INTERNAL REVENUE SERVICE
NATIONAL OFFICE TECHNICAL ADVICE MEMORANDUM

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Taxpayer's Name:
Taxpayer's Address:

Taxpayer's Identification No:
Years Involved:
Date of Conference:

LEGEND:

Taxpayer:

Name A:

Name B:

Organization:

Plan:

Plan A:

Plan B:

Plan C:

Subsidiary 1:

Subsidiary 2:

Subsidiary 3:

State A:

State B:

Case 1:

Case 2:

Year 1:

Year 2:

Year 3:

Year 4:

Year 5:

Number 1:

Number 2

Date A:

Date B:

Title A:

Chapter A:

Chapter B:

Chapter C:

Chapter D:

Bank A:

ISSUE(S):

1. Does Taxpayer qualify for taxation under §833 of the Internal Revenue Code as an existing Blue Cross or Blue Shield organization for taxable years after it lost its Organization license, without regard to any changes in operations or structure?

2. Does Taxpayer's loss of its Organization license constitute a material change in operations or in structure?

CONCLUSION(S):

1. Taxpayer does qualify for taxation under §833 as an existing Blue Cross or Blue Shield organization for taxable years after it lost its Organization license, without regard to any changes in operations or in structure.

2. Taxpayer's loss of its Organization license does not constitute a material change in operation or structure under §833(c)(2)(C).

FACTS:

Taxpayer is a not-for-profit mutually owned corporation which provides health and accident insurance principally in State A. Taxpayer's principal operating subsidiaries are Subsidiary 1, a wholly-owned, for-profit health maintenance organization; Subsidiary 2, a wholly-owned, for profit, subsidiary which provides certain information systems, claims processing, and other administrative services to Taxpayers and customers affiliated with Taxpayer, and; Subsidiary 3, an 80 percent owned for-profit, subsidiary that provides discounted pricing on health care related products and services.

Taxpayer is the successor by merger of several Plans operating in northern State A. The predecessor of Taxpayer was in existence on August 16, 1986, and was exempt from tax for its last taxable year beginning before January 1, 1987. The predecessor of Taxpayer was a member of Organization and held licenses from the Organization for use of the Organization's names and marks on August 16, 1986 and January 1, 1987. Pursuant to §501(m), the tax-exempt status of the predecessor of Taxpayer was revoked for taxable years beginning after December 31, 1986. On Date A, Chapter A of the Code of State A was repealed by an enacted bill that also declared that all hospital service associations would thereafter be governed and taxed as mutual insurance companies under Title A of the Code of State A.

In Year 1, Taxpayer (then known as Name A) attempted to merge with a major hospital group, Name B. The State A Department of Insurance and Organization both

actively opposed the merger. The merger failed, but the failure had repercussions for Taxpayer. Organization revoked Taxpayer's rights to use Organization's trademark and trade name for violating certain Organization licensing requirements. Organization officially transferred the license to operate as a Plan from Taxpayer to Plan C in Year 2. Taxpayer changed its name to drop the Plan name that was previously part of its name. The name change was accomplished with a filing with the state corporation commission.

The attempted merger did result in litigation involving Taxpayer, the Attorney General of State A, and Organization. The Attorney General filed suit in state court seeking a declaration that Taxpayer was a charitable trust under the laws of State A. The suit also sought the removal of Taxpayer's trustees, replacement with trustees satisfactory to the Attorney General, and an appointment of a receiver. This suit, in turn, triggered the revocation of Taxpayer's license by Organization. Taxpayer sought an injunction to prevent the revocation of its license. See, Case 1 (memorandum of opinion and order denying plaintiff's motion for preliminary injunction and granting defendant's motion for preliminary injunction). The court determined that Taxpayer would suffer irreparable harm from losing its rights to use the Plan A names and marks, but that Organization would suffer irreparable harm by use of its marks by a non-licensee. This decision was appealed. In Case 2, the Court of Appeals held that there was a likelihood that Organization would prevail on its claim that licenses had automatically terminated and the order of the District Court was affirmed.

Taxpayer continued under the same contracts that it had previously used in State A. Taxpayer did have to replace the national network of affiliates since it was losing the Plan system's national network. To do so, Taxpayer within a matter of months joined two national healthcare provider networks which provided Taxpayer's subscribers with the same ability to obtain medical services in other states with the physician or hospital payments made by Taxpayer through other network members. Taxpayer continues to operate as a health insurance company under federal and state law.

Of its Number 1 subscribers in Year 1, Taxpayer lost Number 2 subscribers shortly after leaving the Organization. The subscribers that left overwhelmingly represented subscribers that were part of large, national corporate groups, not individuals or members of small groups.

Taxpayer offered one contract with open enrollment in Year 3 and Year 4 but only for a period of time ending with the fulfillment of a state quota, which usually occurred early in the year. Taxpayer did not have full year open enrollment in Year 3 and Year 4: Taxpayer did not have open enrollment in 1986. In 1986, as well as now, individuals could be denied coverage for high-risk or pre-existing conditions or rated higher with a price differential. For group coverage, Taxpayer accepted, rejected, or rated higher groups with high-risk individuals or pre-existing conditions. Taxpayer did not have any community rated business in Year 3 and Year 4; Taxpayer did not have any such business in 1986. In Year 3 and Year 4, Taxpayer was required to accept all

small groups by law, such as the Health Insurance and Portability and Accountability Act ("HIPAA"). Approximately half of Taxpayer's total premiums in Year 3 and Year 4 were from individuals and small groups.

After losing its Organization license Taxpayer continued to offer precisely the same group and individual contracts that it had offered as a member of the Organization except for the change in name. No changes have been made since August 16, 1986, in Taxpayer's coverage of small groups or high-risk individuals except as required to conform to Federal (HIPAA) and corresponding state statute and regulations which would have as their purpose the improved access to coverage for individuals and small groups.

Taxpayer has been a not for-profit corporation since its organization. Currently, Taxpayer is governed by numerous chapters of State A's Code. Taxpayer must follow Chapter B for non-profit corporations, Chapter C for operations of mutual insurance companies, and Chapter D for sickness and accident insurance. Taxpayer states that it is the only active not-for-profit health insurance company in State A.

The Plan name and marks are owned and controlled by Organization, which is a non-profit corporation organized under the laws of State B. As of Date B, The Bylaws of Organization restrict regular membership in the Organization to Plans, which include Plan A and Plan B. Taxpayer is a Plan that is a combination of Plan A and Plan B. Plan A offers hospitalization coverage while Plan B offers medical and surgical coverage.

Organization's Articles of Incorporation state that the purpose of Organization includes the promotion of public health and safety, protection of the Plans' names and marks and maintenance of membership standards.

As owner and licensor of Plan names and marks, the Organization monitored compliance with the licensing agreements and policed any service name or service mark infringement.

The Organization also provided support services for its members Plans:

1. The Bank A served as a clearing house for the transfer of funds between the Plans.
2. The Organization supplied a private telecommunication system which provided computer access for and linked all Plans.
3. The Organization contracted with the federal government on behalf of the Plans to provide health insurance to federal employees. Since Organization was not an insurance company itself, it subcontracted with the member Plans to provide health care coverage for federal employees within each Plan's service area.

4. The Organization contracted with the United States Department of Health and Human Services to deliver Part A of the Medicare program, which it subcontracted to its member Plans.
5. The Organization provided national networks on behalf of its member Plans for various new health care products. The networks served as national marketing vehicles for the member Plans.

As of January 1, 1987, the health care insurance traditionally offered by member Plans had three basic distinctive features:

1. The insurance was a prepaid service benefit program. Each member Plan contracted with hospitals, physicians, and other health care providers within the geographic area and negotiated prices for services to be provided to the Plan's subscribers. After providing services to a Plan subscriber, the health care provider would file a claim directly with the Plan and would be paid directly by the Plan, eliminating any requirement for the subscriber to pay for the services and file a claim for reimbursement by the Plan.
2. The coverage was portable. A subscriber of the Plan could travel anywhere in the United States and process a claim through any other Plan. That Plan would then be reimbursed through Bank A by the originating Plan. In addition, the subscriber who changed residence could automatically transfer coverage to the member Plan in the new locale with a minimum of paper work and delay.
3. As of January 1, 1987, all member Plans were community based not-for profit Plans. The not for profit requirement was eliminated in Year 5. The Plans were based on geographic areas, some operating statewide. None operated outside the state in which it was licensed. Currently, the operations of member Plans are no longer restricted to the states in which they were organized and many Plans are engaged in multi-state operations.

In order to use the Plan names and marks, an entity must become a member of the Organization and apply for licenses from the Organization. As of January 1, 1987, an applicant was required to meet ten membership standards and membership is renewed annually.

1. The Plan must be organized as a not-for-profit entity.
2. The Plan's activities must be directed principally to health care financing and delivery.
3. The Plan must maintain a governing board of a majority of persons other than providers of health care services.
4. The Plan must grant the Organization the right to examine its affairs.
5. The Plan must furnish in a timely and accurate manner all reports and records as required by the Organization's Board.
6. The Plan shall comply with each designated policy adopted by two-thirds affirmative vote of the entire Organization's Board provided that the proposed

designated policy is submitted to the Board and to Plans at least 14 days prior to the Organization's Board meeting at which it is to be considered.
7. The Plan must agree to submit all matters to Board-established mediation before instituting legal action against another Plan or the Association.
8. The Plan must operate in a manner responsive to marketplace demands, which was measured in reference to enrollment, service levels, benefit management activities, and reporting performance.
9. The Plan must maintain adequate financial resources to protect the interests of its subscribers.
10. The Plan must participate effectively and efficiently in each national program adopted by member plans.

Standards one through seven were mandatory whereas noncompliance with standards eight through ten could result in conditional membership status or non-renewal of membership.

The Organization's license agreement allowed Plan A "to use the licensed marks as service marks, in sale and advertising of programs for health care and related services operated on a non-profit basis in a manner approved by [the Organization] in regulations of general application to prevent impairment of the distinctiveness of the Licensed Mark and Licensed Name and the good will pertaining thereto." The Licensed Name could also be used as a trade name by Plan A and could be used in the Plan A's corporate name. Further, the licensed agreement provided that "[t]he rights hereby granted are exclusive to Plan A within the geographical area served by the [Plan A] on the effective date of this License Agreement." The Organization in turn agreed "that it will not grant any other license effective during the term of this Licensed Agreement for use of the Licensed Marks or Licensed Name which is inconsistent with the rights granted to Plan hereunder." "The license hereby granted to Plan A is and shall be personal to the Plan A so licensed and shall not be assignable by any act of the Plan A, directly or indirectly, without the written consent of [the Organization]." The license agreements with all member Plan As were identical.

The Plan B licensing agreement similarly authorized the member Plan Bs to use the name and marks for medical, surgical and other auxiliary health care services "in commerce among the several states or in foreign commerce" but made no mention of geographic areas or rights personal to Plan B or the granting of other licenses inconsistent with the present grant. The license agreements with all member Plan Bs were identical.

LAW AND ANALYSIS:

Section 833 provides that existing Blue Cross or Blue Shield organizations are subject to tax as if they were stock insurance companies under Part II of Subchapter L. Section 833(a)(2) provides for a special deduction determined under §833(b), which is the excess (if any) of 25 percent of the sum of (i) the claims incurred during the taxable

year and liabilities incurred during the taxable year under cost-plus contracts, and expenses incurred during the taxable year in connection with the administration, adjustment, or settlement of claims in connection with the administration of cost-plus contracts, over the adjusted surplus as of the beginning of the taxable year. Section 833(b)(2) provides that the deduction determined under §833(b)(1) for any taxable year shall not exceed taxable income for such taxable year (determined without regard to such deduction). Section 833(a)(3) provides that the reduction to unearned premiums set forth in §832(b)(4)(B) shall not apply to §833 organizations.

To be subject to the provisions of §833, §833(c)(1) provides that an organization must be (A) an "existing Blue Cross or Blue Shield organization" as defined in §833(c)(2), or (B) an organization meeting the requirements of §833(c)(3). Section 833(c)(2) defines the term "existing Blue Cross or Blue Shield organization" to mean any Blue Cross or Blue Shield organization if: (1) such organization was in existence on August 16, 1986, (2) the organization is determined to be exempt from tax for its last taxable year beginning before January 1, 1987, and (3) no material change has occurred in the operations of such organization or in its structure after August 16, 1986, and before the close of its taxable year. Furthermore, any successor to an organization that was an existing Blue Cross or Blue Shield organization as defined in §833(c)(2), and any organization resulting from the merger or consolidation of organizations which meet the requirements of §833(c)(2), are to be treated as existing Blue Cross or Blue Shield organizations for purposes of §833 to the extent permitted by the Secretary of the Treasury.

The Conference Report regarding §833 (section 1012 of the Tax Reform Act of 1986), 2 H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-344 to II-351 (1986), 1986-3 (Vol. 4) C. B. 344 to 351, contains certain principles that are to be applied to determine whether a material change in operations or structure has occurred under §833(c)(2).

First, the merger or split up of one or more Blue Cross or Blue Shield organizations will not constitute a material change in operations or structure.

Second, if a Blue Cross or Blue Shield organization acquires a new line of business or is acquired by another business (other than a health business), the acquisition does not constitute a material change in operations or structure of the organization if (1) the assets of the other business are a de minimis percentage (i.e., less than 10 percent) of the assets of the existing Blue Cross or Blue Shield organization at the time of the acquisition, or (2) the taxpayer can demonstrate to the Secretary of the Treasury that, based on all the facts and circumstances, the acquisition does not constitute a material change in operations or structure of the existing Blue Cross/Blue Shield organization.

Third, a material change in operations occurs if an existing Blue/Cross Blue Shield organization drops high risk coverage or substantially changes the terms and conditions under which high risk coverage is offered by the organization from the terms

in effect as of August 16, 1986. A change in high risk coverage is considered substantial if the effect of the change is to defeat the purpose of high risk coverage. High risk coverage for this purpose generally means the coverage of individuals and small groups to the extent the organization (1) provides such coverage under the specified terms and conditions as of August 16, 1986, or (2) meets the statutory minimum definition of high risk coverage for new organizations. A material change in operations does not occur if an existing organization alters its operations to provide high risk coverage that meets the minimum standards under the conference agreement for new Blue Cross/Blue Shield organizations.

For example, if an existing Blue Cross/Blue Shield organization provides open enrollment to all individuals and small groups of less than 5 individuals, the organization could redefine a small group for purposes of this coverage to mean the lesser of 15 individuals or the minimum number of individuals required for a small group under state law. Such a redefinition of a small group (from 5 to 15 individuals) would not be considered a material change in operations because the organization would meet the minimum standard for a new organization with respect to small group coverage.

On the other hand, if an existing Blue Cross/Blue Shield organization provides, as of August 16, 1986, high risk coverage to individuals and small groups without a premium or price differential to take into account the high risk nature of the business, a change in premium structure for such individual and small group coverage that has the effect of creating a significant price differential to take account of the high risk nature of the business would be considered a material change in operations.

During the Senate debate regarding this provision of the Tax Reform Act of 1986, The Chairman of the Senate Finance Committee (Senator Packwood) discussed the meaning of the material change in operations and structure provision with another member of the Finance Committee (Senator Chafee). The following is one of their exchanges:

> MR. CHAFEE: I would appreciate the chairman's clarifying some aspects of that important provision. The Bill limits the use of the deduction to existing Blue Cross and Blue Shield organization which do not materially change their operations after the date of the conference agreement. Does this mean that any change in the organization's operations after that date will cause it to lose the deduction?
>
> MR. PACKWOOD: Certainly not. The purpose of the limitation is to deny the deduction to the organization only if it makes a change in its operations which is so material that the change has the effect of eliminating coverage for a high-risk segment of its business. An example of such a material change would be the elimination of coverage for individuals.

123 Cong. Rec. 513957 (daily ed. Sept. 27, 1986).

Subsequently, Congressman Rostenkowski, the Chairman of the Ways and Means Committee, made a statement on October 2, 1986, with respect to several of the colloquies between Senator Packwood and other members of the Senate. Although Mr. Rostenkowski stated his belief that certain aspects of the colloquies on §833 did not reflect his understanding of the intent of the conferees, his summary of the intent of the conferees with respect to material change in operations was consistent with the view expressed by Mr. Packwood. Rep. Rostenkowski said, in part:

> It was not the intent of the conferees to prevent an existing Blue Cross and Blue Shield organization from making normal adjustments in their business practices, such as adjustments to reflect new trends in cost containment or adding new coverages. However, it is my understanding that any change in business practice that either eliminates coverage of high risk individuals or small groups or that has the effect of eliminating such coverage is a material change in structure or operation. For example, a premium increase that has the effect of making high-risk coverage unavailable because of the cost of such coverage is treated as a material change.

132 Cong. Rec. E3391 (daily ed. Oct. 2, 1986).

The General Explanation of the Tax Reform Act of 1986 (the “Blue Book”), at pages 587-588, prepared by the staff of the Joint Committee on Taxation (1987), states that the merger or split up of one or more Blue Cross or Blue Shield organizations, or the conversion to mutual status under local law, will not constitute a material change in operations or structure. The Blue Book provides a further explanation of what is considered a change in operations. A material change in operations occurs if the effect is to eliminate coverage for a significant high-risk segment of the plan’s business. Whether a change in operations constitutes a material change in operations depends on all the facts and circumstances.

The Blue Book provides that a material change is presumed to occur if an organization, on or after August 16, 1986, ceases to offer coverage for those individuals or small groups or conversion coverage for those individuals, who leave an employment-based group because of termination of employment. A material change generally occurs if an organization which on August 16, 1986, offered individual coverage that allowed enrollment regardless of medical condition, modifies enrollment practices for that coverage to exclude certain individuals because of a preexisting medical problem.

The Blue Book also states that a material change in operations does not occur if the plan increases its premium rates to reflect increases in health care costs or makes normal changes in products or services to respond to changes and developments generally in the health care environment. Thus, this material change in operations rule is not intended to prevent a plan from making normal adjustments in their business practices, such as adjustments to reflect new trends in cost containment or adding new coverages.

Any change in business practice that eliminates coverage of high-risk individuals or small groups or has the effect of eliminating such coverage, however, is a material change in structure or operations. For example, a premium increase that reflects normal increases in medical costs is not itself treated as a material change. On the other hand, a premium increase that has the effect of making high risk coverage unavailable because the cost of such coverage is treated as a material change.

Similarly, a material change generally will occur if an organization after August 16, 1986, ceases offering individual or small group coverage in a defined geographic area due to a concentration of high risk individuals in that area. In addition, a material change generally will occur if an organization institutes, subsequent to August 16, 1986, a procedure to identify particular individuals within the pool of individual enrollment, reassesses their individual risk due to excessive utilization, and cancels their coverage.

The Blue Book states that the material change rule is not intended to prevent existing Blue Cross and Blue Shield organizations from changing their high risk coverage to respond better to the needs of that population. For example, a material change would not occur if the organization introduced a preferred provider arrangement or a managed care product for individual high risk coverage that included financial incentives or requirements to use more cost effective providers or benefits (e.g. home health or hospice care rather than hospitalization). The material change rule also is not intended to prevent existing Blue Cross and Blue Shield organizations from establishing special coverages that recognize healthy lifestyles. For example, a material change would not occur if smokers were charged a higher premium than non-smokers.

The first issue to be addressed is whether Taxpayer qualifies for taxation under §833 as an existing Blue Cross or Blue Shield organization for taxable years after it lost its Blue Cross and Blue Shield license, without regard to any changes in operations or structure. Does the literal language of §833 require that for any particular taxable period, “an existing Blue Cross or Blue Shield organization” must first of all be a Blue Cross or Blue Shield organization, and second must it meet the additional three conditions of §833(c)(2)(A), (B), and (C)? The question is whether §833(c)(2) continues to requires that an entity to be licensed by Organization as an ongoing requirement of this provision of the Code.

When §833 was enacted, it was intended to apply to a specific group of taxpayers that lost their tax exempt status under §501(m). Taxpayer qualified as an existing Blue Cross or Blue Shield organization under §833(c)(2) for taxable years before the Organization revoked its license. Neither the Code nor the legislative history of §§ 833 and 501(m) (there are no regulations), explain in any detail as to who were existing Blue Cross or Blue Shield organizations on August 16, 1986. At the time these provisions were enacted the Congress knew what entities had licenses from the Organization. However, it must have been assumed that an entity that was allowed to

use the name and marks of the Organization was licensed to do so at the time §833 was enacted. This would mean that licensing was an initial requirement of §833.

We do not find any support in either §833 or its legislative history for a requirement that the entity must continue to be licensed by Organization. Neither the Code provision nor its legislative history explain the licensing requirements of Organization. We do not believe that Congress intended that an unnamed organization would be allowed the control over a taxpayer's use of a specific tax provision without explicitly imposing such a requirement. Therefore, Taxpayer qualifies for taxation under §833 as an existing Blue Cross and Blue Shield organization for taxable years after it lost its Organization license, without regard to any changes in its operation or structure.

The second issue is whether Taxpayer's loss of the Organization license constitutes a material change in operations or structure for purposes of §833(c)(2). To continue to qualify as an existing Blue Cross or Blue Shield organization under §833(c)(2) there is a requirement that no material change has occurred in the operations of such organization or in its structure after August 16,1986, and before the close of the taxable year. The flush language of §833(c)(2) provides that to the extent permitted by the Secretary, any successor to an organization meeting the requirements of §833(c)(2), any organization resulting from the merger or consolidation of organizations each of which has meet such requirements, shall be treated as an existing Blue Cross or Blue Shield organization. In effect, this language provides that such changes are not considered material changes for this provision. The legislative history and the Blue Book do contain guidance as to what is considered a material change in structure or operations. The merger or split up of one or more existing Blue Cross/Blue Shield organizations, or the conversion to a mutual company status under local law, will not constitute a material change in operations or structure. There is no material change in operations or structure in the acquisition of (or acquisition by) a new line of business (other than the health business) if the assets are a de minimus amount (i.e., less than 10 percent) of the existing Blue Cross/Blue Shield organization at the time of the acquisition. Although words generally carry their usual and customary meaning, we believe Congress used "operations" in a narrow context. A change in operations appears to be limited to dropping high risk coverage of individuals or small groups or substantially changing the terms and conditions under which high risk coverage is offered by the organization from the terms and conditions in effect as of August 16, 1986. The focus that the legislative history places on changes to high risk coverage implies that this was the predominant issue that they were concerned with as to a material change in both structure and operations.

Based on the descriptions provided of material change in structure or operations, we conclude that the loss of the license was not a material change in structure. The loss of affiliation with Organization does not affect Taxpayer's corporate structure. The legal organization remained unchanged in all respects. Taxpayer is and has been a not-for-profit entity since 1986. The resulting change in name (by a filing with the state

corporation commission), the change in provider networks and loss of subscribers by taxpayer are changes in operations but they are not the type of change in operations that is described in the legislative history as a material change in operations. Therefore, Taxpayer's loss of the Organization license is not a material change in structure or operations under §833(c)(2)(C).

CAVEAT(S):

A copy of this technical advice memorandum is to be given to the taxpayer(s). Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.