

vendor/prime contractor, its credit quality, the quality of its product and services and the quality of the organisation. Also, some performance risk is minimised by assuring the installation and performance of the asset with acceptance of the asset by the federal government at the outset before funding.

There does not exist an opinion practice of getting opinions on the legal, valid and binding nature of a federal lease on the federal government due mainly to the existence of experienced contracting officers assigned to the transactions.

Conclusions. Commercial leasing tends to focus on the credit quality of the lessee, its ability to pay, regardless of whether the lessee needs the asset or whether the asset performs.

Municipal leasing tends to focus on the essential use of an asset because of the right of the governmental lessee to non-appropriate annually, since the credit quality is not that much of a concern due to the infrequency of bankruptcy and legislation requiring balance budgets and a certain degree of fiscal responsibility.

In addition, but less of concern, is the quality of the vendor, since a problem vendor might lead to a reason for non-appropriation.

Compliance with federal tax requirements is also of importance on lease-purchase transactions to preserve the tax-exempt status of the transaction. Federal leasing, with the superb credit quality of the US government, focuses on the essential use of the asset to the federal government due to the federal government's right annually not to renew or to non-appropriate.

Often more importantly, the vendor/prime contractor is the focus and concern, since its performance under the contract with the federal government remains a risk to the assignee throughout the term of the federal lease.

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HEALTHCARE EQUIPMENT LEASING

Call it the calm before the storm. For those of us in the US healthcare equipment leasing industry, this is the best way to characterise the past year in the business. The market appeared stable, with increasing use of lease financing by hospitals and medical practices.

But just off the radar, a great storm is brewing. It is set to arrive most likely in 2007 and will generate enormous changes within the overall US healthcare market and for lessors currently servicing it.

The impetus for the storm was summed up by Herman H. Kohlman, former national chairman of the Healthcare Financial Management Association, who said, "One of the major reasons that the healthcare industry has had to occupy a reactive position is the absence in this country of a national health policy. We are the only major nation in the western hemisphere that has not, in a formal way, come to a conclusion on what basic level of health care we propose to provide for the members

of our society and whose responsibility it is to provide this basic level to the various groups, such as the aged, the unemployed and the disadvantaged. Yet because we have not developed this basic policy, health care today is being driven primarily by economics, rather than moving forward in a logical manner toward the fulfilment of national health policy objectives."

This insight should come as no surprise to anyone who has been following the evening news or reading the daily newspapers. It reflects a consensus of the problems facing the US healthcare industry today.

What is stunning about the comment is that it was made in 1985.

Flash forward 20+ years and healthcare costs continue to spiral out of control. Congress and several Administrations have refused until now to address many issues, particularly the unsustainable increases in Medicare costs.

The country now faces the prospect of draconian measures that will significantly alter the character of several healthcare segments and will dramatically affect the financial wherewithal of hospitals, corporations and physician practices across the board.

Rumblings of changes began to

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United States

appear in early 2006. They will continue to build as the full impact of the Medicare reimbursement modifications become clearer in 2007 and are made public. There are two areas of particular concern to lessors – outpatient diagnostic imaging and home healthcare – in both of which the leasing industry has substantial focus and exposure.

On a positive note, new healthcare information technology requirements are on the horizon that will provide great opportunities for those in the leasing business.

US healthcare dilemma. Before discussing the changes, it is useful to understand the crux of the US healthcare dilemma and the overall plan for Medicare changes in 2007. The issues and their magnitude are relatively common knowledge.

The US does not compare favourably with other industrialised countries in life expectancy, infant mortality, patient satisfaction and number of doctors *per capita*. Meanwhile, *per capita* healthcare costs are more than 250% higher than the other countries'. This has led the Bush Administration to plan for sweeping changes in Medicare payments commencing in 2007.

While the overall planned impact of these changes is set at around 4%, either positively or negatively, the changes for some hospitals may range as high as 15%–30% for some treatments. In this environment, some institutions may be highly rewarded while others will be extraordinarily hard hit, depending on case mix and degree of specialisation.

The impetus for these changes is a perception that the current system has created imbalances that cause undue financial incentives for the treatment of certain patients and the use of certain protocols. There also is a discrepancy between the reimbursement of many procedures in an in-hospital environment when compared to a more favourable payment in an outpatient setting.

In addition, President Bush's 2004 mandate calling for total paperless billing and a push for increased outcomes reporting will negatively impact institutions that are not able to provide online reporting data. The plan calls for a full market basket update of 3.4% for hospitals submitting quality data but only a 1.4% increase for those not submitting data.

Changes in 2007 incorporate modifications to the current Diagnosis-Related Group (DRG) formula. The Centers for

Medicare and Medicaid Services (CMS) has proposed replacing the current charge-based Health Specific Relative Value methodology with a cost-based system. Additionally, the list of DRGs would be modified to include a severity rating.

The goal is to eliminate imbalances by pushing charges into other areas. This is an outgrowth of significant scrutiny of physician-owned facilities. The number of DRGs would increase from 526 to 861 in 2008. Case severity would be ranked by a score of 1–4 for minor, moderate, major and extreme.

A greater emphasis on medical care, rather than surgical care, could result in an average 6% increase in reimbursement for the former versus a 6% decrease for the latter.

Changes in diagnostic imaging reimbursements. In the area of diagnostic imaging, planned reductions in reimbursement for procedures performed in a physician's office or ambulatory imaging centre are threatening the US\$75bn–US\$100bn radiology and imaging marketplace.

These changes are seen as the result of several factors, such as a higher demand by patients for non-invasive tests and the practice of defensive medicine. It is interesting to note, however, that the number of MRI and CT machines in the US on a *per capita* basis is less than in most other industrialised nations.

Nevertheless, the Deficit Reduction Act of 2005 (DRA) provided for two changes that many providers believe are draconian. The first would cause a reduction in reimbursement for the second and subsequent similar images of contiguous body parts in the same session. This change, to be phased in over two years, would result in a 25% reduction in 2006 and a 50% reduction in 2007.

The second DRA change would place caps on the technical component of imaging services provided in the physician office or ambulatory imaging centre. This reimbursement amount cannot exceed that payable under the Medicare hospital outpatient prospective payment system. Significant lobbying efforts are underway to delay or alter these planned changes.

For lessors in the imaging space, these changes create severe issues. The first is how to protect investments already on the books. A significant increase in both delinquency and defaults can be anticipated if the above measures are adopted as proposed. Secondly, the entire

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methodology of project prove-up and credit analysis will need to be restructured.

Since the early 1990s, the structure of transactions and the credit approval process have become well established. Sophisticated lessors have developed credit-modelling techniques that have ensured a proper risk:reward ratio. With the DRA proposals, those models are out the window.

Home healthcare concerns. A second healthcare segment that is undergoing tremendous change with major implications for the leasing industry is that of home healthcare. This sector already underwent major upheaval six years ago because of reductions in reimbursements.

Those changes created high delinquency rates and losses, many business failures and a significant industry consolidation. Part of the shakeout was necessary and warranted. Since that time, the sector has enjoyed stability – until now.

Most home healthcare leases are traditionally written on a three-year term. The provider of the equipment was reimbursed for as long as the equipment was being used by a patient. When one patient was finished with the equipment, it was used with another and so on.

In 2005, Medicare moved to revise such usage to a rent-to-own scenario for select durable medical equipment. In such situations, once the equipment had been rented to a patient for 12 months, title to the equipment transferred and it becomes the property of the patient.

To complicate matters further, it was proposed that the dealer would be responsible for continued maintenance of the equipment, even though it was no longer in the rental pool.

During 2005, an initiative was undertaken to widen the scope of the equipment categories to include respiratory equipment such as ventilators, respirators and CPAP machines. There is a difference between the House and Senate versions of the bill that would establish the rent-to-own period, with the House providing for a 12-month period and the Senate a 36-month timeframe.

In any event, these changes are causing great disruptions in the marketplace. Among the issues facing lessors is whether 12-month lease terms will be attractive. Much of the equipment is small ticket and it is questionable if sufficient real cash returns will be available to prompt the availability of financing.

Of greater concern is the market's demand for terms longer than 12

months. Will lessors be willing to fund the ever-increasing amount of "air" that will be inherent in the leases as equipment title passes to the patient.

Information technology: A break in the clouds. If there is a silver lining to these dark skies, it may lie in the area of information technology. In April 2004, President Bush mandated that the country develop an automated and integrated Health Information Technology (HIT) system to ensure that every patient's medical records are available at all times. The hope is that this will lead to tremendous cost savings and to the elimination of medical errors.

An ancillary benefit would be in making outcomes reporting more widely available to assist in creating a better-informed consumer. In so doing, there would be great cost savings through the elimination of inefficiencies and a reduction in medical errors. It has been estimated that the full implementation of HIT could save US\$162bn annually.

As the President's mandate takes hold, opportunities for equipment lessors will represent the largest opportunity for the industry within the healthcare sector. The cumulative costs for adoption of the HIT standards are estimated at US\$98bn for hospitals and US\$17.2bn for physicians through 2015.

A study of the costs of implementation for a physician practice reported in the September/October 2005 issue of *Health Affairs* reported an initial average of US\$44,000 per full-time equivalent provider, with an ongoing cost of US\$8,500 per provider per year. This study estimated the average practice would recover their costs in 2.5 years.

A number of healthcare segments may require greater attention in the implementation of the healthcare information technology agenda. This includes pharmacy services. It has been estimated that there are as many as 98,000 deaths each year in the US as a result of medical error – a large percentage of which are the result of patients being administered the wrong medications.

The market for pharmacy automation was estimated to be US\$1.4bn in 2003 and was expected to increase at an average annual growth rate of nearly 12% to US\$2.5bn by 2008. The largest portion of this increase will occur in inpatient pharmacy systems.

Lessors be ready. What is evident from this clamour of change is that the United States is finally beginning to take charge of the healthcare costs in this country

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United States

The Medicare crisis, which has not been as visible as the Social Security debate, is much more daunting and will become critical at a much earlier date.

Despite spending almost 15% of GDP on healthcare, the US still trails the bulk of the western nations in providing medical care to its people, with more than 40 million uninsured citizens. Yet, *per capita* spending of US\$5,267 in 2002 was nearly twice as much as the next closest European country.

Leasing of healthcare equipment has been in fashion over the past several years, with more lessors entering the segment. Some, however, have clearly not recognised the healthcare sector is

unique among leasing markets. Others have reacted neither to the changes that have already begun to occur, nor to the exiting of several segment leaders, either by choice or otherwise.

The past is a mere prelude to the future. Those lessors who want to join this market must accept change or they will surely face real problems down the road, as the healthcare reform storm blows in.

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STATE AND LOCAL TAXES ON EQUIPMENT LEASING

This article is for informational purposes only; it is not intended to be used as tax advice.

Many taxes are not generally applied the same way for automobiles, trucks, equipment and railroad rolling stock. The various taxes with respect to leasing will be treated in relation to the time they occur, rather than on their importance.

Sales and use taxes. Most states have a single sales/use/rental tax on the leasing of equipment. Many of the states which have these taxes require that the leasing companies report and remit tax on the "gross" rents billed or collected from their respective lessees.

The reason for this is obvious in that the gross rentals over the full life of a lease will be greater than the tax on the purchase price. However, in most scenarios, lease rate factors, borrowing rates and the time value of money will in substance make the upfront versus over-the-life collection economics relatively similar.

Illinois, Maine, New Jersey and Ohio require that the lessors pay the sales/use tax up-front at the time the equipment is purchased for lease. The State of Texas differentiates between operating and financing leases, and taxes the financing leases up front.

Arkansas, California, Michigan, Missouri, Nevada, Rhode Island and Tennessee permit the leasing company to

make an *election* either to pay the tax up front on the purchase price, or pay the tax on the rentals.

Tax on the purchase price can be a disadvantage to a leasing company, since it must put out the cash in advance and then collect such *pro-rata* over the life of the lease. This hurts cash flow, and total recovery does not always occur (i.e. bad debts, early terminations, etc.).

However, where allowed, paying tax on the purchase by the leasing company can be advantageous in that it may result in the avoidance of another tax that will be explained later.

Montana, New Hampshire and Oregon do not have a sales/use tax at all. Alaska has no state tax, but the boroughs/counties have such taxes, and some rates are high. Delaware has no state tax, but has a service (use) tax on rental receipts that is assessed against the lessor.

In many states, the localities (cities and counties) have followed suit and have enacted local taxes based on the state law, rules and regulations.

There is a growing trend of local jurisdictions that impose transit district taxes on rental receipts akin to another sales/use tax.

Examples exist in Los Angeles, Santa Clara, San Mateo, San Francisco and Santa Cruz, California; Cook County, Illinois; Philadelphia, Pennsylvania; Austin, Dallas, Ft Worth, Houston and San Antonio, Texas, and Seattle, Washington (see Exhibits A, B and C).

Exemptions from the sales tax. The topic of exemptions is a study all unto itself. Many states, particularly those states basing their revenues on rental receipts, allow a pass-through of an exemption from the exempt lessee to the lessor company.

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Activities: Associate member of the American Automotive Leasing Association.

Genesis Capital Corporation

22372 Rosebriar, Mission Viejo, CA 92692, US. Tel: +1 (949) 476 9304; Fax: +1 (949) 855 9301; Email: gencapca@aol.com. President: Philip D. Pfirrmaun; Managing Director: Andrea C. Roberts.
Activities: Financial advisor to lessees and lessors on new and secondary market lease financings (US\$5m-US\$100m transactions).

Genesis Commercial Capital

17910 Skypark Circle, Suite 105, Irvine, CA 92614, US. Tel: +1 (949) 851 3036; Fax: +1 (949) 851 4946; Email: greg.rieke@gen-cap.com. Contact: Greg Rieke.
Activities: Member of the United Association of Equipment Leasing (JAEL).

Global Aviation Title Insurance Agency LLC

10th Floor, Two Leadership Square, Oklahoma City, OK 73102, US. Tel: +1 (405) 552 2201; Fax: +1 (405) 235 0439; Email: frank.polk@globalaviationtitle.com. President: Frank L. Polk; Also Contact: Scott M. McCreary or Erin M. Van Laanen.
Activities: Insurance agent for First American Transportation Title Insurance Company, in the business of selling aircraft title insurance to owners and lenders, covering any aircraft registered in the United States, and most Geneva Convention countries.

Global Technology Solutions

8318 89th Avenue North, Brooklyn Park, MN 55445, US. Tel: +1 (763) 488 1870; Fax: +1 (763) 488 1875; Email: jon.putnam@gtsinc.biz. Contact: Jon Putnam.
Activities: Member of the United Association of Equipment Leasing (JAEL).

GlobalTech Leasing, Inc.

300 Esplanade Dr, Suite 1960, Oxnard, CA 93036, US. Tel: +1 (800) 414 7654; Fax: +1 (866) 556 7643; Email: csalter@globaltechleasing.com. Contact: Charles W. Salyer
Activities: Member of the United Association of Equipment Leasing (JAEL).

Golden West Financial Services

3130 Harbor Blvd, Suite D2, Costa Mesa, CA 92626, US. Tel: +1 (714) 751 6100; Fax: +1 (714) 431 0715; Email: sltidland@goldenwestfinance.com. Contact: Stephen L. Tidland.
Activities: Member of the United Association of Equipment Leasing (JAEL).