Statement by Lois Lerner, Director of the IRS Exempt Organizations Division, on the IRS Report on Nonprofit Hospitals, at a Press Briefing, Feb. 12, 2009

Good afternoon. Today the IRS is releasing the final report on our Nonprofit Hospital Study, which we began in 2006. We initiated the study for several reasons. First, nonprofit hospitals are one of the largest components of the tax-exempt sector – along with colleges and universities – and we believe it is important for the IRS to have a solid understanding of these organizations because they represent the largest assets and revenues in the tax-exempt sector. Second, because nonprofit hospitals and the environments they operate in have changed markedly over the years, we wanted to learn more about their activities that relate to their tax-exempt status – particularly how they provide and report community benefit. Finally, as in all our major compliance initiatives, we wanted to learn about executive compensation-setting practices among tax-exempt hospitals.

As it turns out the report is very timely. We, as a nation, are about to begin a serious discussion of health care and how it should be delivered in this country. And while the hospital study reflects only a small portion of the issues that will be involved, the study results can help inform that discussion.

In 2006, we sent out questionnaires focusing on community benefit and compensation-setting practices to over 500 tax-exempt hospitals. In July 2007, we issued an interim report summarizing the aggregate community benefit data reported in response to the questionnaires. In that report, we also committed to further analyze that data across demographic segments, such as rural vs. urban hospitals and large vs. small hospitals, and to include the results of that analysis, along with the results of the compensation study and exams, in a final report.

So, why Community Benefit? Hospitals are not per se tax-exempt. Their exemption is based on the promotion of health. To qualify for tax-exemption, they must show that they provide benefit to a class of people, broad enough to benefit the community, and they must be operated to serve a public rather than a private interest. The standard uses a facts-and-circumstances approach to assess whether the hospital is tax-exempt. When this standard was first articulated 40 years ago, health care looked very different than it does today.

Today we have Medicare and Medicaid to reimburse hospitals for medical care for the old and the poor, regardless of whether the hospital is for profit or tax-exempt. Federal law also requires all participating hospitals – for-profit and nonprofit – with emergency rooms to treat all patients in need of emergency care regardless of their ability to pay. So from the outsider's viewpoint, it is sometimes difficult to tell the for-profit from the not-for-profit hospital.

These changed circumstances have caused some to argue that the community benefit standard no longer provides a useful standard for determining tax exemption. So, to obtain information about community benefit practices and reporting, the questionnaire asked about the hospital's patient mix, emergency room, board of directors, medical staff privileges, and a variety of programs such as medical research, professional education, and uncompensated care and community programs.

So, what were the results? Let me start with what the report does NOT do. It does not take a position on what constitutes community benefit or whether the present standard should be retained or modified. In addition, the data in the report is subject to several limitations that you need to keep in mind when reviewing the report.

For example, while the IRS designated the general categories of activities to be reported on, we didn't limit what could be included in a category or how things should be measured. For example, respondents differed as to what they included in their calculations of uncompensated care (some included Medicare shortfalls, or bad debt, and some did not). In addition, the information we received in response to the questionnaire was not independently tested or verified and not all hospitals answered every question. So the community benefit information contained in the report is based on self reporting by the hospitals, and may not represent the true picture of community benefit provided by those hospitals or by the broader nonprofit hospital community. Finally, the information is based on a snapshot view of a single year's activity.

Notwithstanding those caveats, the results of the data analysis are pretty interesting, and worthy of discussion. We divided the hospitals into four groups, depending on the community they served: high population urban hospitals, other urban and suburban hospitals, critical access hospitals and other rural hospitals. We also divided hospitals into five groupings based on annual revenues:

- Under $25M
- $25-$100M
- $100-$250M
- $250-$500M
- Over $500M

We then analyzed the reported community benefit and executive compensation data across these various groups.

Findings Regarding Community Benefit:

- We found considerable diversity in demographics, community benefit activities and financial resources among hospitals.
- Overall, the average community benefit expenditures reported were 9% of total revenues. The median was 6% of total revenues. These percentages were lowest for rural hospitals – both critical access and other rural – and

highest for high population hospitals. The percentage spent on community benefit generally increased with revenue size.

- Other than for a group of 15 research hospitals, the largest reported component of community benefit was uncompensated care. Uncompensated care represented 56% of all community benefit reported. Overall the average uncompensated care reported was 7% of total revenues. The median was 4%.

While the average and the median percentages are interesting, the study showed that community benefit, research, and uncompensated care expenditures were concentrated in a relatively small number of hospitals. 9% of the hospitals reported 60% of the aggregate community benefit expenditures. 14% of the hospitals reported 63% of the uncompensated care expenditures. 3% of the hospitals reported 93% of the research expenditures. So you can see that some reported large expenditures while others reported much smaller amounts.

Another important element relates to a hospital's financial resources —basically what it has available to spend on community benefit. In the study, we looked at excess revenues. By that I mean the amount left over after hospitals pay all of their expenses. The study looked at this based on how the hospitals reported this information on their Form 990. The overall group reported 5% excess revenues (as a percentage of total revenues). Surprisingly, however, 21% of the hospitals reported total expenses greater than their revenues!

This information helps to build a baseline that could inform the ongoing conversation we are having in this country regarding health care delivery, the role tax-exempt hospitals should play in health care, and the standards they should meet to merit tax-exemption. It also suggests that attempts to modify the present standard could have a significant impact on certain hospitals. For example, while the present standard does not contain a quantitative requirement, some have argued that it should. Based on the study data, many hospitals appear to be losing money or operating with tight margins, and could have a very difficult time meeting quantitative tests that key off of charity care or other community benefit expenditure levels.

Findings Regarding Compensation:

Moving on to the executive compensation portion of the study, we found almost every hospital in the study reported using comparability data and independent personnel when setting compensation of its executives. That means compensation decisions were made by disinterested parties, and comparability data was used to set the compensation. Still, the compensation amounts reported as paid to top management officials will be considered high by some.

We examined 20 hospitals in the study to review their executive compensation practices. The hospitals selected for examination were chosen based on their

apparent high compensation relative to others within the study. This does not mean that we selected the 20 highest compensation amounts reported by the hospitals, but we did attempt to select hospitals that reported paying executive compensation amounts on the higher end of the range across various types and sizes. The exams confirmed the widespread use of the rebuttable presumption procedure available to these hospitals, which means that organizations relied on comparability data and independent personnel to establish the compensation, and documented the basis for the decisions that were made. Nearly all the compensation amounts we reviewed were reasonable under the current statutory standard, even though some of the amounts were quite substantial.

Overall, compensation increased with revenue size, and was larger for urban hospitals than it was for rural hospitals. Critical access hospitals and the smallest hospitals reported paying the smallest compensation amounts. The median and average total compensation paid to top officials of hospitals responding to the questionnaire were $$377,000 and $490,000. For the 20 examined hospitals, the median and average total compensation amounts were $1.3M and $1.4M.

Next Steps

While the study is done, we're not done. On the executive compensation front, we need to look more closely at the quality of the comparability data that is being used to establish compensation, especially when for profit comparables are being used. We also need to better understand the impact of the initial contract exception on compensation being paid by hospitals. That exception turns off many of the compensation setting rules for the first contract between the organization and an individual.

We plan to have discussions with various stakeholders about the current status of the law and the issues that have developed in the 40 years since the community benefit standard was issued. While we believe the data we'll be receiving from the new Form 990 hospital schedule will give the IRS and the public a better view of how nonprofit hospitals operate, we won't be seeing any significant data until 2010 or 2011, when the new schedules start to be filed in substantial numbers. In the meantime, we will need to work with others to evaluate what guidance might be needed, and we believe there is a lot of information in this report that can inform those discussions. If the decision is to update or fine tune the present community benefit standard, we need to be sure we have all the right people in the room. This is important work, but it is just a piece of the much bigger healthcare policy debate and possible system changes that the new administration and Congress will be considering. We look forward to working with them and others with expertise in this area to evaluate the intersection of tax-exemption and health policy in this changing environment.

I'd be happy to take any questions.