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CAPITAL FINANCING FOR HOSPITALS: THE NEW YORK EXPERIENCE

JOANNE K. HILFERTY†

The state and federal governments have become increasingly concerned with the rapid escalation of hospital capital expenditures because of the implications of such expenditures for the type of health services provided, the number of hospital beds available and the costs of operating hospitals.¹ The Congressional Budget Office estimated that hospital capital expenditures increased by an average of 15.5 percent per annum between 1970 and 1975 and projected that the expenditures, if unchecked, would reach \$8.0 billion in 1978 and \$14.4 billion in 1982.² During the period from 1970 to 1975, the number of hospital beds increased by an average of 2.3 percent per annum resulting in an increase of almost 100,000 beds and driving the number of hospital beds from 4.2 per 1,000 population to 4.5 per 1,000.³ This accounted for a portion of the increase in capital expenditures; inflation and increased assets per bed accounted for the remainder.

Nevertheless, the state and federal governments have been actively involved in promoting capital expenditures through a variety of mechanisms, including the federal Hill-Burton Program, federal hospital mortgage insurance, cost-based reimbursement covering both depreciation and interest under Medicare and Medicaid, and tax-exempt bond financing by state and local governments or entities authorized by those governments. Moreover, the state and federal governments have mandated extensive capital construction by increasing the stringency of life-

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1. See, e.g., INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONTROLLING THE SUPPLY OF HOSPITAL BEDS (1976); W. MCCLURE, REDUCING EXCESS HOSPITAL CAPACITY (1976); Inglehart, *A Field Day for Goldilocks*, 26 NAT'L J. 1060 (1978); Inglehart, *Capital Deformation*, 40 NAT'L J. 1699 (1977); Inglehart, *Stemming Hospital Growth—The Flip Side of Carter's Cost Control Plan*, 23 NAT'L J. 848 (1977).

2. CONGRESSIONAL BUDGET OFFICE, 95th CONG., 1st SESS., HOSPITAL COST CONTAINMENT ACT OF 1977: AN ANALYSIS OF THE ADMINISTRATION'S PROPOSAL 13 (Comm. Print 1977).

3. Somers & Somers, *A Proposed Framework for Health and Health Policy*, 14 INQUIRY 131, 135 (1977).

safety codes and other structural requirements.⁴

Proposals for containing the escalation of hospital capital expenditures have ranged from a nationwide cap on annual capital expenditures,⁵ to a moratorium on all hospital capital expenditures,⁶ to restrictions on tax-exempt financing for hospitals.⁷ Barring an outright moratorium, federal and state governments must more effectively integrate their financing, planning and cost containment strategies by targeting capital construction toward needed services and underserved areas and by assuring that projects undertaken are cost effective.

In order to explore more fully the public policy implications of hospital financing, this article reviews the government financing mechanisms available nationwide and then focuses on the experience in the State of New York. New York provides an interesting case study for two reasons. First, government financing programs for promoting hospital construction and renovation have been used extensively. Second, state officials have closely scrutinized and reevaluated the appropriate role of tax-exempt financing—for housing, mental health, colleges, universities, nursing homes and hospitals—as a result of the serious difficulties the state encountered in the financial markets in 1975 and 1976. The New York experience thus provides useful insights for other states confronting financial constraints.

I. THE EXISTING NATIONWIDE FINANCING MECHANISMS

The two major government financing programs active today—federal insurance on hospital mortgages and tax-exempt bonds issued by

4. The increasingly restrictive conditions of participation for the Medicare program are one example. See also Wing & Sifton, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, this Symposium.

5. This approach was incorporated in Title II of the Carter Administration's proposed Hospital Cost Containment Act of 1977, S. 1391, H.R. 6575, 95th Cong., 1st Sess. (1977).

6. See, e.g., V. FUCHS, WHO SHALL LIVE? 104 (1974).

7. Representative Dan Rostenkowski, Chairman, Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, stated:

[A]t a time when virtually all health economists believe that there must be more restraint exercised in the development of new facilities, tax-exempt financing authorized through Section 103 of the tax code has become the largest hospital construction program in this country.

... The very existence of easily accessible, no-risk, tax-exempt bonds is an inducement to build. Should not the government reevaluate its tax policy which has become the fiscal basis for much new construction in the hospital industry?

Health Priorities: Where Should the Nation Be Going?, A National Journal Conference Proceedings: The Carter Administration, Congress and Health Policy, Washington, D.C., (May 22-23, 1978).

state and local governmental entities—both involve debt financing⁸ secured by a mortgage or a lease. This use of debt is indicative of the trend in hospital financing over the last decade away from philanthropy and government grants.⁹ Indeed, it is now the fastest growing source of hospital capital funds. Although estimates vary, its rapid rise is extensively documented. The American Hospital Association calculates that debt financing's relative position as a source of capital funds for hospitals has increased from 39.5 percent for projects completed in 1968 to 67.9 percent for projects begun in 1976.¹⁰ These figures include both government-related and private lending sources.

Federal and state governments have assisted and reinforced the trend toward debt financing in two ways. First, Medicare and Medicaid—major sources of revenue for hospitals—have reimbursed hospitals for interest and other capital costs.¹¹ Second, the federal and state governments have actually provided sources of debt financing. Hospital construction financed through federal insurance programs or tax-exempt bond proceeds increased from a negligible share of total funding in the late 1960s to 15.2 percent of total hospital construction for insured mortgages and 34.6 percent for tax-exempt bond proceeds in 1976.¹²

8. The federal Hill-Burton program no longer receives appropriations and has been effectively replaced by the resource development program authorized under the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 3001 (1976); see Wing & Craig, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, this Symposium, at text accompanying notes 184-85.

9. Irwin Wolkstein has identified three stages in the history of hospital capital financing. Originally, philanthropy was the primary provider of capital funds. Next, after a hiatus in hospital construction during the Great Depression and World War II, government grants-in-aid played the predominant role. Finally, since the establishment of Medicare and Medicaid in the late 1960's, internally generated funds—primarily from third-party payors—have become the major source by enabling hospitals to accumulate reserves and/or support debt service requirements. Wolkstein, *The Impact of Legislation on Capital Development for Health Facilities*, in G. MACLEOD & M. PERLMAN, *HEALTH CARE CAPITAL: COMPETITION AND CONTROL* 7 (1976).

10. Lightle, *'70s See New Approaches to Capital Financing for Hospitals*, 52 *HOSPITALS* 131 (1978).

11. See Wolkstein, *supra* note 9, at 21-25. In describing the effect of the Medicare and Medicaid program, Lightle commented that "[t]he reimbursement system itself created incentives for debt financing. By permitting depreciation and interest as allowable expenses, the reimbursement system established a mechanism for hospitals to use future revenues to finance capital needs." Lightle, *supra* note 10, at 135.

12. ICF, INC., *TRENDS IN HOSPITAL CONSTRUCTION AND USE OF FEDERAL SUBSIDIES* 14, 31-32 (Phase III Report, Policy Implications, submitted to Health Resources Administration, Dep't HEW, contract no. HRA-230-77-0083, 1978). Tax-exempt financing increased its share from 22.5% in 1973 to 34.6% in 1976; insured mortgages maintained a relatively constant percentage. The figures cited in another study, BOOZ, ALLEN & HAMILTON, *EVALUATION OF FUTURE HOSPITAL CAPITALIZATION* (1978), are somewhat different, but identify a similar trend. Specifically, they indicate that the share of construction expenditures funded by all debt issues has in-

A. Federal Insurance

The federal government lends its credit to hospitals by providing insurance for mortgages securing loans made to hospitals by traditional, private-sector lenders. This insurance is made available to private nonprofit and proprietary acute care hospitals through the Federal Housing Administration (FHA) pursuant to the provisions of Section 242 of Title II of the Housing and Urban Development Act.¹³ The Department of Housing and Urban Development (HUD) regulates the financial aspects of the program, in many cases in conjunction with FHA's housing and other insurance programs. Many of the financing provisions are the same for several programs; for example, the maximum allowable interest rate was set, as of May 1979, at 10 percent per annum for certain FHA loan insurance programs, including its hospital mortgage program, and for all single family mortgage programs.¹⁴ Similarly, the insurance premium paid by a borrower is .5 percent per annum for all FHA insurance programs.¹⁵

HUD delegates the programmatic aspects of the FHA 242 program to the Department of Health, Education, and Welfare (HEW) through a formal agreement.¹⁶ HEW's activities include reviewing applications, monitoring during the construction period, and determining financial feasibility. The criteria for financing have been established to

creased from 58% in 1973 to 78% in 1977, and that the share allocated to tax-exempt bonds has increased from 25% to 45% over the same period.

13. The program was amended in 1968 to allow mortgage insurance for hospitals, but only for private nonprofit, acute care hospitals. P.L. 90-448, § 1501, 82 Stat. 599 (1968) (codified at 12 U.S.C. § 1715z-7 (1976)). Proprietary hospitals were added to the program in 1970. P.L. 91-609, § 110(a), 84 Stat. 1770 (1970) (codified at 12 U.S.C. § 1715 (1976)). The program is designed for hospital projects requiring construction and renovation rather than merely refinancing of existing indebtedness. See 42 C.F.R. §§ 242.21, .93 (1977). The Housing and Community Development Amendments of 1978, 42 U.S.C. § 1715n (Supp. I 1978), did, however, authorize insurance for entire refinancings of hospitals under another HUD program.

14. Memorandum from L. Simons, Assistant Secretary, Dep't HUD, to all approved mortgagees (April 23, 1979) (copy on file in the office of the *North Carolina Law Review*).

15. In exchange for the insurance, the hospitals pay the FHA an application fee and a commitment fee (together amounting to \$3 per thousand) and, in some cases, an inspection fee (\$5 per thousand). 24 C.F.R. §§ 242.3, 7, .9 (1977). They also pay an annual insurance premium of 0.5% of the outstanding mortgage amount. *Id.* § 207.252(a). In addition, the mortgagee may collect an initial service charge of 2% of the original mortgage amount. *Id.* § 242.19. The term of the mortgage is limited to 25 years. *Id.* § 242.35.

16. DEP'T HEW & DEP'T HUD, MEMORANDUM OF AGREEMENT, SECTION 242, NATIONAL HOUSING ACT, AS AMENDED (1978). This superseded an earlier agreement signed in January 1968 and amended in May 1971. *Id.* The 1978 agreement incorporated the National Guidelines for Health Planning (no more than four short-stay conforming beds per 1,000 population and a community-wide occupancy rate in excess of 80%), 42 C.F.R. § 121 (1978). The Secretary of HUD required that these Guidelines be adopted in final form prior to entering into an agreement containing them. See Letter from Patricia Roberts Harris, Secretary of HUD, to Joseph Califano, Secretary of HEW (July 25, 1978) (copy on file in the office of the *North Carolina Law Review*).

avoid, to the extent possible, defaults that could result in claims against the insurance. The loan amount is limited to 90 percent of the estimated replacement value of the project or 90 percent of the cost of development, whichever is lower.¹⁷ As a result, the mortgage is always backed by a facility that is estimated to be of greater value than the loan amount, although it may not have a greater actual market value. Furthermore, prior to approving a loan, HEW must determine that the project is financially feasible based on reasonable assumptions regarding future events.¹⁸ Finally, there must be a demonstrated need in the community for the services to be provided by the hospital as evidenced by the review and approval of state and local health planning agencies.¹⁹ In setting priorities for financing among eligible projects, however, HEW has not worked closely with these agencies.

The left side of Diagram 1 illustrates the security for an investor in an FHA 242 insured hospital. The investor or mortgagee initially relies upon the hospital's agreement to pay debt service and then upon the pledge of the gross revenues of the hospital.²⁰ The additional security accruing to an investor in an FHA 242 mortgage is illustrated by comparing the position of such an investor after a project has defaulted with that of an investor in a similar, but uninsured mortgage.²¹ When the uninsured project's revenues proved to be insufficient to pay debt service, the investor would foreclose on the mortgage and force a sale. With a first lien, the investor would be entitled to priority in distribution of foreclosure sale proceeds. Yet, it is unlikely that a forced sale would yield an amount even approaching the replacement value of the facility and, therefore, unlikely that the investor would recoup the amount of the outstanding mortgage. Moreover, a significant delay would inevitably be involved in realizing any recovery.

17. 24 C.F.R. §§ 242.27, .29(c) (1977). This provision applies to the construction of new projects. The maximum mortgage amount for a rehabilitation project depends upon how the original property is held, and whether there is an outstanding mortgage. *Id.* § 242.29.

18. HEALTH RESOURCES ADMINISTRATION, DEPT HEW, HEALTH CARE FACILITIES LOAN PROGRAM: POLICY AND PROCEDURES MANUAL 60-70 (1976). In addition, the New York Regional Office published more detailed requirements for financial feasibility studies. DIVISION OF RESOURCES DEVELOPMENT, PHS REGIONAL OFFICE II, HEALTH CARE FACILITIES HANDBOOK: FINANCIAL FEASIBILITY REVIEW AND LOAN MONITORING PROCEDURES 11-20 (1977).

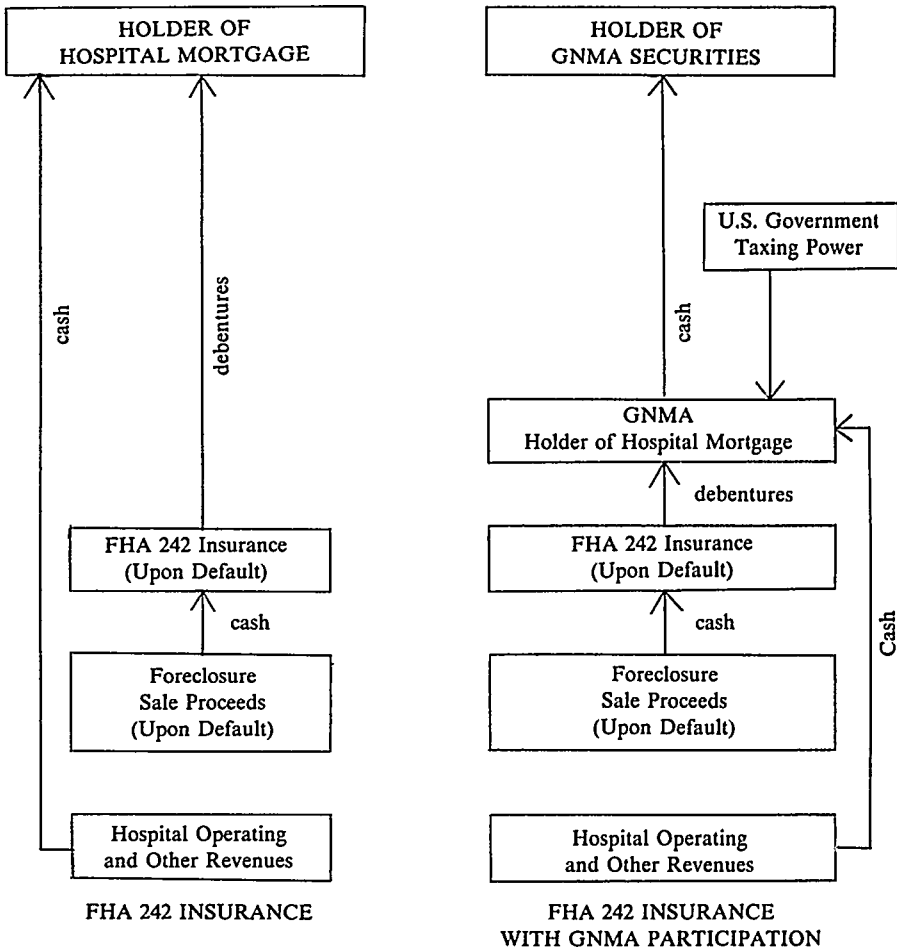
19. 24 C.F.R. § 242.5 (1978). *But see generally* Schonbrun, *Making Certificate of Need Work*, this Symposium.

20. The pledge of revenues can take two forms—all unrestricted revenues ("gross revenues") or unrestricted revenues after payment of operating costs ("net revenues"). Projects benefitting from the FHA 242 program pledge their gross revenues. This device is similar to the traditional "assignment of rents" taken by the mortgage lender on a commercial or residential rental project.

21. The mortgage would be similar in that it constituted a first mortgage lien and was in an amount close to 90% of the replacement value of the project.

DIAGRAM 1

FHA 242 INSURED MORTGAGE FINANCING: STRUCTURE OF SECURITY



When FHA 242 insurance is available, however, the investor avoids both the uncertainties of valuation of the property and the delays of a sale. Upon default, the investor in most cases either assigns the mortgage or conveys the title (which it has acquired through foreclosure or a deed in lieu of foreclosure) to FHA and collects on the insurance an amount equal to the outstanding principal balance of the mortgage.²² When a claim is made, the insurance proceeds are not

22. 24 C.F.R. § 207.258 (1977). In certain very limited cases the mortgagee may choose not

paid in cash but in debentures, a form of registered U.S. Treasury bond. The interest rate on the debentures is set at the time the mortgage is issued and is usually lower than the interest rate on the mortgage. For mortgages entered into on or after January 1, 1979, the debentures are for a term of twenty years and pay an interest rate of eight percent per annum with full payment of principal at the expiration of the twenty years regardless of the term and interest rate of the mortgage loan.²³ (FHA can choose to pay in cash, but historically has chosen not to for the FHA 242 program.) In almost all cases, this form of payment means that the investor does not receive full return on the investment. The interest rate is lower on the debentures than on the original mortgage and will not yield the full value of the mortgage. Similarly, the investor is likely to incur a loss if he elects to sell the debentures for cash since the relatively low interest rate usually requires trading at a discount.

In order to eliminate the risk of investors losing on their investments, and thereby to increase the number of investors interested in the mortgages, the Government National Mortgage Association (GNMA), an organization created to improve liquidity in the market, is often interposed between the mortgage holder and the FHA 242 insurance.²⁴ Under this arrangement, illustrated on the right hand side of Diagram 1, the FHA insured mortgage is pledged to GNMA as backing for its own securities, and the original levels of security then inure to GNMA. The original mortgagee continues to make collections and service the mortgage. If a project defaults, GNMA collects on the FHA 242 insurance, and FHA is responsible for foreclosure. The investor holds GNMA securities and continues to receive full payment in cash whether or not the hospital itself makes required payments. Since GNMA securities are ultimately backed by federal government appropriations, investors face almost no risk of losing principal or interest payments and hold a readily marketable security. Therefore, they are more willing to invest in FHA 242 projects that are combined with GNMA securities than in FHA 242 projects alone.

to call upon the insurance but to foreclose directly and retain the sale proceeds. (This option is not illustrated in Diagram 1.)

23. 24 C.F.R. § 207.259 (1977), *as amended by* 44 Fed. Reg. 23516 (1979).

24. In describing the origin of the GNMA, the Housing and Development Reporter states: "The Government National Mortgage Association . . . provides a secondary market for certain mortgages which would not be well received in the private secondary market. It also provides a source of secondary market financing for other types of mortgages in periods of tight credit." [1979] 7 Hous. & Dev. Rep. (BNA) 81.

As Table 1 indicates, from 1969, when the FHA 242 program began, through September 1977, hospital mortgages were insured for approximately \$1.7 billion, an average of over \$12 million per project.²⁵ There was, however, no consistent trend over that period of time in the number of projects insured each year, the average dollar value of the projects or the total value of insurance issued each year.²⁶

TABLE 1²⁷
FHA-242 MORTGAGE INSURANCE VALUE AND
TOTAL PROJECT VALUE BY YEAR OF APPROVAL, 1969-1977

Year of Approval	Number of Projects	FHA Mortgage Insurance Value	Total Project Value	Average Project Value
		(\$ millions)	(\$ millions)	(\$ millions)
1969	4	\$ 37.68	\$ 55.90	\$13.98
1970	15	113.38	156.68	10.45
1971	20	259.79	345.47	17.27
1972	14	162.43	228.84	16.35
1973	20	225.97	335.06	16.75
1974	15	124.89	252.13	16.81
1975	13	82.25	147.66	11.35
1976	32	603.53	823.50	25.73
1977 (9 mos.)	6	102.27	110.03	13.37
Total	139	\$1,712.19	\$2,475.27	\$17.81

B. Tax-Exempt Financing

State and local governments have assisted nonprofit hospitals in capital financing by providing low cost funds through the issuance of tax-exempt bonds. The first tax-exempt bonds for other than a public hospital were issued by the Connecticut Health and Educational Facilities Authority in 1967.²⁸ Since that time, forty-eight states have authorized such tax-exempt financing. Some have set up statewide hospital financing programs in either discrete health financing authorities²⁹ or in authorities financing other projects such as educational facilities.³⁰

25. The FHA 242 mortgage represented, on the average, 69.2% of the value of the total project.

26. ICF, INC., *supra* note 12, at 68.

27. The source for this table is *id.* at 17.

28. Letter from Robert C. Hector, Executive Director, State of Connecticut Health and Educational Facilities Authority, to author (March 30, 1979) (copy on file in the office of the *North Carolina Law Review*). The bonds were sold competitively at a net interest cost of 5.7%. *Id.*

29. Examples include the New Jersey Health Care Facilities Financing Authority, N.J. STAT. ANN. § 26-21 (West Cum. Supp. 1978), and the North Carolina Medical Care Commission, N.C. GEN. STAT. § 131A (Supp. 1977).

30. Examples include the Connecticut Health and Educational Facilities Authority, CONN.

Others have authorized local governmental units to issue tax-exempt bonds for hospitals.³¹ Table 2 outlines the options available to hospitals in each state. The state and local governments expect two major benefits from authorizing and providing tax-exempt financing. First, hospital construction is encouraged—an important consideration where expansion or modernization and renovation is desired. Second, to the extent tax-exempt financing is substituted for financing with higher interest costs, expenditures for health care are lowered. The direct benefits to states in lower expenditures for Medicaid are somewhat offset by a loss of state (and local) income tax collections in states with such taxes, and in which the income on the bonds is exempt. Most of the tax revenue loss occurs, however, at the federal level.³²

The legal structure and program guidelines imposed on participating hospitals vary widely across states and, in some cases, across programs within states. For example, the agreement between the financing authority and the hospital can be in the form of a mortgage or a lease; the Dormitory Authority of the State of New York has issued bonds backed by both forms of agreement. The Authority may require a first mortgage lien on the entire hospital, regardless of the portion of the hospital actually involved in the construction project, or require a lien only on the specific asset financed.³³ The New York State Housing Finance Agency has taken the former position³⁴ and the Idaho Health

GEN. STAT. ANN. § 10-335 (West Cum. Supp. 1979), and the Massachusetts Health and Educational Facilities Authority, MASS. GEN. LAWS ANN. ch. 53, §§ 1-23 (Law. Co-op. 1979).

31. In Pennsylvania, for example, there are over fifty local authorities that have issued tax-exempt hospital bonds. See BUTCHER & SINGER, INC., HOSPITAL AUTHORITIES OF THE COMMONWEALTH OF PENNSYLVANIA DECEMBER 31, 1978 YEAR-END BOND VALUATIONS (1979) (copy on file in the office of the *North Carolina Law Review*). See also PA. CONS. STAT. ANN. § 2199.5 (Purdon Supp. 1979).

32. See 16 PA. CONS. STAT. ANN., § 2199.5 (Purdon Supp. 1979); J. PETERSON, CHANGING CONDITIONS IN THE MARKET FOR STATE AND LOCAL SECURITIES (1976). See generally JOINT ECONOMIC COMMITTEE, 94th CONG., 2d SESS., CHANGING CONDITIONS IN THE MARKET FOR STATE AND LOCAL GOVERNMENT DEBT (Comm. Print 1976).

33. The major advantages of a first mortgage lien on the entire hospital are that all of the revenues of the hospital are pledged and that, in case of foreclosure, the property obtained will be an operating hospital. The major advantages of obtaining a first mortgage lien on only that portion of the hospital financed are that a revenue producing entity such as a laundry can be financed without disturbing existing financing arrangements, and that new mortgages for additional construction can be obtained from alternate sources without refinancing the existing mortgage.

34. N.Y. PUB. HEALTH LAW § 2874 (McKinney 1979).

TABLE 2³⁵

HEALTH FACILITIES FINANCING AUTHORITIES

State	State Authority For Issuing Tax-Exempt Bonds	State Legislation Enabling Governmental Units to Issue Tax-Exempt Bonds
Alabama	—	X
Alaska	(1)	—
Arizona	(2)	X
Arkansas	—	X
California	—	—
Colorado	X	X
Connecticut	X	—
Delaware	X	—
District of Columbia	—	—
Florida	—	X
Georgia	—	X
Hawaii	X	—
Idaho	X	—
Illinois	X	X
Indiana	—	X
Iowa	—	X
Kansas	—	X
Kentucky	(2)	X
Louisiana	X	X
Maine	X	—
Maryland	X	—
Massachusetts	X	—
Michigan	X	X
Minnesota	—	X
Mississippi	—	X
Missouri	(3)	—
Montana	—	X
Nebraska	—	X
Nevada	—	—
New Hampshire	X	—
New Jersey	X	—
New Mexico	—	X
New York	X	(4)
North Carolina	X	X
North Dakota	—	X
Ohio	—	X
Oklahoma	—	X
Oregon	—	X
Pennsylvania	—	X
Rhode Island	X	—
South Carolina	—	X
South Dakota	X	X
Tennessee	—	X
Texas	—	X
Utah	—	X
Vermont	X	—
Virginia	—	X
Washington	(3)	—
West Virginia	—	X
Wisconsin	(3)	X
Wyoming	—	X
Total	24 (18 active)	34

(1) Statute requires amendment. (2) Established but inactive.

(3) Awaiting test case. (4) Suffolk County only.

Facilities Authority the latter.³⁶ Finally, the terms of the agreements vary greatly. The variables include duration of the loan, repayment schedule (level principal, level debt service or some other arrangement), maximum loan size, availability of construction financing, availability of equipment financing, amount of refinancing permitted and amount of total project cost that the hospital must raise from its own funds.

The initial security for all bonds is the capacity of the financed hospital to generate sufficient revenue to repay interest, principal, and required reserves as well as to continue meeting operating costs. The financing programs vary, however, in the additional tiers of security they provide the investors.³⁷ The first potential level of security above the revenue generating capacity of the hospital is a debt-service reserve fund sufficient to pay the hospital's debt service obligations for a certain period of time (usually less than two years) while the hospital is encountering short-term financial problems or foreclosure proceedings are underway. Bonds secured by the revenue stream of a hospital or by the revenue stream plus a debt-service reserve fund are revenue bonds. The next potential level of security is a pledge by a governmental entity to repay the bonds if the hospital cannot. Such a pledge can take two forms: a "moral obligation" under which a governmental entity is authorized but not legally required to make funds available for payments, or a "legal obligation" or "general obligation" under which a governmental entity is required to make payments and must even raise taxes if necessary to meet the debt service obligations. Examples of both types are illustrated in Diagram 2; numerous variations involving different combinations of security tiers exist.

In addition to the type of security, the marketability of bonds and their interest rates depend upon the credibility and reputation of the issuing entity in the market, the creditworthiness of the particular hospital, the extent to which the bonds are collateralized, the type of hospital reimbursement in the particular state, the extent to which interest

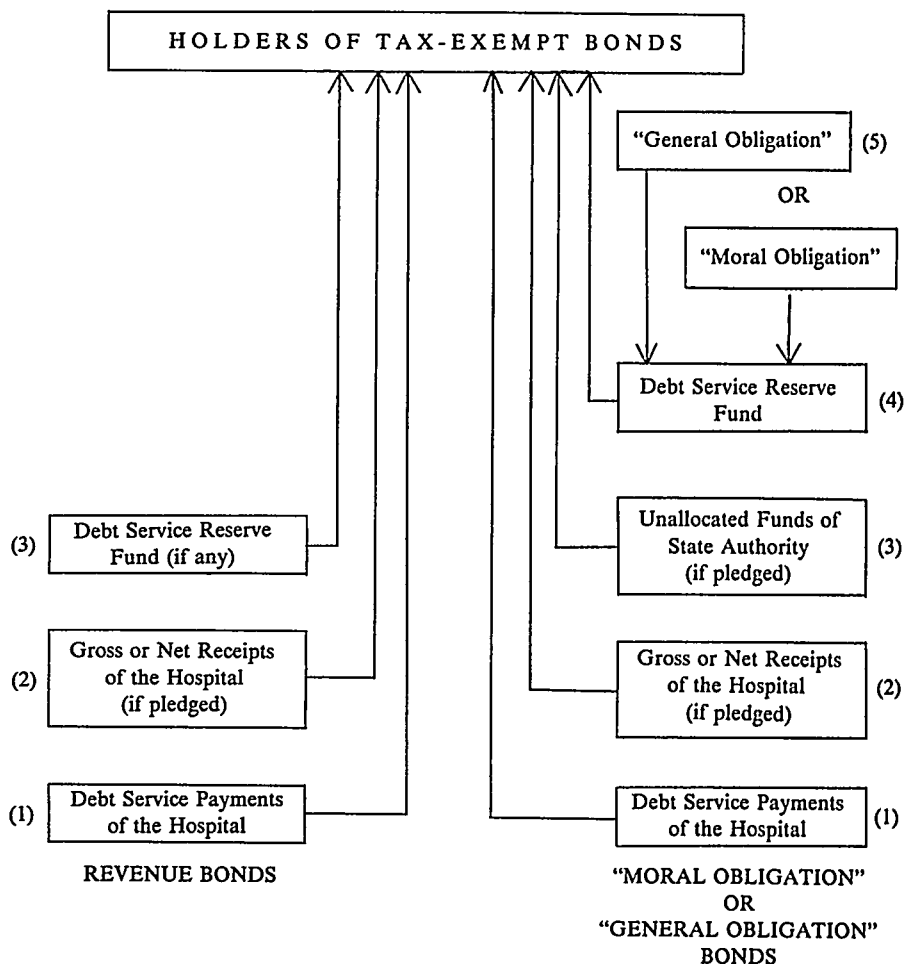
the Council of Health Facilities Financing Authorities, Spring Meeting (Feb. 28-March 3, 1979, Denver, Colo.).

36. IDAHO CODE § 39-1450 (1978 Supp.).

37. For example, to secure the pledge of payment by the hospital, most authorities, before turning to another level of security, require a pledge of the gross or net revenues of the hospital and establishment of a mechanism to assure access to such revenues if the hospital fails to make a required payment. For a definition of gross and net revenue pledges, see note 20 *supra*. See, e.g., Regulatory Agreement Between Lutheran Medical Center and Commissioner of Health of the State of New York (Nov. 19, 1974) [hereinafter cited as Regulatory Agreement] (copy on file in the office of the *North Carolina Law Review*).

DIAGRAM 2

TAX-EXEMPT BOND FINANCING: STRUCTURE OF SECURITY



payments on the bonds are tax exempt (federal, state, and local), the term of the bonds, the size of the issue, the rating assigned by the principal rating agencies (Moody's Investors Service, Inc. and Standard and Poor's Corp.), whether the bonds are publicly sold or privately placed, and the market conditions at the time the bonds are sold.³⁸ The range of interest rates on tax-exempt hospital bonds is a substantial reflection of this array of variables. In 1978, the interest rates ranged

38. For a discussion of characteristics of bond issues that affect marketability, see NEW YORK INSTITUTE OF FINANCE, FUNDAMENTALS OF MUNICIPAL BONDS 27-31 (rev. ed. 1978).

from 4.2 percent on a \$345,000 general obligation issue of the Kalkaska County (Michigan) Hospital Authority, to 9.8 percent on a \$4.9 million revenue issue of the Huntsville (Alabama) Medical Clinic Board.³⁹ Wide variations occur even among the issues of a single authority. For example, in 1978, the Maryland Health and Higher Educational Facilities Authority sold one \$10 million issue at an interest rate of 6.75 percent⁴⁰ and another issue of over \$15 million at 8 percent.⁴¹

From 1972 to 1977, total tax-exempt financing for hospitals nationwide was estimated at \$12 billion, of which an estimated \$3.2 billion was for refinancing existing indebtedness, \$5.8 billion for actual construction, and \$3.0 billion for capitalized interest, debt service reserve fund deposits and other nonconstruction costs.⁴² Annual tax-exempt financing for hospitals escalated from an estimated \$.5 billion in 1972 to \$4.9 billion in 1977.⁴³ The use, however, was not evenly distributed across the country—fifteen states accounted for over 75 percent of all tax-exempt financing.⁴⁴

39. Winders, *Tax Exempt Financing for Hospitals Drops 34% in '78 to \$3,121,689,400*, THE DAILY BOND BUYER, January 19, 1979, at 1, 10-13.

40. Official Statement, \$10,030,000, Maryland Health and Higher Educational Facilities Authority, Revenue Bonds, Suburban Hospital Issue, Series A (June 28, 1978) (copy on file in the office of the *North Carolina Law Review*).

41. Official Statement, \$15,290,000 Maryland Health and Higher Educational Facilities Authority, Revenue Bonds, Howard County General Hospital Issue, Series A (November 21, 1978) (copy on file in the office of the *North Carolina Law Review*).

42. See ICF, INC., *supra* note 12, at 15 (Table 11-7). Two major sources of data on tax-exempt financing by hospitals are the American Hospital Association's *Survey of the Sources of Funding for Hospital Construction*, which appears annually in HOSPITALS, and THE DAILY BOND BUYER. The American Hospital Association *Survey* does not cover the universe of hospitals in the United States and involves only construction financing and not refinancing. THE DAILY BOND BUYER reports all public and some negotiated sales of hospital tax-exempt revenue bonds. It is not possible, however, to extrapolate the number of hospitals involved because some authorities finance multiple projects in a single bond issue, others finance a single project in more than one bond issue, and some finance and then refinance the same project. Moreover, all negotiated sales are not reflected. As a result there are no accurate estimates of the number of hospitals that have received the benefits of tax-exempt financing.

During 1977 and early 1978 when interest rates were at a low ebb relative to earlier periods, a significant number of advance refundings of hospital revenue bonds were undertaken. In an advance refunding, bonds are issued to redeem bonds that are outstanding at a higher interest rate. The primary goal of such refundings is, in most cases, to lower interest costs over the life of a bond issue. However, the Internal Revenue Service proposed restrictive regulations in September 1978, 43 Fed. Reg. 39,822 (1978), revised in October, 43 Fed. Reg. 19,675 (1978) and issued in final form in June 1979, 44 Fed. Reg. 32,657 (1979). These regulations work to limit the amount of costs of issuance that could be included within the arbitrage limitation, and therefore constrained the number of projects for which advance refunding was advantageous. Even before the regulations were adopted in final form, authorities complied with them to avoid the consequences of a potential future determination that bonds issued subsequent to the proposed regulations are arbitrage bonds and therefore not exempt from federal income taxes.

43. ICF, INC., *supra* note 12, at 15.

44. *Id.*

C. Combined Federally Insured Tax-Exempt Financing

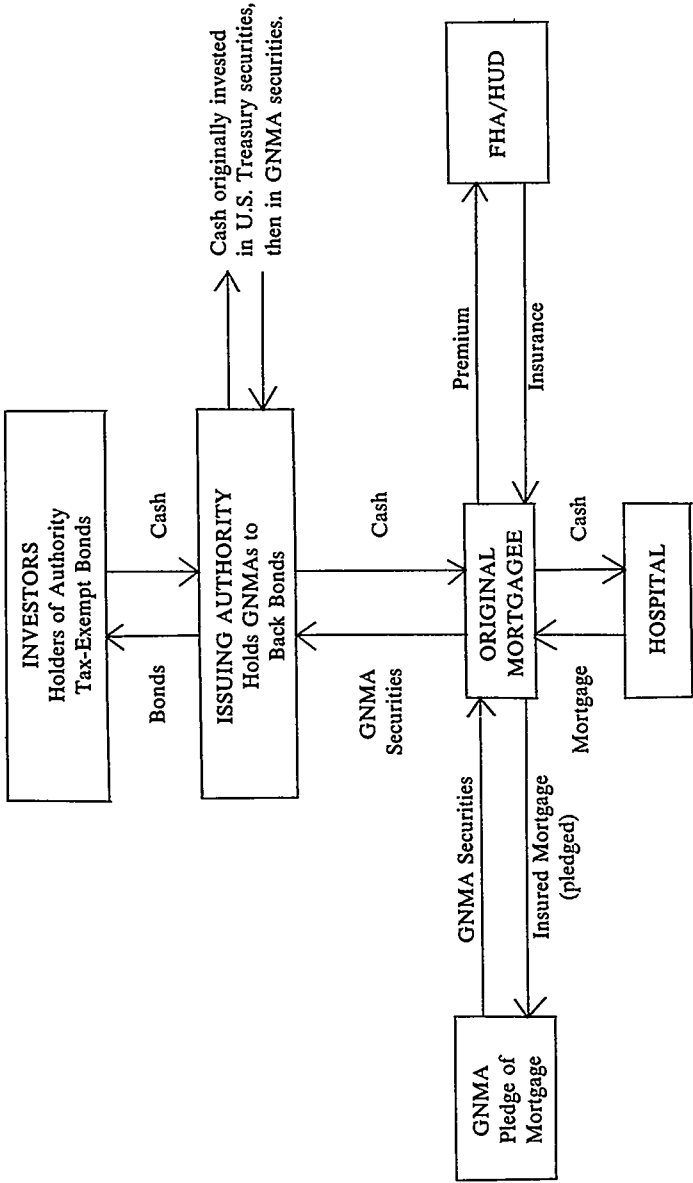
Recently, FHA 242 insurance with GNMA participation was combined with tax-exempt financing, resulting in significantly lower long-term interest rates than a hospital could have obtained from either a conventional FHA 242/GNMA combination or tax-exempt financing alone.⁴⁵ As depicted in Diagram 3, the participants included the hospital, the hospital financing authority, FHA, GNMA, and a financial organization that is both an FHA-approved mortgagee and an approved issuer of GNMA securities (the original mortgagee). The hospital arranged for FHA 242 insurance and a commitment from GNMA for issuance of GNMA mortgage-backed securities. Simultaneous with the mortgage closing, the authority issued tax-exempt bonds and agreed to use the proceeds to purchase GNMA securities as they were issued. In the meantime, the proceeds of the authority's tax-exempt bond issue were invested in United States Government obligations. When the hospital drew down the mortgage funds from the original mortgagee, GNMA issued securities in the amount of the advance. The authority liquidated its investment of the bond proceeds and purchased the GNMA securities from the original mortgagee. The original mortgagee's investment was taken out with each advance. Ultimately, the original mortgagee had no financial investment but remained the mortgagee of record. The risk of the investor in the authority bonds was de minimus throughout this process: authority bonds were backed at all times by United States Government obligations. The first financing of this type was accomplished by the Dormitory Authority of the State of New York in August 1978.⁴⁶

From the point of view of the hospitals and the states, this was the ideal financing method: the hospital paid an exceptionally low interest rate, and the state or state authority had virtually no risk. Within the federal government, however, serious questions were raised regarding the appropriateness of combining exemption from federal income tax with what is essentially a federally guaranteed security. The first concern was the amount of federal subsidy provided. Early in the discus-

45. BLYTH EASTMAN DILLON HEALTH CARE FUNDING, INC., *FHA/GNMA/TAX-EXEMPT COMBINATION PROGRAM—A NEW FINANCING ALTERNATIVE FOR HOSPITALS* (1978).

46. Private Placement Memorandum, Dormitory Authority of the State of New York, GNMA Collateralized Bond Issue: The Elizabeth A. Horton Memorial Hospital, Middletown, New York (July 5, 1978) (copy on file in the office of the *North Carolina Law Review*).

DIAGRAM 3
COMBINED FEDERALLY INSURED, TAX-EXEMPT FINANCING



sions of this methodology, the President of GNMA summarized the issue:

[W]e are concerned with the broad policy implications of knowingly guaranteeing securities which will in turn be used to collateralize tax exempt local debt. The use of tax exempt debt reduces Federal Government revenues and this loss of revenues represents a subsidy to the bond issuers that must be paid for by taxpayers in general.⁴⁷

The second concern was the extent of the security provided to the holders of tax-exempt bonds: "The Treasury has traditionally opposed the combination of federal guarantees and tax exemption on the grounds that it creates a security which is better than the government's own obligations."⁴⁸ The third concern was that the financial configuration entirely removed the financial feasibility of the hospital project itself from the scrutiny of the marketplace. The tax-exempt bonds were rated and purchased on the basis of the guarantee of the federal government. Finally, the methodology was being pursued (but was never applied) in the housing area, which had a much larger potential volume and, therefore, a greater potential for draining the federal coffers by reducing income tax collections.

As a result of these concerns, this method of hospital financing was discontinued by HUD in early 1979 for hospitals and proscribed for all housing except low-income, multi-family subsidized housing.⁴⁹ At the time, only four hospital financings using this method had been completed throughout the country,⁵⁰ but a significant number of applications were pending. The negative aspects of these combination financings—especially the loss of tax revenue—apparently outweighed the salutary effects of lower health care costs. Efforts to reverse this decision, including a suit by one hospital closed out of the program⁵¹

47. Letter from John Dalton, President, GNMA, to J. Christopher McCurdy, Assistant Vice President, Mercantile Mortgage Company (June 14, 1978). Dalton eventually approved a project that employed the methodology; Letter from John Dalton to Edward Shapoff, Senior Vice President, Blyth Eastman Dillon Health Care Funding, Inc. (July 21, 1978) (copies on file in the office of the *North Carolina Law Review*).

48. [1978] 6 HOUS. & DEV. REP. (BNA) 426.

49. Telegram from Lawrence Simons, Assistant Secretary, HUD, to all Regional Housing Administrators, Area Office Managers, and Insuring Office Directors (March 29, 1979) (copy on file in the office of the *North Carolina Law Review*); see Ferris, *HUD Eliminates Federal Guarantees of Housing, Hospital Bond Issues*, THE DAILY BOND BUYER, April 5, 1979, at 1, 18.

50. The four projects were: Elizabeth A. Horton Memorial Hospital, Dormitory Authority of the State of New York, \$26,078,100; United Hospital, Dormitory Authority of the State of New York, \$19,890,000; Raritan Bay Health Services Corporation, New Jersey Health Care Facilities Financing Authority, \$22,610,000; Walther Memorial Hospital, \$9,013,700, Illinois Health Facilities Authority.

51. Beth Israel Medical Center v. Harris, No. 79-1038 (D.D.C., filed April 11, 1979).

and a vigorous campaign by underwriting firms, have been unsuccessful to date. Unless there is a policy or statutory change,⁵² the four outstanding projects will remain anomalies.

II. GOVERNMENT FINANCING IN NEW YORK

The State of New York's entry into the arena of tax-exempt financing for hospitals was closely linked with its early efforts at health planning. In 1964, the state established a statewide health planning network—the first certificate of need program in the nation.⁵³ The original approach was modified and strengthened in 1965⁵⁴ as a result of the recommendations of a citizen's group appointed by the Governor to review hospital services.⁵⁵ The regulation of hospitals was consolidated in one agency, the Department of Health (Department). The Department was given authority not only to approve construction proposals, but also to control reimbursement and review quality of care.

The citizen's group outlined the steps they believed were required for planning a better health care system within the state.⁵⁶ An impor-

52. U.S. Representative John J. Cavanaugh has indicated that he will introduce legislation "grandfathering" hospital projects that were under consideration at the time the HUD decision was made. See Ferris, *Plan to Allow HUD Hospital Deals to Proceed is Expected Today*, THE DAILY BOND BUYER, June 6, 1979, at 1, 18; *Treasury Expresses Misgivings About HUD Hospital Bonds*, THE DAILY BOND BUYER, May 23, 1979, at 1; *Compromise Measure Eyed to "Grandfather" Hospital Deals*, THE DAILY BOND BUYER, May 21, 1979, at 15.

53. Act of April 22, 1964, ch. 730, 1964 N.Y. Laws 1883 (codified at N.Y. PUB. HEALTH LAW § 2904(a) (McKinney 1977)), created the Hospital Review and Planning Council (HRPC), comprised primarily of representatives of the health care delivery industry, and seven regional hospital planning councils. The HRPC, with the advice of the regional councils, was to consider and review all applications for the incorporation or establishment of new health institutions, and all proposals for construction or renovation. In addition, this Act established the four fundamental tests for approval of establishment or construction by the Department of Health or, at the time, the Board of Social Welfare: (i) public need, (ii) character and competence of sponsor or owner, (iii) financial resources, (iv) such other matters as it shall deem pertinent. *Id.* § 2801(a)(2).

54. Act of July 19, 1965, ch. 795, 1965 N.Y. Laws 1873 (codified at N.Y. PUB. HEALTH LAW §§ 2800-2809 (McKinney 1977)).

55. The Governor's Committee on Hospital Costs was a committee of citizens appointed on May 25, 1964, by Governor Nelson A. Rockefeller. Report of the Governor's Committee on Hospital Costs 2 (1965). The mandate to the Committee was:

(1) to study the costs of general hospital care in the State and to make recommendations as to how hospitals may best provide high quality care at the lowest possible cost and (2) to examine the present apportionment of responsibility among State agencies concerned with hospital care and to make recommendations as to how the responsibility of State government may be most effectively carried out.

Id.

56. The objectives of the planning process envisioned by the Committee were as follows:

(1) Inventory the existing health care system (During this step the interrelationships among facilities would be defined, such as the effect additional long term care beds would have on the need for acute care hospital beds within an area.), (2) Define a health

tant tool for implementing the plan was a program for financing hospital plant modernization, rehabilitation and replacement:

The Committee stresses the community nature of the responsibility for making up the backlog of plant needs, both those of obsolescence and those of currently needed but unbuilt structures. It also calls attention to the opportunity implicit in broad-based community financing for replenishment and expansion of plant to impart systematic community-wide pattern to the configuration of facilities. This can be done by making public financing contingent upon the compliance of sponsors with the specifications and ideals of well-conceived community plans.⁵⁷

The Committee called for a major program of state funding for these projects, preferably through low-interest, long-term loans. This recommendation was implemented for nursing homes in 1966⁵⁸ and for hospitals in 1970.⁵⁹

The hospital financing program that was created reflected the legislative intent of the statute:

Many hospitals and other health facilities throughout the state are becoming obsolete and are no longer adequate to meet the needs of modern medicine. As a result of rapid technological changes, such facilities require substantial structural or functional changes. Others are unsuited for continued use by virtue of their existing plants and

care system which matches appropriate resources to people's health needs (This kind of system could remove duplicative services, assure accessibility to health care, and minimize the number of people receiving care in excess of their needs.), and (3) Design a "plan of action" which would be a goal oriented planning process showing how to move from the existing to the desired health care system.

LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW, HEALTH PLANNING IN NEW YORK STATE S-1 to S-2 (Program Audit, January 3, 1977).

57. Report of the Governor's Committee on Hospital Costs, *supra* note 55, at 77. The Committee also recommended a similar program for nursing homes. *Id.* at 77-78.

58. In 1965 the New York Legislature gave final approval to an amendment of the New York Constitution which recognized the public purpose of providing nursing home accommodations to individuals with low income. The amendment, which modified art. 4, §§ 1, 2, was approved at the 1965 general election and became effective on January 1, 1966. *See* 1966 N.Y. Laws 3552-53 (appendix). The legislature implemented the constitutional authorization in 1966 by enacting the Nursing Home Companies Law, 1966 N.Y. Laws 2425 (codified at N.Y. PUB. HEALTH LAW §§ 2850-2866 (McKinney 1977)), and amending the Private Housing Finance Law to authorize the New York State Housing Finance Agency (HFA) to issue bonds for nursing homes, Act of July 28, 1966, ch. 813, 1966 N.Y. Laws 2435 (codified at N.Y. PUB. HEALTH LAW §§ 2850-2866 (McKinney 1977)).

59. In 1969, the Legislature gave final approval to an amendment of the New York Constitution which established a new § 7 of art. XVII authorizing loans to hospitals. The amendment was approved at the 1969 general election and became effective on January 1, 1970. *See* 1970 N.Y. Laws 3530 (appendix). During 1969, the legislature enacted the Hospital Mortgage Loan Construction Law, 1969 N.Y. Laws 2602 (codified at N.Y. PUB. HEALTH LAW §§ 2870-2882 (McKinney 1977)) and amended the Private Housing Finance Law to authorize HFA to issue bonds for hospitals. The law was to become effective only in the event that the constitutional amendment was approved by the electorate. *Id.*

should be replaced. Such inadequate and outmoded facilities deny to the people of the state the benefits of health care of the highest quality, efficiency, and promptly provided at a reasonable cost
⁶⁰

A. *Housing Finance Agency*

The New York State Housing Finance Agency (HFA) was the agency designated to implement this program. A brief review of the history of HFA explains this designation as well as the financial and programmatic structure of the hospital program. When created in 1960, HFA's mandate was to finance the construction of low and middle-income, multi-family housing throughout the state by selling bonds to the private sector to obtain funds to make mortgage loans.⁶¹ It was an independent public benefit corporation chartered by a special act of the legislature in response to growing voter reluctance to approve referenda authorizing state financing of housing by the issuance of state debt.⁶²

New York and other states had frequently by-passed voter referenda and other constitutional limitations on debt issuance by creating independent authorities to issue revenue bonds, but HFA was the first such authority created to finance privately owned housing.⁶³ The security for HFA bonds was different from that of earlier bonds. The "moral obligation" of the state was explicitly stated as additional security for the bonds.⁶⁴ This tier of security was necessary to improve the

60. Act of May 26, 1969, ch. 1035, 1969 N.Y. Laws 2602 (codified at N.Y. PUB. HEALTH LAW § 2871 (McKinney 1977)).

61. See New York State Housing Agency Act, N.Y. PRIV. HOUS. FIN. LAW § 41(2) (McKinney 1976).

62. MORELAND ACT COMMISSION ON THE URBAN DEVELOPMENT CORP. AND OTHER STATE FINANCING AGENCIES, RESTORING CREDIT AND CONFIDENCE: A REFORM PROGRAM FOR NEW YORK STATE AND ITS PUBLIC AUTHORITIES 88 (1976) [hereinafter cited as MORELAND ACT COMMISSION]. For a brief summary of the origin and history of HFA see A. WALSH, THE PUBLIC'S BUSINESS 129-40 (1978).

63. For a discussion of the manner in which New York and other states have circumvented debt limitations and referenda requirements, see Utevsky, *The Future of Nonguaranteed Bond Financing in New York*, 45 FORDHAM L. REV. 863 (1977).

64. The actual wording of the so called "moral obligation" provision is as follows:

In order further to assure the maintenance of such debt service reserve funds, there shall be annually apportioned and paid to the agency for deposit in each debt service reserve fund such sum, if any, as shall be certified by the chairman . . . to the governor and director of the budget as necessary to restore such reserve fund to an amount equal to the maximum amount of principal and interest maturing and becoming due and sinking fund payments required to be made in any succeeding calendar year on the . . . bonds of the agency then outstanding and secured by such reserve fund. The chairman . . . shall annually, on or before December first, make and deliver to the governor and director of the budget his certificate stating the sum, if any, required to restore each such reserve

marketability of the bonds.⁶⁵ Also, HFA bonds were backed by the revenues of a number of projects—a “pool”—rather than the revenues of an individual project.⁶⁶ This avoided the more expensive and time consuming process of selling a myriad of small bond issues, and provided additional security for investors.⁶⁷

The HFA, unlike the Port of New York Authority,⁶⁸ the New York Power Authority, and other authorities in existence at the time, was primarily a financing, and not a development authority.⁶⁹ As a consequence, in the housing program the private sponsor of the housing project was responsible for project plan, design and construction, and a separate state regulatory agency supervised all aspects of the project from construction to operation.⁷⁰

Almost as soon as it began, HFA's role was expanded. It was authorized to finance construction of the State University system in 1962,⁷¹ mental hygiene facilities in 1963⁷² and municipal health facilities in 1968.⁷³ The bonds for each program were independently secured, one from the other, by a separate one-year debt service reserve fund and the assets and revenues were segregated and separately pledged.⁷⁴

The hospital and nursing home programs were logical additions to

fund to the amount aforesaid, and the sum or sums so certified, if any, shall be apportioned and paid to the agency during the then current state fiscal year.

N.Y. PRIV. HOUS. FIN. LAW § 47(5)(c) (McKinney 1976).¹

65. For a discussion of the origin of the “moral obligation” concept, and the perceptions of the individuals involved in establishing the first “moral obligation” bonds for HFA, see MORELAND ACT COMMISSION, *supra* note 62, at 108-15, and A. WALSH, *supra* note 62, at 129-33.

66. While the individual bonds cannot be identified with a particular project, the proceeds of the bond and note issues are strictly segregated on a project by project basis. Therefore, the projects for which the proceeds are to be used and the amounts for each project are specifically identified at the time of the bond or note sale. MORELAND ACT COMMISSION, *supra* note 62, at 96-97.

67. Many of HFA's mortgages, especially housing and nursing home mortgages, are for relatively small amounts (less than \$10 million). Some of the costs of a bond issue do not vary significantly with the size of the issue so there are economies of scale (both for expenses and for record-keeping) in undertaking pooled issues. *Id.*

68. The “Port of New York Authority” is now known as the “Port Authority of New York and New Jersey.” See N.Y. UNCONSOL. LAWS § 6404 (McKinney 1979).

69. MORELAND ACT COMMISSION, *supra* note 62, at 86-97.

70. The Commissioner of Housing and Community Renewal was responsible for such supervision. See N.Y. PRIV. HOUS. LAW §§ 43, 44, 44-a, 44-b, 50, 55 (McKinney 1976).

71. Act of March 30, 1962, ch. 251, § 381, 1962 N.Y. Laws 1073 (codified at N.Y. PRIV. HOUS. FIN. LAW § 47-a (McKinney 1976)).

72. Act of April 30, 1963, ch. 932, § 29-1, 1963 N.Y. Laws 2867 (codified at N.Y. UNCONSOL. LAWS § 4414 (McKinney 1979)).

73. Health and Mental Hygiene Facilities Improvement Act, ch. 359, § 14, 1968 N.Y. Laws 1348 (codified at N.Y. UNCONSOL. LAWS § 4414 (McKinney 1979)).

74. See Official Statement of New York State Housing Finance Agency, Health Facilities

HFA's repertoire and were modeled after the existing mortgage programs.⁷⁵ The financial structure closely followed that of all of HFA's programs: the bonds were backed by a one year's debt service reserve fund and the state's "moral obligation," and were sold for a pool comprised of a number of projects. The program structure closely followed that of HFA's housing mortgage programs and HFA's role was primarily financing, not project development. Private nonprofit hospitals and nursing homes were responsible for initiating projects, obtaining necessary approvals, and contracting with private firms to construct the projects. They were, however, subject to the statutorily mandated supervision of the State Commissioner of Health (Commissioner). The structure of the HFA hospital and nursing home program is quite different from that of most other state tax-exempt hospital programs, which employ individual revenue bonds and are not directly linked with the state health regulatory agency.

The HFA hospital financing program was designed to provide construction and start-up funds for new hospitals and for extensive modernizations and renovations of existing hospitals. This had important ramifications for the structure of the program. HFA required a first mortgage lien on the entire operating hospital regardless of the actual construction financed,⁷⁶ a pledge of all the revenues of the hospital⁷⁷ and an entirely code-conforming hospital at the completion of the construction program. (A code-conforming hospital does not run the risk of significant revenue losses from the decertification of non-code-conforming portions of the existing hospital.) This approach provided the most extensive security for the bondholders. In the event a hospital defaults on payments, HFA can intercept revenues to meet its mortgage obligations through the pledge of the hospital's gross receipts. If foreclosure becomes necessary, HFA's first mortgage lien on the entire hospital assures that the property taken is an operating hospital that can continue to provide services and generate revenue. As a corollary, however, the first mortgage lien on the entire hospital and the pledge of

Bond Anticipation Notes 2 (April 10, 1979) (copy on file in the office of the *North Carolina Law Review*).

75. The hospital program is authorized by N.Y. PUB. HEALTH LAW §§ 2870-2882 (McKinney 1977). The nursing home program was authorized by *id.* §§ 2850-2869.

76. *Id.*; see note 34 *supra*.

77. The hospitals are required to pledge their gross revenues, including income, earnings and receipts regardless of their source (excluding, however, any revenues, income, receipts and earnings which are expressly restricted by law or any instrument of deed, trust or will as to their use or application). A specific mechanism was put in place to capture these revenues should payments not be made. See, e.g., Regulatory Agreement, *supra* note 37.

all hospital revenues mean that for any additional capital borrowing for renovation or expansion, the hospital must either increase its HFA mortgage or refinance it. Thus, HFA must be prepared to consider mortgage increases when additional construction is necessary.

There are additional ramifications of directing the program toward new projects or major reconstructions. Many hospital projects that would be eligible for financing by authorities in some other states were automatically excluded from consideration by HFA. For example, HFA did not finance small projects that were self-supporting in relation to the overall hospital complex, such as laundries and parking garages, but for which the hospital was unwilling to pledge its entire facility and gross revenues. Hospitals with substantial outstanding indebtedness also were ineligible. Initially, the statute did not even provide for refinancing of existing indebtedness; it was later amended to permit refinancing of mortgages held by institutional lenders in amounts reasonably related to the construction program.⁷⁸

In implementing the program, HFA and the Commissioner had different orientations and, in some cases, different concerns. HFA's responsibilities under the statute,⁷⁹ bond resolution,⁸⁰ and mortgage⁸¹ centered implicitly on protecting the interests of its bondholders. This involved, among other activities, reviewing the financial viability of the project and assuring that the property was unencumbered.⁸²

The Commissioner, on the other hand, had two levels of responsibility. His primary responsibilities under the general provisions of the Public Health Law were to assure that health care was readily available to the citizens of the state, was of high quality and was reasonably priced.⁸³ At the same time, under the provisions specifically relating to the HFA program, he had special responsibilities for hospitals financed by HFA. These responsibilities were directed primarily toward maintaining the revenue generating capacity of the hospital and thereby protecting the investor. They included identifying projects for HFA

78. Act of June 17, 1971, ch. 583, § 1, 1971 N.Y. Laws 878 (codified at N.Y. PUB. HEALTH LAW § 2872(5) (McKinney 1977)).

79. N.Y. PRIV. HOUS. FIN. LAW § 41(2) (McKinney 1976).

80. New York State Housing Finance Agency, Resolution Adopted Jan. 8, 1970, Authorizing Issuance of New York State Housing Finance Agency Hospital and Nursing Home Project Bonds, and Supplemental Resolution adopted Oct. 3, 1977 (copies on file in the office of the *North Carolina Law Review*).

81. See Standardized Form Mortgage of the New York State Housing Finance Agency (1970) (copy on file in the office of the *North Carolina Law Review*).

82. *Id.*

83. N.Y. PUB. HEALTH LAW § 2800 (McKinney 1977).

financing that were needed on a planning basis and were financially viable, supervising ongoing operations, and actually intervening and operating the hospital should it encounter serious difficulties or be improperly managed.⁸⁴

Ideally, the Commissioner's responsibilities were to be mutually supporting: projects were only to be undertaken in the context of a comprehensive plan for hospital care that took into consideration the long-range needs of the communities and then only after a review of their cost effectiveness. In actual practice, however, once the projects were operational, there was a potential for conflict. Projects that had met existing community needs when they were planned, could be made superfluous by factors such as changes in medical practice patterns, demographics, or the standards of need and occupancy set by the Commissioner. Yet, the consideration the Commissioner could give to reducing the services provided or imposing financial restrictions had, necessarily, to be weighed against his responsibilities for assuring the continued operation of the project.

In implementing the program, HFA and the Commissioner worked cooperatively, but pursued their own responsibilities. This overlap in responsibilities acted as a check and balance. The Commissioner identified projects for HFA consideration from those hospitals that had successfully hurdled the certificate of need and other review procedures required for all hospital construction regardless of source of financing. There were no specifically articulated criteria for selecting among approved projects, and the Commissioner thus had full discretion in making his selections. As a result, the Commissioner was often subject to intense pressure from hospitals interested in obtaining financing and from local representatives concerned with improving the health care services in their areas.

Once a project was designated for consideration by HFA, specific reviews and certifications were required from the Department before HFA would provide financing for the project. The statute addresses five major areas: compliance with all relevant provisions of the public health law, conformity of the plans and specifications with code requirements, sufficiency of revenues to meet expenses, availability of funds to make the equity contribution, and the existence of a "regula-

84. *Id.* § 2878 provides not only that the Commissioner of Health may operate a hospital when HFA has acquired the fee title, through foreclosure or otherwise, but also that the Commissioner may, whenever there is any violation or anticipated violation of any requirement, proceed against the hospital in the New York Supreme Court. In such an action, the court may appoint a temporary or permanent receiver.

tory agreement" between the hospital and the Commissioner⁸⁵ designed to provide the Commissioner with special controls over the project during the operational period.⁸⁶ This statutory mandate was the basis for detailed reviews by the Department of proposed HFA projects, including evaluation of the code conformance of the entire project, determination of all forms of insurance coverage during and after construction and analysis of funds required for the start-up period.⁸⁷

In practice, the review process was quite fluid. Once the Commissioner designated a project, HFA undertook its own independent review of the two areas that concerned it most—financial feasibility and the mortgagability of the property. Although the Commissioner had completed a preliminary financial review, HFA required an additional, detailed independent assessment by an outside consultant.⁸⁸ In addition, HFA evaluated the title, title policy and easements to assure that in the event of foreclosure there would be no controversy regarding the priority of its lien and, therefore, that the facility would be able to provide services without disruption. When the mortgage was closed and construction initiated, HFA and the Commissioner worked with the hospital to complete the project on time and within the original cost projection. These activities included monthly approvals of mortgage drawdowns by both the Commissioner and HFA and approval of all changes in plans and specifications by the Commissioner.⁸⁹

The Commissioner's dual levels of responsibility continued once the project was operational. All HFA financed hospitals are subject to the supervision the Commissioner exerts over every hospital in the state. This includes rate control, surveys of compliance with physical standards, inspections of the quality of care and certificate of need approval for construction or changes in services. The additional supervi-

85. *Id.* § 2875.

86. *Id.* § 2873, outlines the minimum provisions of the required "regulatory agreement"; specifically, the hospital must agree to refrain from sale, assignment or transfer of the property during the term of the mortgage; to obtain the consent of the Commissioner for modifications of the physical plant, borrowing of any sort and management contracts; to maintain records in a specified manner; and to provide certain financial reports.

87. See Official Statement of New York State Housing Finance Agency, Hospital and Nursing Home Project Bonds, 1977 series A, at 27 (1977) [hereinafter cited as Official Statement].

88. In all cases, the financial feasibility of the project was reviewed by an independent financial consultant. In some cases, the demand for the services to be provided by the project was assessed by the consultant, in others by the Commissioner. *Id.* at 28.

89. Once construction was completed, the Department conducted an audit to set the final mortgage amount and the allowable amount of capital reimbursement under Medicaid and Blue Cross. See 10 N.Y. ADMIN. RULES & REGULATIONS § 87.32(a), (e) (1975).

sion provided to HFA hospitals focuses on the financial soundness of the operation and includes reviews of budgets and financial reports, approval of all equipment leases, review and approval of all property transactions such as the granting of easements, leases, and sales or transfer of land, and approval of all withdrawals from the reserve for replacement.⁹⁰ HFA also reviews many of these items and monitors payment performance and financial reports to assure that the hospitals can continue to meet their mortgage obligations.⁹¹

The combination of these additional regulatory powers, the pooling of a number of projects into one bond issue and the state's "moral obligation" backing the bonds enabled HFA to finance a number of projects that would, standing on their own, have had difficulty raising capital or raising it at reasonable interest rates. These included start-up hospitals with no established financial track record, hospitals located in underserved, low-income areas, certain small rural hospitals and hospitals with limited ability to generate substantial amounts of cash for equity. They would have encountered difficulties standing alone because, as new hospitals, the rating agencies would not have been willing to rate them⁹² or because the market would have perceived risks associated with the geographic location or financial situation of the projects. Yet these projects were considered necessary, on a programmatic and planning basis, by the Commissioner and financially feasible, with the lower interest rates available through tax-exempt financing and low equity requirements, by an independent financial consultant.

From the inception of the hospital program in 1970 to 1974, HFA entered into mortgage commitments of approximately \$325 million for the construction or renovation of twenty hospitals with approximately seven thousand beds.⁹³ The projects ranged from a small upstate community hospital, which had 40 hospital and 39 nursing home beds and

90. The controlling documents are N.Y. PUB. HEALTH LAW §§ 2873, 2878(1.) (McKinney 1977); 10 N.Y. ADMIN. RULES & REGULATIONS § 87.36-.38 (1975); Standardized Form Mortgage of the New York State Housing Finance Agency, *supra* note 81. See also N.Y. PRIV. HOUS. FIN. LAW § 55.3 (McKinney 1976).

91. N.Y. PUB. HEALTH LAW § 2873(b), (c) (McKinney 1977).

92. For example, Standard & Poor's Corporation explicitly states:

We do not currently rate bond issues for nursing homes or life care centers although these areas are being researched . . . It is our policy not to rate start-up facilities, and, similarly, we do not rate issues involving the relocation of a hospital unless a substantial portion of its patients are derived from the area to which the hospital is moving.

STANDARD AND POOR'S CORP., MUNICIPAL AND INTERNATIONAL BOND RATINGS: AN OVERVIEW 38 (1977).

93. In addition, HFA provided mortgage commitments of almost \$500 million to seventy-six nursing homes. NEW YORK STATE HOUSING FINANCE AGENCY, ANNUAL REPORT 26 (1978).

required a mortgage of less than \$1 million,⁹⁴ to a master plan for a Buffalo hospital. The latter called for an eight-year program of upgrading and expanding the existing complex to 560 beds and constructing a suburban inpatient satellite⁹⁵ and involved a mortgage commitment of \$53 million.⁹⁶

In 1973, there was concern within and outside the state government that HFA would be unable to market the volume of hospital and nursing home bonds needed to meet the state's health planning objectives while continuing to market bonds for its other programs in an orderly fashion. As a result, the Medical Care Facilities Finance Agency (MCFFA) was created.⁹⁷ It is a sister agency to HFA in that its programmatic and financial structure are identical and in that it shares HFA's Chairman, Executive Director and staff. In 1973 and 1974, MCFFA entered into mortgage commitments of over \$150 million for five hospitals involving a total capacity of over 1700 beds.⁹⁸ Its projects included the \$23 million renovation of a large upstate hospital⁹⁹ and a new 530 bed replacement hospital for a 200 bed community hospital in Brooklyn. The latter involved the renovation of an abandoned factory in a location separate from the original hospital and a mortgage of over \$60 million.¹⁰⁰

94. See Official Statement, *supra* note 87, at 56-62.

95. See *id.*

96. See NEW YORK STATE HOUSING FINANCE AGENCY, *supra* note 90, at 26.

97. MCFFA was created by the New York State Medical Care Facilities Finance Agency Act of 1973, ch. 392, § 37, 1973 N.Y. Laws 1417 (codified at N.Y. UNCONSOL. LAWS § 7411 (McKinney 1979)). The legislative intent section clearly indicated that it was designed to increase marketing capacity:

In order to permit an acceleration in the implementation of these [hospital and nursing home financing] programs in areas where the public need remains urgent, without jeopardizing the orderly marketing by the New York State Housing Finance Agency of its notes and bonds for other program purposes, it is hereby found and declared that a separate corporate governmental agency . . . be created as a single purpose agency to act in concert with [HFA] and to devote its entire energy and resources to the provision of additional funds for the construction of health and health related facilities In this manner, the broadest possible base of investment by the greatest number of the general public may be had and the initiative and strength of our private enterprise economy may most readily be harnessed for the benefit of the people of the state.

Id.

98. *Id.* In addition, MCFFA provided mortgage commitments of approximately \$50 million to eight nursing homes. NEW YORK STATE MEDICAL CARE FACILITIES FINANCE AGENCY, ANNUAL REPORT 6 (1979).

99. *Id.*

100. PEAT, MARWICK, MITCHELL & CO., SUMMARY OF CONCLUSIONS AND FINDINGS FROM COMMUNITY NEEDS STUDY I-1 (1974) (copy on file in the office of the *North Carolina Law Review*).

B. Dormitory Authority

The Dormitory Authority first entered the arena of tax-exempt hospital financing in the early 1970s.¹⁰¹ The structure of its hospital financing program was not statutorily established. Therefore, the Dormitory Authority used the financing framework of its other programs. Because its enabling statute did not contain a general authorization to finance hospitals, however, an express amendment was required for each individual hospital it intended to finance. The Dormitory Authority was empowered to finance its first hospital in the 1968 legislative session¹⁰² and made a commitment to finance the project in 1970.¹⁰³

The Dormitory Authority's approach to tax-exempt hospital financing was significantly different from that of HFA and MCFFA. The bonds were backed only by the revenue of the individual project and not by the "moral obligation" of the state, nor by a pool of projects.¹⁰⁴ Moreover, the Dormitory Authority was able to finance discrete freestanding operations,¹⁰⁵ such as parking garages and laundries, and had no restriction on the amount of refinancing it could undertake.¹⁰⁶

The Department's role in Dormitory Authority financing was quite different as well. Indeed, the scope of the Department's reviews did not extend beyond that for projects financed by private sources and was based on its overall supervisory responsibilities for hospitals. The Department did not specifically identify projects for the Dormitory Authority to consider financing as it did for HFA and MCFFA, nor did it continue to monitor projects during construction and operation. More-

101. Albany Medical Center Revenue Bonds, Series A (\$22.560 million), discussed in DORMITORY AUTHORITY OF THE STATE OF NEW YORK, ANNUAL REPORT: 1976-1977, at 28-29 (1977). In the mid-1960s, the Dormitory Authority financed two nurses residences at hospitals totaling under \$2 million: Buffalo General Hospital Revenue Bonds (\$1.175 million) and Geneva General Hospital Revenue Bonds (\$.465 million), described in *id.*

102. Act of June 22, 1968, ch. 1046, § 1, 1968 N.Y. Laws 2965 (codified at N.Y. PUB. AUTH. LAW § 1676 (McKinney Supp. 1978)).

103. DORMITORY AUTHORITY OF THE STATE OF NEW YORK, *supra* note 101, at 28-29. Duplication of functions among New York state authorities was not uncommon during this period. Both HFA and the Dormitory Authority financed construction for the State University, and even within HFA three separate programs provided hospital financing (Health Facilities, Hospitals and Nursing Homes, and State University). MORELAND ACT COMMISSION, *supra* note 62, at 100.

104. See N.Y. PUB. AUTH. LAW § 1683 (McKinney Supp. 1978).

105. *Id.* § 1678.

106. *Id.* § 1682. Certain of the other characteristics of the Dormitory Authority (DA) hospital financing program included: "The DA did not issue notes for hospital construction financing; and in the early years of the program, the DA held fee title to the property and leased it to the hospital. In the later years, it entered into a mortgage." DORMITORY AUTHORITY OF THE STATE OF NEW YORK, *supra* note 101, at 28-30.

over, the Dormitory Authority, unlike HFA and MCFFA, was both a development and a financing authority. Thus, planning, design and construction of the projects were directly supervised by the Dormitory Authority staff. From 1970 to 1975, the Dormitory Authority financed nine hospital projects in the state involving a total commitment of over \$115 million.¹⁰⁷

C. FHA 242 Insurance

During the time period in which HFA and MCFFA had made commitments of almost \$500 million to twenty-five hospitals, and the Dormitory Authority over \$100 million to nine hospitals, FHA 242 insurance had been issued for only two projects in New York—one in 1969 and one in 1975—with a total insured value of \$12.2 million.¹⁰⁸ This compared with a nationwide total of over 100 projects with an insured value of over \$1 billion.¹⁰⁹ New York hospitals had state authority financing readily available at much lower interest rates and longer terms than FHA 242 offered. As a result, they did not aggressively pursue the federal insurance program.¹¹⁰

III. THE FISCAL CRISIS AND THE STATE'S RESPONSE

In 1975, the market for New York state and state-related securities began to disintegrate in response to a number of factors, including the temporary default of the New York State Urban Development Corporation (UDC) on short-term notes,¹¹¹ the financial problems of New York City and general market concern with the rapid escalation of financing by the state and its authorities and municipalities. As one member of the underwriting community later commented, "by late 1975, the market for State and Agency paper 'closed down' as we euphemistically put it. Collapsed better describes the event."¹¹² The en-

107. See DORMITORY AUTHORITY OF THE STATE OF NEW YORK, *supra* note 101, at 28-31.

108. See ICF INC., *supra* note 12, at 68 (Table B-3).

109. *Id.*

110. *Id.* The consideration given to FHA 242 insurance in New York was aptly stated in a 1973 publication of the New York Hospital Association in which a comment on the increasing attention focused on the FHA 242 program by hospital administrators was footnoted to make it clear that this was only in states other than New York. A. GLAUDE, AN ANALYSIS OF ARTICLE 28-B, DORMITORY AUTHORITY AND HILL BURTON GUARANTEED LOAN INTEREST SUBSIDY CAPITAL FINANCING PROGRAMS FOR HOSPITALS IN NEW YORK STATE 54 (1973).

111. UDC defaulted on \$104.5 million in notes on February 25, 1975; this default was subsequently cured. MORELAND ACT COMMISSION, *supra* note 62, at 201-03.

112. Rousseau, *Project Financing Suggested as Vehicle for Hospital Bonds*, THE DAILY BOND BUYER, January 31, 1978, at 3, 18.

suing fiscal crisis and the response to it significantly affected the existing hospital financing programs and provide the context for decisions about future hospital financings in New York.

At the time the market closed, HFA and MCFFA had unbonded outstanding commitments of approximately \$2.0 billion of which approximately \$400 million were for hospital and nursing home projects.¹¹³ The implications of these figures must be viewed in the context of HFA's and MCFFA's procedures for obtaining construction and development funds for projects. During the initial stages of a project, HFA and MCFFA sold short-term obligations—one year or less bond anticipation notes. Initially, the funds were invested and, as the project progressed, advanced to pay construction and other costs. As the notes matured, HFA and MCFFA issued new short-term notes to repay the outstanding ones. When a number of projects reached a reasonable degree of completion, long-term bonds were issued to repay the notes, thus replacing a short-term security with a long-term security.¹¹⁴ An important distinction between these bonds and notes is that while the bonds are explicitly backed by the "moral obligation" of the state, the notes are not.

Notes rather than bonds were used to provide funds during the development period for a number of reasons. Under normal market conditions, the interest rates on notes are lower than those on bonds because there is less risk associated with a shorter term.¹¹⁵ Therefore, using notes resulted in lower overall project costs because it resulted in lower capitalized interest costs during the development period. Although bonds for a project might be sold one or more times during the development period, the final bond sale did not occur until construction was completed, the project was operational, and a reasonably accurate estimate of total project cost and, therefore, of total bonds required could be obtained.

This approach to construction financing required ready access to the financial market to sell notes or bonds at least annually to repay outstanding notes and to provide additional financing for outstanding or new commitments. Unfortunately, when UDC defaulted on its out-

113. HFA had approximately \$235 million and MCFFA had approximately \$145 million. Preliminary Official Statement, State of New York 1979 Tax and Revenue Anticipation Notes 36 (1979) [hereinafter cited as Preliminary Official Statement].

114. Bonds are limited by statute to a maximum term of 50 years. N.Y. PRIV. HOUS. FIN. LAW § 46(2)(a) (McKinney 1976). In practice, however, they are generally limited to 40 years.

115. HARRIS TRUST & SAVINGS BANK, PRIMER ON RELATIVE YIELD CURVE VALUES 15-19 (1977).

standing notes in February 1975, this ready access disappeared. The immediate financial impact of the UDC default on HFA was summarized by one commentator in May 1975:

It is beyond question that the corporation's default on its notes has meant that other agencies have had to pay substantially higher interest rates than otherwise would be required. And if this turns out to be more than a passing phenomenon, the costs could be enormous.

The New York State Housing Finance Agency's cost of borrowing has showed a marked increase since the UDC default. In February, before the default, HFA issued short-term bond anticipation notes for an average interest rate of 4.3 per cent. In March, the agency was able to sell only \$53 million of \$95 million in notes offered, and at an average interest rate of 7.4 per cent, more than 3 points above the February rate. In April, with the UDC notes still in default, the agency's notes were sold at about 8.3 per cent. The rate dropped slightly in May, . . . to about 7.6 per cent. During the same period, short-term notes carrying the full faith and credit of the state sold for rates more than two points lower. In recent times, the spread between the state's notes and HFA's notes has fluctuated between one point and one half a point, and HFA attributes the growth of the spread directly to the UDC debacle.

Long-term bonds issued also have been adversely affected. On April 23, the New York State Medical Care Facilities Finance Agency, which is operated by HFA, was able to sell only \$62 million of \$82 million offered in long-term bonds and at an interest rate of 9.6 per cent, the highest yet paid by a state agency.¹¹⁶

The situation deteriorated from May to October when HFA and MCFFA were entirely barred from borrowing in the public capital marketplace. At the beginning of 1975 HFA and MCFFA had already placed a voluntary moratorium on entering into any new commitments;¹¹⁷ by the end of the year they were scrambling to meet existing commitments.

In December 1975, HFA, MCFFA and two other independent authorities that had encountered similar marketing difficulties¹¹⁸—difficulties that were precipitated by events external to these authorities—joined with state officials to develop a plan for meeting temporary

116. Clark, *UDC Crisis: Future Fallout on N.Y. Bonds?*, 1 EMPIRE STATE REP. 193 (1975).

117. New York State Housing Finance Agency Memorandum from P. Belica, Executive Director, to the Agency members (March 13, 1975) (copy on file in the office of the *North Carolina Law Review*).

118. The other two authorities with outstanding indebtedness were the Dormitory Authority and the Environmental Facilities Corporation (EFC); they had respective outstanding commitments of \$300 million and \$30 million (none of it attributable to hospital projects). Preliminary Official Statement, *supra* note 113, at 36.

financing requirements.¹¹⁹ The purpose of this plan, which was put in place in March 1976, was to enable the four authorities to complete all significant projects in progress without defaulting on notes while gradually reentering the market and selling bonds in an orderly fashion. In setting the stage for such a plan, the state took a number of unprecedented steps designed to allay investor concerns and to signal the state's commitment to sound fiscal policies and financial management.

First, the state put its own financial resources on the line for the first time: it directly appropriated funds to pay certain obligations and set up a special contingency fund.¹²⁰ Second, the state placed a statutory limit on all "moral obligation" financing by all state authorities.¹²¹ As a result, all future commitments for new projects had to be financed on a revenue bond basis without extending the "moral obligation" of the state. Finally, the Public Authorities Control Board was statutorily established as an oversight mechanism to supervise borrowing activities. Its mandate was to review and approve proposals by the four authorities to incur new debt or acquire/construct new projects whether or not the projects involved the "moral obligation" of the state.¹²²

Once the plan for temporary financing was in place, the first priority of the four authorities was to find permanent sources of financing

119. The plan to provide interim financing, which became known as the "Build Out Plan," originally extended through September 30, 1978 and was subsequently extended to September 30, 1980. The "Build Out Plan" was a complex and sometimes convoluted plan to provide temporary financing for projects that had commitments from the four authorities. This plan enlisted numerous sources of financing, some of which had not previously invested in tax-exempt obligations, including but not limited to, state or state-related entities such as the Teacher's Retirement System, banks and insurance companies. The debt was placed in accordance with a carefully orchestrated plan, and the commitment of funds by one source was often contingent on participation by another source. Certain projects were suspended as part of the "Build Out Plan." *Id.* at 34-37. The complexity of the financial transactions in the period prior to the "Build Out Plan" is illustrated in Greenhouse, *A Complex Shift of Funds Saves State Finance Unit*, THE NEW YORK TIMES, October 10, 1975, at 1, col. 6. An elaborate plan had already been developed to rescue the New York State Urban Development Corporation.

120. The commitment of state funds included, but was not limited to, an appropriation of \$36 million to HFA and EFC to enable them to pay certain of their notes, a direct appropriation of \$10.1 million, pursuant to the "moral obligation" provision, to replenish the HFA Non-Profit Housing Debt Service Reserve Fund, and a stand-by appropriation of \$80 million in the event that an alternate source of repayment of maturing notes was not available for HFA. Official Statement, \$45,000,000 State of New York Serial Bonds (Pure Waters) 37 (1976).

121. Act of March 15, 1976, ch. 38, §§ 22-23, 1976 N.Y. Laws 1 (codified at N.Y. PRIV. HOUS. FIN. LAW § 47(5)(c) (McKinney 1976)). The cap was set at a level sufficient to enable the authorities to complete all projects for which commitments had been made (including deposits to the Debt Service Reserve Fund) with a small reserve for contingencies. HFA's and MCFFA's hospital and nursing home "moral obligation" financings were capped at \$1.156 billion out of a total authorization of \$3.950 billion. *Id.*

122. N.Y. PUB. AUTH. LAW § 50 (McKinney Supp. 1978). The Public Authorities Control Board was also empowered to review and approve proposals by certain other authorities to incur additional "moral obligation" debt. *Id.*

for their projects.¹²³ HFA's first public sale of Hospital and Nursing Home Program bonds was in October 1977 for approximately \$236 million at 6.99 percent.¹²⁴ In addition to the revenues of the projects, a one year debt service reserve fund and the "moral obligation" of the state, these bonds were backed by a new \$12 million state appropriation for a special reserve fund available to the bondholders, in the event a project is unable to pay its debt service, prior to the debt service reserve fund or the state's "moral obligation."¹²⁵ This level of security was added to attract investors and to assure them of the state's commitment to its authorities.

Through this period, it became evident that the investment community closely identified the state with its authorities and municipalities because they accounted for a substantial portion of the outstanding state and state-related debt. As a result, the financial stability of the state itself was closely tied to that of its authorities.¹²⁶ Indeed, the financial difficulties of the authorities had major ramifications for the state's own ability to enter the financial marketplace and for the interest rate it had to pay. Specifically, the state annually borrows over \$3.5 billion on a short-term basis. In 1975, it was all sold publicly at an interest rate of 5.26 percent;¹²⁷ in 1976, only approximately \$2.75 billion was sold publicly at an interest rate of 7 percent.¹²⁸ Clearly, the state had to supervise the financing activities of its authorities if it was to maintain its own financial viability.

The response of the state and its authorities to the fiscal crisis in New York explains the hiatus in new hospital commitments from 1975

123. By April 1979, the outstanding permanent financing needs of the four authorities—HFA, MCFFA, Dormitory Authority, and EFC—were reduced from \$2.6 billion to less than \$1.0 billion. Preliminary Official Statement, *supra* note 113, at 36. This was accomplished by the public sale of bonds, the sale of individual projects on a revenue bond basis (with or without federal insurance in the case of housing projects), the substitution of private financing, and the permanent suspension of projects. For a discussion of the reentry of New York state and its authorities into the market, see FIRST ALBANY CORP., MUNICIPAL RESEARCH REPORT, NEW YORK STATE: AN EXAMINATION OF AN IMPROVING CREDIT (1977).

124. Official Statement, \$236,445,000, New York State Housing Finance Agency Hospital and Nursing Home Project Bonds, 1977 Series A (October 6, 1977). The first issue for any program was in September 1976. Official Statement, \$149,065,000 New York State Housing Finance Agency, 9% State University Construction Bonds, 1976 Series B (September 16, 1976).

125. Official Statement, \$236,445,000, New York State Housing Finance Agency Hospital and Nursing Home Project Bonds, *supra* note 124, at 4, 38-39.

126. Official Statement, \$45,000,000 State of New York Serial Bonds (Pure Waters), *supra* note 120, at 35.

127. New York State Dep't of Audit and Control, Internal Memorandum (undated) (copy on file in office of the *North Carolina Law Review*).

128. Official Statement, \$2,750,000,000, State of New York, 7% Tax and Revenue Anticipation Notes (April 15, 1976).

to 1978, illustrates the ongoing interrelationships between tax-exempt financing for hospitals and for other purposes in the state, and provides the framework for decisions about future hospital financings. The tax-exempt financing programs had successfully encouraged the construction, renovation and modernization of hospitals in the state and provided loans with significantly lower interest rates than would have otherwise been available. HFA, MCFFA and the Dormitory Authority had never (nor have they since) defaulted on a hospital or nursing home bond or note. Nevertheless, the initiation of new projects was entirely cut off for three years. As a representative of a major investment firm commented when discussing the future of hospital financing in New York:

[T]he effect that we learned, or should have, in 1975 and 1976, was that confidence is more or less indivisible within a state. To the extent that the state or any of its instrumentalities is perceived to be in trouble, all of them will suffer in the marketplace to some degree . . . as the Bible observes, the rain falls on the just and the unjust alike.¹²⁹

The moratorium on state authority hospital financing resulted in a dramatic shift toward the use of the FHA 242 insurance program in the state. As noted above, prior to 1976, only two New York hospitals received insurance valued at \$12 million.¹³⁰ Then, in 1976 alone, however, twelve hospitals received insurance valued at \$290 million. This was almost half of the insurance issued nationwide in 1976, and it exceeded the nationwide dollar value in any preceding year.¹³¹ This shift away from tax-exempt financing resulted in interest costs that were higher than might have been expected with tax-exempt bond financing and, therefore, in higher reimbursements rates paid by third-party payors and consumers of health care.

The upsurge of FHA 242 financing in the state did not, however, fully meet the needs of hospitals in New York.¹³² Many turned to commercial lenders and others deferred construction until they could obtain a financing source. In 1978, the state, responding to the needs of the hospitals, began to consider reactivating its tax-exempt hospital financing program.¹³³ The concerns of the state health care officials

129. Rousseau, *supra* note 112, at 18.

130. ICF INC., *supra* note 12, at 68 (Table B-3).

131. *Id.*

132. For an assessment of the relative merits of various methods from the hospital's perspective, see AMERICAN HOSPITAL ASSOCIATION, CAPITAL FINANCING FOR HOSPITALS 37-49 (1978).

133. During 1978, the Dormitory Authority accomplished two financings by combining the FHA 242 insurance, Government National Mortgage Association participation and tax exemption at a total value of approximately \$46 million. As explained above, this mechanism poses no

were summarized in a letter to HFA in August 1978:

[I]nsofar as the HFA and MCFFA program is concerned, I believe that it is both wise and necessary that we initiate new mortgage loans. While there is generally an oversupply of acute care beds in the State as a whole, many needed hospitals are operating in nonconforming structures which must be renovated if they are to meet safe structural standards and are to be available for future use. It would appear that the [HFA and MCFFA] program could serve as a vehicle to finance necessary renovations, at a relatively low cost, and where the opportunity avails itself, realign bed capacity of the institutions with projected long-range requirements.¹³⁴

These concerns regarding the health care system were, necessarily, weighed against the lessons of the fiscal crisis and the concerns of the financing authorities and the Public Authorities Control Board about further direct or indirect extension of the state's credit. Financing priorities must be set, and the decisions regarding financing hospitals must be made relative to other equally worthy projects. Potential competitors include State University construction, a convention center for New York City, economic development projects and housing.

The state, nonetheless, has decided to pursue additional hospital financing on a limited basis. The Public Authorities Control Board adopted a general framework for financing by HFA, MCFFA and the Dormitory Authority.¹³⁵ The authorities are required to cooperate closely with the Department in project selection and evaluation in an attempt to assure that projects receiving financing are consistent with the state's health planning objectives. HFA and MCFFA had historically used this approach; the Dormitory Authority, however, must adjust its procedures. Hospitals are also required to provide significant equity—ten percent of development costs—to demonstrate their commitment to the project and financial capacity to generate such funds. Finally, capital construction projects must pass a stringent review of financial feasibility. Hospitals will be required to demonstrate that

financial risk to the state or the Authority. See note 46 and accompanying text *supra*. In addition, the Dormitory Authority completed one refinancing for a project that had been in the midst of processing in 1975 when the market collapsed. Private Placement Memorandum, Dormitory Authority of the State of New York, Revenue Bonds, Charles S. Wilson Memorial Hospital Issue, Series A (Sept. 27, 1978).

134. Letter from Richard Berman, Director, Office of Health Systems Management, State of New York Dep't of Health, to Robert Vagt, Executive Director, New York State Housing Finance Agency (Aug. 15, 1978) (copy on file in the office of the *North Carolina Law Review*).

135. Instructions to Staff regarding the Review of Health Care Financing Applications (resolution included in the minutes of the May 16, 1979 Public Authorities Control Board meeting) [hereinafter cited as Instructions to Staff] (copy on file in the office of the *North Carolina Law Review*).

they are needed, not only on the basis of statewide or local planning standards, but also on the basis of the actual demand for the institution by physicians and patients within their service area. In addition, hospitals must demonstrate that they have sufficient economic resources and managerial skills to operate on a financially sound basis.¹³⁶

The specific details of HFA's and MCFFA's financing program have been modified to reflect the statutory and programmatic changes emanating from the fiscal crisis. Specifically, the bonds can be backed only by the revenue of the project, not the "moral obligation" of the state. Therefore, as a practical corollary, the bonds can only be issued for an individual project rather than a pool of projects. In addition, no notes will be issued for construction financing.¹³⁷ The Dormitory Authority did not need to modify its financing approach, which historically involved individual project revenue bonds.

New York authorities are now able to undertake financing for certain projects on a limited basis but are not in a position to assist less secure projects through the "moral obligation" provision as they have in the past. There is a need for a supplemental federal program, perhaps a targeting of the FHA 242 program or a direct grant program, to assure that projects that provide needed hospital services to communities in the state are able to obtain the financing needed in order to continue operating, maintaining their physical plants and providing high quality medical care.

IV. POLICY IMPLICATIONS

This review of capital financing for hospitals provides insights into the interrelationship between hospital capital financing programs and the federal and state governments' long-range health goals of assuring access to care for all citizens, maintaining a high standard for quality of care and bringing the rapid escalation of health care costs under control. Moreover, the New York State experience demonstrates how, at the state and local level, hospital financing interlocks with the financing of other public purpose projects. This review provides a framework for

136. Conditions for New York State Housing Finance Agency, New York State Medical Care Facilities Finance Agency, Hospital Renovation Projects, Noninsured Project Revenue Bonds, and New York State Housing Finance Agency, New York State Medical Care Facilities Finance Agency Financial Feasibility Study Guidelines, adopted by the Members of the New York State Housing Finance Agency on February 23, 1979.

137. Instructions to Staff, *supra* note 135, at 1. The concern with note financing is reflected in the requirement that HFA and MCFFA refrain from entering into any new commitments until substantially all their notes are converted into bonds.

assessing existing capital financing programs and evaluating new proposals to assure that their objectives are realistic, their anticipated outcomes are consistent with stated goals and their expectations for participation at the state and local level are appropriate.

Both state and federal governments agree on the three overall goals stated above, with the federal and some state governments placing particularly high priority, at the present time, on controlling health care costs.¹³⁸ Yet there is little consensus on the specific steps required to achieve these goals. Capital financing for the construction of new hospitals and maintenance of existing ones has implications for all three health policy goals. Capital funds are needed for the construction of new facilities and the renovation of existing ones to improve access to care in underserved areas. Furthermore, to assure that the care they provide is of high quality, hospitals in all areas must maintain their physical plants and periodically upgrade their equipment to reflect technological advances. Finally, capital expenditures affect the cost of health care directly through interest, amortization and other construction related costs. Indeed, the potential for reducing interest costs is the most commonly cited reason for government intervention in hospital capital financing. Moreover, capital expenditures can have an indirect effect through associated changes in hospital operating costs. For example, the construction of a new service such as a neo-natal unit would result in an increase in the intensity and sophistication of the services provided and a concomitant adjustment in equipment, supplies and staffing. Even when a service such as a surgical suite is merely replaced, there is often upgrading, with related increases in operating expenses. Conversely, construction changes may, in some situations, cause a net reduction in costs through increased efficiency.

Most efforts at controlling capital expenditures have relied on the health planning process to weigh the potential advantages and limitations of particular proposals and to control the number and scope of approved projects.¹³⁹ This might be sufficient if such programs were themselves well thought out and effective. Unfortunately, in many cases they are not.¹⁴⁰ Furthermore, the method of financing proposed projects has generally been overlooked by planning programs, and the potential power of government financing programs in reinforcing health planning objectives has not been adequately explored. This is

138. *See generally* Wing & Siltan, this Symposium.

139. *See generally* Wing & Craige, this Symposium.

140. *See generally* Schonbrun, this Symposium.

indicative of the fragmentation and lack of coordination in virtually all health regulatory activities today.

Orchestrating a coordinated effort may be difficult because the government participants themselves have different orientations and are responsive to different constituencies. State health planning officials must respond not only to their professional concerns regarding health needs, but also to the interest of local health planning groups, state-wide health planning advisory councils, individual hospitals and, in some cases, the state legislature, governor and other political forces. State financing authorities usually report to independent boards, are concerned primarily with protecting the interests of existing bondholders and often interact more frequently with members of the financial community than with health planning officials. HEW officials are responsible to their own regional administration and the central administration in Washington, and this may lead to conflicts with the objectives of local and state planners.

Nonetheless, government financing has significant potential as a mechanism to reinforce planning objectives and to coordinate various government efforts. In New York, for example, many areas of the state have excess hospital bed capacity, and the state health planning policy emphasizes mergers and consolidations. Government financing could be made available on a priority basis to assist and encourage such proposals. In addition, hospitals in underserved, low-income areas, which have been unable to generate extra reserves because they have incurred ambulatory care deficits and bad debts of significant size, and new or relocated hospitals, which have no financial track record, have difficulty obtaining financing from nongovernmental sources, despite their importance to the provision of health care. Government financing can assist such institutions in two ways: relatively low requirements for equity contributions enable hospitals to qualify even though they have limited capacity to generate cash contributions, and lower interest costs make demonstration of financial feasibility less difficult. In cases in which tax-exempt revenue bonds are still not marketable, FHA 242 insurance could be used. If even this option is not viable, direct subsidies may be necessary.

Government financing can also be used to discourage or modify projects that are, on detailed review, not feasible or that slip through the certificate of need process. This can be accomplished because financing provides a tool for additional screening and for controlling the construction program. Certificate of need provides a preliminary

screen of the need within the community for the proposed project. Financing, however, usually brings with it more careful scrutiny, such as an in-depth evaluation of the demand for services and of projected financial performance by an independent financial feasibility consultant.

On the other hand, there are certain potential drawbacks to government financing. At a time of acknowledged excess capacity in many areas of the country, including significant portions of New York, the ready availability of government financing may tend to encourage unnecessary expansion. Expansion will be particularly likely when hospital financing is not carefully aligned with health planning activities or when health planning requirements are not sufficiently articulated or enforced, and somewhat lower priority, but politically powerful projects are likely to be approved.

To the extent that government financing encourages excess construction, the savings on individual projects resulting from lower interest rates may be more than offset by the costs of unnecessary construction as well as any associated increases in operating costs. Unnecessary construction can take two forms—entire projects that would not otherwise have been built, and increments of projects permitted either by the more easily met governmental financing requirements or by ineffective review of the need for or cost effectiveness of the increments by government officials. Indeed, it could be argued that government financing removes projects from the scrutiny of the private capital market where financial feasibility must be clearly demonstrated and places it in a more political arena.

Rather than assist projects that would not otherwise be constructed, government financing may merely substitute for commercial mortgages issued in the private market. In fact, the financings accomplished through government to date have not been targeted to projects that could not receive financing without such assistance. HEW has not based its processing of FHA 242 applications on local health planning priorities, and state authorities have directed their programs to the hospitals that are financially secure. As a result, certain projects may have no available source of financing.

The federal or state government assumes a risk by extending its credit, either directly or indirectly. For the federal government, a default may not affect marketing of other issues. For a state, however, the ramifications can be severe. A default on a single hospital project would have limited effect, but a series of defaults could have negative

repercussions in the market for other issues of the authority or, if the situation became sufficiently severe, as the New York experience demonstrated, for the state itself. Furthermore, as a corollary, government financing may come into conflict with future cost containment efforts if such efforts would jeopardize the financial feasibility of a state authority financed or a federally insured project. There would, unquestionably, be reluctance to undertaking a cost containment strategy that would precipitate a default.

The federal and state governments should reassess the role of their hospital capital financing programs as they pursue their long-term health care goals of access, quality and cost containment. The preceding discussion demonstrates that states should be aware of the potential risks, as well as the immediate advantages of tax-exempt financing. The federal government should consider focusing its efforts on hospitals that provide necessary care but pose a greater financial risk than the private market is willing to accept, and the states are able to absorb. Together, the state and federal governments should consider a closer coordination among planning programs, financing programs and other related activities to ensure that both state and federal financing programs achieve the objectives for which they are designed.

