Citizens League non-partisan public affairs research and education in the St. Paul-Minneapolis metropolitan area. **84 S. 6th St., Minneapolis, Mn. 55402 (612) 338-0791**

December 12, 1979

TO: Members, Metropolitan Council

We thought you might appreciate, now, a copy of the Citizens League's 1977 report: "More Care About the Cost in Hospitals."

Its central finding was that the Twin Cities area has a very high quality, and also a very large and expensive, hospital system, whose expansion is essentially unrestrained at the moment, either by public control or by competitive forces in the health care market.

Our central conclusion was that the arrangements for financing medical and hospital care must now be re-examined and re-arranged, to restrain the expansion within some limits set by public policy.

The principal recommendation, short-term, was that the Metropolitan Council and the Metropolitan Health Board impose a "moratorium" on applications for new hospital construction.

This was done and, with the good cooperation of the hospitals in the Twin Cities in withholding their applications, this temporary restraint on investment was effective.

With the completion of the regional hospital plan late last spring, however, this period of voluntary moratorium came to an end. The applications for construction have begun to move toward the Health Board and toward you on the Metropolitan Council. So, the fundamental question now recurs: <u>How</u> can the rate of increase in spending be restrained?

The Citizens League dealt with this question in its statement to the Health Board in June: We said then that the relatively small cut proposed by the plan, in the area's hospital capacity, makes it "essential to maintain a tight control on the flow of new investment into the system." In that statement, and again in our statement in September, we repeated the conclusion of our 1977 report: that, longer-term, controls based on incentives might be both more effective and more desirable than controls based on regulation.

Last fall, therefore, we began in the Citizens League an effort to amplify this recommendation: that is, to explore what sorts of changes in the financing of medical and hospital care might serve to introduce such incentives to restrain expansion. We are not finished with this examination, and we are not prepared now to offer recommendations. But we have found, even to date, our understanding of the facts about hospital capital expansion significantly deepened by what we have heard. We thought it would be useful to share this understanding with you, as background for the decisions you face over the next year or so; most immediately, in connection with the application submitted by Fairview Community Hospitals, but generally, with respect to capital investment in the hospital system.

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If the community had set out deliberately to make it as easy as possible to maximize the flow of money into hospital expansion, it probably would have created substantially the system now in place, here in the Twin Cities area. It has these essentials:

1. Borrowing. There is a long-established practice of borrowing (issuing bonds) for hospital expansion. But until recently, a significant proportion of the cost of most hospitals was paid by community fund drives, or by other kinds of gifts and grants (including those from taxpayers: Hennepin County General Hospital is financed by payments from the taxpayers over 20 years; the federal Hill-Burton program represents another source of tax-financed grant). In this system there was, one way or another, a kind of decision required by someone other than a hospital, whether or not to finance its construction. More recently, however, hospitals have been moving fully toward debt-financing. Drives for donations for hospital capital are a rarity today. So are appeals for tax support, and the use of Hill-Burton is declining. In part, this is because of:

2. Reimbursement. Some years ago, insurers, private and public, agreed to permit hospitals to include, as a part of their daily charge, an item for capital: that is, depreciation and for the reimbursement for any interest on their debt. This had the effect of guaranteeing, almost without limit, that whatever facilities and equipment were built and installed, the hospitals could be reimbursed for them. This greatly reduced the risk of investment in hospital capital, and virtually eliminated the need for hospitals to ask for dollars from other parties in advance of the approval and construction of their project. Rather, it facilitated a turn toward the bond market.

3. Subsidy. Rapidly through the 1970s a further trend has been for hospitals to make use of the public credit, through tax-exempt revenue bonds. Under existing law, the interest income to investors on bonds issued by governmental subdivisions is exempt from federal and state income taxes. Creditors therefore accept a lower rate on the bonds. This reduces the cost of money to hospitals, which in turn permits lower daily rates. The practice is attractive also to local public authorities, who can get hospitals built with no tax revenue involved, and with no charge against their net debt. The impact is on the federal and state governments, whose income tax collections are reduced by the tax exemption.

   This has made obsolete the kind of financing done for Hennepin County in 1969: a referendum for $25 million, repaid by property taxes. A study by Booz, Allen & Hamilton in late 1978 estimated that debt financing by that time represented about 78% of hospital capital; and that this would rise to 100% by 1983, with tax-exempt issues accounting for 80% of the total. Philanthropy, grants and internal operations, the study projected, will disappear by 1985 as a source of revenue for this purpose.

   This practice has been used by hospitals in Minnesota. Until 1978 this was under the general statutes providing for tax-exempt revenue bonds in the state. In that year, Chapter 609 specifically authorized their use for hospitals and health care facilities. What is reported to have been the largest bond issue for hospital capital in the United States took place in the Twin Cities area in recent years, in St. Paul, for United Hospitals.

In summary, the changes of recent years have created an arrangement for flowing capital to hospitals, not subject to the risks of failure that constrain lending to normal commercial enterprises, nor subject to the political process that authorizes a governmental project.

Again: We have not at this point developed a specific recommendation for changes in this situation. We have, however, accumulated a number of suggested changes for consideration, as restraints that might be effective on the flow of money into hospitals for capital expansion. The list includes:

1. Restrain the use of tax-exempt credit.

   This would, simply, provide a return to the payment of market rates for hospital borrowings. It is possible that, if hospitals had to pay the present market rate of 14% or so for capital, they might be more cautious about expansion than when it is possible to borrow at the below-market rates used by government. Higher interest would mean higher daily charges.

   Fundamentally, the tax-exempt bonds came into public law as a way to encourage things deemed to be in the public interest. If, in fact, it is public policy now to restrain, rather than (as in the 1940s) to stimulate the expansion of the hospital capital plant, then a question arises whether the use of tax-exempt financing is a logical part of public law, today, for the hospital system.

2. Continue the use of tax-exempt financing, but change the responsibility for authorizing its use.

   Presently, the authority to authorize tax-exempt borrowing . . . to grant the public credit . . . is vested in local municipalities. A case is made that this is a matter of (at a minimum) metropolitan significance, and that the decision, therefore, ought to be logically the responsibility of a body with jurisdiction over the entire community served by the area's hospital system.

3. Continue the use of tax-exempt bonds, but limit their use to some proportion of the total project cost.

   This would require the hospital either to pay some higher rate on its money, or -- alternatively -- to face a kind of test in the "market" for gifts and grants: from philanthropy, from the federal government, or from local taxpayers in the municipality in which the hospital would be located, who are advocating and supporting its construction.

4. Continue the use of tax-exempt bonds, but (in addition) provide that they shall be full faith and credit bonds.

   Presently, since bonds are not legally an obligation of the municipality, the taxpayers of the area are not at risk, and the elected officials have little incentive to become involved. The prospect of a default on any bonds, from the failure of a hospital in total, would be relatively slight, in all probability -- given the current reimbursement system. Nevertheless, elected officials do pay attention to general obligation bonds secured against local property taxes, that do affect their debt limit and their credit rating.

5. Increase the awareness of the public and of potential investors, of the risks involved in financing hospitals in the Twin Cities area.

   The prospectuses presenting the bond issues do, to be sure, include a section on "bondholders' risks" sometimes titled "Other Factors Affecting Reimbursement), but these prospectuses are drawn by consultants and they tend to be cast in general terms. That is, they do not specifically describe the situation, existing and potential, in this particular metropolitan area. And, since the Twin Cities area does in fact have in place, both in public policy and in the local market for medical/hospital services, strong forces tending to reduce the utilization of hospitals, it would seem that the principle of full disclosure would require a significantly expanded section in the prospectus explaining these risks to potential investors. Such a section should probably be written by a third party knowledgeable about the situation in the area: perhaps the Metropolitan Health Board.

6. Finance hospital capital expansion by local general tax sources.

   Some persons have suggested that it is conceivable the existing debt of the area's hospitals might be assumed by an areawide hospital financing agency, which would then proceed to pay off the existing debt, to raise additional capital from areawide general obligation bond issues, and to authorize -- within the ceiling fixed by its policy decisions -- appropriations to the hospitals for the expansion of facilities and equipment.

We stress again: The Citizens League neither favors nor opposes any of these ideas as the present time. We present them to you only as the responsible suggestions of a number of well-informed persons who have talked with our committee; and who are concerned, as you are, about the very great difficulty of beginning, now, to restrain the rate of investment in hospital capital.

We expect to continue our study and we hope to be able to bring you some recommendations early in 1980.

Sincerely,

Allan R. Boyce, President