A PROPOSAL RELATING TO CERTAIN HEALTH-RELATED 501(C)(3) BONDS

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT REVENUE MEASURES

AND THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

AUGUST 9, 1994

Serial 103–102

Printed for the use of the Committee on Ways and Means

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A PROPOSAL RELATING TO CERTAIN HEALTH-RELATED 501(C)(3) BONDS

TUESDAY, AUGUST 9, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SELECT REVENUE MEASURES,
AND THE SUBCOMMITTEE ON OVERSIGHT,
Washington, D.C.

The subcommittees met, pursuant to call, at 1:15 p.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (chairman of the Subcommittee on Select Revenue Measures) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, JULY 27, 1994

PRESS RELEASE #21
SUBCOMMITTEE ON SELECT REVENUE MEASURES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON SELECT REVENUE MEASURES, AND THE HONORABLE J. J. PICKLE (D., TEX.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE A JOINT PUBLIC HEARING ON A PROPOSAL RELATING TO CERTAIN HEALTH-RELATED 501(c)(3) BONDS

The Honorable Charles B. Rangel (D., N.Y.), Chairman, Subcommittee on Select Revenue Measures, and the Honorable J. J. Pickle (D., Tex.), Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittees will hold a joint public hearing on a proposal to remove the $150 million cap on the amount of nonhospital tax-exempt bonds that can be outstanding on behalf of a section 501(c)(3) organization for certain health-related facilities. The hearing will be held on Tuesday, August 9, 1994, beginning at 1:00 p.m. in the Committee's main hearing room, 1100 Longworth House Office Building.

In announcing this hearing, Chairman Rangel stated: "A number of issues were raised by Members during the Committee's deliberations on health care reform. Not all of these issues could be addressed in the context of the Committee's bill. Among these issues was a proposal to remove the $150 million cap with respect to certain health-related section 501(c)(3) bonds. In light of the Committee's recent actions on comprehensive health care reform legislation, it is appropriate at this time to examine this proposal. I anticipate reviewing further issues related to the health care reform legislation in the near future."

Further, Chairman Pickle stated: "The hearing will allow the Subcommittees to review the impact of the bond cap on health-related facilities, especially in light of pending health care reform legislation. In addition, we will explore whether the goals of health care reform would be furthered by eliminating the bond cap. Our joint hearing will provide interested parties with an opportunity to present their concerns in this area for further consideration."

BACKGROUND

This issue is one of several that were discussed by Members of the Committee during recent deliberations on health care reform legislation. It is anticipated that hearings on other issues related to health care reform that have been referred to the Subcommittee on Select Revenue Measures for hearings will be scheduled in the near future.

Interest on State and local government bonds generally is excluded from income if the bonds are issued to finance direct activities of these governments. Interest on bonds issued by these governments to finance activities of other persons (i.e., private activity bonds) is taxable unless a specific exception is included in the Internal Revenue Code (Code). One such exception is for private activity bonds issued to finance activities of private, charitable organizations described in Code section 501(c)(3) when the activities do not constitute an unrelated trade or business.

To be tax exempt, section 501(c)(3) bonds must satisfy certain requirements specified in the Code, including a limit of $150 million on the amount of outstanding bonds which may be outstanding on behalf of any section 501(c)(3) organization. In applying this $150-million limit, all section 501(c)(3) organizations under common management or control are treated as a single organization. An exception to the limit applies with respect to bonds issued on behalf of section 501(c)(3) hospital facilities (i.e., acute care, primarily inpatient facilities).

The proposal would repeal the $150-million limit for bonds issued on behalf of section 501(c)(3) health care facilities that are not acute care, inpatient facilities.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Individuals and organizations interested in presenting oral testimony before the Subcommittees must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland, or Karen Ponzurick [(202) 225-1721] no later than close of business, Wednesday, August 3, 1994, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee on Select Revenue Measures staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee [(202) 225-9710].

Persons and organizations having a common position are urged to make every effort to designate one spokesperson to represent them in order for the Subcommittees to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. (See formatting requirements below.) This process will afford more time for Members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittees are required to submit 150 copies of their prepared statements to the Subcommittee on Select Revenue Measures office, room 1105 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business on Friday, August 12, 1994, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U. S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Subcommittee on Select Revenue Measures office, room 1105 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee:

1. **All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.**

2. **Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.**

3. **Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.**

4. **A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.**

The above restrictions and limitations apply only to material submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

****

Chairman RANGEL. The subcommittees will come to order.

Today, the Subcommittee on Select Revenue Measures and the Subcommittee on Oversight will receive testimony on a proposal to remove the $150 million cap on the amount of nonhospital tax-exempt bonds that can be outstanding on behalf of section 501(c)(3) organizations for certain health-related facilities.

As you know, the issue of removing the $150 million cap with respect to certain health-related section 501(c)(3) bonds was raised when members of the Committee on Ways and Means deliberated on health care reform earlier this summer. This issue was not addressed in the committee's bill but was referred to the subcommittees for a hearing so we could benefit from testimony from the public and the administration on this significant proposal.

The $150 million cap on the nonhospital section of 501(c)(3) bonds has been in place since the Tax Reform Act of 1986. Many health-related section 501(c)(3) facilities are subject to this cap because they do not qualify as hospitals. Generally, only acute care, inpatient facilities are treated as hospitals for this pay purpose. There is a growing number of other health-related facilities, such as skilled nursing facilities, outpatient ambulatory clinics that are subject to the $150 million cap. This cap limits the amount of tax-exempt financing from which these facilities may benefit.

We are all looking forward to the views of our witnesses today as to whether or not the cap on these types of facilities are appropriate. There have been changes in our health care delivery system in our Nation, and we want to see whether or not it would necessitate removal of these caps, and to what extent would the cap hinder those facilities in carrying out their responsibility, and is providing this access to tax-exempt bonds the best way to assist the facilities in their overall responsibility.

I would now call on my friend, Chairman Pickle for his opening statement.

Chairman PICKLE. Well, thank you, Mr. Chairman. This issue was also referred to the Oversight Committee for hearings.

Mr. Chairman, back in 1986, when we passed the Tax Reform Act, we were concerned about the amount of nongovernmental facilities financed with tax-exempt bonds. Accordingly, we tightened up on the bond provisions for tax-exempt organizations. This year, against the backdrop of health care reform, we are being urged to undo or redo what we did back in 1986.

It seems to me there are two principal questions we should address at today's hearing. First, why is it critical to our efforts to overhaul the health care system that we repeal the tax-exempt bond restrictions that we put in place in 1986? I will be interested in hearing what the witnesses' views are on how the bond caps have adversely affected the efficient delivery of health care services.

Second, if we lift the bond cap on health-related facilities financed by tax-exempt organizations, at an estimated revenue loss of $400 million over the next 10 years, what can the public expect in return in terms of more health or better health services?

And, finally, I would note we also have witnesses today who will urge that the cap should be lifted for colleges and universities and other 501(c)(3) organizations. Again, we should ask what will the

public get as a result of increased use of tax-exempt bonds? I understand that such a change will result in a revenue loss of $1 billion over 10 years.

Mr. Chairman, that will complete my statement at this point.

Mr. RANGEL. Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

I want to welcome the witnesses scheduled for today's hearing. The proposal before us may be small in the context of health care reform, but it is plainly important to the tax-exempt organizations affected by it. Accordingly, I look forward to the witnesses' testimony.

Many of the tax-exempt health care facilities that would benefit from this proposal provide impressive and valuable services to our communities. I think we want to continue to encourage these kinds of activities.

Still, I am interested in the revenue consequences of the proposal, particularly the ultimate revenue consequences if we start down the road of letting some 501(c)(3) organizations out of a $150 million bond cap. Health-related facilities are not the only tax-exempt organizations frustrated by the bond cap. So I think this is clearly an area in which we should look not just at the limited proposal before us but at the broader proposals which are sure to follow.

Again, I look forward to what the administration and the other invited witnesses have to say. As a matter of fact, I have a feeling that by the time Congress finishes with health care reform, we will probably wish we had held a lot more hearings like this on some of the provisions in the final bill.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Hoagland is recognized.

Mr. HOAGLAND. Mr. Chairman, currently Members of the House and Senate are considering health care reform legislation which is intended to encourage health institutions to provide health care in a more efficient and cost-effective manner. One result of health care reform will probably be to accelerate the need to downsize the acute care system. Hospitals and other health care providers will consolidate to reduce inpatient capacity while filling other gaps in the system. An important step toward accomplishing the goal of cost reduction can be achieved by lifting the $150 million volume cap for health care facilities so the cap no longer serves as an impediment to innovative alternative health care programs.

Many institutions which are crucial to the advancement of health care reform are not hospitals. However, current law limits nonhospital facilities to the $150 million volume cap per institution. I am advised that one or more of our witnesses today will discuss the health care institutions that are at the $150 million limitation and I believe we should listen carefully to these witnesses.

Forcing such institutions to borrow in the taxable market will increase their costs and negatively impact their ability to form integrated delivery systems in response to the health care legislation proceeding through the Congress. That will impede progress toward managed care systems, as so many of us advocate.

I firmly believe reform of the health care delivery system should encompass reform of the Internal Revenue Code. The $150 million

volume cap should not stand as an impediment to health care reform, to the formation of networks, the formation of HMOs, and the formation of the whole gamut of managed care institutions which we need to develop if we are to hold down health care costs.

The idea of lifting the volume cap is not new. A provision to lift the $150 million volume cap for all 501(c)(3) institutions was included in H.R. 11, the tax bill that was passed by Congress in 1992 and subsequently vetoed by President Bush. I believe it is time for the Ways and Means Committee to complete the task that was begun in 1992 to lift the $150 million volume cap at least for health-related facilities as soon as we can.

Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Houghton.

Mr. HOUGHTON. Mr. Chairman, I have a lengthy statement, and it might take 1½ hours, but I thought I might submit it for the record instead.

Chairman RANGEL. Without objection.

[The prepared statement follows:]

Mr. Chairman, I am pleased to join you in opening our joint hearing to consider lifting the cap on certain tax-exempt bonds used to finance health-related projects.

Under current law there is a $150 million cap on the amount of tax-exempt bonds which may be issued by any single nonprofit organization. However, a narrow category of health-related projects are exempt from this cap.

In particular, a nonprofit group may finance acute care and primary inpatient facilities without being subject to the $150 million cap. The current exemption recognizes the significant cost involved in building a modern hospital.

However, there are other health-related projects which must comply with the $150 million cap. These include outpatient clinics, skilled nursing facilities, diagnostic centers, and health maintenance organizations.

In the course of health reform markup the committee discussed the possibility of removing the cap on the tax-exempt bonds issued to finance these other types of health care facilities. Today's hearing will explore this subject in depth.

Is the current bond cap appropriate? Or does it need to be modified as a consequence of our overhaul of the Nation's entire health care system? These are the two basic questions which I hope this hearing can help us answer.

Chairman RANGEL. We have a fellow Member and outstanding legislator and leader in international health care that is going to share his views with us. Both committees welcome you.

Did you want to welcome Mr. Stark, Mr. Pickle? You may proceed.

Chairman PICKLE. I have a statement that I think we should stick with the script, Mr. Chairman.

Chairman RANGEL. Welcome, Mr. Stark.

STATEMENT OF HON. FORTNEY PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Let the record show I was welcomed by a slim majority, Mr. Chairman.

I have a 5-minute statement that will take me 1 hour to stumble through, but I would like to express strong opposition to the proposal to loosen the bond rules.

We argued this in 1986 and we let the cap off the hospitals and the hospitals now are running about a 66 percent occupancy with tremendous overexpansion, even in the State of New York, which, because of its good capital control system, had kept occupancy in the nineties but even New York is finding excess capacity now. And I would hate for us to waste money in the future by encouraging

overcapacity in hospices and nursing homes and a variety of areas that were stimulated by overzealous bond salesmen.

The Treasury takes a lemminglike approach. They look one way and point another. They say that the proposal would result in a revenue loss to the Federal Government and, second, they point out that all the members of this committee know that tax-exempt bonds are an inefficient means of providing a subsidy when compared to other more direct programs, such as grants and direct loans. And the proposal may result in a greater than optimal percentage of health care resources being spent in the capital intensive activities when most of us know that we already have too many MRIs, for example, in this country. And the proposal is not consistent with the general tax policy of limiting tax-exempt bonds.

If this were to pass, we would lose the only significant statutory limitation on the potential volume of bonds in the health care field. Far from being a solution, the unlimited use of these bonds would compound the problem of excess spending. You all know that we will be at the rate of about 19 percent of gross domestic product by the year 2000, and this bill would undermine any attempt at cost containment, whether it is through managed competition, which would let the marketplace decide, giving an unfair advantage to the capital intensive procedures, rather than those that might be more effective and lower cost but, indeed, more personnel intensive.

The proponents would argue that the expanded use of tax-exempt financing is necessary to meet the changes in the health care delivery system. But those are as yet unknown. The proposal runs completely counter to the cost containment measure in the Democratic health reform bill, and the major purpose of which is to slow the rate of growth of health care spending. It makes no sense to contain direct spending if we then subsidized indirect and inefficient spending through an unlimited tax-exempt financing method.

Few nonprofit health facilities are anywhere near the $150 million limit. We are now going to provide $100 million a year in help to indigent bondwriters and a few nonprofits who are large enough to be at the cap. I might point out that in our bill we have appropriated $603 million in the Public Health Service appropriations for community clinics and other such facilities which are the intended beneficiaries of this proposal.

I have targeted my comments to removing the cap for health care facilities, because that is the proposal before us today. But as my friend Bill Gradison points out in his ads, we are dealing merely with the ears and the nose of the camel here because I am sure you are all aware that the other body has a provision in its health reform which would remove the cap from all 501(c)(3) organizations and, therefore, we would be expanding the use of tax-exempt bonds far beyond the health care arena and that is the intent.

The volume of nongovernmental bonds also works to a detriment of your local government in issuing financing for State and local government bonds. We are faced here in the District, and we soon will be faced with a proliferation of bonds for convention centers and sports arenas and a whole host of interesting and proposed facilities, but for those of you who worked with Chairman Rangel and

Chairman Pickle and myself to contain the unfettered expansion of tax-exempt bonds, I think that you will realize that this is a first step down the wrong course and that we should continue to look, as we do, to subsidizing and assisting those facilities which are necessary in the public interest, but there has been no evidence, and I am sure there will be no testimony, to suggest that anybody is short of capital today for the needs expressed: For the use of the bonds in this bill.

So I would urge you to be very cautious when we start expanding the limit or taking the cap off of tax-exempt bonds. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Congressman Stark.

[The prepared statement follows:]

TESTIMONY OF REP. PETE STARK
BEFORE THE SUBCOMMITTEES OF
OVERSIGHT and SELECT REVENUE MEASURES
August 9, 1994

Mr Chairmen: I would like to express my strong opposition to a proposal to loosen the bond rules so that "related health care facilities" of 501(c)(3) hospitals can enjoy tax exempt financing without limit.

As you both recall, the Ways and Means Committee was fairly evenly split over removing the proposed $150 million bond cap for 501(c)(3) hospitals during consideration of the Tax Reform Act of 1986. Much to my disappointment, the committee opted in conference to allow hospitals unlimited use of tax exempt bonds to build and expand hospitals.

We are now faced with the fruits of that policy decision. We have a tremendous oversupply of hospital beds. Occupancy rates average 66% nationally. The American Hospital Association 1992 Annual Survey showed that 1,184 hospitals had occupancy rates below 40%.

Far from being a solution, allowing other health care facilities unlimited use of tax exempt financing compounds the problem of excess health care spending. The US spent 14 percent of GDP on health care in 1992, up from 7.4 percent in 1970. CBO projects that spending on health care by the year 2000 will be 18.9 percent if current trends persist. Our efforts at cost containment must not be undermined by tax changes which promote health care expenditures.

The proponents of this proposal argue that the expanded use of tax exempt financing is necessary to meet the changes in the health care delivery system that will result from health reform legislation. As the Chairman of the health subcommittee, I couldn't disagree more with that conclusion. This proposal runs completely counter to the cost containment measure in the House Democratic health reform bill.

A major purpose of HR 3600 is to slow the rate of growth in health care spending. It makes no sense to contain direct spending if we then subsidize indirect and inefficient spending through unlimited tax exempt financing.

The proposal is not only unwise, it is unnecessary. The market is already reshaping itself under current law bond limits. Few nonprofit health facilities are anywhere near the $150 million limit. We should not provide a tax benefit of over $85 million to help bond underwriters and a few nonprofits large enough to be at the cap.

Where health care expenditures are determined to be necessary, Congress can provide direct--accountable--spending as we do now. For example, in 1994 we have appropriated $603 million in public health service appropriations for community clinics, one of the intended beneficiaries of this proposal.

Obviously, I have targeted my comments to removing the cap for health care facilities because that is the proposal before us today. However, I am aware that the Senate may entertain a provision in health reform which would remove the cap for all 501(c)(3) organizations.

It would help to recall why Congress limited the use of tax exempt financing as we did in the Tax Reform Act of 1986. The expansion of the pre-1986 tax exempt financing raised concerns about the erosion of the federal income tax base, the inefficiency of a Federal subsidy administered through the tax system, and the anti-competitive effect that tax exempt financing gave to nonprofits over their for profit competitors. The volume of non governmental bonds worked to the detriment of governmental bonds issued to provide financing for state and local governments.

We should be mindful of the same concerns today as we reconsider tax exempt financing for non governmental purposes.

Chairman RANGEL. About this hospital bed oversupply we have in the private sector where they are not involved with 501(c)(3)s—what information do you have that you can say the 501(c)(3) hospitals and the tax-exempt bonds have caused the oversupply of beds?

Mr. STARK. I would just suggest to you that it has been the financing of the oversupply of beds in those areas unlike New York, which did not have some kind of State control over the expansion of beds, and Mr. Herger in my home State of California, we have about a 50 percent occupancy. And I would submit that 99 out of 100 of those hospitals which are nonprofit were financed with tax-exempt bonds.

Chairman RANGEL. Do we not have the same problem with the private hospitals with an oversupply of beds?

Mr. STARK. No, no, the private hospitals are much more inclined to have a higher occupancy and not be so capricious in financing because they are not given the same cheap interest rates for financing.

Chairman RANGEL. OK. If you can share that data with me, it would help.

[The information requested was not available at the time of printing.]

Chairman RANGEL. You are taking a pretty broad brush, but assuming that we should not remove the cap, since we are hopefully moving in with a new health system, and it would seem to me that maybe a lot of people in certain areas would like to consolidate or form specializations, could you consider with certain types of proposals, where clearly it would be cost containment and expansion of services that are needed in a particular community, and if the language was very tight, whether or not we could remove the cap or allow these other nonhospital but health-related facilities?

Mr. STARK. If the gentleman would yield, why would we not subsidize it? The gentleman is very familiar with an item in the bill we just passed which is giving a subsidy to hospitals in New York City for some $50 million or more per year that is in direct subsidy to that hospital. Far more efficient to do it that way directly with the taxpayers' money than to go out and add two-thirds increased cost to issue tax-exempt bonds. It is a very inefficient way to do the good work we are all interested in doing.

Chairman RANGEL. Well, what particular facilities are you talking about that receive subsidies? I am talking about different types of facilities like maybe skilled nursing homes.

Mr. STARK. Those are the facilities—we are spending $603 million in the first year in the Democratic health bill that we reported out for a variety of community clinics and nonhospital facilities. So that those funds are there, and this bill makes no distinction between putting——

Chairman RANGEL. I know, but whether it is for hospitals or any other type of health-related facility, we should not expand or expose any more debt.

Mr. STARK. There has been limited evidence that we have many facilities hitting that cap, and I think that where they do or subsequently if we had that evidence before us, you might want to raise the cap some. But to take it off, when you have, and I would guess

that out of 6,000 hospitals probably 5,000 of the 6,000 are nowhere near that limit.

If we have a few large facilities that need additional capital we should find a way to do that after they prove there is a broad community need, and we would save a lot of money for the Treasury.

Chairman RANGEL. Can you think of any purpose that you would suggest the use of tax-exempt bonds?

Mr. STARK. I have always preferred interest subsidy as more efficient subsidy and there is also a tradition for communities with general obligation bonds that I think would be hard to change. But I think this committee in the past has considered tax-exempt financing and we have had testimony from the Treasury that it is an inefficient way for us to direct the subsidy.

Admittedly, it is easy to do, or easier to do through the Tax Code, but if you will recall, we had this great influx of industrial revenue bonds, and the problem is that once you open this little subsidy, a lot of very smart people will take advantage of it and find ways that this committee never intended. And then we have to have Mr. Pickle put the genie back in the bottle and reform the industrial revenue bonds. I would rather take it a case at a time and not create the atmosphere that we know how hard it was to stop once it got going.

Chairman RANGEL. Chairman Pickle.

Chairman PICKLE. Mr. Chairman, I appreciate the testimony and statements of Mr. Stark. He certainly has been consistent over the years. Let me put a little different spin on this.

Currently, hospitals are exempt from the cap. In view of your testimony, Mr. Stark, what would you think about putting the cap on the hospitals? Not just exempting the others but putting this same $150 million cap on the hospitals?

Mr. STARK. Mr. Chairman, I have been concerned in the reform package that the one area that we have done nothing about is resource allocation or controlling the construction of facilities. And there is, in many areas of the country, there is a shortage of facilities. There are trauma facilities or absence of trauma facilities where we ought to have them. I find that the Tax Code is a kind of a clumsy way to pick and choose as to where we ought to.

. I happen to prefer a determination by State for allocation of resources. Some call them certificate of needs, but they have a bad name. To put the cap back on hospitals, I might do that prospectively, if we could determine some type of limitation. In other words, arguably for a small hospital in rural California, a $150 million cap is 10 times what they need. In New York City, that may be only half of what they need. So that an absolute cap could create some problems.

But I think given some basis of historical use for the facility and projected needs, I could see being more flexible in the cap than we are now.

Chairman PICKLE. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Hancock.

Mr. HANCOCK. I'd like to ask just a philosophical question here. Do you feel that the availability of tax-exempt bonds drives up the rate on the bonds that are not tax exempt?

Mr. STARK. Excuse me, Mr. Hancock?

Mr. HANCOCK. The fact that you borrow money tax exempt, you pay lower interest rates. Does that not drive the rate up on bonds that are not tax exempt to people that do not have the benefit of tax exemption, and they end up paying more because you only have a finite amount of money supply out there?

Mr. STARK. I do not think so. It does drive the cost of other tax-exempt bonds up. See, people who buy tax-exempt bonds generally are in one category. If you have a lot of new tax-exempt bonds coming in, it could be more expensive for your county or city or State to issue general bonds.

I am not sure that the average person buying savings bonds or putting their money in CDs is affected by the tax-exempt rate. But I am no expert on that.

Mr. HANCOCK. I am talking about the borrower, not the person that is buying the bonds. I am talking about the people——

Mr. STARK. Among borrowers from municipal or among nonprofit borrowers, more tax-exempt bonds could raise the cost for everybody.

Mr. HANCOCK. One more question. The 501(c)(3) organizations are supposed to be not-for-profit, charitable organizations set up for the purpose of providing a service to society rather than to make a profit. Theoretically, that is what it is all about.

In your judgment, how many decisions would be made—and here again this is just speculation—by these organizations whether to expand—but they cannot do it without tax-free bonds—or whether to expand because of the bonds being tax free? In other words, is that ever the deciding factor on whether they expand?

Mr. STARK. Well, I can just suggest to you, for instance in my own State of California, and in my own district in the city of Oakland, where a bunch of enterprising bond salesmen got the city to constantly refinance and issue tax-exempt bonds for purposes you would not believe, roller rinks and all kinds of cockamamie ideas, where the people issuing the tax-exempt bonds made a lot of fees and the good folks on the city council got suckered, I think, into borrowing more than they ever should have.

I suppose that if it was a good purpose and the issue was that you could borrow at 4 percent instead of 6 percent, you could say that this charitable organization saved that much money. If they did not need the money in the first place, you could say they wasted it. And the problem is that most of these bonds are promoted by bond houses and not by sound financial needs, in my opinion.

Mr. HANCOCK. Thank you.

Chairman RANGEL. Mr. Kleczka. I am sorry, Mr. Neal. No? Mr. Hoagland.

Mr. HOAGLAND. Mr. Stark, the arguments you have given in opposition to lifting that cap and expanding the exemption to nonhospital health care related facilities is that we have excess capacity already?

Mr. STARK. No, if the gentleman would yield, I am saying that the excess capacity might very well be considered the result of the previous decision we made to exempt hospitals from the cap, and one would presume that if we lifted the cap in other areas, such as nursing homes or hospices or drug treatment centers, that we would have the same result.

Mr. HOAGLAND. Now, you indicated that you could see some more flexibility in the caps than exist now. Can you be specific in terms of——

Mr. STARK. Well, Mr. Pickle had suggested that we put the cap back on hospitals, which I might find acceptable if we could find a way to categorize that. It is very difficult to do. I mean, a $150 million cap is kind of a one size fits all and, arguably, it might work in rural Nebraska where it would not work in downtown Chicago. So that is always a difficulty with a cap.

Mr. HOAGLAND. Well, are there any institutions in addition to hospitals for which you would favor lifting the cap? Any health care institutions beyond hospitals?

Mr. STARK. I do not think that there has been any proven need that there is a shortage of capital. General Electric has testified that they have not found the MRI site that they would not be willing to finance. Arguably, we have more MRIs around, and we have a great number of nursing homes that seem to do well. And where we did identify the need, it is more efficient, as the Treasury will explain, to do it with subsidies or direct infusions of capital either in interest subsidies or direct capital grants. It is cheaper for the taxpayer.

So in the absence of just pulling off the cap without really knowing where we are going, I am concerned that we are throwing $100 million a year at a problem that does not yet exist and which we might indeed create.

Mr. HOAGLAND. I am sure we are going to hear testimony later today, as soon as this panel is finished, about how we need to expand the exception to all sorts of health care facilities to facilitate mergers and consolidations and downsizing, the more rapid development of managed care institutions, managed competition networks. What is your response to that argument?

Mr. STARK. Well, I think, if the gentleman would yield, he would recognize that it is not an issue of their being able to get capital, to secure tax-exempt financing. I am sure the due diligence and financial projections are just as stiff as they would be through taxable financing. There is, on the margin, some interest savings. That is what we are paying for, the taxpayers subsidy.

Now, these facilities are so precarious that their success is dependent on 200 basis points in their financing, we ought to look over the whole thing. In other words, they would have to make the case that if they can get a 4 percent loan, the facilities will work, and if they would have to pay 6 percent, it will not work. And you have to be gambling a lot of public money on that kind of an assumption when you are making 20-year projections into a health care system where you have not had the opportunity for managed competition to even work yet. You may find that managed competition works so well that we can rebuild all these old facilities and remodel them at a third of the cost.

So I hate to encourage people. I would rather spend the money in home building. Yes, we know if mortgage rates go down people go out and buy houses. But I am not so sure we want to drop interest rates and have people running out and buying a whole bunch of MRIs. We may already have too many.

Mr. HOAGLAND. Well, thank you for those responses and those arguments. I will ask the witnesses, as they appear, to give their best responses to what you just said about whether, for instance, 2 percent can make the difference or not. So we will see what they say. Thank you.

Mr. STARK. Thank you.

Mr. HOAGLAND. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Houghton. Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

Mr. Stark, I just have one question, which is a point of clarification. You mentioned in your testimony that you might support taking the cap off of a few large facilities if that was deemed to be in the public's interest? Did I——

Mr. STARK. Let me put that the other way, if I may, Mr. Payne. Mr. Pickle asked me if I would consider putting the cap back on hospitals. Hospitals right now have no cap.

Mr. PAYNE. Right.

Mr. STARK. And I said I might consider that, but then we would have to have a more flexible cap than just $150 million, because $150 in a huge metropolitan area might be too low. In many rural areas it would, arguably, be too high. So that because, as I had suggested, there had been overcapacity in hospitals, although there does not seem to be much rush now with the high vacancy rate in hospitals, except in rural hospitals where we are having to directly subsidize those with capital infusion to make them viable under any circumstance, so for those very fragile hospitals, even a tax-exempt interest rate does not help them. They need real subsidies to perform a function in communities that are sparsely populated. So subsidies work where we know what we are subsidizing, and in some cases where we do not know exactly what we are subsidizing, we can create monsters that can grow pretty fast.

Mr. PAYNE. But I understood, as you were testifying before Mr. Pickle asked the question, you said that there were relatively few organizations that were now bumping up against the cap and that if there were large organizations that—and if it was deemed to be in the public interest, that there might be some kind of exception applied.

Mr. STARK. We could make exceptions on a case-by-case basis at minimal cost.

Mr. PAYNE. Thank you. That is what I wanted to know.

Mr. STARK. That would be easy, yes, sir.

Chairman RANGEL. Mr. Herger.

Mr. HERGER. I have no questions.

Chairman RANGEL. Mr. Stark, thank you. Is there anything you would like to add to your testimony? Have you made up your mind on this issue?

Mr. STARK. Mr. Chairman, I just am thrilled at the opportunity to be before you today and I look forward to hearing the rest of the witnesses.

Chairman RANGEL. Thank you for your contribution.

Now we will hear the views of the administration, the Tax Legislative Council, Glen Kohl from the Department of the Treasury. And you have someone with you, you can identify?

Mr. KOHL. Yes, this is Mitchell Rapaport, an attorney adviser on my staff.

Chairman RANGEL. Well, you can enter the statement in the record by unanimous consent or read it or proceed as you feel most comfortable.

STATEMENT OF GLEN A. KOHL, TAX LEGISLATIVE COUNSEL, U.S. DEPARTMENT OF THE TREASURY, ACCOMPANIED BY MITCHELL RAPAPORT, ATTORNEY ADVISER

Mr. KOHL. Thank you, Mr. Chairman. I thought I would read portions of my statement.

Chairman RANGEL. Very good.

Mr. KOHL. Honorable chairman and members of the subcommittees, thank you for the opportunity to present the views of the administration on the proposal to modify the restrictions on the use of tax-exempt bonds for certain nonprofit health care providers.

Specifically, the proposal would eliminate the $150 million cap on the amount of tax-exempt bonds that may be outstanding for the benefit of certain health-related facilities operated by qualifying 501(c)(3) organizations. In summary, for the reasons outlined below, the administration—later, I guess—the administration does not oppose the proposal, provided it is financed with an appropriate revenue offset.

As you know, tax-exempt bonds provide a subsidy to the ultimate borrower in the form of lower interest rates. Under the tax-exempt bond rules, State and local governments are generally permitted to borrow on a tax-exempt basis to finance their direct activities. By contrast, unless a statutory exemption applies, interest on private activity bonds, that is, bonds issued by State or local governments to finance the activities of private nongovernmental entities, is taxable.

Exceptions to the general rule that interest on private activity bonds is taxable include bonds issued to provide funding for airports, rental housing, single family mortgages, and student loans, as well as bonds issued for the benefit of section 501(c)(3) organizations. Qualified private activity bonds are subject to a number of limitations that do not apply to other tax-exempt bonds.

In the case of 501(c)(3) organizations, current law places a volume limitation on the particular 501(c)(3) organization. Specifically, no single section 501(c)(3) organization may be the beneficiary of more than $150 million of outstanding tax-exempt bonds.

However, in recognition of the large amounts of capital that hospitals require, this limitation does not apply to bonds to finance hospitals under current law. There is currently no limitation on the amount of a tax-exempt bond that may be issued for the benefit of a section 501(c)(3) hospital. The term "hospital" is generally defined in the legislative history to mean acute care, primarily inpatient facilities.

The proposal would expand the exception to the $150 million limitation so that, rather than being limited to hospitals, it would cover a broader class of health care related facilities. I should say that we do have some concerns regarding the proposal.

First, the proposal would result in a revenue loss to the Federal Government; second, tax-exempt bonds are an inefficient means of

providing a subsidy when compared to other more direct programs, such as grants and loans; and additionally, the proposal may, at the margin, result in a greater than optimal percentage of health care resources being spent on capital-intensive activities. Finally, we are also concerned about the general tax policy objective of limiting the volume of tax-exempt bonds.

While each of these matters is of concern to the administration, we recognize the importance of facilitating the health care providers' ability to adapt quickly to a changing health care environment. The range of health care providers needing large amounts of capital is no longer limited to hospitals within the current tax law definition. For example, the current definition of hospital does not appear to apply to a health care provider that wishes to build and finance more efficient satellite clinics and similar facilities, in addition to more traditional inpatient facilities.

The proposal would also eliminate the arbitrariness of the $150 million limitation which applies currently uniformly to both large and small institutions without regard to the need or the relative scope of the organization's activities.

In summary, although we have concerns regarding the expanded use of tax-exempt bonds, this proposal provides important benefits, particularly in light of health care reform. Therefore, we do not oppose the proposal, provided it is financed with an appropriate revenue offset.

This concludes my remarks, and I would be happy to answer any questions you may have, and the Treasury would be pleased to work with the subcommittee as the proposal moves forward.

[The prepared statement follows:]

STATEMENT OF
GLEN A. KOHL
TAX LEGISLATIVE COUNSEL
DEPARTMENT OF THE TREASURY
BEFORE THE
WAYS AND MEANS SUBCOMMITTEE ON SELECT REVENUE MEASURES
AND THE
WAYS AND MEANS SUBCOMMITTEE ON OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

Honorable Chairmen and members of the Subcommittees:

Thank you for the opportunity to present the views of the Administration on the proposal to modify the legal restrictions on the use of tax-exempt bonds for certain non-profit healthcare providers. Specifically, the proposal would eliminate the $150 million cap on the amount of tax-exempt bonds that may be outstanding for the benefit of certain health-related facilities operated by qualifying section 501(c)(3) organizations. In summary, for the reasons outlined below, the Administration does not oppose the proposal, provided it is financed with an appropriate revenue offset.

Background

General rules for tax-exempt bonds. Generally, the interest on the obligations of a State or political subdivision is excluded from gross income. Tax-exempt bonds provide a subsidy to the ultimate borrower in the form of lower interest rates. Under the tax-exempt bond rules, State and local governments are generally permitted to borrow on a tax-exempt basis to finance their direct activities. By contrast, unless a statutory exception applies, interest on private activity bonds--that is, bonds issued by State or local governments to finance the activities of private, nongovernmental entities--is taxable.

Tax-exempt private activity bonds. Exceptions to the general rule that interest on private activity bonds is taxable include bonds issued to provide funding for airports, rental housing, single family mortgages, and student loans, as well as bonds issued for the benefit of section 501(c)(3) organizations. Qualified private activity bonds are subject to a number of limitations that do not apply to other tax-exempt bonds. Most importantly, tax-exempt private activity bonds are generally subject to an annual volume cap that limits the amount of private activity bonds that can be issued in each year on a State-by-State basis. Thus, the aggregate volume of most tax-exempt private activity bonds is strictly limited.

However, this State volume cap does not apply to private activity bonds issued for section 501(c)(3) organizations. Instead, current law places a volume limitation on the particular section 501(c)(3) organization. Specifically, no single section 501(c)(3) organization may be the beneficiary of more than $150 million of outstanding tax-exempt bonds. However, in recognition of the large amounts of capital that these institutions require, this limitation does not apply to bonds to finance hospitals. Thus, there is currently no limitation on the amount of tax-exempt bonds that may be issued for the benefit of a section 501(c)(3) hospital. The term "hospital" is defined in the legislative history to mean acute care, primarily inpatient facilities.

Proposal and Administration's Position

The proposal would expand the exception to the $150 million limitation so that, rather than being limited to "hospitals," it would cover a broader class of health-related facilities. We do have some reservations regarding the proposal. First, the proposal would result in a revenue loss to the federal government. Second, tax-exempt bonds are an inefficient means of providing a subsidy when compared to other, more direct programs such as grants and direct loans. Also, the proposal may result in a greater than optimal percentage of healthcare resources being spent on capital intensive activities. Finally, we are also concerned that the proposal is inconsistent with the general tax policy objective of limiting tax-exempt bonds. The characterization of bonds for 501(c)(3) organizations as private activity bonds subject to the $150 million limitation is the only significant statutory limitation on the potential volume of these bonds.

Each of these matters is of concern to the Administration. Nevertheless, we recognize the importance of facilitating healthcare providers' ability to adapt to a changing healthcare environment. The range of healthcare providers needing large amounts of capital is no longer limited to "hospitals" within the current tax law definition. For example, the current definition of hospital does not appear to apply to a healthcare provider that wishes to build and finance more efficient, satellite clinics and similar facilities, in addition to its more traditional, inpatient facilities.

The proposal would also eliminate the arbitrariness of the $150 million limitation. Unlike the private activity bond volume cap, which is established based on the population of each State, the $150 million limitation is a flat limit that applies uniformly to both large and small institutions without regard to need or the relative scope of an organization's activities.

In summary, although we have concerns regarding the expanded use of tax-exempt bonds, this proposal provides important benefits, particularly with regard to healthcare reform. Therefore, we do not oppose the proposal to exempt health-related facilities from the $150 million limitation, provided that it is financed with an appropriate revenue offset.

* * *

This concludes my prepared remarks. I would be happy to answer any questions that you may have and Treasury would be pleased to work with your subcommittees as the proposal moves forward.

Chairman RANGEL. Is it your testimony that you would not oppose the proposal for the tax-exempt bonds but you really think there is a better way to finance it, as Congressman Stark was saying?

Mr. KOHL. Yes, we would not oppose the proposal. The proposal relates to the issue of the cap. The issue in question is not the tax-exempt bonds generally but what is the effect of the cap. And as to the proposal to remove the cap, we do not oppose that proposal.

Chairman RANGEL. But as relates to other facilities that may be required under the health bill, assuming it passes, would you allow that to be an exception to the rule? Would you support that?

Mr. KOHL. I am sorry, Mr. Chairman, would we——

Chairman RANGEL. The amendments would expand the exceptions for hospitals contained in the code to include certain nonhospital health care facilities, and those facilities would include clinics, HMOs, diagnostic, cancer, kidney disease treatment, drug-alcohol, home health, and nonhospitals. Would you support these being included?

Mr. KOHL. We would not oppose—we would not oppose the proposal extending to those 501(c)(3) health-related organizations provided there is a sufficient revenue offset.

Chairman RANGEL. Mr. Pickle.

Chairman PICKLE. Well, in that connection, then, what do you call an appropriate revenue offset? What do you mean by that?

Mr. KOHL. What I mean by that is that we believe the proposal should be paid for. We are not taking a position exactly what would be an appropriate revenue offset, more that there needs to be a revenue offset.

Chairman PICKLE. If we lift a cap on a particular health facility or a clinic, would we then say, in that instance, you have to raise enough money to offset that loss, whatever the loss would be?

Mr. KOHL. No, I think——

Chairman PICKLE. Do you have to include that in the bill?

Mr. KOHL. The proposal would be—we do not oppose a proposal that, as estimated, is revenue neutral in the aggregate over the budget window.

Chairman PICKLE. Well, we know—I think there is no controversy, if you did give this exemption there will be a revenue loss. Some estimates are as much as $400 million in 10 year's time in this particular approach. That will be a loss to the Treasury Department and you are saying you do not oppose lifting the cap, but if we did lift the cap it has to be offset by a revenue offset. Now, how do we provide that offset?

How would Congress go about doing that? Can you give me an example? I know what you mean generally that we would have to raise the money to pay for it, but would we just have to do it in connection with that particular one or would we have to come back later?

Mr. KOHL. It would be as a general matter, Mr. Chairman. To the extent this occurred in the context of health care reform generally, it could be funded with cost containment and the other revenue saving measures there.

Chairman PICKLE. I don't want to be critical but it sounds to me like that is kind of a wiggle out. You don't oppose lifting it but we

have to raise some money somehow to offset it in some appropriate manner.

Do you think these clinics and the diagnostic centers, cancer, alcoholic, all the other ones, are necessary, that financing is necessary for them and, therefore, you would have to lift the cap? Do you think it is necessary? Is it vital we lift the cap so that they can be financed?

Mr. KOHL. Mr. Chairman, I believe right now the cap is—I am not sure how large such institutions are. Currently, this cap has a very limited effect, as only to the largest health care providers, and our position here is just with respect to the cap and the efficacy of the cap and we do not oppose——

Chairman PICKLE. But my question is, do you recommend we lift the cap so that these clinics can be financed? Are they needed?

Mr. KOHL. We do not make such a recommendation, rather we just do not oppose.

Chairman PICKLE. You don't know, then. Is there any special reason for lifting the bond cap for health-related facilities but leaving it in place for other facilities such as universities?

Mr. KOHL. Mr. Chairman, we have previously testified that we will—provided there is sufficient funding, we will not oppose lifting the cap for other 501(c)(3) organizations as well.

Chairman PICKLE. Such as universities?

Mr. KOHL. Such as universities.

Chairman PICKLE. Well, Mr. Chairman, that will be it.

Chairman RANGEL. Mr. Hancock.

Mr. HANCOCK. This position of saying you do not oppose the proposal really kind of leaves this committee up in the air. Are you in favor of lifting the cap? Do you think that we ought to broaden it to all the 501(c)(3)s or do you just want to take a neutral position and say to this committee you do what you want to do, but if you do it, you have to raise taxes someplace to make up for it?

Mr. KOHL. We do not—we are saying if it is funded, the revenue offsets could take the form of spending cuts as well. Our view is that this is not our initiative but that we will not stand in the way of it.

Mr. HANCOCK. In other words, you still do not know for sure what you stand for, then? I mean, you do not know whether you are in favor or——

Mr. PICKLE. To what are you referring?

Mr. HANCOCK. I am talking about——

Chairman RANGEL. Regular order here.

Mr. HANCOCK. Look, the administration, I feel, ought to take a position on this thing one way or the other, instead of just a neutral position that we do not oppose. Anybody can say that. That makes everybody happy but it does not really accomplish anything.

Has there been CBO scoring on this? Do we actually have it scored, in other words, for budget purposes? Have they scored how much of a revenue loss it will be?

Mr. KOHL. I believe it is around $100 million over a 5-year period.

Mr. HANCOCK. One hundred million dollars over a 5-year period.

Chairman PICKLE. If you would yield, I had heard from my staff it has been as much as $400 million over 10 years, which would

be at least $200 million over 5 years. So your figures are just half as big as mine, but it is somewhere between $100 and $200 million, at least.

Chairman RANGEL. My figure is $85 million over a 5-year period.

Mr. HANCOCK. If we had some more accurate figures or at least some better figures, or at least an agreement on some figures, maybe we could come up with whether you oppose it or do not oppose it.

As my friend Mr. Pickle said, I have a problem with this revenue offset language. I realize that the budget process requires us to be revenue neutral on a situation like this, but I would like to have a little more information. Maybe when we get into the next panels we can get from the nonprofit community how they propose to make this revenue neutral. Maybe they have some ideas.

Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman. Just a quick question. Have you had a chance to look at the Gephardt health bill?

Mr. KOHL. I am not the Treasury person working on that matter, sir.

Mr. NEAL. I would be curious if you might have some comments on how you believe the current legislation that is moving before the respective committees here, shortly to come to the floor of the house, would be impacted if we were not to lift the cap.

Mr. KOHL. I cannot answer that, sir.

Mr. NEAL. Can your counterpart?

Mr. KOHL. We believe that in the context of health care that an advantage of removing the cap is that it will increase the flexibility of health care providers to respond to the changing needs as more and more services are able to be performed on an outpatient basis.

Now, a hospital at the margin might be tempted to build a facility with beds so it would come within the definition of a hospital under current law, and with the cap removed there would no longer be that temptation to behave less efficiently.

Mr. NEAL. So, essentially, you are saying lifting the cap would be consistent with the changes taking place that are market driven.

Mr. KOHL. Yes, sir.

Mr. NEAL. Thank you.

Chairman RANGEL. Mr. Houghton.

Mr. HOUGHTON. I think my question really has been answered, but it seems to me this makes quite a bit of sense. If you do not want to have tax-exempt bonds, you eliminate it from everything in the health field. If you do want to have it, you should be modern and look at the things that are going to be built. And one of the things which has been clear to me in my observation of what has happened in the health business, particularly in construction, is that a hospital should never consider itself a hospital. Because it now is branching out, at least in the rural communities I represent, into far different other areas, outpatient clinics, long-term health care facilities, individual specialized areas, which are far less expensive to maintain, and which also do not fall under this general hospital category, as you say.

So I think the proposal makes a great deal of sense. And, frankly, although you would require an offset, and we do have antiquated scoring systems, but I think it would be very easy to determine the amount of revenue you get in taxes just on the construction itself of these different facilities over the years. So I do not think it is going to be a burden on the budget or the American public at all.

Thank you very much.

Chairman RANGEL. Mr. Hoagland.

Mr. HOAGLAND. Mr. Kohl, first, I wonder if you could clarify for us how these budget figures are working. I think we have been given, as has Mr. Rangel, a figure of $87 million over 5 years and $400 million over 10 years. Is that your understanding of the revenue loss?

Mr. KOHL. Yes, that is about right. In effect, then, we believe that while it grows in a nonlinear fashion, it will grow larger over time.

Mr. HOAGLAND. I was going to ask you to enlighten us as to how it would cost only $85 million in the first 5 years and $313 million in the second 5 years. It is $313 million more in the second 5 years.

Mr. KOHL. I believe it is a function that each year as time goes on there will be more and more bonds outstanding.

Mr. HOAGLAND. All right. Now, in your statement, you indicate that on page 2, the first paragraph, the last sentence, you indicate the $150 million limitation is the only significant statutory limitation on the potential volume of these bonds. But there are other limitations in statute, are there not, about the appropriate use of such funds?

Mr. KOHL. Yes. As to volume, that is correct, yes. But there are appropriate limitations, arbitrage restrictions, so they cannot just be borrowed and invested. Restrictions within 501(c)(3) that require them to be used for a tax-exempt purpose, yes. So there are other controls in place, though not formally expressed in terms of volume.

Mr. HOAGLAND. As I understand it, the reason the limitation was imposed along with these controls is that back before there was a limitation at all, some institutions were borrowing huge amounts of bonds for purposes other than that contemplated. So the lid was put in place and the restrictions were imposed. Do you have any historical knowledge about that?

Mr. KOHL. I believe that was part of a larger effort to reform tax-exempt bonds that did address some of those issues.

Mr. HOAGLAND. OK. Now, if we were to lift the cap, let's say industrywide, health care industrywide, are there any additional restrictions you would want in place to be sure that the funds were used as intended or as appropriate? Or have you not looked into that?

Mr. KOHL. At this time we do not have the specific recommendations as to that, other that to say that in other contexts the administration has supported the intermediate sanctions proposal applicable to 501(c)(3)s generally.

Mr. HOAGLAND. All right. But in terms of the use of these kinds of funds for capital development, maybe some of your people could look at that issue and if you think those other restrictions need to

be beefed up so as to make lifting the cap easier, you could let us know.

Mr. KOHL. We would be pleased to work with the subcommittees in examining that issue.

Mr. HOAGLAND. Now, finally, I think you and Mr. Houghton have really helped us kind of clear the way here toward why one persuasive reason, Mr. Chairman, as to why we need to broaden this is that hospitals are going to want to put more beds in instead of exploring other more efficient ways of rendering health care, particularly in these—this period of enormous change when we expect, I think, don't we, that we are going to be seeing a whole lot of major change in the next 5 or 10 years as managed care networks are forming?

Certainly in Omaha we are going through the largest period change in my lifetime, and if we restrict tax-exempt bonds to sort of one type of facility, then we are going to be skewing the—this market-oriented development of managed care institutions.

So that is a pretty good reason for removing the cap, don't you think?

Mr. KOHL. Yes, sir.

Chairman RANGEL. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. I am not sure these witnesses are the best ones to address this, but I am not sure I agree with Mr. Houghton's analysis. I am not sure I disagree either.

I haven't heard enough yet, but it seems to me that we ought to think a little bit before we just make this wide open and lift the cap, because as often happens, we have unintended consequences of very noble intentions of the Congress. Perhaps we ought to revisit the whole issue of tax-exempt bonds for hospitals.

I don't know of many hospitals that are adding beds today, even with the tax-exempt status for bonds, so I am not sure of that existence of a no cap for tax-exempt bonds for hospitals. What it may very well do though, if we lift the cap, is drive the market in the way of the few 501(c)(3) organizations that are not able to exceed the cap today.

I am not sure that that is wise policy, particularly in an environment when we are trying to slow the growth of health care costs in this country. We are about to take a step here that it seems to me just looking at it at first blush, anyway, would encourage more health care spending.

So I just want us, before we get on this train and move it along, to think about the bigger context of health care expenditures generally in this society and the fact that we are trying to slow those down. What we are about to do or thinking about doing here is encouraging more health care spending.

So that is all I have right now, Mr. Chairman.

Mr. HOUGHTON. Would the gentleman yield?

Mr. MCCRERY. Sure, I'd be glad to.

Mr. HOUGHTON. If I could just respond to that. It is probably pretty much of a generalization, and that may not be a true statement, but I feel this deeply, that when you find a changing condition in which you must invest more money, despite the fact that

you are eliminating other assets which must be written off, that what you are doing is generating productivity in that area.

For example, we talk about people who do not have any health insurance going to the emergency rooms. I mean, you have got a huge asset. You have got highly technical specialists there. It shouldn't be used for the types of things it is used for. If you can set up a specialized or a first aid station and it might cost $1 million to set that up, it is going to be an advantage to the community and also to the overall taxpayers.

So I think the concept of investing to obsolete is not necessarily a bad one, despite the fact that it takes overall money to do it.

Mr. MCCRERY. And I appreciate what the gentleman says and, as I said at the outset, I am not sure that he is wrong, but I am sure not sure at this point that he is right either. I just think we ought to be very careful before we use the Tax Code to drive actions in the private sector, particularly in the health care sector where there are so many changes taking place, and to me the most powerful thing driving health care changes today is the marketplace, void of any government interference.

A lot of the change that is taking place in the marketplace is taking place despite government policy, and so I just want us to be very careful in this context of health care reform, in this context of spending so much of our gross national product on health care, before we encourage more spending for health care. At this point, I am not convinced that this change is needed to facilitate the changes that are already taking place in the marketplace.

Chairman RANGEL. Mr. Payne.

Mr. PAYNE. I have no questions, Mr. Chairman.

Chairman RANGEL. It would seem to me that maybe you should speak with some people over there at the HHS and see what they suspect the consequences would be if and when the health bill passes and whether they see the need for additional capital out there so that when the Treasury Department says, do what you have to do but pay for it, you might think of some restrictions that you may want to put on it based on what the administration thinks its health needs are going to be.

Because it is possible that we might do this in conference, and so you might get a better idea as to what some of the health providers' problems are and see whether or not, if we decide to pay for it and do it, you might want to think of some restrictions to kind of target it for certain problems that the administration may think would come up, mergers or HMOs or clinics.

Certainly we are trying to move health care out of the hospitals. That is one of the objectives, so you might want to give that some thought, and we thank you for your testimony.

Mr. KOHL. We will do so, Mr. Chairman. Thank you very much.

Chairman RANGEL. Now, we have the State of New York Medical Care Facilities Finance Agency, John Martinez, president and chief executive officer; Lutheran General HealthSystem and Protestant Health Alliance, Stephen Ummel, president and chief executive officer, Lutheran General HealthSystem; and chairman, board of directors, Protestant Health Alliance; Fred Hutchinson Cancer Research Center, Seattle, Wash., Randy Main, vice president and chief financial officer; American Association of Homes & Services

for the Aging, Laverne R. Joseph, president and chief executive officer, Retirement Housing Foundation, Long Beach, Calif.

Mr. Martinez.

STATEMENT OF JOHN G. MARTINEZ, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NEW YORK STATE MEDICAL CARE FACILITIES FINANCE AGENCY

Mr. MARTINEZ. Mr. Chairman and members of the subcommittees, my name is John Martinez and I am the president and chief executive officer of the New York State Medical Care Facilities Finance Agency, referred to as MCFFA.

MCFFA is the largest issuer of tax-exempt bonds for health care in the country and as a result, we are acutely aware of the potential ramifications of national health care reform. Additionally, we are concerned that at a time when emphasis is placed on lowering the cost of health care on the delivery side, significantly less emphasis has been placed on the capital necessary to provide the facilities through which delivery can be accomplished.

Our issue is not a question of a shortage of capital. It is a question of access to affordable capital. Many institutions which will be important to health care reform are not hospitals. Yet current law limits those nonhospital facilities to $150 million per institution in outstanding tax-exempt bonds.

As nonhospitals and hospital systems form integrated delivery systems in response to health care reform, they will conceivably run into the limitations of the $150 million cap. This result will impede the creation of integrated systems that provide a continuum of care in a variety of settings, not just acute facilities.

The definition of hospital for purposes of the $150 million cap is virtually unworkable in today's medical environment and is contrary to the policy of encouraging more outpatient treatment and other less intensive forms of care. Hospitals should become health care.

Health care reform will undoubtedly encourage the development of alternative health care facilities and thereby increase the need for bond issuances by nonhospitals. We have been approached by numerous hospitals planning to extend their operations into nonacute care functions such as neighborhood diagnostic and treatment facilities, medical equipment acquisition entities, and ambulatory care centers, and the list goes on.

In order to access capital in a cost effective way, these new facilities would benefit from affiliations with or ownership by hospitals that have healthy balance sheets. Hospitals that might wish to lend their credit to an otherwise risky or lower rated venture have a limited ability to do so because of the $150 million cap. This cap is an additional barrier to hospital mergers.

Prior to a merger, each hospital, together with affiliates, has its own $150 million limit for nonhospital bonds. Yet, after a merger or other affiliations, such as the creation of a common parent corporation, the institutions would have a single limit.

While corrective action may be possible in some cases, the current law rule clearly presents a potential barrier to hospital mergers. Further, the barrier is one that many hospitals, which are not close to the cap today have not had the occasion to analyze and

would involve undertaking the cost and administrative burden of allocating bond proceeds between hospital and nonhospital projects.

In New York, there are four specific examples I would like to illustrate.

The New York State Association of Retarded Persons, the Nation's largest provider of nonprofit community-based care, is currently at the cap and cannot issue any more tax-exempt bonds for new community facilities. This state of affairs exists at a time when NYSARC is also coping with the consequences of the State of New York's court-mandated deinstitutionalization.

As a result, they are unable to take advantage of the New York mental health facility program which provides a credit enhanced approach to tax-exempt bond financing. This program provides the lowest possible cost of capital for facilities which would not otherwise have access to a cost effective alternative.

These community-based facilities could deliver appropriate care in a less restrictive setting for far lower cost than institutional care. Thus in this instance the cap works against both cost reduction and court-ordered deinstitutionalization.

New hospital affiliations will also likely be affected. I have attached to my written testimony a listing of recent hospital affiliations which will likely be impacted by the cap, and we believe that their lack of access to low cost capital may contribute to a more costly, less efficient, health delivery system.

Mount Sinai Hospital is a facility with an international reputation which last year had to go into a taxable bond route because they are currently at the cap and unable to use tax-exempt financing. And finally, HIP of New York, which is an HMO, will be at the cap in a few weeks because of their continued growth and attempt to have a lower cost of providing health care. And they are currently in New York and New Jersey and soon, because of changes in their corporate structure, will also have this cap impact them in Florida.

We would suggest changing the definition from hospital to health care facility and in the testimony we have listed a series of facilities and uses which we believe would be helpful in addressing the ongoing needs of health care.

In light of the expected dramatic shift away from the acute care facilities toward decentralized community-based facilities, it seems clear that nonhospital 501(c)(3) institutions also play an ever-increasing role in health care reform. Therefore we strongly recommend a redefinition of the types of facilities which would be exempt under the $150 million tax cap.

Thank you.

Mr. NEAL [presiding]. Thank you, Mr. Martinez.

[The prepared statement and attachment follow:]

STATEMENT OF JOHN G. MARTINEZ
PRESIDENT/CEO
STATE OF NEW YORK MEDICAL CARE
FACILITIES FINANCE AGENCY

Mr. Chairman and members of the subcommittees, my name is John G. Martinez, the President/CEO of the New York State Medical Care Facilities Finance Agency (MCFFA). MCFFA is the largest issuer of tax exempt bonds for healthcare in the country. As a result, we are acutely aware of the potential ramifications of national healthcare reform. Additionally, we are concerned that at a time when emphasis is placed on lowering the cost of healthcare on the delivery side, significantly less emphasis has been placed on the capital necessary to provide the facilities through which delivery can be effectuated. Today my testimony will focus on one provision in current federal tax law which may be detrimental to our ability to provide access to low cost capital. That provision is the current cap of $150 million of tax-exempt bonds per non-hospital 501(c)(3) institution.

To address the health care needs of the under-served, particularly in inner city and rural communities, non-profit 501(c)(3) health care institutions will need to provide health care in a more efficient and cost-effective manner. Cost reductions could be achieved by government caps, by encouraging innovative methods of delivering and paying for health care services, or some combination of both approaches.

One result of health care reform that is certain is the acceleration of the need to down-size the acute care system, with hospitals and other health care providers consolidating, to reduce in-patient capacity while filling other gaps in the system (such as continuing care for the elderly). The goal of this "re-tooling" is to find innovative ways to serve consumers more efficiently (such as ambulatory care centers to reduce costly in-hospital stays or community health centers to reduce the use of emergency rooms as primary care facilities).

The $150 Million-Per-Institution Cap Discourages "Non-hospital" Facilities Important to Health Care Reform

Many institutions important to the Health Care Reform Plan are not "hospitals" (e.g., non-profit health maintenance organizations or "HMOs"), yet current law limits these non-hospital facilities to $150 million per institution in outstanding bonds. As non-hospitals and hospital systems form integrated delivery systems in response to health care reform (e.g., long-term care facilities or free-standing ambulatory care facilities) they will conceivably run into the limitations of the $150 million cap. This result will impede the creation of integrated systems that provide a continuum of care in a variety of settings, not just acute care facilities.

The definition of "hospital" for purposes of the $150 million Cap is virtually unworkable in today's medical environment and is contrary to the policy of encouraging more outpatient treatment and other less intensive forms of care: "Hospital" should become "Healthcare."

Current Data Suggests the Immediacy of the Problem Caused by the $150 million Cap

At a time when we are moving toward a "non-hospital" delivery system, the $150 million Cap serves as an important dis-incentive to innovation. While I am certain many other states have health care institutions that are at the $150 million limitation applicable to non-hospitals, my comments focus on New York State.

The Cap As a Barrier to More Efficient and Consolidated Delivery Systems

Health Care Reform will undoubtedly encourage the development of alternative health care facilities (such as HMOs, family clinics, more long-term care and continuing research, and other collaborative efforts between hospitals and non-hospitals) and thereby increase the need for bond issuances by non-hospitals. Further, we have been approached by hospitals planning to extend their operations into non-acute care functions such as neighborhood diagnostic and treatment facilities; medical equipment acquisitions entities; ambulatory care centers; nurse recruiting services; and long-term residential care facilities. In order to access capital in a cost-effective way, these new facilities would benefit from affiliations with or ownership by hospitals that have healthy balance sheets. Hospitals that might wish to lend their credit to an otherwise risky or lower-rated venture have a limited ability to do so because of the $150 million cap. As a result, we are concerned that more non-hospitals will approach the $150 million cap.

The Cap as an Additional Barrier to Hospital Mergers

Prior to a merger, each hospital (together with its affiliates) has its own $150 million limit for non-hospital bonds. Yet after a merger or other affiliation (such as the creation of a common "parent" corporation) the institutions would have a single limit! Any bonds that exceed the $150 million limit could become taxable retroactively to their date of issue, an event that would constitute a default under the typical covenants governing non-hospital 501(c) (3) bonds. This potential problem could be exacerbated by the rule that -- where a non-hospital bond is advance refunded -- both an outstanding refunded bond and the outstanding refunding bond are counted against the Cap.

While corrective action (such as reduction of the amount outstanding by redemption or purchase of a sufficient amount of bonds) may be possible in some cases, the current law rule clearly presents a potential barrier to hospital mergers. Further, the barrier is one that many hospitals -- which are not close to the Cap on a stand-alone basis -- have not had the occasion to analyze (which would involve undertaking the cost and administrative burden of allocating bond proceeds between "hospital" and "non-hospital" projects).

Specific Examples Of These Problems Exist In New York

In New York there are four specific examples where non-profit health care institutions are currently impacted by the cap:

1. Mental Health Facilities Needed for Deinstitutionalization

For example, the New York State Association of Retarded Persons ("NYSARC") -- the Nation's largest provider of non-profit community-based-care--is now at the cap, and thus cannot issue any more tax-exempt bonds for new community facilities. This state of affairs exists at a time when NYSARC is also coping with the consequences of the State of New York's court-ordered mandate to de-institutionalize!

As a result they are unable to take advantage of the New York Mental Health Facility program which provides a credit enhanced structural approach to tax-exempt bond financing. This program provides the lowest possible cost of capital for facilities which would not otherwise have access to a cost-effective alternative. The higher resultant cost of taxable capital only adds to the cost of services provided.

Finally, these community-based facilities can deliver appropriate care, in a less restrictive setting, for far lower cost than institutional care. Thus, in this instance the cap works against both cost-reduction and court-ordered deinstitutionalization.

2. New Hospital Affiliations Which Will Likely Be Affected By the Cap:

Attachment A is a list of recent hospital affiliations, particularly of smaller community hospital facilities forming affiliations with larger teaching hospitals and academic medical centers, affiliations which have already occurred in New York in response to expected healthcare reform. We fully expect that the next step will be toward primary care centers and long-term care centers. These networks will likely find themselves rapidly at odds with the $150 million cap because of the combination of the relatively smaller outstanding debt of the smaller hospitals with the debt of these larger institutions. The result will be higher cost capital at a time when the new system will need the lowest possible capital cost to facilitate long-term economic viability. This lack of access many contribute to a more costly, less efficient health delivery system.

3. Mount Sinai Hospital

Mount Sinai Hospital, a facility with an international reputation, was precluded from using tax-exempt bonds last year for a non-hospital health care related financing because it is already at the statutory cap. As a result, the institution was forced to issue taxable debt for its needed facility. This taxable issue results in a higher debt load to the hospital, with increased debt service payments that must be paid through higher costs to the reimbursement system or higher fees to other users.

4. New York HMO With Affiliates in Other States

Finally, HIP of New York -- which also has an established presence in Florida and New Jersey -- will be at the cap in a matter of weeks and will of necessity turn to the taxable market for financing of its continued plan for growth. As I described above, HIP's problem exists because the cap is imposed at the corporate level. Because it is part of a consolidated, three-state non-profit entity, operations in New York and New Jersey are currently constrained, and as they continue to grow, corporate changes will ultimately affect operations in Florida.

Proposed Solution: Definition of "Health Care Facilities"

The following "conceptual" definition is based on state law which defines the purposes for which health bonds can be issued. We believe it is critical that a policy which encourages more out-patient treatment and other cost-effective forms of care be established by taking health care facilities out of the $150 million-per-institution cap.

The following definition would serve to advance this new policy and facilitate a more cost-effective means for implementation of healthcare reform.

"Health care facility" would mean, with respect to a 501(c)(3) organization, any land, land improvement, building, structure, fixture, utility, system, machinery, equipment or other real or personal property (a "facility") useful for or associated with the delivery of in-patient or out-patient health care service or support that is operated as part of the exempt activities of such 501(c)(3) organization as any of the following:

1. a hospital,

2. a clinic,

3. a health maintenance organization,

4. a diagnostic, treatment, or surgical center,

5. a comprehensive cancer center,

6. a kidney disease treatment center,

7. a drug treatment center,

8. an alcohol treatment center,

9. a home health agency,

10. a hospice agency,

11. a skilled nursing facility,

12. a psychiatric hospital, or

13. a community mental health center;

provided that "health care facility" would exclude any facility that is maintained by a 501(c)(3 organization primarily for lease or rental to health care professionals who are not employed directly by a 501(c) (3) organization or any state or local government.

In light of the expected dramatic shift away from acute care facilities toward de-centralized community based facilities, it seems clear that non-hospital 501(c)(3) institutions will play an ever-increasing role in healthcare reform. Therefore we strongly recommend a re-definition of the types of facilities which would be exempt under the $150 million tax exempt bond cap.

ATTACHMENT A

The New York Times

April 4, 1994, Monday, Late Edition - Final
Correction Appended

SECTION: Section A; Page 1; Column 1; Metropolitan Desk

SMALL HOSPITALS BEING RECRUITED TO JOIN WITH MANHATTAN GIANTS

By ELISABETH ROSENTHAL

Until recently, doctors and administrators at Manhattan's prestigious medical centers looked down on the city's dozens of smaller hospitals, which they referred to condescendingly as community hospitals populated by L.M.D.'s, short for "local medical docs."

But today, with new economic pressures driving the organization of health care, the big-name institutions are aggressively courting those same hospitals, offering to affiliate in exchange for perquisites like low-interest loans to improve weak departments, consultations with internationally recognized academic experts and professorships at some of the best medical schools in the world.

One result is the emergence of a few huge hospital networks in the New York area, and a constantly shifting landscape of hospital alliances that make Balkan politics seem simple in comparison. New York Hospital-Cornell Medical Center, and Columbia-Presbyterian and Mount Sinai Hospitals each already have more than half a dozen smaller hospitals in their respective stables -- mostly in the four boroughs outside Manhattan and in Westchester -- and are actively negotiating with many more.

Such consolidation is taking place all over the country, but is most striking in New York, where hospitals until recently have turned a blind eye to the inevitable arrival of managed care. Now, they feel under pressure to catch up.

"Everyone is talking with everyone else," said Dr. William T. Speck, the president of Columbia-Presbyterian Medical Center, recounting the search for new partners. "You walk into a hospital and think it's perfect for you and then you find out that Dr. Skinner from New York Hospital was there yesterday and Dr. Rowe from Mount Sinai is coming tomorrow."

For the parent hospital, affiliating with smaller institutions brings a steady flow of referrals for tertiary care, highly specialized and often expensive medical procedures, like bypass surgery, that the medical giants need to survive and the community hospitals often cannot perform. And, since most of the smaller hospitals that have signed up cater to working people, most of the patients they refer are insured.

In return, the smaller affiliates get the connection with a big-name hospital and its resources, which they hope will prove a lifeline as other small hospitals are forced to close amid demands for greater efficiency.

But more than that, hospitals large and small are looking toward the future, hoping that their new networks will be attractive to insurers, health maintenance organizations and large companies seeking a full range of medical services for members or employees at a fixed price.

THE SMALL AND POOR MAY BE LEFT OUT

These networks are part of a transformation of medical care in the New York region that seems inevitable whatever the fate of health reform in Washington, as more New Yorkers are pushed into cost-conscious health plans that restrict patients' choices of doctors and hospitals.

"Hospitals are all afraid that when the dust settles there will only be a few efficient health systems operating in New York, and they want to be included in one that's there," said Dr. John W. Rowe, president of Mount Sinai Medical Center.

With the fast pace of consolidations, regulators are already worried that the big networks in New York will not do a good job of serving local communities and that small hospitals in poor neighborhoods will be left out.

The new partnerships often bring together the strangest of bedfellows. The main entrance of Presbyterian Hospital, flanked by the tenements of Washington Heights, can rival a midtown subway station in its bustle and chaos, as hundreds of people stream in each hour. Meanwhile, its new Brooklyn affiliate, Victory Memorial, sits next to a duck pond and a golf course. One recent afternoon there, only four people sat on leatherette chairs in a tidy lobby, and everyone seemed to know each other by name.

At Presbyterian, many patients are minority members on Medicaid, and are poor. At Victory, they are largely white, middle class and well insured. At Presbyterian, with its Ivy League connection, the doctors are culled from the best American medical schools; at Victory, many are foreign graduates.

But today, these very different hospitals have been driven together by a common fear: being left out of the revolution in the health care industry.

"We are trying to prepare for what we think is down the road, when you're going to have to be part of a health-care entity that third-party payers and H.M.O.'s are going to negotiate with," said J. Donald Di Cunto, president of the board of trustees at Victory Memorial.

Paul F. Macielak, vice president for government, community and public affairs at New York Hospital-Cornell Medical Center, used similar terms for the motivation of the medical giants, saying that larger hospitals must reach out for new patients.

"With the trend towards managed care, academic centers have to have a broad base of patients to survive," he said. "If I'm Citibank and I have employees all over the New York region, I'm going to want to contract with a network that has facilities everywhere."

But some health care regulators worry that what makes financial sense for hospitals may not be good for patients. The New York State Department of Health is considering whether to regulate these partnerships out of concern that the smaller hospitals will become mere referral banks for Manhattan's giants, giving little to the communities in return.

"We are now looking at the question of how to deal with these new beasts," said Dr. Mark R. Chassin, the State Commissioner of Health.

Although the parent hospitals insist they will become involved in redressing the historically uneven quality of care in the boroughs outside Manhattan, Dr. Chassin said he was skeptical. For example, he said it was unlikely that the parent hospitals would be willing to accept legal liability for malpractice claims at their affiliates.

He also said he worried that hospitals in poorer areas that served mainly patients on Medicaid had been left out of the bidding war.

"In general, the more financially distressed hospitals that we regard as central to providing care in low-income communities have not been the first places the large networks have looked," Dr. Chassin said.

GEOGRAPHIC DIVERSITY IS GOAL OF ALLIANCES

But Dr. Speck of Presbyterian Hospital said that the large medical centers wanted to forge alliances with hospitals in geographically diverse regions. Presbyterian, he added, recently affiliated with Horton Hospital in Middletown, N.Y., which was in financial distress. Mount Sinai is negotiating with the city to manage two public hospitals in Queens.

And administrators at academic centers say the issue may be moot anyway, since they hope that the nation will have some form of universal health coverage in the next five years, assuring that no patient will be a financial risk.

"My sense is that what's going on out there is a scramble to obtain bodies, and people don't seem concerned about third-party payers versus Medicare or Medicaid," said Mr. Macielak of New York Hospital.

Nonetheless, Victory -- a typical small-town hospital that just happens to be in New York -- is a near perfect partner from the perspective of Manhattan's medical giants.

"Our patient base, and the method in which we maintain the hospital, made us attractive," said Mr. Di Cunto. "We were never financially stressed, so it would not have been necessary to pour in large amounts of money.

"Our equipment is state of the art, and we can give them the tertiary care work they need," he said, referring to giving Presbyterian the procedures that Victory cannot perform.

Victory does not perform neurosurgery, cardiac catheterization or open heart operations -- procedures that generate large revenues for big referral centers. And it does have a brand-new 10-bed cardiac intensive-care unit and a 25-bed cardiac monitoring floor, which turn out a steady flow of patients who need such care. Only about 5 percent of Victory's patients are on Medicaid.

But Victory does have its problems, including the highest Caesarian section rate in New York State, which has approached 50 percent for years. Dr. Speck said that Columbia-Presbyterian would address the issue.

The terms of the affiliation agreements vary greatly depending on the partners involved. But they are far more expansive than the traditional links between hospitals, which generally involved an agreement between a primary care hospital and an academic referral center or medical school for a particular service, like providing residents for a surgery ward or transferring sick newborns in need of intensive care.

Academic titles, once jealously guarded at New York's major hospitals, are now offered to some doctors at the community hospitals to emphasize the new camaraderie and to provide inducements to affiliate.

New York Hospital, which began the affiliation trend in the region, has favored agreements akin to leveraged buyouts: the parent hospital's network can appoint the board of the smaller hospital which, in turn, loses considerable

decision-making power. To save money, business, marketing and personnel departments are merged.

How this loss of autonomy will affect medical care at the smaller hospitals is unclear, but in theory the network could close down a department at a small hospital to make the system more efficient.

SOME NOT READY FOR 'LEAP OF FAITH'

"If we have two hospitals that duplicate services in the same area, our intent would be to bring two together," said Dr. David B. Skinner, president of New York Hospital, adding: "There's no question that some of the hospitals we would be interested in are not ready to take the leap of faith required to join the netowrk, to say, 'Here are the keys to the hospital and we trust that what you will do will be good for the place.' "

In contrast, Mount Sinai and Columbia-Presbyterian have favored loose contracts in which the smaller hospital retains its own board of directors and a large degree of autonomy. Depending on the smaller hospital's needs, the parent institution may agree to provide a variety of services, from help in shoring up a weak pediatrics unit to laundry service to the joint buying of medical supplies at volume discounts.

Although New York University Medical Center has been slow to embark on affiliations, it has recently begun to seek partners as well.

Administrators at hospitals large and small have debated endlessly about which arrangements leave them best positioned for the future.

Dr. Skinner, the president of New York Hospital, says he believes that a tightly knit hospital network will be most efficient.

But Dr. Speck of Columbia-Presbyterian questioned the wisdom of acquiring hospitals at a time when the trend is to outpatient care. "To me, developing hospitals is like collecting Edsels," he said.

Following this logic, Mount Sinai is now trying to draw patients into its network by bypassing the hospitals and negotiating directly with several large group practices of physicians -- an approach that Beth Israel Medical Center has also tried. But this strategy, which has worked in many other parts of the country, may have limited value in the New York area, since most doctors here practice individually or with only a few colleagues.

So as the mating dance goes on, many smaller hospitals debate which princely suitor best fits their needs.

"We feel we're a pretty successful hospital, medically and financially, and we want to preserve whatever autonomy we have -- which we could not do with the agreement New York Hospital was offering us," said an administrator at a small hospital outside Manhattan, which has recently broken off negotiations with New York Hospital and begun discussions with Mount Sinai. He refused to be identified for fear it would jeopardize the hospital's bargaining position.

And, he added: "There's also a lot of pride that goes along with this. We think they need us more than we need them. I'm sure they think the opposite."

HEALTH CARE: A NEW ERA FOR HOSPITALS

Large hospitals are joining with small ones in sweeping agreements to cooperate in a wide variety of programs including marketing, billing, purchasing and medical education as well as general patient care. One result is the formation

of several expanding hospital networks in the New York area.

The new partnerships are very different from the narrow academic relationships that New York's medical schools have long cultivated with community hospitals, in which they provide a particular medical service, generally residents to work in the smaller hospitals' wards. Hospital administrators say that at least some of these traditional relationships are likely to expand signficantly.

COLUMBIA-PRESBYTERIAN MEDICAL CENTER

Columbia-Presbyterian Network Hospitals:
St. Francis Hospital, Roslyn, L.I.
White Plains Hospital
Good Samaritan Hospital
Helen Hayes Hospital, West Haverstraw, N.Y.
Horton Hospital, Middletown, N.Y.
Victory Memorial Hospital, Brooklyn

Columbia University College of Physicians and Surgeons Academic Affiliation Hospitals:
St Luke's-Roosevelt Hospital Center, Manhattan
Morristown Memorial Hospital, Morristown, N.J.
Overlook Hospital, Summit, N.J.
New York Psychiatric Institute, Manhattan
Mary Imogene Bassett Hospital, Cooperstown, N.Y.
St. Francis Hospital
White Plains Hospital Center
Helen Hayes Hospital
Manhattan Eye, Ear and Throat Hospital

MOUNT SINAI MEDICAL CENTER

Mount Sinai Hospital Network Hospitals:
The Arden Hill Healthcare Institutions, Goshen, N.Y.
The Parkway Hospital, Forest Hills, Queens
Phelps Memorial Hospital Center, Tarrytown, N.Y.
Western Queens Community Hospital, Long Island City
St. Mary's Hospital, West Palm Beach, Fla.

Mount Sinai School of Medicine Academic Affiliations Hospitals:
Bronx Veterans Affairs Medical Center
City Hospital Center, Elmhurst, Queens
Englewood Hospital and Medical Center, Englewood, N.J.
North General Hospital, Manhattan
Queens Hospital Center, Jamaica
The Jewish Home and Hospital for the Aged, Manhattan

NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

New York Hospital Network Hospitals (The NYH Care Network):
New York Downtown Hospital, Manhattan
The New York Hospital-Cornell Medical Center (Westchester Division), White Plains
The New York Hospital Medical Center (formerly Booth Memorial), Flushing, Queens
The Hospital for Special Surgery, Manhattan
Community Hospital of Brooklyn
Methodist Hospital of Brooklyn
Silvercrest Extended Care Facility, Jamaica, Queens
Amsterdam Nursing Home Corporation, Manhattan
United Hospital Medical Center, Port Chester, N.Y.
Gracie Square Hospital, Manhattan

Cornell University Medical College Academic Affilation Hospitals:
Blythedale Children's Hospital, Valhalla, N.Y.
Burke Rehabilitation Hospital, White Plains
Catholic Medical Center, Brooklyn and Queens
Hospital for Special Surgery
Jamaica Hospital
La Guardia Hospital, Forest Hills, Queens
Lenox Hill Hospital, Manhattan
Memorial Sloan-Kettering Cancer Center, Manhattan
North Shore University Hospital, Manhasset, L.I.
New York Downtown Hospital, Manhattan
Rockefeller University Hospital, Manhattan
St. Barnabas Hospital, Bronx

CORRECTION-DATE: April 8, 1994, Friday

CORRECTION:

A chart on Monday with an article about links between large medical centers in Manhattan and other hospitals misstated the current academic affiliation of Lenox Hill Hospital. It is affiliated with New York University Medical Center, no longer with New York Hospital-Cornell Medical Center.

Mr. NEAL. We will now hear from Stephen L. Ummel, who is with the Lutheran General HealthSystem, and Protestant Health Alliance.

Mr. Ummel.

STATEMENT OF STEPHEN L. UMMEL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, LUTHERAN GENERAL HEALTHSYSTEM, AND CHAIRMAN, BOARD OF DIRECTORS, PROTESTANT HEALTH ALLIANCE

Mr. UMMEL. Good afternoon, Chairman Rangel, Chairman Pickle and members of the subcommittees. My name is Stephen Ummel, president and chief executive officer of Lutheran General HealthSystem based in Chicago.

I also serve as the elected chairman of the board of the Protestant Health Alliance, an association of some 200 faith-based hospitals and health systems across the country.

On behalf of these organizations and the patients we serve, I am here today to ask for your support of legislation that will repeal the $150 million cap on the amount of nonhospital tax-exempt debt that can be outstanding on behalf of 501(c)(3) organizations.

You may be wondering why this provision in the Tax Code draws the attention of the health care community, especially now during the tremendous debate on health care reform.

In my view, repealing the $150 million cap on nonhospital debt is as important as many other issues and provisions of the health care reform bills that are currently under consideration by Congress. Repealing the cap on nonhospital debt gets to the heart of structural changes in the delivery system that are necessary to allow networks of providers to reduce costs, broaden access, and demonstrate quality.

As you all know, the health care field is quickly restructuring and consolidating. Physicians and hospitals, insurance companies and providers are getting together, and even government-run health care facilities are looking to be part of emerging new community care networks.

I believe the two driving forces prompting these changes are managed care growth and the push from Washington for health care reform. These two forces have caused historically independent health care providers to ask how they could integrate themselves to provide and demonstrate better clinical outcomes at less cost.

Two years ago, Lutheran General HealthSystem, anticipating these and other changes, began organizing a system of care consistent with our religious beliefs and holistic philosophy that advocates the provision of comprehensive health services and health management to a defined population with the ultimate aim of improving health status.

This paradigm shift helped Lutheran General to transform itself from a vertical system with loosely connected hospitals, a children's hospital, large continuing care retirement community, long-term care facilities, a psychiatric institution, and dozens of ambulatory care facilities in 76 sites throughout the city of Chicago and its counties, converting all that into what we hope will be a consumer-oriented seamless continuum of care.

This continuum of care will guide and track individuals over time through a comprehensive network of medical, health, and social services, spanning all levels and sites of care. This is called a continuum of care or the Chicagoland continuum of care. We believe a continuum of care will replace hospitals as the health care product of the future. It is our vision at Lutheran General to operationalize this continuum in 1994 and 1995.

Along with our own organizational transformation, we have always known that to have a true continuum of care for a population, we also have to have complete geographic coverage for that natural medical market. Therefore, concurrent with our own efforts to design and implement a continuum of care, we have for the past 2 years been investigating larger scale networking opportunities.

Our goal is to collaborate with and join other partners, be they physician groups, hospitals, clinics, or other health providers. Together we would be able to realize the economies of scale, delivery restructuring, and complete geographic coverage necessary to become a bona fide community care network.

And after a long and thorough search, we have found such a partner in Evangelical HealthSystem, also based in Illinois, also a western suburb of Chicago. In fact, in June of this year, Evangelical HealthSystem and Lutheran General HealthSystem announced intentions to merge.

Our merger will create one of the largest, lowest cost, and most accessible networks in Chicagoland with close to 200 sites of care, only 8 of which are acute care hospitals. This new network will have over 3,500 physicians and over 19,000 employees. Our emerging continuum and the merger are entirely consistent with the stated goals of health care reform in Washington, be they Republican or Democratic.

The only impediments to our success will be our own inabilities and the structural or financial barriers that are imposed on us by Federal and/or State governments.

A barrier to our success is the reason why I am here today. I am here today to ask that you remove this bond cap that has been placed on nonhospital tax-exempt financing. Nonhospital services, such as outpatient clinics and senior care facilities are the backbone of a continuum of care, not inpatient hospital services. This cap has the potential to impede our success right now. It will do so in the following ways:

First, given the fact that we will be approaching the $150 million bond cap soon after our merger, the combined Evangelical-Lutheran system will be precluded from merging with or affiliating with any other health care providers. We will not be able to add other providers to our continuum of care, including financially distressed inner-city hospitals and other health care providers if their nonhospital debt, combined with ours, exceeds the $150 million cap, as it surely will.

Second, the newly formed Evangelical-Lutheran General system cannot incur any more tax-exempt, nonhospital debt even if it were used for nonhospital health care services, such as ambulatory care clinics and nursing homes. The Evangelical-Lutheran General system would be forced to go to the taxable equity markets for capital

where the difference in interest rates is anywhere from 2 to 2.5 percentage points higher.

For example, on a $100 million issue, this means increased interest payments of between $2 million and $2.5 million per year. These costs would be prohibitively expensive and could limit the development of the continuum of care throughout Chicagoland.

Third, we at Lutheran General and Evangelical understand the immense responsibility and opportunity we have been given to serve the health care needs of Chicago. We are aided in this mission by our tax-exempt status. And, our ability to access the tax-exempt bond markets is a privilege that we must earn and hold sacred.

Growing managed care penetration—given its vastly different financial incentives—will ensure appropriate capital investment and borrowing. Both Evangelical and Lutheran General have responded to this responsibility proactively by our commitment to our communities and to the underserved populations of the inner city of Chicago and its suburbs. In order to continue to provide needed community health services, Evangelical and Lutheran General must be permitted to access the tax-exempt bond markets for nonhospital debt.

In closing, EHS Health Care and Lutheran General HealthSystem are on the verge of creating a truly integrated health system. It will facilitate the rationalization or the "right sizing" of health care delivery throughout Chicagoland.

Concepts such as common paperless medical records that will allow continuity of care across multiple sites, eliminating bureaucracy and paperwork, as well as centralized diagnostic and administrative services that would create and enhance access, convenience, quality, and lower cost for the patient, are all within our immediate reach.

These innovations were unthinkable in the old delivery paradigm. We are excited about the future and we implore you not to let the arbitrary Tax Code developed in 1986 hinder these 1990 advances that will allow us to be a more socially responsible provider of health care to the citizens, to the 8 million citizens of Chicagoland.

I hope you will capitalize on this current opportunity to include a repeal of the $150 million cap in whatever health care reform legislation will pass Congress.

Thank you for the opportunity to testify today. I am happy to try to answer any questions you may have later.

Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF STEPHEN L. UMMEL
PRESIDENT AND CHIEF EXECUTIVE OFFICER
LUTHERAN GENERAL HEALTHSYSTEM AND
CHAIRMAN, BOARD OF DIRECTORS, PROTESTANT HEALTH ALLIANCE

Good Afternoon Chairman Rangel, Chairman Pickle and Members of the Subcommittees. My name is Stephen L. Ummel and I am President and Chief Executive Officer of Lutheran General HealthSystem in Park Ridge, Illinois. I also serve as Chairman of the Board of Directors of the Protestant Health Alliance which represents over 200 faith-based hospitals and health systems throughout the United States.

On behalf of these organizations and the patients we serve, I am here today to ask for your support of legislative efforts to repeal the $150 million cap on the amount of non-hospital tax exempt bonds that can be outstanding on behalf of a Section 501 (c) (3) organization. And, specifically, I will speak to the importance of this repeal to LGHS and its potential merger partner, EHS Health Care.

LGHS and EHS have announced their intention to merge. EHS and LGHS are currently large, independent, not-for-profit, vertically integrated, health care systems located in and around the Chicago metropolitan area. EHS is sponsored by the United Church of Christ and LGHS by the Evangelical Lutheran Church in America. We believe this merger is an excellent response to the demands of the Chicagoland and Illinois health care market and prepares us well for a reformed health care system. Most importantly, it will allow us to serve our patients and citizens in the Chicago metropolitan area more efficiently and effectively.

This merger will create one of the largest, religiously-sponsored health care organizations in the nation, dedicated to the church-originated mission of health care for all people. This new System will create a Chicagoland continuum of care -- a customer-oriented, seamless system composed of services and integrating mechanisms that guides and tracks individuals over time through a comprehensive network of health, medical and social services spanning all levels and sites of care. The goal of such a continuum is to improve the health status of targeted populations.

Through our merger we will become an integrated system of health care for Chicago -- not just a hospital system. Our merger will create one of the largest, lowest cost and most accessible health networks in Chicagoland with 177 sites of care, 3,550 physicians, and over 19,000 employees. Our merged organization will be commonly governed and managed, providing for one strategic vision that can effectively address community needs.

Because we will be commonly governed and managed, we will need to comply with the provision of the Tax Reform Act of 1986 which requires that a 501 (c) (3) organization shall not have more than $150 million of outstanding non-hospital debt. So, even though EHS and LGHS independently are allowed $150 million in non-hospital debt for a total of $300 million, together we will only be allowed $150 million. Organizations that, when they combine, exceed the $150 million cap will not be allowed to merge unless they can find a way to pay down non-hospital debt.

A seemingly obvious solution would be to pay down non-hospital debt with cash. This assumes, however, that the entity has cash to use, applicable bond covenants and laws permit this action and that the pay out of cash is a wise fiduciary decision. Cash availability and balances must be considered in providing working capital for health care services, for the purposes of liquidity and bond ratings. In addition, debt retirement may not be an option for systems because current law sets a limit of one advance refunding for debt on bonds issued after 1986.

In order to be considered hospital debt, the debt must have been incurred to finance or refinance inpatient medical facilities. LGHS had substantial pre-1986 non-hospital debt and both systems have incurred non-hospital debt during subsequent years in order to meet patient care needs. Neither system has exceeded the $150 million cap.

This cap may have made some sense in an era when free standing hospitals were the common structural model for the delivery of medical and health care, but today, with the advent of managed care, medical and information technology, ambulatory care, and health care reform, previously independent health care and hospital systems that

include both inpatient and outpatient health care services are affiliating with each other.

Ironically, the perverse incentive created by this cap will increase costs while policy makers, providers, and purchasers of care are desperately trying to get control of and, ultimately, lower costs. Decisions that will affect the ability of a health care system to provide needed care to their communities will be impeded.

We at Lutheran General HealthSystem and EHS Health Care experience the impact of the cap in the following ways.

First, given the fact that we will be approaching the $150 million cap after our merger, EHS/LGHS will be precluded from merging and affiliating with certain health care providers and systems. For example, we could not add other health systems whose non-hospital debt would, when combined with ours, push us over the $150 million cap.

Second, we could not incur any more tax exempt non-hospital debt even if it were being used for non-hospital health care services such as clinics and nursing homes. This merged entity would be forced to go to the taxable equity markets for capital for non-hospital health care facilities and services where the difference in interest rates is from 2.0 to 2.5 percentage points higher. On a $100 million issue this means it could cost from $2 million to $2.5 million more each year in interest payments. The costs associated with such actions would be prohibitively expensive.

Third, we at LGHS and EHS understand the immense responsibility and opportunity we have been given to serve the health care needs of people. We are aided in this mission by our tax exempt status. And, our ability to access the tax exempt bond markets is a privilege that we must earn and hold sacred.

Both EHS and LGHS have responded to this responsibility in a proactive manner in the past through our commitment to the under-served populations, our partnerships with and sponsorship of the Chicago Department of Health and Cook County Bureau of Health Services, and our local health partnerships aimed at prevention and improving the health status of our communities.

In order to continue to provide needed community health services, EHS and LGHS must be permitted to access the tax exempt bond markets for non-hospital debt.

In closing, EHS Health Care and Lutheran General HealthSystem are on the verge of creating a truly integrated system of care for the Chicagoland area. Concepts such as a common, paperless medical record that will allow continuity of care across multiple sites for patients, health management and preventive care rather than episodic medical care, and centralized diagnostic and administrative services that create and enhance access, convenience, quality, and lower costs for the patient are within our reach. These innovations were unthinkable in the old delivery system paradigm.

We implore you not to let arbitrary Tax Code developed in 1986 hinder these advances that will allow us to truly be an excellent and responsive provider of health care to the citizens of Chicagoland.

I hope you will take this opportunity during this great debate on health care reform to repeal the $150 million bond cap. While the issue seems complex and obscure, I assure that in order to truly achieve structural reform that allows the alignment of incentives for physicians, hospitals, other providers, and the patients we serve this issue must be addressed. It is as important as issues such as insurance reform or administrative simplification.

Thank you for the opportunity to testify today. I would be happy to try to answer any questions you may have.

Lutheran General HealthSystem And EHS Health Care Sites of Care

Hospitals –	Alternative Sites Of Care –
☆ LGHS	○ LGHS
★ EHS Health Care	● EHS Health Care

Chairman RANGEL [presiding]. Mr. Main.

STATEMENT OF RANDY MAIN, VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, FRED HUTCHINSON CANCER RESEARCH CENTER, SEATTLE, WASH.

Mr. MAIN. Mr. Chairman, my name is Randy Main, and I am the vice president and chief financial officer for the Fred Hutchinson Cancer Research Center in Seattle. In this position, I have overseen the issuance of $120 million of tax-exempt debt to finance acquisition of property and construction of new research laboratory buildings for the center.

The Hutchinson Center is an independent, nonprofit institution dedicated to eliminating cancer as a form of human suffering and death and is the only federally designated comprehensive cancer center in the Pacific Northwest covering a five State area.

Since opening its doors in 1975, the center has earned an international reputation by achieving excellence in basic, clinical, and public health science research, including Dr. E. Donnall Thomas' receipt of the 1990 Nobel Prize for Medicine for his pioneering work in bone marrow transplantation.

The Hutchinson Center is home to the Nation's largest research program devoted to cancer prevention and control. It serves as the Federal Government's designated coordinating center for AIDS vaccine trials and is the lead contractor for the women's health initiative, the largest trial of women's health issues ever undertaken.

The center is one of the most cited institutions in scientific literature. The periodical, The Scientist, has ranked the center's molecular biology and genetics program seventh nationwide, and U.S. News and World Report has ranked the center sixth in the Nation for research-based cancer treatment.

In fiscal years 1992 and 1993, the center was the largest recipient of peer reviewed grant and contract support from the National Cancer Institutes.

The center's original facility was constructed in 1975, paid for in large part with Federal construction grants. It had about 400 employees housed in a single building. By 1989, the center had 1,400 employees in multiple locations spread out all across Seattle.

At that time, the board of trustees decided it was necessary to reunite the center on a consolidated campus to improve scientific collaboration. However, the Federal construction funds were no longer available as they were in the past, so the Hutchinson Center was forced to rely on fundraising support and the capital markets for construction funds.

Fundraising typically provides about 10 to 20 percent of a major capital project funding in the Pacific Northwest. We simply do not have the base of personal wealth that exists in many other large metropolitan communities.

Tax-exempt bonds are by far the least expensive source of debt for independent, nonprofit research institutions. In 1991, the center issued bonds to acquire land and construct the first and largest of the four phases of our campus development.

After completion of the second phase, which is scheduled for 1997, we will have about $124 million outstanding in tax-exempt debt, with two phases to go. Phase three contemplates construction

of an ambulatory care or outpatient facility in partnership with the University of Washington. This consolidation of oncology programs from several institutions will permit more effective use of capital funds, more coordinated services to patients, the ability to perform more procedures on an outpatient basis, the integration of teaching, research, and clinical activities in a manner that will result in new insights for treating breast, prostate, colon, and even hematologic cancers.

The final phase, phase four, is to construct space for the center's public health sciences division. This is currently housed in leased space and moving this to our own owned space will generate long-term savings. These projects all qualify for tax-exempt financing, but in total will require the issuance of more than $150 million in debt.

Now, the savings attributed to financing with tax-exempt bonds versus conventional sources reduces our overhead costs, which are passed on to our patients and to our sponsors of our research projects, primarily the National Cancer Institute.

Annual debt service expenses for phase three and four, compared to taxable financing, would be reduced by about $2 million in the first year if the debt cap is eliminated and would total $31 million over the life of the debt. Of that $31 million, about 76 percent of it, or $23 million, is reimbursed by the National Cancer Institute and other Federal sponsors.

In closing, I would like to note the release of the report, "Science in the National Interest," which was released on August 3, 1994 in which the President and the Vice President stated that, "Technology creates jobs, builds new industries, and improves our standard of living, and that it is essential to our children's future that we continue to invest in fundamental research."

The Hutchinson Center is an excellent example of how science, research, and technology have played an important role in the economic growth of the Pacific Northwest. For example, as a result of our research progress, we have spawned the establishment of 10 biotechnology companies.

I understand that in May, then OMB Director Panetta directed each agency to consider the research and technology principles outlined in this report in the development of their 1996 budgets. I suggest the administration and Congress embrace all aspects of facilitating research and development to advance science and technology. This means not only increased funding, but also improving financing mechanisms to enable nonprofit institutions to respond to tremendous research opportunities.

The Fred Hutchinson Cancer Research Center is on the cutting edge of research and development and patient treatment, but our ability to grow is negatively impacted by the $150 million limitation on tax-exempt debt.

Thank you for the opportunity to appear before this distinguished committee to present our concerns. I would be happy to answer any questions you may have.

[The prepared statement follows:]

Statement by Mr. Randy Main
Vice President and Chief Financial Officer
Fred Hutchinson Cancer Research Center
August 9, 1994

Mr. Chairman, my name is Randy Main, and I am the Vice President and Chief Financial Officer of the Fred Hutchinson Cancer Research Center and have been there for ten years. In my capacity as Chief Financial Officer, I have overseen the issuance of $120 million of tax exempt debt to finance the acquisition of property and construction of new research laboratory buildings for the Center. I appreciate the opportunity to appear before you and members of this distinguished committee today.

The Fred Hutchinson Cancer Research Center is an independent, non-profit institution in Seattle dedicated to eliminating cancer as a cause of human suffering and death. It is the only federally designated comprehensive cancer center in the Pacific Northwest, a five-state area covering Alaska, Idaho, Montana, Oregon and Washington.

Since opening its doors in 1975, the Center has earned an international reputation by achieving excellence in basic, clinical and public health research. The Center's Dr. E. Donnall Thomas received the 1990 Nobel Prize for Medicine for his pioneering work with bone marrow transplantation, which is the preferred treatment for several forms of cancer and some other fatal diseases.

The Hutchinson Center is home to the largest research program in the nation devoted to cancer prevention and control. The Center serves as the federal government's designated coordinating center for AIDS vaccine trials and the Women's Health Initiative, the largest trial of women's health issues. Many of the Center's scientists have achieved national and international recognition, including memberships in the National Academy of Sciences. Also, the Hutchinson Center is one of the most-cited institutions in scientific literature. The Scientist has ranked seventh worldwide the Center's molecular biology and genetics program and U.S. News and World Report has ranked the Center sixth in the nation for research-based cancer treatment.

In both fiscal years 1992 and 1993, the most recent years for which figures are available, the Center was the largest recipient of grant and contract support from the National Cancer Institute.

The Hutchinson Center's original facility was constructed in 1975 in large part with federal construction grants. The Center then had about 400 employees housed in 130,000 gross square feet. By 1989, the Hutchinson Center had grown to 1400

employees, with 450,000 gross square feet located in multiple locations around the city of Seattle. At that time, the Center's Board of Trustees determined it was necessary to reunite the Center on a consolidated campus and decided to purchase land towards this goal. However, federal construction dollars were no longer available as they were in prior years, so the Hutchinson Center, like other independent research institutions, was forced to rely on fundraising support and the capital markets for construction funds. Fundraising can only be expected to contribute 10% of a major capital project.

Tax exempt bonds are by far the least expensive source of debt for independent non-profit research institutions. In 1991, the Hutchinson Center issued tax exempt bonds to acquire the property and construct the first phase of its consolidated campus. After the second phase is completed in 1997, the Hutchinson Center will have $124 million of outstanding tax exempt debt. Our third phase contemplates constructing an ambulatory care facility in partnership with the University of Washington. This joint venture will result in consolidation of oncology programs from several institutions, which permits more effective use of capital dollars, more comprehensive and coordinated services to patients, the ability to perform more procedures on an out patient basis, and the integration of teaching, research and clinical activity in a manner which we believe will result in new insights and methods for treating breast, prostate, colon and hematologic cancers. Unfortunately, without elimination of the cap on tax exempt debt, the Center's ability to be a full partner in the project will be curtailed, since the full amount of any tax exempt borrowing will be counted against our debt limit. Finally, the fourth phase plans are to construct space for the Hutchinson Center's Public Health Sciences Division which is currently housed in 160,000 gross square feet. Moving this division from leased to owned space will generate long term savings for the Center and its research sponsors. These projects all qualify for tax exempt financing, but in total will require the issuance of more than $150 million in debt.

The savings attributable to financing with tax exempt bonds versus conventional taxable debt reduces our overall overhead costs which are passed on to our patients and to the sponsors of our research programs, primarily the National Cancer Institute. The removal of the $150 million cap will not only allow us to expand our research capacity but will also allow us to take advantage of favorable market rates and reduce our cost of debt by means of an advance refunding.

We estimate that annual debt service costs for the third and fourth phases will be reduced by $2.0 million in the first year if the $150 million debt cap is eliminated. This would total $31 million over the life of the debt, of which approximately 76% is reimbursed by the federal government.

In closing, I would like to note that on August 4, 1994, the Administration released a report entitled **SCIENCE IN THE NATIONAL INTEREST**. In this report, the President and Vice President stated in their letter that "Technology - the engine of economic growth - creates jobs, builds new industries, and improves our standard of living. ...It is essential to our children's future that we continue to invest in fundamental research." The Fred Hutchinson Cancer Research Center is an excellent example of how science, research and technology have played an important part in the economic growth of the Pacific Northwest. For example, as a result of research progress in our laboratories in the past 18 years, the Fred Hutchinson Cancer Research Center has spawned the establishment of 10 biotechnology companies.

I further understand that in May 1994, then OMB Director Leon Panetta directed each of the agencies to consider the research and technology principles outlined in this report, which was under draft, in the development of their budget for FY 1996. Mr. Chairman, I would submit to you that the Administration and Congress should embrace all aspects of facilitating research and development to advance the art of science and technology in this country. This means not only increased funding for these important programs but financing mechanisms which enable non-profit institutions to position themselves to effectively respond to the tremendous opportunities which exist. The Fred Hutchinson Cancer Research Center is on the cutting edge of research and development, but its ability to grow as research needs increase is at a near standstill due to limited funding resources. We believe that tax exempt bonds are the most efficient and economical method to raise resources in order to meet the challenges that lie before us.

Thank you very much for your consideration of this issue. I will be happy to answer any questions you may have.

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Chairman RANGEL. Dr. Joseph.

STATEMENT OF LAVERNE R. JOSEPH, D.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, RETIREMENT HOUSING FOUNDATION, LONG BEACH, CALIF., ON BEHALF OF AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Mr. JOSEPH. Good afternoon, Mr. Chairman, and members of the subcommittee. My name is Laverne Joseph. I am the president and chief executive officer of Retirement Housing Foundation, which is the Nation's largest nonprofit sponsor and manager of affordable housing for seniors and persons with disabilities.

Our corporate office is in Long Beach, but our facilities are located in 23 States, Puerto Rico, and the Virgin Islands, so I am pleased to be here to be representing not only Retirement Housing Foundation, but the American Association of Homes and Services for the Aging also.

There are 4,000 members in the association, and so I am speaking also on their behalf, and asking that the $150 million bond cap be repealed.

I am going to speak this afternoon from the heart as one who lives with the restrictions of this bond cap. Let me tell you first that RHF is a sponsor and manager of 10,300 apartments, 900 skilled nursing beds, and 400 assisted living units. The majority of our units, 80 percent, are for seniors, families, chronically mentally ill, developmentally disabled, and mobility impaired persons who are at 50 percent of the median income of the area or less. That is called very low or low income. It means that we are serving approximately 14,000 of our Nation's most disadvantaged and vulnerable citizens.

We are a nonprofit, driven by our mission to provide shelter and services which enhance the quality of life for persons in regard—as it relates to their physical, mental, and spiritual well-being.

I hope to be able to address the questions that Chairman Pickle raised and other members of the committee, particularly why is this critical, the repeal of the bond cap and what can the public get from that repeal? RHF is currently very near its $150 million cap.

We have been restricted in our ability to take back some of the RTC facilities, to construct facilities, to rehab facilities that cities have asked us to rehab. We have—I can point to many examples, and I will share them in additional written comments, but I think, for instance, Portland, Ore., where the city has asked us to develop a number of multifamily projects using tax-exempt financing.

The thing that I would like to say and really underscore as regards to health care reform is that the committee and Members of Congress need to see housing as part of the continuum of care of health care. We know, for example, that if we can maintain citizens in housing with supportive services, it is far less expensive than to place them in skilled nursing centers or other higher levels of care.

Why is this critical? We are finding not only more and more seniors, the fastest growing part of our population; we are finding more frailty in that population, persons who need services. And so it is critical that we have the opportunity and the ability to meet

the mission of providing and serving the needs of those populations.

Currently, we are finding among our housing and service providers some of the same things which has happened in the past with the hospital-based providers. There is consolidation. There are talks of acquisitions and mergers as individual providers find that in a highly regulated, legally complex climate, they have to have many resources, personnel, legal, and the like to adequately meet those needs and be in compliance at all levels.

I would be pleased to answer any questions that members of the committee might have, but what the public will get by lifting this cap insofar as AAHSA and Retirement Housing Foundation are concerned is more housing, more services to persons who need those services.

Let me say that there are 250,000 seniors on waiting lists for the kind of facilities that we have. Our largest facility, which is 1,093 units in downtown Los Angeles at 4th and Hill was the instigator in 1981 for the renewal of that entire area. Those 1,093 apartments have 1,600 persons on the waiting list, with a vacancy of six to eight apartments per month.

In 1984, prior to my service with RHF, that facility and several other facilities were syndicated under the passive tax loss program. The funds that were received from those syndications were plowed back into providing more facilities and there are still more planned. We are now very near the end of the syndication period with the right of first refusal to take back Angeles Plaza and other facilities that were so syndicated. For RHF, this will require at least another $80 to $100 million to be able to take back and preserve in perpetuity these facilities for low income vulnerable persons.

This is what we get if the bond cap is repealed. This is why it is so critical, and I really strongly urge the committee to report out a bill which will be compatible with what has been reported in the Senate in terms of repealing this cap so that RHF and the other AAHSA members may continue to effectively meet the needs of low income vulnerable persons.

Thank you very much.

Chairman PICKLE [presiding]. Thank you, Mr. Joseph.

[The prepared statement follows:]

TESTIMONY OF LAVERNE JOSEPH

REPRESENTING THE

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Good afternoon. Mr. Chairman and members of the Subcommittee on Select Revenue Measures, my name is Laverne Joseph. I am President and Chief Executive Officer of the Retirement Housing Foundation (RHF). Located in Long Beach, California, our organization is the owner and /or operator of one hundred twenty four long term care facilities throughout the country. The Retirement Housing Foundation is also a member of the American Association of Homes and Service for the Aging (AAHSA). I am pleased to represent both the RHF and AAHSA and would like to express my appreciation to the Subcommittee for allowing us this opportunity to testify.

The American Association of Homes and Services for the Aging has been a leader of nonprofit long term care and services for the aging since its founding in 1961. AAHSA's primary membership comprises nearly 5,000 community-based not-for-profit nursing homes, independent housing facilities, continuing care retirement communities, personal care homes, and community service programs for the aging. In addition, AAHSA has over 800 associate members including attorneys, professionals, and student-interests in long-term care and housing for the elderly. Affiliated state associations complete AAHSA's membership profile.

We welcome this opportunity to present our views on repeal of the $150 million cap on a tax-exempt bonds for non-hospital health care facilities-organized under section 501(c)(3) of the Internal Revenue Code. As an association, we have maintained a leadership position in advocating for, and advancing the changing environment of long term care in the context of health reform. AAHSA has had the opportunity to testify before Congress on several occasions concerning the need for a continued strong federal presence in helping to finance and develop elderly housing and long term care facilities.

Current demographic projections clearly indicate that the need for elderly long term care will continue to increase. From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent, and those headed by persons over 75 will increase by 52 percent. By 1995, it is anticipated that over 21 million households will be headed by Americans over 65 years of age. With the increasing number of frail elderly (those over 75 years of age), there will be a corresponding need to provide adequate long term care, assisted living housing and support services for this group.

Members of the long term care industry which serve the elderly population are being affected by the existing $150 million dollar cap on tax exempt financing, which has severe implications in at least four primary areas, including the ability to:

- Establish new long-term care facilities for older adults, that provide safe and secure housing with services which allow them to remain independent;

- Renovate and maintain existing, well established and successful supportive housing environments;

- Finance affordable housing, expanding the segments of the population which are served by the non-profit sector; and,

- Consider mergers and acquisitions which respond to the call for managed care systems to manage risk and contain the costs of long term care.

Under current law, hospitals are exempt form the $150 million cap to which all other health care organizations are subject. However, certain types of services which AAHSA members provide are not intrinsically different from the care that provided by hospitals. Subacute care, the development of care plans, nursing care, physician care, pharmaceutical services, rehabilitation, and continuing care for people with chronic illnesses or disabilities are all services that may be provided by nursing facilities as

well as by hospitals. In fact, with the evolution of medical practices over the last two decades , hospitals are discharging patients "quicker and sicker", and care that formerly would have been provided in a hospital setting now may be provided in a nursing facility. This development is part of the trend toward providing non-acute health care in settings less costly than a hospital.

Tax-exempt bonds have become an important means of financing and improving long term care facilities for the elderly. Due to the ever increasing aging population and their need for continuing long term care, many long term care facilities have substantial waiting lists for admission. This ever increasing demand has caused AAHSA to testify numerous times in the past on the need for a continued federal role and leadership in making available resources to fund elderly housing. To accommodate the growth of the aging population and the very special needs this population presents, the facilities must have access to additional low cost financing.

Over the years, tax-exempt organizations have been responsible for a large portion of the development in the institutional long term care field. Religious organizations sponsor 75 percent of AAHSA's facilities. Private foundations, fraternal organizations, government agencies, labor unions and community groups sponsor the other 25 percent. AAHSA's members have enjoyed a long history of service to the community and nation.This tradition of caring and dedicated service to our older citizens is one of which we are extraordinarily proud.The vast majority of our members notably see their mission as providing housing to the elderly, but also in providing a full range of long-term care services designed to maintain the independence of this age group. It is these very services and activities that have historically been considered charitable in nature, and recognized as tax-exempt functions by both the Congress and the Internal Revenue Service.

Our support for repealing the $150 million limit on tax exempt bonds is based on the goals of health reform legislation and situations in which AAHSA members find themselves while attempting to accommodate a changing health care environment. President Clinton's health care reform proposal emphasizes cooperation among health care organizations in providing for a continuum of care and offering incentives in order to operate more efficiently and prevent the duplication of services. The cap on tax-exempt financing, however, is a severe impediment to these efforts. Facilities that have already benefited form tax-exempt bonds may be below the cap on a individual basis. If they merge, however, the sum of their combined debt may exceed the $150 million cap. This situation could be a barrier to many facilities that otherwise might have merged to become more efficient.

For example, one of AAHSA's multi-facility sponsors was considering a merger with another non-profit health care organization. Since both organizations had benefited from tax exempt bonds, however, a new organization formed by the merger of the two would have been over the $150 million limit and rendered the merger prohibitive.

In addition, American Baptist Homes of the West, another multi-facility sponsor, is in the process of planning a renovation for a facility in Washington state. The work will cost approximately $10-$11 million. ABHOW is within $9.5 of the cap, and must therefore decide whether to access more expensive, taxable debt or defer the project. The former will put the facility at some risk of maintaining its viability for current and future markets; the latter will require higher costs, diminishing ABHOW's ability to serve the broadest possible segment of the population.

Another example of problems with the cap can be found in the operations of the Kendal Corporation from Pennsylvania. The Kendal Corporation owns and operates eight facilities in three states, and they are very close to the cap. Within the past 18 months, Kendal has been using taxable financing to fund new projects in an effort to retain tax-exempt capability in the event of an emergency. The result is that all residents of its facilities are already bearing the higher costs consequent to the higher cost of capital.

My own organization, the Retirement Housing Foundation, owns and/or operates 124 long-term care facilities located in several states. Of all the RHF-affiliated senior housing developments, about ten percent have been financed through tax-exempt debt. Eleven projects currently account for the total of $134,418,964 in tax-exempt debt outstanding to RHF affiliates.

RHF affiliates have used most of this tax-exempt debt to finance facilities delivering more than one level of care to senior adults, including health care in skilled nursing facilities. Only $19.5 million of our total outstanding debt is not related to health care facilities.

The eleven projects currently financed with tax-exempt debt have all but exhausted RHF's ability to do tax-exempt financing. In order to continue our efforts to provide safe, decent, and sanitary housing to low- and moderate-income senior citizens, we will be forced to find other sources of capital. Since there has been a substantial reduction in government subsidies for housing construction and renovation, RHF will have to look to banks and other financial institutions for long-term capital. Our inability to use more tax-exempt financing will have a direct impact on the affordability of the housing and services we will be able to provide.

For example, one of our recent projects was a 150-unit apartment complex with ten additional units of enhanced services for the more infirm and 120 beds of health care. Financing was secured through $22,595,000 in tax-exempt financing at a blended rate of 7.75% for a thirty-year loan, including discounts and costs of issue. Those bonds were issued in April of this year.

In contrast, last month we closed a bank loan on properties of similar characteristics for just over $20 million. The bank's rate is 9.125% interest for 25 years, which will reset at the end of the third year to a rate about 3.5% over similar-term Treasuries. The loan is only for seven years, so the project will need to renew its financing with the existing lender or find new financing at that time.

If the bank loan's terms were applied to the April, 1994 bond issue, the installment payments on the loan would be $159,600 more per year. The bonds secure the rate and terms for thirty years, while the bank loan will change rates in three years and will not exist in seven years.

Since the only source of debt repayment for the non-profit owner is the rent from the project's residents, a bank loan on a project will mean that the residents of the project financed by the bank will pay about $552 more each year for their apartments or their health care solely because of the source of the financing.

In turn, the increased costs to residents result in increased expenses for the Medicaid program, which covers more than half of the residents of the skilled nursing facility. Had the bank loan been used for the April, 1994 bond issue, the Medicaid reimbursement for residents of that skilled nursing facility would have been $30,000 higher every year.

Furthermore, many of our projects would not even be able to obtain conventional financing. For the last few years, banks and other sources of taxable debt have been largely unwilling to make loans on senior service centers, particularly those with health care. They do not have an interest in properties in "marginal" areas, where rents are reduced in an attempt to serve lower-income persons. Instead, lending institutions want to loan on relatively new properties in good neighborhoods, with income exceeding expenses such that the net income is more than 120% of the requested debt service. Lenders have expressed concern to RHF about the aging population in our affiliates and the population's continued ability to pay for services.

Many providers of non-profit continuums of care have long histories of operating successful managed care systems. The continuing care retirement community (CCRC) places the resident at the most appropriate level of care on the campus, often delivering services to the residents' units to help them maintain their independence. These providers have long understood that minimizing institutionalization is not only most desirable to the resident, but cost effective as well. Furthermore, even in low income housing, many non-profit providers funded services coordinators to integrate community based programs for their residents, allowing them to "age in place". Their ability to establish networks, as appropriate, is imperative to the creation of a fully integrated health care system

Repeal of the bond cap will enable non profit providers to continue innovative efforts in continuing care, congregate housing and other options designed to link older persons with access to a continuum of care. Long term care nursing facilities cannot operate outside the scope of health care reform, but must integrate comprehensive options and solutions to long term care for the elderly into the systems that will evolve.

In addition to specific criteria institutions must meet in order to qualify as a 501(c)(3) organization and be eligible for tax exempt bonds, we believe that any legislation repealing the existing $150 million cap must address the ever growing concern with fraudulent activity within the organization and prevent the formation of illegitimate or "shell" 501(c)(3) organizations that have as their primary purpose the acquisition of tax-exempt bonds but are without a true charitable purpose.

Objective criteria could be proposed that would ensure that members of the development team certify that there is no "identity of interest" with other members of the development team. Board members of the 501(c)(3) organization should also maintain an "arms-length" distance in the design, management, marketing, or financing of a project, if they or their employer is compensated for such participation. To serve as an obstacle to illegitimate or "shell" 501(c)(3) organizations, any 501(c)(3) organization seeking financing through tax-exempt bonds must demonstrate that it or its parent non-profit entity has been in existence for a minimum number of years prior to the closing of any tax-exempt financing.

Mr. Chairman, it is important to note that nonprofit care and services for the elderly has been a vital force in America since the founding of our nation, Many AAHSA members have been involved in such are and service for over a century . In order to maintain this commitment of providing service to the aged in the most effective and efficient manner, however, nonprofit organizations need to be assured of an equally important commitment of tax exemption and tax-exempt financing by the government. This mutual partnership which has existed since the beginning of this country must—and hopefully will—continue.

Chairman PICKLE. Now, Mr. Main, have you testified?

Mr. MAIN. Yes, I have.

Chairman PICKLE. Does this complete the panel? I was out. All right, I am going to ask a question of you and just for sort of factual background—I am going to ask it of the other panelists too, so let me go down the list.

Mr. Main, are you, that is, your group, at the $150 million cap now?

Mr. MAIN. No, we are not now.

Chairman PICKLE. Where are you now?

Mr. MAIN. Right now we are at $119 million. We have anticipated exceeding the $150 million within the next 4 to 5 years.

Chairman PICKLE. All right. Mr. Joseph.

Mr. JOSEPH. We are currently at $134 million, sir, but as you get close to the bond cap, the issuers become very nervous about issuing additional bonds. We have also had to turn back a number of opportunities in the past because of the possibility of exceeding that cap and there are numerous opportunities in the future for service and providing low-income affordable housing that would take us way over the cap.

Chairman PICKLE. How many more bonds do you expect to issue let's say in the next 10 years?

Mr. JOSEPH. How many could we issue in the next 10 years?

Chairman PICKLE. Do you intend to?

Mr. JOSEPH. As an organization, as RHF? The demand is so great for housing, it is conceivable that we could issue, if we had the ability, as much as several hundred million dollars more, $200, $300, perhaps as much as $500 million.

Chairman PICKLE. All right.

Mr. Martinez.

Mr. MARTINEZ. I am not a 501(c)(3) entity. We represent hospitals and nonhospital providers in that we issue the tax-exempt debt on their behalf for the State of New York.

Chairman PICKLE. You are not subject to the $150 million cap?

Mr. MARTINEZ. No. The institutions that we issue the bonds on behalf of are the ones that are subject to the $150 million cap.

Chairman PICKLE. But you don't plan to issue additional bonds?

Mr. MARTINEZ. Our problem will be that we can continue to issue bonds for these nonprofit providers, but when they reach the cap, we will have to issue taxable bonds, which will cost the health care system in New York substantially more than issuing tax-exempt debt.

Chairman PICKLE. I want to come back to your own situation because I didn't get to hear your testimony.

Mr. Ummel.

Mr. UMMEL. Yes, Lutheran General HealthSystem alone is at $126 million at the present time. Evangelical HealthSystem is at $18 million, so upon the merger, we will have $144 million, so we are very close to the bond cap at the present time.

Chairman PICKLE. You are at the bond cap now. Let's assume your merger does take place. What amount do you want to issue then?

Mr. UMMEL. We have no short-range plans for additional borrowing. However, we are talking with other network partners who

have such debt, some of which are in the inner city of Chicago, many of which are religiously sponsored, who will be precluded from coming into this emerging new network because of the limitation.

Chairman PICKLE. Do you say that since your merger would be the largest health delivery system of this kind in Chicago, the whole area, then I would assume you would want to lift that cap considerably?

Mr. UMMEL. Yes.

Chairman PICKLE. Will you double it? Will you double that amount or triple it, or what?

Mr. UMMEL. Well, we do know that the nonhospital health care market is under capacity. In Illinois, there is a shortage of long-term care beds. We also, as an industry, have not been investing over the years in nonhospital facilities because all the reimbursement and incentives were for acute, inpatient care, so we know we will have to invest in nonhospital care to provide access at less cost for the patients.

Chairman PICKLE. Thank you, Mr. Chairman.

Chairman RANGEL [presiding]. We have testimony this morning that this tax-exempt bond is a very expensive type way to finance capital expenses. They suggested that if indeed there is a need, that it would be better to use direct subsidies in order to take care of it, rather than just to remove the cap on health facilities.

Have any of you given any thought to the expense that is involved to the government in allowing tax-exempt bonds to be issued, or the alternative, to find out what the needs are and to subsidize them? The government experts say that it is less expensive.

Mr. Main.

Mr. MAIN. Now, are you talking about direct government grants?

Chairman RANGEL. Yes.

Mr. MAIN. We would be delighted to access any direct government grants that would be available, and we do attempt to do that for our construction projects. For our last construction project, a major construction project of two laboratory buildings costing $80 million, we had a total of $2 million of Federal construction grants awarded for that, which was the maximum that could be awarded to any one institution in that period.

So we will always seek any direct government subsidies that are available. They simply are not available to the extent they used to be in prior years.

Chairman RANGEL. But all of you would agree that if direct subsidies were made available, this would be a less expensive method of financing building and expansion?

Mr. UMMEL. As an integrated health system in Chicago, we believe that the most cost-effective method of accessing needed capital is tax-exempt financing.

At the present time, 40 percent of our patients and reimbursement is managed care. Both our facilities and our physicians are now at equal risk under managed care agreements to invest very wisely in any capital expansion of our developing new network.

For the first time now, physicians are under the same economic or financial incentives as are the hospitals, nursing homes, and other facilities in our network, hence under capitation, or managed

care, we are not going to be encouraged to invest in anything, much less tax-exempt financing, unless it is extremely cost effective, otherwise it is going to detract from our yearend margins under managed care.

So we feel that tax-exempt financing within an emerging, developing, managed care environment, will motivate providers to borrow and invest far more wisely than they ever have before.

Chairman RANGEL. Thank you.

Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman. We may create a problem here. I think it has been mentioned before that if we take the cap off from the health care facilities, the next step would be all 501(c)(3) organizations want to go remove the cap. But they all have the same caps. How do we address that?

If we remove it on these organizations, we are talking about a revenue loss estimated from $80 to $400 million. How do we address what happens if all 501(c)(3) organizations come in, and there are a lot of them, extremely well organized. What do we do then? Any ideas?

Mr. MCCRERY. If the gentleman would yield, Mr. Hancock. If I am not mistaken, Dr. Joseph is advocating that very change, are you not?

Mr. JOSEPH. Yes. We see housing as part of the health care continuum, and we have found and we can provide information for you that it is much less expensive to care for someone in housing providing supportive services than it is to place that person in a nursing home.

What we have in the health care continuum I call a compression down through the system, in that in housing today, many of our clients or residents have the kind of acutity that was formerly cared for in assisted living or personal care, or whatever you called it.

Personal care, likewise, is caring for persons who used to be in assisted living. Skilled nursing is caring for people that used to be in hospitals, and so there is a compression of acutity down through the system. It is cost driven. It is consumer driven. It is health care reform driven, but we definitely are advocating if we are going to be part of the solution and a cost-effective part of the solution, the cap has to come off for the housing and assisted living and skilled nursing providers.

And we believe that it is cost effective for the reasons that I stated, and that it is necessary, particularly in communities where banks will not go into the inner city to provide the financing, and nonprofits cannot compete in the capital markets with the GE capitals and the large for-profit corporations of the world. They simply cannot compete for the equity.

Mr. HANCOCK. Even though you are talking about lifting the cap within the area of not exactly health care, but of senior citizen housing and that type of thing?

Mr. JOSEPH. Again, I say housing is part of health care, because if we can maintain people in housing, in senior housing with supportive services, social service coordinators who network with the community, it is much more cost effective than placing that person in assisted living or skilled nursing.

Mr. HANCOCK. Is your position then that in this particular area there would be offsetting reductions in the cost, that we wouldn't have as much revenue loss as it would appear right now as a result of the savings in the delivery of the service? Is that——

Mr. JOSEPH. Well, I think there would certainly be an offset. I don't have a study which shows exact numbers. I have seen various studies indicating that it costs as much as $5,000 less per person to remain in supportive housing services than it does to place that person in a skilled nursing center, but I don't have any exact studies to compare the offsets.

Mr. HANCOCK. Mr. Main.

Mr. MAIN. I would like to add another perspective to that. In order to borrow, you have to be a good credit risk. In the State of Washington, you have to have a credit rating of A or better to issue through the Washington Health Care Facilities Authority. Most 501(c)(3) organizations simply do not have the financial strength or the credit rating to be able to issue debt.

Mr. HANCOCK. Thank you, Mr. Chairman.

Chairman PICKLE [presiding]. The Chair recognizes Mr. Hoagland.

Mr. HOAGLAND. So, Mr. Main, in connection with that, what you are saying is one control that would limit the issue of 501(c)(3) bonds is the marketplace, because it is not going to issue bonds to facilities that are going to—that will be unable to repay the debt because the hospital bed, they will say, will be unoccupied or in other respects, it would not be a wise investment?

Mr. MAIN. Exactly. Feasibility studies must be performed to demonstrate the financial viability of the proposal before the marketplace will issue the bonds.

Mr. HOAGLAND. I was curious, I was interested in the statement at the bottom of the second page where you talk about the amount of reimbursement that the Federal Government makes of your cost and the extent to which tax-exempt bonding saves us money through the Medicare, Medicaid programs, and others.

I wonder if you could elaborate on this, the last paragraph on page 2. We estimate that annual debt service costs for the third and fourth phases will be reduced by $2 million in the first year if the $150 million debt cap is eliminated. This would total $31 million over the life of the debt, of which approximately 76 percent is reimbursed by the Federal Government.

Mr. MAIN. Yes.

Mr. HOAGLAND. Would you elaborate on that for us?

Mr. MAIN. Yes. We anticipate issuing another $80 million in debt over the next 20 years. Currently, a major portion of our business is research and about 80 percent of that research is sponsored by the National Cancer Institute.

The National Cancer Institute pays for the direct cost of research and the related indirect cost which includes facilities-related expenses. So if you have a choice between financing with taxable debt or as in the cases we have done with our public health science group, leasing space from a commercial developer, you end up paying a much higher rate per square foot than you would if you were to borrow with tax-exempt funds, build and own.

So the cost that we end up passing on to our research sponsors is reduced significantly and the Federal Government would pick up—would benefit to the tune of 76 percent of those total savings.

Mr. HOAGLAND. Now, has anybody costed that out, tried to weigh those savings against the costs of tax-exempt bond financing to see how the government does?

Mr. MAIN. Well, in order to get reimbursement for our first issuance of debt, we had to get approval from OMB and HHS, we had to demonstrate the savings, and we had approvals from the National Cancer Institute, HHS, and OMB, and they were satisfied that the savings were significant enough that they should approve the reimbursement of the interest.

Mr. HOAGLAND. Let me switch to another topic here, if the Chairman will allow. It seems to me that the focus of our efforts needs to be on the effect of the cap, not whether tax-exempt bonds generally are good or not, in connection with what Mr. Houghton and Mr. McCrery have said earlier, a lot of people have problems with tax-exempt bonds and I think rightfully so.

We can argue the pros and cons of that, but that is not really the issue here today because the tax-exempt bond status for hospitals is here to stay. Nobody is seriously talking about putting a cap back on. The question is what effect does it have—what effect does a cap have, the cap itself?

And it seems to me that the cap of limiting everything except hospitals encourages inefficient investment in itself. I mean, it creates a nonneutral playingfield where the government policy of capping all health care related facilities except hospitals has the effect of steering capital toward hospitals.

So if we really want a government-neutral environment where market forces can be fully felt as close to perfect competition or perfect government environment as possible, I am sorry, as perfect an investment environment as possible, then we would want to remove the cap for all health-related facilities.

So the government policy has no effect; does that make sense? Dr. Joseph, does that make sense?

Mr. JOSEPH. Yes, it makes sense to us definitely because, as I said, we believe it is the cost-effective way of providing care for the vulnerable in society and addressing one of the major, major problems, which is homelessness and housing needs, particularly for the low- and very low-income persons. The marketplace will take care of it.

Mr. HOAGLAND. Mr. Martinez, you are with the financing agency of New York. Is it correct that not having a cap on hospitals but having one on everybody else, distorts investments, in your view?

Mr. MARTINEZ. Well, I don't know that it distorts investment. I think what you are going to find as we move forward is that hospitals will need less capital as they begin investing in more community-based facilities, and you are going to see a shift in the marketplace from the centralized approach where you will have huge hospitals investing literally billions of dollars to one in which the investments are going to go to affiliates into new nonprofits that are set up, and that will then link themselves with the hospital.

We fully expect in the future you will see a downsizing in hospitals. You will actually see some closure, but that will be offset

then by the community-based facilities and then on a net basis, you likely aren't going to see nearly as much debt being issued in the future as you have seen in the past with just acute care oriented hospitals.

Mr. HOAGLAND. But the current situation with respect to caps is likely to slow down that movement, isn't it?

Mr. MARTINEZ. Oh, absolutely. Many of the facilities that we are speaking with are concerned because they are going to begin to explore the taxable market. When they move into the taxable market that is going to automatically increase the cost to the reimbursement system which is of concern to us because our prime goal is to try to find the lowest overall cost.

What we have tried to do to facilitate low cost for some facilities where they don't have a strong capital base is to create our own form of credit enhancement through a mortgage insurance program that the State created about 15 years ago and that is the way that they are able to access a more affordable capital base.

Mr. HOAGLAND. One final question, Mr. Chairman, if I might, what then is your response to Congressman Stark's statement that lifting the volume cap for health-related facilities would compound the problem of excessive health care spending. That is the position that he has taken.

Mr. MARTINEZ. I don't believe that that is true. I know the way that our system in New York works, we are very highly regulated and as with many institutions around the country, you have to prove a need.

Circumstances do change. Demographic patterns change and what may have been approved 10 years ago may no longer hold true today. But as we move forward, I think that we need to recognize that the financing needs have to be a reflection of the existing structure in the way that we want to try to keep the overall cost down. We cannot always look to the past and assume that mistakes that may have been made in the past are going to be replicated as we move forward.

Mr. HOAGLAND. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Houghton.

Mr. HOUGHTON. Yes, I would like to ask you a couple of questions, but I would like to just put the questions in context.

You see what people are worried about. They are worried about really two things: One, the abuse of the 501(c)(3)s. And I do not know how many 501(c)(3)s come into the market every year, but it is something like 30,000 new ones. No one goes off the books. They all increase. And I do not know what it costs the Federal Government, but it is a tremendous amount of money. So there is a natural worry about that.

The other thing, of course, is, are we, by unleashing this different funding mechanism for other than hospitals, making it possible for the thing to happen which Mr. Stark worried about: More competition, one hospital vying with the other, one unit vying with the other, and duplicating facilities in the community where we should not be duplicating in the first place.

However, let me ask you a question. Suppose we did this—and I am not necessarily advocating this—suppose we did not eliminate caps but just raised the cap, let's say to $300 million from $150

million. And, also, suppose we took a lot of the restrictions off hospitals so you could do something with the basic plans you have rather than building or adding or changing. What would that do?

Mr. MARTINEZ. Well, first, I am not certain that increasing the cap to $300 million will solve all of the issues that are of concern. As an example, many of the hospitals that are forming these alliances and are creating mergers are going to have a single cap, and $300 million, even at that level, may not be sufficient to address the kind of growth that they will do. There is going to be competition, but the competition is going to change from individual hospital to individual hospital to networks and there will be an emphasis on increased efficiency and there will not be a likely scenario where you are going to find a lot of duplication in terms of equipment and facilities.

People are going to have to be much more conscious of the overall cost effectiveness of the system they create. Certainly an expansion of the cap will be helpful, but it will not resolve the entire issue we are looking at.

You have new——

Mr. HOUGHTON. I understand you do not want any discipline at all superimposed on you by the government. You want to be able to do what you think is right because the economics would dictate that.

Mr. MARTINEZ. I would not say we are looking for no discipline whatsoever. I think that what we are looking at is that if we are going to have a complete overhauling of the health care system, which is being discussed currently, that we should be looking for the most efficient way to deliver the services and to keep the overall cost to the Federal Government and to the State governments at the lowest possible level under the Medicare and Medicaid systems, and that what we are advocating is a less expensive way for the bricks and mortar in the facilities to be financed and to be paid for than other sources that are currently available.

I do not believe that it is asking for the door to be opened and a floodgate to occur, because I think there are many significant restrictions under the Tax Code still that you have to comply with even if the cap is going to be removed.

Mr. HOUGHTON. Yes?

Mr. UMMEL. I would like to reiterate my earlier comments about the steady almost double digit annual growth rates of managed care across this country. And some would argue or forecast that by decade end managed care will be by far the prevalent mode of health care finance. But under these largely capitated health care plans, again, where all the facilities and physicians are under a common economic incentive, debt will be a very sensitive cost to these health care networks, thus they will want to minimize it because it will only detract from their yearend earnings and the pool that they will all divide at the end of the year.

This kind of economic governer or pressure has never yet existed in health care delivery and financing before. And I think it will, in the private sector, self-regulate borrowing—tax-exempt borrowing—and minimize it. And, you will see much more prudent investment by not-for-profit health care delivery systems.

Mr. HOUGHTON. Yes.

Mr. JOSEPH. If I may, I would also like to make a comment on that. I think there is a discipline in the system in that the various issuing agencies require that there be a need for the facility, at least as far as housing, skilled nursing, and assisted living are concerned, and furthermore, that the sponsor or owner guarantee, and obviously there is a strong incentive for self-discipline if you are guaranteeing together with the issuing authority those tax-exempt bonds.

You are quite right that there are every year new nonprofits coming on the scene, some of which survive, some of which do not. The new or smaller nonprofits still would be able to issue even with the cap. But what the cap does for the larger providers is to punish us for having been efficient, for having been successful in meeting the needs and for being on the cutting edge in mergers and consolidations in order to more effectively and cost efficiently meet these needs.

And I will be pleased to submit in writing a listing of the larger nonprofit housing and skilled nursing and assisted living providers and some of the ways we have been impeded by the cap.

[No information was received.]

Mr. HOUGHTON. Just one more question, Mr. Chairman, if I can. Nobody seemed to address the question of reducing the restrictions posed now. A room, a unit that could be used for anything you wanted, x ray, long-term health care, outpatient, hospital bed, whatever it was. Would that help you?

Mr. JOSEPH. I am not sure I understood the question.

Mr. HOUGHTON. Well, there are restrictions, including the payments by the government, in terms of how you use various facilities. If those restrictions were lifted so that you could use a hospital room, for example, for anything you wanted in the community, whether it was long-term health care, whether it was an outpatient room, whether it was for some other particular specialty in the medical arena, would that take pressure off your financing?

Mr. JOSEPH. Well, if you are addressing that question to me, I think probably the hospitals need to answer it. We in the past have considered on some occasions taking over hospitals and converting them to other kinds of services but backed away from them for a variety of reasons, including the efficiencies and so forth. But what you are proposing would not help us as providers of housing and services for seniors and low-income families.

Mr. UMMEL. Congressman, perhaps I can speak to that. As a health system with all kinds of facilities within its orbit in Chicago, because of the building code, State health care licensure, and national accrediting standards, it is usually impractical or illegal or contrary to prevailing regulations to convert most hospital facilities into other kinds of health care services. There are always a few exceptions.

We are finding in our focus groups and our market research that most health consumers today do not want to go to hospitals for any kind of health care, certainly nonacute care, because they are usually large, difficult to access facilities, difficult parking, long walks. They are intimidating. People want community-based, more accessible, more friendly environments in which to get less cost health care alternatives.

But there are those more overriding legal accrediting barriers to converting hospital infrastructure into nonhospital care facilities.

Mr. HOUGHTON. Maybe you could put the hospitals on the national historic roles and convert them to something special like maybe an oldtime hospital.

Thank you very much, Mr. Chairman.

Chairman RANGEL. Mr. McCrery.

Mr. MCCRERY. Mr. Chairman, I still have some time, but I have no more questions.

Chairman RANGEL. Let me thank the panel for the excellent testimony you have given. Chairman Pickle.

Chairman PICKLE. Well, Mr. Chairman, earlier I had posed a question to Mr. Martinez. I want to follow through on that just a little bit.

I asked the question were you subject to the cap or how close are you. Since you represent the State of New York, and you actually control the issuance of these tax-exempt bonds, it would seem to me from your testimony, then, that your concern or your recommendation to lift the cap is because you see a need for a lot of mergers, one; that a lot of groups will come together, and because you anticipate with mergers they are going to need more bond financing than they do now. You specifically want to get away from acute care delivery, and, therefore, if it would be a hospital, it would not be subject to a cap and it could issue a lot more bonds. Is that essentially what you are recommending?

Mr. MARTINEZ. I am suggesting as we move into health care reform, the type of delivery system that we are going to need is quite different from the acute care hospital format that has been used in the past. It is inefficient and very expensive for people to go to the emergency room as their primary health care provider.

We want to see more of the community-based health care providers be in a position to gain access to affordable capital. We believe there is an offset when you begin developing these community-based facilities. You will then be putting less capital into the acute care facilities and, in essence, not be any worse off than we are with no cap on the hospitals at this point.

Clearly, we believe that is the wave of the future. Our interest as an issuer on behalf of the State of New York is to find the lowest overall cost, and we believe that in the current market environment, the most efficient and the least costly way is to lift the cap and encourage the development of these community-based health care facilities.

Chairman PICKLE. Do you have any conflict with the hospitals over that, the regular hospitals? If you are going to get away from acute care delivery and go into these clinic hospitals, is there opposition among your regular hospitals on that approach?

Mr. MARTINEZ. Most of our hospitals are, in fact, merging or forming associations in order to actually compete within this new environment. They are encouraging the creation of these small health care providers.

In fact, today, my staff are meeting with two hospitals that are contemplating the creation of six distinct diagnostic and treatment centers in the community that will have a direct linkage back to the hospital and the hospital will actually provide referrals to these

facilities, because it is a more cost-effective way in order for them to survive as institutions and for health care to be provided at the lowest possible cost.

Chairman PICKLE. Well, then, the sum of it is that you anticipate many more bonds being issued, tax-exempt bonds being issued and because of it you want to get the cap removed so you can get on with it?

Mr. MARTINEZ. Absolutely. One way or the other we are going to pay for health care reform. We believe that we should try to find the least costly way. If we do not have the ability to issue tax-exempt bonds, people will go to the taxable market and that will mean the reimbursement system is going to pay a higher sum.

Twenty million dollars on each billion dollars of financing is a substantial amount of money to be paying as a differential for being in the taxable market. And since we are one of the largest issuers in the country, and we are probably the largest, we have issued over 13 billion dollars' worth of debts in the last 20 years and you can see that at that level it is a huge cost to the reimbursement system.

Chairman PICKLE. Well, I think you are being honest about your statement and the purpose of why you want to lift the cap. So I think I understand that. Mr. Ummel.

Mr. UMMEL. Congressman Pickle, maybe I can add to his reply in saying out there in the real world, in the not-for-profit health care field, we acknowledge excess hospital capacity. We also have heard calls for cost containment, so we are voluntarily, across this land today, have already taking initiatives, each day, each week, to form new integrated health networks, voluntarily.

We are doing so to recycle this excess capacity and to minimize it. We are doing it to reduce operating costs and avoid planned capital investment. We are doing it to link all these levels and sites of care from health promotion on the one end to long-term care on the other and everything in between, and link those into a commonly managed and governed health network. That network will be able to accept capitation payments and deliver care on a prepaid basis to a large population. We are doing this to improve continuity and quality of care. But we are being blocked in doing so for the public benefit by this cap.

Chairman PICKLE. I thank you and thank you, Mr. Chairman. That is all the questions I have.

Chairman RANGEL. On behalf of the full committee, I want to thank the entire panel for the enlightening testimony that you have given to us. It will be of great assistance to us in the future. Thank you so much.

The next and last panel, Dan Holdhusen, vice president and chief financial officer and treasurer of Evangelical Lutheran Good Samaritan Society; Sterling Ellis, assistant treasurer of the National Benevolent Association of the Christian Church; Cyrus M. Jollivette, vice president for government relations, University of Miami; and Stephen Claiborn, managing director for Lehman Brothers, Public Securities Association.

The committee has copies of the full testimony. You may read it or highlight the testimony. Without objection, your full statements will be entered into the record.

We will start with Mr. Holdhusen.

STATEMENT OF DAN HOLDHUSEN, VICE PRESIDENT, CHIEF FINANCIAL OFFICER AND TREASURER, EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY

Mr. HOLDHUSEN. Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Chairman, may I interject. I anticipate a vote on the floor here before long. They may want to condense their statements within a 5-minute period because we may have to leave in a few minutes.

Mr. HOLDHUSEN. Yes, sir, Mr. Chairman. Members of the subcommittees, thank you for the opportunity to testify here today.

My name is Dan Holdhusen. I am the vice president and chief financial officer of the Evangelical Lutheran Good Samaritan Society.

For over 70 years, the society has provided long-term care for the elderly through nursing home and residential facilities. Today, the society, which is exempt from Federal income taxation as a charitable organization, operates 241 health care and related facilities in 26 States. It is the largest not-for-profit provider of nursing home facilities in the United States. The society provides a total of 18,344 nursing home beds and 5,075 senior apartment units, most of which are located in very rural settings in States including Iowa, Kansas, Minnesota, Nebraska, New Mexico, North and South Dakota, and Texas. The society also serves in the States of California, Florida, Indiana, Oklahoma, Oregon, Texas, and Wisconsin. In many of our rural communities, the society is the largest employer. We employ over 16,000 full time equivalents in the 26 States we operate in.

Our goal over the last 73 years of business has been to provide these services in a Christian atmosphere of caring, concentrating all of our resources to make our residents as comfortable and as productive as possible. As a not-for-profit, our focus is not on the return to shareholders but, instead, it is for the care of the residents and the employees. In addition, to ensure its mission of providing care to elderly persons in its communities is fulfilled comprehensively, the society operates some 120 separate programs to furnish a wide range of community-based services for the elderly. Such programs include home health service, Meals on Wheels, senior companion programs, and a wide variety of health care and related services that are all aimed at permitting elderly persons who are ill and in some way unable to live independently to remain in their homes as long as possible.

In recent years, the society has been asked by its local communities and by other nursing home providers to develop or acquire nursing home facilities. These new centers, along with additions, renovations and replacements to existing facilities, have been financed principally by the issuance of tax-exempt debt. As you know, the Tax Reform Act of 1986 imposed a limit of $150 million on the aggregate amount of outstanding nonhospital funds for 501(c)(3) organizations, such as the society.

Because of the increased demand across the country for long-term care facilities and senior housing, and because the society has attempted to meet this need by constructing and acquiring facilities

with tax-exempt financing, the society has been subject to this limitation since that time. At the same time, the society is facing increased financial pressure in achieving its mission to provide low-cost, high-quality nursing care facilities due to dramatic labor, energy, and materials cost increases, Medicare and Medicaid cuts, and the rising demands for indigent care.

Since the passage of the 1986 Tax Reform Act, we have struggled to borrow as little as possible through tax-exempt bonds, saving what small amount of capacity that became available each year for projects with the greatest impact on the communities that we serve. As of the end of 1993, we had $286.888 million of outstanding long-term debt, of which approximately $140 million was in taxable debt. We estimated this taxable debt increases our cost of borrowing by approximately 2 percent, representing about $2.8 million of additional interest expense each year.

This $2.8 million in additional interest expense is passed on to our residents through either higher per diem rates or our long-term care centers or higher apartment costs in our senior apartment units. Since the majority of our long-term health care residents are covered by the welfare system, Medicare or Medicaid, much of our additional interest expense is passed on, when possible, through the welfare reimbursement systems.

We also find that we get shorter principal amortization in the taxable marketplace. They are two completely different marketplaces in which to work than we do in the tax-exempt marketplace. As a result, cash flow is materially diminished, which places a greater pressure on our resident rates.

The introduction of the $150 million limitation on tax-exempt bonds has materially altered the way in which the society manages its financial affairs. Our interest expense has greatly increased, the amortization of debt has shortened, our ability to react to market changes has been reduced, and our ability to acquire, maintain, and rebuild our infrastructure has been greatly harmed. In a period when consolidation must bring better services to our frail elderly, it would be an incalculable benefit to have the $150 million cap removed.

In recognition of the need to maintain the availability of adequate long-term care facilities for the elderly at the lowest feasible cost, the society respectfully requests you to provide an exception to the $150 million cap for health care providers, including nursing homes. Alleviating the burden of the limitation is critical to making health care reform work for our not-for-profit nursing homes and the elderly patients and rural communities we serve.

Thank you very much.

[The prepared statement and attachment follow:]

**TESTIMONY OF DAN HOLDHUSEN,
VICE PRESIDENT,
CHIEF FINANCIAL OFFICER AND TREASURER,
EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY,
BEFORE THE SUBCOMMITTEE ON SELECT REVENUE MEASURES
AND THE SUBCOMMITTEE ON OVERSIGHT,
HOUSE WAYS AND MEANS COMMITTEE
AUGUST 9, 1994**

Chairman Rangel, Chairman Pickle and Members of the Subcommittees, thank you for the opportunity to testify here today. I am Dan Holdhusen, Vice President, Chief Financial Officer and Treasurer of the Evangelical Lutheran Good Samaritan Society. For over 70 years, the Society has provided long-term care for the elderly through nursing homes and residential facilities. Today, the Society, which is exempt from federal income taxation as a charitable organization under Section 501(c)(3) of the Internal Revenue Code, operates 241 health care and related facilities in 26 states. It is the largest nonprofit provider of nursing home facilities in the United States. The Society provides a total of 18,344 nursing home beds and 5,075 senior apartment units, most of which are located in very rural settings. The Society's executive offices are located in Sioux Falls, South Dakota, and many of its facilities are located in Iowa, Kansas, Minnesota, Nebraska, New Mexico, North Dakota, South Dakota and Texas (see the Appendix to this statement). The Society employs over 16,000 FTEs in 26 states.

The Society's nursing homes (i.e., licensed nursing facilities) provide long-term health care and convalescent care for adults, including those who are admitted as an intermediate step after hospitalization and before returning to their homes. Admission is ordinarily under the supervision of the resident's personal physician. Charges for services normally consist of a per diem room rate. Such charges are reimbursed to the Society by Medicaid and Medicare for over half the present residents of the Society's various facilities. Consequently, the Society and its Good Samaritan Centers are subject to considerable federal, state and local regulation, particularly in the areas of life safety, health care and food preparation. The Society attempts to provide nursing home services to residents at the lowest feasible cost, and participates in the Medicaid program to enable indigent residents to continue occupancy and receiving health care services.

Our goal during our 73 years of business has been to provide these services in a Christian atmosphere of caring, concentrating all of our resources to make our residents as comfortable and productive as possible. As a not-for-profit, our focus is not a return for shareholders but a concern for residents and employees. In many of our rural communities, the Society is the largest employer and often the sole source of rural health care. We estimate that in six of the states where we operate, the Society is one of the top 10 employers. Therefore, the Society's facilities are an important source of both long-term health care and resident services and employment in certain rural regions of the United States.

In addition, to ensure that its mission of providing care to elderly persons in its communities is fulfilled comprehensively, the Society operates approximately 120 separate programs to furnish a wide range of community services for the elderly. Such programs include home health care, Meals on Wheels, senior companionship services, and a wide variety of health care and related services that are all aimed at permitting elderly persons who are ill or in some way unable to live independently to remain in their own homes. Given the rural communities where most of our services are concentrated, these programs typically make the difference for many elderly persons between remaining in the familiar environment of home and being forced to move to an institution.

In recent years, the Society has been asked by its local communities and by other nursing home providers to develop or acquire nursing home facilities. These new centers, along with additions, renovations and replacements to existing facilities, have been financed principally by the

issuance of tax-exempt debt. As you know, the Tax Reform Act of 1986 imposed a limit of $150 million on the aggregate amount of outstanding non-hospital bonds for any Section 501(c)(3) organization. Because of the increased demand across the country for long-term care facilities and senior housing, and because the Society has attempted to meet this need by constructing and acquiring facilities with tax-exempt financing, the Society has been subject to the $150 million limitation since 1986.

At the same time, the Society is facing increased financial pressure in achieving its mission to provide low-cost, high-quality nursing home facilities. This is because:

- The Society's labor costs have increased dramatically, forcing it to place increased reliance on volunteers and donors to provide assistance at its facilities;
- There is increased uncertainty regarding the future of contribution payments from Medicaid and Medicare;
- In addition to the increased general demand for long-term care beds, the Society faces added demands of providing beds and services to indigents lacking resources to pay; and
- The Society must absorb rising labor, energy and materials costs in pursuing its mission.

This problem is compounded by the Society's need to renovate and upgrade existing facilities, most of which are well over 20 years old, as well as to adapt to changes in long-term care methods and technology. As a result, the Society has experienced difficulty and higher costs in constructing, developing, renovating, rehabilitating or acquiring new nursing home facilities without the benefit of tax-exempt financing.

Since the passage of the 1986 Tax Reform Act, we have struggled to borrow as little as possible through tax-exempt bonds, saving the small capacity that becomes available each year for projects with the greatest impact on the communities we serve. As of December 31, 1993, the Society had $286,888,000 of outstanding long-term debt, of which approximately $140 million was in taxable debt. We estimate that this taxable debt increases our cost of borrowing by 2%, representing $2.8 million of additional interest expense per year.

This $2.8 million in additional interest expense is passed on to our residents through either higher per diem rates in our long-term care centers or higher apartment costs in our senior apartment units. As of year-end 1993, 54.6% of our residents were covered by Medicaid, 3.9% of our residents were Medicare beneficiaries, and the remaining 41.5% were private-pay residents. Since the majority of our long-term health care residents are covered by Medicare or Medicaid, much of our additional interest expense is passed on, when possible, through the Medicare/Medicaid reimbursement system. Further, because of passthroughs to our private pay residents, they often become dependent on Medicare/Medicaid more quickly than if we could borrow at tax-exempt rates.

Not only does the additional interest expense that we are required to bear because of the $150 million cap hurt our ability to provide low-cost, high-quality care, we find that we get shorter principal amortization in the taxable marketplace than in the tax-exempt marketplace. As a result, cash flow is materially diminished, placing even greater pressure on resident rates.

Finally, the $150 million limitation has greatly curtailed the amount of refunding that the Society can accomplish in order to take advantage of lower interest rates. The result is that we are unable to manage our tax-exempt debt in the manner that would be most beneficial to take advantage of lower interest rates and thereby minimize increases in rates to our residents.

The introduction of the $150 million cap on tax-exempt bonds has materially altered the way in which the Society manages its financial affairs. Our interest expense has greatly increased, the amortization of debt has been shortened, our ability to react to market changes has been reduced and our ability to acquire, maintain and rebuild our infrastructure has been greatly harmed. In a

period when consolidation must bring better services to our frail elderly, it would be of incalculable benefit to have the $150 million cap removed.

In recognition of the need to maintain the availability of adequate long-term care facilities for the elderly at the lowest feasible cost, the Society respectfully requests Congress to provide an exception to the $150 million bond cap for health care providers, including nursing homes. For these purposes, we would suggest defining a nursing home as a facility that:

- Is licensed under and;
- Is in compliance with the laws of a state or local government, and which is:
- In compliance with federal law regarding Medicaid standards for operating nursing homes;
- Is primarily used to provide long-term care for the elderly, disabled, or sick persons;
- Has a requirement that every resident ordinarily be under the supervision of a physician; and
- Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered nurse on duty at all times.

The demands for nursing home and related community outreach services such as we provide will only increase in the coming years as health reform and its repercussions in the market proceed. Alleviating the burden of the $150 million cap is crucial to making the system work for our nonprofit nursing homes and the elderly patients and rural communities we serve.

August 8, 1994
Doc. #13518

TYPES AND CAPACITIES OF FACILITIES

State	# of Facilities	Nursing Beds	Assisted Living	Apt. Units	Mobile Homes Cap.	Total Beds/Units	# of Facilities	Nursing Beds	Assisted Living	Apt. Units	Total Beds/Units	# of Facilities	Apt. Units	Grand Total
		Owned and Leased					Managed					Related HUD Corporations		
Arizona	4	413	30	233		676						1	60	736
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
California	1	59	22	109		190								190
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Florida	3	290	115	1,061	385	1,851								1,851
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Idaho	5	465	26	159		650						2	65	715
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Indiana	2	202	28			230						1	24	254
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Kansas	17	1,364		89		1,453	2	153			153	2	170	1,776
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Minnesota	21	1,810	46	176		2,032	4	81	115	36	212			2,244
ELGSSM**	27	2,660	82	111		2,853	53	273		46	319			3,098
Missouri							1	100			100			100
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nebraska	25	2,018		858		2,876						2	123	2,999
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
North Dakota	14	932	32	17		981	2	117			117			1,098
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Oklahoma	2	88				88								88
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
South Dakota	19	1,497	27	68		1,592								1,592
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Washington	3	346		104		450								450
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Wisconsin	5	443	20	78		541								541
TOTALS	206	17,156	513	4,786	385	22,840	22	1,188	125	289	1,602	13	694	25,136
*At 1.5 Occupancy Add				2,393	193	2,586				145	145		347	3,078
Total Capacity	206	17,156	513	7,179	578	25,426	22	1,188	125	434	1,747	13	1,041	28,214

**ELGSSM: The Evangelical Lutheran Good Samaritan Society of Minnesota

Chairman RANGEL. Mr. Jollivette.

STATEMENT OF CYRUS M. JOLLIVETTE, VICE PRESIDENT FOR GOVERNMENT RELATIONS, UNIVERSITY OF MIAMI; AND ALSO ON BEHALF OF PUBLIC HEALTH TRUST OF DADE COUNTY, JACKSON MEMORIAL HOSPITAL, AND MIAMI MEDICAL CENTER

Mr. JOLLIVETTE. Good afternoon. Mr. Chairman, and members of the Subcommittees on Select Revenue Measures and Oversight.

I am Cyrus Jollivette of Miami, Fla., a former board chairman of the Public Health Trust of Dade County, which operates, among other facilities, Jackson Memorial Hospital, the anchor of the Miami Medical Center, and one of the Nation's busiest and largest medical complexes. I am also a vice president at the University of Miami, whose School of Medicine utilizes the public Jackson Memorial Hospital as its primary teaching facility and provides the staff at the Miami Medical Center.

I appreciate the opportunity to appear before you today to applaud your leadership in considering a change in existing law that would remove the $150 million cap with respect to certain health-related section 501(c)(3) bonds. This is an issue of vital importance to many, many section 501(c)(3) organizations. Your proposal is an essential and critical one.

The Miami Medical Center is a true public-private partnership and I am proud to represent it. Recognized nationally and internationally for the scope and quality of its care, the Miami Medical Center is unique in its commitment and capacity to render that care to all local residents regardless of their ability to pay.

Jackson Memorial Hospital is one of the Nation's largest public hospitals and providers of indigent care and has evolved from a traditional county hospital to a center of medical excellence in patient care, research, teaching, and service in partnership with a private nonprofit institution, the Miami School of Medicine.

The numbers at the Miami Medical Center can be staggering. On our 67-acre central city campus, we operate more than 1,500 licensed beds, handle more than 60,000 inpatient admissions, treat more than 100,000 patients in the Emergency Care Center, handle nearly 350,000 outpatient visits to more than 100 specialty clinics, deliver nearly 10,000 babies, and perform close to 40,000 surgical procedures each year. All these services are provided by more than 10,000 people—nurses, physicians, allied staff and volunteers—each committed to our unique mission to provide a single standard of excellent care to every patient who seeks leadership.

Over two-thirds of our patients are publicly funded through Medicaid, Medicare, State, or county support. And 78 percent of our patients are ethnic minorities, 36 percent Hispanic, 33 percent black, and 9 percent Haitian. At the Miami Medical Center, the boundaries of its public and private nonprofit constituent institutions are blurred. This is generally the case in academic medical centers. It is especially true at the Miami Medical Center.

At our medical center, a private university utilizes the public hospital as its primary teaching facility where in any year care may be provided utilizing dozens of languages. A university physician may start her day making rounds and treating patients at the

Miami VA hospital. A short time later she will treat both public and private patients side by side in the public Jackson Memorial Hospital inpatient or outpatient facilities, as well as supervise medical interns and residents before walking a short distance to her university or hospital office where she might review her correspondence and counsel medical students, all before retreating to a laboratory to monitor her ongoing research.

She never realizes or even considers on whose property she might be standing at any given moment of her busy, busy day. She is simply giving and supervising care, teaching her students, and conducting vital medical research.

To a Miami Medical Center physician, the institutional boundaries are simply imperceptible. It is clear that the health care facility needs in Florida, and especially in the Miami metropolitan area, are indeed critical. It is also clear that private nonprofit entities play an integral role in the delivery of essential health services in Miami.

Accordingly, Chairman Rangel and Chairman Pickle, your legislative proposal that would afford certain nonprofit health-related entities access to tax-exempt financing is of great importance. We strongly support it.

While not all of the private nonprofit entities that play key roles in the delivery of health services in the Miami area would not directly benefit from this proposal, we believe that it is important on its merits.

For example, the Miami Medical Center, which as I have explained, provides the staff at the medical center, including the Jackson Memorial Hospital, alone faces more than $70 million in critical infrastructure, patient care, equipment, research, and teaching facilities needs, needs which would be financed with taxable debt unless the $150 million cap is lifted.

We sincerely hope that Congress ultimately will reinstate prior law, the effect of which would be to eliminate the financial disadvantage between substantially identical section 501(c)(3) organizations, and to treat more equally those in the private nonprofit and charitable organizations that are engaged in similar activities serving the public interest.

That is the hope, Mr. Chairman, but I am here today especially to voice support for your very important proposal. Also, Chairman Rangel, I have been empowered to voice NYU's and Columbia's support for your proposal. Thank you for the opportunity to appear before you today.

Chairman RANGEL. Thank you.

[The prepared statement follows:]

Testimony of
Cyrus M. Jollivette, Vice President
University of Miami
before
the Subcommittees on Select Revenue Measures
and Oversight of the
Committee on Ways and Means
Tuesday, August 9, 1994

Good afternoon, Chairman Rangel, Chairman Pickle, and members of the Subcommittees on Select Revenue Measures and Oversight.

I am Cyrus M. Jollivette of Miami, Florida. I am a former board chairman of the Public Health Trust of Dade County, which operates among other facilities, Jackson Memorial Hospital, the anchor of the Miami Medical Center, and one of the nation's busiest and largest medical complexes. I am also a vice president at the University of Miami, whose School of Medicine utilizes the public Jackson Memorial Hospital as its primary teaching hospital and provides the staff at the Miami Medical Center.

I appreciate the opportunity to appear before you today to applaud your leadership in considering a change in existing law concerning section 501(c)(3) bonds—a proposal that would remove the $150 million cap with respect to certain health-related section 501(c)(3) bonds. This is an issue of vital importance to many, many section 501(c)(3) organizations. Your proposal is an essential and critical step.

The Miami Medical Center is a true public-private partnership and I am proud to represent it. Recognized nationally and internationally for the scope and quality of its care, the Miami Medical Center is unique in its commitment and capacity to render that care to all local residents regardless of their ability to pay. In affiliation with the Miami Medical School, Jackson Memorial Hospital has evolved from a traditional county hospital to a center of medical excellence, all in partnership with a private university—the University of Miami.

The numbers at the Miami Medical Center can be staggering. On our 67-acre central city campus we operate more than 1,500 licensed beds, handle more than 60,000 in-patient admissions, treat more than 100,000 patients in the Emergency Care Center, handle nearly 350,000 outpatient visits to more than 100 specialty clinics, deliver nearly 10,000 babies annually, and perform close to 40,000 surgical procedures each year. All these services are provided by more than 10,000 people—nurses, physicians, allied staff, volunteers—each committed to our unique mission to provide a single standard of excellent care to every patient who seeks help.

At the Miami Medical Center the boundaries of its constituent institutions are blurred. This is generally the case in academic medical centers. It is especially true at the Miami Medical Center.

At our medical center, a private university utilizes a public hospital as its primary teaching hospital. A university physician may start her day making rounds and treating patients at the Miami VA hospital. A short time later she will treat both public and private patients side-by-side in the public Jackson Memorial Hospital in-patient or out-patient facilities, as well as supervise interns and residents, before walking a short distance to her university office where she might review her correspondence and counsel medical students, all before retreating to her laboratory to monitor on-going research projects. The university physician really does not realize or consider on whose property she might be standing at any given moment. She is simply giving and supervising care and conducting vital research. The institutional boundaries are simply imperceptible.

The health care facilities needs in Florida, and especially in the Miami metropolitan area are, indeed, critical. Ours is a fast growing region. It is also clear that private, nonprofit entities play an integral role in the delivery of essential health services in Miami.

Accordingly, Chairman Rangel and Chairman Pickle, the legislative proposal that would afford certain nonprofit health-related entities access to tax-exempt financing is of great importance. We strongly support it.

While certain of the nonprofit facilities and entities that play key roles in the delivery of health services in the Miami area would not directly benefit from this proposal, we believe it is important on its merits.

For example, the Miami Medical School, which as I have explained provides the staff at the medical center, including the Jackson Memorial Hospital, alone faces more than $70 million in critical infrastructure, patient care, research, and teaching facilities needs, needs which would be financed with taxable debt unless the $150 million cap is lifted.

We sincerely hope that Congress will reinstate prior law, the effect of which would be to eliminate the financial disadvantage between substantially identical section 501(c)(3) organizations, and to treat more equally those private nonprofit and charitable organizations that are engaged in similar activities advancing the public interest.

That is a hope, Mr. Chairmen. But, I am here today to voice support for the very important step which your proposal provides.

Thank you for the opportunity to appear before you today.

Chairman RANGEL. Mr. Ellis.

STATEMENT OF STERLING C. ELLIS, ASSISTANT TREASURER, NATIONAL BENEVOLENT ASSOCIATION OF THE CHRISTIAN CHURCH (DISCIPLES OF CHRIST)

Mr. ELLIS. Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today.

My name is Sterling C. Ellis. I am the assistant treasurer for the National Benevolent Association of the Christian Church, Disciples of Christ, with headquarters in St. Louis, Mo., and I am here today to testify in favor of lifting the ban of the $150 million tax-exempt, nonhospital bonds for 501(c)(3) organizations.

Our organization is a 107-year-old general unit of the Christian Church, Disciples of Christ, with primary focus on care of the elderly, the chronically mentally ill, mentally retarded, developmentally disabled, services for abused and neglected children, and low-income housing. The NBA has 80 units in 26 States, spread throughout the country. Our primary focus in recent years has been in providing a continuum of care for the elderly and, in particular, for the low- and middle-income groups.

According to the latest nonprofit times survey, the NBA is the 28th largest charity in the United States, with 82½ percent of its revenue going directly to programs and services, as we serve over 10,500 residents daily and over 26,000 persons annually.

To date, we have $114 million in tax-exempt bonds outstanding, which include both current and advanced refunded issues. Our organization intends to issue, within the next 2 years, an additional $50 million in long-term financing with particular emphasis on tax-exempt bonds. A combination of the current balance and future plans will put us over the current $150 million cap. The projects included in the $50 million additional debt include expansion and renovation of retirement centers, nursing homes, and services for children.

Given current interest rate spreads between tax-exempt and taxable financing, we anticipate that the spread will generate an additional $1 million annually in debt service costs if these costs—projects were to be financed on a taxable basis as compared to a tax-exempt basis.

By contrast, the $114 million currently outstanding represents a savings as compared to taxable financing of approximately $1.5 million per year. This has allowed the NBA to keep its costs competitive and to permit people of lesser means to enjoy the benefits of our facilities.

These savings translate into our ability to provide charity care in excess of $14 million per year through donations, gifts, and reduced operating costs. It should be noted that there has never been anyone displaced from any of our facilities for lack of funds in our 107-year history.

As a 501(c)(3) organization, we are unable to raise equity capital to develop projects which reduce borrowing costs, fund working capital, and pay profits to owners for their investment. Instead, to remain competitive we must find savings in fixed costs such as interest expense and rely on the benevolence of donors to help fund the projects and operations.

The effect of the current cap could best be illustrated by example. We are currently planning to construct 70 replacement nursing beds at the Ramsey Home in Des Moines, Iowa, in 1997. Given today's spread between taxable and tax-exempt fixed 30-year bond rates, for an organization with our rating, the annual debt service cost difference would be $128,000 or $152 per month per resident. This adds 6.8 percent to the cost of providing nursing services each day, or approximately $5. Over the 30-year life of the debt, this translates into $3.8 million in costs that must be passed on in all or part to the residents, their families, donors, or State Medicaid programs.

The difference in costs are not just limited to senior services. The NBA is also planning a replacement residential housing facility and school for abused and neglected children in Denver, Colo., known as the Colorado Christian Home, during fiscal year 1995. The difference in annual debt service cost would be over $107,000 per year, or $720 per resident per year, or over $3.2 million over the life of the debt. Converting this to human terms means four to six children cannot be served on a residential basis if taxable financing is used versus tax-exempt financing. This also means our daily costs are increased 4 to 5 percent.

Lifting the cap will permit the NBA to continue its mission of providing services to all who seek its shelter.

Thank you, Mr. Chairman, and members of the committee.

[The prepared statement follows:]

STATEMENT OF STERLING ELLIS
ASSISTANT TREASURER
NATIONAL BENEVOLENT ASSOCIATION OF THE CHRISTIAN CHURCH

My name is Sterling C. Ellis. I am the Assistant Treasurer for the National Benevolent Association of the Christian Church (Disciples of Christ), with headquarters in St. Louis, Missouri. I am here today to testify in favor of lifting the ban of $150,000,000 tax-exempt, non-hospital bonds for 501(c)3 organizations. I appreciate the opportunity to appear before this committee today.

Our organization is a 107 year old general unit of the Christian Church (Disciples of Christ), with primary focus on care of the elderly, the chronically mentally ill, mentally retarded/developmentally disabled, services for abused and neglected children, and low income housing. The NBA has 80 units in 26 states, spread throughout the country. Our primary focus in recent years has been in providing services for the elderly and, in particular, the low to middle income group.

According to the latest Non Profit Times survey, the NBA is the 28th largest charity with 82.5% of its revenue going directly to programs and services, as we serve over 10,500 residents daily and over 26,000 persons annually.

To date, we have $114,000,000 in tax-exempt bonds outstanding which include both current and advance refunded issues. Our organization intends to issue, within the next two years, an additional $50,000,000 in long term financing with particular emphasis on tax-exempt bonds. A combination of the current balance and future plans will put us over the current $150,000,000 dollar cap. The projects included in the $50,000,000 additional debt include expansion and renovation of retirement centers, nursing homes, and services for children.

Given current interest rate spreads between tax-exempt and taxable financing, we anticipate this will generate an additional one million dollars annually in debt service costs if these projects were to be financed on a taxable basis as compared to a tax-exempt basis.

By contrast, the $114,000,000 currently outstanding, represents a savings as compared to taxable financing, of approximately one and a half million dollars per year. This has allowed the NBA to keep it's costs competitive and to permit people of lesser means to enjoy the benefits of our facilities.

These savings translate into our ability to provide charity care in excess of $14,000,000 per year through donations, gifts, and reduced operating costs. It should be noted that there has never been anyone removed from any of our facilities for lack of funds in our 107 year history.

As a 501(c)3 organization, we are unable to raise equity capital to develop projects which reduce borrowing costs, fund working capital, and pay profits to owners for their risks in investing. Instead, to remain competitive we must find savings in fixed costs such as interest expense and rely on the benevolence of donors to help fund the projects and operations.

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The difference in costs are not limited to just senior services. The NBA is also planning a replacement residential housing facility and school for abused and neglected children in Denver, Colorado known as the Colorado Christian Home during fiscal year 1995. The difference in annual debt service cost would be over $107,000 per year of $720 per resident per year, or over $3,200,000 over the life of the debt.

Converting this to human terms means four to six children cannot be served on a residential basis if taxable financing is used versus tax exempt financing. This also means our daily costs are increased four to five percent.

Lifting the cap will permit the NBA to continue its mission of providing services to all who seek its shelter.

Chairman RANGEL. Chairman Pickle.

Chairman PICKLE. Well, I want to ask the same question I have asked the other panelists.

Chairman RANGEL. And we will start on the left. I am sorry, would you yield? I forgot Mr. Claiborn. He has not testified yet.

Chairman PICKLE. Of course.

Chairman RANGEL. I am terribly sorry, Mr. Claiborn.

STATEMENT OF STEPHEN CLAIBORN, MANAGING DIRECTOR, LEHMAN BROTHERS INC., HOUSTON, TEX., ON BEHALF OF THE PUBLIC SECURITIES ASSOCIATION

Mr. CLAIBORN. Thank you and good afternoon. My name is Steve Claiborn. I am a managing director of the securities firm of Lehman Brothers in our Houston, Tex., office where I specialize in capital financing for public and nonprofit health care organizations. I appear before you this afternoon on behalf of the Public Securities Association, however, of which my firm is a member.

PSA is the international trade organization of securities firms and banks that underwrite and trade municipal securities, U.S. Government and Federal agency securities, mortgaged-backed securities, and money market instruments. PSA's membership includes all firms that underwrite securities issued by public and nonprofit health care organizations. As such, we take a strong interest in the efficiency and quality of the Nation's health care delivery system.

We commend President Clinton and Congress for their commitment to health care reform, and we commend both Chairman Rangel and Chairman Pickle for holding this hearing.

PSA also recognizes Chairman Rangel and Congressman Hoagland for their efforts in urging the Ways and Means Committee to repeal the $150 million per institution volume cap issued by 501(c)(3) nonhospital health care organizations. Our comments this afternoon will focus on the need for that important policy change.

The Internal Revenue Code contains a $150 million limit on outstanding tax-exempt bonds issued by most nonprofit 501(c)(3) organizations. An exemption from the limit is provided for debt used to finance hospital facilities. Nonhospital facilities, such as outpatient emergency care clinics, community health centers, and long-term care facilities, do not qualify for the exemption.

One of the primary goals of health care reform is to encourage health care providers to broaden their ability to offer services on a noninpatient basis as a means of containing costs. However, as they seek to provide a continuum of services in a variety of settings, nonprofit health care organizations will become increasingly constrained by the volume cap when financing nonhospital facilities. These facilities often provide certain kinds of care more efficiently, and at lower per patient cost than hospitals, but could ironically face higher financing costs because they fall outside the definition of "hospital" in the code. If forced to issue securities on a taxable basis to meet additional financing needs above the level of the volume cap, their costs and capital would likely increase by 200 to 300 basis points, or 2 or 3 percent a year.

Current law, therefore, is a disincentive to the evolution of nonprofit health care delivery. In order to offer care as efficiently as possible, the Nation's nonprofit health care providers must be free

to construct, operate, and maintain facilities other than hospitals without the financial restrictions imposed by the nonhospital 501(c)(3) volume cap.

Repeal of the entire volume cap was successfully passed by the 102d Congress in 1992. In the context of this year's health care reform effort, exempting all health care institutions, not just hospitals, from the volume cap would allow nonprofit health care organizations to meet their community's needs in the broadest and most efficient way possible.

PSA believes that responsibly crafted health care reform would benefit public and nonprofit health care providers and would strengthen the Nation's health care system overall. We look forward to working with members of the Ways and Means Committee as the congressional debate over health care reform continues.

Thank you for the opportunity to testify today. We would be pleased to respond to any questions.

Chairman RANGEL. Thank you, Mr. Claiborn.

Mr. Hancock.

Mr. HANCOCK. Mr. Chairman, I have a lot of questions but I would yield first to Mr. Pickle.

Chairman RANGEL. Mr. Pickle.

Chairman PICKLE. I want to ask again the question. Each of you go through that, if you will. Are you at the $150 million cap?

Mr. JOLLIVETTE. We have been at the cap since the inception in 1986.

Chairman PICKLE. I did not hear you.

Mr. JOLLIVETTE. We are at the cap, sir.

Chairman PICKLE. Already at the cap?

Mr. JOLLIVETTE. Yes.

Chairman PICKLE. If you are already at the cap, how many more bonds do you anticipate you will want to issue over the next 10 years?

Mr. JOLLIVETTE. Over the next 5-year planning window for our institution, we anticipate capital projects totaling about $220 million. About $145 million or so would require new borrowings. The difference between the $220 million and the $145 million, we anticipate, would be from donors, and so that there would be about 145 million dollars' worth of new borrowing over the next 5 years.

Chairman PICKLE. Mr. Ellis.

Mr. ELLIS. We are currently at $114 million. We plan in the next 2 years to issue another $50 million. If you carry that out beyond the next 2 years, the next 5 years, you can take that $50 million figure and make it $80 million. But currently we are at $114 million.

Chairman PICKLE. And you anticipate another $80 million?

Mr. ELLIS. Yes, sir.

Chairman PICKLE. All right, Mr. Holdhusen.

Mr. HOLDHUSEN. Our organization, the Good Samaritan Society, has approximately $300 million in long-term debt in total. Nearly $150 million is tax exempt. So we are at the ceiling now at the present time. We anticipate our capital needs in the next 5 years to be approximately $25 million per year, so anywhere from $125 to $150 million more in capital.

Chairman PICKLE. Mr. Claiborn.

Mr. CLAIBORN. Well, some of our clients are at or near the cap. But I want to make two points quickly. One, I don't think this cap would be nearly the issue that it is absent health care reform. I think it is the health care reform that is making this——

Chairman PICKLE. Are you announcing that we should pass the health care reform?

Mr. CLAIBORN. I think health care reform is happening whether Congress takes any action or not.

Chairman PICKLE. Go ahead.

Mr. CLAIBORN. The other point I want to make is that the volume cap repeal is also an issue because of the mergers that are happening. It may not only be a matter of selling new bonds but also facilitating mergers between two organizations that would be over the cap after the merger.

Chairman PICKLE. Well, do all of you agree that you anticipate the issuance of more bonds because of the pending health care reform bill or are you going to go ahead and make this bond issuance regardless of what happens on the health issue?

Mr. JOLLIVETTE. Some of our anticipated borrowings relate directly to health care reform. Over the past 2 years the Miami Medical School has been involved in a very detailed planning process preparing itself, if you will, for the changes that are taking place in the health care field, education, training, et cetera. And there are extensive needs at the medical school relating to equipment, facilities for patient care, systems, and critical infrastructure items that will come online because of the changes that have been made there due to health reform as we move to managed care and other types of services.

Chairman PICKLE. All right, sir, thank you. I thank you, Mr. Chairman.

Chairman RANGEL. Mr. Hancock.

Mr. HANCOCK. Are you familiar with any proposed mergers, Mr. Claiborn, that have not taken place because of this cap?

Mr. CLAIBORN. I am not personally involved in any, but I have heard talk of some and, again——

Mr. HANCOCK. I understand that you are primarily involved in the issuing of these securities. Am I correct, the Public Security Association? That is, your interest in it rather than the health care field; am I correct there?

Mr. CLAIBORN. Yes, sir. But we also give advice on mergers and acquisitions.

Mr. HANCOCK. Fine. You are the people that actually arrange to sell the bonds; am I correct?

Mr. CLAIBORN. Yes, sir.

Mr. HANCOCK. Do you think there will be more or less of these or do you think that the tax-free status is going to determine whether we build these facilities or do not build the facilities other than the hospitals?

Mr. CLAIBORN. I think there may be some of that, but maybe 10 or 20 percent of the projects would not happen if they could not be done tax exempt. I do think there is a 2 or 3 percent annual pass-through of the increased interest cost if they have to be done taxably.

Mr. HANCOCK. One final question. If more health care facilities are financed by tax-exempt revenue bonds, and that is what most of them are, will this inhibit future efforts at cost containment, since the Congress up here is trying to do something to reduce the cost, global budgeting and what have you. Might that jeopardize the revenue stream which is servicing the bond debt?

Mr. CLAIBORN. I really do not think so. Most of the projects we see, even though they cost money, have as their impetus to reduce the annual cost of health care. So they increase the efficiency of the delivery system at the cost of some initial investment. We are not seeing new beds being proposed. In fact, what we are doing is consolidating obsolete, older facilities into newer, more efficient facilities. Therefore, I believe that the capital that would be spent on consolidations would actually reduce the cost of health care going forward.

Mr. HANCOCK. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Hoagland.

Mr. HOAGLAND. Thank you, Mr. Chairman.

Mr. Holdhusen, I want to note that you have 25 facilities in Nebraska.

Mr. HOLDHUSEN. Yes, sir.

Mr. HOAGLAND. And I would compliment Good Samaritan on its choice of locations.

Mr. HOLDHUSEN. Thank you.

Mr. HOAGLAND. You particularly have in Hastings, Nebr., a wonderful skilled nursing facility which really contributes greatly to the quality of life and the economic viability of Hastings and that area. I think it is important that we encourage the use of 501(c)(3) bonds to produce such results in rural States like Nebraska. We have a great need for skilled nursing facilities to care for our elderly and we appreciate the fact that you have, if I can use your own testimony here, "saved a small amount of 501(c)(3) capacity that becomes available each year for projects with the greatest impact on the communities Good Samaritan serves." That really does help Hastings a lot. And hopefully, lifting the volume cap will permit Good Samaritan and other 501(c)(3) entities to maximize their contributions to the communities they serve.

Do you have any thoughts about that?

Mr. HOLDHUSEN. Yes, we are a very clear presence in the State of Nebraska with the 25 facilities. In fact, Good Samaritan is headquartered in Sioux Falls, S. Dak., which is somewhat central to those, about six, upper Midwestern States, and about 60 to 70 percent of our facilities are there. Very clearly a rural presence.

We have the ability, with the tax-exempt issuances capacity that we have, to place those in various venues. If it is in the State of Nebraska, the State of North Dakota, the State of South Dakota, typically we make that decision, however, because of our limited capacity based upon the financial needs of that particular community.

In the State of Nebraska, it has a relatively more favorable reimbursement system in Medicaid than we do in other venues. So, therefore, unfortunately in the case of Hastings, where we are presently considering an infrastructure improvement, we have not allocated a tax-exempt capacity because we have such a limited

amount. Therefore, it has changed the way in which we make decisions because of the limitations and we have to apply that capacity in those venues where it is less favorable in terms of its reimbursement.

But we attempt to—that is one of the reasons why we are hopeful, with this limitation being lifted, if that is the prospect here, which we encourage, we will be able to apply that to other rural areas such as Hastings, Nebr., and other small towns.

Mr. HOAGLAND. Well, it seems to me that is a very good reason in and of itself for lifting the cap, and thank you for your work in Nebraska.

Mr. HOLDHUSEN. Thank you.

Mr. HOAGLAND. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Claiborn, can you give me and the subcommittee any idea as to what has happened over the last 3, 4, or 5 years, with respect to the total volume of tax-exempt bonds for hospitals?

Mr. CLAIBORN. Yes, sir. I don't have the specific numbers, but the volume has been up significantly. However, I think that is very misleading because almost all of it is a matter of taking advantage of the lower interest rates to refund outstanding bonds that were initially done at a higher interest rate. I wish I had more specific numbers, but roughly about $30 to $32 billion in hospital revenue bonds have been sold. Only about $10 billion of that—and it is difficult to estimate it because a lot of issues have part refunding and part new money, actually new money. So that now that the refundings have effectively gone away due to higher interest rates, we look forward near-term to about a $10 billion new money in the market in the future.

Mr. MCCRERY. I am talking about the bonds for new construction, how does that compare with years past? Since, say, 1986 or 1988?

Mr. CLAIBORN. It is really pretty stable throughout that period in the $8 to $10 billion range. And I think right now there is not any kind of new construction planning going forward until the health care issue becomes more resolved. I think people, wisely enough, are not making hundred-million dollar commitments without knowing what health care is going to look like, with a few notable exceptions for specific reasons.

Mr. MCCRERY. I ask for a couple of reasons. One, the information that I pick up just going back home and talking with hospital administrators and folks in the medical care business is that there is an overcapacity of hospitals. There are too many hospital beds, and very few hospitals are full to capacity, and that is one reason some of them are having financial difficulty. The combination of lower reimbursement rates for Medicare and Medicaid, too high a percentage of Medicare and Medicaid patients in their hospitals, and too few beds filled.

And then the tenor of the discussion today, at least from the groups that we have had, other than Mr. Stark, seems to me to be, well, if we do not remove this cap, then you are going to encourage more hospital building because you do not have a cap on the tax-exempt bonds for hospitals.

I am not sure that is correct. I am not sure that we are going to see more hospital building just because we have no cap on the level of tax-exempt bonds. So, then, if it is not a matter of competition between hospital building and other health care facility building, then we are faced with the question, square up, I think, is it in the best interest of the health care system as a whole to remove the cap on these nonhospital facilities? I do not think we have really addressed that sufficiently.

We have heard a lot of testimony from specific organizations today that they are going to bump up against the cap pretty soon and, gee, it would be swell if we could get more tax-exempt bonds to finance more good things to do for people. But in the larger context of health care reform and what is happening in the health care system and getting costs down, one of the primary concerns that I have is that our health care system as a whole does not reveal to the consumer of health care the true cost of delivering that health care.

And, essentially, what we are talking about today is hiding more of the true costs of delivering health care to the consumer, because we are going to lower the costs of capital and, therefore, you do not have to pass through as great a capital cost to the consumer, and so the consumer is going to have just that little bit more hidden from him.

Admittedly, it is at the margin, but still it is a little bit more that that consumer is not going to know he is spending to get health care. And, therefore, your utilization rate goes up and that is one of the two big factors in driving up health care costs, utilization and prices. We are hopeful that prices are going to undergo some restraint here, but utilization is the other big reason costs are going up, and what we are talking about today really is hiding more of the true cost of health care reform or of delivering health care and, therefore, lessening the restraint on utilization.

So I just wanted to point that out. I do not think the question before us is one of encouraging more hospital construction. I think hospitals are done. Stick them with a fork. The question really is should we encourage through the Tax Code more construction of alternative health care delivery systems.

And I think, Mr. Chairman, that is the question we need to address straight up, and I just wanted to point that out and see if any of the witnesses had any information that might lead us to a sound decision.

And thank you, Mr. Claiborn, for your comments. I am sorry, too, you do not have all that data with you today, but I think you have given us some idea.

Chairman RANGEL. If there are no further responses or statements the witnesses want to make, let me thank you on behalf of the Chairman of the full committee and the other members for helping us resolve this very controversial but important issue that we may be taking up at some time during the conference. We appreciate the contribution you have made. The committee stands adjourned, subject to the call of the Chair.

[Whereupon, at 3:55 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF BRUCE YARWOOD
LEGISLATIVE COUNSEL
AMERICAN HEALTH CARE ASSOCIATION

Chairman Rangel, Chairman Pickle and members of the Subcommittees, I'm Bruce Yarwood, Legislative Counsel to the American Health Care Association (AHCA). On behalf of our more than 11,000 nursing facility members across America, thank you for providing me with the opportunity today to address this distinguished panel of two important subcommittees. I commend you for holding a hearing on an issue that we believe to be very important in ensuring that sufficient long term care services will be available in years to come for our growing elderly population.

For your information, AHCA is a federation of 51 affiliated associations representing 11,000 non-profit and for-profit nursing facility, residential care, and subacute care providers nationally. Over 1,500 of our members are non-profit facilities, many of which strongly support removing the $150 million cap on the amount of nonhospital tax-exempt bonds that can be outstanding on behalf of a tax-exempt organization providing long term care nursing services. We support this proposal and encourage you to include it in health reform measures currently under consideration or any subsequent tax legislation that may come up before the end of the 103rd Congress.

Each year, our Association publishes a Nursing Facility Sourcebook called Facts and Trends. In our most recent edition, on page 53 Figure 11, we show a graph of the growth in the elderly population over 85 years of age. Over the next 59 years, that population is projected to grow from 3.4 million in 1991 to 15.3 million in 2050. Approximately 25 percent of the elderly over 85 years of age live in nursing facilities at least some of the time. If trends continue, and they appear likely with the continued improvements in medical technology, the 25 percent factor indicates that nursing facility patients over the age of 85 will grow from around 850,000 currently to almost 4 million. Capacity for these patients must grow and tax-exempt financing is one of the most efficient ways to ensure that capital for additional capacity exists to meet future demographic trends.

Currently, numerous members of the American Health Care Association have tax-exempt bonds outstanding in amounts near or over the $150 million cap. This cap hinders the ability of long term care providers from building new facilities for older Americans that can provide innovative housing allowing seniors to remain independent. The cap hinders our members' ability to financing housing for the elderly or to undertake mergers or to buy additional facilities to meet the needs of new managed care systems enacted to control costs. Finally, it limits the ability of our providers from repairing and maintaining existing facilities.

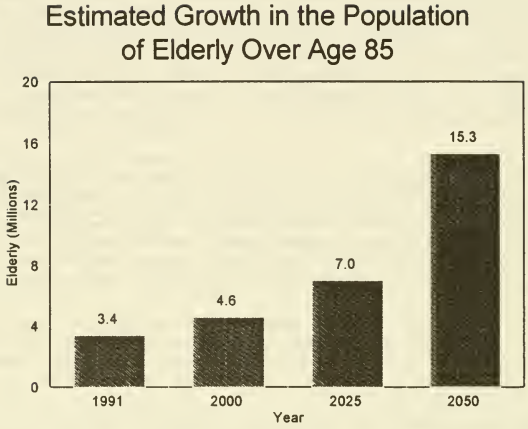
Removing the $150 million cap is also a matter of ensuring there is a level playing field and open competition within the health care continuum. Hospitals are currently exempt from the cap while nursing facilities, which are in fact today competing with hospitals for subacute care patients and traditional core nursing patients, are subjected to the cap. Allowing hospitals to utilize tax-exempt funds to build nursing beds without allowing similar treatment for nursing facilities places such facilities at a competitive disadvantage and limits competition within the health care continuum. At a time when nursing facilities are being recognized as much more cost efficient alternatives to acute care settings, it is not in the best interest of cost-containment to give less-efficient providers financial incentives not available to nursing facilities.

Access to capital to meet the future needs of an aging and "sicker" senior population is essential if we are going to meet the challenges ahead of us in long term care. In 1993, skilled nursing facilities lost return on equity payment for capital under Medicare. This severely impacted access to capital sufficient to meet future patient needs. With current reductions in Medicare reimbursement and potentially large future cuts, it will be very difficult for skilled nursing beds to be added to meet demand.

Your committees have the opportunity to take a major step forward in providing for the future institutional needs of America's senior citizens. Without your help, in future years, nursing bed shortages are likely and patient needs may be at risk.

Finally, it is vital that a level playing field be the basis for competition in any revised health care system, thus it is important that nursing facilities have equal access to tax-exempt capital. On behalf of the American Health Care Association, let me reiterate our support for the proposal to eliminate the $150 million cap on health-related tax-exempt bonds. We applaud your interest in this issue and urge you to move it forward in health reform or tax legislation to be considered yet this year.

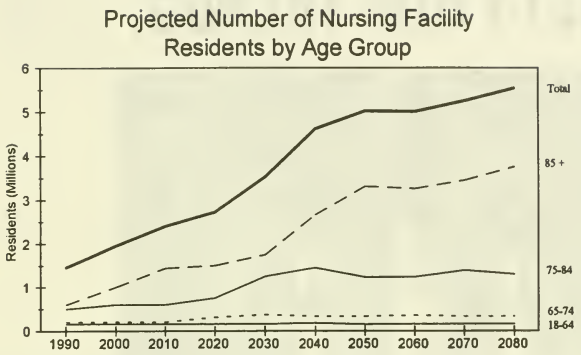
Figure 11



Source: Census Bureau

Census Bureau statisticians estimate that the elderly population will continue to rise through the first quarter of the 21st century, then take a dramatic jump more than two-fold between 2025 and 2050 as the "Baby-Boomer" generation enters old age. In Census Bureau's new report, *We the American Elderly,* September 1993, they estimate the likelihood of living in a nursing home to increase dramatically with age. Only a fraction of 65 to 74 year olds lived in nursing facilities in 1990 (1.4 percent) compared with 6 percent of those 75 to 84 years of age and 25 percent of those 85 years old and over. This means that the oldest old comprise over half (53 percent) of the total current nursing facility population of 1.6 million people.

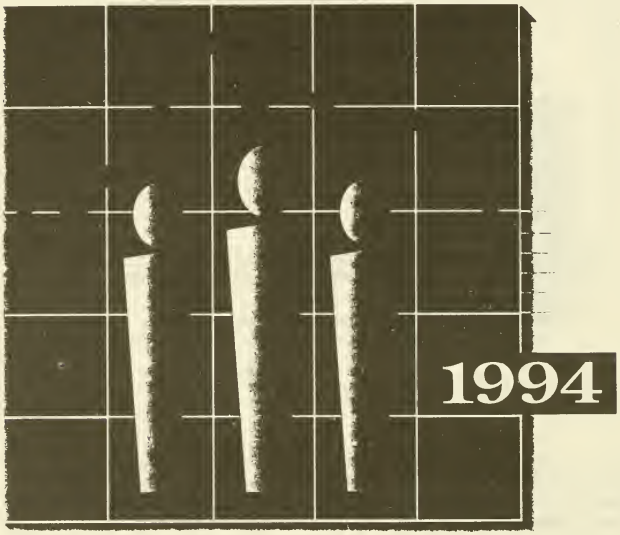
Figure 10



Source: Congressional Budget Office, Policy Choices for Long Term Care, June 1991

Commensurate with expected increases in the elderly population and decline in mortality, the Congressional Budget Office (CBO) estimates that the number of nursing facility residents will rise steadily until 2020 and then increase sharply for the next 20 years, doubling by the year 2040. By 2050, the CBO expects the nursing facility population to have trebled from its 1990 level.

FACTS and TRENDS:



The Nursing Facility Sourcebook

ahca
American Health Care Association

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Statement
of the
American Hospital Association
Submitted to the
Subcommittee on Select Revenue Measures
and
Subcommittee on Oversight
of the
House Committee on Ways and Means
on
A Proposal Relating to Certain Health Related 501(c)(3) Bonds

August 9, 1994

The American Hospital Association (AHA) welcomes the opportunity to provide this statement for the record on lifting the $150 million cap on the amount of nonhospital tax-exempt bonds that can be outstanding on behalf of a section 501(c)(3) organization for certain health related services.[1]

The AHA strongly recommends that this cap be repealed in order to encourage the development of seamless integrated delivery systems which are capable of managing the health care needs of a defined population.

The Congress has already gone on record supporting the repeal of the cap for all 501(c)(3) organizations, however, as a provision of H.R. 11 it was vetoed by President Bush. The Senate leadership's health reform bill would repeal the cap. We urge the House to re-affirm its earlier commitment.

Situation

This hearing comes at a unique and important time in the continuing transformation of the American health care delivery system. This transformation is being driven by the unrelenting move of private and public payers toward managed care. The reason is managed care's cost restraining incentives which depend on employees using provider networks made up of doctors and hospitals that have agreed to accept the respective managed care plan's payment rates and conditions. More than half of all insured U.S. employers are now in some kind of managed-care plan, and the trend is inexorably upward.

Managed care's challenge to doctors and hospitals is the ability to provide care to a defined population at a set price. Known as capitated contracting, this pre-requisite for survival is driving the development of integrated delivery systems involving hospitals, physicians and other providers capable of managing the health needs of a defined population. Capitated contracting is the glue that holds together these integrated delivery systems.

[1] Section 145 of the Tax Reform Act of 1986 restricts the outstanding amount of tax-exempt bonds that any 501(c)(3) organization may have at any time to $150 million. This $150 million restriction does not apply to hospital tax-exempt bonds, i.e., acute care, primarily inpatient facilities. Two or more organizations under common management or control are treated as one organization. Consequently, any merger of health care organizations combines their debt for purposes of applying such limits.

Formation of integrated delivery systems in many communities often begins at the community level with the merger of acute inpatient hospital services and an appropriate mixture of physicians, e.g., multi-specialty group practices and primary care physicians. In some areas, this core integrated system may merge or align with other area hospitals and physician groups in order to develop a regional capitated contracting capability.

It is at this point in the evolution of integrated delivery systems that 501(c)(3) tax exempt hospitals can run into problems relative to the $150 million cap on non-hospital tax exempt financing. For example, if two hospitals planned to merge and each had $80 million in non-hospital tax-exempt bonds outstanding, they would violate the cap. The merger would be delayed until they could find a legal way around the cap or pay back some of the debt.[2] Any bonds that exceed the $150 million limit could become taxable retroactively to their date of issue, an event that would constitute a default under the typical covenants governing non-hospital 501(c)(3) bonds. These hospitals would be required to run up significant legal fees looking for potential violations and ways to resolve them.

The same situation could exist for the merger of hospitals and non-hospital health facilities such as outpatient surgery clinics, long term care facilities, hospices, etc. These providers constitute pivotal sites of service for a fully integrated health delivery system. However, if their aggregate debt violates the cap, the merger could not occur if they were unable to find a way around the restriction.

Rationale for Repealing or Modifying the Cap

The ability to expand coverage and control costs through the use of managed care is a pivotal strategy for both the House and Senate leadership's health reform bills. Managed care's ability to achieve its full economic potential relies on the availability of fully integrated delivery systems on sound financial footings. The fact is that the $150 million cap will arbitrarily restrict the evolution of integrated delivery systems by limiting integration options.

The largest impact of the cap may be most felt in the urban and inner city areas where hospitals and other health facilities do not have the same level of access to alternative sources of capital, e.g., retained earnings, philanthropic contributions, etc. Nor would they likely be as able to access taxable sources of capital because of the increased financing costs: the interest rates on a 30-year taxable bond issue are about two percentage points higher than on a comparable tax-exempt bond. Because the patient base in low income areas would likely be unable to support the debt service costs of taxable bonds, inner city tax exempt health systems which are up against the cap, could find it increasingly difficult to raise the capital necessary to address the service needs of their communities.

Even if the aggregate non-hospital tax exempt debt of the merging parties is less than the $150 million cap, the aggregate amount could be near enough to the ceiling that future access to the tax-exempt capital market may be unavailable. Such access could be necessary to finance consolidation of existing debt, renovate or replace aging facilities as services are consolidated, acquisition or construction of clinics, senior health services, or prevention and screening services. Also such debt may be necessary for new computer systems to link all the facilities in the network. Such a restriction could prevent the full realization of an integrated delivery system and weaken its competitive position.

Another consequence of the $150 million cap is that an organization with high non-hospital health care related debt which could not be advance refunded could be seen as an unattractive merger candidate. Thus, the $150 million cap, which was meant to prevent well-endowed organizations such as universities from reaping profits by investing lower-rate tax-exempt funds in higher-yielding securities, could instead freeze out health facilities from integrated delivery systems. Such situations could lead to economic hardships and even, in some cases, closures,

[2] However, debt retirement may not be an option for one or both hospitals because current law sets a limit of one advanced refunding for hospital debt on bonds issued after 1986.

for such facilities. This effect may fall disproportionately on providers in urban and inner city areas, whose ultimate survival and availability to underserved populations may depend on their ability to become part of integrated delivery systems.

Other Issues Relative to Tax Exempt Financing

While not a subject of this hearing, we would like to point out two other tax exempt financing barriers to the development of integrated delivery systems. One is the restriction to only one advance refunding on tax exempt bonds issued after 1986. Advance refunding enables hospitals to refinance long-term debt at lower rates before the first call date on the bonds. The one-time limit has prevented some hospitals from further reducing outstanding debt and, for some, has restricted hospitals that want to merge.

The second issue is the limitation on the "private placement" of tax exempt bonds with banks for those 501(c)(3) health care providers issuing less that $5 million in tax-exempt bonds. This adversely impacts health care providers in rural and underserved urban areas in need of funding to upgrade their facilities. Such upgrades may improve their attractiveness as potential merger candidates. In any event, they would be better able to serve their respective communities.

In summary, elimination of the $150 million cap on 501(c)(3) tax-exempt non-hospital health care debt would remove a serious obstacle in the way of providers who are developing new and creative organizations in response to the demands for a more integrated, cost-effective and user-friendly health care delivery system.

Thank you for the opportunity to present this statement. We look forward to working with the committee and are prepared to help.

STATEMENT OF JAMES L. SCOTT
PRESIDENT
AMHS INSTITUTE

The AmHS Institute which represents the 40 voluntary, not-for-profit healthcare systems that comprise American Healthcare Systems (see attached list of shareholders) is pleased to submit a statement for the record on cap on tax-exempt bonds. We commend the Subcommittee on Select Revenue Measures and the Subcommittee on Oversight of the House Committee on Ways and Means for formally engaging the issue of lifting the $150 million cap on the amount of non-hospital tax-exempt bonds that can be outstanding on behalf of a section 501(c)(3) organization.

The AmHS Institute strongly supports the repeal of the existing cap in order to eliminate an economic barrier to the evolution of integrated delivery systems. Such systems are providing the delivery backbone for growth of managed care plans around the country.

Congress has already gone on record supporting the repeal of the cap for all 501(c)(3) organizations (H.R. 11 which was vetoed by President Bush). We believe that the reasons for supporting the cap are even more important now than they were earlier. The Senate leadership included the Finance Committee's approved repeal of the cap in its health reform bill. We strongly endorse the subcommittee's efforts to build the record in support of the repeal.

Section 145 of the Tax Reform Act of 1986 restricts the outstanding amount of tax-exempt bonds that any 501(c)(3) organization may have at any time to $150 million. This $150 million restriction does not apply to hospital tax-exempt bonds, i.e., acute care, primarily inpatient facilities. Two or more organizations under common management or control are treated as one organization.

The problem for two or more hospitals wishing to create an integrated delivery network or an existing integrated delivery system evaluating new opportunities is that the law requires that the existing tax-exempt debt for non-hospital health care projects be aggregated. However, the cap remains at $150 million per each 501(c)(3) organization. For example, if two hospitals planned to merge and each had $90 million in tax-exempt non-hospital health related bonds outstanding, they would violate the cap. The same problem exists for an integrated delivery system that has total tax-exempt non-hospital debt of less than $150 million but is considering a merger with another 501(c)(3) health facility with tax-exempt non-hospital debt which when added to system's debt would exceed the cap. In both cases, the merger would be delayed. At that time the choices available to the two potential merger partners would be to pay back some of the debt, which may not be an option for one or both parties because current law sets a limit of one advanced refunding for hospital debt on bonds issued after 1986, or break off merger discussions. In the latter of our two examples, merger candidates such as the one described, would likely be screened out earlier in the process.

Any bonds that exceed the $150 million limit could become taxable retroactively to their date of issue, an event that would constitute a default under the typical covenants governing non-hospital 501(c)(3) bonds.

Continued access by tax-exempt hospitals and health systems to the tax-exempt capital market is essential to maintain the current competitive parity between for-profit and non-profit hospitals and health systems. For-profit health care companies can raise capital through the public offering of stock or through taxable sources. If tax-exempt providers are denied access to the tax-exempt financing market, for-profit hospitals will be given a distinct competitive advantage due to the increased debt service costs of non-profit organizations.

The $150 million cap will restrict the evolution of integrated delivery systems by limiting integration options. Such limitations will compromise managed care's ability to achieve it's full potential for expanding coverage and controlling health care costs.

The $150 million cap could also adversely impact the availability of appropriate community services in inner city areas. In these areas, tax-exempt hospitals serve poorer patients who would likely be unable to support the higher costs of taxable bond debt as the interest rates on a 30-year taxable bond issue are approximately two percentage points higher than on a comparable tax-exempt bond. If the hospital or health system could not access the tax-exempt financing market there could probably be few if any viable options available. And, such a situation would likely make the tax-exempt organization an unlikely candidate for subsequent consolidations.

The House leadership's health reform bill includes a number of provisions which would impose new qualification requirements on 501(c)(3) and 501(c)(4) tax-exempt health care organizations. Compliance with these new qualification requirements should remove any remaining doubt as regards the commitment of tax-exempt hospitals to serve their respective communities - elimination of the tax cap would allow them to be better able to fulfill these responsibilities.

In summary, elimination of the $150 million cap on 501(c)(3) tax-exempt non-hospital health care debt would remove a serious obstacle to the continued transformation of the American health care delivery system. Tax-exempt integrated delivery systems are taking the nation's health delivery system out of its fee-for-service focus to that of managed care. Repeal of the cap will demonstrate Congressional acknowledgement of the imperative of this reform.

ATTACHMENT

AMERICAN HEALTHCARE SYSTEMS

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Summit Medical Center
Irwin Hansen, President & CEO

UniHealth America
Terry Hartshorn, Pres. & CEO

Yankee Alliance
Paul O'Neill, President & CEO

Harvard Community Health Plan

25th Anniversary

Statement by Harold Putnam, Chief Financial Officer, Harvard Community Health Plan, Inc., to a joint hearing of the Subcommittee on Select Revenue Measures and the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C., August 9, 1994.

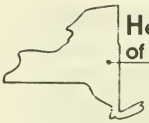
Chairman Rangel, Chairman Pickle and members of your committees:

Harvard Community Health Plan strongly supports the removal of the $150 million cap on the amount of non-hospital tax-exempt bonds that can be outstanding on behalf of a section 501(c)(3) organization for certain health related facilities. The cap on tax-exempt financing is arbitrary and inequitable, and is putting a drag on the development of cost-effective health care services. It especially makes no sense at a time when our nation is trying to control health care costs and extend coverage to underserved populations, and it should be repealed.

Since its founding 25 years ago as New England's first prepaid group practice, Harvard Community Health Plan has had a clear mission: "We provide excellent health care at a reasonable cost to people in all segments of the community." Pursuing that mission has allowed HCHP to grow from 88 members to more than 565,000, including Medicaid, Medicare, non-group and employer-group members. We provide our members with a broad network of physicians and other medical professionals, many of whom practice in the sixteen multispecialty health centers that HCHP operates. Most of our urban members in the Greater Boston area receive their care at health centers that were constructed using tax-exempt financing.

Since 1988, however, when HCHP reached the $150 million cap, we have had to rely on alternative, more expensive arrangements such as leasing or taxable financing. A major ambulatory care specialties center, which we intend to build in Boston, and which will be especially important in providing high-quality, cost-effective services to our urban and Medicare members, has been delayed, in part, by our need to find financing in taxable debt markets. Although HCHP is one of the most well-respected HMOs in the country, and one of the most financially sound, we are virtual unknowns in the taxable debt markets. This creates barriers that make the financing of our health care facilities considerably more expensive and time-consuming than in the tax-exempt markets that know us well.

I hope your committee will vote to encourage more cost-effective health care delivery and restore the equity that was taken away by the $150 million tax-exempt cap. Thank you for your consideration of this important matter.



STATEMENT
OF THE
HEALTHCARE ASSOCIATION OF NEW YORK STATE
SUBMITTED TO THE
SUBCOMMITTEE ON SELECT REVENUE MEASURES
AND
SUBCOMMITTEE ON OVERSIGHT
OF THE
HOUSE COMMITTEE ON WAYS AND MEANS
ON
A PROPOSAL RELATING TO CERTAIN HEALTH RELATED
(501(C)(3) BONDS
AUGUST 10, 1994

Chairman Rangel and Chairman Pickle, the Healthcare Association of New York State appreciates the opportunity to provide a statement to your Subcommittees on the lifting of the $150 million cap on the amount of non-hospital tax-exempt bonds that can be outstanding on behalf of a section 501(c)(3) organization for certain health related services.

The Healthcare Association of New York State highly recommends that this cap be repealed in order that access to capital by non-profit health care facilities be available in order that these facilities may play a leadership role in developing integrated networks of care in their communities.

Current Situation

The movement to health care reform makes access to capital by health care facilities essential if they are to play a leadership role in developing integrated networks of care and assume financial risk for an enrolled population. In New York State, as across the country, the health care market is undergoing a natural progression toward a more competitive system. Health care providers are attempting to vertically integrate with each other to offer comprehensive services at bundled prices. Some facilities are preparing to take on risk by becoming insurers or providing comprehensive services for a capitated payment rate, but health care provider efforts in these areas are encumbered by a lack of access to capital.

Facilities now need capital to develop primary care initiatives within their communities; to build information systems; finance administrative start-up costs to develop insurance products;

participate in risk-taking initiatives; develop physician relationships; and update and maintain existing infrastructures.

Current law restrictions on tax-exempt financing could make it difficult for non-profit health care providers to implement these initiatives in order to meet the goals of health care reform. The $150 million cap on the amount of non-hospital tax-exempt bonds that can be outstanding on behalf of section 501(c)(3) organizations for certain health related services makes these entities unattractive partners when as a result of a merger there would be a violation of the cap. Such mergers at best would be delayed until a legal way can be found to avoid the implications of the cap or a merger would not be consummated as a result of the cap. Also, any bonds that exceed the cap could be taxable retroactively to the date of issue, an event that in effect would constitute a default under typical bond covenants. This current situation requires the use of significant legal assistance which is expensive and increases the cost of providing health care which is an antithesis of what health care reform is attempting to do.

The goal of health care reform is to develop a seamless integrated health care delivery system that would provide primary, acute and long term care to a defined population. The existing cap would preclude or at best make difficult the formation of this seamless integrated delivery system in that the financings required to merge with non-hospital health facilities such as clinics, nursing homes, hospices, freestanding ambulatory care centers, etc. would fall under the $150 million cap which in effect may discourage such formations or at best make them more difficult.

Why Repeal or Modify the Cap

The emphasis on health care reform is to expand coverage and control costs and eventually reach a situation where everyone will be covered for health care. One basis for this expansion of coverage and control of cost has been the use of the concept of managed care. Managed care can only be successful economically if fully integrated delivery systems are able to be formed and the financings for formation be available. The $150 million cap that currently exists would only have the effect of limiting the formation of these integrated delivery systems. Ironically, the areas that may be most adversely impacted by this cap are the urban and inner-city areas where health care facilities do not have the same access to capital as other facilities. The $150 million cap should be eliminated in order for the development of managed care and the formation of integrated delivery networks in order to meet the goals of health care reform.

Other Issues

Although not specifically identified in the release related to your hearing, an issue that the Healthcare Association of New York State believes should be addressed is the advance refundings of financings by section 501(c)(3) organizations. Advance refunding limits must be changed. Due to recent decline in interest rates many health care providers have advance refunded existing bonds to lower their current cost. Under current law they are precluded from undertaking another advance refunding. Under health care reform, additional refundings will be needed to restructure debt and to modify existing bondholder covenants. Therefore, health

care facilities should be allowed at least two, if not more, advance refundings of bonds issued since 1986. The lack of ability to advance refund would again make facilities unattractive as merger partners in the developing of integrated delivery systems.

Another issue is the limitation on the private placement of tax-exempt bonds with banks for those filed under section 501(c)(3) health care providers issuing less than $5 million in tax-exempt bonds. This provision adversely impacts rural health care providers in need of funding to either upgrade facilities or provide new services. Consideration should be given to increasing the level of funding via private placement.

Conclusion

In conclusion, we recommend that the $150 million cap on section 501(c)(3) tax exempt non-hospital health care debt be eliminated to allow for the creation of organizations to respond to the current incentives of developing seamless integrated delivery systems to meet the goals of health care reform. Also, the response to the issues of advance refundings and private placement should also be considered for similar reasons.

The Healthcare Association of New York State thanks you for this opportunity to make this statement. We are available to answer any questions on our statement and look forward to working with the Committee if needed.

TESTIMONY OF
THE HEALTHCARE FINANCING STUDY GROUP
FOR HEARINGS BEFORE THE SUBCOMMITTEES
ON SELECT REVENUE MEASURES AND OVERSIGHT,
HOUSE WAYS AND MEANS COMMITTEE
REGARDING A PROPOSAL RELATED
TO CERTAIN HEALTH-RELATED §501(c)(3) BONDS
AUGUST 12, 1994

Introduction

The Healthcare Financing Study Group ("HFSG") is pleased to submit this testimony to the Select Revenue Measures and Oversight Subcommittees regarding Congressman Rangel's proposal concerning §501(c)(3) bonds. The HFSG is a national trade association of investment bankers, bond counsel, bond insurers and other firms that serve the needs of non-profit health care institutions for capital to finance the efficient delivery of health care services throughout the United States.

Tax-Exempt Health Providers

Non-profit institutions play a large and vital role in providing health care and related services throughout the United States, often operating under the sponsorship of religious organizations, fraternal societies, charitable foundations, and community groups. Unlike for-profit entities, non-profit health care providers must elevate their patients' interests over profit-making objectives. The motive to maximize profits may cause for-profit providers to avoid locating in a particular geographic area or avoid providing certain benefits, because to do so would be unprofitable. By contrast, non-profits generally are obligated to serve all persons in the community regardless of ability to pay. Non-profits typically bear the responsibility of providing services in very rural or inner city areas where the costs of providing care are especially high.

Non-profits conduct the majority of medical research and education in the United States -- compared with the minimal research and education offered by for-profits. It is non-profits that typically offer specialized care units such as burn and trauma centers, which are costly to operate and rarely provide commensurate return on the investment. Similarly, the children's hospitals in the United States are non-profit, and these facilities, again, provide relatively high-cost, low-return services for the nation and their communities such as pediatric intensive care units, infant intensive care units, neonatal units, and tertiary care such as treatment for congenital defects, pediatric nephrology, and pediatric hematology/oncology.

Increasingly, non-profit hospitals and nursing homes are expanding their services to the community through a growing variety of outreach services and outpatient clinics. One example is the Children's Hospital and Medical Center of Seattle. Among the numerous community outreach programs operated by this non-profit hospital are: a Children's Resource Center, which provides child and teen health information through community education programs and a newsletter; a Parent Resource Center, which offers information and education about children's health; and the Odessa Brown Children's Clinic, which provides medical, dental and counseling services to children in inner-city Seattle with programs that include a sickle-cell disease clinic, foster care medical case management, a dental clinic, health education, and nutrition counseling. Another example is the Evangelical Lutheran Good Samaritan Society, which provides nursing home services in 26 states and now operates 120 separate outreach programs, ranging from Meals on Wheels to senior companionship, that help elderly persons live independently in their own homes and communities.

In recent years HFSG members and their health provider clients have had to confront forces beyond their control (or the control of Congress) that have led to significant consolidation and downsizing of the non-profit sector, particularly in acute care. Changes in health care delivery under any reform plan will only contribute to this trend. Reform is intended to, and therefore likely will, shift resources away from tax-exempt acute care and extended care facilities into the primary

and preventive care arena. Additionally, the cost containment that is an imperative of successful health reform will increase imperatives for efficiency in operations and facilities. Existing institutions will need to be merged or otherwise converted into facilities that are more responsive to the changing health care marketplace, old facilities may have to be sold or torn down, and new facilities may have to be constructed.

Another growi· ·rend confronting non-profit health care providers in the United States is the increasing deman· r long term care services as the population continues to age. By next year, an estimated 21 million households will be headed by Americans over 65. As the number of frail elderly (those over 75) continues to grow, the need for long term care, whether in residential facilities or in the community, and related outreach services will continue to rise. And cost-driven changes in medical practice during the last ten years have led to earlier and earlier hospital discharges, with the result that care which once would have been furnished in a hospital is now provided by a nursing facility. In fact, many long term care facilities already have long waiting lists.

The $150 Million Bond Cap

Responding to these numerous changes in health care service delivery requires new sources of financing -- which, for non-profits, is primarily tax-exempt bonds. The Tax Reform Act of 1986 imposed a limit of $150 million on the aggregate amount of outstanding qualified Section 501(c)(3) bonds, **other than hospital bonds**, from which any 501(c)(3) organization may benefit. In determining whether the $150 million limitation has been exceeded, advance refundings are taken into account. Historically, hospitals were viewed as the appropriate beneficiaries of tax-exempt financing, and this view justified an exception to the $150 million limitation for qualified Section 501(c)(3) hospital bonds. Because health reform, under almost any plan, will propel a shift from acute care to primary and preventive care, and because the population is aging, there will be increased demand across the country for non-hospital long-term care and managed care entities. At the same time, the existence of excess capacity in the acute care sector may require restructurings of acute care facilities, or renovations of such facilities to become providers of primary, preventive, or other non-acute care services. Such renovations will necessarily increase overall efficiency and reduce costs in the health care system. Yet because the resulting entities will not be "hospitals" under the current, narrow statutory exception, such beneficial restructurings will subject non-profit providers to the $150 million cap.

Health reform legislation encourages the development of non-traditional, non-hospital health delivery systems, but the $150 million cap creates a powerful disincentive for the creation of these new systems. While traditional non-profit hospitals may need to shift resources into areas such as neighborhood diagnostic and treatment facilities, long-term residential care facilities, medical equipment acquisition entities and the like, the $150 million cap restricts their ability to modify their services in the interests of efficiency and cost-effective care. The cap also restricts the ability of non-profit long term care providers to meet the demand for their services. Finally, the cap prevents many non-profit health providers that are now paying relatively high interest rates from lowering their costs of capital through advance refundings of their bonds, because the original bonds are still considered to be outstanding for purposes of the cap. Because of the cap, the dramatic drop in interest rates that occurred in the early 1990s has passed many of these institutions by.

The federal government shares in such unnecessarily high financing costs in more ways than one. Whenever a non-profit institution is the recipient of research funding from the National Institutes of Health, the increased financing cost requires a larger grant than would otherwise be the case. The Medicaid program, which uses a cost-reimbursement system, absorbs increased financing costs incurred by long term care facilities, which must raise their per diem rates to cover the additional financing costs. The same increases in per diem rates, of course, also fall on private pay residents in long term care facilities -- and accelerate the point at which such private pay residents become dependent on Medicaid.

Specific examples of the problems caused by the cap abound. One New York institution represented by an HFSG member had to turn to the higher-cost taxable bond market for a necessary project because the institution had already reached the $150 million limitation. Another non-profit organization, a multi-state provider of nursing homes that has been at the cap since 1986, has been forced to do the same. Many other facilities have chosen to forego expansion or reconstruction of outdated facilities in lieu of pursuing taxable bond financing. Other health care educational and research systems are facing similar prospects. A major Washington state clinic that wishes to refund existing bonds and to merge with another local facility -- steps intended to increase operating efficiency and reduce costs -- can do neither as a result of the cap. A large cancer research center in the same state is prevented from refunding to obtain lower interest rates because, for cap purposes, it is considered a "non-hospital" institution.

A possible solution to some of these problems might be to pay down non-hospital debt with cash in order to stay below the cap. However, there are numerous obstacles to such a solution, even where the cash is available. Because current law imposes a limit of one advance refunding for debt on bonds issued after 1986, debt retirement may not be an option. Additionally, a competing demand for cash comes from the need for working capital for the delivery of health care. Additionally, cash availability is important to bond ratings and institutional liquidity. And finally, paying down non-hospital debt with cash may violate bond covenants. For all of these reasons, there is no ready solution for institutions that need to finance structural changes but find themselves today at or near the $150 million bond cap.

The new emphasis on non-hospital care and the fact that non-profit health care institutions must increasingly provide whole continuums of care makes a bond cap exception limited to "hospitals" obsolete. A logical solution to these problems would be to expand the exception to the $150 million limit to cover not only hospitals, but also non-hospital health care facilities, including nursing homes, ambulatory care centers, primary care clinics, and others. Alternatively, the $150 million cap should be lifted in its entirety.

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