NEW YORK CITY TAX APPEALS TRIBUNAL

In the Matter of	:	DECISION
AETNA, INC.	:	TAT (E) 12-3 (GC) TAT (E) 12-4 (GC)
Petitioner.	:	

The Commissioner of Finance of the City of New York (Respondent) filed an exception to a Determination of an Administrative Law Judge (ALJ) dated July 22, 2014 (ALJ Determination), which cancelled Notices of Disallowance (Notices) of refunds of New York City General Corporation Tax (GCT) issued by the New York City Department of Finance (Department) for Aetna, Inc. (Petitioner) for the calendar years ended December 31, 2005 and December 31, 2006 (Tax Years).

Respondent appeared by Martin Nussbaum, Esq., Assistant Corporation Counsel of the New York City Law Department. Petitioner appeared by Peter L. Faber, Esq., and Maria P. Eberle, Esq., of McDermott Will & Emery, LLP.

Petitioner is a holding company, incorporated in Pennsylvania and headquartered in Hartford, Connecticut.[1] Petitioner has a number of subsidiaries that are health maintenance organizations (HMOs).

Petitioner's HMO doing business in New York State (State) is its subsidiary, Aetna Health, Inc. (Aetna Health NY). Aetna Health NY also is doing business in New York City (City). Aetna Health NY operates in the State under a "Health Maintenance Organization Certificate of Authority" issued by the State Department of Health, Division of Managed Care.

[1] Except as otherwise noted, the ALJ's Findings of Fact, although paraphrased and summarized herein, generally are adopted for purposes of this Decision. Certain Findings of Fact not necessary to this Decision have not been restated and can be found in the ALJ Determination.

Petitioner filed combined GCT returns (Form NYC-3A) with 63 subsidiaries for the 2005 Tax Year and with 69 subsidiaries for the 2006 Tax Year. Petitioner filed timely claims for refunds of GCT for each of the Tax Years (Refund Claims) based on Petitioner's assertion that its HMOs were exempt from the GCT as "insurance corporations" because they were "doing an insurance business" in the State. On its Refund Claims, Petitioner recalculated its GCT liability for each of the Tax Years by excluding 27 HMO subsidiaries from its combined GCT return for the 2005 Tax Year, and 28 HMO subsidiaries from its combined GCT return for the 2006 Tax Year.[2]

Respondent denied the Refund Claims for each of the Tax Years on the grounds that HMOs are not insurance corporations and therefore are subject to the GCT and includible in Petitioner's combined GCT returns for the Tax Years. The Notices denied GCT refunds of $482,733 for the 2005 Tax Year and $639,489 for the 2006 Tax Year.

There are four HMO business models: (1) the staff model, (2) the group model, (3) the independent physician association (IPA) model, and (4) the network model. In the staff model, physicians are salaried and are employees of the HMO. The staff model provides medical services to its members through its physician-employees. In the other business models the HMO does not provide healthcare services through its own employees, but provides access to those services through its network of physicians and hospitals engaged as independent contractors. In the group model, the HMO does not employ the physicians directly, but contracts with a group practice. Some groups will only treat the HMO's members.

In the IPA model, unrelated physicians form an organization that represents their interests and negotiates the terms and conditions of fee reimbursements, hours, etc. with the HMO. IPA physicians generally see other patients in addition to the HMO's

[2] The Refund Claims asserted that the excluded HMO subsidiaries were doing an insurance business in the State. However, the Record does not include specific information regarding the activities of any of Petitioner's HMO subsidiaries in the State other than Aetna Health NY. In statements attached to each of Petitioner's combined GCT returns for the Tax Years, Petitioner concludes that all of its subsidiaries meet the requirements for inclusion in a combined GCT return, i.e., ownership, unitary business and distortion. Nothing in the Record contradicts those statements. Stipulation Ex A, B. For ease of presentation, the HMO subsidiaries excluded from Petitioner's combined GCT returns for the Tax Years for purposes of the Refund Claims are referred to as the "Excluded HMOs."

members. Aetna Health NY is an IPA model HMO. The network model is a blend of the IPA and group models, in which the HMO may contract with a group practice in one county and with an IPA in another.

HMOs make extensive use of primary care physicians (PCPs) to deliver health care services. A PCP is a family doctor, usually a general practitioner, who takes care of a patient's initial medical needs, provides referrals to specialists, and also provides some preventative health care services. Paul Macielak, the President and CEO of the New York Health Plan Association during the Tax Years, testified that PCPs are one of the "hallmarks" of an HMO because they manage a patient's total healthcare and counsel the patient on diet, smoking cessation, and other health maintenance measures. Under a "gatekeeper plan," a patient is required to visit a PCP for all medical and healthcare needs. The PCP will refer the patient to specialists if the PCP deems such referrals to be necessary. Under a "non-referral plan," the patient does not require a PCP referral to see another doctor. Where PCPs perform a "gatekeeper" function, they enable the HMO to maintain the quality of patient care and control costs. Except for a co-pay amount, all visits to a PCP, or to doctors referred by the PCP, are fully covered by Aetna Health NY. More than half of Aetna Health NY's enrollees were in PCP plans.

During the Tax Years, Steven Logan was the General Manager and Senior Vice President of Petitioner's Northeast Region, which included Aetna Health NY. Mr. Logan testified that Aetna Health NY's plans consisted of "those that required a gatekeeper, one that didn't require a gatekeeper but requested the selection of one, those that had no primary care physician elected, and certain plans [that] had out-of-network coverage, coverage for non-contracted providers with Aetna [Health NY]." (Tr 174.)

HMOs compensate their physicians in two ways. In a fee-for-service arrangement, the HMO pays the HMO physician's claim for medical services based on a pre-arranged fee schedule specified in the physician's contract. During the Tax Years, the fee-for-service arrangement was principally used to compensate specialists. HMOs also compensate physicians using capitation payments, under which the HMO pays the physician a fixed amount each month for each patient the physician sees, regardless of

how many times the patient sees the physician during the month. Aetna Health NY made capitation payments to PCPs but not to specialists.

Mr. Macielak testified to the differences between HMOs and indemnity insurance. HMOs control the cost of their health care plans through contractual relationships with participating physicians. HMO physicians are compensated for their services based on pre-arranged fee schedules. Indemnity insurers have no contractual relationship with the physicians. Mr. Macielak explained that indemnity insurers control their costs through the use of deductibles and by paying only 70%-80% of the "usual and customary charge" in a particular geographic area. (Tr 83-84.)

During the Tax Years, Aetna Health NY's customers consisted primarily of corporate and governmental employers looking to "provide medical coverage for their employees as part of their employee benefit plan." (Tr 152.) The employer entered into a "group contract" with Aetna Health NY to provide coverage to its employees. The employer would select the plan benefits and pay the premiums on behalf of its employees; usually there was an employee contribution.

Petitioner asserts that Aetna Health NY was "conducting an insurance business" in the State during the Tax Years and, therefore, was not subject to the GCT and must be excluded from its combined GCT returns for the Tax Years.[3] Petitioner asserts that, for purposes of the GCT, "conducting an insurance business" should be interpreted "under common sense notions of insurance" as well as under a "plethora" of State and federal authorities. Petitioner argues that the "essence of insurance" under federal and State authorities is "risk-shifting" and "risk-distributing," which describe the activities of Aetna Health NY in the State and City.[4]

Respondent argues that the "relevant inquiry" is not how HMOs are regulated but how they were intended to be taxed under the specific legislative history of the GCT and

[3] Petitioner's Brief in Opposition to the Exception (Pet Br) at 45. However, Petitioner's Refund Claims were based on calculating its combined GCT liability for each of the Tax Years omitting all of the Excluded HMOs from its combined GCT returns for the Tax Years.

[4] Pet Br at 11.

the former City Insurance Corporation Tax (discussed below.)[5] Respondent asserts that Insurance Law §1109(a) exempts HMOs that comply with Article 44 of the Public Health Law (PHL) from the requirement that they be licensed as an insurer, as well as from all other provisions of the Insurance Law except for certain specified provisions. Respondent also asserts that HMOs are "primarily in the business of providing access to health care services, not insurance. . . ."[6]

The ALJ concluded that the income from Petitioner's HMOs should not be included in its combined GCT returns for the Tax Years, and cancelled the Notices.[7]

For the following reasons, we reverse the ALJ Determination and conclude that Petitioner is required to include the Excluded HMOs in its combined GCT returns for the Tax Years.

Section 11-603.1 of the Administrative Code of the City of New York (Administrative Code) imposes the GCT on corporations "[f]or the privilege of doing business, or of employing capital, or of owning or leasing property in the city in a corporate or organized capacity, or of maintaining an office in the city. . . ." Administrative Code §11-603.4(a) describes certain corporations not subject to the GCT, such as banking corporations and utilities taxable under other chapters or subchapters of Title 11 of the Administrative Code. The predecessor provision to Administrative Code §11-603.4(a), former Administrative Code §R46-3.0.4(a), also exempted from the GCT corporations subject to the City Insurance Corporation Tax under former Title R, part 4, of the Administrative Code.

Effective July 1, 1974, the City Insurance Corporation Tax was repealed. (L 1974, ch 649, §11.) However, the legislation authorizing the GCT, L 1966, ch 772, §3.4, (GCT Enabling Legislation), was not amended to remove the exclusion for corporations taxable under the former City Insurance Corporation Tax. The Department has consistently

---

[5] Resp Br at 5.
[6] Resp Br at 39.
[7] The ALJ concluded that "Petitioner was doing an insurance business" during the Tax Years. ALJ Determination at 27. We assume she meant Aetna Health NY rather than Petitioner.

taken the position that corporations that would have been subject to the former City Insurance Corporation Tax remain exempt from the GCT.[8]

Consistent with the GCT Enabling Legislation, the General Corporation Tax Rules of the City of New York (GCT Rules) provide at 19 RCNY §11-04(b) that "an insurance corporation as defined in former §R46-41.0.4, Administrative Code (Repealed)" is exempt from GCT. Former Administrative Code §R46-41.0.4 provided that "[t]he term 'insurance corporation' . . . shall include a corporation . . . *doing an insurance business in this state*. . . ." (Emphasis added.)

We disagree with Petitioner's assertion that the question should be governed in part by "common sense notions" of insurance. Petitioner's witnesses testified extensively regarding the differences and similarities between indemnity insurance providers and HMOs. From the perspective of the individual participating in one type of plan or the other, both offer some means of limiting out-of-pocket medical expenses, whether preventative or unanticipated. However, the perception of the enrollee or insured is irrelevant where, as here, there is an extensive and specific statutory structure governing the taxation of HMOs and insurance companies. We also disagree with Petitioner's assertion that the question before us is not whether all HMOs or a certain type of HMO is "doing an insurance business" in the State but whether Aetna Health NY is "doing an insurance business" in the State.[9] Nothing in the testimony or other evidence submitted suggests that there is anything unusual in the HMO business conducted by Aetna Health NY that would suggest that Aetna Health NY's activities in the State constitute doing an insurance business regardless of whether other HMOs are considered to be doing an insurance business in the State.[10]

The phrase "doing an insurance business in this state" was not defined under the City Insurance Corporation Tax. Former §R46-41.0.2 provided:

---

[8] *See e.g.,* Finance Letter Ruling No. 004772-006 [2000].

[9] Pet Br at 1.

[10] We note that in any event, the Refund Claims are based on a calculation of Petitioner's GCT liability for each of the Tax Years omitting the Excluded HMOs from its combined returns, not just Aetna Health NY.

> "Every such insurance corporation *which shall obtain a certificate of authority to transact business in this state* or a renewal of such certificate from the superintendent of insurance, shall upon the expiration of such certificate for any cause, or upon its ceasing to transact new business in the city continue to pay a tax upon its business remaining in force in the city at the rate and as computed in this subdivision." (Emphasis added.)

This provision suggests that a corporation that received a certificate of authority from the superintendent of insurance was considered to be doing an insurance business, and therefore exempt from the GCT, until that certificate expired.

Insurance Law §1101(b) describes a number of actions that constitute "doing an insurance business in this state" including "making, or proposing to make" an "insurance contract", "collecting any premium, membership fee, assessment or other consideration for any policy or contract of insurance" and "doing any kind of business . . . specifically recognized as constituting the doing of an insurance business within the meaning of this chapter. . . ."

Insurance Law §1101(a) defines "insurance contract" as

> "any agreement or other transaction whereby one party . . . is obligated to confer benefit of pecuniary value upon another party . . . dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event."

In 1976, New York State enacted legislation to promote the development of HMOs through a substantial amendment of Article 44 of the PHL. (L 1976, ch 938.) PHL §4400 declares that the legislative purpose behind the new HMO statutory scheme was to encourage: "the expansion of health care services options. . . . Without such an expansion, increased health insurance and other benefits will continue to escalate the costs of medical care and overload the health care delivery system." PHL §4400 further states: "The health maintenance organization concept, through which members of an enrolled population are each entitled to receive comprehensive health services for an

advance or periodic charge, represents a promising new alternative for the delivery of a full range of health care services at a reasonable cost." To that end, the HMO offers a "comprehensive health services plan" which must include, at a minimum, "all those health services which an enrolled population might require in order to be maintained in good health" including physician and hospital services, diagnostic and radiologic services, emergency services, and preventative health services. (PHL §4401[2], [3].)

PHL §4411 provides, in relevant part, that "no health maintenance organization shall include in its name the words "insurer", "casualty", "health and accident" *or any words generally regarded as descriptive of the insurance function. . . .*" (Emphasis added.) Thus, the legislature intended that HMOs not be perceived by the general public as "insurers" or even as engaged in an "insurance function." This provision makes it clear that, in overhauling Article 44 of the PHL, the State Legislature did not consider HMOs to be providing insurance in any "common sense" understanding of that word. Rather the State Legislature enacted PHL §4411 specifically to prevent any conflation of HMOs with insurers.

We note that PHL §4406 provides that "The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent *as if it were a health insurance subscriber contract. . . .*" (Emphasis added.) That provision would not have been necessary if an HMO contract were otherwise considered an "insurance contract" under the Insurance Law.

Insurance Law §1109(a), as in effect during the Tax Years, provided that:

> "An organization complying with the provisions of article forty-four of the public health law *may operate without being licensed under this chapter and without being subject to any provisions of this chapter except*: (1) to the extent that such organization must comply with the provisions of this chapter by virtue of such article, and (2) the provisions of sections three hundred eight, three hundred thirteen, three hundred thirty-two, one thousand three hundred one, one thousand three hundred two, one thousand three hundred seven, two thousand one hundred three, two thousand one hundred twelve, two thousand one hundred fourteen, two thousand one

> hundred fifteen, two thousand one hundred seventeen, two thousand one hundred twenty-three, two thousand six hundred eight-a, two thousand six hundred twelve, three thousand two hundred twenty-four-a, four thousand three hundred eight, four thousand three hundred seventeen, four thousand three hundred eighteen, four thousand three hundred twenty, four thousand three hundred twenty-one, four thousand three hundred twenty-two, and four thousand three hundred twenty-three of this chapter." (Emphasis added.)

Therefore, HMOs complying with PHL Article 44 are not subject to any provision of the Insurance Law not expressly made applicable to HMOs by Insurance Law §1109(a). Consequently Insurance Law §1101 ("doing an insurance business") and Insurance Law §1102(a) (licensing requirement for insurers that "do an insurance business in this state") do not apply to HMOs complying with PHL Article 44. If an HMO fails to comply with Article 44 of the PHL, Insurance Law §1109(b) provides that the HMO "shall be deemed to be engaged in the business of insurance" and must be licensed. Respondent argues that when read together, Insurance Law §§1109(a) and (b) intend that an HMO that complies with Article 44 of the PHL is not "deemed to be engaged in the business of insurance."[11] We agree.

Moreover, those specific provisions of the Insurance Law expressly applicable to HMOs distinguish the business of an HMO from "doing an insurance business." For example, Insurance Law §2103, which concerns the licensing of insurance agents, provides that:

> "The superintendent [of insurance] may issue a license to any person, firm or corporation who or which has complied with the requirements of this chapter, authorizing such licensee to act as an insurance agent with respect to the lines of authority for life insurance . . . accident and health insurance . . . including *for this purpose, health maintenance organization contracts . . . on behalf of any insurer . . . or health maintenance organization*, which is authorized to do such kind or kinds of insurance or *health maintenance organization business in this state*." (Emphasis added.)

[11] Resp Br at 19.

Similarly, Insurance Law §2117(a) provides that:

> "No person, firm, association or corporation shall in this state act as agent for any *insurer or health maintenance organization* which is not licensed or authorized to *do an insurance or health maintenance organization business in this state*." (Emphasis added.)

Finally, Insurance Law §2123(a)(1) prohibits any "agent or representative of any *insurer or health maintenance organization* authorized to transact life, accident or health insurance *or health maintenance organization business* in this state" (emphasis added) from making misleading statements or misrepresentations in promotional materials or circulars.

Thus, even those provisions of the Insurance Law applicable to HMOs distinguish between "insurers" and HMOs and between entities doing an "insurance business" and those doing a "health maintenance organization business." Reading those provisions of the Insurance Law *in pari materia* with the GCT Enabling Legislation[12] makes it clear that HMOs are not exempt "insurance corporations" within the meaning of the GCT Enabling Legislation and are, therefore, taxable under the GCT.

We conclude that the ALJ erred in relying on authorities beyond the applicable statutes and from outside the State in interpreting the phrase "doing an insurance business" in Insurance Law §1101 to the exclusion of other provisions of the Insurance Law. Under settled principles of statutory construction, statutory "language should not be read in isolation, but within the context of the entire statute. . . ." (*Scott v Massachusetts Mutual Life Ins. Co.*, 86 NY2d 429, 435 [1995]; McKinney's Statutes §§97, 98.)

We, therefore, reject Petitioner's contention that language in Insurance Law §1109(a) generally excluding HMOs from provisions of the Insurance Law is not relevant to the question of whether HMOs are "doing an insurance business" under Insurance Law §1101. (Pet Br at 40-42.) Petitioner's reading of Insurance Law §1109(a) ignores both

[12] *See Matter of Inter-County Tit. Guar. and Mtge. Co. v State Tax Commn.*, 28 NY2d 179, 184 (1971).

the broadly-worded exemption of HMOs from "any of the provisions" of the Insurance Law (with express exceptions) and those other provisions of the Insurance Law cited above that distinguish between "insurers" and HMOs and between an "insurance business" and a "health maintenance organization business."

In support of its position, Petitioner cites 11 NYCRR §243.1(a) as evidence that HMOs are insurers. Under that regulation, the term "insurer" includes HMOs for the purpose of certain record keeping requirements. (Pet Br at 31.) At the outset, we note that the regulation expressly provides that the definition is for the limited purpose of that part of the regulations dealing with record keeping. In any event, the regulatory definition includes HMOs in a list that also includes other organizations expressly exempted from being licensed under the Insurance Law and "*exempt from the doing of an insurance business*" under "§1108 or other section of the Insurance Law." (Emphasis added.) Thus, rather than supporting Petitioner's argument that HMOs are insurers, that regulation supports the opposite conclusion.

In support of its contention that Aetna Health NY is doing an insurance business within the meaning of Insurance Law §1101, Petitioner also relies on two legal opinions issued by the State Insurance Department (Pet Br at 31-33, 41.) The ALJ also gave significant weight to these two opinions in reaching her conclusion that HMOs are doing an insurance business. (ALJ Determination at 20-22.)

The first of these two legal opinions is addressed to Michael Scharff[13] from Paul A. Zuckerman, Associate Attorney in the Office of General Counsel of the Insurance Department dated August 21, 1991 (1991 Opinion). The 1991 Opinion is marked "Privileged and confidential pre-decisional deliberative opinion from counsel to client" and is stamped "Restricted." It appears, therefore, that the 1991 Opinion was not intended to be made available to, or to be relied upon, by the general public. The 1991 Opinion addressed the question of whether the term "insurer" as used in 11 NYCRR §215, which "establishes minimum standards of conduct in the advertising of accident and health insurance," should be read to include an HMO.

[13] Mr. Scharff's title is not included in the letter.

The 1991 Opinion specifies that it is limited in scope. It states that "[t]his opinion turns solely on whether an HMO is an insurer for the purposes of [11 NYCRR §215]. . . ." More specifically, the 1991 Opinion considers whether an HMO is an "insurer" for the limited purpose of allowing the Superintendent of Insurance to regulate the advertising of its enrollee contracts as if they were accident and health insurance policies. In answering that question, the 1991 Opinion states that "§1109(a) provides that an organization complying with PHL Article 44 may operate without being licensed under the Insurance Law and without being subject to *any provision of the Insurance Law,* except" as required by Article 44. (Emphasis added.) The 1991 Opinion concludes that Article 44 of the PHL requires compliance with 11 NYCRR §215 because:

> "PHL §4406 provides that the contract between an HMO and an enrollee shall be subject to regulation by the Superintendent of Insurance as if it were a health insurance subscriber contract. Since [11 NYCRR §215] governs advertisements of accident and health insurance contracts, it follows that an HMO is subject to its requirements, including the filing of a certificate of compliance."

Therefore, the conclusion in the 1991 Opinion is based on a specific exception to the general exemption of HMOs from the provisions of the Insurance Law under Insurance Law §1109(a). While the 1991 Opinion also contains a broad statement that an HMO is "doing an insurance business", that statement appears to be based on a portion of regulation 11 NYCRR §215.4(c) including "any other legal entity" in the definition of "insurer." The author of the 1991 Opinion reads that phrase to mean that the list of entities in the definition was not intended to be exclusive. However, the full phrase in the regulation is "any other legal entity *which is defined as an insurer in the New York Insurance Law* and is engaged in the advertisement of a policy as herein defined." (Emphasis added.) Thus the regulation merely defines an insurer as any entity defined as an insurer under the Insurance Law and provides no support for the broad statement in the 1991 Opinion. In any event, it is not clear from the 1991 Opinion whether, or to what extent, it was ultimately relied on by the Insurance Department. The last sentence of the

1991 Opinion recommends that 11 NYCRR §215 be amended to specifically provide that it applies to HMOs. No such amendment was ever enacted.

A New York State Insurance Department Opinion of Counsel issued on February 13, 2004 (2004 Opinion), also cited by Petitioner and the ALJ, is likewise of limited application. The 2004 Opinion specifically states that it is an "informal" opinion. The 2004 Opinion addresses the question of whether a particular HMO is subject to "examination by the [Insurance] Department" and to "the provisions of Article Four of the [Insurance Law]." The 2004 Opinion correctly cites PHL §4409(2), which provides that HMOs are subject to Insurance Law §308, which, in 2004, authorized the superintendent of insurance[14] to direct any inquiry to "any health maintenance organization, any authorized insurer or rate service organization. . . ."[15] Insurance Law §409(a), part of Article 4 of the Insurance Law, also provides expressly that it applies to HMOs having more than 60,000 enrollees. Thus the HMO at issue in the 2004 Opinion, which had more than 60,000 enrollees, was expressly subject to Article 4 of the Insurance Law. The 2004 Opinion also cites the general statement in the 1991 Opinion regarding HMOs as doing an insurance business. However, as discussed above, we reject the reasoning underlying that general statement in the 1991 Opinion. In any event, as was the case in the 1991 Opinion, the conclusions in the 2004 Opinion depended on provisions of the Insurance Law expressly applicable to the HMO in question. For the foregoing reasons, we find neither the 1991 Opinion nor the 2004 Opinion persuasive on the relevant question before this Tribunal as to whether HMOs are insurers "doing an insurance business" and, therefore, exempt from the GCT.

In concluding that Aetna Health NY is an "insurer," the ALJ also relied on the United States Supreme Court decision in *Rush Prudential HMO v Moran*, 536 US 355 (2002) (*Rush*). (ALJ Determination at 17, 20, 26.) *Rush* held that the Illinois HMO Act was not pre-empted by ERISA because it was within a specified exception to ERISA pre-emption as a state law "which regulates insurance."

---

[14] Now the superintendent of financial services. (Insurance Law §107[a][41] as amended by L 2011, ch 62, part A, §104[d].)

[15] It is notable that HMOs were added to that provision in 1997. (L 1997, ch 666, §1.)

Rush is not relevant to the case before this Tribunal. The question in *Rush*, whether an Illinois statute was pre-empted by ERISA, has no bearing on the specific statutory scheme governing HMOs and insurance corporations under the GCT. *Rush* did not purport to interpret New York law, and its conclusion that the Illinois HMO Act "regulates insurance" for purposes of ERISA is irrelevant as to whether the State Legislature considered HMOs to be "doing an insurance business" for purposes of the Insurance Law or the GCT Enabling Legislation.

Moreover, *Rush* is distinguishable from the case before us due to essential structural differences between the Illinois regulatory scheme on which *Rush* turned and the New York law governing HMOs. The Court emphasized that Illinois was one of "at least 40" states that "regulate HMOs primarily through the States' insurance departments. . . ." *Rush*, at 369. The Illinois HMO Act is part of that state's insurance law[16] not the public health law as is the case in New York.[17] Illinois HMOs apply to the Director of Insurance for a certificate of authority to do business,[18] while New York HMOs apply to the Commissioner of Health.[19] New York, therefore, is not among the 40 states described in *Rush* in which the state insurance departments primarily regulate HMOs.

We conclude from the relevant provisions of the PHL and the Insurance Law comprising the statutory scheme authorizing HMOs in the State, that HMOs complying with PHL Article 44 are not "insurers," do not issue "insurance contracts," and are not "doing an insurance business in this state" within the meaning of Insurance Law §1101(a)(1). Such HMOs, therefore, are not "insurance corporations" within the meaning of the GCT Enabling Legislation and are not exempt from the GCT.

The State Department of Taxation and Finance (DTF) issued an Advisory Opinion, TSB-A-93(4)C (DTF Advisory Opinion), in which it ruled that an IPA model HMO, with facts substantially identical to Aetna Health NY in all relevant respects, was not "doing an insurance business" and, therefore, was not an "insurance corporation"

---

[16] 215 Ill. Comp. Stat. 125.
[17] PHL §4400, *et seq.*
[18] 215 Ill. Comp. Stat. 125/2-1(b).
[19] PHL §4402.

taxable under Article 33 of the Tax Law. Although State advisory opinions are not binding on the DTF except as to the specific taxpayer to whom they are issued under the specific facts stated in the advisory opinion,[20] nevertheless, we accord the DTF Advisory Opinion significant weight as the sole written authority directly addressing the taxation of HMOs in the State. The ALJ dismissed the DTF Advisory Opinion on the basis that it "predates the Supreme Court decision in *Rush*." (ALJ Determination at 20.) As we have concluded that *Rush* has no relevance to the present case, we reject the ALJ's conclusion. We also note that the DTF Advisory Opinion was issued after the 1991 Opinion, which the ALJ found persuasive. Petitioner merely argues that the DTF Advisory Opinion was incorrect in its reasoning and conclusion. We disagree.

The strongest argument for according weight to the DTF Advisory Opinion is that it is the only administrative guidance issued by the DTF on the taxability of HMOs. While the 1991 Opinion and the 2004 Opinion are by their own terms "restricted," "pre-decisional" and "informal" documents, the DTF Advisory Opinion is binding on the DTF, albeit only with respect to the taxpayer requesting the opinion. Moreover, the DTF Advisory Opinion addressed the direct issue of taxation of HMOs in the State, unlike the 1991 Opinion and 2004 Opinion, which addressed non-tax questions regarding HMO regulation that are governed by specific non-tax statutory provisions. The conclusions in those opinions did not depend on a general finding that HMOs are insurers, rendering the broad statements on that question merely the equivalent of dicta. By contrast, the DTF Advisory Opinion directly addressed the question of whether HMOs were subject to tax as business corporations under Article 9A of the Tax Law. Moreover, no subsequent authority directly on point contradicts the DTF's conclusion.

Finally, we note that the exemption of HMOs from taxation as "insurance corporations" for State tax purposes during the Tax Years is supported by the fact that the State Legislature amended Article 33 of the Tax Law in 2009 (2009 Amendment) to redefine HMOs as taxable "insurance corporations."[21]

---

[20] 20 NYCRR §2376.4.
[21] L 2009, ch 57, Part B-1.

Petitioner's contention that the 2009 Amendment did not affect the taxability of HMOs, but was a mere clarification of existing law, is contrary to the 2009 Amendment's legislative history. In explaining the amendment, a State Senate Finance Committee report clearly states that the amendment was a change in the law:

> "This provision reclassifies for-profit health maintenance organizations as Article 33 insurance corporations *from their current status as corporate franchise tax profits-based Article 9-A business corporations*."[22] (Emphasis added.)

The 2009 Green Book Report of the Fiscal Committees on the Executive Budget similarly states that the legislation:

> "[e]xtends the current insurance tax to for-profit HMO's [sic]. These companies would now pay taxes based on 1.75 percent of premiums *rather than through the corporate franchise tax*."[23] (Emphasis added.)

That the legislation was clearly intended as a change in the tax treatment of HMOs is further proven by the fact that it was expected to result in approximately $120 million in additional annual revenue.[24]

The ALJ dismissed Respondent's position that the 2009 Amendment changed the prior law, because the legislative history did not specify "whether, in enacting the 2009 amendments, the legislature regarded HMOs as doing an insurance business." (ALJ Determination at 25.) We disagree. Even if we were to disregard the various statements in the legislative history quoted above, which make it clear that HMOs were taxable as business corporations before the amendment, the 2009 Amendment added HMOs to the list of entities taxable under Article 33 of the Tax Law, not as corporations "doing an insurance business," but separately as "insurance corporations." Tax Law §1500(a), as amended, provides:

---

[22] Resp Br, Bill Jacket Appendix, New York State Senate Finance Committee Budget Fact Sheets SFY 2009-10, at 34.

[23] Resp Br, Bill Jacket Appendix, 2009 Green Book Report of the Fiscal Committees on the Executive Budget, Summary of the Revenue Provisions Contained in the Enacted Budget.

[24] Resp Br, Bill Jacket Appendix, New York State Senate Finance Committee Budget Fact Sheets SFY 2009-10, at 34.

> "The term 'insurance corporation' includes a corporation, association . . . *doing an insurance business. . . . The term 'insurance corporation' also includes a health maintenance organization required to obtain a certificate of authority under article forty-four of the public health law.*" (Emphasis added.)

It is notable that when the 2009 Amendment was enacted, no amendment was made to either the Insurance Law or to the PHL to eliminate the general HMO exemption from "doing an insurance business" for purposes of the Insurance Law.

For the reasons stated above, we reverse the ALJ Determination, sustain the Notices and deny in full the Refund Claims.[25] Commissioner Frances J. Henn did not participate in this decision.

Dated: June 3, 2016
New York, NY

Ellen E. Hoffman
President and Commissioner

Robert J. Firestone
Commissioner

[25] We have considered all of the other arguments of the Parties and find them unpersuasive.