

# The Health of Health Care


**Health Care Reform Update**  
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**Hospital-Physician Integration**  
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**Tax Effect on Businesses**  
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June 8, 2010  
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## Health Care Reform Update



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David is the leader of HORNE's health care reimbursement and advisory services. With more than 25 years of experience, David's practice is concentrated in the health care industry providing assurance, reimbursement and advisory services for a wide range of organizations including hospitals, outpatient centers, home health care agencies, skilled nursing facilities, assisted living centers, rural health clinics and mental rehabilitation centers.

**Professional Affiliations**

- Healthcare Financial Management Association
  - National Board of Examiners
  - Editorial Review Board for HFM Journal
  - Region 9 Conference Committee
- American Institute of Certified Public Accountants
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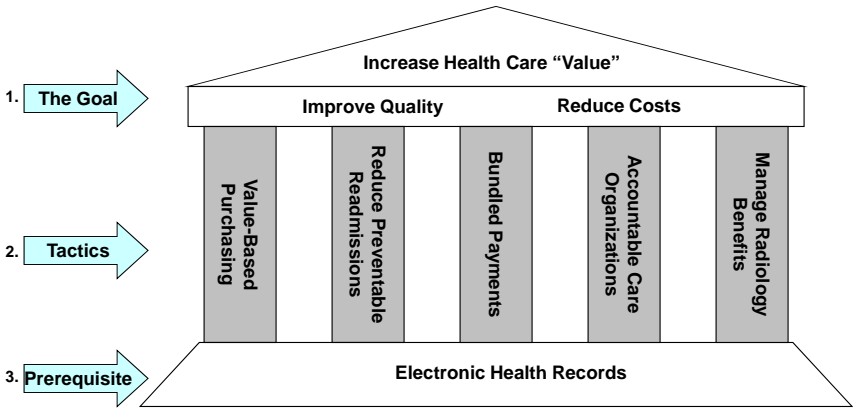
### Health Care Reform Update

- Senate Patient Protection Act and Affordable Health Care Act, HR 3590, combined with the Health Care and Education Reconciliation Act of 2010, HR 4872
- PPCA



### Health Care Delivery System Reform

The Senate Finance Committee Legislation Will Include Payment Reforms Aimed at Improving the Delivery System




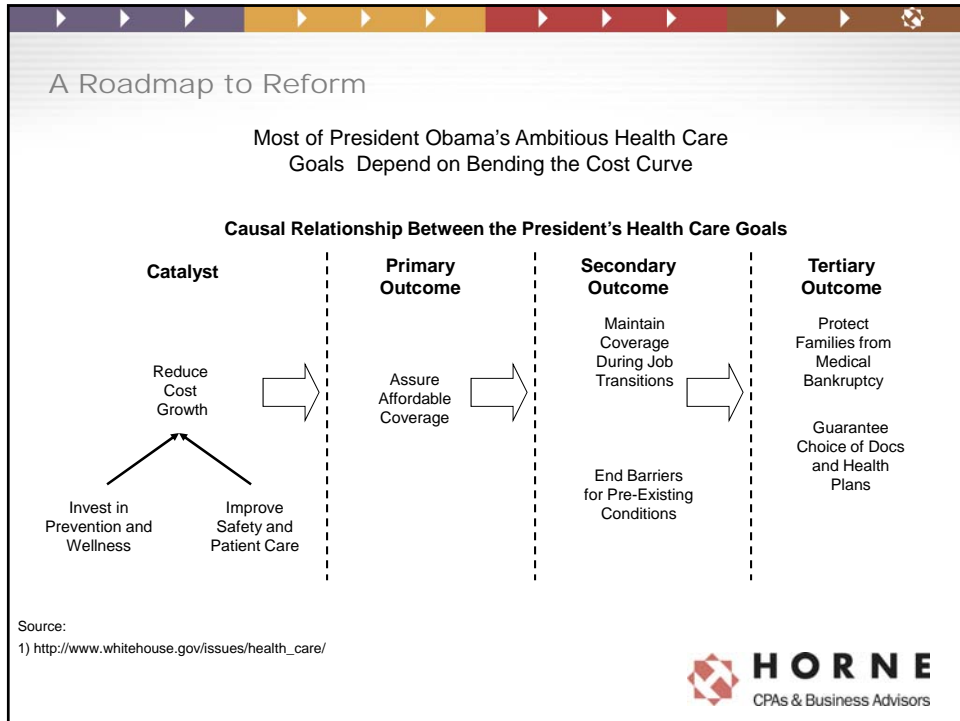
**1. The Goal** → Increase Health Care "Value"

**2. Tactics** →

- Improve Quality: Value-Based Purchasing, Reduce Preventable Readmissions
- Reduce Costs: Bundled Payments, Accountable Care Organizations, Manage Radiology Benefits

**3. Prerequisite** → Electronic Health Records





- ### Selected Provisions
- **Estimated Cost of Bill**
    - Net cost \$938 billion over 10 years
    - Coupled with reductions in Medicaid DSH, Medicare DSH and Hospital payments updates of \$500 billion
    - Total cost of bill \$1.438 trillion
  
  - **Coverage of People**
    - Reduces number of uninsured by 32 million by 2019
    - 23 million people left uninsured by 2019
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## Selected Provisions

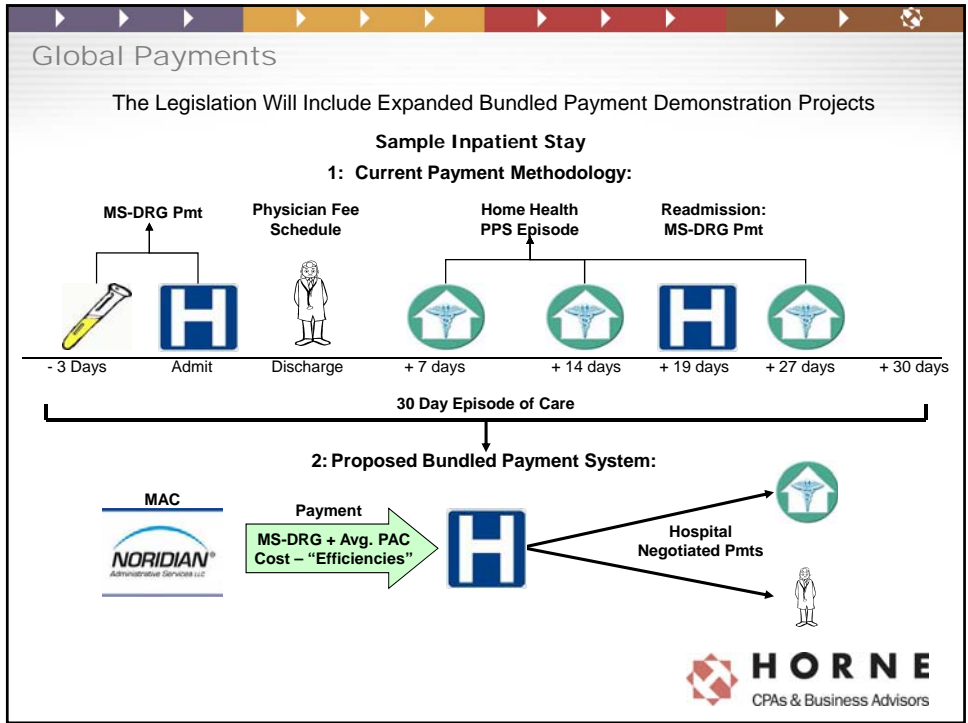
- **Individual mandates and employer responsibility**
  - 2014 All U.S. citizens and legal residents would have to obtain coverage or face a tax penalty
  - Insurance exchanges will be provided
  - Employers will provide coverage or will be charged a “free rider” assessment
  
- **Health Insurance Reforms**
  - Eliminates annual and lifetime benefit limits
  - Restricts dropping coverage
  - Pre-existing conditions eliminated by 2014
  - Dependent children covered up to age 26



## Selected Provisions

- **Administrative Simplification**
  - Moving to standardized processes by evaluation of systems every 3 years using input from the National Committee on Vital Statistics, the Health Information Technology Policy Committee, the Health Information Standards Committee, standard setting organizations and stakeholders
  
- **Delivery System Changes**
  - Bundling – beginning 2013 pilots thru 2015
  - Readmissions – 2013 penalties for “excessive re-admissions”
  - Accountable Care Organizations – 2012, allows hospitals and physicians to provide leadership in voluntary ACOs. Some savings to be shared
  - Innovation Center – 2011 creates a Center for Medicare and Medicaid Innovation designed to improve quality and reduce program expenditures





- ### Selected Provisions
- Independent Payment Advisory Board (IPAB)
    - Binding payment recommendations on Medicare and non-binding on private insurers payments to providers
    - Exclusion such as hospitals (except CAH) until 2019
  - 340B drug program extended
  - Graduate Medical Education – no reductions in IME payments but re-distributes 65 percent of unused residency to primary care and surgeons
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Selected Provisions

- Excise Tax on High-Cost Health Plans – 2018 coverage limits of \$10,200 single and \$27,500 family at 40% of value exceeding limits
- Medical Device Tax – 2013 at 2.3% tax on medical device manufacturers
- Other revenue - \$67 billion tax on health insurers in 2014 and \$33 billion on pharmaceuticals in 2011



Financially Positive or Negative for Health Care Providers

- Yes
- Previous services may be losers – reductions in high utilization of Medicare and Medicaid vs. uninsured
- Cost of services will be the key – savings thru ACOs, reductions in private insurance payments and volume changes impacting delivery



Financially Positive or Negative for Health Care Providers

- Modeling
  - Market Basket Update
  - DSH-UPL
  - Hospital Acquired Conditions
  - Physician Payment Revisions
  - Contracts with other payers



Something To Think About

- Be proactive, explore how to make the new legislation work in your organization
- Ignoring the delivery and payment system changes will be detrimental
- Most importantly, understand totally where your revenue comes from and how this will change
- Tax Exemption



## Hospital-Physician Integration



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### Gregory D. Anderson, CPA/ABV, CVA

Greg serves as the director of HORNE's health care valuation services group. He concentrates his practice in the design, implementation and valuation of hospital/physician employment and other compensation arrangements; financial analysis and consulting on compensation plans for physician group practices; and valuation of medical practices, hospitals, diagnostic facilities, ambulatory surgery centers and other health care facilities. He presents programs to health care attorneys and other health care organizations on issues related to the fair market value of physician compensation arrangements, medical practice valuation issues, and the Stark law.

#### Professional Affiliations

- American Institute of Certified Public Accountants
- Mississippi Society of Certified Public Accountants
- National Association of Certified Valuation Analysts
- American Health Lawyers Association, Affiliate Member
- Healthcare Financial Management Association, Affiliate Member
- Medical Group Management Association, Affiliate Member




## Market Forces Driving the Need for Integration

- Antiquated medical staff model
- Physician lifestyle concerns
- Rising hospital ER call payments
- Increasing regulation and enforcement related to hospital-physician relationships
- Physician reimbursement
- Practice overhead and working capital requirements
- Quality pressures
- General concerns about health care reform




Integrated Structures

- Physician employment
  - Hospital employment
  - Foundation model
  - Hospital-owned clinics and provider-based entities
- Contractual alignment
  - On-call and coverage arrangements
  - Medical directorships
  - Professional service agreements
  - Gainsharing
  - Clinical co-management agreements
  - Leases
- Joint ventures
- Electronic health records



The Future of Integration

- Physician employment
- Contractual alignment
- Joint ventures
- Electronic health records
- Health care reform



## Physician Employment

- Practice acquisition and physician employment are dominating the landscape and will gain further momentum in hospital-physician alignment
  - Multi-specialty employment
  - Employment of hospital-based specialists
  - Challenge with production and quality incentive compensation models



## Contractual Alignment

- On-call and coverage arrangements
  - Payment reforms may limit hospital budgets
  - Insurance reform may mean less uncompensated care
- Medical directorships and other PSAs
  - Rolled up into employment arrangements as feasible
  - Increased regulatory scrutiny
- Gainsharing and other pay-for-performance arrangements
  - Increased regulatory acceptance and quality imperatives
- Leases
  - Elimination of per-click and revenue-based arrangements



## Joint Ventures

- Ambulatory surgery
- Physician ownership of hospitals
- Real estate joint ventures
- Equipment joint ventures
- Accountable care organizations
- Challenges
  - Reimbursement
  - Regulation



## Electronic Health Records

- Stimulus Act (ARRA 2009); HITECH Act provisions
  - Hospital and provider incentive payments for meaningful use of certified EHR
  - Early adoption is encouraged
    - Increasing complexity over time
    - Decreasing incentives with later adoption
    - Financial dis-incentives for non-adoption
- Stark acceptance of community-wide health information systems
- Hospital-physician collaboration through MSOs and managed care organizations



## Health Care Reform

- Payment reform will accelerate alignment of hospitals and physicians
- Tightening of resources will require new approaches to the medical staff model
- Quality, safety and transparency will affect strategic and operational decisions
- Capital and IT investments will be dictated by availability of capital resources and government incentives



## Planning Points for Physicians and Hospital-Owned Groups

- Analyze impact of reimbursement changes
- Implement strategic decisions about patient and payer panels
- Incorporate certified EHR systems with meaningful use
- Weigh options regarding hospital or larger group alignment and pilot programs



## Tax Effect on Non-Profits



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### **Marsha Dieckman, CPA**

Marsha serves as a partner in the firm's tax practice. She has extensive knowledge in the areas of tax consulting and compliance for healthcare clients with a focus in not-for-profit and high-wealth individuals.

Marsha joined HORNE in 2001 and has more than 15 years of experience. Before her career with HORNE, Marsha was tax manager for an international accounting firm.

#### **Professional Affiliations**

- American Institute of Certified Public Accountants
- Healthcare Financial Management Association
- Mississippi Society of Certified Public Accountants



## Background

- Section 501(c)(3)
- Benefits
- Requires charitable purpose
- Community benefit standard since 1969
- No sanctions under present law, other than revocation



## Section 9007 of PPACA

- Adds IRC Section 501(r)
  - A 501(c)(3) hospital will not be treated as such, unless it:
    - meets the community health needs assessment requirements
    - meets the financial assistance policy requirements
    - meets the requirements on charges
    - meets the billing and collection requirements



## Application (IRC Section 501(r)(2))

- In general:
  - to an organization which operates a facility which is required by a State to be licensed as a hospital
  - to any other organization which the Secretary determines has the provision of hospital care as its principal tax-exempt function or purpose
- Organizations with more than 1 facility
  - must meet the requirements separately with respect to each such facility
  - the organization shall not be exempt with respect to any facility for which such requirements are not separately met



## Community Health Needs Assessment

- IRC Section 501 (r)(3)
  - An organization must conduct a “community health needs assessment”:
    - every three years
    - adopt an implementation strategy to meet the identified community health needs
  - “Community health needs assessment” takes into account input from:
    - persons who represent the broad interests of the community served by the hospital facility
    - includes those with special knowledge of or expertise in public health and is made widely available to the public



## Written Financial Assistance Policy (IRC 501 (r)(4))

- Must include:
  - eligibility criteria, whether is care free or discounted
  - basis for calculating amounts charged to patients
  - method for applying for financial assistance
  - if no separate billing and collections policy, the organization’s actions for nonpayment, including collections action and reporting to credit agencies
  - measures to widely publicize the policy within the community to be served
  - include a written emergency care policy



Limitation On Charges (IRC Section 501(r)(5))

- Organization must:
  - limit amounts charged for emergency/medically necessary care provided to those eligible under the financial assistance policy to not more than the lowest amounts charged to individuals who have insurance covering such care
  - prohibits the use of gross charges



Billing & Collection Requirements (IRC Section 501(r)(6))

- Organization may not engage in extraordinary collection actions before making a reasonable efforts to determine whether the individual is eligible under the financial assistance policy



## New IRC SEC. 4959

- **Excise Taxes on Failures by Charitable Hospitals**
  - if a hospital organization to which section 501(r) applies, fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed a tax equal to \$50,000 per year of failure



## Reporting & Disclosure (IRC Section 6033(b)(15))

- **Mandatory review by Secretary of Treasury**
  - at least once every 3 years, of the community benefit activities (currently Schedule H, Form 990) of each hospital to which IRC 501(r) applies
  - information reported should include the community health needs identified, how they are being addressed, and if not give the reasons
- The audited financial statements of the organization must be included with the Form 990



## Effective Dates (PPACA Section 9007(f))

- Section 9007 (except as provided below) applies to taxable years beginning after the date of the enactment
- Community health needs assessment applies to taxable years beginning after the date, which is 2 years after the date of the enactment
- Excise tax applies to failures occurring after the date of the enactment of this act



## Tax Effect on Businesses



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### Kathy Watts, CPA

Kathy is a partner at HORNE where she provides health care, assurance and taxation services. Her primary concentration is in both the financial and operational aspects of medical practices including startups, mergers and dissolutions, employee benefits and payroll services, outsourced accounting, physician compensation modeling, practice and clinic transfers of ownership, benchmarking and fee schedules, and tax planning and consulting.

Kathy joined HORNE in 2004. She has more than 25 years of experience providing assurance and tax services and has significant knowledge specifically in federal and state planning and compliance.

### Professional Affiliations

- American Institute of Certified Public Accountants
- Medical Group Management Association
- National Society of Certified Healthcare Business Consultants
- Health Care Advisors Association
- Tennessee Society of Certified Public Accountants
- Board Member
- Treasurer
- Member of Council



### Most Small Businesses Exempt from Penalties for Not Offering Coverage to Employees

- Businesses with less than 50 employees are not required to provide health insurance coverage to employees; and thus, they are exempt from the so called “pay or play” penalty



### Small Business Health Tax Credit (effective now)

- Small businesses purchasing health insurance for employees are eligible for a 35% (25% for tax-exempt entities) tax credit for years 2010, 2011, 2012 and 2013
  - In 2014, the credit percentage amount increases to 50% (35% for tax-exempt entities)
- For purposes of the credit, a small business has
  - 25 full-time equivalent employees or less
  - the average annual wages of \$50,000 or less
  - the business has to pay 50% or more of the insurance premiums



### Penalty for Employers not Offering Coverage (beginning in 2014)

- The penalty is assessed on large employers
  - 50 or more full-time employees
- Businesses must offer “minimum essential coverage” to avoid the penalty
  - Business pays 60% of cost
- The non-deductible penalty is assessed per employee, per month
  - No qualifying coverage offered = \$167 per employee, per month penalty
    - \$2,000 per year
  - Some, but not all employees offered qualifying coverage = \$250 per employee, per month
    - \$3,000 per year



### Penalty for Individuals Remaining Uninsured (beginning 2014)

- Individuals must maintain “minimum essential coverage”
  - Offered by government sponsored programs
  - Offered under eligible employer sponsored plan
  - Offered under state insurance exchange
- Penalty amount is the lesser of a flat dollar amount or percentage of income
  - 2014: \$95 or 1% of household income
  - 2015: \$325 or 2% of household income
  - 2016 and later: \$695 or 2.5% of household income (indexed thereafter)



### "Cadillac Tax" on High-Cost Health Plans

- Beginning in 2018, a 40% non-deductible excise tax is imposed on insurance companies based on health insurance premiums exceeding certain amounts
- The tax is not on employers; however, it is expected that employers and employees will ultimately bear the impact in the form of high premiums passed on by insurers
- Cadillac plans are premiums exceeding
  - \$10,200 for single coverage
    - \$1,650 additional amount for ages 55 and older
  - \$27,500 for family coverage
    - \$3,450 additional amount for ages 55 and older



### Additional 0.9% Medicare Tax on Wages and Self-Employment Income (beginning in 2013)

- Employee portion of Medicare tax increased by 0.9%
- Applies to wages and self-employment income in excess of \$250,000 for joint returns, \$125,000 for married filing separate and \$200,000 for all others
- Employer has the obligation to withhold the additional tax on wages (without regard to spouse's wages); employee is liable to the extent not covered by the employer
- Self-employed individuals are not allowed a deduction for ½ of the additional 0.9% tax (0.45%)



New 3.8% Medicare Tax on Investment Income (beginning in 2013)

- Individuals, estates and trusts will be required to pay 3.8% tax on net investment income such as interest, dividends, annuities, royalties, rents, capital gains and income from passive activities
- Applies to the excess amount of income in excess of \$250,000 for joint returns, \$125,000 for married filing separate and \$200,000 for all others
- The additional tax is subject to individual estimated tax provisions



Cost of Employer Provided Health Coverage Reporting on Form W-2 (beginning 2011)

- The aggregate cost of employer-sponsored coverage will be reported on employee's Form W-2
- For employees participating in multiple plans, employers will have to disclose the aggregate value of all plans
- For example, an employee may enroll in a major medical plan, a dental plan and a vision plan. In that case, employers report the total value of the combination of all health related insurance policies



## Tax Breaks for Medical Expenses Limited to Prescription Drugs and Insulin (beginning 2011)

- Qualified medical expenses eligible for reimbursement are limited to prescription drugs and insulin
- Individuals participating in of the arrangements are no longer able to use pre-tax dollars to reimburse themselves for over-the-counter drugs
  - Flexible Spending Account (FSA)
  - Health Reimbursement Account (HRA)
  - Health Savings Account (HSA)
  - Archer Medical Savings Account (MSA)



## Contact Information

### Health Care Reform Update

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HORNE LLP is one of the top 50 accounting and business advisory firms in the country, as reported by the Public Accounting Report (PAR), and one of the top 10 accounting and business advisory firms in the Southeast. With 13 offices in Mississippi, Tennessee, Alabama, Louisiana, Texas and Arizona, the firm has more than 475 team members serving clients across the nation.

For more information on HORNE, visit [www.horne-llp.com](http://www.horne-llp.com).

