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FHA HOSPITAL MORTGAGE INSURANCE PROGRAM

Health Care Trends and Portfolio Concentration Could Affect Program Stability

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Health, Education, and
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The Honorable Alfonse M. D'Amato
Chairman
The Honorable Paul S. Sarbanes
Ranking Minority Member
Committee on Banking,
Housing, and Urban Affairs
United States Senate

The Honorable Jim Leach
Chairman
The Honorable Henry B. Gonzalez
Ranking Minority Member
Committee on Banking and
Financial Services
House of Representatives

The Department of Housing and Urban Development (HUD), through the Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program, insures loans to finance the renovation or construction of hospitals that meet certain criteria. FHA mortgage insurance protects lenders against losses they might incur if hospitals fail to make their mortgage payments. As of August 1995, FHA insured about $5 billion in outstanding mortgages.

The Multifamily Housing Property Disposition Reform Act of 1994 (P.L. 103-233, Apr. 11, 1994), required that we report on three FHA insurance programs—hospital, nursing home, and retirement service center—in FHA's multifamily loan insurance portfolio. This report provides the results of our evaluation of the Hospital Mortgage Insurance Program.[1] As agreed with your staff, we (1) identified factors, including those related to health care market trends, that could affect the stability of the program's portfolio and obtained information on the program's financial performance; (2) evaluated the methodology that FHA used to estimate the program's fiscal year 1994 loan loss reserve; (3) evaluated the relationship between the purpose of the Hospital Mortgage Insurance Program and HUD's mission; and (4) determined whether FHA has the expertise to manage the program.

[1]The results of our other studies on the nursing home and retirement service center insurance programs are provided in a separate report: HUD Management: Greater Oversight Needed of FHA's Nursing Home Insurance Program (GAO/RCED-95-214, Aug. 25, 1995).

To develop our information, we (1) interviewed officials from FHA, the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS), hospitals, health care and hospital associations, and mortgage and investment banking firms; (2) analyzed health care data; (3) reviewed program financial data; (4) reviewed FHA's documentation regarding its 1994 loan loss reserve methodology; and (5) reviewed applicable program laws, regulations, and policy statements. Our review did not include an evaluation of underwriting criteria, the premium structure of the program, or whether the program is needed. (See app. IV for a detailed description of our objectives, scope, and methodology.) Our work was performed between August 1994 and December 1995, in accordance with generally accepted government auditing standards.

Results in Brief

Since its inception, the program has made a net positive cash contribution to HUD's General Insurance Fund,[2] according to FHA. However, the program is currently faced with potential financial risks that could affect the future stability of the portfolio. For example, more than $4 billion or about 87 percent of the FHA-insured hospital mortgages' unpaid principal balance is concentrated in New York state with many New York hospitals having the largest individual unpaid principal balances. In addition, state actions, such as the recent decision in New York to reduce hospital Medicaid spending by about $140 million in one year, could further strain the financial condition of many of the already financially weak program hospitals. Future health care policy changes and trends, like managed care, that challenge hospitals to control costs and restructure the way they deliver health care can also threaten program hospitals' ability to remain solvent.

Although FHA had a loan loss reserve estimate of $458.25 million as of September 30, 1994, this estimate is not a reliable measure of program losses because of methodology limitations. In estimating the reserve, FHA used questionable assumptions regarding default probabilities and loss rates. For example, FHA had no justifiable basis for the loss rates it applied to hospitals with a lower than 50-percent probability of default. In

[2]The Hospital Mortgage Insurance Program is part of HUD's General Insurance Fund, which obtains revenues from insurance premiums and the proceeds of sales of mortgages and foreclosed properties. It incurs expenses for administration, payments of insurance claims, and costs of maintaining and selling foreclosed properties. In addition to the hospital insurance program, this fund's insurance portfolio supports a variety of multifamily and single-family insured loans. These include rental apartments, cooperatives, condominiums, housing for the elderly, nursing homes, manufactured housing, home improvement loans, and disaster loans.

addition, FHA's methodology did not incorporate health care market trends, a risk factor that can affect the future viability of program hospitals.

Our evaluation of the relationship between the purpose of the Hospital Mortgage Insurance Program and HUD's mission found that HUD's mission is broad enough to encompass the purpose of the program. However, the extent to which the program contributes to HUD's mission is unclear because HUD does not measure program outcomes. Further, FHA's staff has limited expertise in health care to independently manage key program functions. FHA relies on HHS' staff expertise in health care and hospital finance and management to assess projects' feasibility and monitor hospitals' financial performance. We also learned that some program users have raised concern with the length of the mortgage insurance application process. Applications can take more than 1-1/2 years to be approved.

Background

In 1968, the Congress added Section 242 to the National Housing Act establishing the Hospital Mortgage Insurance Program. In considering this amendment to the National Housing Act, the House Committee on Banking and Currency[3] cited a serious shortage of hospitals and the need for existing hospitals to expand and renovate. Private lenders seemed reluctant to provide capital financing at reasonable terms. The purpose of the program is to "assist the provision of urgently needed hospitals for the care and treatment of persons who are acutely ill . . .." Consequently, Section 242 authorized HUD to provide insurance for hospital mortgages secured from lenders to finance the construction and renovation of hospitals.[4]

Many hospitals need to borrow money from lenders to finance construction and renovation projects. Lenders often raise capital by selling bonds to investors and use the hospitals' mortgage payments to pay bondholders. Mortgage insurance, like private bond insurance, guarantees that bondholders will be paid if the hospital stops making payments on its loan. According to the Health Care Financing Study Group,[5] about 60 percent of hospitals that seek financing require insurance to enhance

[3]Currently the Committee on Banking and Financial Services.

[4]The Hospital Mortgage Insurance Program supplemented the Hill-Burton Program. Under Hill-Burton, HHS, formerly the Department of Health, Education, and Welfare, made loan guarantees and direct loans to hospitals for construction and modernization projects.

[5]The Health Care Financing Study Group is comprised of investment and mortgage banking firms actively involved in financing health care facilities throughout the United States, both conventionally and on a government-supported basis.

their credit because they cannot get a loan on their own financial strength. Eighty-three percent of these hospitals can get private bond insurance but about 17 percent cannot because private insurers consider them too risky. Some hospitals that cannot get private mortgage insurance apply to FHA's hospital insurance program.

FHA's Hospital Mortgage Insurance Program staff and HHS' Division of Facilities Loans staff jointly manage the hospital program. The Congress gave HUD statutory responsibility for the program. The House Committee on Banking and Currency, in recommending that HUD be given this responsibility, cited FHA's more than 35 years of experience with promoting housing construction through its housing insurance programs. The Committee was concerned, however, that HUD's staff did not have specialized knowledge of health care needed to administer this program. As a result, the Committee recommended and the Congress enacted the requirement that a state agency must certify that a hospital is needed before it can participate in the program. Also, the Committee expected HUD to draw upon HHS' hospital expertise to devise standards for insuring hospitals' mortgages. Through a memorandum of agreement, HUD formally delegated authority to HHS to review and approve proposals for hospitals' mortgage insurance. HUD retained authority to make the final insurance commitment and endorse the mortgage note.

The Hospital Mortgage Insurance Program requires hospitals to have the state certify the need for the proposed projects and then meet underwriting criteria before insurance applications can be approved. Since 1988, hospitals have obtained FHA insurance approval to construct acute care facilities, ambulatory care centers, and operating rooms and to renovate maternity and emergency departments and surgical suites. In addition, hospitals have obtained approval to purchase equipment, install new computer and fire alarm systems, and build parking facilities.

The use of hospital inpatient services, however, has declined over time. Current trends indicate a greater focus on cost containment and delivering health care on an outpatient basis.

Potential Financial Risks on the Stability of the Hospital Program

Overall, the financial performance of the hospital program has reflected a net positive cash flow from operations over the past 25 years, according to HUD data. However, in several years, the program has experienced financial losses. The bulk of the losses occurred between 1989 and 1991, when HUD had to pay lenders about $147 million because of hospital defaults.[6] The current composition of the program's portfolio with the concentration of insured loans in New York, changes in state policies, trends in the health care market, and the probability of future changes in federal health care policies pose risks that may threaten the future stability of the program. Two reasons given in a 1992 HUD study[7] for why some hospitals defaulted on their loans were changes in the policies and practices of state and local governments and changes in Medicare and Medicaid reimbursement.

The Hospital Program Portfolio and Its Financial Performance

The hospital program has made a positive net contribution of $221 million to HUD's General Insurance Fund, even though there have been years with negative cash flows (see fig. 1). Information obtained from FHA shows that from fiscal year 1969 through 1994, FHA collected $370 million in premiums and fees and paid $200 million in insurance claims and $13 million in salaries and other administrative expenses. FHA recovered about $64 million of claim payments from mortgage payments and the sale of the mortgages or properties. As of September 30, 1994, 19 hospitals had defaulted;[8] FHA disposed of 10 and retained loan management responsibility for the remaining 9 hospitals. For these 9 hospitals, the total unpaid principal balance is $108 million and accrued delinquent interest is $44 million. (See app. I for a description of the hospital program's financial performance from fiscal year 1969 through 1994.)

[6]A default occurs when a hospital has at least one payment outstanding, the loan is assigned to HUD, and HUD pays a claim.

[7]Organizational Review of the Hospital Mortgage Insurance Program, Office of Management and Planning (OMAP), HUD (Washington, D.C.: 1992), pp. 23-24.

[8]One of the 19 hospitals also defaulted on an insured loan obtained to cover a 2-year operating loss.

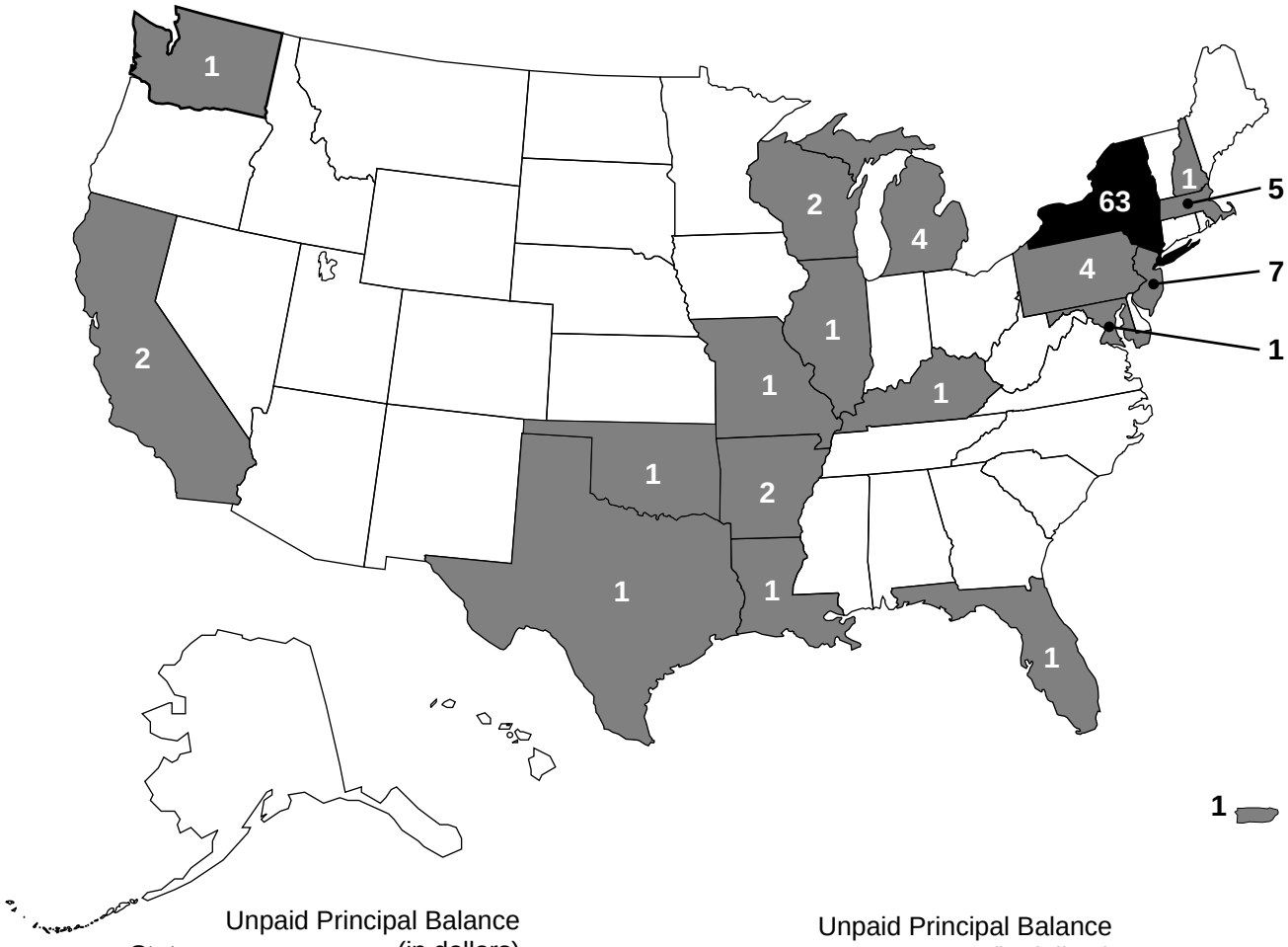
Figure 1: FHA's Hospital Mortgage Insurance Program Cash Flow From Operations, Fiscal Years 1969-94

(Figure notes on next page)

Source: FHA Hospital Mortgage Insurance Program staff.

As of August 1995, the hospital program portfolio was comprised of 100 projects in 18 states and Puerto Rico (see fig. 2). The portfolio has an aggregate unpaid principal balance of about $5 billion. (See app. II for individual unpaid principal balances of FHA-insured hospital projects, by state.)

Figure 2: Distribution of Hospital Projects and Unpaid Principal Balances, by State, in the FHA Hospital Mortgage Insurance Portfolio, August 1995



State	Unpaid Principal Balance (in dollars)
Arkansas	2,600,490
California	1,809,901
Florida	11,362,651
Illinois	6,063,326
Kentucky	9,285,024
Louisiana	2,493,799
Maryland	9,099,451
Massachusetts	221,070,490
Michigan	23,112,498
Missouri	4,305,135

State	Unpaid Principal Balance (in dollars)
New Hampshire	2,537,862
New Jersey	233,335,878
New York	4,184,837,396
Oklahoma	387,472
Pennsylvania	63,359,725
Puerto Rico	15,782,102
Texas	12,286,708
Washington	220,096
Wisconsin	15,555,484

(Figure notes on next page)

Note: Numbers within states reflect the number of hospital projects insured.

Source: FHA Hospital Mortgage Insurance Program staff.

The majority of the hospital program projects, 63 percent, are in New York. The unpaid principal balance on mortgages for these projects is about $4.2 billion or 87 percent of the portfolio's aggregate unpaid principal balance. Also, 9 of the 10 largest hospital mortgages are in New York. These mortgages account for about $2.4 billion or 50 percent of the portfolio's total unpaid principal balance. Included in these mortgages is a $591 million loan, the largest single loan amount FHA has insured in the history of the program. Since 1988, 17 of the 20 projects that FHA insured have been for New York hospitals. In addition, as of August 1995, 6 of the 10 mortgage insurance applications under review by HHS and FHA were for projects in New York.

New York's Reimbursement System Is a Factor in Hospitals' Reliance on FHA Program

The hospital program has become a major financing vehicle for many New York hospitals. Several officials stated that New York hospitals rely on FHA mortgage insurance, in part, because the state's reimbursement system hinders hospitals' ability to access capital in the private market. "New York's restrictive reimbursement system makes it the most regulated nationwide," according to a Moody's Investors Service report.[9] Except for Medicare, New York utilizes an all-payer fixed rate system to reimburse hospitals. The state controls all third-party payers' rates of payments by setting a fixed payment for each hospital based on patient diagnoses. The rate-setting system is a regulatory method of budgeting for hospitals. The goals of the rate-setting system are cost containment and access to hospital care. However, New York state officials said that this system constrains hospitals' profitability, which weakens their creditworthiness. According to a Moody's Investors Service report, New York hospitals' credit ratings are the weakest in the nation.[10]

In other states, hospitals' credit ratings are generally stronger, which enables many of them to access capital in the private market. These hospitals primarily rely on bond financing backed by their revenues and projected ability to make loan payments or by commercial bond insurance

[9]Health Care Finance: Hospital Revenue Bonds, State of New York, Moody's Investors Service HC71-14 (New York: 1994), p. 3.

[10]Health Care Finance: Hospital Revenue Bonds, State of New York, Moody's Investors Service, p. 1.

instead of FHA's Hospital Mortgage Insurance Program. In contrast, private insurers are reluctant to back bond sales to finance some New York hospital projects because the hospitals are considered too risky.

Concentration of Insured Projects in New York Poses Program Risks

The lack of portfolio geographic diversification and the large individual unpaid loan balances in New York pose a risk to the program. The concentration of the portfolio in New York makes the program susceptible to New York policies and other factors specific to the state. The strength of a portfolio lies in its diversity because portfolio diversification decreases the risk from losses. In addition, a single default of a large loan could lead to insurance claims that could significantly burden the program. A 1992 HUD report stated that the concentration of FHA-insured projects in a single state and large loan amounts are major controllable risks to the program that should be avoided or minimized.[11]

FHA does not limit the number of projects in a particular state nor does it cap individual loan amounts it insures as a means of controlling risks to the program. The legislation authorizes the Secretary of HUD to set the terms and conditions under which HUD will insure projects, but the law does not specifically authorize FHA to limit the number of projects accepted into the program from a geographic area or to limit the loan amounts it insures. In fact, in 1974, the Congress removed existing caps on loan amounts.

FHA officials stated that they are taking action to diversify the portfolio by marketing the program to attract hospitals from other states. For example, FHA officials reported working with mortgage bankers to increase program awareness to hospitals outside New York. They reported that, as of August 1995, they had received four applications from hospitals in Illinois, New Jersey, Pennsylvania, and Puerto Rico. By expanding the portfolio, FHA also increases the program's total outstanding mortgage amount. Officials involved in the financing of hospital projects told us that hospitals in other states may not be interested in the FHA program for several reasons, including the program's high premiums, lengthy application process, and a lack of program awareness.

For some future hospital projects, FHA is considering ways to reduce the risk of financial losses. For example, FHA is considering a proposal to establish risk-sharing arrangements with the public and private sector. According to FHA officials, the risk-sharing partner would assume

[11]Organizational Review of the Hospital Mortgage Insurance Program, OMAP, p. 27.

underwriting responsibilities, have an equity position in the hospital, and share in any losses that result from defaults. In an October 1993 report, we noted that HUD terminated FHA's multifamily housing coinsurance program in January 1990. The program enabled FHA to share the risk of insuring a multifamily mortgage with participating lenders. However, problems with the program resulted from deficient conceptual design and failures in administration.[12]

New York's Health Care Policy and Future Federal Policy Changes Increase Risks to the Program

Changes in state health care policies that reduce hospitals' revenues can negatively affect the financial stability of hospitals, particularly the financially weaker hospitals in FHA's hospital program. Recent changes in New York's Medicaid policy would reduce hospitals' patient revenues and could increase program hospitals' risk of default. The New York state fiscal year 1996 budget contains health care cost-cutting measures that are estimated to reduce state Medicaid hospital spending by $138 million, resulting in an estimated total hospital revenue loss of $553 million.[13] State analyses of the reduction in Medicaid spending for individual hospitals estimate that FHA-insured hospitals will lose $170 million in Medicaid revenue. Also, individual program hospitals may lose between 0.31 percent and 4.25 percent of total revenues.

Some New York hospitals' already marginal operating margins[14] may deteriorate further as a result of the loss in Medicaid revenue. Our analysis of 1994 Health Care Financing Administration data for 52 program hospitals in New York indicates that 49 had negative operating margins. The average operating margin for the 52 hospitals was –5.6 percent. Our analysis shows that, on average, operating margins for the 52 hospitals would deteriorate by 26 percent in 1 year because of the state's reduction in Medicaid spending. Thus, the ability of some of these hospitals to absorb the cuts and possible future state Medicaid spending reductions without defaulting on their FHA-insured loans is questionable.

In the past, state policy changes have precipitated hospital defaults. For example, three hospital defaults in Illinois resulted in a $27 million loss to the program. According to a 1992 HUD report, two of these defaults were

[12]Housing Finance: Expanding Capital for Affordable Multifamily Housing (GAO/RCED-94-3, Oct. 27, 1993).

[13]The total provider loss includes federal, state, and county Medicaid contributions.

[14]The operating margin is a commonly used measure of hospitals' profitability. It is used to measure profitability on all patient care operations and is net patient revenue minus operating expenses, divided by net patient revenue. Because for many hospitals net patient revenue does not include all operating revenue, this measure tends to understate operating profitability.

caused, in part, by the state setting a Medicaid reimbursement rate that was too low to cover the hospital's cost of treating Medicaid patients or the state delaying Medicaid reimbursement to hospitals.[15]

The extent to which New York hospitals are able to reduce expenses will affect their ability to withstand revenue losses. According to FHA, HHS, and New York health care officials, hospitals are expected to reduce expenses and implement revenue enhancers to mitigate Medicaid revenue losses and remain viable. Hospitals with large Medicaid caseloads are particularly vulnerable to reductions in Medicaid spending. Our analysis of 1994 data from 52 New York program hospitals shows that for about one-third of the hospitals, their Medicaid inpatient days were greater than 25 percent.[16] Plans developed by New York program hospitals to respond to the state's Medicaid cuts include cost-containment measures, such as reducing staff, salaries, and benefits and revenue enhancement measures, such as decreasing the length of stay and increasing admissions. Hospital and hospital organization officials reported that some hospitals had already begun taking cost-cutting measures before the budget decision was made. In reaction to the cuts, FHA required New York hospitals awaiting application approval to submit sensitivity analyses on the impact of the cuts. In addition, HHS required New York program hospitals to submit an action plan for responding to the cuts. After evaluating the hospitals' responses, FHA and HHS increased their monitoring efforts for those hospitals identified as most vulnerable to the cuts.

In addition to changes in state policies, future changes in federal health care policies can also restrict hospitals' revenues. For example, the Fiscal Year 1996 Congressional Budget Resolution proposes cumulative Medicare reductions of $270 billion, from current law projections, over the next 7 years. In addition, the Budget Resolution proposes reducing Medicaid outlays by about $180 billion. As the congressional debate on deficit reduction continues, other proposals for containing the cost of federal health care spending on Medicare and Medicaid could surface.

To Remain Viable, Program Hospitals Must Respond to Health Care Delivery Trends

Changes in the delivery of health care can adversely affect the viability of hospitals that do not take action to successfully control costs and compete in the marketplace. One major shift in the way health care is delivered is the change from a focus on hospital inpatient care to outpatient care. From 1983 through 1993, there were 5.4 million or 15 percent fewer

[15]Organizational Review of the Hospital Mortgage Insurance Program, OMAP, pp. 23 and 30.

[16]Our analysis also shows that one-half of program hospitals had Medicare inpatient days of 50 percent.

community hospital admissions nationwide.[17] Over the same period, the average length of stay for patients admitted to hospitals declined from 7.6 to 7.0 days. American Hospital Association (AHA) data show for the same 10-year period that hospital occupancy rates declined by 10 percent and 522 community hospitals closed—a decline of 9 percent.[18] In contrast, more dramatic than the decline in inpatient hospital use was the increase in hospital outpatient visits. Community outpatient visits increased about 75 percent over the 10-year period. This change in outpatient volume reflects an overall restructuring of the health care delivery system.

Some of the factors driving the trends in health care include advances in technology that allow more care to be delivered in outpatient settings; changes in reimbursement incentives, such as the introduction of diagnostic related groups under the prospective payment system in the early 1980s; and the growth of enrollment in managed care health plans. As these trends continue, the need for hospital acute care beds will continue to decline. Health care association representatives cite managed care as a significant trend facing some hospitals. Because of the increased enrollment in managed care plans, hospitals that cannot become a part of a managed care network or compete in this environment stand to suffer financially from a loss of market share.

Understanding the overall impact of these health care trends on the future need of the program would require further analysis which was beyond the scope of this review. Any such analysis should have to consider, at a minimum, (1) the characteristics of program hospitals compared with nonprogram hospitals accessing capital, (2) the ability of program hospitals to obtain financing on the private market without FHA mortgage insurance, (3) the costs and benefits of the program including the public good that the program serves, and (4) the program's underwriting criteria and premium structure.

Managed Care Penetration in New York Could Affect Viability of Program Hospitals

The growth of managed care in New York can negatively affect some FHA-insured hospitals' financial condition and, as a result, increase the risk of financial loss to the insurance program. In 1993, the penetration of managed care plans in New York was more than 24 percent. Also, there is

[17]Community hospitals include institutions that are nonfederal, short-term, general, and other special hospitals whose facilities are open to the public. Not included in this category are hospital units of institutions, long-term hospitals, psychiatric hospitals, and alcoholism and chemical dependency facilities.

[18]According to an AHA report, the decline in the number of community hospitals was especially rapid between 1985 and 1990, however, the number of hospital closures has since slowed. See 94/5 Hospital Statistics: The AHA Profile of United States Hospitals, American Hospital Association.

a push in the state for the adoption of mandatory Medicaid managed care. Managed care emphasizes health care cost control, which includes avoiding unnecessary admissions and lengthy stays.

Managed care also focuses on cost and utilization control measures. However, few New York hospitals have experienced managed care pricing and utilization controls. New York hospitals may be at a disadvantage in a managed care market because they generally have high lengths of stay. In addition, according to a Moody's Investors Service report, "in a managed care market where the key variable is cost, the generally high-cost urban teaching facilities which are disproportionately located in New York, will definitely be at a disadvantage."[19]

In addition, these hospitals have large teaching and research costs and significant fixed costs tied to their large physical plants and debt loads. The potential effect on teaching hospitals can be important to the program because, according to FHA data, the program insures 44 teaching hospitals of which 34, or 77 percent, are in New York.

Hospitals that reduce costs and develop cooperative relationships with other health care providers may be able to mitigate the negative financial impact of managed care. Some program hospitals in New York and other states are affiliating and forming networks with other health care providers to reduce costs and increase service area. For example, one hospital reduced costs by establishing an affiliate in which financial and support services were consolidated and shared within its provider network. In addition, several hospitals reported affiliating with community hospitals and physician groups, as well as developing satellite clinics to broaden their patient base.

An HHS official stated that, in reviewing hospitals' applications, HHS considers whether the hospitals are preparing for managed care and addressing other health care trends. In addition, according to an HHS official, HHS examines affiliate contracts and insures that the contracts are not a drain on the hospitals' finances. Also, program hospitals are required to obtain FHA approval for some mergers and affiliate transactions. FHA officials also reported that FHA consultants consider health care trends in their review of hospitals' applications.

[19]Health Care Finance: Hospital Revenue Bonds, State of New York, Moody's Investors Service, p. 2.

Methodological Flaws Limit the Reliability of the Loan Loss Reserve Estimate

FHA's loan loss reserve estimate of $458.25 million, as of September 30, 1994, is not reliable because of weaknesses in the methodology that FHA used to calculate the estimated loan losses.[20] The assumptions that FHA used to estimate key variables such as default probabilities and the actual loss rates were not directly linked to or justified by a detailed documented analysis of loss exposure in the hospital mortgage insurance portfolio. In an October 1994 report we discuss this principle as it applies to depositary institutions.[21] Further, FHA's methodology did not incorporate some health care market trends that are likely to impact the future financial performance of program hospitals. The net effect of the methodological flaws on the reserve estimate is unclear because FHA's default assumptions and their exclusion of market trends could overstate or understate the loan loss reserve estimate.

In estimating loan loss reserves, FHA—which is subject to the Government Corporation Control Act—is required to follow generally accepted accounting principles (GAAP) for financial statement reporting purposes. However, in our October 1994 report, we stated that this authoritative accounting guidance, established for private sector institutions, does not provide sufficiently detailed direction for establishing loan loss reserves. As a result, our evaluation of the methodology used by FHA is based on this general GAAP principle for loss recognition and our experience in applying other principles in other situations involving the estimation of loan loss reserves.[22]

Assumptions Not Based on Detailed Analysis of Loss Exposure in the Portfolio

FHA's assumptions regarding default probabilities and loss rates were not supported by analysis of the loss exposure of each individual insured loan or other evidence that justified the estimates used. Specifically, FHA computed the probability of each program hospital appearing on HHS' Credit Watch List[23] and then used these probabilities as proxies to

[20]This estimate, calculated on a present value basis, represents the amount that FHA expects to lose from defaults through 2002 on hospital loans insured as of September 30, 1994. The estimate is about 11 percent of the unpaid principal balance of FHA's insured hospital portfolio as of this date.

[21]The report discussed inconsistencies in the use of individual loan assessments and loss history in establishing loss reserves and the need to link the loan loss reserve to a detailed documented analysis of current loss exposure in the loan portfolio. Depositary Institutions: Divergent Loan Loss Methods Undermine Usefulness of Financial Reports (GAO/AIMD-95-8, Oct. 31, 1994).

[22]We also considered Statement of Federal Financial Accounting Standard No. 1, Accounting for Selected Assets and Liabilities, which provides more detailed guidance on loss reserves than GAAP.

[23]The Credit Watch List is a listing of hospitals that are in financial difficulty. HHS develops the list based on its monitoring of change in hospitals' financial condition. The list does not include hospitals that have defaulted on their loans.

measure the default probability of each hospital in the portfolio.[24] The probability of a hospital being on the Credit Watch List, however, is not a valid proxy for estimating the default probabilities for the entire portfolio because a hospital appearing on this list is a more common occurrence than a hospital defaulting. HHS' data show that from 1984 to 1994 there were on average 167 hospitals in FHA's portfolio. During this period, 16 hospitals (or 9.6 percent) defaulted on their loans and there were 82 hospitals on the Credit Watch List (49 percent). HHS data indicate that the majority of the default probabilities that FHA used to calculate the loan loss reserve were higher than the actual default rate of hospitals in the program. FHA's approach for measuring default probabilities resulted in estimates of program hospitals' default probabilities that ranged from about 3 to 80 percent with the majority of the default probabilities in the 10 to 40 percent range. However, FHA's approach may have underreserved for loans that have high default probabilities because FHA did not consider the full unpaid principle balance when applying the loss percentages.[25] Moreover, FHA's use of the Credit Watch List overstates the hospitals' default probabilities for loans less likely to default. FHA officials reported that they preferred to use the Credit Watch List as an indicator of the probability of default because, in their view, the Credit Watch List provides a prospective approach to estimating defaults.

Regarding the loss rates, FHA applied percentages that were in some instances arbitrarily set and not linked to documented evidence of the individual insured loan's likely losses. For example, FHA assigned the historical average loss rate of 70 percent to the hospitals it predicted were most likely to default on their mortgages[26] (that is, hospitals with estimated default probabilities of 50 percent or more) and graduated downward the loss rate for hospitals that had estimated default

[24]FHA used regression analysis to estimate the probability of a hospital appearing on the Credit Watch List. The analysis was based on six financial indicators: liquidity, profitability, capital structure, liquid assets to liabilities, trends of these indicators, and a combination of trends and financial indicators. FHA averaged the predicted probabilities resulting from these six indicators. In effect, the average predicted probability for the hospitals in the portfolio is the same as the percentage of hospitals on the Credit Watch List. FHA assumed that a hospital's average on these probabilities was a good estimate of the hospital's probability of default.

[25]GAAP generally requires that 100 percent of the principle balance be considered for reserving purposes when default is more likely than not to occur (that is, defaults that are considered probable). FHA's analysis shows that it considered less than 100 percent of the principle balance in applying reserve percentages for the loans FHA identified as having high default probabilities. This practice understates reserves for loans more likely than not to default.

[26]According to FHA, losses have averaged 70 percent from the sale at foreclosure or property disposition of eight of the nine hospital mortgages taken into inventory and sold since 1974. Loss data were not available for the ninth hospital.

probabilities lower than 50 percent.[27] The 70-percent loss rate was based on losses HUD experienced from the sale at foreclosure or property disposition of eight of the nine hospital mortgages taken into inventory and sold since 1974. However, a better method for estimating the loan loss reserve would be to do a comprehensive analysis of the individual loss exposure for defaults considered probable—hospital loans with 50 percent or higher default probabilities. This entails not only reviewing the financial condition of the hospital, which FHA did, but considering other factors such as the likelihood of foreclosure versus FHA continuing to carry the loan. Further, FHA had no justifiable basis for the loss rate percentages applied to the hospitals that had default probabilities lower than 50 percent. FHA's rationale was that in the future it could recover more from disposing of hospitals with default probabilities below 50 percent because these hospitals are considered to be stronger financially, based on the hospitals' financial condition in 1994. FHA arbitrarily assumed that these hospitals would default later[28] and have a higher value at the time of sale because they would have a broader patient base and higher net patient revenue. We question the validity of these assumptions because FHA provided no analysis to support the loss rates applied to hospitals with a lower than 50 percent probability of default.[29] Because FHA had no basis for the loss rate percentages used for these categories of loans, it may be misstating the loan loss reserve estimate.

Health Care Market Trends That Might Affect the Future Viability of the Program Were Not Included in the Analysis

FHA's loan loss reserve methodology did not incorporate newly developed events, such as health care market trends, that can affect the future financial condition of program hospitals. For example, by omitting analyses of the potential impact of managed care, the loan loss reserve did not consider developing events that can impact program hospitals' revenues. A reduction in revenue related to managed care could result in program losses. Overall, FHA's exclusion of health care market trends in its methodology may have understated or overstated the loan loss reserve estimate depending on the impact that the specific market trend has on the program hospitals. While FHA officials acknowledged the importance of

[27]The loss rates were 50 percent for default estimates between 40 and 50 percent, 25 percent for those between 30 and 40 percent, 10 percent for defaults estimates between 20 and 30 percent, and 2 percent for default estimates between 0 and 20 percent.

[28]FHA assumed that hospitals with default likelihoods of over 80 percent would default in 1995; those between 70-80 percent in 1996; 60-70 percent in 1997; 50-60 percent in 1998; 40-50 percent in 1999; 30-40 percent in 2000; 20-30 percent in 2001; and 2-20 percent in 2002. FHA officials said that they arbitrarily set the specific years in which the defaults would occur.

[29]FHA's underlying assumptions were that some insured loans would have loss rates equal to the historical average and others would have loss rates below the historical average. However, because none of the insured loans was assumed to have a loss rate above the historical average, FHA is assuming that future loss rates would be less than the historical average indicates.

health care trends, they stated that they had not developed an approach to incorporate such factors into their analysis.

Program Purpose Relates to HUD's Mission but Achievement of Goals Is Not Routinely Measured

HUD's mission is broad enough to encompass the purpose of the hospital program. HUD's overall mission includes increasing opportunities for housing and community development and, through FHA, providing mortgage insurance for construction projects. The purpose of the program is to assist with providing for urgently needed hospitals. In the report supporting the establishment of the hospital program, the House Committee on Banking and Currency cited FHA's experience with promoting construction through its insurance programs. Subsequently, the Congress made providing mortgage insurance for hospital construction a part of HUD's mission by giving the department statutory responsibility for the program.

HUD officials reported that through FHA the program supports the department's mission because it (1) provides an opportunity for hospitals to obtain financing for construction and renovation projects that they may not otherwise obtain in the private market and (2) promotes one of the department's goals of economic lift by increasing employment, economic development, and neighborhood stabilization. The program also has as one of its specific goals promoting neighborhood stability and economic lift.[30]

Although FHA officials believe that the hospital program is consistent with HUD's mission, the extent to which the program accomplishes the department's goals and thereby supports its mission is not routinely measured. For example, HUD does not measure the extent to which local employment increased as a result of the program or the effect an insured project had on stabilizing a community. Performance measurement data would be useful for HUD to determine the strategic importance of the program to its mission and to evaluate the extent to which program benefits or outcomes outweigh program risks.

Although no legal requirement existed for performance measurement, the Government Performance Results Act (GPRA) of 1993 requires federal agencies to submit a strategic plan to the Congress in the fall of 1997 and

[30]In addition, FHA also established the following five program goals: (1) provide access to capital for facilities that cannot get conventional financing, (2) make facility modernization and improved patient care possible, (3) support governmental and market-driven health care reforms, (4) ease health care costs, and (5) provide technical assistance to help "turn around" troubled facilities.

an annual performance plan in fiscal year 1999.[31] In response to GPRA requirements, HUD officials stated that HUD established performance measures for some of its major programs. These measures include increasing the number of first-time home buyers and increasing benefits to low- and moderate-income home buyers. However for the hospital program, HUD officials stated that the agency has not developed performance measures, in part, because of the program's relatively small size and HUD's lack of data systems to track specific performance measures.

FHA Program Management Responsibilities Shared With HHS Staff

FHA has limited health care expertise to independently manage the program. FHA's headquarters staff has overall responsibility but shares program responsibilities with HHS staff because of HHS' experience with hospitals and health care. Managing the program requires, in part, (1) familiarity with health care regulations, insurance practices, reimbursement systems, and trends; (2) an understanding of the indicators of a hospital's financial condition; and (3) knowledge of the unique construction guidelines that apply to hospitals. According to a 1992 HUD report, HHS has staff with skills and experience in business administration, financial analysis, and accounting in the health care industry, as well as architects and engineers who specialize in overseeing the construction of health care facilities.[32] The majority of the tasks related to managing the initial phases of the program's loan cycle—loan development and management—have been delegated to HHS. FHA has primary responsibility for managing the latter stages of the program's loan cycle—loan assignment and property disposition (see app. III for a description of each agency's responsibilities during the phases of the loan cycle).

A 1992 HUD report shows that FHA and HHS' efforts to manage the program have produced mixed results. The report raised some concern about their past performance in loan development and management and the management of assigned loans and disposition of HUD-owned hospitals. However, the report concluded that, for the most part, HHS staff had done a good job and HUD's staff was getting more involved and gaining experience in working with troubled hospitals.[33] As agreed with your staff, our review

[31]The strategic plan is to contain the agency's mission, long-term goals and objectives, and strategies for achieving these goals and objectives. The annual performance plan is to contain annual performance goals to gauge the agency's progress toward accomplishing its longer-term strategic goals and identify the performance measures the agency will use to assess its progress.

[32]Organizational Review of the Hospital Mortgage Insurance Program, OMAP, pp. 82-83.

[33]Organizational Review of the Hospital Mortgage Insurance Program, OMAP, pp. 15, 22, 37, 43, 45, 52, and 83.

did not include an evaluation of FHA and HHS' performance in program management.

Length of Application Process Criticized

The hospital and finance agency officials we interviewed raised concerns about the length of time it takes to get mortgage insurance applications and loan modifications[34] approved by HHS and FHA. Our analysis of 12 loan applications approved since September 1990 shows that the average time from the date an application was first submitted to HHS to FHA's final approval was more than 18 months. In contrast, a Price Waterhouse study reported that private insurers approve mortgage insurance applications for health facilities in 2 to 4 weeks.[35] In addition, according to HUD's 1992 report, the median timeframe for selected modification approvals was more than 9 months.[36] Several hospital and finance agency officials said that the application and loan modification processes are lengthy primarily because of the number of offices involved in reviewing the applications. FHA and HHS officials attribute some of the delay to hospitals not responding to their questions in a timely manner. The lengthy approval processes may hinder hospitals' ability to take advantage of favorable market interest rates, several officials said. One hospital reported that it had to pay an additional 65 basis points[37] on its interest rate because of the time that elapsed between HHS' recommendation to approve the application and FHA's final approval.

FHA recognizes that the approval processes are lengthy and stated that a reasonable goal for approving applications is 6 months. FHA and HHS recently initiated efforts to streamline the application process. These efforts include using a team approach to analyze applications and involving FHA's field staff earlier in the process. However, FHA officials stated that their approval timeframes will generally never match those of private sector insurers because the hospitals that FHA insures are financially weaker and require closer screening and evaluation.

[34]Loan modifications are modifying or waiving existing loan terms and conditions. These changes include, but are not limited to, buying or selling equipment, leasing property, and merging or restructuring the corporation.

[35]Assessment of Loan Management Procedures to Identify Strategies to Improve Health Care Facilities' Financial Performance, Price Waterhouse (1994), p. 13.

[36]Organizational Review of the Hospital Mortgage Insurance Program, OMAP, p. 77.

[37]A basis point is equal to one one-hundredth of one percentage point, or 0.01 percent.

Conclusions

Although the hospital program had made a positive dollar contribution to the General Insurance Fund as of fiscal year 1994, the accumulation of more than $4 billion of insured projects and the large loan amounts in New York pose risks to the future stability of the program. The continued buildup in New York may further exacerbate this risk. Further, trends in health care and changes in state and federal health care policies that reduce hospitals' revenues will impact program hospitals.

FHA officials are aware of the risks of concentration and health care changes associated with the current portfolio. Portfolio concentration is a controllable program risk for the future. But the law that authorizes the Secretary of HUD to set the terms and conditions under which HUD will insure projects does not specifically authorize FHA to use as options for diversifying the portfolio, limiting the number of projects accepted into the program from a geographic area, or limiting the amounts it insures. Health care trends and changes in health care policies are risks beyond FHA's control. Hospitals currently in the FHA program must make adjustments to respond to these changes or they could suffer significant financial losses. To reduce the potential financial losses associated with future insured mortgages, FHA is considering risk sharing with the public and private sectors. However, the risk to the current portfolio remains.

Flaws in FHA's methodology for estimating loan losses limit the reliability of FHA's loan loss reserve estimate. The implications of health care trends for program hospitals were not factored into FHA's methodology for estimating potential loan losses. In addition, the approach that FHA used to determine default and loss rate assumptions was not reliable. FHA did not consider the full loss exposure in estimating reserves for hospitals that it identified as having high default probabilities. As a result of these flaws, the loan loss reserve estimate could be understated or overstated.

While FHA has developed performance measures for some of its major programs in response to GPRA, it has not developed performance measures for the hospital program. Performance measures would help HUD evaluate the program's effectiveness.

Matter for Congressional Consideration

Given the risks associated with the portfolio's geographic concentration and the possible implications for the program of current health care trends, the Congress may wish to explore further with HUD officials options for reducing the program's risk by, for example, limiting the program's risk exposure in a particular state and capping mortgage insurance amounts.

Recommendations

To improve the reliability of FHA's loan loss reserve estimate, insure future compliance with federal performance measurement requirements, and minimize potential financial losses from future projects, we recommend that the Secretary of HUD

- perform a comprehensive analysis of individual loan loss exposure when default is considered probable; link the loan loss reserve estimate to documented analyses that justifiably support loss rates and default percentages; and consider newly developed events, such as health care trends and policy changes, that can affect the performance of loans in estimating loan loss reserves;
- develop performance measures and begin collecting the data needed to track the performance of the Hospital Mortgage Insurance Program; and
- pursue risk-sharing arrangements in which a private or public entity would share in potential financial losses from hospital defaults on future FHA-insured projects only after a thorough evaluation of the benefits and drawbacks of risk-sharing ventures, taking into account past experiences of FHA's multifamily housing programs.

Agency Comments and Our Evaluation

On November 22, 1995, we provided a draft of this report to HUD and HRSA for comment. Although HRSA did not provide comments, HUD generally agreed with the report's findings and conclusions. In response to our recommendations, HUD reported that it will (1) incorporate additional data on market trends and health care policy changes into FHA's loan loss reserve methodology as such data become available and can be quantified; (2) develop and implement performance measures for the program in fiscal year 1997; and (3) conduct front-end risk analysis and incorporate multifamily's risk-sharing experience into its plans for the hospital risk-sharing program. (See app. V.).

HUD did not, however, concur with our evaluation of its 1994 loan loss reserve methodology. Contrary to what we concluded, HUD stated that it (1) used the financial position of the hospitals, not their appearance on the

Credit Watch List to predict the probability of default, (2) based its loss rates on a review of all losses incurred in foreclosure or property disposition sales since the beginning of the program, (3) considered the full unpaid principal balance in estimating the loan loss reserve, and (4) included health care market trends through its analysis of the current financial condition and trends in the financial condition of individual hospitals.

Predicting the Probability of Default

HUD's comment that FHA used the financial condition of the hospitals, not appearance on the Credit Watch List, to predict probability of default is inconsistent with the documentation that FHA provided on the method used for estimating the program's loan loss reserves. FHA's documentation states that financial indicators "were used to predict the probability that a hospital would appear on HHS' Watch List." FHA averaged the probabilities estimated by these indicators to convert "the predictors of appearance on the Watch List to a likelihood of default." Further, as stated in the report, our review of HHS data showed that the majority of default probabilities that FHA used were higher than the actual default rate of hospitals in the program. Clearly, FHA did not adjust the predicted probabilities of default for this difference.

Determining Loss Rates

Regarding the loss rates, HUD commented that FHA's analysis was based on all losses incurred in foreclosure and property disposition since the inception of the program. HUD also stated that the loss rates were adjusted downward for mortgages with probabilities of default lower than 50 percent based on the assumption that hospitals with a better financial condition would be worth more at foreclosure.

As discussed in our report, the 70-percent average loss rate that FHA used for hospitals with high default probabilities was based on actual losses experienced in the foreclosure or property disposition of only eight mortgages taken into inventory and sold since 1974. Thus, FHA's historical analysis was not statistically significant and was based on information that was not adjusted for current real estate market trends. We believe that FHA's use of this historical analysis to determine loss reserves for loans where default is considered more likely than not (that is, hospital loans with 50-percent or higher default probabilities) may overstate or understate the reserves on these loans. We believe that individual loan analysis of mortgages in the current portfolio provides for a more accurate

means to measure loss exposure on loans where default is considered more likely than not.

Although as a matter of generally accepted practice, using historical data may under some circumstances be appropriate for groups of loans with a lower than 50-percent default probability, FHA arbitrarily adjusted a questionable 70-percent loss rate downward for such loans and provided no supporting analysis to justify the resultant loss rates. We believe that this analysis was inappropriate for this group of loans with lower default probabilities. Therefore, these loss rates do not provide a reliable basis for estimating FHA's reserves.

Accounting for the Full Unpaid Principal Balance

With respect to accounting for the full unpaid principal balance in estimating potential losses, HUD stated that it "multiplied the full unpaid principal balance by the probability of default and then by the loss rate—a standard approach to factoring the probability of default into a loss estimate."

However, this approach has the effect of reducing the unpaid principal balance. Proper application of GAAP requires 100 percent of the unpaid principle balance for reserving purposes when default is more likely than not to occur. Including default probabilities in the reserve calculation may be appropriate for loans where default is not considered more likely than not, but once that threshold has been determined, the full amount of the loan balance should be considered in calculating the loss estimate.

Including Health Care Trends

HUD stated that its methodology reflected current health care market trends. We agree that some health care market trends may be reflected in hospitals' financial statements. However, some rapidly evolving health care market trends, such as managed care, may not be reflected in the hospitals' financial statements that HUD uses because of the time lag in financial reporting. FHA's loan loss reserve methodology does not include a mechanism to identify and adjust for such trends. Historical trends should be adjusted to reflect changes in economic and business conditions, such as managed care, in order to provide a reasonable estimate of current loss exposure. Data on hospitals' utilization rates may be used in analyzing health care trends.

HUD also commented on other issues that did not accurately reflect the information presented in our report. For example, HUD commented that we

found the program to be "consistent with and contributing towards the mission of HUD." However, this is not a conclusion of our report. Our report cites the statements of HUD officials that the program supports and is consistent with the Department's mission. We concluded that HUD's mission is broad enough to encompass the purpose of the hospital program, not that it contributes to the mission of HUD. (See p. 18.)

HUD also commented that it agreed with our concern that the proposed federal Medicare and Medicaid cuts could have a "significant adverse impact on the hospital industry, including some hospitals with mortgages insured by FHA." Our report does not make a value judgment about the proposed federal Medicare and Medicaid reductions on the hospital industry or hospitals in the program. Instead, we report that future changes in federal health care policies can restrict hospital revenues and increase risks to the program. (See p. 12.)

While HUD commented that our report noted "many urban community and teaching hospitals need credit enhancement but cannot meet all of the standards of the private insurers," we did not differentiate among which types of hospitals need credit enhancement.

HUD provided additional reasons for the program's concentration in New York other than the state's reimbursement system. Despite these reasons and recent actions taken in efforts to address these risks, the program's concentration and the large individual unpaid loan balances in New York continue to pose program risks. Specifically, the concentration of the portfolio in New York makes the program susceptible to New York policies and other factors specific to the state. (See p. 10.)

HUD also noted actions that it is initiating to geographically and economically diversify its portfolio. According to HUD comments, these actions include increasing program awareness and developing new products to meet market demands. Although we recommended that HUD pursue risk-sharing arrangements and suggested that the Congress consider exploring with HUD options for reducing program risks; for example, by limiting the program's risk exposure in a particular state and capping mortgage insurance amounts, we do not endorse expanding FHA's Hospital Mortgage Insurance Program. By expanding the program, FHA increases the program's total outstanding mortgage amount. In fact, because the overall impact of health care trends and policy changes is unclear, we stated that to understand the overall impact of these changes

on the future of the program would require further analysis given its original purpose and the current composition of the portfolio. (See p. 13.)

We are sending copies of this report to appropriate congressional committees; the Secretary of HUD; the Secretary of HHS; the Director, Office of Management and Budget; and other interested parties. We also will make copies available to others on request.

Please contact me at (202) 512-7119 if you or your staff have any questions. Other major contributors are listed in appendix VI.

Sarah F. Jaggar
Director, Health Financing
and Public Health Issues

Contents

Figures

Abbreviations

AHA	American Hospital Association
FHA	Federal Housing Administration
GAAP	generally accepted accounting principles
GPRA	Government Performance Results Act
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development

Financial Performance of FHA's Hospital Mortgage Insurance Program, Fiscal Years 1969-94

Dollars in thousands[a]

Fiscal year	Fees and premium earned	Claims paid	Net of recovery and holding cost[b]	Salaries and administrative expenses	Net cash flow from operations for the year
1969	$11	$0	$0	($1)	$10
1970	234	0	0	(12)	221
1971	1,255	0	0	(50)	1,205
1972	2,756	0	0	(86)	2,670
1973	4,144	0	0	(133)	4,012
1974	5,028	(26,867)	13	(159)	(21,985)
1975	5,356	0	991	(169)	6,178
1976	6,186	0	1,935	(243)	7,878
1977	9,117	0	1,990	(337)	10,770
1978	11,502	0	6,262	(363)	17,401
1979	11,150	0	2,582	(378)	13,354
1980	11,253	(12,105)	2,407	(418)	1,137
1981	13,763	0	2,409	(516)	15,656
1982	15,708	0	1,995	(548)	17,155
1983	18,640	0	12,040	(663)	30,017
1984	20,435	0	298	(673)	20,060
1985	22,369	0	7,061	(869)	28,560
1986	25,373	0	1,317	(876)	25,814
1987	27,385	(5,351)	1,308	(898)	22,443
1988	25,335	0	29	(901)	24,463
1989	22,694	(34,606)	1,432	(844)	(11,324)
1990	23,450	(21,240)	6,118	(872)	7,456
1991	24,571	(91,179)	803	(883)	(66,687)
1992	22,866	0	6,420	(828)	28,458
1993	20,521	(4,202)	5,897	(773)	21,442
1994	19,008	(4,180)	474	(714)	14,589
Total	**$370,110**	**($199,730)**	**$63,781**	**($13,207)**	**$220,953**

Source: FHA.

[a]These amounts were not adjusted for inflation.

[b]This column includes the amount FHA recovers from mortgage payments and the sale of the mortgages or properties and the amount paid in taxes, rent, insurance, maintenance, and other holding expenses.

FHA-Insured Hospital Projects' Unpaid Principal Balances, by State, August 1995

Project	Unpaid principal balance
Arkansas	
1	$1,365,254
2	1,235,236
Subtotal	2,600,490
California	
1	1,210,456
2	599,445
Subtotal	1,809,901
Florida	
1	11,362,651
Subtotal	11,362,651
Illinois	
1	6,063,326
Subtotal	6,063,326
Kentucky	
1	9,285,024
Subtotal	9,285,024
Louisiana	
1	2,493,799
Subtotal	2,493,799
Maryland	
1	9,099,451
Subtotal	9,099,451
Massachusetts	
1	151,986,224
2	30,637,783
3	27,398,992
4	6,725,307
5	4,322,184
Subtotal	221,070,490
Michigan	
1	15,279,345
2	3,773,294
3	3,137,481
4	922,378
Subtotal	23,112,498

(continued)

Project	Unpaid principal balance
Missouri	
1	4,305,135
Subtotal	4,305,135
New Hampshire	
1	2,537,862
Subtotal	2,537,862
New Jersey	
1	83,732,411
2	58,311,090
3	31,765,110
4	20,420,021
5	16,987,817
6	16,969,713
7	5,149,716
Subtotal	233,335,878
New York	
1	590,797,000
2	380,241,760
3	372,438,614
4	364,192,332
5	204,573,918
6	140,979,861
7	136,555,425
8	131,418,238
9	110,113,928
10	94,763,000
11	91,896,764
12	88,735,802
13	88,678,093
14	87,755,400
15	72,560,788
16	70,722,167
17	64,465,065
18	60,866,708
19	58,959,262
20	52,714,233
21	50,420,949

(continued)

Project	Unpaid principal balance
22	43,470,870
23	42,298,615
24	40,740,246
25	38,213,163
26	36,501,710
27	36,030,000
28	35,091,398
29	30,720,000
30	30,580,690
31	30,081,568
32	27,242,060
33	26,940,025
34	26,633,787
35	25,750,401
36	25,124,360
37	23,062,692
38	22,089,824
39	21,143,165
40	21,028,658
41	20,430,852
42	19,908,217
43	18,726,104
44	18,223,927
45	17,171,818
46	15,597,580
47	15,593,213
48	15,557,416
49	15,449,366
50	14,857,896
51	14,664,349
52	14,088,396
53	13,929,748
54	11,860,561
55	9,385,082
56	9,318,357
57	8,256,858
58	8,253,678

(continued)

Project	Unpaid principal balance
59	7,487,455
60	7,368,244
61	5,411,324
62	5,281,195
63	1,423,221
Subtotal	4,184,837,396
Oklahoma	
1	387,472
Subtotal	387,472
Pennsylvania	
1	28,400,264
2	19,226,647
3	8,154,756
4	7,578,058
Subtotal	63,359,725
Puerto Rico	
1	15,782,102
Subtotal	15,782,102
Texas	
1	12,286,708
Subtotal	12,286,708
Washington	
1	220,096
Subtotal	220,096
Wisconsin	
1	8,989,065
2	6,566,419
Subtotal	15,555,484
Total (100 projects)	**$4,819,505,488**

Source: FHA Hospital Mortgage Insurance Program staff.

HUD's and HHS' Responsibilities in FHA's Hospital Mortgage Insurance Program Loan Cycle

	HHS	HUD
Development		
Provide applicant guidance and assistance (including preapplication conference)	x	x
Conduct initial site visit to hospital	x	x
Review and approve construction plans, specifications, and contracts	x	
Engage independent feasibility consultant		x
Recommend to HUD approval or disapproval of hospital's application	x	
Make final underwriting determinations, conduct any needed legal reviews, issue firm commitment, close and initially endorse loan		x
Conduct preconstruction conference, monitor construction work, and process requests for advances of mortgage proceeds	x	
Review cost certification, inform lender of maximum insurable mortgage amount, and process final advance	x	
Arrange final closing and finally endorse mortgage		x
Loan Management		
Monitor hospital's financial performance by reviewing financial statements and conducting periodic site visits	x	
Receive, review, and recommend to HUD approval or disapproval of special requests and loan modifications (for example, partial release of security, transfer of physical assets, bond refundings, or major capital projects)	x	
Approve special requests and loan modifications		x
Conduct site visits to troubled hospitals to determine actions needed to prevent or cure defaults	x	x
Review quality and condition of insured hospital loan portfolio and determine amount of loan loss reserve		x
Assignment		
Receive/process assignment of loan and pay insurance claim		x
Review assigned hospital's operational performance and financial condition and conduct site visits as needed	x	x
Receive, review, and recommend to HUD approval or disapproval of proposed workout agreements or mortgage modifications	x	
Bill for and collect mortgage payments		x
Disposition		
Analyze hospital's situation, evaluate alternative uses, secure appraisal, make decision to foreclose, and arrange and hold foreclosure sale		x

(continued)

	HHS	HUD
Contract for management services and repairs, as needed, to protect asset if HUD is mortgagee-in-possession or acquires hospital through foreclosure or deed-in-lieu		x
Develop marketing plan; advertise and sell hospital		x

Source: FHA Hospital Mortgage Insurance Program staff.

Objectives, Scope, and Methodology

The specific objectives of our review were to (1) identify factors, including those related to health care market trends, that could affect the stability of the program's portfolio and provide information on the program's financial performance; (2) evaluate the methodology FHA used to estimate the program's fiscal year 1994 loan loss reserve; (3) evaluate the relationship between the purpose of the hospital mortgage insurance program and HUD's mission; and (4) determine whether FHA has the expertise to manage the program.

To identify factors that could affect the stability of the program's portfolio, we (1) researched the literature and used HUD's 1992 internal report on the hospital mortgage insurance program; (2) interviewed program officials in FHA and HHS headquarters and field offices; (3) interviewed senior financial officers from seven hospitals in New Jersey, New York, Puerto Rico, and Texas;[38] (4) interviewed representatives from the Health Care Financing Study Group, New Jersey Health Care Facilities Financing Authority, New York State Medical Care Facilities Finance Agency, Goldman, Sachs & Co., Merrill Lynch and Co., AMBAC Indemnity Corp., Municipal Bond Investors Assurance Insurance Corp., Greater New York Hospital Association, Healthcare Association of New York State, State of New York Department of Health, the law firm of Krooth & Altman, and other state health and hospital organizations that are knowledgeable about or involved with the program; and (5) convened a panel of investment bankers and hospital financial officers.

We used the Health Care Financing Administration's Health Care Provider Cost Report Information System, the New York State Department of Social Services Medicaid Provider Ranking List, and the New York State Department of Health's estimation of Medicaid cost containment to demonstrate the effect of New York's fiscal year 1996 Medicaid spending reductions on program hospitals. We calculated 1994 operating margins for 48 of 57 New York program hospitals. Nine hospitals did not have 1994 cost report information available or did not have the state's estimation of Medicaid cost containment. We reduced calendar year 1994 net patient revenues by the New York State Department of Health estimation of Medicaid cost containment. Two assumptions of our analysis were that (1) the effects of the proposed changes on net patient revenue would be the same in each year and (2) the hospitals took no action to reduce expenses.

[38]This was a nonrandom, judgmental sample of states. Each state was chosen because it illustrates one or more of the following: (1) a high proportion of the program's unpaid principal balance, (2) several mortgage loans in default, (3) varying health care regulatory environments, and (4) market trends in diverse geographic areas.

To evaluate the methodology FHA used to estimate its 1994 hospital loan loss reserve, we reviewed the description of the hospital loan loss analysis and other related documents. We evaluated the methodology and discussed the statistical estimation model and assumptions FHA used with FHA and HHS officials. Also, we interviewed investment bankers and bond insurers to determine conventional approaches private industry uses in estimating loss reserves. As agreed with Committee staff, we did not assess the accuracy of the estimated amount of the program's loan loss reserve.

To evaluate the relationship between the purpose of the hospital program and HUD's mission, we reviewed and analyzed the applicable laws, regulations, and policy statements related to the Department's and FHA's missions. We reviewed the legislative history to determine the purpose of the program. We also interviewed FHA officials to discuss how the program's purpose supports HUD's mission.

To determine whether FHA has the expertise to manage the program, we interviewed agency officials and representatives from hospitals and state health and hospital organizations, as previously mentioned. Our review of FHA's expertise to manage the program did not involve an evaluation of risks to the program resulting from program management or organization. Our 1990 report and internal HUD studies have previously addressed organizational issues.[39]

The approach to accomplishing the objectives of this review was discussed with and agreed to by staff from both the Senate and House Banking Committees.

[39]Financial Audit: Federal Housing Administration Fund's 1988 Financial Statements (GAO/AFMD-90-36, Feb. 9, 1990); Federal Managers' Financial Integrity Act Report for Fiscal Year 1991, HUD; and Organizational Review of the Hospital Mortgage Insurance Program, Office of Management and Planning, HUD (1992).

Comments From the Department of Housing and Urban Development

U. S. Department of Housing and Urban Development
Washington, D.C. 20410-8000

December 11, 1995

OFFICE OF THE ASSISTANT SECRETARY
FOR HOUSING-FEDERAL HOUSING COMMISSIONER

Mr. Mark V. Nadel
Associate Director
National and Public Health issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Nadel:

On behalf of Secretary Cisneros, I am responding to your November 22, 1995 letter which transmitted a draft report entitled FHA Hospital Mortgage Insurance: Health Care Trends and Portfolio Concentration Threaten Program Stability (GAO/HEHS-96-29) for review and comment by the Department of Housing and Urban Development.

The Department and its Federal Housing Administration (FHA) would like to thank the General Accounting Office (GAO) for its fair and balanced report on the challenges facing the Section 242 Hospital Mortgage Insurance Program. FHA is pleased that GAO found the Program to be consistent with and contributing towards the mission of HUD. FHA is also pleased with GAO's conclusion that the Program generated over $220 million in net revenues since its inception through FY 1994, and FHA continues to project a negative credit subsidy impact on HUD's budget. If premiums and fees collected and expenses incurred in Fiscal Year 1995 are also included, the cumulative net income generated by the Program is over $240 million. The Program's very low claim rate was another positive fact cited in the report.

FHA agrees with GAO's concern that the reductions over seven years in Medicare and Medicaid of $270 billion and $163 billion respectively recently proposed and voted on by the Congress could have a significant adverse impact on the hospital industry, including some hospitals with mortgages insured by FHA. Recent studies and projections by hospital associations across the country indicate that many teaching and community hospitals, highly dependent on Federal reimbursement, would suffer severe financial problems if the proposed cuts are fully implemented. These conclusions raise serious public policy concerns.

While the vast majority of the nation's hospitals have in the past faced significant financial challenges and have proven their resiliency, according to a recent study, the proposed Medicare and Medicaid cuts represent an historically unprecedented challenge to the financial viability of the entire hospital industry. To be sure, the rules that have governed the Federal financing of health care for three decades are being fundamentally changed.

FHA agrees with GAO's conclusion that the health care industry is undergoing dramatic changes, including: the shift toward outpatient and community-based care; advances in technology; the growth of managed care; and the enactment of cost containment policies by state and Federal governments, especially regarding Medicare and Medicaid reimbursement. Consequently, hospitals across the country are having to adapt to new and highly competitive market conditions. To survive, many hospitals will have to establish affiliations with other financially stronger institutions or become part of integrated delivery systems which offer expanded networks of providers, reduced costs, and a better capacity to secure a larger share of the market. To respond to these industry changes and new market conditions, most hospitals will continue to need access to lower-cost capital. Moreover, according to recent U.S. Commerce Department projections, replacement of obsolete and inefficient facilities will continue to push hospitals to seek needed capital at increasing levels well into the next century.

Through the Section 242 Program, FHA has supported and strengthened various state and Federal policy initiatives and market-driven health care reforms aimed at containing costs and improving health services in communities across the country. Recent hospital projects approved for FHA insurance illustrate this fact. These include:

- Expansion of outpatient and community-based facilities to provide accessible primary and preventive care and serve as referral sources for hospitals;
- Consolidation of hospital services and streamlining of physical layouts to facilitate provision of more efficient care;
- Redesign and expansion of intensive care and recovery areas to accommodate more patients and new technologies; and
- Conversion of unused inpatient facilities to rehabilitation and skilled nursing facilities for which market demand remains high.

As your report noted, many urban community and teaching hospitals need credit enhancement but cannot meet all of the standards of the private insurers. These hospitals are candidates for FHA hospital mortgage insurance. According to health care industry groups, demand for FHA insurance programs will be even greater in the future as health care facilities undergo upgrading and consolidation demanded by managed care, downsizing, etc. Recent inquiries and feedback from the industry point to an increase of applications involving smaller facilities from more geographically diverse areas than currently in the FHA hospital portfolio. We expect this trend to be confirmed by

Price Waterhouse, which was recently engaged by FHA to prepare, among other things, an updated and comprehensive market assessment of the current and future demand for existing and potential hospital/health care credit enhancement products.

FHA agrees with the GAO that changes need to be made in the Program to better manage risk, increase revenues, improve customer service, and more efficiently provide its products. As your report suggests, issues such as the Program's high premiums, lengthy application process, and low visibility must be addressed. To meet these challenges, FHA has already undertaken a number of initiatives to strengthen management and oversight of its current portfolio, assure that new hospitals applying for FHA insurance are acceptable credit risks and geographically diverse, and to streamline processing of new applications and mortgage modifications for currently insured hospitals.

RISK MANAGEMENT AND OVERSIGHT

To strengthen FHA's current hospital portfolio, the following actions are being taken:

- A Management Information System (MIS) which will automate and integrate data about the current hospital portfolio is being developed.
- Program policy changes are now being considered to afford currently insured hospitals greater flexibility in their daily operations under the terms of the mortgage, without increasing risk to FHA.
- Senior-level discussions and planning activities are underway to achieve greater coordination in the oversight of the FHA insured hospital portfolio in New York among FHA, the U.S. Department of Health and Human Services (HHS), the Dormitory Authority of the State of New York, and the New York State Department of Health.
- Financial sensitivity analyses of the impact of anticipated shortfalls in Federal and state reimbursement and management plans to counteract them are now required from new applicants and from FHA-insured hospitals in New York where most of the current portfolio is located.
- A covenant which commits an applicant hospital to take appropriate actions to mitigate potential revenue shortfalls if Medicare and/or Medicaid reductions are implemented is now required as a condition for the issuance of mortgage insurance.

- More effective and efficient organizational models to improve coordination and management of the Program and customer service are presently being studied.

- Proposed legislation to transform FHA into a new government-owned Federal Housing Corporation (FHC) was recently submitted to Congress by the Administration. The new FHC would be a results-oriented, financially accountable, public purpose enterprise providing credit enhancement to meet affordable housing, home ownership and health care needs nationwide. The FHC would operate with greater flexibility and efficiency in meeting those needs.

- FHA is closely monitoring the level of dependence on Medicare and Medicaid of its insured hospitals.

- FHA is developing enhancements to its current portfolio monitoring systems.

- A hospital risk-sharing rule has already been drafted that, if approved, would permit FHA to enter into risk-sharing partnerships with state and local health facilities financing agencies, and private sector firms.

PROCESS STREAMLINING

FHA is taking the following actions to streamline the processing of new applications.

- FHA is actively working with HHS to streamline the Section 242 review and approval process and to improve the quality and predictability of outcomes. This includes: conducting joint preapplication meetings and site visits; ongoing consultations throughout the review process; and greater communication with the applicant.

- FHA and HHS have implemented other time-saving measures for processing insured hospital applications including: using a team of analysts from HHS Headquarters and Regional Offices; engaging an independent FHA consultant to analyze the feasibility of an application prior to HHS's initial recommendation; and routinely addressing major legal and administrative closing issues prior to approvals to issue commitments.

- An expedited process for hospitals applying for mortgage insurance of $10 million or less has already been established.

PORTFOLIO DIVERSIFICATION

FHA is initiating the following actions to geographically and economically diversify its portfolio:

- In concert with the Administration's regulatory reform efforts, HUD regulations pertinent to the hospital mortgage insurance are being streamlined to make them more understandable and usable by current and potential customers.
- A hospital market analysis is presently being conducted by Price Waterhouse to determine FHA's current market penetration, forecast its future market share, and to develop new products to meet new market demands.
- A marketing strategy to increase awareness of the Program nationwide and promote applications from geographically and economically diverse hospitals is being developed for implementation.
- Increased communication with national and regional health care associations and the sponsorship of industry meetings are taking place to gather input and raise the Program's visibility.

CURRENT PORTFOLIO CONCENTRATION IN NEW YORK STATE

Your report correctly pointed out that FHA's hospital mortgage insurance portfolio is predominantly concentrated in New York. You stated that this resulted from the State's restrictive reimbursement system, which constrains hospitals' profitability and weakens their creditworthiness, thus making it extremely difficult for them to access private bond or mortgage insurance. There are other related factors, such as those outlined below, which also contribute to the large number of FHA hospitals in New York and should be cited in your report.

- During the 1970s, the State imposed a moratorium, which lasted about ten years, on the issuance of Certificates of Need (CoNs) for hospital construction and major renovation projects. During this period, many New York hospitals were forced to forego needed improvements and modernization. When the moratorium was lifted in the early 1980s, there was a tremendous amount of pent-up demand for capital to fund improvement projects.
- New York requires credit enhancement for issuance of tax-exempt bonds.

- New York's hospitals, particularly those in the New York metropolitan area, are among the oldest and largest in the country.

- New York's hospitals serve higher proportions of Medicaid, Medicare and uninsured patients than hospitals in other states.

- New York has the highest concentration of teaching hospitals in the country.

While New York admittedly has the highest concentration of FHA-insured hospital loans, the default rate on the New York portfolio has been less than one percent. This compares very favorably with a 2.4 percent default rate for the Program as a whole, which, in turn, compares very favorably with other public and private sector mortgage insurance programs. Notwithstanding this historic low default rate, FHA recognizes the Program risks posed by the geographic concentration of its hospital mortgage insurance portfolio, and has initiated a number of significant actions, described below, to manage and mitigate those risks.

- Following the announcement in late 1994 of the State's plan to make major cuts in Medicaid reimbursement, FHA began working with HHS to identify those hospitals with the highest Medicaid dependency and to assess the impact of the proposed cuts on individual hospitals.

- When the final cuts were passed in the spring of 1995, FHA, through HHS, required hospitals which expected to suffer revenue losses of greater than two percent to formulate action plans to offset potential losses. It should be noted that the final cuts passed by the New York State legislature were significantly less severe than those originally proposed.

- FHA directed that an assessment be done of the impact on hospitals in its New York portfolio of the State Medicaid cuts. During the summer of 1995, HHS conducted an intensive review and analysis of the financial condition of each FHA-insured hospital in New York. This included a review of the hospitals' recent financial statements, budgets and Medicaid action plans, and, when warranted, site visits to individual hospitals. The results of HHS' reviews were submitted to FHA in October and November 1995. HHS concluded that virtually all of the hospitals had responded to the original proposed cuts by implementing major cost reduction actions. As a result, most of the hospitals were projecting greater profitability for 1995 than shown in their original budgets. HHS will continue this close monitoring of the New York portfolio.

- For all mortgage insurance applications from New York hospitals which were being processed either during or subsequent to the time when the State Medicaid cuts were enacted, FHA has also required the hospitals' feasibility consultants to develop and submit sensitivity analyses showing the impact of the cuts and the hospitals' responses as compared with their original feasibility projections.

- In the past, FHA worked very closely with the New York State Medical Care Facilities Finance Agency (MCFFA) on issues relating to portfolio monitoring and asset management. Although MCFFA was the largest mortgagee in the Hospital Mortgage Insurance Program, none of its loans have ever been assigned to FHA, due in large part to this close working relationship. In fact, in several instances, FHA, HHS and MCFFA have taken joint actions to prevent or cure defaults which otherwise could have resulted in assignments to FHA.

- In September 1995, MCFFA was merged with the Dormitory Authority of the State of New York (DASNY). DASNY assumed MCFFA's insured portfolio, and all future tax-exempt financings for New York hospitals will now be done through DASNY. Prior to the effective date of the merger, FHA initiated a series of meetings with DASNY to ensure that the State remains committed to providing adequate staff and financial resources for portfolio monitoring and asset management. The DASNY Board recently passed a resolution (See Appendix I) strongly affirming its commitment to working with FHA to take measures to "avoid defaults and to assist in or provide for the cure of defaults." The DASNY Board includes senior State officials appointed by the Governor, such as the Director of Budget and Commissioner of Health, as well as representatives of State legislative leaders from both political parties.

- As stated earlier, FHA has been working with senior officials from DASNY, the New York State Department of Health, HHS and the hospital associations to identify various ways to increase coordination and communication concerning insured hospitals with the goal of reducing the risk of defaults to hospitals, FHA, and bondholders.

- Another measure taken by FHA to reduce the risk of default for insured hospitals was the implementation of a policy for the review and approval of applications for debenture lock refundings of tax-exempt bonds. These refundings reduce FHA's risk by enabling hospitals to lower their monthly debt service costs. To date, FHA has approved debenture lock refundings for 24 New York Hospitals with original mortgage

amounts totalling $2.5 billion. Three other insured hospital loans with original mortgage amounts totalling $130 million have been refunded without the need for a debenture lock.

- Recently FHA identified 28 additional New York hospitals whose mortgages could be eligible for refunding and thus take advantage of current lower rates. FHA is now working closely with DASNY and the investment banking community to accomplish as many of these refundings as expeditiously as possible.

In regard to your report's specific recommendations, FHA offers the following responses:

LOAN LOSS RESERVE

FHA does not concur with GAO's critique of its current loan loss reserve methodology. In advancing its methodology FHA has used logistic regression, financial risk indicators, default forecasting equations and actual financial data secured from individual hospital financial statements. To accurately reflect trends in its hospital portfolio, FHA has used five years of financial data for each insured hospital. A point-by-point response to GAO's concerns is included as an enclosure to this letter. (See Appendix II).

While FHA and GAO may disagree on several components of the methodology used for computing last year's hospital loan loss reserve, there seems to be agreement that there can be more than one acceptable method to arrive at a reasonable loss reserve figure. It should also be noted that the hospital loan loss reserve was determined using Generally Accepted Accounting Principles (GAAP) and was approved by FHA's independent auditor as a reasonable projection of what losses may be incurred throughout the life of the current portfolio.

Please be assured that as additional data on market trends, managed care, capitative reimbursement and Medicare/Medicaid cuts become available, and can be quantified, they will be incorporated into FHA's hospital loan loss reserve model.

PERFORMANCE MEASURES

FHA will develop and implement performance measures for the Section 242 Hospital Mortgage Insurance Program in FY 1997.

RISK-SHARING

FHA intends to introduce a risk-sharing program for hospital mortgage insurance in FY 1996. This program would be an addition to, and not a replacement for, FHA's existing full hospital

mortgage insurance products. Moreover, it seeks to implement a policy decision previously made at FHA to develop risk-sharing programs.

To solicit input from the industry, FHA conducted a "Hospital Risk-Sharing Round Table" on November 1, 1995. The objective of this meeting was to gather views from a diverse group of industry experts regarding the establishment of this program. The round table was attended by all major components of the hospital and investment banking communities to assure maximum feedback and to avoid the possibility of one segment of the industry having an advantage over another when the program goes forward. Interest in the proposed hospital risk-sharing program was articulated by a majority of the attendees, with particularly strong interest expressed by representatives from New York.

A draft proposed rule to implement the hospital risk-sharing program was placed in Departmental clearance on December 4, 1995. Subsequently, the rule will be sent to the Office of Management and Budget and Congress for review. FHA anticipates publishing the proposed rule in early spring 1996.

To assure that the proposed hospital risk-sharing program is fully evaluated prior to its implementation, FHA has contracted with Price Waterhouse to provide, among other things, an assessment of hospital risk-sharing prior to publication. FHA is also requesting that HUD's Office of Inspector General review and comment on the proposed rule within the context of the now defunct co-insurance program to assure that any pitfalls experienced in co-insurance are not repeated in the risk-sharing program. Hospital Mortgage Insurance Program staff will continue to consult with the Office of Multifamily Housing (MF) concerning its risk-sharing program. As a result, staff can incorporate MF's risk-sharing experience into the hospital risk-sharing program design. Finally, the required Front End Risk Analysis (FERA) will be conducted prior to the program's implementation to identify and minimize any potential difficulties in administering the program.

PROGRAM EXPERTISE

Despite successfully administering the Program with the assistance of HHS for nearly 30 years, FHA sought to enhance its own expertise in health care because it is the lead agency authorized to, and responsible for, conducting the final reviews of applications, approving commitments of mortgage insurance, and setting policies, goals and overall direction of the Program. In 1990, FHA added to its staff an individual with over 25 years of broad health care and hospital administration experience. Other staff with substantial experience and expertise in financial analysis, underwriting and actuarial analysis were subsequently

added to the Program. The last three consecutive individuals appointed to the position of Program Director have had extensive health care policy, hospital administration or health care financing experience. FHA remains committed to securing the necessary expertise from HUD, HHS or other sources to ensure effective and efficient management of the Program.

In closing, FHA once again extends thanks to the GAO for conducting a rigorous, objective and balanced analysis of its Hospital Mortgage Insurance Program. FHA looks forward to working with the Administration, the Congress and the GAO to improve and strengthen the Program's capacity to facilitate the provision of quality and cost-effective health care services to thousands of people in communities across the country, while at the same time reducing financial risk to the American taxpayer. Similarly, by leveraging billions of dollars in private capital to improve hospital facilities during its nearly three decades of operation, the Program has also helped create major employment and economic development opportunities in cities and towns throughout the U.S.

Please feel free to contact me at 202-708-0599 if you need additional information.

Sincerely,

John U. Sepùlveda
Director
Hospital Mortgage Insurance Staff

Enclosures

A P P E N D I X I

Dormitory Authority Meeting September 20, 1995

A RESOLUTION OF THE MEMBERS OF THE BOARD OF THE DORMITORY AUTHORITY RELATING TO ITS FHA-INSURED MORTGAGE HOSPITAL REVENUE BOND PROGRAM

WHEREAS, the Members of the Board of the Dormitory Authority have adopted the Dormitory Authority of the State of New York Master FHA-Insured Mortgage Hospital Revenue Bond Resolution(the "Master Resolution"); and

WHEREAS, it is the purpose of this Resolution to induce the United States Department of Housing and Urban Development to continue to issue its commitments to insure mortgages pursuant to its Hospital Mortgage Insurance Program in the State of New York.

NOW, THEREFORE, be it resolved that the Members of the Board of the Dormitory Authority express the commitment of the Board to undertake immediately a process which has as its purpose the provision of further assurances to its bondholders and to the United States Department of Housing and Urban Development, the insurer of mortgages entered into by the Authority under its FHA-Insured Mortgage Hospital Revenue Bond Program, including, but not limited to, improvements of its monitoring and portfolio management and oversight programs in order to avoid defaults and to assist in or provide for the cure of defaults, and the provision of additional security features to reduce the exposure of the United States Department of Housing and Urban Development in relation to the Department's Hospital Mortgage Insurance Program.

This Resolution shall take effect immediately.

APPENDIX II

RESPONSE TO GAO'S CRITIQUE OF
HOSPITAL LOAN LOSS RESERVE METHODOLOGY

December 1, 1995

GAO questioned the method used by FHA to estimate the hospital loan loss reserve. Below are FHA's responses to GAO's specific concerns.

"FHA's assumptions regarding default probabilities and loss rates were not supported by analysis of the loss exposure of each individual insured loan or other evidence that justified the estimates used."

FHA used logistic regression to identify the most efficient financial indicators in six different categories--profitability, liquidity, capital structure, current assets relative to liabilities, financial trends, and a combined category--for predicting that a hospital mortgage would appear on the HHS Watch List--an indication that a hospital was troubled in some respect. Then FHA made the reasonable assumption that mortgages in the worst financial condition on all of the indicators were most likely to default. FHA used the financial condition of the mortgages, not appearance on the Watch List to predict probability of default. Not all hospitals on the Watch List were found to have a high probability of default, and vice versa.

The analysis was based on five years of financial data for each individual insured loan in the portfolio. In addition, currently insured loans were compared with loans that had prepaid and defaulted since 1987.

FHA's estimate of its loss exposure was based upon examination of all of the losses incurred in foreclosure and property disposition sales since the beginning of the program.

"... FHA's approach may have underreserved for loans that have high default probabilities because FHA did not consider the full unpaid principal balance when applying the loss percentages."

FHA multiplied the full unpaid principal balance by the probability of default and then by the loss rate--a standard approach to factoring the probability of default into a loss estimate. On the basis of the analysis, none of the mortgages had a 100 percent probability of default, and consequently, all of the unpaid principal balances were reduced to reflect the risk of default. FHA did not underreserve for loans; instead, it took the probability of default into account in estimating potential losses.

"Regarding the loss rates, FHA applied percentages that were in some instances arbitrarily set and not linked to documented evidence of the individual insured loan's likely losses."

FHA based its loss rates on a review of actual all losses incurred upon foreclosure sale or property disposition sale since the beginning of the program. Loss rates were adjusted downward for mortgages with lower probability of default on the assumption that loss rates should be based on currently available information. If a mortgage were to default despite its low probability of doing so, it follows from that analysis that it would be in better financial condition than mortgages with high probabilities of default, and so, other things being equal, would be worth more at foreclosure sale or property disposition sale. Loss estimates are repeated each year. An improvement or worsening of any hospital's condition would be taken into account in the following year's analysis. FHA assumed that each year's loss estimate should be based on what is known at the time that it is made.

FHA did not consider potential sales prices or alternative uses for individual hospitals for hospitals with high probabilities of default. Doing so might lower loss estimates because the bulk of FHA's insured hospitals are located in New York where real estate values are high. However, such a method would be too onerous given that real estate values are invariably hypothetical in the absence of actual sales.

"Overall, FHA's exclusion of health care market trends in its methodology may have understated or overstated the loan loss reserve estimate depending on the impact that the specific market trend has on program hospitals."

FHA's methodology focused upon the current financial condition and trends in the financial condition of individual hospitals. Insofar as individual hospitals are being favorably or unfavorably affected by health care market trends, it should be reflected in the hospitals' financial statements. Major policy changes in Medicare and Medicaid funding may be implemented over the next seven years. As these policy changes are authorized and implemented, they will be taken into account in the preparation of future hospital loan loss reserve analyses.

On the basis of this review of GAO comment's, FHA concludes that it employed a sound methodology based on financial analysis of individual mortgages to estimate its hospital loan loss reserve. Its estimate is based on known rather than hypothetical data, and so constitutes the best estimate that can be made on the basis of currently available data. The estimate will be revised as new data become available.

As GAO itself reports, "... authoritative accounting guidance does not provide sufficiently detailed direction for establishing loan reserves." FHA is committed to a continuing process of improving its loan loss reserve estimate methodologies. To do so, it will take into account feedback regarding the previous year's analysis, actual experience, and current interagency efforts at standardization of loan loss reserve methodology that include the GAO, OMB, the Treasury Department, and HUD among other agencies.

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