COMMENTS PURSUANT TO
INTERNAL REVENUE SERVICE NOTICE 2003-31
ON POSSIBLE REGULATIONS UNDER SECTION 501(m) OF THE INTERNAL
REVENUE CODE

The following comments are the product of a joint effort of members of the
Section of Taxation and members of the Health Law Section of the American Bar Association. The Health Law Section is submitting under separate cover comments that are substantially identical to these comments.

These comments are the individual views of the members of the Section of
Taxation who prepared them and do not represent the position of the American Bar Association or the Section of Taxation.

These comments were prepared by individual members of the Committee on
Exempt Organizations of the Section of Taxation. Principal responsibility was exercised by Frederick J. Gerhart and Michael A. Clark. Substantive contributions were made by Robert W. Friz and LaVerne Woods. Additional substantive contributions were made by Frederick J. Krull of the Tax Section’s Committee on Insurance Companies. These comments were reviewed on behalf of the Section of Taxation by Richard Bromley for the Section of Taxation’s Committee on Government Submissions and by Carolyn M. Osteen, Council Director for the Committee on Exempt Organizations.

Although members of the Section of Taxation who participated in preparing these comments have clients who would be affected by the federal tax principles addressed by these comments, or have advised clients on the application of such principles, no such member (or the firm or organization to which such member belongs) has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these comments.

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EXECUTIVE SUMMARY

Section 501(m) denies tax-exempt status to an organization if it engages in “commercial-type insurance” to a substantial extent. If the commercial-type insurance activity is less than substantial, it is subjected to unrelated business income tax. Section 501(m) provides an exception for health maintenance organizations. The Internal Revenue Service has announced an intention to propose regulations under section 501(m) and has requested comments on what those regulations should contain.

These comments address three areas. First, they suggest that in defining “commercial-type insurance” the proposed regulations should (1) refer to relevant principles of the unrelated business income tax and the integral part doctrine and (2) exclude self-insurance. Second, these comments suggest that in interpreting the HMO exception, the proposed regulations should look to state-licensing statutes both in defining an HMO and in describing the activities that an HMO can conduct without engaging in commercial-type insurance. Third, these comments suggest relevant factors in determining when an organization’s commercial-type insurance activity should be considered substantial.
I. Introduction

On May 7, 2003, the Internal Revenue Service issued Notice 2003-31, 2003-21 I.R.B. 948, which acknowledged the need for guidance under section 501(m) of the Internal Revenue Code and announced the intention to propose regulations to:

“define the term “commercial-type insurance” and address how section 501(m) applies to organizations described in section 501(c)(3) and section 501(c)(4), including health maintenance organizations.”

Notice 2003-31 requested comments on the content of the regulations to be proposed.

We welcome the opportunity to respond to Notice 2003-31. We commend the Internal Revenue Service for recognizing the need for guidance and seeking comments.

Section 501(m) was enacted by the Tax Reform Act of 1986 and became effective on January 1, 1987. Section 501(m)(1) denies tax-exempt status under either section 501(c)(3) or section 501(c)(4) to an organization if a substantial part of its activities consists of providing “commercial-type insurance.” Section 501(m)(2) provides that “commercial-type insurance” representing less than a substantial part of an organization’s activities will be treated as an unrelated trade or business. Section 501(m)(3) provides five exceptions to the term “commercial-type insurance,” including one for HMOs. No regulations or published guidance has been promulgated under section 501(m).

These comments are limited to the three areas mentioned above in the Executive Summary. They do not address other issues involving tax-exempt status under section 501(c)(3) or section 501(c)(4).

II. Comments on Definition of “Commercial-Type Insurance”

Notice 2003-31 specifically requests comments on the definition of “commercial-type insurance” and the factors that may be indicative of it. Neither “insurance” nor “commercial-type insurance” is defined in the Internal Revenue Code or regulations.

A. Items Included in Commercial-Type Insurance

Much has been written on the meaning of “insurance” and its basic features of risk shifting and risk distribution. E.g., Helvering v. LeGierse, 312 U.S. 531, 539 (1941). Notice 2003-31 acknowledges, based on the legislative history of section 501(m), that risk shifting and risk distribution are the defining characteristics of insurance for purposes of section 501(m).

Notice 2003-31 also surveys the statements in the legislative history and the cases dealing with what constitutes “commercial-type insurance”. H.R. Rep. No. 99-426, 99th Cong., 1st Sess. at 664-665 (1986), reprinted in 1986-3 C.B. (vol. 2) 1, 664-665 (“provision of insurance to the general public at a price sufficient to cover the costs of insurance” and “any insurance of a type provided by commercial insurance companies”); Paratransit Insurance Corporation v.
Commissioner, 102 T.C. 745, 754 (1994) (“every type of insurance that can be purchased in the commercial market”); Florida Hospital Trust Fund v. Commissioner, 103 T.C. 140, 158 (1994), aff’d on other grounds, 71 F. 3d 808 (11th Cir. 1996) (insurance “normally offered by commercial insurers”).

One factor not mentioned in Notice 2003-31 is whether in defining commercial-type insurance it would be helpful to look to the substantial body of law defining an unrelated trade or business, including section 513 of the Code and the regulations thereunder. The same factors that help distinguish an unrelated business from an exempt activity could be useful in defining “commercial-type insurance” under section 501(m).

The purpose of the unrelated business income tax is similar to the purpose of section 501(m), i.e., to prevent tax-exempt organizations from unfairly competing with commercial enterprises. Much the same effect of enacting section 501(m) could have been accomplished by adding a specific provision to section 513 defining commercial-type insurance as an unrelated business. In fact, under section 501(m)(2) an insubstantial level of commercial-type insurance activity is treated as an unrelated business, although the tax is then computed under the more appropriate insurance company provisions of subchapter L instead of sections 511-513.

Several of the criteria used to define an unrelated business should be appropriate and helpful in determining whether an activity is “commercial-type.” For example, if an activity “contributes importantly” to the accomplishment of an exempt purpose, that should be a factor indicating that it is not a “commercial-type” activity. Treas. Reg. § 1.513-1(d)(2).

Another factor that should be relevant in defining commercial-type insurance is the integral part doctrine, which allows related organizations to provide services freely to each other without jeopardizing their tax-exempt status or subjecting their operations to the unrelated business income tax. For example, a subsidiary providing electric power solely to its tax-exempt parent and other related organizations can itself be tax-exempt under the integral part doctrine. Treas. Reg. § 1.502-1(b). The applicability of the integral part doctrine should be another factor indicating that an activity is not a “commercial-type” activity.

B. Excluding Self-Insurance from Section 501(m)

We suggest that the proposed regulations specifically exclude self-insurance from the definition of commercial-type insurance. The legislative history clearly supports this suggestion, as follows:

“Similarly, commercial-type insurance does not include arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance). (Footnote omitted.) For example, if a hospital that is exempt from tax under section 501(c)(3) establishes a trust to accumulate and hold funds for use in satisfying malpractice claims against the hospital, the arrangement does not constitute insurance and accordingly is not treated as providing commercial-type insurance.”
This legislative history confirms the continuing validity of the Service’s long-standing position that an entity created by a hospital to self-insure against professional liability claims is itself tax-exempt under section 501(c)(3). E.g., Rev. Rul. 78-41, 1978-1 C.B. 148. This position is based in part on the integral part doctrine discussed above. The Service has relied on the quoted language from the General Explanation to recognize, although in nonprecedential guidance, that self-insurance is not commercial-type insurance subject to section 501(m). GCM 39761 (Jan. 29, 1988). The proposed regulations should expressly confirm this undisputed principle.

III. Comments on Section 501(m)(3)(B)

Notice 2003-31 specifically requests comments on section 501(m)(3)(B), which excludes from “commercial-type insurance” the following:

(B) incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations.

In interpreting this provision, the proposed regulations should address separately its two basic elements. The first element is the definition of an HMO. The second element is the meaning of the language “incidental health insurance … of a kind customarily provided by” HMOs.

These comments on section 501(m)(3)(B) first focus on the definition of “HMO,” taking the position that the proposed regulations should adopt a broader definition than the one the Service has used previously. They then analyze the language “incidental health insurance … of a kind customarily provided by” HMOs before finishing with a comment on the role of section 501(m)(3)(B).

A. Defining an HMO

Defining an HMO is the first step in applying section 501(m)(3)(B). It is generally recognized that an HMO is both a health care provider and an insurer. It provides or arranges for a broad range of health care services to its subscribers or members (“subscribers”), including preventive care, wellness services, and health education. In addition, it bears the financial risk of providing health care to its subscribers. HMOs also have a managed care feature pursuant to which they coordinate and partner with providers in various ways to manage the care of their subscribers. We will review the HMO definition that the Service has used administratively and then offer an alternative definition for the proposed regulations.

1. Prior Administrative Position
Prior to the issuance of Notice 2003-31, the Internal Revenue Service’s interpretation of section 501(m)(3)(B) was reflected in GCM 39829 (Aug. 24, 1990) and the examination guidelines for HMOs found in Part 7.8.1 of Chapter 27 of the Internal Revenue Manual (the “IRM HMO Guidelines”). Although not precedential guidance, GCM 39829 and the IRM HMO Guidelines reflected the Service’s ruling and administrative position on the application of section 501(m) to HMOs.

GCM 39829 narrowly defines the class of HMOs that can qualify for the section 501(m)(3)(B) exception. GCM 39829’s rationale is that Congress only intended to protect an HMO under section 501(m)(3)(B) if its principal activity is providing health care services rather than providing insurance. To satisfy this “principal activity” standard, GCM 39829 concludes that the HMO must shift substantial risk to its providers through the use of fixed payment methods such as capitated fees and salaried physicians. GCM 39829 offers the staff-model HMO, with its salaried physicians, as the model most clearly covered by section 501(m)(3)(B), but also includes group model, network model and IPA model HMOs if they shift risk to providers through capitation or other fixed-payment methods.

The IRM HMO Guidelines implement the rationale of GCM 39829. The Guidelines acknowledge that an HMO can also accomplish the shift of substantial risk to providers through a substantially discounted fee-for-service schedule subject to a substantial withhold.

2. Support for Broader Definition of HMO

The definition of HMO in GCM 39829 and the IRM HMO Guidelines is unduly restrictive. HMOs use a variety of methods to manage care and shift financial risk to their providers in addition to those recognized by GCM 39829 and the IRM HMO Guidelines, including utilization review, bonuses, risk pools, and a wide range of incentive arrangements. Moreover, the limited budgets of Medicaid HMOs may limit their ability to use the techniques sanctioned by GCM 39829 and the IRM HMO Guidelines.

A broader definition of HMO is supported by (1) the legislative history of section 501(m)(3)(B), (2) Congressional policy favoring HMOs, and (3) the recent decision of the United States Supreme Court in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151 (2002) (“Rush Prudential”).

a. Legislative History of Section 501(m)(3)(B)

There are two elements of the legislative history of section 501(m) that support a broader reading of section 501(m)(3)(B). First, the legislative history of section 501(m)(3)(B) itself supports a broader exclusion for HMOs. Second, the absence of any transition rules for HMOs akin to the elaborate transition rules and relief provisions that were offered to Blue Cross and Blue Shield Plans that lost their tax-exempt status under section 501(m) indicates that Congress did not intend to change the tax-exempt status of HMOs.

delves on how the Committee Reports to the 1986 Act and TAMRA vary in the way they describe section 501(m)(3)(B), and as a consequence fails to give sufficient weight to the final word on Congressional intent, which was reflected in the following language in TAMRA’s Conference Report:

“Under the 1986 Act, the provision relating to organizations engaged in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). The conference agreement clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organization-type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization.” (Emphasis added.)


This legislative history specifically states that section 501(m) “did not alter the tax-exempt status of” HMOs and that section 501(m) contains a “general exemption for” HMOs regardless of whether they provide physician services through employees, partners or under contract. It also clarifies, without the need to amend the statute, that this general exemption extends to vision, dental and other services provided by HMOs. This legislative history strongly supports, if not mandates, a broader interpretation of section 501(m)(3)(B).

The absence of transition rules and relief provisions for health maintenance organizations further supports a broader reading of section 501(m)(3)(B). The 1986 Act contained several transition and relief rules that eased the revocation of tax-exempt status for Blue Cross and Blue Shield Plans, including a “fresh start” basis rule and the special deduction contained in section 833(b). If Congress had intended section 501(m) to revoke the tax-exempt status of a substantial number of HMOs, it presumably would have enacted similar transition and relief rules for them.

b. Congressional Policy Favoring HMOs

When section 501(m) was enacted as part of the 1986 Act, Congress favored and promoted HMOs as a cost-effective means of delivering and financing health care. This policy was reflected in the Health Maintenance Act of 1973, Pub. L. No. 93-222, and its amendments, codified as amended at 42 U.S.C. §§ 300e, et seq. The Supreme Court recently stated: “The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices.” Pegram v. Herdrich, 530 U.S. 211, 233 (2000). This Congressional policy favoring HMOs at the time section 501(m) was enacted supports a broader interpretation of section 501(m)(3)(B).
c. Effect of Rush Prudential

The rationale of GCM 39829 is that section 501(m)(3)(B) was only intended to protect HMOs whose principal activity is providing health care. This “principal activity” rationale is based on a central premise that an HMO can reduce its role as an insurer through certain prescribed ways of shifting risk to providers. The Supreme Court’s opinion in Rush Prudential calls this central premise into question.

In Rush Prudential an HMO had denied coverage to a subscriber and then had attempted to avoid the independent review of that decision provided under Illinois’ HMO statute on the ground that ERISA preempted the Illinois statute. The Supreme Court rejected that position, holding that the HMO was engaged in the business of insurance, that the Illinois statute in question was an insurance statute, and that ERISA does not preempt state insurance laws.

The HMO argued that it was principally a health care provider, not an insurer, because it had shifted financial risk to others, a position similar to the “principal activity” rationale of GCM 39829. The Supreme Court gave that argument short shrift, stating that the HMO had merely reinsured the risk:

“The problem with Rush’s argument is simply that a reinsurance contract does not take the primary insurer out of the insurance business, [citation omitted], and capitation contracts do not relieve the HMO of its obligations to the beneficiary. The HMO is still bound to provide medical care to its members, and this is so regardless of the ability of physicians or third-party insurers to honor their contracts with the HMO.” [122 S.Ct. at 2162.]

Although Rush Prudential did not deal with section 501(m), it involves the very same issue of the extent to which an HMO is an insurer. Rush Prudential directly undermines the central premise of GCM 39829 that an HMO becomes less an insurer when it shifts substantial risk to providers. Rush Prudential confirms that such an exercise merely constitutes reinsurance; the HMO is no less an insurer.

Accordingly, after Rush Prudential the "principal activity" rationale of GCM 39829 is no longer relevant. An HMO should not be defined based on the extent to which it is an insurer. Rush Prudential makes it clear that HMOs can be and are insurers. Thus, the central premise underlying the “principal activity” rationale, i.e., that an HMO is less an insurer if it shifts risk to its providers, was discredited by Rush Prudential. For that reason alone, GCM 39829's approach to defining an HMO should be abandoned.

3. Proposed Broader Definition

Based on the foregoing, it is respectfully submitted that GCM 39829 and the IRM HMO Guidelines are too restrictive in defining the types of HMOs covered by section 501(m)(3)(B). A broader definition would be more in keeping with Congressional intent to provide a general exemption of HMOs from section 501(m) without regard to their model or type.
We suggest that the proposed regulations define an HMO by reference to whether an organization is licensed or regulated as an HMO under state law. This approach has ample precedent in other provisions of the Code and regulations dealing with insurance, where Congress and the Service have deferred to state law and industry standards in defining terms. See, e.g., Treas. Reg. §§ 1.831-3(a) and 1.801-3(a)(1) (formerly § 1.801-1(b)) (definition of “insurance company” gives significant weight to whether company is subject to state insurance laws); section 7702(a) (defining “life insurance contract” in part by reference to applicable state or foreign law); section 832(b)(1)(A) and (b)(6) (deferring to the annual statement filed with the National Association of Insurance Commissioners in computing certain items of income and expense of insurance companies); section 832(b)(7)(E) (reference to state rules for reciprocals); section 832(e)(1)(A) (computing deduction by reference to amount required by state law to be set aside in a reserve for mortgage guaranty insurance losses); and section 833(c)(2) and (4) (defining existing Blue Cross or Blue Shield organizations and certain applicable organizations). See generally, Sears, Roebuck and Co. v. Commissioner, 96 T.C. 61, 85-87 (1991), aff’d in part and rev’d in part, 972 F.2d 858, 866-877 (7th Cir. 1992).

In this regard it is worth noting that section 9832(b)(3) of the Code defines the term “health maintenance organization” in part by reference to whether an organization “is recognized under State law as a health maintenance organization.” Although section 9832 deals with group health plan requirements and is unrelated to section 501(m), it is one provision of the Code that defines health maintenance organization.

Precedent for looking to state law in the exempt organizations area is also found in the fact that “charitable” is defined for purposes of section 501(c)(3) by reference to state law. Its meaning for purposes of section 501(c)(3) is defined “in its generally accepted legal sense” and by looking to the “general law of charity.” Treas. Reg. § 1.501(c)(3)-1(d)(2); Rev. Rul 69-545, 1969-2 C.B. 117.

Using state licensure to define an HMO should simplify the administration of the tax laws. It would avoid drawing lines between different models of HMOs for this purpose. It would also avoid balancing the health care and insurance roles of HMOs. Moreover, a definition based on state law would not be frozen in time and would evolve with the development of HMOs and state licensing standards.

It may not be practical to rely exclusively on state licensure in defining an HMO. It may be necessary to create a general definition as an anti-abuse provision to guard against aberrant state laws, or to provide for situations where an HMO is not licensed or regulated under a state statute. For example, section 9832(b)(3) includes within the definition of HMO an organization that is “regulated under State law for solvency” in the same manner as an HMO. A general definition could be based on a representative state HMO Act and could provide that if the organization in question could qualify under that state HMO Act, the organization will be treated as an HMO for purposes of section 501(m)(3)(B). Regardless of the basis for any such general definition, it should broadly define HMOs so that it is consistent with the Congressional intent reflected in the Conference Report quoted above to provide a general exemption for HMOs from section 501(m).
Even if state licensure is not the exclusive criterion in defining an HMO, it should at least create a presumption that an organization is an HMO for purposes of section 501(m)(3)(B). This would give effect to Congressional intent to provide a general exemption for HMOs from section 501(m), and should simplify the administration of the tax laws.

B. Incidental Health Insurance Customarily Provided by HMOs

The second element of section 501(m)(3)(B) is the meaning of the language that excludes an HMO only to the extent it provides “incidental health insurance … of a kind customarily provided by such organizations.” The key issue in interpreting these two phrases is the extent to which Congress intended it to limit the kinds of activities an HMO may conduct.

1. Prior Administrative Position

GCM 39829 treats these two phrases as placing a substantial limitation on the kinds of activities that HMOs may conduct under section 501(m)(3)(B). GCM 39829 does so by addressing the language in two parts, first focusing on the meaning of the phrase “incidental health insurance” and then focusing on the meaning of the phrase “customarily provided by such organizations.”

GCM 39829 concludes that Congress intended to use “incidental” in its qualitative sense rather than its quantitative sense, but then applies the term solely in support of the position that to be covered by section 501(m)(3)(B), an HMO must shift substantial risk to providers. That position, as noted above, was discredited by Rush Prudential. Accordingly, GCM 39829’s view of “incidental” is undercut in the same manner as its definition of an HMO.

GCM 39829 interprets the phrase “of a kind customarily provided by” HMOs to exclude from section 501(m)(3)(B) “out of plan benefits” such as “point of service” benefits. GCM 39829 concludes that such benefits do not have the fundamental and essential HMO characteristic that subscribers must obtain services from a panel of providers affiliated with the HMO, which GCM 39829 refers to as the “lock-in” feature of HMOs.

2. Support for Broader Interpretation

GCM 39829’s interpretation of these two phrases as a substantial limitation on HMO activities is inconsistent with the language in the TAMRA Conference Report quoted above declaring a “general exemption for” HMOs from section 501(m). The Congressional intention to provide a “general exemption” for HMOs supports a view that the language “incidental health insurance … of a kind customarily provided by” HMOs was not intended as a substantial limitation on HMO operations.

GCM 39829’s limiting interpretation is based in part on the position that only HMO benefits that were in existence and commonly offered by HMOs when the 1986 Act was enacted should qualify under section 501(m)(3)(B). There is no clear indication that this is what Congress intended, or whether instead Congress intended that section 501(m)(3)(B) should evolve with the HMO industry and apply to benefits they customarily provide from time to time. The fact that Congress used a clarification of section 501(m)(3)(B) in the TAMRA Conference Report to ensure that vision and dental services are excluded from section 501(m), rather than
amending section 501(m)(3)(B) for that purpose, supports a broader, evolving view of the kind of services covered by section 501(m)(3)(B). Practitioners have also expressed disagreement with GCM 39829’s assessment of the kinds of HMO activities and practices that were prevalent in 1986.

We agree with GCM 39829 that Congress used “incidental” in section 501(m)(3)(B) in its qualitative sense rather than its quantitative sense. We also agree that, used qualitatively, “incidental” means a “necessary concomitant to” or “normal consequence of”. In that light, it is appropriate to read the two phrases “incidental health insurance” and “of a kind customarily provided by” as conveying one thought. The two terms complement each other. Both describe the kind of health insurance that an HMO may provide. The remaining issue, then, is to determine the kind of health insurance that is customarily provided by HMOs as a normal consequence of their operations.

3. **Suggested Interpretation for Proposed Regulations**

We suggest that the proposed regulations interpret the two phrases “incidental health insurance ... of a kind customarily provided by” HMOs as encompassing any type of health insurance allowed under the terms of an HMO’s license. If a state HMO statute allows an HMO to conduct a type of insurance activity under the terms of its HMO license, that insurance activity can fairly be described both as incidental to the HMO’s operations and as a kind of insurance customarily provided by HMOs. If an HMO were to engage in insurance activity outside the scope of its HMO license or under a different license, that activity would not be covered by the HMO exclusion of section 501(m)(3)(B) and would be tested separately under section 501(m).

This reference to state law can look for precedent to the same insurance provisions of the Code and regulations discussed above. It would advance the clear Congressional intent to provide a general exemption from section 501(m) for HMOs. It would also simplify the administration of the tax laws and allow HMOs the flexibility of adapting to changing regulatory requirements and industry conditions without fear of section 501(m).

C. **Role of Section 501(m)(3)(B)**

It is worth emphasizing the limited effect that a broader interpretation of the HMO exclusion of section 501(m)(3)(B) would have. The standards that the Internal Revenue Service applies to determine whether an HMO is tax-exempt under section 501(c)(3) or section 501(c)(4) are entirely separate and independent from section 501(m). Only after an HMO is recognized as tax-exempt under section 501(c)(3) or section 501(c)(4) does section 501(m) even become relevant. Accordingly, the Service could continue to favor staff model and other “provider-type” HMOs over “arranger-type” HMOs in applying its exemption standards under section 501(c)(3) and section 501(c)(4), even if those factors are not taken into account in applying section 501(m)(3)(B).

Section 501(m) was targeted primarily at Blue Cross and Blue Shield Plans. As demonstrated by the legislative history cited above, Congress did not intend section 501(m) to alter the tax-exempt status of HMOs and provided a general exemption from section 501(m) for
HMOs in section 501(m)(3)(B). To give effect to that Congressional intent should have no effect on the Service’s continuing ability and responsibility to determine under what circumstances an HMO should qualify for tax-exemption under section 501(c)(3) or section 501(c)(4).

IV. Comments on Interpretation of “No Substantial Part”

A. Need for Guidance

Although Notice 2003-31 does not request comments on the appropriate standards for applying the “no substantial part” language of section 501(m)(1), we believe it is a suitable subject for the issuance of guidance. It would be very helpful for organizations described in section 501(c)(3) or section 501(c)(4) to have an objective limit on the level of commercial-type insurance.

B. Position Taken in IRM HMO Guidelines

Prior to Notice 2003-31, the IRM HMO Guidelines used 15% as a safe harbor in applying the “no substantial part” test of section 501(m)(1) to HMOs. Commercial-type insurance was not considered a substantial part of an HMO’s activities so long as it was less than 15% of its activities. If an HMO’s commercial-type insurance exceeded the 15% safe harbor, the IRM HMO Guidelines applied a facts and circumstances test to determine whether the commercial-type insurance was substantial. On two somewhat related points, the IRM HMO Guidelines defined “substantial” discount and “substantial” withhold to mean “at least 15%.”

C. Prior Guidance on Meaning of Substantial

At the time section 501(m)(1) was adopted, it was stated that “no substantial part” was intended to have the same meaning as under the existing law applicable to section 501(c)(3) and section 501(c)(4) organizations. See, e.g., Staff of the Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986 585 (1987), citing Haswell v. United States, 500 F.2d 1133 (Ct. Cl. 1974); Seasongood v. Commissioner, 1227 F.2d 907 (6th Cir. 1955); and section 501(h) of the Code. Although there are detailed regulations interpreting section 501(h) and the related excise tax under section 4911 of the Code, the regulations under section 501(c)(3) give no guidance as to the meaning of “substantial” that would be relevant to the interpretation of section 501(m). Section 501(c)(4) does not preclude lobbying, and the section 501(c)(4) regulations understandably thus give no useful guidance to assist taxpayers in ascertaining the meaning of the “no substantial part” standard in section 501(m).

In Haswell, the Court of Claims concluded that a determination of whether lobbying activities were “substantial” in relationship to the other activities of an exempt organization could best be made by evaluating the amounts spent on lobbying in comparison to the amounts spent on other activities of the organization. In Haswell, the court concluded that approximately 20% of the expenditures of a small organization with total expenses ranging from $50,000 to $103,000 in the two years in issue was “substantial.”

The 20% test of Haswell is somewhat less than the limit chosen by Congress for organizations of a similar size making the lobbying election under section 501(h) of the Code.
Such organizations must have lobbying expenditures exceeding 30% of their exempt purpose expenditures over a four-year period to lose their section 501(c)(3) status.

In *Seasongood*, the court accepted the estimate of the taxpayer that “propaganda” accounted for less than 5% of the “time and effort” of the organization. The court concluded that the prohibited activities were not “substantial” in relationship to the other activities of the organization. *Seasongood* thus establishes a safe harbor of 5% that is clearly not substantial, but is not helpful in setting an upper limit of what is substantial.

Although not directly on point, it is also relevant to examine the term “substantially all,” which is defined in several provisions affecting tax-exempt organizations as meaning 85%. See, e.g., Treas. Reg. §§ 1.514(b)-1(b)(1)(ii); 53.4942(b)-1(c) and 53.4948-1(b); Rev. Rul. 76-208, 1976-1 C.B. 161. If “substantially all” means 85%, “substantial” should mean something more than 15%. The IRM HMO Guidelines are consistent with this view because the Guidelines’ facts and circumstances test allows commercial-type insurance to exceed 15% and still be considered less than substantial.

**D.  Suggested Definition of “No Substantial Part”**

We have three suggestions in defining “no substantial part” for purposes of section 501(m)(1). First, the proposed regulations should adopt a general definition of “no substantial part” that is consistent with the IRM HMO Guidelines’ two-pronged approach. A safe harbor should allow anything up to 15% to be considered insubstantial, and the substantiality of commercial-type insurance exceeding 15% should be analyzed based on the facts and circumstances. This approach adequately acknowledges that “substantial” can mean more than 15%. We note that a safe harbor of more than 15% could well be justified, especially here where there is no reason to be restrictive in interpreting “no substantial part” under section 501(m)(1), because any commercial-type insurance that is allowed is subject to the unrelated business income tax.

Second, we suggest that the “no substantial part” test be applied primarily by looking to premium revenue, which is the most appropriate objective standard. Both Haswell and section 501(h) focus on the level of expenditures, which is an appropriate measure of lobbying activity, and is certainly preferable to the more amorphous standards used in the *Seasongood* case and cases such as *Christian Echoes National Ministry, Inc. v. United States*, 470 F.2d 849 (10th Cir. 1972), *cert. denied*, 414 U.S. 864 (1973). However, in other provisions of the Code where exceeding a certain amount or percentage of income may cause the organization to lose its exempt status for some period of time (for example, section 501(c)(12) and section 501(c)(15)), revenue is used as a measure of “excess” or “substantiality.” We believe that a similar approach focusing on premium revenue would be most reasonable in interpreting section 501(m).

Third, we suggest that the test of “no substantial part” be applied over a period of several years. Although there is no statutory mandate in section 501(m) for a multi-year test akin to section 501(h) or the “normally” test of section 170(b)(1)(A)(vi), the IRM HMO Guidelines allowed the use of a four-year period for this purpose. Moreover, in this context a multi-year test
could be regarded as part of a “facts and circumstances” analysis and, as noted above, there is no reason to be restrictive in defining “no substantial part” for purposes of section 501(m)(1).