

Statement of

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Before the Subcommittee on Housing and Community Development  
Committee on Banking, Finance and Urban Affairs

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There should be no release of this  
statement before its delivery,  
scheduled for 2:00 p.m. (EDT), May  
17, 1979.



On its surface, the issue before this Subcommittee is relatively narrow: whether or not to support the Department of Housing and Urban Development's decision to prohibit the use of the Federal Housing Administration's (FHA) Section 242 mortgage insurance for hospital projects involving tax-exempt bonds. There are important legal questions involved in this that I will not address. Putting these legal questions aside, however, the issue is broader than it first appears, for it raises several fundamental tax and health policy questions such as:

- o Should the federal government subsidize hospital construction projects?
- o Can hospital costs be restrained by lowering the interest rates paid by hospitals? and
- o Is tax-exempt bond financing an efficient subsidy mechanism?

Before examining each of these questions, I will briefly describe the combination financing plan that is at issue and the benefits claimed for it.

#### GNMA/TAX-EXEMPT BOND COMBINATION FINANCING

Under this form of financing, state or local hospital authorities issue tax-exempt bonds that are secured, not by the hospital itself and its revenues, but by securities of the Government National Mortgage Association (GNMA). These GNMA securities are backed by the full faith and credit of the U.S. government, thus providing gilt-edged security for the bondholders. In order to get the backing of these GNMA securities, however, the mortgage on the hospital must be insured under the Federal Housing Administration's Section 242 hospital mortgage insurance program, since by



law GNMA can only issue securities that are backed by FHA, Veterans' Administration (VA), or Farmer's Home Administration (FmHA) insurance.<sup>1</sup> Thus, getting FHA Section 242 mortgage insurance is the key step in the combination financing operation.

A number of complex steps are required to get GNMA backing for a hospital project. They are set out in detail in the attached Appendix.

The proponents of combination financing argue that it will reduce hospital costs. Because GNMA securities place the full faith and credit of the U.S. government behind the hospital project for which they are issued, bond purchasers are willing to accept a lower interest rate than they otherwise would on tax-exempt bond issues. More importantly, the GNMA guarantee enables many higher-risk projects that could not otherwise be financed in the tax-exempt bond market to gain access to this type of low-cost financing.

Such access can be important to hospitals, because tax-exempt bonds have now become the predominant source of hospital financing. In 1978, over 50 percent of hospital financing was done through tax-exempt bonds, whereas almost no hospital financing was done in this way before 1971.

Reducing the interest costs that hospitals must pay may result in somewhat lower hospital charges. These cost savings are financed, however, by the federal subsidy provided by the tax exemption on the bonds. An

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1. Section 306(G) of the National Housing Act requires GNMA securities to be based on and backed by a trust or pool composed of mortgages that are insured under the National Housing Act, or Title 5 of the Housing Act of 1949, or that are insured or guaranteed under the Serviceman's Readjustment Act of 1949 or Chapter 37 of Title 38 of the United States Code. See 82 Stat. 540, section 309.



important issue, therefore, is whether the hospital cost savings are greater or less than the amount of the federal tax subsidy. Before turning to that question, it may be useful to consider briefly the question of whether the federal government should subsidize hospital construction projects at all.

#### SHOULD THE FEDERAL GOVERNMENT SUBSIDIZE HOSPITAL CONSTRUCTION PROJECTS?

When the FHA Section 242 hospital mortgage insurance program was enacted in the Housing and Urban Development Act of 1968, the House Committee on Banking and Currency concluded that it was needed because of a shortage of hospital beds:

There is a serious shortage of hospital facilities in the Nation today and, even where hospitals presently exist, many of them are in need of extensive expansion and modernization. (House Report No. 1585, June 25, 1968, p. 97.)

This is no longer the case. There are now approximately 150,000 excess hospital beds in the United States. Almost 3 out of every 10 hospital beds in private, short-term hospitals are vacant at any one time. Many analysts believe that this vacancy rate could be reduced without seriously endangering the quality of care in our nation's hospitals. A significant proportion of the days spent in hospitals by patients may also be unnecessary.

A general consensus exists among those who have studied the hospital sector that broad, unrestricted, federal subsidies for hospital construction in the United States are no longer desirable. Reflecting this, grants under the Hill-Burton program--the federal government's main program for





support of hospital construction--have been essentially discontinued. A total of less than \$33 million in grant money is still available, most of it for rehabilitation and modernization of older facilities: between 1963 and 1967 the amount available ranged from \$200 million to \$270 million a year. The Hill- Burton loan guarantee program has also been essentially discontinued. Thus, FHA Section 242 is the only remaining general insurance program for hospital financing. The Carter Administration has further reflected this concern with excess hospital capacity by including provisions in its health planning and hospital cost-containment proposals aimed at reducing the number of hospital beds in the country.

Even if federal support for hospital construction can be justified in some cases, it is doubtful whether reduced interest costs would provide much stimulus. The certificate-of-need process, which requires that all large hospital projects receive approval from a state health planning agency before being built, limits the expansion of hospital facilities. Moreover, interest costs represent a relatively small fraction (usually less than 20 percent) of all construction costs. Lowering interest charges by a few percentage points is not likely to be the crucial factor in determining whether a particular project is undertaken.

As indicated earlier, however, the GNMA/tax- exempt bond combination financing technique may enable some hospitals that otherwise could not get financing at all to enter the tax-exempt bond market. In these cases, combination financing will clearly lead to some hospital construction that would otherwise not take place. The question then is whether a particular



project is especially deserving of a federal subsidy by reason of its unique caseload, location, or some other characteristic. In light of the general excess of hospital facilities nationwide, however, a heavy burden of proof should probably be placed on hospital projects seeking federal subsidies for additional construction.

#### CAN HOSPITAL COSTS BE RESTRAINED BY LOWERING THE INTEREST RATES PAID BY HOSPITALS?

Combination financing is used for two main purposes:

- o To finance new construction or the purchase of new equipment; and
- o To refinance existing, mostly taxable, debt at lower tax-exempt interest rates.<sup>2</sup>

#### New Construction

The use of this technique to finance new hospital construction is likely to be limited to those situations in which the GNMA guarantee is the crucial factor enabling the hospital to gain access to tax-exempt financing. For hospitals that have good bond ratings and ready access to the tax-exempt bond market, the small extra interest rate advantage afforded by the GNMA guarantee is likely to be largely offset by the fees involved in this complex type of financing.

It is difficult to estimate how much additional tax-exempt financing of new construction might be induced by the availability of GNMA guaranties. If the GNMA guaranties stimulate 10 percent more tax-exempt financing each

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2. Refinancing of existing debt was not eligible for FHA Section 242 insurance before last year, when an amendment permitting it was added on the Senate Floor to the Housing and Community Development Amendments of 1978. (Cong. Rec., p. S11253, July 20, 1978.) The Senate amendment was modified in the House-Senate conference to impose somewhat more stringent limitations on refinancing than were contained in the Senate amendment. (H. Rept. No. 95-1972, pp. 86-87.) This change in Section 242 opened the way for the use of combination financing to refinance existing debt.



year, this would represent about \$300 million to \$400 million a year of additional tax-exempt financing and hospital construction.

For those projects that could not go forward without the combination of tax-exempt financing and the GNMA guarantee, or that could do so only at much higher interest rates, it is not clear whether combination financing would increase or reduce hospital costs. If combination financing simply reduces the interest costs on projects without increasing the size or number of new facilities, some reductions in hospital costs will occur. These potential cost reductions are very difficult to estimate, however. If, on the other hand, combination financing results in an increase in hospital capacity, it may raise hospital costs, insofar as new facilities tend to generate additional hospital stays and further increases in the use of medical services. Given the apparent excess of hospital facilities, it is not clear that cost decreases in financing new construction would outweigh cost increases.

#### Refinancing

In the cases where combination financing is used to refinance existing taxable debt at lower, tax-exempt rates, the calculation of hospital cost savings is more straightforward. The costs that the hospital has to pay are reduced by the difference between the taxable and the tax-exempt interest rates. It is not certain, however, whether all of these cost savings will be passed through to consumers in the form of lower hospital charges. In addition, since the cost savings to hospitals are financed with a federal tax subsidy on the tax-exempt bonds, the federal government must be concerned with whether the savings that are passed through are greater or less than the amount of the subsidy.



Reduction in hospital charges. Industry sources estimate the taxable hospital debt outstanding at between \$4 billion and \$8 billion. Not more than \$2.5 billion to \$3.0 billion of this, however, would likely be refinanced through the GNMA/tax-exempt bond plan. Between \$500 million and \$800 million of the taxable debt is accounted for by older issues that already carry relatively low interest rates. Another \$1.3 billion represents issues financed through the Hill-Burton guaranteed loan program. These issues already have a government guarantee equal to that provided by GNMA securities, so they can be refinanced in the tax-exempt market without using the GNMA combination plan. (Several tax-exempt refinancings using the Hill-Burton guarantee have already occurred.)

If \$2 billion of the outstanding taxable debt is refinanced at lower, tax-exempt interest rates, the total reduction in interest costs for the hospitals involved will average about \$50 million a year. This assumes that the taxable interest rates average about 9 percent, and the tax-exempt rates about 6.5 percent.

In the case of the federal government, much of the interest-rate savings would be passed on, because the medicare and medicaid programs both provide reimbursement based on a formula that takes into account changes in hospital interest costs. Since the federal share of total hospital costs at the hospitals likely to be involved in the program is about 50 percent, the federal government would stand to gain about 50 percent of the interest rate savings obtained by hospitals. If the annual interest-rate savings are \$50 million, the federal government would get \$25 million.





For nonfederal payers, it is much less clear that the cost savings obtained by hospitals would be passed on. Blue Cross plans that reimburse hospitals on the basis of costs would receive a proportionate share of the savings, but other private payers (for example, commercial insurers and other Blue Cross plans) might not share in them, because competitive pressures are not likely to force a reduction in charges. There is considerable evidence that competitive pressures in the hospital industry are weak; even when competition is effective, the proportion of hospitals that would benefit substantially is so small that it would not be reflected in the market price.

Federal revenue losses. For each \$1 billion in existing taxable debt that is refinanced at lower tax-exempt rates, the federal government would lose about \$27 million a year in foregone revenues over the life of the bonds.<sup>3</sup> If \$2 billion in taxable debt is refinanced, therefore, the federal government will lose \$54 million a year in lost revenues. This exceeds the estimated total potential interest-rate savings of \$50 million from \$2 billion of refinancing.

#### Other Considerations

Even when the hospital cost savings from the combination financing technique are considered alone, apart from the cost in federal revenues foregone, the savings appear quite small in the context of total hospital

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3. The revenue loss is calculated by multiplying the amount of interest that would have been earned on taxable investments earning 9 percent interest by an assumed marginal tax rate of 30 percent. While investors do not normally shift directly from full taxable to fully tax-exempt investments, an increase in the volume of tax-exempt securities sets off a chain reaction of investment shifts that in the end has the same effect.



costs. Total expenditures by community hospitals in fiscal year 1980 are estimated at over \$75 billion, and the total savings from combination financing of \$50 million would come to less than 0.1 percent of that total. Thus, even if these costs savings were passed on to hospital payers, the overall effect on hospital costs would be very small.

Furthermore, in the event that the Administration's hospital cost-containment bill is passed, lower interest costs to hospitals might actually result in no net cost savings. Under the current Administration bill, interest rate savings provided by combination financing would not affect the hospital's revenue ceiling or any of the other measures used to induce lower costs. Consequently, hospitals could use interest-rate savings to offset cost increases in other parts of their budgets, thus defeating the purpose of the bill. To prevent this from happening, the various formulas in the cost-containment bill would have to be adjusted to take into account the effects of combination financing.

#### IS TAX-EXEMPT BOND FINANCING AN EFFICIENT SUBSIDY MECHANISM?

As indicated earlier, the revenue losses from additional tax-exempt bond issues would be greater than the potential hospital cost savings. Even if these savings were passed on in full in the form of lower hospital charges, the cost to the federal government would exceed the potential benefits to hospital patients and insurers.

This is simply an illustration of the inefficiency of tax-exempt bond financing as a subsidy mechanism. Numerous studies of the tax-exempt bond market have estimated that the federal government loses about \$1.33 in



revenues for each \$1 in interest savings received by the issuers of tax-exempt bonds. The reason is that a significant portion of the subsidy goes to bondholders in high marginal tax brackets rather than to the state and local governments that issue the bonds. In our estimates for the combination financing plan, we have assumed lower revenue losses than these studies suggest. Instead of assuming a marginal tax bracket of around 35 to 40 percent for the purchasers of tax-exempt bonds, as most of these studies do, we assumed a marginal rate of only 30 percent.

The general inefficiency of the tax-exempt bond subsidy mechanism is compounded under the GNMA combination financing plan, since its complex structure requires a number of different steps and a variety of participants, each of whom charges a fee for his services. Since, as noted earlier, approximately 50 percent of all hospital financing is now done through the use of tax-exempt bonds, anything that would make this form of financing more prevalent deserves careful examination.

#### OTHER ISSUES RAISED BY COMBINATION FINANCING

I will now turn to three other issues raised by this form of combination financing.

##### Increased Borrowing Costs for GNMA and State and Local Governments

Combination financing would likely increase the volume of GNMA securities outstanding, now at a level of about \$53.0 billion. As a result, GNMA would probably have to pay somewhat higher interest costs on its securities, thus adding to federal budget outlays. Combination financing could



also result in higher borrowing costs for state and local governments. For each additional \$1 billion in tax-exempt financing stimulated by combination financing, interest rates on all tax-exempt bonds would likely be pushed up by about 0.05 percentage points. Thus, state and local governments could experience higher costs in financing schools, roads, and other projects.

#### A Precedent for Combination Financing of Single-Family and Multifamily Housing

If combination financing were permitted for hospitals, it might stand as a precedent for combination financing of single-family and multifamily housing insured under FHA or other federal insurance programs. The Department of Housing and Urban Development currently permits combination financing for Section 8 multifamily rental projects, but not for other multifamily projects or for single-family housing. If combination financing were permitted for all FHA- and VA-insured housing projects, for example, the revenue losses could become very large.

#### Problems in Financing the Federal Debt

Finally, combination financing might pose problems to the federal government in financing the national debt, because tax-exempt bonds backed by the full faith and credit of the U.S. government might be more attractive than the Treasury's own debt issues. If so, the bonds could make it harder to finance the debt and require the Treasury to pay higher interest rates on Treasury bills. The result would be somewhat higher debt servicing costs and a rise in total federal expenditures.





CONCLUSION

The seemingly narrow proposal to allow Section 242 insurance, GNMA securities, and tax-exempt bonds to be combined in a single financing plan touches on a number of important tax and health policy issues. The full implications of the rapid growth in tax-exempt financing of hospitals during the last five years have not been fully examined by the Congress or the Administration. The combination financing proposal offers this Subcommittee and the committees involved with tax and health policy issues an opportunity to give the issue greater consideration than it has received so far.



## APPENDIX

### HOW GNMA-GUARANTEED FINANCING OPERATES

Obtaining GNMA-guaranteed tax-exempt financing for hospital projects is a complex process that involves the work of many persons.

1. A hospital that is undertaking a new project will retain a bond underwriter to handle the financing. This will also occur in the case of a refinancing--when a hospital is replacing outstanding debt with new debt issues.
2. Once the project has received a certificate of need, the project proceeds as follows:
  - a. The state or local government agency that issues tax-exempt hospital bonds is contacted, and agrees to issue bonds for the project. In four states--California, Hawaii, Alaska, and Missouri--a state or local government must agree to allow the bonds to be issued by the hospital on behalf of the government, because no financing authority is empowered to issue tax-exempt hospital bonds.
  - b. A private lender must agree to lend money to the hospital for the project, and the Federal Housing Administration (FHA) must agree to provide insurance on the mortgage loan under the Section 242 program.



- c. The lender then obtains a commitment from GNMA to allow the lender to issue GNMA securities backed by the mortgage on the hospital project. This step cannot take place until the project has obtained FHA insurance, because GNMA's statutory authority limits it to issuing securities backed by a federal insurance program such as FHA's Section 242.
- d. The government agency that issues the tax-exempt bonds uses the proceeds of the bonds to purchase the GNMA securities from the private lender. The lender then uses the proceeds of the mortgage on the hospital, as they are paid over time, to make payments on the GNMA securities that are now held by the government agency that issued the tax-exempt bonds. The government agency then uses the proceeds from the GNMA securities to make payments to the holders of the tax-exempt securities.
- e. GNMA, for its part, guarantees that the payments on the GNMA securities will continue to be made to the government agency that holds the securities, even if the private lender is unable to make the payments.

