

Statement of

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Subcommittee on Health and the  
Subcommittee on Oversight  
of the  
Committee on Ways and Means  
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Mr. Chairman, I am pleased to be here to discuss the **effects** of federal policies on hospital acquisitions, which are of interest particularly because they increase Medicare's costs. Although my statement will concentrate on hospital acquisitions, it is important to note that this issue is only part of a broader concern about over-investment in the health-care industry generally. My statement today will cover:

- o Recent trends in hospital investment;
- o The reasons **for** increased purchases of hospitals;
- o The effects of these acquisitions on Medicare and the overall health-care system; and
- o Some possible alternatives to current policy.

#### RECENT TRENDS IN HOSPITAL INVESTMENT

In recent years, there has been an increasing trend toward investor ownership of hospitals, particularly by chains. Most purchases involve investor-owned hospitals acquiring other investor-owned hospitals, but some public and private **nonprofit** hospitals are also being bought.

Between 1972 and 1982, the number of hospitals remained virtually unchanged, while the total number of beds increased by 15 percent, which was slightly higher than the increase in population during the same period. Although growth in total hospital capacity has not been dramatic, significant changes are occurring in the makeup of the industry. Between 1972 and 1982, the number of beds in public hospitals increased by only 2 percent; in contrast, the number increased by 15 percent in private, nonprofit hospitals and by 60 percent in investor-owned hospitals.

At present, investor-owned hospitals account for roughly 10 percent of all hospital beds. Within the investor-owned segment, the number of hospital chain operations has been growing over the past five years, while the number of independent hospitals has declined. Between 1978 and 1983, the number of hospitals operated by chains of three or more facilities increased by 72 percent; the number of beds in these hospitals increased by 62 percent. Conversely, both the number of independent investor-owned hospitals and the number of beds in them decreased by 34 percent.

In addition to acquisitions of existing hospitals, the number of investor-owned facilities under construction has increased. Between 1981 and 1983, the capacity of these new hospitals expanded by an average of about 6,900 beds a year, compared with an annual average increase of 4,700 beds during the preceding three years--an increase of 47 percent.

## REASONS FOR INCREASED ACQUISITIONS

Investment in health care--and, in particular, acquisitions of existing facilities--is occurring for several reasons. Some of these are unique to the health-care industry. For example:

- o Medicare and most other insurers reimburse their shares of capital costs, either directly or indirectly. As a result of this third-party payment system, hospitals are not subject to the same constraints on their investment decisions as other industries.
  
- o New investment in hospitals is more likely to involve acquisition than new construction. Since "need" generally has to be demonstrated to state review boards before new hospitals can be constructed, investors have an incentive to take over existing facilities and thereby avoid lengthy approval processes. Hospital purchasers are most likely to be investor-owned chains, because they have better access to the equity and debt capital needed to purchase and modernize existing facilities.

Although the health-care industry is in some ways unique, it is also responsive to much the same motivations and conditions that affect investment generally. The tax cuts enacted in the Economy Recovery Tax Act of 1981 (ERTA), which accelerated depreciation and increased invest-

ment tax credits, have generally tended to encourage periodic sales of facilities.

Although both Medicare policies and tax provisions encourage hospital acquisitions, the relative significance of these incentives and their aggregate **effects** are difficult to quantify. It seems likely, however, that overall profit opportunities and general tax advantages are more important than the increase in Medicare's reimbursements for capital costs that occurs upon a change in ownership.

#### Medicare's Reimbursement Policies

Currently, capital **costs--that** is, payments for depreciation, interest costs, and also for return-on-equity to **investor-owned hospitals--are** excluded from Medicare's prospective payment system and continue to be reimbursed on a reasonable cost basis. Medicare's depreciation payments are based on historical costs and made on a straight-line basis over the useful life of the **asset--generally 40** years for a new hospital building.

When a hospital is purchased, several factors raise Medicare's costs. First, the buyer is permitted by Medicare's reimbursement rules to revalue assets and use a new depreciation schedule based on the sale price. 1/

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1. Medicare limits the revalued amount to the lower of either the purchase price or the current cost of reproducing the facility, less depreciation on the reproduction cost to **reflect** the actual age of the assets that were purchased.

Return-on-equity payments also increase because they are based on the revalued amount. Finally, Medicare reimburses its share of interest costs on borrowing used to finance the purchase. On the other hand, Medicare "recaptures" past depreciation payments by requiring that the seller pay Medicare any **profit** earned on the sale, up to an amount equal to the total of all depreciation payments Medicare has made to the seller over past years. 2/

### Tax Provisions

Recent changes in tax law have encouraged both acquisitions and new construction throughout the economy. Under ERTA, the depreciation recovery periods for both structures and equipment were substantially shortened, and the investment tax credit for equipment was increased. The major change affecting the hospital industry was the reduction in depreciation recovery periods for buildings and improvements from a minimum of 35 years to 15 years. For new buildings, the depreciation basis is construction cost; for existing buildings, it is sales price. Thus, whenever structures sell for more than they originally cost, their depreciation basis will increase upon transfer of the property. This, coupled with shorter recovery periods,

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2. Capital gains taxes are paid by the sellers of an investor-owned hospital on any profit that exceeds **Medicare's** recapture of past depreciation payments, but the sellers of a nonprofit hospital are not subject to this tax.

raises after-tax returns and sales prices and encourages turnover. The new rules on movable equipment are less likely to stimulate acquisitions. 3/

Under current law, purchasers of health-care facilities frequently benefit not only from generous tax write-offs, but also from tax-exempt financing. The large investor-owned chains have access to many forms of debt and equity capital, including tax-exempt bonds. They receive tax-exempt financing through small issue industrial revenue bonds (IRBs), which have a \$10 million cap on the amount of the bond and on the total capital expenditure on the facility. Although not suited for major hospital complexes, small issue IRBs have provided low-cost financing for acquisition of individual hospitals, clinics, nursing homes, physician-owned medical office buildings, and other related facilities.

#### EFFECTS OF INCREASED ACQUISITIONS ON MEDICARE AND THE OVERALL HEALTH-CARE SYSTEM

Hospital acquisitions directly increase Medicare's payments for capital costs. The Congressional Budget Office (CBO) estimates that over the 1985 to 1989 period, revaluation of new acquisitions will account for \$750 million of Medicare payments, and another \$80 million in Medicaid payments, because many state Medicaid programs follow Medicare's reimbursement rules.

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3. Most hospital equipment can be depreciated in three to five years, which may be more favorable than previous law in some cases and less favorable in others. For used property, the investment tax credit is limited to the first \$125,000 of cost.

Whether other insurers also pay more for hospital care because of acquisitions depends on the net effect of two **factors--increased** payments for capital and possibly lower payments for operating costs. Insurers other than Medicare pay more as a result of acquisitions either directly, through cost reimbursement of capital similar to Medicare's, or indirectly through higher charges for services. Total hospital payments may be lower, however, if multihospital systems are able to take advantage of economies of scale in management or make other improvements to operate the hospital at lower cost than the previous owner, and if these efficiencies are translated into lower charges. (This offset would not affect Medicare, at least in the short-run, because prospective payment rates are not directly related to a hospital's costs.) Studies to date have not shown **investor-owned** hospital chains to be more efficient, however. This situation may reflect little more than the lack of incentives for **efficiency** under cost reimbursement, though, so some speculate that it might change in the future. 4/

Hospital acquisitions may also affect quality of care, but it is difficult to make general statements about whether quality would improve or decline because of the diversity of specific situations. For example, in some cases,

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4. One study of California hospitals found that investor-owned chains had operating expenses per admission 2 to 5 percent higher than other non-public hospitals. Robert V. Patterson and Hallie M. Katz, "Investor-Owned and Not-for-Profit Hospitals", New England Journal of Medicine, August 11, 1983, pp. 347-353.



the hospital being purchased is an older, county-operated facility and the quality of care might improve if the new owners modernize the hospital to a greater extent than the community would have. Indeed, anecdotal evidence suggests that inability to modernize may sometimes be the reason for the sale. 5/ On the other hand, access to care by the poor might be reduced, if the new owners do not provide the same level of care to **Medicaid** beneficiaries or indigent patients as had previously been provided by the community. Effects of ownership change on access may not be as important when the hospital being acquired is an independent investor-owned facility, however.

#### OPTIONS

**Medicare's** payments for capital costs associated with hospital acquisitions could be reduced by changing reimbursement policy. In addition, changes in tax policy could affect hospital acquisitions; tax policy changes are an indirect means of regulating investment, however, and would have effects that reach far beyond the health-care industry. For these reasons, the options presented here deal only with Medicare policies.

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5. In the case of government hospitals, inability to **finance** improvements may be the result of difficulties in gaining voter approval for bond issues. Also, in these and other cases, an independent facility faces higher borrowing costs than chains, which are less risky because their earnings depend on the performance of several hospitals.

Because the Congress plans to include payments for capital costs in the prospective payment system by 1987, intermediate steps to **change--and** perhaps further **complicate--Medicare's** reimbursement rules related to hospital acquisitions might not be desirable. This would especially be true if the intermediate changes made the expansion of prospective payment more **difficult**. On the other hand, depending on the design and the length of the transition to complete prospective payment of capital costs, current and future acquisitions could continue to raise Medicare's outlays for many years. Given the pressure on the federal budget as a whole, the Congress might want to avoid this outcome by modifying Medicare's reimbursement rules now.

#### Disallow Revaluation of Assets for Medicare Reimbursement

Instead of reimbursing the higher capital costs related to hospital acquisitions, Medicare could simply continue the same depreciation payments made to the previous **owner--a** change currently under consideration. In addition, increases in the basis for interest and return-on-equity payments resulting from an acquisition would be disallowed. If this option were in place beginning in fiscal year 1985, five-year savings to Medicare and Medicaid would total roughly \$830 million.

Under this option, Medicare's capital payments would not change as a result of new ownership. Despite the fact that payments to a new owner

would be less than under current law, a high proportion of acquisitions would probably still occur. In fact, the tax system would **offset** some of the lost Medicare **payments--most** acquisitions are made by taxable **entities--** because the new owner's tax liability would also decline. On the other hand, some might argue that this approach is unfair because it would not compensate the buyer for that part of the purchase price that represents the capital costs of replacing the assets acquired. Moreover, it might significantly reduce the **profits** of some hospital owners.

#### Allow Medicare to Share in Capital Gains

Another option that has been suggested would extend Medicare's recapture provision by collecting part of the capital gain earned on the sale, with Medicare's proportion based on the share of the **hospital's** costs that Medicare represented. For example, if a hospital received \$2 million on the sale (over and above repayments to Medicare for past depreciation) and Medicare's share of costs had averaged **40** percent, Medicare would receive \$800,000. As under current law, the new owner could begin a depreciation schedule based on the new purchase price, and Medicare would pay all interest and return-on-equity payments associated with the sale.

Under this approach, Medicare's gains from the sale of nonprofit or government-operated hospitals would represent completely new federal income, because these sales are not subject to capital gains taxes. In

addition, a portion of the payments from the sales of investor-owned hospitals would be new revenue. (The remainder would be offset by a reduction in capital gains taxes paid by the seller.) 6/ Medicare savings would also be achieved immediately, rather than accrued slowly over time. On the other hand, it is possible that more acquisitions would be discouraged than under the previous option. If so, **Medicare's** recapture of past depreciation payments would fall. Moreover, in cases involving the sale of a government-operated facility to an investor-owned hospital chain, some might find it more desirable to pay the purchaser less over time (under the first option that prohibits revaluation) than to collect money from the seller at the time of purchase.

## CONCLUSION

A number of factors, including several federal policies, encourage the acquisition of hospitals, which in turn increases Medicare's payments. Consequently, in addition to deciding how to include capital in Medicare's prospective payment rates, the Congress may wish to make intermediate changes in **Medicare's** reimbursement of capital. In doing so, however, it is important to remember that any changes made now might influence the design of the **final** reimbursement system.

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6. Total federal revenue would be the same whether Medicare shared in the before-tax or after-tax capital gains, but the distribution between receipts to the Hospital Insurance (HI) trust fund and receipts to the general treasury would vary. The HI trust fund would receive more if the before-tax capital gains were shared with Medicare, and the seller was taxed only on the remainder.