

DOCUMENT RESUME

06837 - [B2227254]

[Return on Investment in For-Profit Hospitals]. HRD-78-152;  
E-164031(3). July 31, 1978. 8 pp.

Report to Jay B. Constantine, Chief, Health Professional Staff,  
Senate Committee on Finance; by Philip A. Bernstein (for Gregory  
J. Ahart, Director, Human Resources Div.).

Issue Area: Health Programs: Reimbursement Policies and  
Utilization Controls (1208).

Contact: Human Resources Div.

Budget Function: Health: Health Care Services (551); Health:  
General Health Financing Assistance (555).

Organization Concerned: Department of Health, Education, and  
Welfare.

Congressional Relevance: Senate Committee on Finance.

Authority: 50 U.S.C. 1215(b). American Hospital Association, et.  
al. 7. Weinberger, CW 75-0928.

The adequacy of return on investment in for-profit hospitals allowed under the medicare program was questioned. A June 1977 study by a private firm concluded that investor-owned hospitals are considered by investors to be high-risk investments, and that to be compatible with normally expected rates of return in industries of compatible risk, the medicare return on equity should be increased from 1.5 to 3.7 times the rate of return on Social Security Trust Fund investments. The information available to investors, however, indicates that the financial strength of investor-owned hospitals is strong and raises questions about the validity of the study's conclusions. A comparison of the medicare return on equity with the return allowed by selected State hospital rate-setting bodies and the Department of Defense indicates that medicare rates are not out of line with the rates applicable to other programs and activities. Two of the three States having comprehensive regulatory authority over hospital rates allow a return on equity about the same as that of medicare. The Department of Health, Education, and Welfare has in process three studies which may have a bearing on the overall issue of the adequacy of medicare reimbursement for proprietary hospitals. (RRS)



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## UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

HUMAN RESOURCES  
DIVISION

JULY 31, 1978

B-164031(3)

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

Dear Mr. Constantine:

This is an interim reply to your letter of January 17, 1978 concerning the adequacy of return on investment in for-profit hospitals allowed under the Medicare program. We are presently preparing a complete report based on our inquiries into the questions raised in your letter. We understand that the Senate Committee on Finance will soon have a mark-up session on legislation which deals, in part, with the return on investment in for-profit hospitals, and this interim reply is intended to provide you with the preliminary results of some of our work to date.

Your letter asked for our evaluation of a June 1977 study by a private firm entitled "Evaluation of Medicare Return on Equity Payments to Investor-Owned Hospitals." This study concluded that investor-owned hospitals are considered by investors to be high-risk investments, and that to be compatible with normally expected rates of return in other industries of compatible risk, the Medicare return on equity should be increased from 1.5 to 3.7 times the rate of return on Social Security Trust Fund investments.

Although we have not yet completed our evaluation of this study, we note that information available to investors indicates that the financial strength of the investor-owned hospital industry is strong and raises questions about the validity of the study's conclusions. For example, a Value Line Investment Survey dated December 23, 1977 stated:

"The proprietary hospital chains scored big earnings advances in 1977. We estimate that the industry's profits rose more than 25% year to year, largely

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on the strength of recent capacity additions and the expansion of outpatient services.

"We look for further earnings growth in 1978, approximately 20%-25%. That would be about double the improvement the average corporation is likely to achieve . . . ."

On June 28, 1977, the President and Chairman of the Board of Directors of National Medical Enterprises, Inc. (one of the major chain organizations of for-profit hospitals) gave a speech to the Los Angeles Society of Financial Analysts in which he stated, in part:

"Fiscal 1977 was the ninth consecutive year of strong growth for National Medical Enterprises, an unblemished record from our first year of operations in 1969 . . . ."

\* \* \* \* \*

"Our compound rate of growth \* \* \* works out to 29 percent for revenues and 25 percent for net after taxes since our founding."

\* \* \* \* \*

"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 said:

"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. 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."

\* \* \* \* \*

This information clearly indicates that the proprietary hospital industry is generally in a strong financial position and has a good outlook for continued growth.

A comparison of the Medicare return on equity with return on equity allowed by selected State hospital rate-setting bodies and the Department of Defense indicates that, except for Blue Cross plans, the Medicare rates are not out of line with the rates applicable to those other programs and activities. The Medicare rates in effect during May and June 1978 ranged from about 11 to 12 percent. Using a rate of return calculated at 3.7 times the rate of return on Social Security Trust Fund investments (as suggested by the June 1977 study) would produce a Medicare return on equity ranging from about 28 to 31 percent. Two of the three States having comprehensive regulatory authority over hospital rates allow a return on equity about the same as that of Medicare; New York's rate was 10.8 percent

and Washington's rate was 10 percent. The other State-- Maryland--allowed a return on equity of 14 percent; but Maryland has only 3 for-profit hospitals. Additionally, unlike the Medicare program and the policy of New York's and Maryland's regulatory bodies, Washington recognizes income taxes as a cost to be considered in establishing hospital rates.

We also obtained information relating to the rate of return on equity allowed in setting rates of payment under two Blue Cross Plans. Blue Cross of Florida, which pays 100 percent of hospital charges, used a 15 percent rate in determining return on equity and also recognizes income taxes as a cost. Blue Cross of Greater Philadelphia, which pays on the basis of hospital costs used a rate of 10.5 percent. Although the Philadelphia plan does not recognize income taxes as a cost to be reimbursed, hospitals are allowed 5 1/2 percent of total allowable costs if they achieve specified minimum occupancy levels for medical and surgical units ranging from 80 to 90 percent depending on the hospital's size.

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. There is a difference between this policy and Medicare's policy 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 agencies, 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 below.

<u>Applicable time period</u>	<u>Rate of Return</u>	
	<u>Medicare program 1/</u> (percent)	<u>Defense contracts 2/</u> (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

1/The interest rates applicable under the Medicare program vary depending upon (1) the month the provider entered the program or the providers' reporting year starts, and (2) the month in which the provider's reporting year ends.

2/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 five years (50 U.S.C. 1215(b)(2)).

Another factor which we believe should be considered in evaluating the possible effects of any changes in return on equity in for-profit hospitals concerns the occupancy rate of those 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. There is no penalty or adjustment imposed by Medicare specifically on account of low occupancy, and generally a provider will be allowed a return on the entire equity apportioned to Medicare patients irrespective of whether there are unused or underutilized beds in the facility. Although it is a matter of conjecture, we believe that any significant increase in the allowable return on equity for proprietary hospitals would probably result in increased pressure for added proprietary hospital facilities.

Finally, HEW has in process three studies which may have a bearing on the over-all issue of the adequacy of Medicare reimbursement for proprietary hospitals.

1. Study of adequacy of return on equity for proprietary hospitals

On June 2, 1976, the U.S. District Court, District of Columbia, ordered the Secretary of HEW to make a study to determine the proper level of return on equity capital for proprietary hospitals (419 F. Supp. 253 (1976)). The plaintiff, an owner of several proprietary hospitals, brought suit contending that contrary to law, HEW's regulations concerning return on equity (1) failed to reimburse proprietary hospi-

tals their reasonable costs, and (2) forced individuals not covered by Medicare to bear a portion of the cost of services to individuals covered by Medicare.

The court found that a determination of the needed return on equity inherently requires a detailed study of the various factors affecting the economics of the proprietary hospital industry and the court directed the Secretary to make such a study. HEW has undertaken such a study and expects to complete it by about September 1978.

2. Study of the 8 1/2 percent differential for routine nursing services.

In determining hospital costs for Medicare reimbursement, routine inpatient nursing costs are computed at the rate of 108 1/2 percent of actual costs. In May 1975, HEW issued regulations terminating the nursing differential effective with any provider's first cost reporting period beginning after June 1975. HEW acknowledged that it had received complaints objecting that studies of the differential had not been made. However, HEW said that changed conditions so significantly altered the circumstances underlying the need for a differential, the concept of a differential for routine nursing care was no longer valid.

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 because HEW had not conducted any studies of the differential. 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; CW. No. 75-0928).

HEW did not appeal the court decision, but the Department 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. We have been advised that after the limited study is completed, HEW will determine whether a full-scale study is warranted.

3. Study of the reasonableness of the allocation of malpractice insurance costs to Medicare program.

In computing Medicare reimbursable costs, no adjustment is made for any differential between Medicare and non-Medicare patients based on frequency of malpractice suits or the size of malpractice awards or settlements. HEW is making a study to determine whether Medicare and Medicaid patients bear a disproportionate share of malpractice costs. The study, covers the 4-month period of July 1, through October 31, 1976, and includes information from the nine largest malpractice carriers who collectively account for about 85 to 90 percent of the malpractice insurance industry. It will separately deal with hospitals and physicians. An HEW representative informed us on July 27, 1978, that the study had been completed and was with the Secretary of HEW for final approval before being released.

Other studies of malpractice insurance have been made by the insurance industry, but we were only able to identify one study containing information on age of litigant and size of malpractice awards or settlements. This was a study by the National Association of Insurance Commissioners published in May 1977. All insurers who had written at least \$1,000,000 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 regarding the malpractice awards identified:

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




Because most Medicare patients are age 65 or older, the above data indicates that the Medicare program, which pays about 20 percent of hospital costs, is being allocated a disproportionate share of malpractice insurance costs.

\* \* \* \* \*

We trust this information will be helpful to the Senate Finance Committee's deliberations.

Sincerely yours,

Philip A. Bernstein

 Gregory J. Ahart  
Director