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EXEMPT ORGANIZATIONS HOSPITAL COMPLIANCE PROJECT FINAL REPORT

On February 11, 2009 the IRS issued its Final Report on its Exempt Organizations Hospital Study. This project commenced in May 2006 with the objective "to study non-profit hospitals and community benefit, and to determine how non-profit hospitals establish and report executive compensation". The project involved sending out a questionnaire to 544 non-profit hospitals and analyzing their responses. The Final Report includes 489 respondent hospitals but generally summarizes data for 485 hospitals that provided sufficiently complete data. Except for some of the compensation data that was actually examined, the information provided by the respondents was not independently verified. The community benefit standard is the legal standard for determining whether a non-profit hospital is tax exempt under 501(c)(3) of the Internal Revenue Code.

The study looked at four community types:

- High population hospitals - located in the 26 largest urban areas
- Other urban and suburban hospitals
- Critical access hospitals - federally designated rural hospitals
- Other rural hospitals

The report also reported based on the hospitals annual revenues:

- Under \$25 million
- \$25 million to \$100 million
- \$100 million to \$250 million
- \$250 million to \$500 million
- Over \$500 million

The report's key community benefit findings included conclusions that there was considerable diversity in demographic, community benefit activities and financial resources amongst hospitals; average and median percentages of total revenues spent on community benefit were 9% and 6% respectively, other than for a small group (15) of hospitals reporting large medical research expenditures (7% (average) and 4% (median) of total revenues in uncompensated care); uncompensated care accounted for 56% of aggregate community benefit expenditures. The overall group of hospitals reported excess revenues of 5% of total revenues, with big hospitals generally the most profitable and critical access hospitals least profitable. It was no surprise that community benefit expenditures generally increased as uninsured rates of the hospital's surrounding area increased.

The Summary of Executive Compensation Findings reported that nearly all hospitals reported complying with important elements of the rebuttable presumption procedure available to establish compensation under the Intermediate Sanction Rules. Average and median total compensation amounts reported as paid to the top management official were \$490,000 and \$377,000, respectively. Again, the high numbers were with high population and other urban and suburban hospitals with critical access hospitals on the low end. Certain hospitals were selected for examination based on high compensation amounts paid and that group had average and median levels of \$1.4 million and \$1.3 million respectively for the top management official.

The final report notes its limitations based on the data requested, the sample selected, and the year of selection and observed that “both the community benefit and reasonable compensation standards have proved difficult for the IRS to administer” and that any attempt to refine the exemption standard “will seriously impact the existing tax exempt, hospital sector because of the hospitals varying practices and financial capabilities”. It is thought that maybe more accurate and complete data on community benefit expenditures through the revised Form 990 requirements may assist in future discussion regarding the community benefit standard.

The area of executive compensation poses similar challenges, but in today’s environment this will continue to be an area of interest to the public and regulatory authorities. The report noted that “the IRS will seek a better understanding of the impact of certain aspects of existing law, including the permitted use of for profit comparables and the rule excepting the initial contract between the organization and the executive”.

This project, along with ongoing Healthcare Board of Directors initiatives and other regulatory compliance reviews, further encourage hospital systems to have adequate internal and external compliance and review capabilities to keep up with the various challenges.

For complete information:

[//www.irs.gov/charities/charitable/article/0,,id=203109,00.html](http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html)

What Does the Future Look Like for Healthcare?

It is becoming increasingly more complex, attempting to plan for the future in the healthcare area. The questions are obvious but the answers are not. A number of different approaches to the future are out there and providers’, insurers’, politicians’ and patients’ views vary dramatically on what is needed and how to address it. A recent article published in Health Affairs, The Policy Journal of the Health Sphere, written by Andrea Sisko, Christopher Truffer, Sheila Smith, Sean Keehan, Jonathan Cylus, John A. Posal, M. Kent Clemens and Joseph Lizonitz, attempted to project health spending through the year 2018. This study was very extensive and includes in depth actuarial analysis, economic assumptions, technology initiatives and health sector concerns and it is one analysis of how the future may evolve. However, I think it provides some solid insight and raises legitimate questions.

- For the period, growth in national health spending outpaces GDP by 2.1% and rises to 20.3% of GDP by 2018.
- Public payers project to become the largest source of funding for *healthcare by 2016* and are projected to pay more than 50% of all health spending by 2018.

The model was developed using the current legal framework and was heavily based on the 2008 Medicare Trustees Report. This means that the potential changes that healthcare reform proponents are looking for have not been considered. However, an attempt has been made to look at the with or without impact of statutory controls over physician payment rates (that have been legislatively overturned for the last 5 years), shortages of providers (in particular primary care physicians and registered nurses), the current recession, population growth and baby boomers amongst others.

Some Highlights:

- Medicare spending to increase 8.1% in 2008, 6.2% – 8.6% for 2011 – 2018.
- Prescription drug spending (10.2% increase on average) fastest growing component of medicare.
- Medicaid spending to increase 6.9% in 2008 ranging from 7.8% to 9.6% in other years.
- Private Health Insurance spending to increase 5.8% in 2008 and fluctuating in that range through 2018.
- Out of pocket spending is projected to fluctuate up and down between a 3.8% increase in 2008 and a 5.7% increase by 2018.
- Hospital spending to increase by 7.2% in 2008 but decrease through 2010 and then climb to 7.0% by 2018.
- Physician and Clinical Services spending to increase by 6.2% in 2008 and fluctuating in this range through 2018.

All of these assumptions and results can and will vary dramatically over the next 10 years and the uncertainty of the current economic downturn and political change could significantly impact the projected results. What I think this does say is the simple things we all know:

- Healthcare costs will rise
- Any solution has significant uncertainties
- Population is aging
- Shortages of certain types of providers are inevitable
- Technology and research will most likely keep people alive longer
- Fraud and abuse will continue and enforcement will be enhanced

Where will the funding come from? Continued pressure to reduce utilization and reimbursement is inevitable.

The best, the brightest, the most prepared and forward thinking will be the most successful.

For a copy of the complete article: Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook. Please contact me at simmonc@baratzcpa.com

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