REPORT BY THE U.S.

General Accounting Office

Evaluation Of A Proposal To Increase Medicare Equity Return Payments To For-Profit Hospitals

This report discusses questions raised by the Senate Committee on Finance concerning a proposal to increase Medicare equity return payments to for-profit hospitals. The proposal is based on a recent study by a private consulting firm, which recommends a 147-percent increase in the rate of Medicare equity return. GAO does not, however, believe that the study presents a persuasive justification for increasing the rate of equity return to the extent recommended.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-164031(3)

Mr. Jay B. Constantine
Chief, Health Professional Staff
Committee on Finance
United States Senate

SEN 04119

Dear Mr. Constantine:

This report is in response to your January 17, 1978, letter concerning Medicare reimbursement for return on equity in for-profit hospitals. This response supplements our July 31, 1978, interim reply. Information in this report was developed in response to your questions and is mainly divided into parts to correspond to those questions. Part IV is our analysis of a June 1977 study by a private consulting firm entitled "An Evaluation of Medicare Return on Equity Payments to Investor-Owned Hospitals."

As requested, we did not obtain written comments on this report from the Department of Health, Education, and Welfare (HEW) or from the Federation of American Hospitals, which financed the private study. We did, however, discuss various aspects of this report with officials of HEW, the Federation of American Hospitals, and the consulting firm which performed the private study and took their comments into consideration in preparing this report.

Medicare's return on equity is calculated at one and one-half times the average rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. As of October 1978 the equity return rate amounted to about 12 percent. This report discusses a number of factors affecting the decision whether to increase the rate of return to 30 percent as recommended by the private study. In summary, we do not believe that a persuasive case has been made for increasing the rate of Medicare equity return to the extent recommended. The most important reasons supporting our belief are:

1. The congressional intent of equity return payments was to (1) provide a fair return on invested funds and (2) attract capital investment to nursing homes so that for-profit providers could offer the full range of medical services needed by Medicare recipients. These payments originated from congressional concern that nursing home services covered by Medicare would not be available to recipients because of inadequate financial incentive to for-profit providers. (Public Law 89-713, approved Nov. 2, 1966, which authorized the payment of equity return, applied only to nursing homes. However, the conference report for this law (H. Rept. 2317, 89th Cong., 2nd Sess.) expressed congressional intent that equity return payments also be made to for-profit hospitals. (See p. 23.))

   Presently, however, a large surplus of unneeded hospital facilities exists, and Federal and State governments are striving to control excess hospital capacity. Since one of the primary purposes of equity return payments was to attract needed capital investment to extended care facilities, the proposal to increase such payments to hospitals seems questionable at this time. (See p. 21.)

2. The Medicare rate of equity return is about one-half a percent less than the weighted average equity return allowed by five State hospital regulatory bodies. (See p. 12.)

3. For several reasons (see our discussion beginning on p. 27) we believe the private study should not be relied on as a basis for increasing the rate of Medicare equity return by the 147 percent recommended.

A major issue raised by the private study is the nonallowability of corporate income taxes as a Medicare-reimbursable cost. The study states that, because for-profit hospitals must pay income taxes on Medicare equity return payments, the after-tax rate of equity return is substantially less than the rate determined pursuant to law. In fact, about 77 percent of the recommended increase in equity return is, in effect, a compensatory factor for Medicare's non-reimbursement of income taxes. The remaining 23 percent is an adjustment which the study states is necessary to bring

for-profit hospitals' equity returns in line with those of comparable risk industries.

Income taxes are not an allowable cost for Medicare purposes because HEW does not consider income taxes as a cost of providing patient care. As a practical matter, if HEW's policy on non-allowability of income taxes is to be revised, it seems to us that the private study's recommended compensatory increase in the rate of equity return is not a prudent way to achieve this objective for two reasons. First, many for-profit hospitals are not organized as corporations and do not pay corporate income tax. Likewise any for-profit hospital corporations organized as "subchapter S corporations" under Internal Revenue Service rules pay no corporate income tax. Therefore, any increase in equity return allowed these hospitals as compensation for corporate income taxes would, in effect, compensate them for such taxes even though none were paid. Second, although a for-profit hospital corporation may be subject to corporate income tax, the hospital does not necessarily pay a fixed percentage of income tax on equity return payments. For example, a hospital's equity return payments might be entirely offset or reduced by other losses and the hospital would pay no income tax or a lesser amount of tax than would apply to equity return payments.

If the Congress did decide that corporate income taxes should be recognized for Medicare reimbursement purposes, we believe that a preferable system would be to increase the rate of equity return for each hospital paying corporate income tax. For example, if a hospital's income tax was 45 percent of taxable income and the pre-tax Medicare rate of equity return was 10 percent, then the allowable Medicare equity return could be adjusted to 18.2 percent. A pre-tax equity return of 18.2 percent equates to an after-tax equity return of 10 percent based on a 45-percent corporate tax rate.

On the other hand, such an increase could be viewed as being discriminatory against for-profit hospitals not organized as corporations because they would not benefit from an increased rate of equity return.

As agreed, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director

APPENDIX I

EVALUATION OF A PROPOSAL TO INCREASE MEDICARE EQUITY RETURN PAYMENTS TO FOR-PROFIT HOSPITALS

Contents

APPENDIX I

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

INTRODUCTION

Under the Medicare program administered pursuant to title 18 of the Social Security Act, the Department of Health, Education, and Welfare (HEW) reimburses hospitals' reasonable costs of providing medical care to eligible persons. In computing reimbursable costs, HEW allows for-profit hospitals to include an allowance for return on owners' equity. Equity return is computed at one and one-half times the average rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. As of October 1978 the equity return rate amounted to about 12 percent.

The payment of equity return to for-profit hospitals originated with the enactment of section 7 of Public Law 89-713, approved November 2, 1966, which authorized the payment of equity return to for-profit nursing homes. Although this act did not provide for equity return to hospitals, the conference report (H. Rept. 2317, 89th Cong., 2nd Sess.) stated that for-profit hospitals should also be allowed an equity return.

Our review was made at HEW headquarters in Washington, D.C.; Health Care Financing Administration offices near Baltimore, Maryland; and Medicare intermediary offices in Dallas, Texas, and Van Nuys, California. We discussed the issues in this report with representatives of HEW, State hospital regulatory commissions, Medicare intermediaries, Blue Cross insurance plans, and the for-profit hospital industry and took their comments into consideration in preparing this report.

PART I

DETERMINATION OF NET EQUITY

IN FOR-PROFIT FACILITIES

Extent to which equity bases for given proprietary facilities have been increased over original historical cost through sale and/or resale.

In 1976, 340 of all 752 proprietary hospitals were located in California or Texas. We examined the records of the Medicare intermediaries responsible for most hospitals in Texas and Southern California and identified 25 hospitals sold between February 1973 and October 1976 which were proprietary hospitals before and after the sale. (Intermediary records were not readily available in connection with sales occurring before February 1973.)

These 25 hospitals excluded those acquired by purchasing corporate stock. HEW regulations provide that when hospitals are acquired by a transfer of corporate stock, the transaction is not recognized, in itself, as a change of ownership for Medicare purposes and revaluation of asset and other accounts is not allowed. An HEW representative said these regulations have been challenged in several court suits. In one of these suits, which is expected to establish a precedent for subsequent cases, the U.S. District Court, Central District of California, ruled in May 1977 that where, in addition to the purchase of corporate stock, a purchaser assumed the management of and made known its intent to liquidate the corporation, the provider who purchased the hospital was entitled to revalue hospital assets for Medicare purposes. This ruling has been appealed to the U.S. Court of Appeals, but an HEW official said in November 1978 that a ruling was not expected for at least a year because of the court's backlog. Thus, because HEW regulations did not recognize stock purchases as hospital sales for Medicare purposes, these acquisitions were excluded from our review.

Also, we did not examine the cost reports and other records for 12 of the 25 hospitals for the following reasons.

--For eight hospitals, the intermediaries had not completed their audits and settlements for the accounting period after the sale.

--One hospital had stopped participating in the Medicare program soon after the sale.

--For three hospitals, change of ownership occurred under circumstances in which changes in owners' equity and other accounts were not recognized for Medicare purposes. For example, one hospital was transferred from one subsidiary of a company to another subsidiary, but asset valuations were not changed.

As shown below, the equity basis for 11 of the remaining 13 hospitals whose cost reports we examined decreased as a result of the sale.

State and hospital	Average equity (note a) Before sale	After sale	Difference
Texas:			
Hospital #1	$ 733,064	$ -	$ (733,064)
Hospital #2	1,545,830	494,478	(1,051,352)
Hospital #3	525,392	76,615	(448,777)
Hospital #4	92,457	13,216	(79,241)
Hospital #5	546,692	78,429	(468,263)
Hospital #6	106,044	1,595,468	1,489,424
Hospital #7	1,297,875	486,219	(811,656)
	4,847,354	2,744,425	(2,102,929)
California:			
Hospital #1	531,589	271,988	(259,601)
Hospital #2	1,102,153	2,577,000	1,474,852
Hospital #3	554,068	-	(554,068)
Hospital #4	1,287,818	-	(1,287,818)
Hospital #5	649,334	-	(649,334)
Hospital #6	69,884	-	(69,884)
	4,194,846	2,848,993	(1,345,853)
Total	$9,042,200	$5,593,418	$(3,448,782)

a/Hospital sales occurred at varying times between February 1973 and October 1976. The average equity amounts shown were the basis used to compute equity return during the accounting periods immediately preceding and following the sale.

When hospital sales occur which are recognized by Medicare for reimbursement purposes, the financial position of the new owners is different from that of the former owners in most respects and many factors affect the determination of owners' equity. For example, owners' equity is affected by the amount of cash invested from their own resources. The greater the cash investment, the greater the equity.

Even though the owners' equity declined in most cases, the after-sale value assigned to the fixed assets for Medicare depreciation purposes usually exceeded the value of those assets for the former owners, as shown below.

State and hospital	Fixed asset valuation		
	Before sale	After sale	Difference
Texas:			
Hospital #1	$ 1,577,994	$ 1,775,659	$ 197,665
Hospital #2	1,764,893	2,327,898	563,005
Hospital #3	544,126	600,984	56,858
Hospital #4	86,573	162,076	75,503
Hospital #5	101,847	973,435	871,588
Hospital #6	1,248,322	2,776,439	1,528,117
Hospital #7	3,955,315	3,612,008	(343,307)
	9,279,070	12,228,499	2,949,429
California:			
Hospital #1	6,781,353	7,800,000	1,018,647
Hospital #2	1,776,952	2,250,000	473,048
Hospital #3	699,952	1,532,255	832,303
Hospital #4	3,200,700	4,400,000	1,199,300
Hospital #5	281,903	480,775	198,872
Hospital #6	45,600	74,455	28,855
	12,786,460	16,537,485	3,751,025
Total	$22,065,530	$28,765,984	$6,700,454

As shown above, the total fixed asset valuation of the hospitals increased by about $6.7 million, or about 30 percent, following the sales. Of this amount, about $2.7 million represented increases in land values. The remaining $4 million worth of increases in fixed asset valuations are subject to being written off as depreciation expense over the remaining useful lives of the assets. Thus, as a result of the hospital sales, the Medicare program and other cost-based payers will be allocated additional costs in future years.

Extent to which purchase/sale of facilities at higher prices has been financed through non-cash, non-standard debt.

Our review did not reveal any evidence that the 13 hospital sales were financed with non-standard debt instruments. The sales prices of the 13 hospitals totaled $36.7 million; $16.9 million was financed through the assumption of existing liabilities, $9.2 million was financed through loans made to the buyers, and $10.6 million was paid in cash. However, in most cases we could not determine from intermediary records how much cash was provided through the buyers' own resources and how much was provided through borrowings from other sources such as banks.

Who evaluates the "reasonableness" of the real property values for net equity used as the basis for reimbursement?

HEW regulations provide that for depreciation purposes the valuation of depreciable assets of a facility purchased as an ongoing operation before August 1970 may not exceed the fair market value of the assets at the time of sale. If acquired after July 1970, the value of the assets may not exceed the current reproduction cost depreciated on a straight line basis over the life of the assets to the time of sale or the fair market value of the tangible assets purchased subject to the limitations applicable to depreciable assets. According to an HEW official, this criteria can only be applied through the appraisal process.

In this regard, HEW defines an appraisal expert as

> "* * * an individual or a firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishing or reconstruction of the historical cost of such assets, employs a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques, is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation."

An HEW official said that it is the responsibility of the intermediaries--contractors which perform claims processing and paying functions for institutional providers under Medicare--to see that appraisals are made in keeping with the regulations.

In Texas, six hospitals were appraised by appraisal firms, and these appraisals substantiated the new cost bases established for the hospitals. Another hospital in Texas was not appraised, but it was sold at a loss and the new owner capitalized the building at a lower value than the former owner. An intermediary representative said appraisals were not normally required if a new owner capitalized a hospital at a value which was the same or less than the value used by the former owner.

In California, evidence of appraisals existed for four of the six hospitals included in our review. In the case of another hospital, neither intermediary nor hospital representatives could provide any evidence that an appraisal was made. And, in the final case, hospital representatives said that an appraisal was made before the hospital sale in August 1974 and promised to send us a copy of the appraisal. However, as of February 1979, we had not received a copy.

Representatives of the California intermediary stated that even though their records did not document appraisal results in all cases this did not necessarily mean that appraisals were not made. They suggested that appraisals could have been examined by their auditors even though the audit files did not document such examinations. They also stated that as a matter of routine audit procedure they presently require appraisals of hospitals when they are sold.

To what extent are "intangible" assets the basis for net equity determinations?

Intangible assets include goodwill, patents, copyrights, leases, licenses, franchises, and similar valuable but nonphysical things which are owned. Intangible assets can usually be included in the computation of equity return if the amount is reasonable and the assets are related to patient care. However, pursuant to HEW regulations, goodwill purchased in an acquisition on or after August 1, 1970, cannot be included in computing equity return. Since November 1976, goodwill purchased before August 1, 1970, may be included in computing equity return but only until the sum of the rates of allowable return on equity capital equals 100 percent. For example, if a hospital's equity return was computed at 10 percent each year for 10 years, the hospital would no longer be eligible to claim equity return based on goodwill.

An HEW representative said there have been three U.S. District Court decisions ruling that, contrary to HEW's interpretation of Medicare regulations, goodwill could be included in computing equity return. These decisions have been appealed to the U.S. Court of Appeals, but the HEW representative said in November 1978 that a ruling was not expected for at least a year because of the court's backlog.

There is no overall information readily available on the extent to which intangible assets form part of the basis for net equity determinations. An HEW official stated that few intangible assets were contained in an HEW sample of hospital cost reports. He also stated that, in his opinion, the amount of intangible assets reported by proprietary hospitals was insignificant.

Eleven of the 13 hospitals we reviewed had not recorded any intangible assets in their accounts for Medicare purposes. Two hospitals in California had recorded only relatively minor amounts as "other assets". For example, one hospital had $2,915 of "other assets" which represented about 0.5 percent of $644,315 total assets. Information in the intermediary's files did not identify the exact nature of these "other asset" balances for either of the two hospitals; however, the hospitals had a negative equity balance (that is, liabilities exceeded assets) and were not entitled to any equity return for Medicare purposes. Thus, in both cases, the "other asset" amounts did not contribute to any equity return payments.

With respect to present short-term acute care beds in for-profit hospitals, what proportion were built following specific approval of construction by formal public regulatory process?

We were unable to identify any readily available information showing what proportion of acute care beds in for-profit hospitals were built following specific approval of construction by a formal public regulatory process. Many States have certificate-of-need programs giving the States varying degrees of control over capital expenditures for health facilities. Generally, these programs require a certificate of need when there will be a substantial capital expenditure, a change in the number of beds, or a change in service. However, an HEW official stated that HEW does not have data on State approvals and rejections of applications for proprietary hospital facilities.

APPENDIX I

In connection with another recent review, we have obtained information relating to the certificate-of-need programs administered by Alabama, Florida, New Hampshire, Utah, and Virginia. 1/ The information relating to Virginia covered July 1, 1976, through March 31, 1977. The information relating to the other four States covered calendar year 1976. There were 445 requests for health facilities reviewed by the State agencies; however, 404 of the requests were for non-hospital facilities and equipment such as nursing homes, renal dialysis centers, total body scanners, and X-ray machines.

Only 41 of the 445 requests were for beds in hospitals as shown in the following table.

	Requests	Number of beds involved
For-profit hospitals:		
Disapproved	3	466
Approved	4	204
Nonprofit hospitals:		
Disapproved	1	16
Approved	33	937

Although this data is somewhat limited in scope, it shows that requests by for-profit organizations for new hospitals or additions to existing hospitals were disapproved at a higher rate than such requests by nonprofit hospitals.

1/The report based on this review is entitled "Status of the Implementation of the National Health Planning and Resources Development Act of 1974" (HRD-77-157, Nov. 2, 1978).

PART II

OTHER COST PAYERS

Extent to which Blue Cross plans and other non-indemnity hospital cost payers specifically recognize and allow a return on net equity or investment.

The 71 Blue Cross plans are the major private non-indemnity hospital insurance plans--those plans which directly reimburse hospitals on behalf of insured participants. We discussed with representatives of the following Blue Cross plans their policies relating to allowing equity return in reimbursing hospitals.

1. Blue Cross of Northern California (Oakland).
2. Blue Cross of Greater Philadelphia.
3. Genesee Valley Medical Care, Inc. (Rochester, New York).
4. Blue Cross of Northeast Ohio (Cleveland).
5. Blue Cross of Kansas City (Kansas and Missouri).
6. Blue Cross of Greater New York.
7. Blue Cross of Southern California (Los Angeles).
8. Blue Cross of Florida.
9. Mutual Health Insurance (Indianapolis, Indiana).
10. Group Hospital Inc. (Dallas, Texas).

Four of the plans (Genesee Valley Medical Care, Inc., Blue Cross of Northeast Ohio, Blue Cross of Kansas City, and Mutual Health Insurance) had no for-profit hospitals in their service areas and therefore had no policy on reimbursing hospitals for owners' equity. Only two of the remaining six plans--Blue Cross of Greater Philadelphia and Blue Cross of Greater New York--routinely allow for-profit hospitals an equity return in determining reimbursement rates.

Blue Cross of Greater Philadelphia determines equity in the same manner as under the Medicare program and computes equity return at a rate of 10.5 percent. Although this rate approximates the rate used under the Medicare

program, there are other features of this Blue Cross plan which could significantly affect the net income of hospitals. In lieu of considering income taxes as a reimbursable cost, Blue Cross of Greater Philadelphia computes reimbursable costs of for-profit hospitals at the rate of 105.5 percent of actual costs. However, the plan imposes a penalty if hospitals do not achieve the following specified minimum occupancy levels.

Type of service	Minimum occupancy
Obstetrics and pediatrics	65 percent
Medical and surgical	
Less than 100 beds	80 "
100 to 150 beds	85 "
More than 150 beds	87 1/2 "

If a hospital does not achieve these minimum occupancy levels, the penalty is imposed by computing the daily reimbursement rates based on total allowable costs divided by the number of patient days which the hospital would have reported if the minimum occupancy level had been achieved. This computation will result in lower daily reimbursement rates than rates computed on the basis of actual patient days. When the minimum occupancy penalty was first imposed in 1974, all or most of the 10 for-profit hospitals under the plan were adversely affected, but by 1977 only 3 hospitals were affected.

Blue Cross of Greater New York allows hospitals an equity return based on the same percentage and equity amount used for the Medicare program.

Also, in some instances Blue Cross of Florida allows for-profit hospitals an equity return. Blue Cross of Florida is primarily a charge-based reimbursement system, that is, hospitals are reimbursed on the basis of their specified charges. However, if any increase in a hospital's proposed charges exceeds 80 percent of any increase in the Consumer Price Index for hospital charges, Blue Cross reviews the hospital's supporting cost information to determine the reasonableness of the proposed increases. As part of its review, Blue Cross allows equity return computed at 15 percent or the average return for service industries as published by Business Week, whichever is lower. Currently, the 15-percent rate of return is being used.

A representative of Blue Cross of Florida stated that about three-fourths of the proposed rate increases fall below the 80-percent cutoff point and the reimbursement to

such hospitals is based on their charges rather than a review of their costs.

Blue Cross of Florida was the only plan which specifically recognizes income taxes as a reimbursable cost. However, we were informed that there had been considerable discussion among Blue Cross of Florida officials as to whether income taxes should continue to be considered a reimbursable cost.

Two of the plans (Blue Cross of Northern California and Group Hospital, Inc.) reimburse hospitals on the basis of their charges and do not specifically consider or allow equity return. The remaining plan (Blue Cross of Southern California) reimburses hospitals on the basis of their costs but does not specifically allow equity return as an element of cost. Blue Cross of Southern California computes reimbursable costs based on 106 percent of actual costs to allow for expansion, but this feature applies to nonprofit as well as for-profit hospitals.

Extent to which return on net equity is specifically recognized in States having statewide hospital rate regulatory bodies covering all hospitals and all payers.

Four States have regulatory bodies that control the amounts for-profit hospitals may charge all patients except Medicare patients. In addition, the Maryland regulatory body establishes hospital rates for all payors including rates for Medicare patients. The following table shows the rates used by these regulatory bodies in allowing return on owners' equity and identifies whether corporate income taxes are treated as a reimbursable cost.

State	Percent of equity return	Corporate income taxes treated as reimbursable cost
1. Colorado	15 percent	No
2. Maryland	14 percent	No
3. Massachusetts	Medicare rate	No
4. New York	Medicare rate	No
5. Washington	10 percent	Yes

Based on a corporate tax rate of 45 percent, Washington's equity return would equate to about 18 percent on a pre-tax basis. As of October 1978, Medicare's equity return rate was about 12 percent. Using Washington's pre-tax rate of 18 percent and the Medicare 12-percent rate for Massachusetts and New York, the average rate of equity return for the five States was 14.2 percent--about 2 percent more than the Medicare rate. However, as shown in the following table, the two States which account for most of the for-profit hospital beds used the Medicare rate of equity return. Also, the weighted average rate of equity return for the five States (based on the number of for-profit hospital beds in each State) is about 12.6 percent or only slightly more than Medicare's 12 percent.

State	Percent of equity return	For-profit hospital beds	
		Number	Percent
1. Colorado	15 percent	570	4.9
2. Maryland	14 percent	619	5.3
3. Massachusetts	Medicare rate	1,871	16.0
4. New York	Medicare rate	7,901	67.7
5. Washington	18 percent	711	6.1
		11,672	100.0

Extent of return on net equity specifically recognized and reimbursed by the Federal Government under contracts with non-health sellers of goods and services to the Government.

The two basic sets of regulations under which the Federal Government buys and pays for goods and services are the Federal Procurement Regulations and the Armed Services Procurement Regulations.

The Federal Procurement Regulations concerning negotiated contracts, including fixed-price or cost-reimbursement contracts, do not allow reimbursement of interest costs or provide for a return on net equity in determining contractors' costs. However, the regulations specify that various factors be considered in determining the profit or the fee in such contracts. One of the factors which must be considered is the extent of a contractor's total investment (that is, both equity and borrowed capital) in the performance of the

contract. A General Services Administration representative stated there was no prescribed interest rate or methodology for determining profit or fee based on a contractor's investment. Rather, the determination is left to the discretion of the contracting officer.

The Armed Services Procurement Regulations were revised effective October 1, 1976, to provide for recognizing the cost of capital committed to facilities as an allowable cost in negotiated defense contracts exceeding $100,000 priced on the basis of cost analysis. A difference between this policy and Medicare's policy exists in that under the Armed Services Procurement Regulations the cost of money used for facilities capital is an imputed cost based on the capital used in contract performance without regard to its source as between equity or borrowed capital. A return on borrowed capital is not allowed under the Medicare program, but, unlike Defense programs, the Medicare program treats interest costs incurred as an allowable expense.

The rates of return used under the Medicare program to compute return on equity capital have been generally higher than the rates used by Defense agencies in computing the cost of capital committed to facilities, as shown in the following table. However, the following data should be interpreted with caution because the Armed Services Procurement Regulations provide for the negotiation of a profit or fee in addition to the cost of capital committed to facilities.

Applicable time period	Rates of return: Medicare program (note a)	Rates of return: Defense contracts (note b)
	(percent)	
July 1 to Dec. 31, 1976	9.8 to 11.2	8.5
Jan. 1 to June 30, 1977	9.6 to 10.7	7.8
July 1 to Dec. 31, 1977	10.4 to 11.0	8.8
Jan. 1 to June 30, 1978	10.8 to 12.4	8.3

a/The Medicare equity return rates vary depending upon (1) when the provider entered the program or when the provider's reporting year starts and (2) when the provider's reporting year ends.

b/This rate is determined by the Secretary of the Treasury, taking into consideration current private commercial rates of interest for new loans maturing in approximately 5 years (50 U.S.C. 1215(b)(2)).

APPENDIX I

Federal income taxes are not allowable as an expense in negotiating contracts under the Federal Procurement Regulations or the Armed Services Procurement Regulations.

PART III

EFFECTIVE RATE OF RETURN ON NET EQUITY

The extent, if any, to which "management" fees and other central office expenses (of a chain operation) allocated to Medicare affect return.

HEW regulations provide that provider payments to its home office are reimbursable by Medicare if such payments

--are compensation for home office services performed for providers,

--are related to patient care,

--do not exceed the costs to the home office of providing the services, and

--do not exceed the price of comparable services that could be purchased elsewhere.

We believe that a provider's net equity is not affected by the payment of an appropriate share of home office costs. When a provider makes payments to its home office, the provider's equity is reduced. However, the provider's equity is then increased when Medicare reimburses it for that portion of its home office payments allocable to the Medicare program.

As an illustration, assume that a provider properly reimburses its home office $1,000 for services performed. Assume further that all of the provider's patients are Medicare patients. Under these circumstances, the provider's equity would be reduced by $1,000 when it paid home office costs, but the provider's equity would be increased $1,000 when it was reimbursed by Medicare, resulting in no net effect on the provider's equity.

Extent to which return is enhanced by payments by beneficiaries for non-covered services.

The costs of non-covered services are not allowable for Medicare reimbursement purposes. However, there are two concepts under which net income or losses from non-covered services might be viewed as affecting equity return. First, net income or losses from non-covered services would increase or decrease owner's equity and cause Medicare payment for equity return to be greater or less than would be the case if such income or losses were excluded from owner's equity.

HEW regulations provide that equity return be computed on the basis of (1) the owner's investment in plant, property, and equipment related to patient care and (2) net working capital maintained for necessary and proper operations of patient care facilities. One factor which affects the amount of owner's equity is net income or loss resulting from patient care activities, including Medicare. Another factor affecting owner's equity is net income or loss resulting from activities not related to patient care which increase or decrease net patient care assets. For example, if net income from a gift shop (a non-covered service) is commingled with hospital operating funds and used in activities related to patient care, such net income could increase the equity base used to compute Medicare equity return.

To the extent that net income or loss from non-patient care activities affects the assets used in providing patient care, it seems appropriate that such income or loss be considered in determining Medicare return on equity.

Under the second concept, net income or losses from non-covered services might be considered as an addition to or a reduction in the return on equity resulting from patient care activities. However, we were unable to identify any readily available source of overall information identifying hospitals' income or losses from non-covered services. The cost reports for the 13 hospitals examined and the financial reports filed with the Securities and Exchange Commission by large for-profit hospital organizations did not contain sufficient information to enable us to determine income or losses from non-covered services. Also, representatives of HEW and the hospital industry were not aware of any studies or compilations showing hospitals' income or losses from non-covered services.

Effect of the 8.5 percent nursing differential allowed by Medicare in terms of the validity of the differential.

In computing hospital costs for Medicare reimbursement, routine inpatient nursing costs are computed at the rate of 108.5 percent of actual costs. The 8.5 percent nursing differential became effective in July 1969 and was based on a 1966 American Hospital Association study, which showed that the cost of inpatient nursing care to the elderly exceeded the average cost of inpatient nursing care to other patients by 7 to 10 percent. HEW selected the midpoint between the two percentages--8.5 percent--as the differential.

The study results were based on data obtained at 51 hospitals in 9 areas of the country. HEW estimated that the nursing differential would result in increased Medicare reimbursement of about $60 million for fiscal year 1970.

In May 1975, HEW issued regulations terminating the nursing differential effective June 1975. HEW stated that the differential was being terminated for the following reasons.

--The Social Security Amendments of 1972 expanded the scope of Medicare coverage to include certain individuals under age 65: [(1) disabled individuals under age 65 after they were eligible for social security or railroad retirement disability benefits for at least 24 months and (2) insured individuals under age 65 with chronic kidney disease and their families.] As of January 1975, approximately 8.5 percent of all Medicare beneficiaries were under age 65, and about 28 percent of those entering on Medicare rolls in 1975 were under age 65. (In 1978 about 11 percent of Medicare beneficiaries were under age 65.)

--HEW expected that the ratio of Medicare beneficiaries under age 65 to the total Medicare population would continue to increase.

--Since the nursing differential was created, hospitals had made expanded use of special care units, such as cardiac care units, and Medicare patient utilization of special care units was as much as 18 percent greater than their rate of utilization of routine nursing care units. Costs in special care units were substantially higher than in routine units, and effective January 1, 1972, Medicare reimbursement regulations were changed to recognize the extra costs of special care units and Medicare above average use of those units.

Soon after HEW's announcement of the elimination of the nursing differential, a number of hospital associations filed a court suit asking for a summary judgment declaring the regulation eliminating the differential to be unlawful. On August 1, 1975, the U.S. District Court, District of

Columbia, granted a summary judgment enjoining HEW from terminating the differential and stated that the termination was arbitrary and capricious, lacked a rational basis, and was otherwise not in accordance with law (American Hospital Association, et al. v. Weinberger; Civ. No. 75-0928).

HEW did not appeal the court decision, but it is presently funding a limited study of the differential. The contractor will evaluate nursing activity over a 24-hour period at 15 hospitals in 3 States. An HEW representative said in March 1979 that the study should be completed by about the end of April 1979. After the limited study is complete, HEW will determine whether a full-scale study is warranted.

To what extent is there a malpractice premium differential?

On the basis of a 1976 survey of 4,352 non-Federal hospitals by a private organization, HEW representatives estimated that malpractice insurance costs represent about 2.5 percent of total hospital costs. Applying this estimate to fiscal year 1977 total inpatient costs in non-Federal hospitals of about $47 billion, hospital malpractice insurance costs total about $1.2 billion.

HEW has financed a recent study by a private firm to examine several aspects of malpractice claims, including the question of whether Medicare and Medicaid patients bear a disproportionate share of malpractice costs. The study includes information from the nine largest malpractice carriers who collectively account for about 85 to 90 percent of the malpractice insurance industry.

The study, which was released in January 1979, shows that the Medicare and Medicaid programs are paying a disproportionately high share of hospitals' malpractice costs. For example, Medicare paid for 21 percent of hospital discharges in 1973. However, not more than 13 percent of the malpractice claims closed in 1976 (for incidents which, for the most part, occurred in 1973) were filed by Medicare patients. Also, the average award to Medicare patients was about $11,000 whereas the average award to all other patients was about $29,000. The study estimated that for a 4-month period in 1976, the awards to Medicare patients totaled about $2.2 million or about 4 percent of the $51.3 million awarded to all patients.

On March 15, 1979, HEW published a proposed rule in the Federal Register which would require malpractice costs to be directly apportioned to Medicare and Medicaid on the basis of actual malpractice loss experience, instead of the current apportionment basis of overall utilization of provider services. According to HEW, the Medicare and Medicaid programs account for only about 12.6 percent of the total dollar awards in malpractice cases but pay over 40 percent of hospital malpractice insurance costs. According to HEW, its proposed rule will save $310 million in fiscal year 1980--$40 million under the Medicaid program and $270 million under the Medicare program. The estimated savings for both programs is expected to increase to $730 million by fiscal year 1984.

We identified another recent study containing information on the age the litigants and the size of malpractice awards or settlements. This study by the National Association of Insurance Commissioners was published in May 1977. All insurers who had written at least $1 million in malpractice insurance in any year between 1970 and 1975 were asked to report information for claims paid or otherwise closed between July 1, 1975, and June 30, 1976.

The study falls short of fully meeting Medicare's needs because (1) awards and settlements are not separately shown for hospitals and physicians and (2) Medicare patients are not distinguished from other patients. Nevertheless, a portion of the study shows the following facts regarding the malpractice awards identified:

	Number of awards	Total amount	Percent	Average amount of awards
Awarded to those age 65 or younger	4,460	$839,593,596	99.3	$188,250
Awarded to those over age 65	526	5,853,548	0.7	11,128
Total	4,986	$845,447,144	100.0	

Because most Medicare patients are age 65 or older, the above data suggests that the Medicare program, which pays about 23 percent of hospital costs, is being allocated a disproportionate share of malpractice insurance cost.

A spokesman for the for-profit hospital industry said that in many respects cost apportionment between Medicare and non-Medicare patients is an averaging process. He acknowledged that a disproportionate share of malpractice costs are probably apportioned to the Medicare program, but he said in other areas a disproportionate share of costs properly chargeable to Medicare patients are charged to non-Medicare patients. For example, he said part of the costs of preparing Medicare cost reports are apportioned to non-Medicare patients.

Extent to which the effective rate of return paid by Medicare is increased in low-occupancy for-profit hospitals.

In 1976, the occupancy rate in for-profit hospitals averaged 65 percent or 12 percent less than the average occupancy rate of 77 percent in all other hospitals. HEW officials said no penalty or adjustment was imposed by Medicare specifically for low occupancy.

However, it is possible that a low occupancy rate could cause a hospital's Medicare reimbursement to be reduced pursuant to section 223 of the 1972 amendments to the Social Security Act. Under this section, HEW sets cost limits each year for hospitals' routine costs based on the size of the hospitals and the per capita income in areas where the hospitals are located. The cost limits are high enough to permit routine costs of over 80 percent of all hospitals to be covered in full. If a hospital's occupancy rate were low enough, this could cause the hospital's costs to exceed the limit for routine costs. However, other factors could also contribute to a hospital's exceeding the cost limit, for example, inadequate emphasis on total cost control. Also, the limit applies to nonprofit as well as for-profit hospitals.

Conceptually a low occupancy rate might be interpreted as increasing the effective rate of Medicare equity return. For example, if a hospital has an occupancy rate of 50 percent and the Medicare equity return rate is 10 percent, it might be theorized that the effective rate of Medicare equity return is 20 percent. However, we question the validity of this concept.

Medicare equity return is based on equity of the owners in the hospital minus the cost of any assets not related to patient care. We believe the effective rate of equity return should be viewed from the owner's perspective, that is, what rate of return do owners earn on their investment in providing patient care? From this perspective, the effective rate

of equity return is not affected by the occupancy rate. As discussed on the following pages of this report, from the Government's perspective the payment of equity return on unneeded hospital capacity could reasonably be interpreted as subsidizing overcapacity and inefficiency, but we do not believe this affects the rate of return which owners receive on their equity.

To what extent does allowance of a return on excess and underutilized capacity (apart from allowance of depreciation expense) serve to subsidize overcapacity and inefficiency?

In recent years hospital costs have increased at a much faster rate than most other consumer prices. One of the factors contributing to the large increases in hospital costs has been an overexpansion of hospital capacity. There are many surplus hospital beds; a Senate Finance Committee report (S. Rept. 95-1111, Aug. 11, 1978) stated that recent studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 or about 10 percent of total available beds. Estimates of the savings that would accrue from closure or conversion of unused or underutilized hospital facilities range from $2 billion to $4 billion annually.

Several attempts to contain soaring hospital costs have been undertaken. For example, section 1122 of the Social Security Act was added by the Social Security Amendments of 1972 to assure that Federal funds appropriated under the act were not used to support unnecessary capital expenditures for health care facilities. This section provided that equity return and reimbursement for other expenses related to capital expenditures could not be paid for facilities determined by State planning agencies to be unneeded.

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641, Jan. 4, 1975) strengthened the Federal Government's authority to control building of unneeded health facilities. This act, among other things, authorizes the Secretary of HEW to enter into agreements with States to designate a State agency to carry out the act's requirements. Each State agency must administer a certificate-of-need program which provides that (1) a determination of need be completed before substantial expenditures are made for new institutional health services or facilities and (2) only those services or facilities found to be needed shall be offered or developed in the State. If after September 30, 1980, an agreement designating a State agency to carry out the act's

requirements is not made between the Secretary of HEW and a State, the Secretary may not grant Federal assistance to that State for alcoholism and mental illness prevention, rehabilitation and treatment, or health planning.

As of November 1978 the Secretary of HEW had entered into agreements with each State governor. These are conditional designation agreements under which HEW will determine the capacity of the State agencies to carry out the responsibilities under the act. If HEW determines that the State agencies are functioning satisfactorily, full designation is granted to the State agencies.

In spite of these initiatives, hospital costs have continued to rise and efforts to control increases in hospital costs are continuing. For example, the Senate Finance Committee recently recommended the approval of House bill 5285, which proposes reducing overall hospital costs by providing financial incentives to close down or convert underutilized bed capacity or services in short-term hospitals to approved uses. However, the 95th Congress adjourned before this bill was enacted into law.

To the extent that the Medicare program pays equity return for excessive and underutilized capacity in for-profit hospitals, it could reasonably be said that the Medicare program is subsidizing overcapacity and inefficiency and is counterproductive to the programs and initiatives undertaken by the Federal Government to control excess hospital capacity.

A representative of the for-profit hospital industry said that due to shifts in population new hospitals are needed in some geographic locations, and he indicated that an adequate equity return was needed to encourage capital investment to provide those needed hospitals. We realize that some communities may need new or expanded hospital facilities. However, we are not aware of any evidence pointing to a lack of financial or other incentives to provide additional hospital facilities where needed. On the contrary, certificate-of-need programs have been enacted to control the building of unneeded health facilities.

Is it good public policy to allow increases in return on net equity indiscriminately to all for-profit hospitals without regard to considerations of efficiency, productivity, and the delivery of care?

The payment of equity return to for-profit hospitals for Medicare patients originated with enactment of section 7 of Public Law 89-713, approved November 2, 1966, which added a provision to section 1861 (v)(1) of the Social Security Act requiring that:

> "Such regulations [prescribed by the HEW Secretary for determining reasonable cost] in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund."

Although the language of the act referred to "extended care services" and not to hospital services, the conference report (H. Rept. 2317, 89th Cong., 2nd Sess.) stated:

> "The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them."

Our review of the legislative history of this act indicates there was concern over inadequate nursing home facilities and one of the primary purposes of the act was to attract sufficient capital investment so that private enterprise would provide adequate nursing home care for Medicare patients. In view of this background and the current surplus of hospital

beds, we do not believe it would be good public policy to allow a general increase in equity return to all for-profit hospitals inasmuch as such an increase might create an incentive for the addition of more hospital beds.

Proponents of increasing Medicare return on equity have disagreed with this view and maintain that the issue is not whether return on equity capital will encourage the addition of more hospital beds but rather whether equity return is adequate to reward investors for the use of their money. Their position is that the construction of new hospital facilities is regulated by certificate-of-need programs.

We realize that the certificate-of-need requirement, if effectively implemented, should reduce or eliminate the construction of unneeded health facilities. Yet, although the requirements of the National Health Planning and Resources Development Act of 1974 are a relatively recent development, about 20 States had certificate of need programs by 1972 and excess hospital capacity is still a national problem. Data published by the American Hospital Association shows that the national occupancy rate in hospitals has steadily declined from 83 percent in 1966 to 76 percent in 1976.

Also, a January 1976 report prepared under an HEW contract concludes that, although certificate-of-need programs tend to reduce expansion of the number of hospital beds, this reduction is accompanied by an increase in other types of hospital investment (such as for new equipment) and the total level of hospital investment is not reduced.

We agree that a comparison of the rate of Medicare equity return with the rate earned by other comparable industries should be a major factor in any decision to increase the Medicare rate of equity return. However, we do not agree that other factors, such as the current surplus of hospital facilities, should be ignored in making this decision. In this connection, we note that when equity return payments were authorized by the Congress the main rationale for this action was concern about inadequate nursing home facilities and the expectation was that an equity return allowance would encourage construction of additional facilities.

A related question is whether it would be good public policy to allow selective increases in equity return to for-profit hospitals based on efficiency, productivity, and the delivery of care.

Medicare payment for equity return may be considered either (1) a reimbursement for economic cost or (2) a profit in the traditional accounting sense. When viewed from an economic cost standpoint, equity return is considered as a cost analogous to what could have been earned on an investment in another sector of the economy, that is, money invested in a hospital could have been invested in relatively risk-free investments yielding interest. In the traditional accounting sense, equity return is considered as the residual of revenues, if any, exceeding costs.

If equity return is viewed as a bona fide economic cost of providing patient care, then there would be no basis for discriminating for or against individual hospitals on the basis of their relative efficiency, productivity, or quality of health care provided. Although Medicare reimbursement to hospitals may be restricted under section 1122 of the Social Security Act or section 223 of the 1972 amendments to the Social Security Act, the Medicare program normally reimburses hospitals for their necessary and proper costs of providing patient care (including depreciation, interest, nursing care, equity return, etc.) without regard to hospitals' efficiency, productivity, or delivery of health care. To apply a different criteria to equity return would, in our opinion, be difficult to defend as a discriminatory policy as to the source of capital. For example, it would be somewhat inconsistent to pay a highly efficient hospital a higher rate of equity return than the rate paid to an inefficient hospital since the costs for equity return conceptually are the same for both hospitals.

If equity return is viewed as profit in the traditional accounting sense, then it would be appropriate to allow variations in the rate of return based on efficiency, productivity, and delivery of care. This concept would be compatible with conditions in the private sector in which the profitability and ultimately the equity return are affected by efficiency, productivity, and competition.

The Medicare equity return has certain features reflecting both the economic cost and traditional accounting viewpoints. The equity return is treated as a "cost" by the Social Security Act. Also, although Medicare reimbursement is limited in some instances pursuant to section 223 of the 1972 amendments to the Social Security Act, the rate of return is assured by the Medicare program in most instances and there is little risk that hospitals will fail to receive the equity return allocable to Medicare patients. These features support the view that equity return should be viewed from the economic

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cost viewpoint. Conversely, the legislative history of section 7 of Public Law 89-713 authorizing payment of equity return for Medicare patients makes it clear that its purpose was to create a financial incentive for capital investment, and we believe that this purpose contemplates a profit in the traditional accounting sense.

We realize there are legitimate rationales for both viewpoints. On balance, however, we believe that the controlling issue is the apparent intent of the Congress to pay a profit to attract capital investment and that Medicare equity return may be considered a profit in the traditional accounting sense. Thus, it would seem appropriate to base the rate of return upon considerations of efficiency, productivity, and delivery of care. However, the question of whether there should be an effective increase in the average rate of equity return is a separate issue which should be considered on its own merits.

PART IV

GAO ANALYSIS OF "AN EVALUATION OF MEDICARE RETURN ON EQUITY PAYMENTS TO INVESTOR-OWNED HOSPITALS" A JUNE 1977 REPORT PREPARED BY A PRIVATE CONSULTING FIRM FOR THE FEDERATION OF AMERICAN HOSPITALS

"An Evaluation of Medicare Return on Equity Payments to Investor-Owned Hospitals (hereafter referred to as the private study) concludes that Medicare equity return payments are too low in relation to for-profit hospitals' above average financial and business risks, and that, as a consequence, non-Medicare patients bear Medicare's equity payment shortfall. The private study also concludes that Medicare payment for equity return should be increased from 1.5 to 3.7 times the rate paid on Federal Hospital Insurance Trust Fund investments--an increase of 147 percent.

As of October 1978, the Medicare equity return rate was 12 percent; the private study's recommendation would result in a rate of about 30 percent. As an alternative, the private study stated that if income taxes were recognized by Medicare as a reimbursable cost the equity return payment should be increased from 1.5 to 2 times the trust fund rate which would have resulted in a 16-percent equity return rate as of October 1978.

For the following reasons, we do not believe that a persuasive case has been made for increasing the rate of Medicare equity return to the recommended level.

--Some of the data in the private study shows that actual after-tax equity return earned by for-profit hospitals is generally commensurate with the after-tax equity return earned by firms in comparable industries or industries of comparable risk. Although hospitals earned a higher rate of after-tax equity return from non-Medicare patients than from Medicare patients, the private study's assertion that non-Medicare patients are thereby subsidizing Medicare patients is an elusive argument. (See p. 28.)

--The private study compares equity return of for-profit hospitals with selected firms

in 24 industries. However, equity returns of these selected firms may not fairly represent 14 of the 24 industries. Value Line (an investment rating service) publishes equity return data for 14 of the 24 industries containing information on many more firms than the private study's analysis. And, Value Line's data shows that equity return averaged about 1 percent less than that computed by the private study. (See p. 30.)

--Publicly available information shows that the stocks of for-profit hospitals are considered highly profitable and attractive investments. (See p. 31.)

--The private study is based on equity return earned by 10 major hospital management companies, but the study does not examine equity return earned by independent, investor-owned hospitals which account for about one-half of all investor-owned hospital beds. (See p. 34.)

--The private study suggests that an increase in the rate of equity return might be needed to compensate for Medicare's disallowance of certain costs for reimbursement. We believe that Medicare's cost disallowances should be considered on their own merits and that the rate of equity return should not be increased to compensate for the disallowance of some hospital costs for Medicare reimbursement. (See p. 35.)

--The private study is based, in part, on the assumption that all for-profit hospitals pay corporate income tax; however, about 12 percent of for-profit hospital beds are in hospitals which are not organized as corporations. (See p. 35.)

Actual return on equity earned by for-profit hospitals

Some of the data in the private study shows that actual after-tax equity return earned by for-profit hospitals is generally commensurate with the after-tax equity return

earned by comparable industries or industries of comparable risk. The average after-tax equity return earned by 10 major investor-owned hospital firms for 1969-75 was 10.8 percent, which was close to the 11.2- to 16.3-percent range the private study concludes is an appropriate equity return.

For 1969-75, after-tax equity return for the 10 major investor-owned hospital firms was 10.8 percent; Standard and Poor's 400 industrials averaged 12.3 percent; and the 24 service and consumer industries examined by the private study averaged 13.3 percent. (The consulting firm which made the private study did not compile equity return data on the 24 industries; instead it used equity return data compiled by other firms.) However, 5 of the 24 industries (trucking, electric utilities, telephone, nursing homes, and airlines) had characteristics which we believe are similar to hospitals--absence of price competition and/or some degree of external control or regulation over prices and/or services--and these 5 industries earned after-tax equity returns averaging 10.2 percent or slightly less than for-profit hospitals.

The private study concludes that although no industry is exactly comparable with investor-owned hospitals, the hotel/motel industry is the closest approximation. The hotel/motel industry had equity return of 11.2 percent compared with the hospitals' 10.8 percent. Also, the private study selected 10 industries similar to the for-profit hospital business. The drug, hospital supply, and nursing home industries were selected because they were medical service industries and possibly similar to for-profit hospitals in demand or nature of the products and services. The airline, electric utility, and trucking industries were selected due to possible similarities in regulatory effects. The hotel/motel, real estate, and restaurant industries were selected because, like hospitals, they are occupancy sensitive industries. Finally, the aerospace industry was selected due to the possibility that government contracting may affect overall industry risk in a similar manner as the hospital industry. These 10 industries had an average equity return of 11.3 percent compared with for-profit hospitals' 10.8 percent.

We believe that the actual after-tax equity return earned by the 10 major hospital management companies was generally in line with after-tax equity returns in comparable industries or industries of comparable risk. The private study shows that in most years the rate of Medicare-allowed equity return (before taxes) was less than the actual after-tax return earned by the 10 companies. Also, inasmuch as

income taxes are not a reimbursable Medicare expense, the private study computed an effective average after-tax Medicare equity return of 5.5 percent for 1969-75. Because this rate was less than the 10.8-percent actual average after-tax equity return earned by for-profit hospitals, the private study concludes that non-Medicare patients subsidized the use of hospital services by Medicare patients.

An HEW official said that income taxes are not recognized as a reimbursable Medicare cost because such taxes are not considered a cost incurred in rendering patient care. Medicare's policy of not considering income taxes as a reimbursable cost is generally consistent with cost-based procurement under the Federal Procurement Regulations and the Armed Services Procurement Regulations. Under these two regulations, Federal income taxes are not a reimbursable cost under cost-based procurements although these two regulations differ from Medicare's in that State income taxes are treated as a reimbursable cost.

Data in the private study indicates that hospitals earn a greater equity return from non-Medicare patients than Medicare patients, and the private study asserts this shows that non-Medicare patients "subsidize" Medicare patients. However, we believe this is an elusive argument. Demand for hospital services is relatively insensitive to price regardless of whether the price is set through a fee schedule published by the hospital or is based on a cost reimbursement system. Patients seldom have the knowledge necessary to evaluate the services available or the reasonableness of the price, even if they know the price. If Medicare equity return were based on the equity return paid by non-Medicare hospital patients, then Medicare would be constantly pressed to pay what the market would bear in a noncompetitive industry. This would be inconsistent with national objectives of controlling hospital costs and prices.

Private study results may not fairly represent equity return of 14 industries

The private study compares for-profit hospitals' equity return with that from selected firms in 24 industries. However, the equity return data of these selected firms may not fairly represent 14 industries. 1/

1/Brewers, broadcasters, cosmetics, department stores, food chains, food processors, hospital supplies, publishers, shoes, soft drinks, telephone, trucking, tobacco, and vending/food services.

The investment rating service Value Line periodically publishes financial data, including equity return earned by different industries. In fact the data on equity return earned by 80 firms included in the private study's 14 industries were also included in the comparable industries analyzed by Value Line. However, Value Line's analysis of the 14 industries was based on data from 260 firms whereas the private study's analysis of these 14 industries was based on data from only 80 firms. Therefore, we believe Value Line's analysis is more likely to be representative of the industry as a whole.

The basis used by the private study and Value Line to determine equity return was slightly different. The private study determined equity return by dividing net after-tax income (excluding extraordinary items) by one-half the sum of beginning and year-end net worth. Value Line determined equity return by dividing net after-tax income (excluding extraordinary items) by owners' equity at the end of the reporting period. In order to convert Value Line's equity return data to a base comparable to that used by the private study, we adjusted the equity return by dividing net after-tax income (excluding extraordinary items) by one-half the sum of beginning and year-end net worth.

For 1975 the equity returns computed by the private study for the 14 industries averaged 14.3 percent or about 1 percent more than the average of 13.4 percent based on adjusted Value Line data. We believe the tendency for the private study industry groups to show higher equity returns than the comparable Value Line industry groups raises a question as to whether the private study's data accurately represents the equity return earned by the 24 industries. If the pattern we identified in 14 industries is typical for all 24 industries, the private study overstates the equity return earned in other industries by about 1 percent.

For-profit hospitals are profitable and attractive investments

The private study concluded that investors consider the for-profit hospital industry to be a high-risk investment. Value Line assigns safety ratings from 1 to 5. The ratings are based mainly on stocks' short-term price volatility around the stocks' own long-term price trend. Six of the major for-profit hospital organizations have been assigned a Value Line safety rating of 4--meaning that the stocks of these organizations are considered in the next-to-highest risk category insofar as short-term stock price volatility is concerned.

However, the safety or risk element is only one of two major assessments by Value Line of its expectations for stocks' price performance. The other major Value Line assessment is timeliness, which is the stocks' expected price performance over the next 12 months. Value Line ranks about 100 industry groups in order of their timeliness--the top ranked industries are those whose stock prices are expected to improve most significantly. In December 1977 Value Line ranked the for-profit hospital industry number 1 for timeliness and noted that it had been ranked number 1 for the past year. In June 1978 and January 1979 Value Line reaffirmed its number 1 ranking for the hospital industry. Therefore, although for-profit hospital stocks are considered to be risky because of the short-term volatility of their stock prices, they are preferred as investments above all other industries because of the expected long-term increase in their stock value.

In its discussion of the "financial leverage" and "interest coverage" ratios, the private study expresses concern about the amount of debt of for-profit hospitals relative to other industries and places for-profit hospitals in the highest risk quartiles using both ratios. During the same month that the private study was published (June 1977), the president and chairman of the board of directors of National Medical Enterprises, Inc. (a major for-profit hospital chain) gave a speech to the Los Angeles Society of Financial Analysts in which he addressed the question of for-profit hospital debt levels. He said:

> "Our debt-equity ratio is about 2 to 1. We do not feel this is unduly burdensome for several reasons.
>
> "First of all, about 50 percent of our debt service is virtually guaranteed by the federal government, through the cost-reimbursement programs. This makes our 2 to 1 ratio compare more with a 1 to 1 in other industries."
>
> * * * * *
>
> "So far as our lines of credit are concerned, we have plenty of capacity left."

On January 24, 1978, the same corporate officer gave a speech to the New York Society of Security Analysts in which he discussed present and future prospects for his company and the industry. He said, in part:

"The five major hospital management companies which are listed on the New York Stock Exchange * * * illustrate dramatically the growth and profitability which has been our experience."

* * * * *

"The growth and development of our company and the entire industry has not gone unnoticed. A growing number of financial publications, advisory services and institutional investors have focused attention on our field, which in turn has been reflected in the outstanding stock price performance of this group in 1977, while the overall stock market was down. NME's [National Medical Enterprise's] stock, adjusted for splits, increased in price by some 77 percent in 1977, a period during which the Dow was down approximately 17 percent."

* * * * *

"We have raised our cash dividend eight times in the past two and a half years * * *"

* * * * *

"Our return on equity has risen from 9.8 percent in 1974 to 13.8 percent at May 31, 1977. It should be about 14.8 percent for fiscal year 1978 and well above 16 percent for fiscal year 1979."

* * * * *

"* * * we think we can keep profits growing at a 25 percent compound rate over the next several years. We think we are in a good financial condition for expansion and I think that the prognosis for our company and our industry is excellent.

"As I see it, we are a growth company that is going to stay a growth company for a long time, because we are in an industry that is going to stay a growth industry for a long time."

In this connection, Value Line published the following data in December 1978 showing for-profit hospital earnings expressed as a percentage of net worth.

Year	Percent of earnings to net worth
1974	10.3
1975	11.5
1976	13.3
1977	14.9
1978 (estimated)	15.5
1979 (estimated)	17.0

In the final analysis, it appears to us that the for-profit hospital industry is healthy and is considered a profitable and attractive investment.

Private study excludes equity return earned by independent hospitals

The private study's analysis is based on the equity return earned by 10 major for-profit chain organizations which owned, leased, or managed a total of 378 hospitals. The equity return earned by independent hospitals not affiliated with chains was not examined by the private study. Yet, these hospitals account for about one-half of all investor-owned hospital beds.

The private study compares certain financial and statistical data of chain organizations with independent hospitals and concludes that equity returns of the two types of hospitals are comparable. However, we believe the data examined by the private study is inconclusive as to whether independent hospitals' equity returns are comparable with those of hospital chain organizations. For example, the data shows that in 1975 the return on total capital earned by independent for-profit hospitals was 11.3 percent compared to 10.7 percent earned by chain organizations. Moreover, unlike the private study's treatment of hospital chain organizations, it does not make a specific assessment of independent hospitals' business risks in order to compare their earnings with other businesses or industries of comparable risk. Accordingly, we believe the private study does not represent a valid basis for assessing the adequacy of equity return to independent hospitals.

Medicare cost disallowances and equity return

In addition to its proposed increase in the rate of equity return from 1.5 to 3.7 times the Federal Hospital Insurance Trust Fund rate, the private study states that the equity return may need to be further increased to 5.1 times the Federal Hospital Insurance Trust Fund rate or to about 41 percent to compensate for Medicare's disallowance of certain costs for reimbursement. According to the private study, Medicare's cost disallowances include income taxes, routine Securities and Exchange Commission registration costs, other stock maintenance costs, fair market value of land used for hospital expansion, and hospitals acquired through the exchange of stock.

With respect to the disallowance of income taxes, the private study's proposed increase in the rate of equity return from 1.5 to 3.7 times the Hospital Trust Fund rate is intended to compensate for the nonallowability of income taxes as a reimbursable cost. Medicare's other cost disallowances are intended to insure that Medicare only reimburses hospitals' reasonable costs as required by the Social Security Act. We believe that the merits of Medicare's cost disallowances should be individually considered on the basis of an evaluation of the reasons for the cost disallowances and that the rate of equity return should not be increased to compensate for such disallowances.

Corporate income taxes not applicable to all for-profit hospitals

The private study is based on the earnings experience of 10 large for-profit hospital chains organized as corporations, and the study's conclusion concerning the needed increase in the Medicare rate of equity return is based in large measure on the experience of the 10 hospital chains in paying corporate income tax. The private study states that the effective rate of Medicare after-tax equity return is substantially less than the before-tax rate because hospitals must pay corporate income tax on Medicare equity return payments and income taxes are not a reimbursable expense for Medicare purposes.

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However, some for-profit hospitals do not pay corporate income tax. In 1976, about 12 percent of all for-profit hospital beds were in hospitals organized as sole proprietaries or partnerships. Likewise any for-profit hospital corporations organized as "subchapter S corporations" under Internal Revenue Service rules would pay no corporate income tax. If the private study's suggested increase in the Medicare rate of equity return were applied to hospitals not paying corporate income tax, these hospitals would be receiving indirect reimbursement for corporate income taxes even though no such taxes were paid.

APPENDIX II

LETTER FROM CHIEF, HEALTH PROFESSIONAL STAFF, SENATE COMMITTEE ON FINANCE

APPENDIX II

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

January 17, 1978

The Honorable
Elmer B. Staats
Comptroller General of the
United States
Washington, D. C. 20548

Dear Mr. Staats:

A continuing issue with respect to Medicare reimbursement has been that relating to the question of return on investment in for-profit hospitals.

As you know, present law authorizes payment of a return on net equity equal to one and one-half times the average current rate of return on Social Security Trust Fund investments.

Understandably, the for-profit institutions contend that that return--approximately 10 percent before taxes at present--is inadequate.

This issue of appropriate and appropriateness of return has been repeatedly raised by Members of the Finance Committee. It is expected to be raised again during this coming session of the Congress.

As in the past, we are again calling upon you for assistance and good counsel.

It would be very much appreciated if you and your capable associates would review and respond to the attached questions and material. These include questions relative to return on equity propounded by Committee staff; and the issues and questions explicitly and implicitly included in the enclosed report, "Evaluation of Medicare Return on Equity Payments to Investor-Owned Hospitals." The report, prepared by a private consulting firm, ICF, Incorporated, was financed by the Federation of American Hospitals.

APPENDIX II

Thank you again for your help. Please let us know of any additional clarification you might need. We would, of course, appreciate any additional observations and recommendations you may have.

Sincerely,

Jay B. Constantine

Jay B. Constantine
Chief
Health Professional Staff

Enclosure

APPENDIX II

I. Determination of Net Equity in For-Profit Facilities

1. Extent to which equity bases for given proprietary facilities have been increased over original historical cost through sale and/or resale at higher prices since 1965? Magnitude of those increases, if illustrations are available.

2. Extent to which purchase/sale of facilities at higher prices has been financed through non-cash, non-standard debt; i.e., letter stock, common or preferred stock or other corporate equity or bond issues?

   Extent of valuation of equity and debt obligations at date of purchase and at present.

3. Who evaluates the "reasonableness" of the real property values for net equity used as the basis for reimbursement? How objective and valid is that appraisal process in theory and in fact?

4. To what extent are "intangible" assets the basis for net equity determinations? Is there any indication of "overweighting" of intangible as opposed to tangible assets in Medicare net equity valuations?

5. With respect to present short-term acute care beds in for-profit hospitals, what proportion were built following specific approval of construction by formal public regulatory process?

II. Other Cost Payers

1. Extent to which Blue Cross plans and other non-indemnity hospital cost payers specifically recognize and allow a return on net equity or investment? Illustrations, if available, of the definition of net equity and returns allowed.

2. Extent to which return on net equity is specifically recognized in States having Statewide hospital rate regulatory bodies covering all hospitals and all payers?

3. Extent of return on net equity specifically recognized and reimbursed by the Federal Government under contracts with non-health sellers of goods and services to the Government?

APPENDIX II

III. Effective Rate of Return on Net Equity

1. The extent, if any, to which "management" fees and other central office expenses (of a chain operation) allocated to Medicare affect return.

2. Extent to which return is enhanced by payments by beneficiaries for non-covered services; i.e., television, private room, as well as other sources of income such as office rentals, parking lot fees, etc.

3. Effect of the 8½ percent nursing differential allowed by Medicare in terms of the validity of the differential. That is, are additional nursing costs actually incurred to that extent and, if not, does not the differential increase the facility's return?

4. To what extent is there a malpractice premium differential? That is, Medicare patients, according to available data, bring fewer suits and receive lower awards (because of age and income expectations). No adjustment is presently made in the allocation of hospital malpractice premium costs in consideration of these factors. Does the malpractice differential therefore work to the economic benefit of the hospital's ownership?

5. Extent to which the effective rate of return paid by Medicare is increased in low-occupancy for-profit hospitals. For example, in a hospital with average occupancy of 50 percent, is not the Medicare return based upon total assets of the hospital--including unused and underutilized beds and services--rather than those portions of the hospital regularly utilized in providing patient care.

6. In the latter case, to what extent does allowance of a return on excess and underutilized capacity (apart from allowance of depreciation expense) serve to subsidize overcapacity and inefficiency?

7. Is it good public policy to allow increases in return on net equity indiscriminately to all for-profit hospitals without regard to considerations of efficiency, productivity, and the delivery of care? [See GAO note.]

GAO note: Question #7 was received orally after the January 17, 1978, letter.

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