Cite as Det. No. 01-079, 21 WTD 198 (2002)

BEFORE THE APPEALS DIVISION
DEPARTMENT OF REVENUE
STATE OF WASHINGTON

In the Matter of the Petition For Correction of Assessment of	)	D E T E R M I N A T I O N
	)	No. 01-079
. . .	)	Registration No. . . .
	)	FY . . ./Audit No. . . .
	)	Docket No. . . .

[1] RULE 111: B&O TAX – DEDUCTIONS -- ADVANCES & REIMBURSEMENTS -- CAPITATION PAYMENTS. When a taxpayer receives funds to procure services from a third party for services the taxpayer did not or could not provide and the taxpayer is liable to the third party solely as agent for its customer, the amounts received are not considered part of the taxpayer's gross income. When a health care provider receives payments on a per member basis for all covered services under a group health plan (capitation payments) and is itself liable for any third-party service that may be provided to members, such payments are not deductible as advances and reimbursements.

[2] RULE 233: B&O TAX -- DEDUCTIONS -- QUALIFIED MEDICAL SERVICE ORGANIZATIONS -- AGENCY. Qualified medical service organizations are entitled to deduct from their gross income amounts paid to physicians and hospitals rendering medical services to subscribers of the organization when the organization contractually acts solely as the agent of the physicians and hospitals.

Headnotes are provided as a convenience for the reader and are not in any way a part of the decision or in any way to be used in construing or interpreting this Determination.

Mahan, A.L.J. – Primary and specialty care medical clinic contends that the portion of the capitation payments it receives or is entitled to receive from other managed health care organizations ("payers") and uses to pay hospitals and specialists should be treated as pass

through payments and not subject to business and occupation (B&O) tax. Alternatively, it contends that it should be treated as an organization similar to a medical service bureau.[1]

ISSUES:

1. Are portions of the capitation payments the taxpayer receives from payers and uses to pay for medical specialists and hospital services gross income of the taxpayer's business or are they advances and reimbursements deductible under Rule 111?

2. Does the taxpayer qualify under WAC 458-20-233 (Rule 233) as an organization similar to a medical service bureau that is able to deduct prepayments from its gross income?

FACTS:

The taxpayer is a nonprofit, quasi-governmental agency that provides primary medical care and certain specialty medical care for its patients and arranges for independent hospitalization and other specialty care for its patients through a network of managed care providers. Various forms of group medical plans cover most of the taxpayer's patients. Under the terms of the group plans, members must generally seek professional services directly from approved independent medical providers, such as the taxpayer. In order to be included on a list of approved providers, medical providers, such as the taxpayer, must generally agree to limit the amounts they charge for particular procedures that they may perform for their patients.

The Department of Revenue (Department) audited the taxpayer's records for the January 1, 1994 through March 31, 1998 period and issued a deficiency assessment in the amount of $ . . . . Under Schedule 13 of the assessment, the Department disallowed deductions from B&O tax for third-party medical services in the amount of $ . . . .

The disallowed third-party payments involved capitation payments made to the taxpayer by group medical plan providers. Capitation payments are prepayments for medical services covered under a group plan. Payers make such payments on a monthly per member basis for each member assigned to the taxpayer for covered services under a benefit plan. The taxpayer states that the disallowed deductions involved capitation payments it received from plan providers "on behalf of third-party physicians and hospitals" to which it referred member patients.

In general, group plan members must initially seek medical services from a primary care physician, such as those employed by the taxpayer, for the provision of medical services covered under the benefit plans. To the extent the primary care physician cannot provide the services, he or she must refer patients to other independent providers. As a schedule to one contract states:

[1] Identifying details regarding the taxpayer and the assessment have been redacted pursuant to RCW 82.32.410.

> Primary care providers are intended to be the patient's first source of care. Primary care providers are authorized to make medically necessary referrals to specialists within [the payer's] network. When necessary expertise does not exist in the [payer's] network, referrals outside the network must be authorized in advance. . . .

In general, except for emergency care or services outside the network area, other providers to whom patients are referred must agree with the payers or the taxpayer to limit the amounts to be charged for particular procedures. Hospitals and other independent providers to which patients are referred maintain and control their own staff, equipment, facilities, employees, and support staff. The taxpayer does not control, direct, or supervise the performance of the professional services provided by such independent providers. Such providers also pay their own malpractice insurance premiums and are independently licensed by the state.

Under the various agreements to limit amounts to be charged for covered services, the taxpayer and other medical service providers are prohibited, consistent with state law, from charging or collecting from members for covered services.[2] However, under the contracts the taxpayer and other providers are allowed to bill member patients directly for "deductibles, co-payments, co-insurance, and/or charges for non-covered services." The taxpayer and other providers remain at risk for nonpayment of such amounts.

The taxpayer does not just refer patients to other providers, but agrees to be financially responsible for payment of the services to be provided by other independent medical providers. One agreement provides that the taxpayer "shall provide, or arrange for the provision of and be financially responsible for" the capitation services. Under that agreement, covered capitation services may include inpatient hospital services, hospital based physician services (e.g., anesthesiologist, pathologist, and radiologist services), outpatient hospital services, other professional services (e.g., home health agency care and infusion therapy), skilled nursing facility care, and general health care professional services, including primary care, outpatient, and diagnostic services.

Under the terms of another agreement, the taxpayer "provides or arranges professional services through employment and contractual relationships with physicians and other health care providers and arranges hospital services through contractual relationships with hospitals." That agreement provides for referrals to other providers under contract with either the taxpayer or the insurer "for specialty care or other Covered Services that cannot be directly provided by [the taxpayer]." That agreement further provides that, with the exception of certain stop-loss provisions, the taxpayer "accepts full financial responsibility for all Covered Services provided or arranged for [the payer's] members . . . ."

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[2] For example, every contract between an HMO and participating provider must provide that "the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization." RCW 48.46.243.

Consistent with these agreements, under a representative agreement with an independent specialist, the taxpayer remains contractually liable for the payment of covered or capitation services. The agreement between the taxpayer and a network provider expressly provides the taxpayer "is responsible for payment for those authorized medical services Provider provides to [taxpayer's] Patients that are covered by [taxpayer's] capitation agreements." Although the taxpayer is responsible for payment of the covered services, the agreement also provides that the provider must bill a payer directly for the covered services. When payers are billed directly by providers, the taxpayer states that the payers "withhold any amounts they pay directly to [taxpayer's] contract providers" from the capitation payments due to the taxpayer. According to the taxpayer, under other contracts providers may bill the taxpayer directly, where it acts as a "delegated claims facility," processing all claims arising out of covered or capitation services.

To the extent the capitation or prepayments are sufficient, they are used to cover both the services the taxpayer may provide and for any referral service for which the taxpayer is financially responsible. To the extent the capitation or prepayments are not sufficient to cover the taxpayer's services and services provided by third-party providers, the taxpayer may suffer a loss. According to the taxpayer, it is also paid a fee for administering and making the referrals, which amount is included in the agreed capitation fee amount.

The representative provider contract is silent as to whether the taxpayer is acting as an agent of the referral providers. The agreements with payers expressly state that the taxpayer is an independent contractor and not an agent of the payers.

ANALYSIS:

1. Introduction

Managed care has a broad range of organizational structures. Typically managed care organizations have included health maintenance organizations (HMOs) and health care service contractors (HCSCs). Although the taxpayer is not an HMO or an HCSC, it provides medical services in a managed care setting and some of its services are ones that have in the past been provided by HMOs and HCSCs. An understanding of the nature of the services provided by HMOs and HCSCs is necessary to an understanding of the nature of the services provided by the taxpayer, as a managed health care provider.

Under Washington law, HMOs are specifically identified as health care providers. They are defined as organizations that enter into "agreements with or for the benefit of persons or groups of persons, which require prepayment for health care services by or for such persons in consideration of the health maintenance organization providing health care services to such persons." RCW 48.46.020. In contrast, under Washington law an HCSC is not specifically identified as a health care provider, but as an organization sponsored by or connected with health care providers. An HCSC is defined as an organization "sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of

persons or groups of persons as consideration for providing such persons with any health care services." RCW 48.44.010(3).

HCSCs include medical service bureaus, medical service organizations, and blue shield organizations. *See* WAC § 246-455-020 ("health care service contractors, e.g., Blue Cross, county medical bureaus, Washington Physicians Service"). Such organizations have been governed by RCW 48.44 for many years. *See Ketcham v. King County Medical Service Corp.*, 81 Wn.2d 565, 567, 502 P.2d 1197 (1972) ("health care service contractors, such as King County Medical Service Corporation and the other named health care contractors, are regulated by the health care services act, RCW 48.44").

In 1993, the legislature removed prepayments received by any "health maintenance organization, health care service contractor, or certified health plan" from the B&O tax. *See* RCW 82.04.322. Instead, prepayments to these organizations were made subject to a premium tax under RCW 48.14.0201, which tax is collected by the insurance commissioner's office. RCW 48.14.0201 covers health maintenance organizations, as defined in RCW 48.46.020, and health care service contractors, as defined in RCW 48.44.010. Prepayments received by the taxpayer, which is neither an HMO nor an HCSC, were not removed from the B&O tax.

Historically, HCSCs were not considered to be providing services related to insurance, but were part of a cooperative movement to purchase medical services at lower cost. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 226 (1979); *Fishback v. Universal Service Agency*, 87 Wash. 413, 151 P. 768 (1917); 43 Am. Jur 2d *Insurance* § 11 (1999). Washington courts, however, began distinguishing the earlier cases based on changes in contract language. *See, e.g., McCarty v. King Cty. Medical Service Corp.*, 26 Wn.2d 660, 679, 175 P.2d 653 (1946) (holding that the service corporation was not a consumer cooperative but "in the contract before us, not an agent of, but a coprincipal with, the physicians, hospitals, and employers, as contracting parties with the employee"). Most recently, in *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert denied*, 525 U.S. 1141 (1999), the Ninth Circuit Court of Appeals addressed whether certain changes in Washington health care law were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*, and stated:

> In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Some commentators in fact describe managed care plans as combining "insurance functions with health-care vehicles." John D. Blum, *Symposium On Health Care Policy: What Lessons Have We Learned From The Aids Pandemic: Article: Safeguarding The Interests Of People With Aids In Managed Care Settings*, 61 Alb. L. Rev. 745, 748 (1998). This may be particularly true when "an entity assumes the risk of providing health care for a fixed capitated payment of plan enrollees, that entity becomes in effect the insurer for the care of the enrollees." Eleanor D.

Kinney, *Article: Procedural Protections for Patients in Capitated Health Plans,* 22 Am. J. L. and Med. 301, 307 (1996).

While managed care plans each present unique elements, "certain commonalities such as prepayment (capitation/discounted fee-for-service), use of primary care physician gatekeepers, limits on specialty care, and use of drug formularies are in evidence across plan models." John D. Blum, *Symposium On Health Care Policy: What Lessons Have We Learned From The Aids Pandemic: Article: Safeguarding The Interests Of People With Aids In Managed Care Settings*, 61 Alb. L. Rev. 745, 748 (1998). One of the developments in managed care is for the gatekeeper physician to accept prepayments for medical services and, thereby, assume some of the HCSC's or HMO's risk:

> In the American health care system, payers are rapidly moving toward the use of capitation as the preferred method for paying for health care services for sponsored patients. In capitation, the payer pays a provider organization a set rate per patient to care for a group of patients. The provider organization assumes the risk of the actual costs of caring for these covered lives. The theory of capitation is that providers, by assuming risk, will have incentives to contain their costs.

Eleanor D. Kinney, *Article: Procedural Protections for Patients in Capitated Health Plans*, 22 Am. J. L. and Med. 301 (1996).

Consistent with this trend, the taxpayer accepted prepayments from HMOs and HCSCs and assumed the risk of its member patients' care, including the payment of any covered hospital and specialist charge. It effectively became an insurer for the care of the member patients. It now seeks to avoid paying B&O tax on the portion of the capitation payments it received and used to pay for services performed by hospitals and specialists.

The taxpayer first asserts in a generalized manner that, because it does not itself provide hospital or specialty services, capitation income related to such hospitalization and specialist charges was not gross income from its business activities. However, the scope of the taxpayer's business included both health care functions and functions analogous to an insurance business. It received payments from HMOs and HCSCs to perform these functions and to assume the risks that it did. Absent a specific provision to limit taxation, the full capitation payments it received are subject to tax as its gross income. *See* RCW 82.04.080; *Engine Rebuilders, Inc. v. State*, 66 Wn.2d 147, 150, 401 P.2d 628 (1985) (in general, the "the idea implicit in this definition [of gross income] is that the tax applies to everything that is earned, received, paid over to or acquired by the seller from the purchaser.").

The taxpayer next asserts it was acting as an agent of its patient members in referring them to third-party hospitals and specialists. Accordingly, under WAC 458-20-111 (Rule 111), it should be able to treat the payments for hospital and specialist charges as pass-through payments. For the reasons set forth below, we find the taxpayer was not acting as their agent with respect to the payments at issue. More importantly, under its contracts it was directly liable for the hospital

charges. As such, the payments are expressly excluded from pass-through treatment under Rule 111.

The taxpayer further contends that the payments should be treated as pass-through payments under WAC 458-20-233 (Rule 233). It reasons that, because it contractually assumed certain functions and risks associated with HCSCs (although it is not an HCSC or an HMO), it should be considered a similar organization. Because certain HCSCs and similar organizations were allowed pass-through treatment for hospital and other charges under Rule 233, it should be afforded the same treatment. For the reasons stated below, we find the taxpayer falls outside the plain meaning of the rule, and it was not entitled to the exemption provided by Rule 233.

2. Are the payments nondeductible expenses of the taxpayer's business or are they advances and reimbursements?

The state imposes B&O tax on the gross income of the business. RCW 82.04.220. The term "gross income of the business" is broadly defined, and the tax is imposed "without any deduction on account of the cost of tangible property sold, the cost of materials used, labor costs, interest, discount, delivery costs, taxes, or any other expense whatsoever paid or accrued and without any deduction on account of losses." RCW 82.04.080. Although this statute does not allow expense deductions, the Department adopted Rule 111, an administrative rule excluding certain "pass through" expenses from the definition of gross income.[3] *Walthew, Warner, Keefe, Arron, Costello & Thompson v. Department of Rev*., 103 Wn.2d 183, 186, 691 P.2d 559 (1984).

In general, for pass-through treatment under this rule, payments by the taxpayer must: (1) be customary reimbursements for advances made by the taxpayer to procure services for the client; (2) be for services that the taxpayer does not or cannot render; and (3) not involve fees or costs for which the taxpayer is personally liable, except as the customer's agent. *Rho Co. v. Department of Rev*., 113 Wn.2d 561, 567-568; 782 P.2d 986 (1989); *Christensen v. Department of Rev.*, 97 Wn.2d

[3] In relevant part Rule 111 provides:

> The words "advance" and "reimbursement" apply only when the customer or client alone is liable for the payment of the fees or costs and when the taxpayer making the payment has no personal liability therefor, either primarily or secondarily, other than as agent for the customer or client.
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> There may be excluded from the measure of tax amounts representing money or credit received by a taxpayer as reimbursement of an advance in accordance with the regular and usual custom of his business or profession.
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> The foregoing is limited to cases wherein the taxpayer, as an incident to the business, undertakes, on behalf of the customer, guest or client, the payment of money, either upon an obligation owing by the customer, guest or client to a third person, or in procuring a service for the customer, guest or client which the taxpayer does not or cannot render and for which no liability attaches to the taxpayer. It does not apply to cases where the customer, guest or client makes advances to the taxpayer upon services to be rendered by the taxpayer or upon goods to be purchased by the taxpayer in carrying on the business in which the taxpayer engages.

764, 769, 649 P.2d 839 (1982).[4] More specifically, the taxpayer on behalf of its patients must procure or arrange for services from specialists and hospitals, which services the taxpayer does not or cannot render and for which it has no liability for payment of costs other than as an agent.

With respect to this first requirement, a taxpayer who is hired to provide a service, rather than to procure or arrange for a service, and who then hires a subcontractor or an independent contractor to provide part of the service, cannot qualify the subcontract work as a pass-through payment. This is true even if the taxpayer is not licensed to provide the service and it has an agreement that it is not liable to the subcontractor when a customer fails to pay for the service. Such payments to a subcontractor are nondeductible expenses of providing the service. *See, e.g., Mills & Uchida Court Reporting, Inc. v. Department of Rev.*, No. 46110 (Bd. of Tax Appeals 1996). In the present case, the taxpayer received payments that are not advances for the reimbursement of any particular service. It received prepayments regardless of any service actually being procured. The payments were for the taxpayer effectively insuring or covering the risk of care being needed by the patient members. Because it was receiving payments for services it actually provided, not advances or reimbursements, it does not satisfy the first element.

As to the second element, Rule 111 states the deduction "does not apply to cases where the customer . . . makes advances to the taxpayer upon services to be rendered by the taxpayer in carrying on the business in which the taxpayer engages." The taxpayer seeks to exclude the capitation amounts it received from the medical plan providers for a member-patient's medical care, including hospital or specialists costs. However, this taxpayer could and did render services analogous to an insurance business. Because the prepayments were for both a health care function and an insurance function, a service rendered by the taxpayer in carrying on its business, the second element of Rule 111 was also not met.

As to the third element under Rule 111, the existence of an agency relationship must be decided under the common law of agency. *Rho*, 113 Wn.2d at 571.[5] An express or implied agency relationship is a consensual relationship whereby one party acts on behalf of and, in some material degree, under the direction and control of another. *Hewson Constr., Inc. v. Reintree Corp.*, 101 Wn.2d 819, 823, 685 P.2d 1062 (1984).[6] The burden of establishing the agency

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[4] In *Rho*, a temporary personnel company sought to have payments for temporary employees' wages treated as pass-through costs. The only issue was whether Rho was acting solely as an agent in paying the temporary employees. The case was remanded for a factual determination on this issue.

[5] As stated in *Rho*, 113 Wn.2d at 571, "[A]gency is a legal concept that depends on the manifest conduct of the parties; it 'does not depend upon the intent of the parties to create it, nor their belief that they have done so. . . . [A]n agency exists although the parties did not call it agency and did not intend the legal consequences of the relation to follow.' Restatement (Second) of Agency § 1, comment b (1958), *quoted in Busk v. Hoard, supra* at 129. It follows that an agency can be implied, if the facts so warrant, not only if the contracts are silent as to agency, but even if the parties execute contracts expressly disavowing the creation of an agency relationship."

[6] Restatement (Second) of Agency § 1 (1958) defines an agency relationship as follows:

> Agency is the fiduciary relation which results from the manifestation of consent by one person to another that the other shall act on his behalf and subject to his control, and consent by the other so to act.

relationship is on the party asserting it. *Id.* The agency concept is flexible; it may be established for a limited purpose, or it may be broad. *CKP, Inc. v. GRS Constr. Co.*, 63 Wn. App. 601, 821 P.2d 63 (1991), *rev. denied*, 120 Wn.2d 1010 (1992).

In this case, even if we were to find the taxpayer was acting as an agent for its patients in making referrals (a finding that we do not need to make), it was not acting as their agent with respect to the capitation payments at issue. As previously discussed, it was not receiving advances to reimburse for costs resulting from the referrals. Rather, it was receiving payments for effectively insuring member patients against risk of care, as a principal or co-principal. The taxpayer was not acting merely as an agent of its patients. *See* 70 C.J.S. *Physicians and Surgeons* § 132, at 578 (1987).[7]

Further, Rule 111's third element requires that the taxpayer's liability for payment for such services must be solely that of an agent. When a taxpayer is acting as an agent, but is also personally liable for payment of expense charges, such charges are considered costs of the agent's business and are not deductible as pass-through payments. *See, e.g.*, WAC 458-20-207 (an attorney's advances on behalf of a client for nonlitigation expenses are excludable from B&O tax "only when the attorney does not have any personal liability to the third-party provider for their payment"); WAC 458-20-258 (travel agents and tour operators may have personal liability for rooms and tickets).

In the present case, under the terms of its contracts, the taxpayer was directly and primarily liable to the providers for payment of the provider's charges. It was not liable solely as an agent. The payments to third party providers were the taxpayer's nondeductible costs of doing business.

For these reasons, the taxpayer was not entitled under Rule 111 to deduct from its gross income payments to third-party providers.

3. Is Rule 233 applicable to the taxpayer's business?

Taxpayer contends that even if it does not meet the requirements of Rule 111, it falls squarely within the exclusion from gross income set forth in Rule 233.[8] Rule 233 is an administrative rule

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[7] As to the financial liability of a referring physician, this treatise provides:

> In the absence of any statute to the contrary, a physician summoned by another physician for assistance, under an arrangement that the summoning physician will be responsible, is entitled to recover from the summoning physician; but, where the summoning physician acts merely as the agent of the patient, the doctor called in to assist may not recover from such summoning physician. [Footnotes omitted.]

[8] Rule 233 discusses the B&O tax liability of medical service bureaus, associations, and similar health care organizations. In relevant part Rule 233 provides:

> All medical service bureaus, medical service corporations, hospital service associations and similar health care organizations engaging in business within this state are subject to the provisions of the business and occupation tax and are taxable under the service and other business activities classification upon their gross

specifically directed to the taxability of medical and hospital service bureaus and associations and similar health care organizations. Qualifying organizations may deduct from their gross income amounts paid to member physicians, hospitals, and ambulance companies.

Rules of statutory construction apply to the interpretation of administrative rules and regulations. *Multicare Medical Ctr. v. Department of Social and Health Services*, 114 Wn.2d 572, 591, 790 P.2d 124 (1990). In interpreting statutes, we must determine legislative intent; to do so we look first to the language of the statute. *Lacey Nursing v. Department of Rev.*, 128 Wn.2d 40, 53, 905 P.2d 338 (1995). The language of a statute must be read in context with the entire statute and construed in a manner consistent with the general purpose of the statute. *Graham v. State Bar Ass'n*, 86 Wn.2d 624, 627, 548 P.2d 310 (1976). In ascertaining the meaning of a particular word as used in a statute, a court must consider both the statute's subject matter and the context in which the word is used. *Chamberlain v. Department of Transp.*, 79 Wn. App. 212, 217, 901 P.2d 344 (1995).

Further, exemptions to a tax are narrowly construed; taxation is the rule and exemption is the exception. *Budget Rent-a-Car, Inc. v. Department of Rev.*, 81 Wn.2d 171, 174, 500 P.2d 764 (1972). In this case, the rule in its first paragraph sets forth the general rule that medical bureaus and similar organizations are subject to tax. In the second paragraph, the rule identifies those bureaus and similar organizations that are subject to the exemption from tax. Under the second paragraph, not all medical bureaus and similar organizations are qualified organizations, entitled to the exemption. By its terms, the second paragraph of Rule 233 requires qualifying organizations: (1) by contract to act solely as an agent of the physicians who provide the medical services; and (2) to have members or subscribers.

With respect to the agency requirement, the taxpayer relies on the Board of Tax Appeals' decision in *Group Health Northwest v. Department of Rev.*, No. 91-11 (Bd. of Tax Appeals 1992). In that case Group Health was an HMO that provided specialty medical services and referred patients to contract physicians and hospitals for services that it did not provide. The Board of Tax Appeals concluded that the payments were deductible under Rule 233. The Board, with little analysis, appears to have found Group Health was acting as an agent based on a finding that "contract physicians look to Group Health…as a source of patients." Because it also

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income. The term "gross income" as defined in RCW 82.04.080 is construed to include the total contributions, fees, premiums or other receipts paid in by the members or subscribers. Insofar as tax liability is concerned it is immaterial that such organizations may be incorporated as charitable or nonprofit corporations.

Certain of these organizations operate under contracts by the terms of which the bureau or association acts solely as the agent of a physician, hospital, or ambulance company in offering to its members or subscribers medical and surgical services, hospitalization, nursing, and ambulance services. In computing tax liability such bureaus and associations, therefore, will be entitled to deduct from their gross income the amounts paid to member physicians, hospitals and ambulance companies. No deduction will be allowed with respect to amounts retained as surplus or reserve accounts or to amounts expended for the purchase of supplies or for any other expense of the bureau or association other than as provided herein.

Under contracts wherein these organizations furnish to their members medical and surgical, hospitalization and ambulance services as a principal and not as an agent, no such deduction is allowed.

has contract physicians that look to it as a source of patients, the taxpayer contends it should receive similar treatment.

We do not follow the Board's reasoning or analysis for several reasons. First, we question whether the facts or analysis as presented in the decision were sufficient for finding the taxpayer to have been acting solely as an agent. In this regard, its conclusion appears contrary to the Board's later analysis of agency in *Mills & Uchida Court Reporting, Inc. v. Department of Rev.,* No. 46110 (Bd. of Tax Appeals 1996). Further, contrary to the Board's broad finding, most HMOs and HCSCs would probably not be viewed as acting solely as agents. *See McCarty v. King Cty. Medical Service Corp.,* 26 Wn.2d 660, 679, 175 P.2d 653 (1946). The *Group Health* decision also did not involve capitation payments, which are at issue in this case and which present different agency issues, as were discussed *infra* in the context of Rule 111. Because Group Health was a member organization, the membership requirement was also not at issue.

When the Department has been directly confronted with similar issues in the context of entities asserting they are similar organizations, it has had occasion to address both the agency and the membership issues. In Det. No. 87-332, 4 WTD 205 (1987), a medical group sought to deduct all payments to referral specialists under the theory that it should be treated as a qualified medical service organization under Rule 233. That determination held that the clinic did not meet the Rule 233 requirements both because it did not directly have members or subscribers and because it was acting as a principal and not solely as an agent. *See also* Det. No. 89-512, 8 WTD 373 (1989). It continues to be the Department's policy that both elements must be met and, as a result, we are unable to construe the Rule's agency and member requirements in the taxpayer's favor.

As to the membership requirement, the taxpayer asserts that, because not all HSCSs had members, that requirement should not be binding so long as it is providing similar services. We recognize that not all HSCSs were required to have members, but could accept prepayments from or on "behalf" of members. *See* RCW 48.44.010(3). However, Rule 233 was not intended to apply to all HSCSs or similar organizations, only to those that met the requirements outlined in the second paragraph of the rule. Because the taxpayer did not meet those requirements, it is not entitled to the exemption for tax provided in Rule 233. We have no basis in the law to extend the reach of the exemption in the manner sought by the taxpayer.

DECISION AND DISPOSITION:

Taxpayer's petition is denied.

Dated this 6th day of June, 2001.