

C. PHYSICIAN INCENTIVE COMPENSATION
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1. Introduction

Health care organizations are under continuous pressure to improve their performance by increasing efficiency and productivity, improving quality of care and patient satisfaction, and reducing costs. In an effort to achieve these goals, health care organizations have developed various physician incentive compensation arrangements in an attempt to more closely align physician compensation with the goals of the health care organization. The purpose of this article is to analyze the effect of incentive compensation methods within the framework of compensation arrangements that the Service has viewed as reasonable.

IRC 4958, the section of the Internal Revenue Code that provides for exercise taxes on excess benefit transactions (also known as "intermediate sanctions"), is important when considering physician compensation arrangements. However, until the proposed regulations under IRC 4958 are finalized, it is premature to include in this article a discussion of this aspect of physician compensation. (But see the article in this CPE text "Section 4958 Update.")

2. Tax Principles Relating to Physician Compensation

IRC 501(c)(3) prohibits inurement of the net earnings of an organization to any private shareholder or individual. Reg. 1.501(c)(3)-1(c)(2) states that an organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private individuals.

Reg. 1.501(a)-1(c) states that the term "private shareholder or individual" refers to persons "having a personal and private interest in the activities of the organization." For convenience, persons meeting this definition are sometimes referred to as "insiders."

At one time, for purposes of applying the private inurement proscription, it was believed that all physicians were insiders. See G.C.M. 39862 (12/2/91). However, physicians per se are not insiders. Whether a physician is an insider depends on an analysis of all the facts and circumstances concerning whether the physician's relationship with the organization offers the physician the opportunity to make use of the organization's income or assets for personal gain. As stated in a recent appellate court decision:

The test is functional. It looks to the reality of control rather than to the insider's place in a formal table of organization. The insider could be a "mere" employee - or even a nominal outsider, such as a physician with hospital privileges in a charitable hospital. Harding Hospital, Inc. v. United States, 505 F.2d 1068, 1078 (6th Cir. 1974)

United Cancer Council, Inc. v. Commissioner, 165 F.3d 1173, 1176 (7th Cir. 1999).

IRC 501(c)(3) requires that an organization be organized and operated exclusively for exempt purposes. Reg. 1.501(c)(3)-1(c)(1) provides that an organization will be regarded as operated exclusively for exempt purposes only if it engages primarily in activities that accomplish one or more of the exempt purposes specified in IRC 501(c)(3). But an organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose. Thus, an organization that operates primarily in a manner that results in conferring impermissible private benefit on one or more persons does not satisfy this requirement.

Thus, any compensation arrangement between an IRC 501(c)(3) organization and an employee or an independent contractor must not result in private inurement if that person is an insider, and must not

confer impermissible private benefit whether or not that person is an insider. IRC 501(c)(4) also contains a prohibition against inurement or net earnings to the benefit of any private shareholder or individual. This prohibition is effective, generally, for inurement occurring on or after September 14, 1995.

Implicit in these two proscriptions is the requirement that the compensation actually paid must be reasonable. For a discussion of reasonable compensation, see the 1993 CPE Text at 191.

3. Precedential and Non-Precedential Authority

In analyzing any type of incentive compensation program various authorities should be considered.

A. Court Cases

Lorain Avenue Clinic v. Commissioner, 31 T.C. 141 (1958), involved a tax-exempt clinic controlled by a small number of employed physicians. The clinic compensated its employed physicians using a "point system." Under this arrangement, a sum of money was set aside as total salary, which would be divided among the physicians in a ratio based on each physician's point scores. Thus, a physician's compensation was based on the number of points assigned to the physician. Points were based on the amount of the physician's charges for professional services, the number of patient visits, the number of new patients seen, the length of time the physician was associated with the clinic during which the physician had total charges above a certain minimum, and other criteria. However, substantially all of the organization's net receipts, after all expenses other than salaries, were set aside and distributed to the physicians, including the small number of employed physicians who were in control. These controlling physicians received the bulk of the distributions. The Tax Court held that this arrangement violated the proscription against inurement of net earnings.

In Birmingham Business College v. Commissioner, 276 F.2d 476 (1960), a tax-exempt school that compensated its three employee-shareholders in proportion to their stock ownership did not qualify for exemption.

In Sonora Community Hospital v. Commissioner, 46 T.C. 519 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968), two doctors who previously owned the hospital facilities and founded the hospital shared in the fees from the privately operated laboratory and x-ray departments within the hospital although they performed no associated services. This showed that the hospital operated to a considerable extent for the private benefit of the two founding doctors, rather than exclusively as a charitable organization.

B. Revenue Rulings

Rev. Rul. 69-383, 1969-2 C.B. 113, provides that a fixed percentage compensation plan of an exempt hospital does not result in prohibited private inurement if: (1) the compensation plan is not merely a device to distribute profits to persons in control or to transform the organization's principal activity into a joint venture; (2) the compensation plan is the result of arm's-length bargaining; and (3) the compensation plan results in reasonable compensation by comparing the amounts paid to amounts received by physicians at similar hospitals having comparable responsibilities and patient volume. Whether these criteria are met, depends upon the facts and circumstances of each case.

In this revenue ruling, the Service approved a compensation arrangement where the hospital paid a radiologist a fixed percentage of the radiology department's gross billings, adjusted by an allowance for bad debts. However, as G.C.M. 39862 (11/22/91) explains, at page 11, the physician was not receiving a percentage of the revenues of the hospital's radiology department. The hospital was acting as the billing and collection component for the physician's services performed at the hospital and the physician was receiving a fixed percentage of only his/her billings. The G.C.M. states:

[T]he hospital in Rev. Rul. 69-383 was billing (presumably on a global charge basis) and collecting for the radiologist's professional services, as well as its own facility charge. Thus, the percentage compensation at issue represented an allocation of a portion of the global charge (referred to as the "professional component") to the physician to compensate him for his services. The hospital retained the remainder (the "technical" or "facility component") as compensation for use of its facilities and equipment.

Rev. Rul. 97-21, 1997-1 C.B. 121, provides that certain physician recruitment incentives provided to persons who do not have substantial influence over the affairs of the recruiting hospital can be consistent with IRC 501(c)(3) status. This revenue ruling includes four situations that do not affect exempt status because the recruiting incentives result in reasonable compensation for services from the staff physicians.

C. General Counsel Memoranda (G.C.M.)

In G.C.M. 32453 (11/30/62), a tax-exempt health maintenance organization (an "HMO") arranged for medical services to subscribers by entering into contracts for medical services with independent groups of private physicians. Terms of the contracts provided that the HMO compensates its private physicians a capitated amount plus 50 percent of certain net revenues (a withhold) with the other 50 percent of the revenues payable to hospitals that provided services to the HMO's subscribers. The purpose of this incentive was to maximize efficiency of services and shift most of the risk under the plan to the physicians and hospital. In practice, the capitated amount was 92 to 97 percent of the total amount paid under the contract, and the remaining portion (3 percent to 8 percent) comprised the incentive compensation portion that could not exceed 10 percent of the total compensation payable. The G.C.M. approved this percentage compensation arrangement after determining the presence of the following factors:

- i. A completely arm's-length contractual relationship, with the service provider having no participation in the management or control of the HMO;
- ii. The contingent payments served a real and discernible business purpose of the exempt organization independent of any purpose to operate the organization for the direct or indirect benefit of the service provider (e.g., achieving maximum efficiency and economy in operations by shifting away the principal risk of operating cost to the service provider to alleviate the organization's need to carry large insurance-type reserves);
- iii. Compensation was not dependent principally upon incoming revenue of the exempt organization, but upon the accomplishment of the objectives of the compensatory contract (e.g., the success of the employer organization and the service provider in keeping actual expenses within the limits of projected expenses upon which the ultimate prices of charitable services are based);
- iv. Review of the actual operating results revealed no evidence of abuse or unwarranted benefits (e.g., prices and operating costs compare favorably with those of other similar organizations); and
- v. Presence of a ceiling or reasonable maximum to avoid the possibility of a windfall benefit to the service provider based upon factors bearing no direct relationship to the level of service provided.

G.C.M. 35638 (1/28/74) allowed a compensation plan in which participants shared savings generated by productivity improvements. The G.C.M. allowed this plan because it was arm's-length, and "it was a means of providing reasonable compensation to employees without any potential for reducing the charitable services or benefits otherwise provided...." A reduction of charitable services occurs if the exempt organization eliminates charitable programs to pay incentive compensation and/or expends all of its profits on physician salaries without saving a certain percentage of its profits for use in the community, such as expanded educational programs, increased programs for the indigent, etc.

G.C.M. 38283 (2/15/80) concluded that an exempt organization will not violate the requirements for exemption merely by adopting and operating an incentive compensation plan in which profits are a factor in the compensation formula.

G.C.M. 38394 (6/2/80), provides that compensation arrangements with physicians result from arm's-length bargaining if they are established by independent compensation committees (consisting of non-physician employees) or independent boards of directors.

G.C.M. 39498 (4/24/86) examined guaranteed minimum annual salary contracts where the physicians' salaries were subsidized in order to induce them to commence employment at a hospital. The G.C.M. acknowledged that the compensation plans did not per se constitute devices to distribute profits or transform the arrangement into a joint venture. The G.C.M. concluded that the entire compensation package (rather than just the portion of the compensation plan in question) must be examined to determine whether it is reasonable and serves no more than incidentally private interests. Lastly, the G.C.M. stated that it was impossible to determine, in connection with an advance ruling request, whether the compensation considered as a whole constituted reasonable compensation.

G.C.M. 39670 (10/14/87) states that a deferred compensation plan under which deferred amounts are invested does not automatically jeopardize the exempt status of the organization maintaining the plan. Chief Counsel stated it would rely on Rev. Rul. 69-383, supra, to determine if a compensation program results in prohibited inurement or private benefit.

G.C.M. 39674 (10/23/87) approved two profit sharing incentive compensation plans based on the economic performance of the hospitals. In the G.C.M., the plans resulted from arm's-length bargaining and the purposes of the plans included cost containment and quality of service. Under these plans, all employees were eligible to participate, not just the physicians; the amounts that could be paid were subject to a maximum percentage of each employee's base compensation; and payments depended on standards designed to measure quality of patient care and patient satisfaction.

4. Incentive Compensation Factors

In analyzing any physician incentive compensation arrangement the Service has generally considered various factors to determine whether the arrangement violates the proscriptions against private inurement and impermissible private benefit.

A. Independent Board of Directors and Conflicts of Interest Policy

Was the compensation arrangement established by an independent board of directors or by an independent compensation committee?

In determining whether a health care organization complies with the community benefit standard established in Rev. Rul 69-545, 1969-2 C.B. 117, one significant fact the Service considers is whether the organization has a community board of directors. The Service considers a community board as one in which independent persons who are representative of the community comprise a majority. Another significant fact the Service considers is whether the board of directors has adopted a substantial conflicts of interest policy. This policy should include restrictions barring a physician, who is a voting member of the board of directors and who receives compensation from the organization, from discussing and voting on matters pertaining to that member's compensation. This policy should also restrict physicians from membership on the organizations compensation committee and should preclude a voting member of a compensation committee from voting on matters pertaining to that member's compensation. However, physicians are not prohibited from providing information to the board of directors or to any committee regarding a physician compensation. See the article in this CPE text "Tax-Exempt Health Care Organizations, Revised Conflicts of Interest Policy."

B. Reasonable Compensation

Does the compensation arrangement with the physician result in total compensation that is reasonable?

The Service will not rule on whether compensation to be paid to any particular employee is reasonable since this involves a factual matter that cannot be determined in advance. See section 8.01, Rev. Proc. 99-4, 1999-1 I.R.B. 115, 129. However, in considering applications for recognition of exemption and requests for private letter rulings, the Service considers whether the compensation information indicates a potential problem with inurement or impermissible private benefit.

Therefore, the Service may request from health care organizations more information on compensation plans, such as representative physicians' employment contracts, especially those that apply different methods in determining incentive compensation. In addition, reliable physician compensation survey data for the physician specialty and geographic locale are helpful in establishing reasonableness.

C. Arm's-Length Relationship

Is there an arm's-length relationship between the health care organization and the physician, or does the physician participate impermissibly in the management or control of the organization in a manner that affects the compensation arrangement?

D. Ceiling

Does the compensation arrangement include a ceiling or reasonable maximum on the amount a physician may earn to protect against projection errors or substantial windfall benefits?

E. Reduction in Charitable Programs

Does the compensation arrangement have the potential for reducing the charitable services or benefits that the organization would otherwise provide?

F. Quality of Care and Patient Satisfaction

Does the compensation arrangement take into account data that measures quality of care and patient satisfaction?

G. Net Revenue Based

If the amount a physician earns under the compensation arrangement depends on net revenues, does the arrangement accomplish the organization's charitable purposes, such as keeping actual expenses within budgeted amounts, where expenses determine the amounts the organization charges for charitable services?

H. Joint Venture

Does the compensation arrangement transform the principal activity of the organization into a joint venture between it and a group of physicians?

I. Distribution of Profits

Is the compensation arrangement merely a device to distribute all or a portion of the health care organization's profits to persons who are in control of the organization?

J. Business Purpose

Does the compensation arrangement serve a real and discernible business purpose of the exempt organization, such as to achieve maximum efficiency and economy in operations that is independent of any purpose to operate the organization for the impermissible direct or indirect benefit of the physicians?

K. Abuse or Unwarranted Benefits

Does the compensation arrangement result in no abuse or unwarranted benefits because, for example, prices and operating costs compare favorably with those of other similar organizations?

This includes effective controls to avoid increases in compensation predicated on increases in fees charged to patients. Effective controls to guard against unnecessary utilization are also important.

L. Services Personally Performed

Does the compensation arrangement reward the physician based on services the physician actually performs, or based on performance in an area where the physician performs no significant functions?

5. HMOs

Many HMOs have their own unique incentive compensation arrangements. Usually, the HMO contracts with independent primary care physicians to provide primary health care services to the HMO's enrollees. Typically, each enrollee chooses or is assigned a particular physician to serve as the enrollee's primary care physician. Thus, each physician is responsible for a certain group of enrollees, known as the physician's "panel." The primary care physician serves as a "gatekeeper." Except for emergency services, the patients in the physician's panel must obtain a referral from the primary care physician before utilizing inpatient or outpatient hospital services, specialist physician services, and ancillary health care services.

Many HMOs pay primary care physicians on a fee-for-service basis that represents a substantial discount from usual and customary fees charged by similarly situated primary care physicians for comparable services. In addition, the HMO may withhold from the fees that it pays to each physician a fixed percentage and places this amount in a reserve set aside for each physician (also known as a "risk pool"). At the end of the year, the amount in this risk pool is available for distribution to the physician based on a combination of factors, such as whether the total medical expenses incurred by the patients in the physician's panel exceed the budgeted expenses for the panel, and whether the physician achieved certain patient satisfaction standards, quality care standards and efficiency standards.

In these situations, even though a physician may receive a distribution from the risk pool only if there is a surplus in the physician's budget, because any distribution also directly depends on whether the physician achieved certain patient satisfaction standards, quality care standards and efficiency standards, the physician's overall compensation would not violate the proscriptions against private inurement or impermissible private benefit.

6. Summary

Health care organizations continuously strive to improve the quality of their services and at the same time reduce the costs associated with these services. Incentive compensation is a method of achieving these objectives by compensating physicians in a manner that aligns these objectives with the health care organization's goals. In determining whether a health care organization utilizing an incentive compensation program complies with the proscriptions against private inurement and impermissible private benefit, the Service will examine all the relevant incentive compensation factors discussed in this article.