NEW YORK CITY TAX APPEALS TRIBUNAL
ADMINISTRATIVE LAW JUDGE DIVISION

In the Matter of the Petition	:	**DETERMINATION**
Of	:	**TAT(H) 12-3(GC)** **TAT(H) 12-4(GC)**
AETNA, INC.	:	

Gallancy-Wininger, A.L.J.:

Petitioner, Aetna Inc., 100 Park Avenue - 12th Floor, New York, New York 10017 filed two Petitions for Hearing (Petition or Petitions) with the New York City (City) Tax Appeals Tribunal (Tribunal) to review Notices of Disallowance (NOD) of two refund claims (Refund Claims) based on claimed overpayments of City General Corporation Tax (GCT). The first Petition, TAT (H) 12-3, filed with the Tribunal on February 10, 2012, seeks review of an NOD issued by the City Department of Finance (Department or Respondent) dated February 12, 2010, denying a refund in the amount of $482,733, for a claimed overpayment of GCT for the period from January 1, 2005 to December 31, 2005. The second Petition, TAT (H) 12-4, also filed with the Tribunal on February 10, 2012, seeks review of an NOD issued by the Department dated April 25, 2011, denying a refund in the amount of $639,489 for a claimed overpayment of GCT for the period from January 1, 2006 to December 31, 2006. The period in issue is January 1, 2005 through December 31, 2006 (Period in Issue). The two Petitions were consolidated for Hearing by former Chief Judge Warren P. Hauben.

Petitioner appeared by Peter L. Faber, Esq. and Maria P. Eberle, Esq., of the firm of McDermott Will & Emery, LLP. Respondent was represented by Martin Nussbaum, Esq., Assistant Corporation Counsel.

A Hearing was held on January 29, 2013, at which time testimony was taken and a Joint Stipulation As To Facts and

Exhibits was admitted into evidence. Additional Exhibits were admitted into evidence at the Hearing. Petitioner submitted a post-hearing brief summarizing its legal position on May 1, 2013. Respondent submitted a post-hearing brief summarizing its legal position on July 11, 2013, and Petitioner submitted a post-hearing reply brief on August 12, 2013.

In response to a letter from the undersigned dated March 3, 2014, offering Petitioner and Respondent the opportunity to comment on a restricted opinion dated August 21, 1991, (1991 Opinion) of the New York State (State) Department of Insurance[1] and an informal opinion (2004 Opinion) issued by the Office of the General Counsel of the State Department of Insurance (http://dfs.ny.gov/insurance/ogco2004/rg040208.htm Re: HMO is Subject to Article Four of the New York Insurance Laws [Feb. 13, 2004, accessed July 7, 2014]), copies of which were attached to the Tribunal's letter, Petitioner submitted letters to the Tribunal dated March 6, 2014 and March 14, 2014 and Respondent submitted letters to the Tribunal dated March 12, 2014 and March 18, 2014.

ISSUE

Whether the HMOs were "doing an insurance business" in New York State and therefore are not subject to GCT and not properly includable in Petitioner's GCT combined report for the Period in Issue. (*See* former City Administrative Code § R46-3.0.)

FINDINGS OF FACTS

Petitioner, Aetna, Inc., a Pennsylvania corporation, is a holding company. Petitioner's subsidiaries include health maintenance organizations (HMOs).

[1]The Department of Insurance became the Department of Financial Services in 2011. L 2011, ch 62.

Petitioner timely filed a combined GCT report, Form NYC-3A, for calendar year 2005 (2005) and a combined GCT report, Form NYC-3A, for calendar year 2006 (2006). Petitioner's GCT reports reported income and expenses for 63 affiliated entities for 2005 and 69 affiliated entities for 2006.

Petitioner timely filed Refund Claims, requesting refunds of GCT paid for the Period in Issue. The basis of the Refund Claims is Petitioner's position that its affiliated HMOs should not have been included in Petitioner's original GCT reports which were filed on a combined basis for the Period in Issue. Petitioner asserts that the HMOs were "doing an insurance business" in New York State and therefore not properly includable in Petitioner's GCT combined reports for the Period in Issue.

Petitioner's refund claim for 2005 identified 27 entities whose income was included in its consolidated return for the 2005 tax year. Its refund claim for 2006 identified 28 entities whose income was included in its consolidated return for the 2006 tax year.

Respondent disallowed Petitioner's refund claim for 2005 on the basis that "HMO's are not entitled to the exemptions for corporations doing an insurance business within the State. . . Laws of 96 Chapter 772[2]." Respondent disallowed Petitioner's refund claim for 2006 on the basis that "HMO's are not classified as insurance companies and are includable for GCT purposes in the New York City combined return. . . ."

There are four generally accepted HMO business models: (1) the staff model, (2) the group model, (3) the independent physician association, also referred to as an "individual practice association" (IPA) and (4) the network model. In the

[2]It is assumed that the reference to the Laws of "96" is a typographical error which should have read "Laws of 1966."

"staff" model, physicians are salaried and are direct employees of the HMO. This type of HMO provides medical services to its members through its physician-employees. In the "group" model, the HMO does not employ the physicians directly but contracts with a multi-specialty group practice. The physicians, not the HMO, provide medical services to HMO members. In the "IPA" model, unrelated physicians come together in an organization that represents their interests in negotiating with the HMO regarding reimbursement and other matters. The physician may maintain his or her own office and may see non-HMO members (but does not have to). The physicians are not employees of the HMO. The physicians, not the HMO, provide medical services to HMO members. In the "network" model, an HMO contracts with any combination of groups, IPAs, and individual physicians. The physicians, not the HMO, provide medical services to HMO members.

Petitioner's subsidiary, Aetna Health Inc. (Aetna Health),[3] operated as an IPA model HMO in New York during the Period in Issue.

There are two primary ways in which HMOs compensate physicians for medical services provided to members: (1) fee-for-service payments consisting of the amount of the covered claim pursuant to an agreed compensation schedule, or (2) capitation payments, consisting of a fixed dollar amount for each member who selects a particular primary care physician.

Under the fee-for-service model, the HMO pays the physician for each individual service rendered to a patient. The fee is typically pre-arranged in a contractual arrangement with the HMO.

Under the capitation model, the HMO and the physician agree to a per-member per-month payment, which is paid by the HMO

[3]Aetna Health acquired other companies that operated as HMOs in New York State, some of which may have been in existence during the Period in Issue.

regardless of the amount of care that the patient receives. Under the capitation model, if the patient requires care at a cost in excess of the capitation payment, the physician would only be entitled to receive the capitation payment but would nevertheless be required to furnish the necessary care to the patient.

HMOs use primary care physicians who are typically general practitioners, family medicine practitioners, internists or pediatricians. These physicians will take care of a patient's basic health care needs and provide some preventative services. The role of a primary care physician in an HMO depends on whether the HMO is regarded as a "gatekeeper" plan or a "non-referral" plan.

Capitation payments were made by Aetna Health to primary care providers but not to specialists.

During the Period in Issue, payments to primary care physicians for medical claims accounted for less than 10% of Aetna Health's operating costs.

A "gatekeeper plan" is an HMO plan that requires its members to obtain referrals from a primary care physician before seeking treatment from other physicians within the HMO's network. A "gatekeeper" either provides a member with care or directs the member to appropriate care. Gatekeepers reduce unnecessary medical expenses.

A "non-referral" plan does not require that its members obtain referrals from primary care physicians before seeking treatment from other physicians within the HMO's network.

Paul F. Macielak, Esq., President and Chief Executive Officer of the New York Health Plan Association, a trade

association of insurance companies in New York, was offered by Petitioner as an expert regarding the business and operation of HMOs and his testimony was accepted as expert testimony as to such matters. Mr. Macielak did not provide a written report.

Mr. Macielak testified to the characteristics of both HMOs and indemnity insurance companies. Indemnity insurance companies (unlike HMOs), maintain no contractual relationship between the insurance company and the medical professional providing services to the insured member. The contractual relationship is between the indemnity insurance company and its insured member. There is no agreement between the company and the medical service provider as to the amount of the fee to be paid for the provider's services. Instead, the indemnity insurance company will, after the insured pays a deductible amount, pay a specified percentage (e.g., 70% or 80%)of the usual and customary charges of the medical services.

Mr. Macielak testified generally that in his opinion:

a) Insurance involves the payment of a known expected cost (an insurance premium) in exchange for financial protection from an unknown and potentially severe and financially damaging loss that may or may not occur.

b) In the context of health insurance, the risk of loss being transferred is the risk of a catastrophic medical condition that could produce a significant medical cost for an individual.

c) By accepting insurance risk from a large number of individuals, an insurance company that sets its premiums at a sufficient level can financially manage that risk in the aggregate.

Mr. Macielak opined that risk is much more predictable for a large group of persons than it is for a particular individual. He identified this phenomenon as the Law of Large Numbers, which is a statistical theorem that states that an unexpected occurrence becomes more predictable in the aggregate when examining a large number of possible occurrences.

Steven Logan, Petitioner's President and CEO, testified that by collecting insurance premiums set at appropriate levels from multiple policyholders, an insurance company can spread or distribute the cost associated with the occurrence of a particular loss across a large pool of policyholders.

A policyholder (or contract holder) under an HMO could be an individual, a business, or a government. Aetna Health's most common contract holders were groups who provided medical coverage for their employees and dependents.

The terms used by Petitioner and by the State Public Health Law, respectively, to refer to the individuals participating in an HMO are "members" or "enrolees."

When Aetna Health and an employer agree on a benefit plan and rates, they enter into a "Group Agreement" which outlines the terms upon which Aetna Health will provide coverage to the contract holder's employees who are members or enrolees under the Group Agreement.

Aetna Health provides coverage to members of the contract holder's group in exchange for premiums and, Aetna Health's Group Agreements contain provisions regarding the payment of premiums. The payment of premiums is the responsibility of the contract holder and Aetna Health bills the contract holder for the premiums. Typically but not always, the employee has some responsibility for contributing a portion of the premium.

Covered benefits generally include medically necessary items such as primary care physician office visits, hospital visits, routine physical examinations, specialist physician benefits, diagnostic, laboratory and x-ray services and cancer treatment.

Each Group Agreement includes a Certificate of Coverage that outlines the specific benefits available to members. The Certificate of Coverage included with Aetna Health's Group Health Agreements contains provisions regarding the out-of-pocket expenses (co-payments) required to be paid by a member at the time the member receives certain medical benefits.

During the Years in Issue, most of Aetna Health's plans had co-payment requirements. The co-payment amount that a member is required to pay is not impacted by the number of visits a member makes to a physician or the type of procedure performed.

Once enrolled, a member receives an identification card which contains information regarding basic co-payment requirements and whether the plan is a gatekeeper plan or a non-referral plan, a copy of the Certificate of Coverage and, if the member elects to receive a paper copy, a network directory of providers.

A provider (other than one compensated by capitation payments) sends Aetna Health a claim for the difference between the co-payment and the amount that the provider is entitled to receive from Aetna Health for the provider's services. Aetna Health provides the member with an explanation of benefits to advise the member that Aetna Health paid the claim and whether the member has any responsibility.

Approximately 50% of Aetna Health's policies are "gatekeeper plans." If a policy is a gatekeeper plan, the member designates the primary care physician from a voluminous Network Directory of

Providers with names of medical providers that are members of Aetna Health's network.

Certain of Aetna Health's policies provide for out-of-network coverage for medical services provided by a provider with which Aetna Health does not have a contractual relationship and all of Aetna Health's policies provide for out-of-network coverage in an emergency situation. Petitioner did not establish either the percentage of Aetna Health's expenses attributable to, or the percentage of contracts providing for, non-emergency out-of-network coverage.

Aetna Health contracts with IPAS and other medical providers who agree to become members of its network following a credentialing process.

Physicians and hospitals in Aetna Health's network are independent contractors and are free to see patients who are not members of its HMO. Aetna Health's forms of Physicians Group Health Agreements, Primary Care Physician Agreements and Hospital Services Agreements entered into during 2005 and 2006 state that the providers are independent contractors.

Aetna Health's group health agreements specifically provide that Aetna Health does not make any "express or implied warranties or representations concerning the qualifications . . . or quality of services of any [p]hysician, [h]ospital or other participating provider."

Aetna Health does not itself furnish medical services to its members. It does maintain a 24-hour nurse hotline. However, the nurse does not have a file with patient information and does not prescribe medication.

Aetna Health compensates its providers (other than primary physicians) for covered medical expenses based on the fee-for-service model. Primary care physicians may be compensated based on either the fee-for-service model or the capitation model.

The Primary Care Physician's Agreement and Hospital Services Agreement which contain the terms of the agreements between Aetna Health and those primary care physicians and hospitals furnishing medical services to HMO members, describe a "Plan" as "A Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document." (Petitioner's exhibit 1, tab F at 3, tab G at 3.)

Aetna Health's premiums are subject to review and change by its management each year. Such a review takes into account such items as use of medical services, estimated administrative expenses, forecasted medical claims and the potential for profit. Aetna Health files premium rate applications with the Department of Financial Services.

The Primary Care Physician Agreement and Hospital Service Agreement each contain a clause that reads, "WHEREAS, Company offers, issues and administers Full Risk Plans and Plans for Plan Sponsors that provide access to health care services to Members[.]" (Petitioner's exhibit 1, tab F at 3, tab G at 3.)

The Primary Care Physician Agreement states that Aetna Health employs:

> systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage participating physicians and to minimize unnecessary medical costs consistent with sound medical judgment. (Petitioner's exhibit 1, tab F at 10.)

A physician who enters into a Primary Care Physician's Agreement agrees to comply with pre-certification and utilization management requirements.

The Hospital Services Agreement also contains utilization review provisions.

The Notes to Aetna Health's Financial Statements as of December 31, 2005 (Financial Statement), read in part, "Premium revenue for prepaid health care is recognized as income in the month in which enrollees are entitled to health care services." The Financial Statement was "prepared in conformity with accounting practices prescribed and permitted by the New York State Insurance Department."

STATEMENT OF POSITIONS

Petitioner asserts that its HMOs were insurance corporations "doing an insurance business" in New York State within the meaning of the GCT enabling legislation. (*See* L 1966, ch 772, Model Act §41 [4].) Therefore, Petitioner asserts that the HMOs are not subject to GCT and income and expenses of the HMOs were not properly includable in a GCT combined report for the periods at issue. (*See* GCT Rules of City of NY [19 RCNY §11-92 (c)].)

Respondent asserts that Petitioner's HMOs were not doing an insurance business in New York, either within the meaning of the GCT enabling legislation, or when read in *pari materia* with other parts of the State Health Law, the State Tax Law and the City Administrative Code. Respondent asserts that Petitioner was providing access to health care services.

Respondent further asserts that a 2009 amendment to §§ 1500(a) and 1502-a of Article 33 of the State Tax Law (L 2009, ch 57), (which refers to HMOs and subjects HMOs to a premium tax),

demonstrates a recognition that until such amendment, HMOs were not doing an insurance business for tax purposes. Respondent argues that if HMOs were doing an insurance business, the specific reference to HMOs in the 2009 amendment to State Tax Law §§1500(a) and 1502-a would have been superfluous.

Respondent asserts that Petitioner is bound by its characterization of the form of its business (*i.e.*, that it provides access to health care services), in its marketing materials and operations.

Respondent further asserts that a claim of exemption must be strictly construed against the taxpayer claiming such exemption.

There is no dispute as to Petitioner's computation of the amount of its Refund Claims.

CONCLUSIONS OF LAW

Section 11-603 of the Administrative Code imposes the GCT on corporations "for the privilege of doing business, or of employing capital, or of owning or leasing property in the [C]ity in a corporate or organized capacity, or of maintaining an office in the [C]ity. . . ."

Prior to 1974, corporations subject to the City Insurance Corporation Tax were exempt from the GCT. (L 1966, ch 772, Model Act § 3; part IV of tit R, ch 46 of the former Administrative Code eff prior to 9/1/86, § R46-3.0)

Effective July 1, 1974, the State Legislature repealed the City Insurance Corporation Tax. (L 1974, ch 649, § 11.) However, Finance Letter Ruling No. 004772-006 [2000] provides:

> [T]he exemption for insurance corporations remains in effect as a result of the GCT's

> enabling legislation from which the exemption in the former section of the Administrative Code was derived. This enabling legislation was never amended to reflect the repeal of the City Insurance Corporation Tax, and it still precludes the City from subjecting insurance corporations to the GCT.

Laws of 1966, ch 772, Model Act § 41.4 (Model Act §41.4) states that, "The term "insurance corporation," as used in this part, shall include a corporation, association . . . by whatever name known, *doing an insurance business in this state*. . . ." (Emphasis supplied.)

GCT Rules of City of NY (19 RCNY) § 11-92 (c) prohibits the inclusion of insurance corporations, formerly taxable under the former City Insurance Corporation Tax (former Administrative Code Pt IV, tit. R, ch 46), in combined reports.

In order to determine whether Petitioner is "doing an insurance business" it is necessary to consider whether insurance is present and whether Petitioner's HMOs are insurers.

The Concept of Insurance

In *Metropolitan Life Insurance Company v Knapp* (193 A.D. 413, 416 [3rd Dept 1920] *affd* 231 NY 630 [1921]), the Appellate Division, Third Department, quoting Webster[']s [Dictionary], stated that "'insurance' [is a] contract whereby, for a stipulated consideration, called a premium, one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril."

State Insurance Law § 1101 (a) (1) provides as follows:

> "Insurance contract" means any agreement or other transaction whereby one party, the "insurer", is obligated to confer a benefit of pecuniary value upon another party, the "insured" or "beneficiary", dependent on the happening of a fortuitous event in which the

> insured or beneficiary has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event.

State Insurance Law § 1101 (a) (2) defines "fortuitous event" as:

> any occurrence or failure to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party.

Cases regarding captive insurers are instructive as to the question of whether insurance is present. In *Ocean Drilling & Exploration Co. v United States*, (988 F2d 1135, 1148 [US Court of Appeals, Fed Cir 1993]), in considering whether payments by a parent to a wholly-owned insurer constituted insurance premiums that were deductible for federal income tax purposes, the United States Court of Appeals discussed the three-prong test established by decisions of the United States Tax Court to determine whether insurance exists. The test considers the presence of: (i) insurance risk; (ii) risk shifting and risk distributing; and (iii) commonly accepted notions of insurance.

1. Presence of Insurance Risk

As to the first consideration, the presence of insurance risk, the Court, quoting the Tax Court in *AMERCO v Commr.*, (96 TC 18, 1991 WL 4981 [1991]), stated:

> Basic to any insurance transaction must be risk. An insured faces some hazard; an insurer accepts a premium and agrees to perform some act if or when the loss event occurs. If no risk exists, then insurance cannot be present. "Insurance risk" is required; investment risk is insufficient. If the parties structure an apparent insurance transaction so as to effectively eliminate the effect of insurance risk therein, insurance cannot be present.

The risk transferred must be a risk of economic loss. (IRS TAM 200033046 [2000][4], citing *Allied Fidelity Corp. v Commr.*, 66 TC 1068 (1976); *affd*, 572 F2d 1190 [7th Cir. 1978], *cert den*, 439 US 835 [1978].)

2. Risk Shifting and Risk Distributing

The second consideration is whether there is risk shifting and risk distributing. The Tax Court in *Harper Group v Commr.*, (96 TC 45, 58-59 [1991]), quoting *Beech Aircraft Corp. v United States*, (797 F2d 920, 922 [10th Cir. 1986]) stated "'Risk-shifting' means one party shifts his risk of loss to another, and 'risk distributing' means that the party assuming the risk distributes his potential liability, in part, among others." The Court found that

> [I]nsurance is an arrangement or device which must be examined from the perspective of both the insured and the insurer. From the insured's perspective, insurance is protection from financial loss provided by the insurer upon the payment of a premium, i.e., it is a risk transfer device. From the insurer's perspective, insurance is the pooling of a large number of similar risks of a group of insureds out of which pecuniary benefits for a fortuitous loss to any insured members are paid, i.e., it is a risk distribution device. (*Harper* at 57).

3. Commonly Accepted Notions of Insurance

In *Ocean Drilling*, the Court of Appeals for the Federal Circuit, noted that "the Tax Court did not discuss how to apply the requirement that insurance must be present in the commonly

[4]Internal Revenue Service Technical Advice Memorandum (IRS TAM) 200033046 analyzed various categories of HMO to determine whether there was a transfer of economic risk and, with respect to an HMO falling into more than one category, the taxpayer's predominant activity.

accepted sense. The Tax Court dealt with this requirement by applying the facts of each case to determine if insurance existed in a commonly understood manner." (*Ocean Drilling* at 1148.) However, the Court in *Harper* looked to the organization of the insurer, found that the sufficiency of its capitalization was not in dispute, that its premiums were the result of arms-length transactions and that its policies were valid and binding. (*Harper* at 60; *see also, Americo* at 42.) In *Kidde Industries v US*, (40 Fed Cl 42, at 51, 52 [1997]), the Court of Federal Claims concluded that a captive insurer's arrangement was consistent with commonly accepted notions of insurance based on the insurer's organizational structure, and because the insurer's contracts were written to allocate risk; premiums were established based primarily on predictions as to the amount of future claims; and claims were handled in a manner consistent with commonly accepted notions of insurance.

Treatment of HMOs Under Federal Tax Law

HMOs have been distinguished from traditional insurers on the basis that there is no risk shifting to the HMO (or similar organization) because the HMO provides prepaid medical services to its members (similar to a consumer cooperative), rather than indemnifying its members for the cost of medical care (as would a traditional insurer). (*See Jordan v Group Health Ass'n*, 71 App DC 38 [1939]; Rev Rul 68-27, 1968 WL 15297; IRS FSA 1999-1134 [2013] WL 1928554[5]; *Group Life & Health Insurance Company v Royal Drug Company*, 440 US 205 [1979]).[6] In Internal Revenue Service Technical Advice Memorandum (IRS TAM), 200033046 2000 WL33119573, the IRS contrasted various HMO arrangements, determining that HMO arrangements based on capitation fees do not constitute insurance

[5] The Internal Revenue Service(IRS) stated that a determination is required as to the predominant activity of the taxpayer.

[6] *Group Life* (at 1070) held that a prepaid pharmacy plan was an arrangement for the purchase of goods, not involving risk spreading and did not constitute the "business of insurance."

while a non-staff model HMO that does not pay its providers on a fixed-fee basis[7] assumes a financial risk that constitutes insurance.

However, IRS TAM 200033046 was issued prior to the decision of the United States Supreme Court in *Rush Prudential HMO v Moran*, (536 US 355 [2002]). In *Rush*, the Supreme Court addressed whether a provision of Illinois' Health Maintenance Organization Act[8] is preempted by ERISA[9] or whether, the Illinois statute regulates insurance (in which case the statute would prevail). Citing *Group Life & Health*, the Court found that "[t]he commonsense enquiry focuses on [']primary elements of an insurance contract [,][which] are the spreading and underwriting of a policyholder's risk['] . . . ." (440 US at 367) The Court determined that the HMO in *Rush* both provided health care and did so as an insurer. The HMO in *Rush* did not cease to be an insurer and was obligated to provide medical services to its members even if it limits its exposure by such means as capitated contracts with providers and contracts with third-party insurers. (*Rush* at 371)

In *Carter v State Farm Mutual Automobile Insurance*, (808 A2d 466, 472 [2002]), the District of Columbia Court of Appeals determined that HMOs were insurers, finding that HMOs accept risk and are ordinarily considered as being providers of insurance." The Court quoting *Pegram v Herdrich*, (530 US 211 [2000]), stated:

> Beginning in the late 1960's, insurers and others developed new models for health-care delivery, including HMOs. The defining

[7]The IRS conditioned its determination regarding non-staff model HMOs on the proviso that there not be significant fee withholding pending compliance with budget and utilization standards.

[8]The underlying issue involved the right to independent medical review of denials of certain benefits conferred under the Illinois Health Maintenance Organization Act (215 ILCS ch 125).

[9]Employee Retirement Income Security Act of 1974, 88 US Stat 832, as amended, 29 USC § 1001 *et seq*.

> feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed. The HMO thus assumes the *financial risk* of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums.

In Internal Revenue Service Technical Advice Memorandum (IRS TAM) 9412002, 1993 WL 604368, involving two IPA model HMOs, the IRS distinguished the facts in Rev. Rul. 68-27, (which involved medical service contracts under which medical services were provided by salaried medical professionals), determining that an IPA model HMO's contracts with its members constitute insurance contracts, because the risk shifting and risk distribution requirements for insurance had been satisfied. (*See also* Internal Revenue Service Technical Advice Memorandum (IRS TAM) 201117027, 2011 WL 1619105.)

New York

In New York, HMOs are presently regulated under both Article 44 of the State Public Health Law and various provisions of the State Insurance Law.

State Insurance Law § 1102(a), provides:

> An organization complying with the provisions of article forty-four of the public health law may operate without being licensed under this chapter and without being subject to any provisions of this chapter, except: (1) to the extent that such organization must comply with the provisions of this chapter by virtue of such article . . . . (Emphasis supplied.)

Section 1102(a)(2) enumerates 22[10] sections of the Insurance Law that are applicable to HMOs, governing such matters as supervision by the Superintendent of the Department of Financial Services over contracts and premiums; limitations on exclusions for preexisting conditions; licensing of agents; standardization of certain enrolee contracts; and requirements that certain individual and group contracts be community-rated. Section 1109 (d) of the State Insurance Law governs HMOs with respect to permitted investments. Article 74 of the State Insurance Law governs HMOs with respect to rehabilitation liquidation, conservation and dissolution.

Insurance Law § 1109(e) provides that the State Superintendent [of the Department of Financial Services] may promulgate regulations to effectuate the purposes and provisions of both the State Insurance Law and article forty-four of the State Public Health Law and may modify requirements applicable to the contracts between a health maintenance organization and its subscribers.

The Commissioner of Health is required to cooperate with and consult with the Superintendent of the Department of Financial Services and certain matters require the approval or must meet the requirements of the Superintendent. (*See e.g.* Public Health Law §§ 4400; 4403 1. (c); 4403 1.(h); 4406)

Doing an insurance business is defined in Insurance Law § 1101 (b)(1) to include:

> (A) making, or proposing to make, as insurer, any contract, including either insurance or delivery of a policy or contract of insurance to a resident of this state or to any firm, association, or corporation authorized to do business herein, or solicitation of

[10] Of the 22 sections enumerated in State Insurance Law § 1102 (a) (2), two sections, State Insurance Law §§ 313 and 332, have been repealed. (*See*, L 2001, ch 62, pt A.)

> applications for any such policies or contracts; (Emphasis supplied).
>
> * * *
>
> (C) collecting any premium, membership fee, assessment or other consideration for any policy of insurance. (Emphasis supplied).

A 1993 Advisory Opinion (1993 Advisory Opinion) issued by the State Department of Taxation and Finance *(TSB-A-93(4)[c])* states that:

> Under Article 33 of the Tax Law, "doing an insurance business" is not defined. However, historically, the Department of Taxation and Finance looks to the Insurance Law for such definition.
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> * * *
>
> [I]f the business conducted by an HMO organized under Article 44 of the Public Health Law complies with the provisions of Article 44 of the Public Health Law, such HMO is not considered to be doing an insurance business for the purpose of Article 33 of the Tax Law.

It is noted that this 1993 Advisory Opinion predates the Supreme Court decision in *Rush*.

The 2004 Opinion regarding whether HMOs are subject to examination by the State Department of Insurance, concluded that HMOs are insurers, and must comply with Insurance Law § 409(g). The 2004 Opinion quoted the following language contained in the 1991 Opinion[11]:

[11]The 1991 Opinion discussed whether an HMO was obigated to file a certificate of compliance with minimum standards for advertising certain insurance including health insurance. The 1991 Opinion is headed "Privileged and Confidential Pre-Decisional Deliberative Opinion from Counsel to Client" and bears the word "Restricted."

> [w]hile the term *insurer* is not defined in the Insurance Law, it is commonly understood to mean any entity that is doing an insurance business. *Doing an insurance business* is defined in the Insurance Law under Section 1101(b). An HMO that provides a comprehensive health services plan is doing an insurance business under § 1101 and, as noted, the comprehensive health services plan is accident and health insurance . . . . However, Section 1109 (a) provides that an organization complying with Public Health Law Article 44 may operate without being licensed under the Insurance Law and without being subject to any provision of the Insurance Law except to the extent that Article 44 requires the HMO to comply with the provisions of the Insurance Law. This exemption, however, does not make the HMO any less of an insurer; it merely exempts the HMO from certain requirements.
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> * * *

The 2004 Opinion stated further ". . . since HMOs are engaged in the business of insurance, HMOs must report fraud pursuant to N.Y. Ins. Law 405." (Emphasis supplied).

The 1991 Opinion held that a comprehensive health services plan (as defined under § 4401(2) of the Public Health Law) is a plan

> . . .through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge. Such plan is clearly accident and health insurance, as defined in Insurance Law § 1113 (a)(3).

The 1991 Opinion also stated:

> While the term insurer is not defined in the Insurance Law, it is commonly understood to mean an entity that is doing an insurance business. Doing an insurance business is defined in the Insurance Law, under §1101(b). An HMO that provides a comprehensive health

> service plan is doing an insurance business under § 1101. . . .

Respondent points out that § 301 of the Insurance Law grants the State Superintendent of Financial Services the authority to issue regulations. While the regulation set forth in 11 NYCRR § 2.5 established parameters for the issuance of opinions by specifically authorized persons, § 301 of the Insurance Law, does not expressly authorize the issuance of opinions.[12] The State Supreme Court, in *Valley Stream Medical & Rehab*, (15 Misc 3d 576, 579), citing State Administrative Procedure Act § 102 [2] [b][iv], has held that such opinions are "interpretive statements and statements of general policy which in themselves have no legal effect but are merely explanatory. . . ." (*See Application of Park Radiology P.C., v Allstate Insurance Company*, 2 Misc 3d 621, 626 fn 2 [2003]; *State Farm Mutual Automobile Insurance Co., v Mallela*, 372 F3d 500, 506 [2nd Cir 2004]).

Title 11 of the State Code of Rules and Regulations ("State Insurance Department Regulations") contains regulations that apply to HMOs. For example, Regulation § 243.1 (a) defines the term "Insurer" for the purposes of Part 243[13], specifically to include health maintenance organizations and Regulation § 52.42 requires that "contracts, certificates, applications, riders and endorsements used by an HMO to provide benefits and their proposed rates must be filed with and approved by the superintendent [of the Department of Financial Services] in accordance with section 4308 of the Insurance Law." 11 NYCRR § 52.42 also contains regulations regarding guaranteed subscriber rates and certain commissions or fees payable by an HMO to an insurance broker. *See also* 11 NYCRR §§ 52.20 (b) (6) and

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[12] Section 302 (a) (2)of the Financial Services Law, which was added in 2011, after the Years in Issue, authorizes the Superintendent to issue guidance, *inter alia*, interpreting the provisions of the Insurance Law.

[13] 11 NYCRR Part 243 is captioned "Standards of Records Retention by Insurance Companies."

(c)(8)(regarding coverage for pre-existing conditions and creditable coverage, respectively).

The State Public Health Law

State Public Health Law § 4401.1 defines a "Health maintenance organization" or "organization" as:

> . . . any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan.

State Public Health Law § 4401.2 defines "Comprehensive health services plan" or "plan" as:

> . . . a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge. . . (Emphasis supplied.)

And, State Public Health Law § 4401.3 defines "Comprehensive health services" as:

> . . .all of those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services . . . .

State Public Health Law § 4403.1 (c) provides that a certificate of authority shall not be issued unless the applicant is "financially responsible." State Public Health Law § 4403.1

(c) further provides that the term 'financially responsible' means that 'the applicant shall assume full financial risk on a prospective basis for the provision of comprehensive health services . . . .' (Emphasis supplied.) Any insurance or other arrangement by the HMO to establish financial responsibility must be approved by the superintendent of the Department of Financial Services as a prerequisite to the issuance of a certificate of authority. (State Public Health Law § 4403. 1 [c]).

State Public Health Law § 4406.1 provides:

> The contract between an HMO and an enrollee shall be subject to regulation by the superintendent [of the Department of Financial Services] as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law.

The Commissioner of Health is required to consult with the Superintendent of the Department of Financial Services before approving the implementation of an out-of-plan benefits system by an HMO. (State Public Health Law § 4406. 2 [a]).

It is apparent that both the Department of Health and the Department of Financial Services play a significant role in the regulation of HMOs.[14] Statutes, regulations and informal opinions treat HMOs as insurers for a variety of statutory and regulatory purposes.

In 2009, State Tax Law § 1500(a), "Franchise Taxes on Insurance Corporations," was amended specifically to add HMOs to the definition of "insurance corporation." Tax Law § 1502-a,

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[14] State Public Health Law §§ 4408.5 and 4408.6 require HMOs to file reports with the Superintendent of Financial Services regarding their financial condition and, in the case of HMOs providing indemnity plans, the percentage of utilization and certain other information.

which imposes a tax on non-life insurance companies on "all gross direct premiums, less return premiums thereon, written on risks located or resident in" New York, was amended to include HMOs among the entities subject to such tax. Respondent asserts that if HMOs were regarded as "doing an insurance business" in New York, the specific reference to HMOs in the 2009 amendments to Tax Law §§ 1500 (a) and 1502-a would have been superfluous and, that where possible, statutes must be read in a manner to provide every word with meaning. Respondent concludes that the specific addition of HMOs to the 2009 amendments to §§ 1500(a) and 1502-a is evidence that HMOs were not regarded as "doing an insurance business" during the Years in Issue. Petitioner asserts that there are a number of possible reasons for specific reference in the 2009 amendments to Tax Law §§ 1500(a) and 1502-a. Neither Petitioner nor Respondent cites specific legislative history regarding whether, in enacting the 2009 amendments, the legislature regarded HMOs as "doing an insurance business." Respondent's position that the specific reference to HMOs was required because HMOs were not regarded as insurers goes beyond the literal reading of the 2009 amendments. This is particularly true since HMOs were subject to regulation under both the Insurance Law and the Public Health Law prior to the 2009 amendments. The 2009 amendments are prospective, for tax years beginning on or after January 1, 2009. (L 2009 ch 57, part E-1 §10) and do not apply to the Years in Issue.

Respondent asserts that Petitioner is bound by its characterization of its product as "access to health care services" in Petitioner's contracts, marketing materials and annual statement. (*See Spector v Commr.*, 641 F2d 376 (5th Cir), *cert den* 454 US 868 [1981]). In support of this assertion, Respondent points to the Notes to [Petitioner's] Financial Statement that state that "Premium revenue for prepaid health care is recognized as income in the month in which enrollees are entitled to health care services." (Petitioner's exhibit 1, Tab Q at 25.1, Petitioner's exhibit 1, Tab R at 25.1.) Petitioner

asserts in its Reply Brief that the portion of the Notes cited by Respondent merely reflects an accounting concept not relevant to whether or not Petitioner is doing an insurance business. In further support of its position, Respondent also points to Petitioner's Primary Care Physician Agreement which refers to Petitioner offering "Full Risk Plans and Plans for Plan Sponsors that provide access to health care services to Members[.]" Respondent asserts that Petitioner markets the provision of health care services in its marketing materials. Petitioner is both an insurer and a corporation which arranges for the provision of medical services. (*See Rush at 367.)*

Exemptions from taxation must be strictly construed against the taxpayer claiming the exemption. *(Matter of Grace v New York State Tax Comm.*, 37 NY2d 193 [1975]). However, an exemption should not be interpreted so narrowly as to defeat its settled purpose. (*Grace* at 196). Section 3.4 of the Model Act, states that "[c]orporations subject to tax under part . . . four [the Insurance Corporation Tax]. . .shall not be subject to tax under this part. . . ." The definition of "insurance corporation" in Model Act §41.4 "include[s] a corporation, association, joint-stock company or association, person, society, aggregation or partnership, by whatever name known, doing an insurance business in this state. . ." (Emphasis supplied). The purpose of the exemption in § 3.4 of the Model Act is clear: if a corporation was doing an insurance business in New York, then it was not intended to be covered by § 3 of the Model Act, which imposes the GCT. All that is required for a corporation to fall within the exemption, is that, by whatever name known, it does an insurance business in New York. Petitioner does an insurance business in New York.

Petitioner has established that its HMO insureds pay premiums for coverage and that the HMO provides its members with coverage against economic loss that may be caused by unforseen medical expenses. Accordingly, insurance risk is present in

contracts covering the members of Petitioner's HMOs. The members of Petitioner's HMOs spread the risk of loss due to unforseen medical expenses to the HMOs. The HMOs distribute the risk of loss among their respective members. Premiums are established yearly following an internal review process and the filing of a premium rate application with the Department of Financial Services. There does not appear to be an issue regarding the adequacy of capitalization of Petitioner's HMOs, their corporate organization, or their procedure for handling claims (other than that the HMOs are not indemnity insurers). Petitioner's HMOs are subject to significant regulation under the State Insurance Law and the State Public Health Law.

ACCORDINGLY, IT IS CONCLUDED THAT Petitioner was doing an insurance business during the Period in Issue. The income from Petitioner's HMOs should not be included in its combined entire net income as reported on GCT returns for the Period in Issue. Petitioner is entitled to a refund of GCT attributable to income received by its HMOs for the 2005 and 2006 periods. The Petition of Aetna, Inc. is granted and the Notices of Disallowance dated February 12, 2010 and April 25, 2011, are each cancelled.

DATED: July 22, 2014
New York, New York

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Jean Gallancy-Wininger
Administrative Law Judge