

Legal Issues of Firms with Hybrid Organizational Structure in the Healthcare and Insurance Industry

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Abstract

This study presents the complex issues related to hybrid organizational structure, i.e., nonprofit organizations that own for-profit subsidiaries, in the healthcare and insurance industries. The tax code allows chartering of tax-exempt entities if they are organized exclusively for a benevolent purpose with no private individual benefitting from its earnings. These organizations, however, can charter for-profit subsidiaries. This hybrid form has increased in prevalence in the healthcare industry in recent years and raises the question of when an organization no longer warrants nonprofit status. We discuss legal issues related to tax code and competitiveness and illustrate with a case study.

Keywords: healthcare, insurance, non-profit, tax, antitrust

1. Introduction

In the aftermath of the financial crisis of 2008 and the ensuing recession, the United States faces a host of difficulties that need to be alleviated to assure the long-term well-being of its citizenry. Two issues in particular have received a great deal of attention by policy makers, legislators and the media.

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The first matter is the size and unsustainability of federal budget deficits and the second is the lack of availability and affordability of quality health care. Solving the first problem is simple in theory; the federal government needs to increase revenues, decrease expenditures or some combination of the two. Accomplishing such an initiative is not as simple in practice, however. Questions of fairness regarding where and from whom additional funds are raised and expenditures are denied will always be raised.

Ensuring the public's access to affordable health care is a more complicated issue. The United States has a complex system of health care delivery and financing with public and private and for-profit and non-profit providers and insurers. In addition, there are a substantial number of arrangements between non-profit and for-profit organizations.

The health care delivery and financing system has seen a great deal of consolidation in recent years, both horizontal and vertical (Haas-Wilson & Gaynor, 1998). Questions have been raised as to whether this trend has resulted in an anti-competitive industry that is not serving the public as well as it should (Gaynor & Haas-Wilson, 1999).

This study focuses on the tax and antitrust issues related to a subset of organizations in the health care delivery and financing system that we refer to as those with a "hybrid" organizational structure. These are organizations that are either non-profit health care organizations that own for-profit medical insurance subsidiaries or for-profit health care organizations that own non-profit insurance subsidiaries. These organizations have incentives to use the non-profit entity to further the profitability of the other. Included in these incentives is one to expand their operations and monopolize local markets.

We discuss the legal matters of, one, when these organizations should be subject to taxation and, two, when they should be required to cease expansionary activities.

2. Introduction to the Law of Non-profit Corporations

An important legal issue facing the healthcare and medical insurance industry today is when a non-profit corporation no longer warrants non-profit status. Normally, income and profits are subject to federal income taxation pursuant to the rules contained in the Internal Revenue Code. However, provisions in the code allow for the chartering of tax-exempt entities known as non-profit corporations. Rules regarding whether an organization qualifies as a tax-exempt entity are stipulated in § 501© (3) of the code and applicable IRS Regulations (hereinafter denoted by Treas. Reg.). These regulations state that a non-profit corporation is one that is organized and operated exclusively for a charitable, scientific or educational purpose and that no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Even if an organization receives tax-exempt status, it is still free to start joint ventures with for-profit corporations and own for-profit subsidiaries. These hybrid organizational structures can be as simple as a common parent-subsidiary relationship to a highly complex array of various non-profits, for-profits, and joint ventures with both other non-profits and for-profit corporations. In large complex situations, it is often difficult for even the participants in the business arrangements to understand the organizational dynamics and corporate control of the entity. Problems can arise in these ventures when the for-profit entity involved benefits from the tax-exempt status of the non-profit corporation.

The IRS has been highly attentive to these situations and reserves the right to revoke the tax-exempt status of a non-profit when it violates the 4-part test it has developed in Treas. Reg. §1.501© (3) 1 to determine if tax-exemption is proper. Cafadi and Cherry (2008) describe the language of Treas. Reg. §1.501© (3)1 as a 4-part test used to determine if tax-exempt status of an organization is proper (p. 145). It consists of the Organizational Test, the Operational Test, the Private Inurement Test, and the Political Activities Test, though the latter three are all contained under separate subheadings under the Operational Test heading in the regulation.

The Organizational Test first looks specifically at the non-profit's articles of organization to determine if its purpose is one that warrants tax-exempt status. The IRS can determine if the organization was chartered for an exempt purpose specified in § 501© (3) by reviewing the articles of organization. According to Treas. Reg. §1.501©(3) 1, "an organization fulfills the requirements of the Organizational Test if it is "organized exclusively for one or more exempt purposes only if its articles of organization [. . .] (a) limit the purposes of such organization to one or more exempt purposes; and (b) do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities , in activities which in themselves are not in furtherance of one or more exempt purposes."

This is likely the easiest test for an organization to satisfy because of the limited scope of information the IRS examines to justify tax exemption. The Organizational Test can be viewed as a "birth certificate test" with the IRS looking at the non-profit's articles of organization and any additional written documents for which the organization was created to determine if the original purpose of the organization was one that justifies tax exemption.

It is also important to understand that these documents may change over the course of an organization's life as it reorganizes or creates new ventures and additional organizations. Consequently, the Organizational Test is applied to an organization throughout its existence.

The Operational Test heading, which can be broken down into the remaining three tests (the Operational Test, the Private Increment Test, and the Political Activities Test) must then be examined in light of the various activities the organization is involved in to determine if tax-exempt status is proper. The Operational Test ascertains whether or not the organization engages primarily in activities which accomplish one or more of such exempt purposes specified in § 501©(3). The crux of this test is the provision that the organization will not satisfy the requirements of tax-exemption "if more than an insubstantial part of its activities is not in furtherance of an exempt purpose" (Treas. Reg. §1.501© (3) 1- (b)).

The IRS will generally assess the character of the activities the organization is conducting to determine if it deserves tax-exempt status. It will specifically look at the purpose "towards which an organization's activities are directed, and not the nature of the activities themselves," to determine "the organization's right to be classified" as a non-profit organization (*Golden Rule Church Association v. Commissioner*, 1964, p. 728). The test considers several factors regarding an organization's operation. Included in these are the particular manner in which an organization's activities are conducted, the commercial nature of those activities and the existence and extent of annual or accumulated profits (*American Institute For Economic Research v. United States*, 1962, p. 938).

In addition, the test includes determination of whether or not the type of business the organization is conducting is ordinarily carried on by commercial for-profit corporations, and if the organization is being operated primarily for a non-exempt purpose. The court held in *B.S.W. Group v. Commissioner*, 1978 that competition with commercial firms is strong evidence of the predominance of a non-exempt commercial purpose. It is difficult for an organization that is engaged in multiple businesses and ventures to satisfy this test because of the extent to which the IRS will look at the totality of the organization's activities (p. 358).

The Private Increment Test is stated in Treas. Reg. §1.501(c)(3) 1 –(2) as “[a]n organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.” This regulation defines a private shareholder or individual as “persons having a personal and private interest in the activities of the organization.” If it is determined that a private individual has received a benefit from the non-profit organization then its exempt status may be in jeopardy.

In analyzing whether or not an organization has violated the Private Increment Test, regulators assess four factors. The first is the reasonableness of any funds or salaries paid by the organization to a private individual. The second factor is the reason or reasons why the funds were paid. Third, the type of agreement that confers the benefit is considered. Lastly, the statuses of persons in the organization who formed the agreement and issued the funds are evaluated. By considering these factors, regulators will determine if a private individual has received a benefit from the tax-exempt organization and if this private increment warrants a revocation of the organization's tax-exempt status.

Several different cases on the topic of private inurement have arisen in the last few decades. These cases involve private individuals receiving benefits from the tax-exempt status in many different types of organizations, including religious institutions, educational institutions, and charitable organizations. A lead case that discusses the Private Inurement Test in regards to a charitable organization is *United Cancer Council, Inc. v. C.I.R.*, 1999. In this case, it was held that even though the charitable organization had an exclusive arrangement with its fundraiser and the fact that a large fraction of expenses for the fundraising campaign were initially fronted by the fundraiser.

Finally, the Political Activities Test, as stated in Treas. Reg. §1.501(c)(3) 1 – ©(3), is used to determine if the organization influences legislation through lobbying efforts or through other efforts designed to influence the political process and legislators. If it is determined that the organization seeks to influence legislation, both for the passage or non-passage of legislation, then it cannot satisfy the requirements of §501(c)(3). A non-profit may not participate in any “substantial lobbying” or any “electoral campaigning”. If an organization desires to continue to enjoy its tax-exempt status, then it must refrain from participating in any political activities prohibited by the regulations. Substantial lobbying and electoral campaigning are included in these prohibited activities (*Slee v. Commissioner*, 1930).

These tests are not only applicable when the non-profit corporation is chartered; they are applicable throughout the entire lifetime of the corporation. As a result, an organization must be constantly cognizant of its activities to protect its tax-exempt status. These tests become more complex when the organization at hand has a hybrid organizational structure of joint ventures and parent-subsidiary relationships with for-profit organizations. Adequate safeguards need to be instituted to ensure compliance with the regulations.

One potential mechanism is appointing a §501© (3) Compliance Officer who oversees inter-firm relationships and ensures regulations are being followed. This corporate officer would be responsible for ensuring that the organizational dynamics and corporate control of the entity are maintained in compliance with all rules concerning §501© (3) and all applicable regulations.

Non-profits with a hybrid organizational structure are more numerous than the general public may surmise. They are particularly abundant in the health care industry. Recent decades have seen numerous non-profit hospital corporations starting joint ventures with for-profit corporations and owning for-profit health insurance subsidiaries.

Examples of these organizational schemes include the University of Pittsburgh Medical Center, a non-profit that owns University of Pittsburgh Medical Center Insurance Services, a mix of several different for-profit and non-profit subsidiaries. Bay State Health is another example of this type of organization. Kaiser Permanente takes the reverse form: a for profit medical system that owns non-profit insurance subsidiaries. There are several reasons why a non-profit healthcare provider may desire a hybrid structure.

An organization may want to isolate risk amongst several different entities through the process of incorporation. A non-profit health care provider that is affiliated with an educational institution may want to start a for-profit corporation to market the fruit of their research. A non-profit parent health care provider may also want to start a for profit health insurance subsidiary to provide a reliable source of patients to its facilities. These scenarios are generally permissible. However, the IRS has strict guidelines on when joint ventures and for-profit subsidiaries are properly administered and the tax-exempt status of the non-profit involved is maintained.

Revenue Ruling 98-15 1998-1 C.B. 718 discusses the Internal Revenue Service's treatment of joint ventures involving non-profit corporations. The ruling delineates under what conditions a non-profit corporation may engage in a joint venture with a for-profit corporation. It gives direction as to how the joint venture must be managed for the non-profit corporation to maintain its tax-exempt status. The Ruling states that when a non-profit starts a joint venture with a for-profit corporation and incorporates the joint venture as an LLC treated as a partnership for federal tax purposes, the activities of the LLC will be considered to be the activities of the non-profit partner when determining the tax-exempt status of the non-profit partner.

The ruling states that a joint venture will satisfy the Operational Test if the non-profit partner furthers a charitable purpose in its participation and acts exclusively in furtherance of its tax-exempt purpose and only incidentally for the benefit of the for-profit owners.

Revenue Ruling 98-15 1998-1 C.B. 718 also states that a non-profit organization may contract a private party to conduct activities on behalf of and use the assets of the non-profit as long as the non-profit retains ultimate authority over its assets and the activities managed by the private party and the terms of the agreement are reasonable. If a private party is permitted to control or use the non-profit's activities or assets for its own benefit, and that benefit is not incidental to furthering of tax-exempt purposes, the non-profit will fail the Operational Test and a revocation of the non-profit's tax-exempt status would be proper. The ruling effectively pronounces that a non-profit may engage in a joint venture with a for-profit corporation if the non-profit maintains control of its assets and does not bestow benefits on the private owners of the for profit organization.

It follows that these concepts would also be held true in a parent-subsidary relationship as exists in the case of a non-profit health care provider starting a for-profit subsidiary health insurance corporation.

3. Antitrust Issues in the Healthcare and Insurance Industries

Another issue that derives from the size and business practices of certain non-profit corporations and specifically health insurance corporations is the application and enforcement of state and federal antitrust legislation on them. Beginning in the late 1800's, the federal government and likewise state governments began regulating the competitive practices in which businesses were engaged.

There exists a long historical tradition prior to this era in Europe and in the common-law for the regulation of competition and competitive practices of individuals and businesses by the state. The reason for this regulation is that unfair and anticompetitive practices such as the monopolization of industries and price fixing are viewed as detracting from social welfare due to the monopolist's ability to raise the prices of its goods or services beyond a price that the market would set. Practices such as monopolization, price fixing and the sharing of pricing information among various firms in a given industry was made illegal through various legislative acts such as the Sherman Act and the Clayton Act.

For most of the 20th Century, non-profit organizations were not held to the standards of antitrust legislation. However, in 1982, the U.S. Supreme Court ruled in *American Society of Mechanical Engineers v Hydrolevel Corp.* that non-profit organizations are subject to Sherman. It follows that non-profit organizations' horizontal and vertical integration activities are liable to the same scrutiny as for-profit entities' activities are. Federal Trade Commission antitrust actions against medical facilities have been few since then but have increased recently.

There have been ten FTC actions against medical facility mergers since 2005 on grounds they inhibited competition. On December 11, 2011, an administrative law judge upheld the FTC's complaint against ProMedica Health Systems, a hybrid organization, and ordered Promedica to divest the recently acquired St. Luke's Hospital on the grounds it harmed competition by reducing the number of competing hospitals in the Toledo area to three.

A complication of applying this rule of law in the specific case of non-profit healthcare organizations that own for-profit medical insurers is the fact that the insurance industry, including medical insurers, has a limited exemption from the Sherman Act under the McCarran-Ferguson Act of 1945.

In the last decade, the healthcare industry has seen significant consolidation through mergers and acquisitions (Jaklevic, 2002). These actions have resulted in a market that is highly concentrated by FTC and DOJ standards and "many large cities such as Boston, Minneapolis, Pittsburgh, Philadelphia, St. Louis and San Francisco (and others) have come to be dominated by 2-3 large hospital systems." (Gaynor, 2006). Included in these mergers and acquisitions are hybrid organizations acquiring hospital and healthcare facilities. A pertinent question is whether or not these acquisitions by the non-profit healthcare parent are designed to expand the network of the subsidiary for-profit insurance corporation, whereby the parent could lose its non-profit status.

4. History of Federal Regulation of the Insurance Industry

It may be difficult for one to imagine a time in American history when the shifting of the various risks associated with business and life through the use of insurance contracts was not considered commerce.

However, up until recently, the United States Supreme Court held that the federal government, by the way of the powers vested in Congress through the Commerce Clause of the US Constitution, could not regulate the insurance industry because the sale of insurance policies did not constitute commerce.

This stance would shape the development of the insurance industry and the laws that regulated it until the Supreme Court changed its position in the 1940's. It is important to understand the historical development of federal regulation of the insurance industry to understand federal regulation in its current form. The first major ruling on federal regulation of the insurance industry was in *Paul v. Virginia*.

In that landmark 1868 case, Justice Field of the United States Supreme Court, writing for the majority, held that the sale of an insurance contract was not interstate commerce but rather was only a local contract. In early 1866, two acts of the state legislature of Virginia made it a criminal offense for a foreign insurance corporation and its agent to conduct its business without first obtaining a license to do so and depositing bonds of a specific amount varying with the amount of capital employed with the treasurer of the state.

In May 1866, Samuel Paul, a citizen of Virginia and an agent of several different insurance companies incorporated in New York, began to carry on the business of selling fire insurance policies after he had filed with the Auditor of Public Accounts in Virginia that he would be serving as the agent of the companies he represented. Paul then applied to the proper officer of the state to obtain a license as required by the statutes; however, he and the companies he represented did not comply with the provisions which required the depositing of the bonds and he did not give the officer a receipt from the treasurer as proof of the bonds' existence.

For these reasons, the officer refused to issue him a license to conduct business in the state. Paul was convicted under the statute and fined fifty dollars after he issued an insurance policy to a citizen of Virginia. Paul appealed the decision of the Circuit Court, arguing that the statutes that the Virginia legislature passed were unconstitutional under the US Constitution, specifically in violation of the Privileges and Immunities Clause and the Commerce Clause.

The Supreme Court of Appeals of Virginia affirmed the lower court's decision and the US Supreme Court granted certiorari. Though argued under two distinct theories, one dealing with the Privileges and Immunities Clause and the other based on the Commerce Clause, the latter argument is the one that is pertinent to a discussion on the court's view of federal regulation of the insurance industry. Therefore, we present a discussion only of the argument based in the Commerce Clause. In *Paul v. Virginia*, Justice Field, writing for the majority, stated that:

[i]ssuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the assured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. They are not subjects of trade and barter offered in the market as something having an existence and value independent of the parties to them.

They are not commodities to be shipped or forwarded from one State to another, and then put up for sale. They are like other personal contracts between parties which are completed by their signature and the transfer of the consideration. Such contracts are not inter-state transactions, though the parties may be domiciled in different States. [. . .] They are, then, local transactions, and are governed by the local law.

They do not constitute a part of the commerce between the States any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce.

In 1944, the Supreme Court overruled the *Paul* decision in *US v. South-Eastern Underwriter's Association*, and held that the sale of insurance contracts was interstate commerce and was subject to federal regulation under the Commerce Clause.

In the case, 200 private stock fire insurance companies and 27 individuals were indicted for alleged violations of federal antitrust statutes consisting of conspiracies to restrain interstate trade and commerce by price fixing, maintaining non-competitive rates, and monopolizing trade and commerce. The defense argument was that the Sherman and Clayton Acts did not apply to the insurance industry because insurance was not commerce as ruled in *Paul v. Virginia*. Justice Black delivered the majority opinion of the court. The majority held that:

[o]ur basic responsibility in interpreting the Commerce Clause is to make certain that the power to govern intercourse among the states remains where the Constitution placed it. That power, as held by this Court from the beginning, is vested in the Congress, available to be exercised for the national welfare as Congress shall deem necessary. No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance. The court viewed the size and extent of the insurance industry at the time the case was decided and noted its growth in complexity from the time of *Paul v. Virginia*. More importantly, the court looked to the fact that the “[i]nterrelationship, interdependence, and integration of activities in all the states in which [insurance companies] operate are practical aspects of the insurance companies’ methods of doing business” and that this justifies its characterization as interstate commerce.

After *US v. South-Eastern Underwriter's Association* overruled *Paul v. Virginia*, the Commerce Clause opened up the application of the various federal antitrust statutes to insurance companies. Insurance companies could no longer exchange pricing information and actuarial statistics with one another because the sharing of such information would be a violation under Section I of the Sherman Act as an illegal restraint of trade through a price fixing scheme. This in turn made it more difficult for insurance underwriters to determine a fair price for an insurance contract.

Consequently, to protect themselves from the risk of loss in the absence of better statistical information, insurance companies began to raise the rates on insurance policies. Moreover, this created a barrier to the formation of new insurance companies that did not have access to statistical and pricing information to price their policies. As a result, Congress quickly saw the need to restore the former way in which insurance companies engaged in business and passed the McCarran-Ferguson Act in 1945. The McCarran-Ferguson Act was generally worded to exempt all insurance companies, including fire insurers, homeowner's insurers, health insurers, and a host of other insurers, from federal antitrust regulation. This act would shape the second half of the 20th Century for the insurance industry.

In recent years, the skyrocketing price of health insurance has caused considerable debate over the repeal or reform of the McCarran-Ferguson Act or the creation of a limited exception to the general exemption of insurance companies for health insurers. In 2011, two separate bills were introduced to the US House of Representatives aimed at reforming and amending the provisions of the McCarran-Ferguson Act. On March, 17, 2011, U.S. House Representative Paul Gosar of Arizona's 1st Congressional District, along with thirteen co-sponsors, introduced H.R. 1150, cited as the Competitive Health Insurance Reform Act of 2011, to the House of Representatives.

On June 1, 2011, the bill was later referred to the House Subcommittee on Intellectual Property, Competition and the Internet. The bill explains the purpose of the proposed amendments that are to attach to the end of the McCarran-Ferguson Act in specific detail. The bill is essentially designed to eliminate the McCarran-Ferguson exemptions of federal antitrust legislation to health insurers; however, it does not go so far as to allow private class action lawsuits against an insurance company for individuals injured by a violation of any antitrust legislation.

On May 23, 2011, U.S. House Representative Peter DeFazio of Oregon's 4th Congressional District, along with four co-sponsors, introduced H.R. 1943, cited as the Health Insurance Industry Fair Competition Act, to the House of Representatives. The bill was then referred to the House Subcommittee on Intellectual Property, Competition and the Internet on July 11, 2011. The bill is designed to make an exception from the general exemption of federal antitrust regulation of insurance companies under the McCarran Ferguson Act for health insurance companies. The bill, aimed at amending the McCarran-Ferguson Act at the end of 15 U.S.C.A. § 1013, reads in part as follows:

If passed, either one of these bills would restore federal regulation of antitrust violations of health insurance companies to the federal government. It is conceivable that the various tying arrangements that non-profit health care providers have with for-profit health insurance organizations would be more heavily scrutinized. This may in turn drive down the price of health insurance because individuals would have more choice in the health care providers they would use and the health insurance they would have. However, as of now, it seems that the passage of either one of these bills is not very likely. The withdrawals of every co-sponsor of each bill give a strong indication that the chances of either one of the bills passing is small.

The main relevant legal issue is at what point a non-profit corporation no longer deserves non-profit benefits if a joint venture or a subsidiary for-profit corporation begins to direct the actions or benefits from the non-profit parent corporation's tax-exempt status. In the case of non-profit healthcare organizations owning for-profit health insurance firms, there needs to be clear delineation of whether the healthcare organization bestows private benefits on the owners and managers of the insurance company or not. If it does, then the rule of law concerning the for-profit insurance firm should hold and the healthcare organization should be liable to scrutiny from tax code regulators.

If it does not bestow benefits, then the rule of law of the non-profit health industry should hold whereby the organization is subject to antitrust legislation.

5. A Brief History of the University of Pittsburgh Medical Center

In Pittsburgh, Pennsylvania, the fabric of the city is dominated by a fierce rivalry in the marketplace for health care and health insurance. The University of Pittsburgh Medical Center (UPMC) dominates the landscape on buildings, billboards, and in the local media. Atop of the former US Steel Tower, the tallest building in Pittsburgh, the letters UPMC shine out over the city. UPMC touts the financial successes of the non-profit company. Last year alone, UPMC posted \$9 Billion in revenues and \$406 Million in operating profits. However, Pittsburgh was not always dominated by corporate giant UPMC. It became the regional powerhouse it is today only over the last few decades.

The University of Pittsburgh Medical Center was founded in two separate places by two separate entities. Both founders had intentions of a charitable and benevolent future for their institutions.

The first facility was a medical school founded for the purpose of training young professionals in the art of medicine. In 1886, the Western Pennsylvania Medical College was founded by a group of doctors who wanted to start a medical school that was not located, like every other medical school of the time, in eastern cities such as Philadelphia or Boston.

Shortly thereafter, the Western Pennsylvania Medical College sought to join with the then Western University of Pennsylvania in order to be affiliated with a large educational institution. In 1908, The Western Pennsylvania Medical College was completely integrated into the Western University of Pennsylvania and the resulting organization was renamed the University of Pittsburgh.

In 1893, the wife of a Presbyterian minister named Louise Lyle founded Presbyterian Hospital on the North Side of Pittsburgh. In the 1920's, the management of what had by that time become the University of Pittsburgh had a desire to own a medical center to complement its growing medical school. It enticed Presbyterian to move to the University's campus. The new Presbyterian Hospital opened in 1938. Throughout the next fifty years, the University of Pittsburgh and Presbyterian Hospital grew organically and became affiliated with additional local hospitals as well. However, growth was subdued until 1986. In 1986, the Western Psychiatric Institute and Clinic, Presbyterian Hospital, and the Ear and Eye Hospital of Pittsburgh all affiliated to various extents with the University of Pittsburgh and unified under one organization that in 1990 adopted the name UPMC.

In the early 1990's UPMC began to buy out smaller Pittsburgh based hospitals for the intended purpose of being able to offer more specialized treatments to even more patients. In 1990, UPMC officially acquired the previously affiliated Montefiore Hospital.

Originally a hospital founded by Pittsburgh's Jewish community, the facility now specializes in many different types of complex procedures, including transplants, and is located adjacent to UPMC Presbyterian, of which it is now a part. UPMC acquired Shadyside Hospital in 1996 and the facility is now the center of UPMC's oncology division.

In 1997, UPMC started its Insurance Services Division for its stated purposes of complementing its provider network and gaining efficiencies in its business model. In 2008, UPMC continued its growth by merging with Mercy Hospital, a Catholic hospital, which was originally founded by the Sisters of Mercy in Pittsburgh. In addition to these mergers and acquisitions, UPMC has completed many more business deals expanding its enterprises all the way from Northwest Pennsylvania to Dublin, Ireland to Japan.

At this point, UPMC has become a major player not only in the health care provider business but also in the health insurance business and has become one of the largest corporations in the city of Pittsburgh. The question then becomes has UPMC outgrown its non-profit status? Has the reason for this quick growth been for the purpose of expanding the services it offers its patients or to expand its UPMC Insurance Service's subscriber network, a for-profit corporation?

6. Conclusion

There are two distinct legal issues relevant to medical care and insurance hybrids that are illustrated by the UPMC – UPMC Insurance Services case study. The first issue is whether or not the parent non-profit health care provider in these arrangements warrants tax-exempt status.

The second issue is whether or not the systematic acquisitions of health care facilities by the parent non-profit and tying arrangements with its insurance subsidiary justify the enforcement of federal antitrust legislation.

The major issue to consider is whether or not the for profit insurance subsidiary is either in control of any of parent non-profit's assets or is benefitting from any of the medical care facility's activities. This situation would violate the provisions of § 501(c)(3) and would justify a revocation of the non-profit's tax-exempt status. The regulations also suggest that the systematic acquisition of hospitals and health care facilities by a parent non-profit hospital corporation will violate its tax-exempt status when the main purpose of the acquisitions is to expand the network of the subsidiary for-profit insurance corporation. This would give the for-profit subsidiary the benefit of being able to expand its subscriber network if tying arrangements exist in its insurance contracts. These situations should be closely monitored by tax regulators for possible action.

In addition, the systematic acquisition of medical care facilities by non-profit healthcare organizations should be monitored by antitrust regulators to gauge their effects on the competitiveness of the market. Scrutiny should be stronger for hybrid organizations since there is a greater incentive for these organizations to engage in anti-competitive behavior than their healthcare counterparts that don't own for-profit insurance companies.

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