EXEMPT NO MORE: AN EXAMINATION OF THE NINTH CIRCUIT'S RECENT APPLICATION OF SECTION 501(C)(4) TO NON-PROFIT HEALTH INSURANCE PROVIDERS

I. INTRODUCTION

The recent decision of the Ninth Circuit Court of Appeals in *Vision Service Plan v. United States*[1] has created a great deal of uncertainty in the health care industry concerning the requirements that a non-profit health insurance provider must meet in order to qualify as a tax-exempt social welfare organization. This Note will analyze the impact of the Ninth Circuit's decision on both the health care industry and on purchasers of health insurance. In addition, this Note will argue that the United States Congress should, as a matter of public policy, take immediate legislative action to establish a clearer and more liberal set of guidelines to allow non-profit health insurance providers such as Vision Service Plan to continue to operate under a non-profit, tax-exempt business model in order to keep quality health care accessible and affordable to all Americans.

II. BACKGROUND

Congress has long recognized that private-sector health insurance providers are an integral part of maintaining a high level of public health in America.[2] During much of the last century, the traditional model of governance has been that private businesses and government would share the burden of providing for the benefits and social needs of working Americans.[3] Michigan Congressman Thaddeus McCotter characterized

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1. Vision Service Plan, Inc. v. United States, 265 F. App'x 650 (9th Cir. 2008).

2. *See* Rev. Rul. 69-545, 1969-2 C.B. 117:

> The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.

See generally Otto Shill, *Revocation of Blue Cross & Blue Shield's Tax Exempt Status: An Unhealthy Change?*, 6 B.U. J. TAX L. 147 (1988).

3. *Auto Industry Financing and Restructuring Act of 2008: Hearing on H.R. 7321 Before the H. Financial Services Comm.*, 110th Cong. (2008) (statement of Rep. Thaddeus McCotter, US Congressman, Michigan 11th District):

> The traditional model of governance throughout the 20th century of the United States, because we were an industrial power, was that business would pick up

this concept in his recent statement before the House Financial Services Committee as the "two pillars to help undergird American prosperity."[4] It was with this model of governance in mind that Congress enacted legislation that allowed certain providers of health insurance to operate as tax-exempt entities, provided that they organize themselves as non-profit social welfare organizations.[5] Congress's intent in enacting this legislation was to make certain that the federal government was doing its part to ensure that health care remained accessible and affordable to Americans while preventing private organizations that compete in the marketplace from unfairly profiting from this special designation.[6]

One organization that took advantage of this designation was Vision Service Plan (VSP). VSP was established in 1955 by a group of optometrists in Northern California who sought to create the first non-profit entity that would contract with small businesses and municipalities to provide employees with vision benefits.[7] Today, VSP contracts with over 26,000 doctors in nearly 20,000 physician offices and serves over 55 million members.[8] Put another way, one out of every six Americans currently receives their eye care benefits through VSP.[9] Represented among these members are employees of half of the companies on Fortune Magazine's 2007 Fortune 500 list.[10]

In 1960, VSP applied for and was granted a tax exemption as a social welfare organization under U.S.C. section 501(c)(4).[11] In the four decades that followed, VSP experienced tremendous growth as private businesses and municipalities began to recognize the importance of including vision care insurance in their employee benefits packages.[12] Then, in 2002, without any material change in VSP's operations,

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some of the benefits of employees and government would pick up some of the social needs of employees. And there was always the tension as to which would do what, but you had two pillars to help undergird American prosperity.

4. *Id.*

5. *See, e.g.*, 26 U.S.C. § 501(c)(4) (2000).

6. Shill, *supra* note 2, at 150-51.

7. VSP History, http://www.vsp.com/about/vsp-history.html (last visited Jan. 10, 2010).

8. *See* VSP Facts, http://www.vsp.com/cms/about/facts.html (last visited Jan. 10, 2010); About VSP, http://www.vsp.com/cms/about/aboutvsp.html (last visited Jan. 10, 2010).

9. VSP Facts, *supra* note 8.

10. VSP Fast Facts, http://www.vsp.com/newsroom/html/fast_facts.jsp (last visited Oct. 22, 2009).

11. Vision Service Plan, Inc. v. United States, No. S-04-1993, 2005 U.S. Dist. LEXIS 38812, *1 (E.D. Cal. Dec. 12, 2005); *see also* Gil Weber, *Why VSP Lost its Tax-exempt Status* (Apr. 15, 2008), *available at* http://www.odwire.org/forum/showthread-.php?t=16650 (last visited Jan. 10, 2010).

12. VSP History, *supra* note 7.

business philosophy, corporate governance, or charitable activities, the IRS revoked VSP's tax-exempt status upon a finding that VSP was not a social welfare organization within the meaning of section 501(c)(4).[13] The IRS ordered VSP to immediately pay over $4 million in corporate income taxes for fiscal year 2002.[14] VSP brought suit in the U.S. District Court for the Northern District of California to regain its tax-exempt status and asked the court to order a refund of the corporate income taxes it had paid.[15] The trial court, however, granted summary judgment to the government, ruling that VSP operated primarily for the benefit of its members rather than for the benefit of the community and was therefore not entitled to a tax exemption as a social welfare organization under section 501(c)(4).[16] On appeal, the Ninth Circuit Court of Appeals affirmed the lower court's ruling, holding that VSP did not operate exclusively for the promotion of social welfare within the meaning of section 501(c)(4) because the public benefits that it provided fell short of the applicable standard.[17] VSP subsequently filed a petition for certiorari with the United States Supreme Court[18] and retained former United States Solicitor General Kenneth Starr to handle its appeal.[19] The petition was denied by the Supreme Court in January of 2009 in a one-line order.[20]

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13. *Vision Service Plan*, 2005 U.S. Dist. LEXIS 38812 at *1.

14. *See* Kevin Kemper, *VSP Fighting for Refund from IRS*, COLUMBUS BUSINESS FIRST, July 7, 2006 ("Vision Service is asking that a judge declare it a nonprofit organization and force the IRS to refund more than $4 million it paid in corporate income taxes.").

15. *See Vision Service Plan*, 2005 U.S. Dist. LEXIS 38812.

16. *Id.* at *2:

> It is frequently the case that an organization is found not to qualify under 501(c)(4) because it is operating primarily for the benefit of its members, rather than for the purpose of benefiting the community as a whole...The court concludes that despite VSP's charity work, the membership-based structure as well as the types of services offered, demonstrate that VSP's primary activity is not the promotion of social welfare.

17. *Vision Service Plan*, 265 F. App'x at 651:

> VSP is not operated exclusively for the promotion of social welfare because it is not primarily engaged in promoting the common good and general welfare of the community . . .While VSP offers some public benefits, they are not enough for us to conclude that VSP is *primarily* engaged in promoting the common good and general welfare of the community.

18. *See* Brief of Petitioner-Appellant, Vision Service Plan, Inc. v. United States, 129 S. Ct. 898, *petition for cert. filed*, No. 08-164 (Aug. 7, 2008).

19. Press Release, Vision Service Plan, *VSP Vision Care Takes Tax-Exempt Appeal to Supreme Court* (July 16, 2008), *available at* http://www.vsp.com/cms/newsroom/press_release/articles/tax_appeal.html (last visited Jan. 18, 2010).

20. Vision Service Plan, Inc. v. United States, 129 S. Ct. 898 (2009).

The existence of health care coverage in the United States can be traced back to the Civil War. In the decades preceding the Civil War, private charities were the primary organizations involved in the provision of health care.[21] As the war raged on and casualties mounted, the American government became influenced by a newly created program in Great Britain for low-income workers whereby the government provided workers with pensions, unemployment benefits, and health care though a social security program.[22] The United States government thereafter began to provide basic health care coverage to Union soldiers for accidental injuries sustained during travel by railroad or boat.[23]

It was not until the early twentieth century, however, that anything resembling modern-day managed health care plans began to emerge. One of the earliest examples began in Tacoma, Washington in 1910, when the Western Clinic began to offer "a wide range of medical services to lumber mill" employees for a flat monthly fee of fifty cents.[24] The services provided by the Western Clinic are often cited as the first time that health care services were paid for on a capitulated basis.[25] This concept of prepayments in exchange for medical services is still the core idea behind modern-day Health Maintenance Organizations (HMOs).[26]

Later on, in the 1920s, as doctors and hospitals became more knowledgeable about diseases to the point that they could reliably treat common illnesses, they began to charge more for their services than

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21. Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities In Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 752-53 (2005) (explaining that "private charities were significantly involved in health care in the decades surrounding the Civil War, particularly for children and sanitary public health programs").

22. *See generally* Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries*, 41 AKRON L. REV. 557 (2008) (citing THEODORE MARMOR, POLITICS OF MEDICARE 7 (Aldine De Gruyter 1973)).

23. Roland Jefferson III, History of Health Care in the United States (Jan. 19, 2008), http://www.easyarticlesubmit.com/Article/History-Of-Health-Care-In-The-United-States-/52073.

24. Dill Financial, A Brief History of Health Care in America, ASSOCIATED CONTENT, Aug. 13, 2007, *available at* http://www.associatedcontent.com/article-/339640/a_brief_history-_of_health_care_in_america.html?cat=5 (last visited Jan. 18, 2010).

25. *See* Dennis McIntyre, M.D., Lisa Rogers, M.H.S. & Ellen Jo Heier, M.H.S., *Overview, History and Objectives of Performance Measurement*, 22 HEALTH CARE FINAN. REV. 7, 9-10 (Spring 2001) ("Sometimes cited as the first example of an HMO . . . is the Western Clinic in Tacoma, Washington. Starting in 1910, the Western Clinic offered, exclusively through its own providers, a broad range of medical services in return for a premium payment of $0.50 per member per month."); *see also* Sandra G. Blake & Tracy S. Hunger, *An Introduction to Managed Care and its Impact on Community Pharmacy*, DRUG STORE NEWS (Dec. 8, 1997).

26. McIntyre, Rogers, & Heier, *supra* note 25, at 9; Blake & Hunger, *supra* note 25.

many people could reasonably afford to pay.[27] This disconnect between the fees that hospitals charged and the ability of patients to pay them led to substantial growth in the creation of managed health insurance plans during the latter half of the 1920s.[28] In 1929, for example, the first cooperative health care plan for rural farmers was started in Elk City, Oklahoma.[29] That same year, the Baylor Hospital in Dallas, Texas created a government-subsidized managed care system for 1500 teachers to cover hospital services, which helped keep the teachers' premiums affordable.[30] This system was the beginning of what would later come to be known as Blue Cross/Blue Shield.[31] While initially viewed by organized medicine as threatening,[32] the success of Blue Cross/Blue Shield eventually convinced commercial insurers, who had previously not considered medical care to be a very lucrative market, to enter the health insurance field.[33]

Prior to 1986, prepaid health care plans were routinely granted a tax exemption under section 501(c)(4),[34] which provides an exemption to social welfare organizations. Originally, the Blue Cross/Blue Shield carriers met the definition of a social welfare organization. [35] However,

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27. Timothy Noah, *A Short History of Health Care*, SLATE (Mar. 13, 2007), http://www.slate.com/id/2161736.

28. Dill Financial, *supra* note 24 (citing examples such as a plan established by Ross-Loos Medical Group (which later became CIGNA) which provided prepaid services to municipal employees).

29. McIntyre, *supra* note 25, at 10:

> In 1929, Michael Shadid, M.D., established a rural farmers' cooperative health plan in Elk City, Oklahoma. Participating farmers purchased shares for $50 each to raise capital for a new hospital in return for receiving medical care at a discount. Shadid promptly lost his membership in the county medical society and was threatened with having his license suspended. However, 20 years later, he was vindicated by an out-of-court settlement in his favor of an antitrust suit against the county and State medical societies.

30. *Id.*

31. *Id.*

32. *Id.* The formation of the various Blue Cross/Blue Shield plans, as well as many HMOs, in the midst of the Great Depression reflected neither consumer demand nor non-physician entrepreneurism but rather, providers wanting to protect and enhance patient revenues. Many of these developments were threatening to organized medicine, best represented by the American Medical Association (AMA), which adopted a strong stance against prepaid group practices and all they represent, favoring indemnity insurance as an alternative. The AMA's stance at the national level set the tone for continued State and local medical society opposition to prepaid group practice and attempts to seriously manage care in an organized, systematic fashion.

33. Noah, *supra* note 27.

34. Shill, *supra* note 2, at 150.

35. *Id.* at 150-51. ("BCBS, as originally conceived, met the definition of a social welfare organization. The plans were formed to benefit the community as a whole.

national exposure of the plans resulted in increased competition between these plans and commercial insurers, which led to a debate as to whether it was fair to allow the Blue Cross/Blue Shield carriers to qualify for a tax exemption when they were in direct competition with commercial insurers that were required to pay corporate income taxes.[36]

In response to this debate, Congress sought to strike a compromise in determining which non-profit health care organizations should and should not be exempt from taxation when it passed the Tax Reform Act of 1986.[37] Section 501(m) was included in this act, denying tax-exempt status to health care organizations that offer "commercial type" insurance.[38] The effect of this section was that some providers of health insurance would remain tax-exempt while others would not, their fate turning on the question of whether they fell into the category of providers that Congress intended to regulate through taxation.[39]

III. ANALYSIS

A. The Correlation Between a Non-Profit Business Model and Higher-Quality Health Care

The ruling in *VSP v. United States* has created a great deal of uncertainty in the health care industry as to the requirements that a non-profit health insurance provider must meet before it may qualify for a tax exemption as a social welfare organization.[40] As a matter of basic economics, the act of exempting an organization from paying corporate income taxes causes its operating costs to decrease, which encourages

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National exposure for the plans was sought to make health insurance coverage generally available for those who could not otherwise afford it.").

36. *Id.* Such expansion, however, has engendered competition with commercial insurers and some commentators hold the view that BCBS plans, having become like commercial insurers, should not be exempt from taxation as social welfare organizations. Others retain the view that the original aim of BCBS in providing pervasive health coverage is still an important social issue and still a principle goal of the plans. Thus, they contend that the BCBS tax-exempt status should not be revoked.

37. Brief of Petitioner-Appellant, *Vision Service Plan*, *supra* note 18, at 5.

38. 26 U.S.C. § 501(m) (2000).

39. *See generally* Shill, *supra* note 2, at 152-53.

40. Brief of Petitioner-Appellant, *Vision Service Plan*, *supra* note 18, at 5. ("[T]he Ninth Circuit [decision] has cast tax exemption law into turmoil, introducing unprecedented uncertainty in a nonprofit industry that relies on tax exemptions in order to fulfill its basic mission of providing health care for the benefit of the community to all applicants.").

the exempt activity or activities in which the organization engages.[41] When the requirements that a health insurance provider must meet in order to qualify for tax-exempt status become less certain, however, much of the incentive that these organizations have to organize as non-profits is removed.[42]

Such a policy has several consequences. Aside from the increased operating costs that get passed on to consumers, studies have shown that health insurance providers that operate under an ownership model whereby they sell debt and equity to investors who seek returns on their investments provide a lower quality of care than their non-profit counterparts.[43] A 1999 study,[44] for example, which performed a direct quality comparison between for-profit and non-profit HMOs, found that investor ownership was consistently associated with lower quality[45] and that for-profit HMOs scored lower than non-profit HMOs on each of the study's fourteen quality indicators.[46] From a public health standpoint,

41. *See* Allen v. Wright, 468 U.S. 737, 788 (1984) (Stevens, J., dissenting) (arguing that the granting of preferential tax treatment to a 501(c)(3) organization encourages the exempt activity while the denial of such treatment discourage the activity).

42. Brief of Petitioner-Appellant, *Vision Service Plan, supra* note 18, at 24.

43. *See generally* John P. Geyman, *The Corporate Transformation of Medicine and Its Impact on Costs and Access to Care,* 16 J. AM. BD. OF FAMILY PRAC. 443, 449 (2003); *see also* David U. Himmelstein et al., *Quality of Care in Investor-Owned vs. Not-for-Profit HMOs,* 282 J.A.M.A. 159, 162 (July 14, 1999).

44. Geyman, *supra* note 43, at 444.

45. Himmelstein et al., *supra* note 43, at 163.

> In multivariate analyses controlling for model type, method of data collection, and region, investor ownership was consistently associated with poorer quality. For instance, investor ownership was associated with decreases in rates of mammography of 4.8 percentage points and of eye examinations for patients with diabetes of 9.7 percentage points.

Id.

46. *Id.* at 161.

> In univariate comparisons, investor-owned plans had lower rates for all 14 quality indicators . . . . The largest differences were in the 2 measurements of the quality of care for patients with serious medical illnesses. Among patients discharged from the hospital after a myocardial infarction (with no concurrent diagnosis contraindicating β-blocker therapy), on average 59.2% of patients in investor-owned HMOs compared with 70.6% of patients in not-for-profit plans filled a prescription for a β-blocker . . . Among patients with diabetes receiving insulin or oral hypoglycemic agents, on average 35.1% of those in investor-owned plans vs 47.9% in not-for-profit plans had received an eye examination within the past year ($P<.001$). Investor-owned plans also had lower rates of all routine preventive services that we evaluated. The rate of completion of immunizations for 2-year-olds averaged 63.9% in investor-owned HMOs vs 72.3% in not-for-profit plans . . . the proportion of women aged 52 to 69 years who had undergone mammography within the past 2 years averaged 69.4% in investor-owned plans and 75.1% in not-for-profit plans.

this information is cause for concern when one considers that about two-thirds of all HMOs in the United States are for-profit organizations, many of which are investor-owned.[47]

There are several reasons behind this difference in quality of care. For one, for-profit HMOs are typically market-driven entities that place a stronger focus on managing costs than providing care.[48] A 2000 study that compared the two largest health insurers in the state of California, one a for-profit insurer and the other a non-profit insurer, found that the non-profit insurer spent a significantly higher percentage of each health insurance premium dollar it collected on medical care than did the for-profit insurer.[49] Additionally, for-profit HMOs tend to navigate the marketplace in a way that allows them to both avoid enrolling sicker patients and to separate themselves from physicians who order a large number of tests and spend a high amount of face-time with patients.[50]

While Congress limited the scope of section 501(c)(4) regarding its application to health insurance providers when it added section 501(m) with the passage of the Tax Reform Act of 1986, it also expressed an intent to preserve the tax-exempt status of some non-profit health care organizations.[51] Indeed, section 501(m) acts as a savings clause by preserving the tax-exempt status of health care organizations that do not offer "commercial-type" insurance.[52] Thus, the issue then becomes a question as to the circumstances under which a non-profit health care organization will be deemed to offer "commercial type" insurance.[53]

Id.

47. Geyman, *supra* note 43, at 444-45.

48. *Id.*

49. *Id.* at 445-46.

> That for-profit versus not-for-profit makes a big difference is shown by this recent finding: in California, the 2 largest health insurers are Kaiser Permanente (not for profit) and Blue Cross (for profit); in 2000, Kaiser spent 96% of every premium dollar on medical care, whereas Blue Cross spent just 76% on medical care.

Id.

50. *Id.* at 444. ("Proprietary HMOs attempt to "cherry pick" the market; avoid sicker enrollees; erect barriers to specialist referral, costly diagnostic tests, and hospitalization; and divest themselves of high-utilizing physicians who order too many tests or spend too much time with patients.").

51. *Id.*

52. Brief of Petitioner-Appellant, *Vision Service Plan, supra* note 18, at 5.

53. Shill, *supra* note 2, at 153.

> Section 501(m)(3) provides limited guidance concerning the definition of "commercial-type insurance." The law and committee reports define commercial-type insurance very broadly and then exempt specific groups from the application of the definition. They do not discuss the types of products that will be considered "commercial-type" insurance. Rather, the subsection

B. Community Benefit

While for-profit organizations are both legally and ethically responsible to their investors and shareholders,[54] non-profit organizations are primarily responsible to the memberships they serve.[55] That is, they are legally and ethically responsible to their community.[56] As such, entities that are organized under section 501(c)(4) as social welfare organizations are not permitted to retain any excess revenues in the form of profits.[57] For this reason, non-profit organizations that generate excess revenues are able to apply these revenues toward some type of community benefit or charitable cause. One recent study determined that the community benefit expenditures from hospitals alone that are organized under section 501(c)(4) totaled more than $9.3 billion.[58]

With regard to VSP, the organization uses its excess revenues to provide eye care at no cost to more than 50,000 low-income children each year through its Sight for Students and Healthy Families

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describes several activities which do not fall within the "commercial-type insurance" classification.

Id.

54. THE VALUE OF NON-PROFIT HEALTHCARE 2-3 (Alliance for Advancing Nonprofit Healthcare 2008), *available at* http://www.nonprofithealthcare.org-/reports/5_value.pdf (last visited Jan. 10, 2010):

> For-profit health care organizations are legally and ethically responsible primarily to their owners and/or stockholders, and are obligated to do well for the benefit of these owners. Their primary goal is private inurnment. As a consequence, for-profit health care performance can be measured most simply by profitability and return on equity for shareholders.

Id.

55. *Id.* at 3.

> Nonprofit health care organizations...are primarily responsible and accountable to the communities and populations they serve. They are legally and ethically bound to "do good" for the benefit of their communities. Their governing bodies are comprised of leaders from the communities they serve. Rather than inuring to the benefit of private owners, the earnings and reserves of nonprofit health care organizations are reinvested to benefit the community. A portion of those investments are made to improve quality, service, and efficiency, usually in highly competitive environments. The remaining investments are made in a variety of community programs, services, or products that do not cover their costs, in order to improve the health status of vulnerable populations and the broader community.

Id.

56. *Id.*

57. Roger Russell, *VSP Exempt Case May Impact Larger HMO Sector*, ACCOUNTING TODAY, Oct. 6, 2008, at 3.

58. I.R.S., HOSPITAL COMPLIANCE PROJECT INTERIM REPORT 48 (July 2007) ("[T]he 487 respondents that submitted a questionnaire reported aggregate potential community benefit expenditures of these specific items of $9.3 billion.").

programs.[59] VSP partners with three other charities to provide these benefits: Prevent Blindness America, the National Association of School Nurses, and the National Council of La Raza.[60] All three charities submitted amicus briefs to the United States Supreme Court on VSP's behalf with respect to the organization's appeal in *VSP v. United States*.[61]

If health insurance providers lose their tax-exempt status and thus lose their incentive to organize as non-profit entities, the logical result will be that less funding will be available to support community benefit programs, such as Sight For Students. Since for-profit organizations are legally and ethically responsible to their investors, any excess revenues generated by an organization, such as VSP under a for-profit business model rather than a non-profit business model, would get applied, first and foremost, in a way that benefits the organization's investors.

C. The Identifying Characteristics of a Non-profit Organization

Some commentators have applauded the Ninth Circuit's decision in *VSP v. United States* and have characterized VSP as a prime example of what is wrong with the section of the tax code that grants exempt status to certain health insurance providers.[62] Such criticism, however, has focused primarily on the executive compensation packages at

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59. *See* Sight For Students Home Page, http://www.sightforstudents.org.

> Sight for Students is a VSP charity that provides free vision exams and glasses to low-income, uninsured children. The program operates nationally through a network of community partners who identify children in need and VSP network doctors who provide the eyecare services. More than 50,000 children each year receive a free comprehensive exam and corrective lenses if needed through Sight for Students. These are children who would otherwise not receive the eyecare and eyewear they need to do their best work in school and perform their best at play. VSP founded Sight for Students in 1997 and was one of the original commitment-makers to America's Promise, which strives to bring together organizations dedicated to helping our nation's youth.

Id.

60. Roger Parloff, *Cloud of Uncertainty Over Non-profit HMOs*, FORTUNE, Sep. 22, 2008; *see also* Press Release, Vision Service Plan, VSP Vision Care's Appeal to Supreme Court Bolstered by Filing of Three Amici Briefs (Sept. 17, 2008), *available at* http://www.vsp.com/cms/newsroom/press-releases/articles/amici-briefs.html (last visited Jan. 18, 2010).

61. *See* Brief for Prevent Blindness America as Amici Curiae Supporting Petitioner, Vision Service Plan, Inc. v. United States, No. 08-164, 2008 WL 4217961 (Sept. 10, 2008); *see also* Brief for National Association of School Nurses, as Amici Curiae Supporting Petitioner, Vision Service Plan, Inc. v. United States, No. 08-164, 2008 WL 4217961 (Sept. 10, 2008); *see also* Brief for National Council of La Raza, as Amici Curiae Supporting Petitioner, Vision Service Plan, Inc. v. United States, No. 08-164, 2008 WL 4217961 (Sept. 10, 2008).

62. *See, e.g.*, Weber, *supra* note 11.

organizations like VSP,[63] while ignoring much of the community benefits and decreased health insurance costs that these organizations provide.[64]

Section 501(c)(4) provides tax-exempt status to organizations that are "not organized for profit but operated exclusively for the promotion of social welfare."[65] As the court noted in *VSP v. United States*, "[a]lthough the words exclusively and primarily have different meanings, courts interpret the word exclusively to mean primarily."[66] In holding that VSP is not a social welfare organization within the meaning of section 501(c)(4), the district court cited a U.S. Treasury regulation which holds that an organization is not operated primarily for the promotion of social welfare if it operates in a way that is similar to a for-profit business.[67] Despite the fact that VSP's bylaws provide that it "shall operate as a non-profit corporation . . . operated exclusively for the promotion of social welfare,"[68] the court found that VSP operates in a manner similar to organizations that are operated for profit.[69] The court based much of its ruling upon its finding that VSP pays its executives and officers high salaries and bonuses "directly from the net earnings."[70]

A broader examination of this aspect of the court's reasoning, however, demonstrates that the salaries that VSP pays to its executives are in fact in line with those paid to top management at other section 501(c)(4) organizations. According to the court opinion in *VSP v. United States*, VSP's Chief Executive Officer, Roger Valine, was paid a base salary of $395,000 for fiscal year 2003 in addition to what the court refers to as "a sizeable bonus."[71] The court apparently felt this was excessive compensation for the chief executive of a 501(c)(4) organization. By comparison, however, the American Association of Retired Persons (AARP), which is one of the better known 501(c)(4)

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63. *Id.* (arguing that VSP offers its executives high salaries and other forms of compensation that are more consistent with a for-profit corporation than a non-profit).

64. *Id.*

65. 26 U.S.C. § 501(c)(4) (2000).

66. *Vision Service Plan*, 2005 U.S. Dist. LEXIS 38812 at *8.

67. *Id.* at *24 (citing 26 C.F.R. § 1.501(c)(4)-1(a)(2)(ii) (2000)) ("[A]n organization is not operated primarily for the promotion of social welfare if its primary activity is carrying on a business with the general public in a manner similar to organizations which are operated for profit.").

68. *Id.* at *23-24.

69. *Id.* at *26-27.

70. *Id.* at *26 ("Although VSP's by-laws provide that VSP has no equity owners. . . . VSP executives and officers receive bonuses that are taken directly from the net earnings.").

71. *Id.*

organizations, paid its CEO, Bill Novelli, $420,000 in 2003.[72] Similarly, Wayne LaPierre, the CEO of another well-known 501(c)(4) organization, the National Rifle Association (NRA), received an annual salary of $623,823 in 2004.[73] If the compensation that VSP pays to its top management is comparable to that of other 501(c)(4) organizations, then the court's conclusion is undermined to the extent that it held that VSP is operated like a for-profit business based on the executive compensation packages that it pays to its top managers.

Some might argue that both the NRA and AARP are both large organizations and that higher executive compensation is therefore warranted in order to attract top talent that is capable of managing such organizations. Indeed, the AARP had approximately 39 million members[74] with revenues of $1.17 billion[75] and net assets of $318 million in 2007.[76] Likewise, the NRA, with its nearly 4 million members,[77] recently reported revenues of $205 million[78] and assets totaling $222 million.[79] By comparison, however, VSP currently has over 55 million members,[80] reported revenues of $1.9 billion[81] and assets of $850 million[82] for fiscal year 2003. Therefore, since the membership size and financials of the AARP and NRA are similar to those of VSP, the comparison is appropriate.

Setting aside for a moment the issue of whether VSP should or should not qualify for a tax exemption under existing law, it seems difficult to conceive of a policy argument that could justify granting a tax exemption to organizations such as the NRA or AARP, whose main purpose is to lobby elected officials on behalf of their members, while denying an exemption to non-profit health insurance providers such as VSP. This is especially true when the United States government is either

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72. Deborah Solomon, *Questions for William Novelli: A Senior's Moment*, N.Y. TIMES, Dec. 7, 2003, at 62B.

73. I.R.S. Filing, Form 990 (2004), N.R.A., *available at* http://gunguys.com/lapierresalary.pdf (last visited Jan. 18, 2010).

74. Summary of 2007 Consolidated Financial Statements, AARP, http://assets.aarp.org/www.aarp.org_/articles/aboutaarp/AnnualReports/AARP_financials.pdf (last visited Jan. 18, 2010).

75. *Id.*

76. *Id.*

77. Chris W. Cox, NRA-ILA: Who We Are, And What We Do, http://www.nraila.org/About (last visited Jan. 18, 2010).

78. I.R.S. filing, form 990 (200), National Rifle Association, http://gunguys.com/lapierresalary.pdf (last visited Jan. 18, 2010).

79. *Id.*

80. VSP Facts, *supra* note 9.

81. Weber, *supra* note 11.

82. *Id.*

unwilling or unable to assume one hundred percent of the costs of providing health insurance to all of its citizens. If Congress is willing to recognize lobbying organizations as tax-exempt social welfare organizations under section 501(c)(4), then it should also recognize non-profit health care organizations that provide community benefits and whose continued existence helps keep health care accessible and affordable to all Americans. If current tax law does not in fact recognize the relative importance of providing accessible, affordable health care compared to the organized lobbying of elected officials, then Congress should, as a matter of public policy, change the existing tax code to reflect this distinction.

D. Impact of the Obama Administration's Health Care Plan

The United States is the sole remaining western democracy that allows a substantial portion of its population to remain without health care coverage.[83] Commentators have suggested various reasons behind this policy and have weighed in on the feasibility of providing universal health care coverage within the United States.

Some believe that access to health care is a fundamental right that belongs to everyone,[84] and that the provision of health care is a moral obligation of a society that has the means to provide it.[85] These commentators have suggested that a sense of national solidarity among westernized democracies in Europe is what has enabled them all to adopt some form of universal health coverage,[86] and that a lack of solidarity in the United States is a primary cause of the country's absence of universal health care coverage.[87] Others have suggested that the lack of universal health care in the United States stems primarily from a widespread belief among Americans that such a system would be too expensive given current economic realities.[88] Critics of this argument, however, have

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83. James B. Roche, *Related Matters: Health Care in America: Why We Need Universal Health Care and Why We Need It Now*, 13 ST. THOMAS L. REV. 1013, 1013 (2001).

84. *Id.* at 1015 (arguing that health care is not merely a service which is enjoyed but a fundamental right to which all citizens are entitled).

85. *Id.* at 1017.

86. *Id.* at 1018.

87. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 4 (2005) (citing Daniel Callahan, *It's the Culture, Stupid: Lack of Solidarity Is Responsible for U.S. Failure to Provide Universal Health Care*, 8 COMMONWEALTH, Feb. 2000).

88. *See* Roche, *supra* note 83, at 1013 ("[E]conomic feasibility is often cited as the largest obstacle to enacting meaningful reform.").

responded by suggesting that the implementation of a universal health care plan in the United States would actually save the country money.[89]

During the campaign for the 2008 American presidential election, President Barack Obama outlined the details of what has now become his administration's policy on health care reform, which is a plan that aims to make health care coverage available to every American.[90] The Obama campaign estimated that this plan would cost between $50-60 billion over five years[91] and would pay for it by rolling back tax cuts on income exceeding $250,000 to pre-2001 levels.[92]

Some have suggested that this estimated price tag is on the high end of what universal heath coverage would ultimately cost,[93] while critics have suggested that the actual cost will run much higher.[94] One of the critics' main arguments is that the Obama campaign's numbers rely too heavily on key assumptions.[95] For example, while President Obama has touted the fact that his health care plan allows Americans the choice to keep their current health insurance plans if they are happy with them,[96] some have suggested that the plan relies too heavily on the assumption that a certain number of Americans will, in fact, choose that option.[97] The Obama campaign addressed this concern by proposing that large employers that do not offer their employees health care coverage or do not make a "meaningful contribution" to the cost of quality health coverage would be required to contribute a percentage of their payroll toward the cost of their employees' health care.[98] The critics' naturally responded by arguing that this requirement would cause an increase in the costs of doing business in the United States[99] and that these costs

89. *See* DAVID CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM, Intro (Oxford University Press 2004); *see also* Roche, *supra* note 83, at 1013-14 (arguing that current spending on health care in the United States is more than enough to finance a universal health care system).

90. Obama Health Care Plan, Oct. 25, 2009, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

91. *Id.*

92. Obama Health Care Questions & Answers, Oct. 25, 2009, http://www.barackobama.com/pdf/Obama08_HealthcareFAQ.pdf.

93. CUTLER, *supra* note 89.

94. *See* Kevin Sack, *On Health Plans, the Numbers Fly*, N.Y. TIMES, Oct. 22, 2008, at A1, *available at* 2008 WLNR 20081278 (Westlaw) (citing studies that projected that the Obama health care plan will cost between $1.17 trillion to $1.6 trillion over 10 years).

95. *Id.*

96. Obama Health Care Plan, *supra* note 92.

97. Sack, *supra* note 94.

98. Obama Health Care Plan, *supra* note 90.

99. JOHN HOLAHAN & LINDA J. BLUMBURG, URBAN INSTITUTE, AN ANALYSIS OF THE OBAMA HEALTH CARE PROPOSAL (2008), *available at* http://www.urban.org/uploadedPDF/health_Proposal_summaries.pdf (last visited Jan. 18,

would ultimately get passed on to consumers.[100] Commentators who support the President's plan however, argue that the plan would in fact reduce business-sector costs by a substantial amount,[101] and that the bulk of these reduced costs would be derived from a reduction in fraud and waste through the increased use of information technology.[102]

Whatever form the health care plan offered by the Obama administration ultimately takes, all sides appear to agree that at least a significant portion of the population will need to continue paying out of pocket for private-sector health care coverage in order to keep the costs of government-funded health care coverage low enough to maintain the economic feasibility of providing universal health care in America. For this reason, Congress will need to do its part to keep private-sector health insurance accessible and affordable to Americans. One course of action that Congress can take in order to further this goal is to enact clearer, more liberal set of guidelines to ensure that non-profit health insurance providers such as VSP may continue to operate under a tax-exempt, non-profit business model without interference by the courts or by administrative agencies such as the IRS. The economic certainty that such legislation would bring would serve to encourage providers of health insurance that are eligible to organize as non-profit social welfares organizations to do so, which would further the goal of providing accessible and affordable quality health care to every American.

2010) ("The [Obama] approach relies on an employer mandate, which could increase costs to some businesses and engender the same political opposition that has contributed in the past to the defeat of past reform efforts.").

100. Greg C. Reeson, *The Obama Referendum*, NEW MEDIA JOURNAL, June 12 2008, *available at* http://www.newmediajournal.us/staff/reeson/2008/06122008.htm ("Under Obama's plan . . . [e]mployers who fail to contribute to their employees' health care costs will be required to pay money into the national plan. Does anyone believe that these costs will not be passed on to consumers?").

101. David M. Cutler, J. Bradford Delong & Ann Marie Marciarlle, *Why Obama's Health Plan Is Better*, WALL STREET JOURNAL, Sept. 16, 2008, at A25 ("[T]he impact of the Obama Plan will be profound . . . annual business-sector costs will fall by about $140 billion.").

102. *Id.* ("One-third of medical costs go for services at best ineffective and at worst harmful. Fifty billion dollars will jump-start the long-overdue information revolution in health care to identify the best providers, treatments and patient management strategies."); *see also* President Barack H. Obama, Inaugural Address (Jan 20, 2009) ("We will . . . wield technology's wonders to raise health care's quality and lower its costs.").

IV. CONCLUSION

By requiring non-profit health insurance providers such as VSP to pay corporate income taxes, the United States government not only increases the operating costs of such organizations, most of which get passed on to consumers, but also removes any incentive these providers have to organize as non-profit organizations in the first place. Such a result increases the likelihood that health care providers will choose to organize as for-profit institutions, which can have a negative effect on the quality of health care that purchasers of health insurance receive and eliminate many of the community benefits that non-profit social welfare organizations provide.

If the federal government is unwilling or unable to assume one hundred percent of the costs of providing health care coverage to all of its citizens, the next best thing it can do is to refrain from taxing organizations that are capable of picking up the slack. Purchasers of health insurance are ultimately less concerned with the salaries paid to those managing the organizations that provide their health care coverage than they are with knowing that health care will remain accessible and affordable.

For the reasons stated above, the United States Congress should, in response to the Ninth Circuit's application of section 501(c)(4), take immediate action to establish a clearer and more liberal set of legislative standards to guide providers of health insurance that wish to organize as non-profit social welfare organizations. Congress must now decide whether policing the compensation packages of non-profit executives at the expense of purchasers of health care coverage is really what section 501(c)(4) was intended to do and, if so, whether such a policy is still sound given current economic and social realities.

JOHN E. SCHEIBELHUT