. 273, 273 (1994) (quoting Fred Gerhart, of the law firm Dechert, Price and Rhoads, counsel to Geisinger).

104. *Id.*

105. *Id.*

106. *Id.*

107. *See* Hopkins, *supra* note 95, at 785.

108. *See* Carson, *supra* note 103, at 273. The author summarized Mancino's views by stating that "the Third Circuit has 'created an unworkable test.' The question should not be whether the affiliation resulted in a greater segment of the population being served by the healthcare system . . . but rather whether the system's overall ability to serve the public is enhanced." *Id.*

109. *See infra* Section I & note 4.

HMOs lose exemption unless they duplicate services already provided by related entities. Even if the unprecedented approach of the Third Circuit is abandoned and the traditional integral part doctrine readopted, under the Tax Court's analysis, healthcare organizations will be left in the same quandary.[110] There are no readily discernable public policy reasons underlying such an approach.[111]

B. The Historical Public Policy Approach to Healthcare

As a matter of public policy, healthcare organizations historically have been exempt from federal income tax under section 501(c)(3) of the IRC and its predecessors.[112] As previously discussed, hospitals were the dominant form of healthcare delivery until the latter part of this century.[113] The IRS, the courts, and scholars alike have recognized that in light of the ever-changing political and economic environment, the policy considerations underlying exemption for healthcare organizations require a flexible definition of charitable medical care.[114]

As the nature of healthcare continues to change, considerable debate has arisen regarding the policy rationales surrounding exempt healthcare organizations. In a 1991 article, Mark Hall and John Colombo criticized the traditional theories underlying exemption for healthcare organizations.[115] They argued that only those healthcare organizations funded primarily

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110. *See* Geisinger, 100 T.C. at 394 (applying in part the traditional integral part test and holding GHP not entitled to exemption).

111. *See* McNulty, *supra* note 98, at 935 (asserting that "[t]he Tax Court's approach seems to unnecessarily narrow the integral part theory. There appears to be no compelling policy reason to preclude an organization seeking exemption under the integral part theory from, in effect, expanding the class of charitable beneficiaries served by the affiliated organizations").

112. *See* Hall & Colombo, *supra* note 14, at 317-18.

113. *See* Marmor, *supra* note 2.

114. *See* Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278, 1287-88 (D.C. Cir. 1974); Rev. Rul. 69-545, 1969-2 C.B. 117 (modifying requirements set forth in Rev. Rul. 56-185, 1956-1 C.B. 202); Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1019 (1988) (stating that "notions of what may be 'charitable' must develop and change with 'contemporary' society and its institutions"); Robert S. Bromberg, *Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective*, *in* TAX PROBLEMS OF NON-PROFIT ORGANIZATIONS 249 (1970).

115. *See generally* Hall & Colombo, *supra* note 14, at 307. The authors criticize the per se, government burden, and community benefit theories of tax exemption and suggest a donative theory as the appropriate standard for granting exemption.

through philanthropic donations should be entitled to exemption under section 501(c)(3).[116] Other scholars have taken a much broader view of tax exemption. For example, Boris Bittker and George Rahdert developed a theory based on the premise that activities not undertaken for profit are inherently untaxable.[117] Finally, Rob Atkinson argued for an "altruism" theory which would encompass a broader scope of nonprofit organizations than does the current law.[118]

In addition to the theories underlying exemption in general, there may be some reasons to be concerned about exemption specifically in the healthcare arena. It often has been suggested that due to the nature of healthcare, incentives for care providers are most appropriately aligned with societal values in a nonprofit framework.[119]

While no theory of tax exemption in the healthcare arena is flawless, the community benefit standard seems to be a reasonable attempt at balancing the underlying policy considerations. The obvious problem arises in defining community benefit and identifying those healthcare organizations which provide a requisite amount of it justifying exemption. If community benefit is to remain the standard under which healthcare organizations are granted or denied exemption, Congress, the IRS, and the courts must look carefully at the construction of community benefit. The definition resulting from the Geisinger litigation is unnecessarily restrictive and unwarranted in light of legal precedent and public policy.

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116. *Id.*

117. *See generally* Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299 (1976) (arguing that the income of nonprofit organizations does not fall under any traditional tax definition of income, and even if it did, it would be impossible to calculate an appropriate tax rate).

118. *See* Rob Atkinson, *Theories of the Special Tax Treatment of Nonprofit Organizations, in* FEDERAL AND STATE TAXATION OF EXEMPT ORGANIZATIONS (1994) (arguing that essentially any organization which provides secondary benefits to society, and whose income is not realized in profits by its founders, should be entitled to exemption).

119. *See* Hall & Colombo, *supra* note 14, at 370-71 (acknowledging that some scholars have argued that the nonprofit form is more attractive to patients because they place more trust in physicians who do not have opportunistic incentives).

V. CONCLUSION

In response to the rising costs of healthcare and the ever-evolving body of medical technology, the function of care providers and the methods of delivery have changed dramatically. One dominant form of restructuring has centered around the development of HMOs. Due to financial and operational considerations, many HMOs have been organized as separate entities. Such restructuring of traditional healthcare institutions has led to a number of difficulties with respect to the tax treatment of some of these organizations. In particular the construction and application of the community benefit and integral part doctrines have led to much confusion in the nonprofit community.

In *Sound Health*, the Tax Court held that a subscribership, open to the public with little or no financial barriers to entry provided a substantial community benefit warranting exemption under section 501(c)(3). However, in *Geisinger I*, the IRS and the Third Circuit retreated from this position. While it is not clear what basis the Court employed to make its decision, it is clear that the *Sound Health* standard was effectively modified. No longer is an open subscribership enough to get over the community benefit hurdle. Whatever the current standard, one thing seems clear: freestanding HMOs which themselves provide little or no direct medical services are no longer entitled to exemption as public charities under section 501(c)(3). This approach represents an unwarranted and unnecessary departure from the traditional flexible standard of charitable care.

In addition to altering accepted notions of community benefit, the Tax Court and the Third Circuit redefined the integral part doctrine in *Geisinger II*. The Tax Court held the activities of GHP to be unrelated to the exempt purposes of the other organizations in the System on the grounds that GHP served only its subscribers, and not the patients of the other entities. This is puzzling, to say the least, given that the express purpose of all the entities within the Geisinger System is to promote healthcare in the community. The Third Circuit then proceeded to change the test to encompass a previously uncontemplated "boost" requirement. The "boost" requirement

finds no basis in legal precedent or public policy, and undoubtedly has added confusion to the integral part analysis.

As we move into the twenty-first century, continued change in the healthcare field seems evident. To accommodate these changes, tax policy also must evolve to facilitate the development of new forms of delivery. Only time will tell, but the *Geisinger* decisions seem to be a step in the wrong direction. Not only have they served to restrict available options regarding the structure of delivery systems, but both *Geisinger I* and *II* have created much uncertainty for those attempting to create new healthcare organizations. Congress and the IRS would do well to carefully examine their current positions with an eye toward clearing up the uncertainty which has resulted from *Geisinger*.