REPORT 4

BOARD OF TRUSTEES

Resolution 17-412: The Pennsylvania Medical Society (PAMED) Support and Provide Financing to Develop and Execute a Physician Survey Assessing Patterns of Healthcare Financial Spending and Its Effect by Consolidation of Hospital and Hospital Network Systems, Monopolies of Healthcare Facilities, and Excluding Private Practice Physicians from Caring for Their Patients that have a History of Treatment by the Physician in Local Healthcare Facilities.

Resolution 17-412, introduced at the 2017 Annual House of Delegates meeting and referred to the Board of Trustees for study, has two overall objectives. First, Resolution 17-412 seeks financing from PAMED to develop and execute a physician survey to: assess the patterns of how healthcare is being affected in Pennsylvania by consolidation of hospitals and healthcare network systems; and the patterns of insurance carriers creating narrow physician networks.

Second, the resolution asks PAMED to investigate and lobby federal legislators to enforce the regulations contained in the IRS' Community Benefit Standard from IRS Revenue Ruling 56-185, as modified by IRS Revenue Ruling 69-545, for non-profit healthcare systems using the results of these surveys.

DECISION

As provided in the analysis below, the Board of Trustees recommends that Resolution 17-412 be adopted as amended.

ISSUE #1 – PHYSICIAN SURVEY

I. 2017 SURVEY AND THE NEED FOR A SECOND SURVEY

On May 1, 2018, a conference call was conducted with members of Northampton County Medical Society (Northampton) to review the resolution and to obtain information necessary to complete this board report. Northampton's primary concerns revolve around two major themes: independent-practicing physicians being blocked from practicing in a hospital or other healthcare facility and insurers limiting the number of physicians that are part of insurers' networks, thus causing those physicians to be "out-of-network" physicians. The combination of these two factors can have a devastating impact on a physician's practice. By being excluded from hospital privileges, a physician is limited in where he or she can provide necessary services to patients, particularly in areas where there may be one or two main hospitals. Second, by being excluded from insurer networks, physicians are put at a disadvantage, particularly in

markets where one or two insurers dominate. By not being available at certain healthcare facilities or being able to accept certain types of insurance, physicians can be placed at a competitive disadvantage relative to "employed physicians" who are part of a large healthcare network with multiple insurance options or with insurance that is integrated with the healthcare system.

Regarding legislative and legal areas, the first issue regarding healthcare systems can be classified as "any willing provider" or "open medical staff" status. Under this scenario, a healthcare system or hospital agrees to allow any qualified healthcare provider to practice or be a part of its medical staff at its facility subject to the healthcare provider being willing to abide by the terms and conditions of the healthcare facility that are applicable to all similarly-situated healthcare providers. A physician would be able to provide services in a hospital provided the physician was willing to abide by hospital bylaws and regulations that are applicable to all physicians that provide services at that hospital.

Regarding legislative and legal areas, the second issue regarding insurers can be classified as "narrow network" status. Under this scenario, insurers limit the providers that they accept into their network for various reasons. For those physicians that are out-of-network, they are put at a disadvantage because many patients will seek the services of in-network physicians to ensure procedures and other services are covered by the insurer at a lower cost to the patient. Like "any willing provider" status, an insurer that has an open network, as opposed to a narrow network, agrees to accept any qualified healthcare provider subject to the healthcare provider being willing to abide by the insurer's terms and conditions that are applicable to all similarly-situated healthcare providers.

In discussing these issues with Northampton, their desire for a physician survey is to assess whether healthcare consolidation is limiting medical staff privileges and if insurer narrow networks are placing independent-practicing physicians at a competitive disadvantage or worse, driving these physicians out of business or to another state to practice.

In 2017, at the request of Northampton, PAMED conducted a limited survey of approximately 300-member physicians regarding similar themes. Of those surveyed, 72 responded. The survey asked the following questions (with accompanying responses provided):

Question 1:	**Responses**
As an independent physician, have you ever been denied medical staff privileges at a hospital or health network system?	
Yes	9
No	63

Question 2:	**Responses**
Have you ever been granted privileges at one hospital in a network system, but denied privileges at another affiliated hospital in the network?	
Yes	4
No	2
Question 3:	
If you answered "yes" to question 1 or 2, what reasons were given for the denial of medical staff privileges? (Select all that apply)	
Failure to meet or maintain requirements as set forth in medical staff/hospital bylaws and/or policies	2
Requirement that you become an employed physician of that hospital and/or health system to maintain medical staff privileges	2
Requirement that you be exclusive to that hospital and/or health system to maintain medical staff privileges	1
Economic reasons	2
No specific reason was given	1
Other (please explain in no more than 3 to 4 sentences)	1
Question 4:	**Responses**
As an independent physician, were your medical staff privileges ever revoked or have your privileges ever been revoked during a re-credentialing process?	
Yes	7
No	60
Question 5:	**Responses**
What reasons were given for the revocation of your medical staff privileges? (Select all that apply)	
Failure to meet or maintain requirements as set forth in medical staff/hospital bylaws and/or policies	2
Requirement that you become an employed physician of that hospital and/or health system to maintain medical staff privileges	0
Requirement that you be exclusive to that hospital and/or health system to maintain medical staff privileges	0
Economic reasons	1
No specific reason was given	0

Other (please explain in no more than 3 to 4 sentences)	1
Question 6:	**Responses**
Have your patients ever requested you for their care at a hospital or health network system and you were not notified by hospital staff (or the patient was referred to and seen by an employed hospital physician without your notification)?	
Yes	29
No	30
Question 7:	**Responses**
As an independent physician, have you ever been denied scheduled time for a surgery, procedure or test by a hospital or health system due to the blocked time of system employed physicians?	
Yes	12
No	47
Question 8:	**Responses**
Which area of the Commonwealth do you practice medicine?	
Northwest (Erie and surrounding areas)	3
Southwest (Pittsburgh and surrounding areas	15
Northcentral (State College, Williamsport and surrounding areas)	5
Southcentral (Harrisburg and surrounding areas)	13
Northeast (Lehigh Valley, Wilkes-Barre/Scranton and surrounding areas)	10
Southeast (Philadelphia and surrounding areas)	13

Respondents were also given the opportunity to provide additional comments if they wanted to do so.

II. 2015-2017: LEGISLATION

During the May 1 meeting, a discussion was held concerning prior legislation that had been provided to Northampton concerning any willing providers and narrow networks. One of main reasons the limited survey was conducted in 2017 was to provide information to Northampton to take to legislators in hopes of getting bills introduced on these issues.

In 2015, at the request of Northampton, PAMED drafted legislation regarding open medical staffs. Northampton was to provide this legislation to a local legislator and PAMED's Government Relations staff offered to assist as requested. In 2017, again at the request of

Northampton, PAMED provided insurer narrow network legislation (along with conducting the limited survey above) to Northampton for them to provide to a local legislator. As in 2015, PAMED Government Relations staff offered to provide any assistance Northampton required.

In February 2018, Rep. Robert Freeman (D-136), a legislator serving part of Northampton County, began circulating a co-sponsorship memo that amends the Health Care Facilities Act to ensure that physicians have access to medical staff membership and can continue to provide appropriate care for their patients. As of July 2018, a bill has yet to be introduced. Given that Rep. Freeman is a Democrat, this being an election year, and the legislative session is ending, it is unlikely that that there will be much support for this bill and even more unlikely that it will have enough support to become law. It is likely the Hospital and Healthsystem Association of Pennsylvania (HAP) will oppose this bill. It is also likely insurers will oppose this bill as an open medical staff bill could give way to a narrow network bill (which Northampton has not provided to a legislator for filing as a bill).

In discussing the results of the limited survey with Northampton during the May 1 meeting, Northampton would like a larger survey, preferably of independent practicing physician members, to gauge whether any willing provider or narrow networks are issues across the Commonwealth or are relegated to certain areas. One of Northampton's goals is to have hard numbers to provide to legislators in hopes of garnering more support for legislation.

III. EXPECTIONS AND COSTS FOR A STATEWIDE SURVEY

After the May 1 meeting with Northampton, a meeting was held with a PAMED staffer in the Communications Department. Conducting a statewide membership survey of all practicing physicians (this would not include residents and students) would entail sending out an email to approximately 8,000 members. Instead of limiting the survey to independent practicing physicians, the survey could be sent to all members, but questions could be included in the survey asking those members how they practice. Including employed physicians would be recommended because any survey would want to capture employed physicians who may have been independent practicing physicians at one time.

A survey would likely include PAMED staff from Legal, Communications, Membership, and IT. Legal, as the lead on this Resolution, would help draft the questions with Northampton's input. Communications would refine the questions to ensure they are phrased properly, ensure that the questions don't suggest an answer, and tally the results. Membership would provide the email addresses for the members that the survey would be sent to. IT would help upload and format the survey to send to the members.

Under current cost structures, it costs PAMED $.005 (half-cent) for each email sent out. With approximately 8,000 emails being sent, the cost to email the survey to approximately 8,000

members would be approximately $40. Staff estimates that it would take approximately 10 to 20 hours to draft the survey, send it to members, and tabulate the results.

Per the Communications staff, past surveys that go to membership yield approximately a 1% to 2% response rate. Given this response rate, we estimate that approximately 200-300 members would respond to this survey. It must be kept in mind that the limited survey that was conducted in 2017 was sent to specific members that had chosen to opt-in to receiving surveys from PAMED on various subjects. Given their willingness to take surveys, these members produce a higher response rate, thus a main reason for the 24% response rate from last year's limited survey (72 out of 300).

ISSUE #2 – LOBBYING THE FEDERAL GOVERNMENT

IV. IRS REVENUE RULINGS

As part of its role in administering the United States Tax Code, the Internal Revenue Service (IRS) issues revenue rulings in which it provides guidance on provisions of the Internal Revenue Code (IRC).

In 1954, the IRS issued Revenue Ruling 56-185, in which it provided guidance on criteria or tests to be met in determining whether a hospital qualifies for exemption from federal income tax under section 501(a) of the IRC of 1954 as a 501(c)(3) organization. Under section 501(c)(3) of the IRC, organizations are exempt from income tax in part as follows:

> Section 501(c) of the Internal Revenue Code of 1954 describes certain organizations exempt from income tax under section 501(a) and reads, in part, as follows:
>
> (3) Corporations, and any community chest, fund or foundation, organized and operated exclusively for religious, charitable, scientific * * * purposes, * * * and no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

The IRS ruled that: the only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for educational, scientific or public charitable purposes. Usually, the ground for exemption is that it is organized and operated for public charitable purposes.

The IRS further opined that hospitals must meet, among other things, the following general requirement regarding use of its facilities to meet the exemption criteria under the IRC:

> It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors. Such limitation on the use of hospital facilities is inconsistent with the public service concept inherent in section 501(c)(3) and the prohibition against the inurement of benefits to private shareholders or individuals. *It is recognized, however, that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area. (Emphasis added).*

In 1969, Revenue Ruling 56-185 was modified by IRS Revenue Ruling 69-545. Under that ruling, the IRS was once again tasked with determining whether a non-profit hospital claiming exemption under section 501(c)(3) of the IRC is operated to serve a public rather than a private interest and thus is exempt from federal income tax. In this ruling, the IRS determined whether two non-profit hospitals qualified for exemption from federal income taxes based upon how each hospital conducted its business.

The IRS used several factors to determine that one of the hospitals was not operating for charitable purposes. In determining this, the IRS found that this hospital, while transferred to a non-profit organization, had continued to operate for the private benefit of its original owners (five doctors) who exercised control over the hospital through the board of trustees and the medical committee. Further, these doctors used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients. The IRS found that these factors indicated that the hospital operated for the private benefit of its original owners rather than for the exclusive benefit of the public.

In its 1969 ruling, the IRS focused on the actions of the original owners (five doctors) and how their actions benefitted themselves, to conclude that the hospital did not meet the exemption criteria in the IRC. Two of the factors mentioned by the IRS were the doctors' control of medical staff privileges and limitations on what patients were admitted to the hospital. These factors were not the sole factors in the IRS' decision, but two factors in a series of factors that the IRS used in ruling on that hospital's non-profit status.

Taking these two revenue rulings, the IRS does look to medical staff privileges as one factor in a series of factors that it uses to determine whether a hospital is meeting the requirements of non-profit status under the IRC. However, as indicated, the mere fact that a hospital does not open its medical staff does not, by itself, render a hospital's non-profit status null and void. As the IRS opined in its 1956 ruling, "that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area." The IRS' statement shows that a non-profit hospital is not prohibited from restricting medical staff privileges or that it must open its medical staff to any physician who meets certain qualifications. Rather, a non-profit hospital can still maintain its non-profit status with a restricted medical staff in some form.

V. ISSUES AND POSSIBLE ALTERNATIVES

During the May 1, 2018 meeting with Northampton, a discussion occurred regarding the resolution directing PAMED to investigate and lobby federal legislators to enforce the IRS rulings using the results of the survey discussed earlier in this report. In part, Northampton is hoping to use the results of the survey to show that there is an issue regarding medical staff membership at non-profit hospitals to such an extent that non-profit hospitals are in violation of their non-profit status.

There are several concerns with this resolution. First, as indicated above, a non-profit hospital is not prohibited from limiting its medical staff to some degree. Second, even if the PAMED survey yields a high response rate that shows many physicians have been denied medical staff privileges at non-profit hospitals, the results of that survey are limited to Pennsylvania. Bringing the results of a survey restricted to Pennsylvania to federal legislators or the IRS would likely not be enough evidence to prompt a wholesale investigation into non-profit hospitals. Third, as with any federal agency, the IRS' interpretations are not clear and absolute, meaning that the IRS is free to interpret the IRC within reason. Fourth, it is unlikely that under this administration that there will be a push to actively investigate non-profit hospitals, particularly with only the results of a small survey conducted within one state. Fifth, it is unclear, even after the discussion with Northampton, what exactly PAMED is supposed to "investigate" so that it can adequately lobby federal legislators. A survey, without other concrete evidence, is not likely to yield political willpower to do more.

A discussion was had during the May 1, 2018 to determine whether there are adequate alternatives to the resolution. Given that if there is an issue with non-profit hospitals and medical staff privileges in Pennsylvania that there are likely issues across the country, it was discussed whether this issue would be better addressed through the American Medical Association (AMA). Traditionally, when there are national/federal issues to address, the AMA

has been in a better position to address those issues. This idea received support during the conference call as a possible alternative.

However, even if it is decided to direct Pennsylvania's AMA delegation to bring this issue to the AMA, it is advisable to allow the AMA to determine how best to bring this issue to the attention of federal legislators and/or the IRS, whether that be through the results of a nationwide survey of AMA members, through a letter directed to the IRS asking it to look into this issue further, or through some other method as determined by the AMA. It is not recommended that any resolution passed by PAMED's House of Delegates restrict PAMED's AMA delegates in presenting a resolution to the AMA.

RECOMMENDATIONS

Based upon the information provided, it is recommended that Resolution 17-412 be amended and adopted as follows:

1. As to the member survey, it is recommended that a member survey be conducted in 2019 after the member renewal period (after March 1, 2019). It is recommended to wait until after the PAMED membership renewal period so that PAMED staff has the most up-to-date membership list in which to distribute the survey. PAMED staff will work with Northampton to develop the survey questions. Results of the survey will be given to Northampton and provided to the Board of Trustees as an information report.

2. As to the IRS issue, it is recommended that PAMED direct its AMA delegation to bring this issue before the AMA at its 2018 interim meeting or 2019 annual meeting (whichever our delegation determines is the more appropriate venue). Specifically, PAMED's AMA delegation would bring a resolution before the AMA regarding whether to lobby federal legislators, the IRS, and/or other appropriate federal officials regarding reviewing tax exempt status for non-profit hospitals and specifically whether non-profit hospitals' decisions to have closed medical staffs violate their tax-exempt status. The AMA, in its discretion, can determine how best to address federal officials, whether it be through correspondence, meetings, or other methods.

AMENDED RESOLUTIONS

RESOLVED, that the Pennsylvania Medical Society (PAMED) provide financing to develop and execute a physician member survey in 2019 to assess actions taken by hospitals, health systems and/or insurers in limiting or restricting medical staff membership and/or insurer networks within the Commonwealth; and, be it further

RESOLVED, that the Pennsylvania delegation to the AMA present a resolution at the next appropriate AMA meeting to direct the AMA to lobby federal legislators, the IRS, and/or other appropriate federal officials to investigate and review whether non-profit hospitals and other applicable health systems are meeting the provisions of the Internal Revenue Code relating to their tax exempt status, when they restrict or otherwise limit medical staff privileges or maintain closed medical staffs, and to take appropriate action to ensure that non-profit hospitals and other applicable health systems continue to meet charitable purposes as required under applicable sections of the Internal Revenue Code.

CONCLUSION

The Board of Trustees recommends that Resolution 17-412 be adopted as amended.

John Gallagher, MD
Chair