tax-exempt bank loans still an option for providers

Banks are continuing to invest in tax-exempt debt for various reasons, including availability of capital, reduced market risk, insufficient credit ratings for other investment options, and a desire to deliver good customer service.

For the past two years, commercial banks have been a significant source of tax-exempt financing for healthcare organizations. Driven by an expanded definition of bank-qualified debt provided in the American Recovery and Reinvestment Act of 2009, commercial banks issued approximately $70 billion in direct, tax-exempt loans in 2009 and 2010, according to The Bond Buyer (see, for example, Temple-West, P., “Bill Would Raise Small-Issuer Limit for Bank-Qualified Debt,” May 19, 2011). And although this expanded definition no longer exists, commercial banks continue lending to not-for-profit and publicly owned hospitals and health systems by directly purchasing tax-exempt debt (with fixed or variable interest rates).

The American Recovery and Reinvestment Act of 2009 made temporary but important changes to federal law that expanded the capability of banks to purchase tax-exempt debt in 2009 and 2010. The public policy goal was to encourage bank financing of new construction projects in the public and not-for-profit sectors that would increase jobs and stimulate a struggling U.S. economy. The act modified the bank-qualified tax-exempt debt issue exception to allow $30 million in bank qualified debt to be issued for each borrower (such as a not-for-profit hospital or health system), rather than for each issuing municipality or authority. This debt could be used either to refund prior debt or to finance new capital projects.

The legislation also permitted banks to deduct 80 percent of the cost of buying and carrying tax-exempt debt, so long as their total holdings of such securities did not exceed 2 percent of their assets. These so-called “2 percent de minimis debt” issues had no dollar limit, but could be used only for new capital projects (refunding of prior debt issues was not permitted). These changes more than doubled bank purchases of tax-exempt debt in 2009 and 2010. In 2009, banks purchased $33.1 billion in tax-exempt debt, and in 2010, $36.7 billion, according to The Bond Buyer.
These temporary debt provisions expired on Dec. 31, 2010. Nonetheless—and somewhat surprisingly—many banks have continued to actively purchase “non-bank-qualified” tax-exempt debt issued on behalf of healthcare organizations.

Healthcare organizations should carefully evaluate the pricing of tax-exempt bank loans and their structure and security requirements.

The Trend Toward Tax-Exempt Bank Loans

Although each individual bank has its own reasons for continued investment in tax-exempt debt, the following seem to be common themes in our discussions with many bankers.

Available capital. Currently, banks have capital to lend, and investment-grade rated (“BBB” or better) hospitals and health systems are creditworthy lending opportunities. In today’s weak economy, demand for bank lending in the private for-profit sector continues to be slow, and many organizations with debt needs are lower-rated credits. Investment in BBB and better-rated healthcare credits is attractive to many banks because the demand is present and the creditworthiness of these organizations is generally acceptable.

Market risk reduction. For years, banks have issued letters and lines of credit in support of their qualified healthcare clients’ tax-exempt variable rate demand bond issues (demand bonds). The majority of demand bonds are purchased by tax-exempt money market funds. During the financial market crisis in 2008, many bank letters and lines of credit were drawn on to purchase demand bonds tendered by money market funds as investors redeemed their shares. These draws forced many banks to purchase large amounts of tendered bonds at tremendous expense while sharply increasing their healthcare clients’ cost of borrowing. Consequently, banks prefer direct purchase of tax-exempt debt to reduce their “contingent liquidity risk” created by letters and lines of credit for demand bonds.

Credit ratings. Many banks interested in extending credit to not-for-profit healthcare organizations no longer have sufficient long- and/or short-term debt ratings to adequately support demand bonds in the market. Money market funds, the largest purchaser of demand bonds, will usually not invest in a demand bond if the supporting bank’s long-term debt rating is below a grade of “A” and/or its short-term (liquidity) rating is less than “P1.” However, banks with insufficient ratings can still participate in the tax-exempt financing market by buying tax-exempt debt issued by their healthcare clients.

Low capital costs. Although the bank’s cost of carry is no longer deductible, the cost of carrying these securities remains extremely low. Interest rates on bank-purchased tax-exempt debt are still higher than most banks’ cost of carrying this debt. Currently, the banks’ benchmark borrowing rate (the federal funds rate) is just 0.25 percent. Additionally, many banks rely on customer deposits to fund loans that can have a funding cost of zero. As a result, banks still see a profit when lending money at “tax-exempt” interest rates to their clients.

Customer service. Direct debt purchases are an attractive alternative for banks’ healthcare clients compared with other types of tax-exempt debt offerings. A public issuance of debt is time consuming and expensive when compared with debt placed directly with a bank. When it comes to demand bonds, the banks’ healthcare clients recognize the reduced risks of non-bank-qualified debt, such as reduced credit risk, put risk, and basis risk. Many banks view purchasing tax-exempt debt as a vital service for their customers.

Future availability of liquidity (Basel III). Healthcare borrowers may be more reluctant to purchase or renew bank letters of credit in the future because of an impending bank industry regulation known as Basel III. Basel III is an international banking accord with rules that are set to take effect in January 2015 and that will be enforced in the United States by the Federal Reserve Bank. Under Basel III, banks must set aside high-quality reserves, such as cash or U.S. Treasury securities, for 100 percent of their guarantee obligations,
such as letters of credit for tax-exempt debt issues. Banks are currently required to reserve much less for these same guarantees (typically, 10 percent of their guarantee obligations). The higher bank reserve requirements are expected to reduce the availability of bank letters of credit and raise their annual costs significantly. By purchasing tax-exempt debt rather than issuing supporting letters and lines of credit, banks are limiting their exposure and their clients’ exposure to the potential negative effects of Basel III.

**Important Considerations**
Healthcare organizations should keep three important considerations in mind when evaluating the potential for tax-exempt bank financing.

**Pricing.** Theoretically, pricing of a non-bank-qualified loan is relatively straightforward. The bank offers a loan at an interest rate that incorporates the tax-exempt status of the interest income while covering its cost of capital and compensating itself for the risk it is undertaking to extend credit to a borrower. The risk compensation portion of the interest rate varies with the creditworthiness of the borrower and the length of time the loan is scheduled to remain outstanding (typically referred to as the “credit spread”).

With bank-qualified debt, in addition to the tax-exempt interest component, 80 percent of the cost of capital is allowable as an expense deduction. The combination of the deduction and the exemption enables banks to price the capital cost component of the interest rate at aggressive levels. Although the credit spread component is subject to individual banking analysis, in general, the overall interest rate on bank-qualified debt is competitive when compared with public debt issuance levels. In many (if not most) instances, the pricing is more aggressive than for public debt issuance levels when the demand bond risk factors (such as put risk, credit risk, and basis risk), bond remarketing fees, and issuance costs are incorporated into the comparison.

The cost of capital for non-bank-qualified debt is much more dynamic in today’s marketplace. Not only is the bank’s cost of capital no longer deductible as an expense, but also the exempt income portion may be considered an unknown because the profitability of many banks is at risk (what good is tax-exempt income if there is no income?). Many banks also will reduce their interest rate in return for a client’s deposit accounts or purchase of other bank services, adding to the factors that affect how a bank will price the debt. As a result, pricing varies significantly from bank to bank for non-bank-qualified tax-exempt debt.

For example, on a variable rate bank-qualified loan, one often sees a pricing formula with a capital cost component equal to 67 percent of one month London Interbank Offered Rate (LIBOR) plus the credit spread. For non-bank-qualified debt, the percentage can vary from the typical 67 percent of one month LIBOR. And in the case of one bank, the credit spread will vary over time with changes in one month LIBOR. Although each bank may have its own approach to pricing

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**Tax-Exempt Healthcare Financing by Banks: A Short History**

Before January 1986, commercial banks were major purchasers of tax-exempt debt. However, when the Tax Reform Act of 1986 became effective on Jan. 1 of that year, the legislation denied banks the ability to deduct the carrying cost of tax-exempt debt (the interest expense incurred to purchase or carry an inventory of securities). For banks, the change had the effect of eliminating much of the benefit of owning tax-exempt debt.

In the years that followed, banks stopped buying tax-exempt debt—with one exception. To encourage lending to small municipalities and eligible not-for-profit organizations (like hospitals) for capital projects in rural areas, the legislation provided an exception permitting banks to deduct 80 percent of the carrying cost of “bank-qualified” tax-exempt debt issues. To be considered bank-qualified, the debt must be issued by a state, county, municipality, or public authority that issues no more than $10 million in tax-exempt debt during any calendar year.

The tax incentive motivated banks to purchase smaller tax-exempt issues. In 2008, for example, banks purchased bank-qualified debt totaling $15.3 billion, according to The Bond Buyer.
based on a different capital cost, non-bank-qualified debt continues to be a viable, competitive alternative to public debt, especially considering the reduced levels of risk and lower issuance costs.

**Structure.** Like other long-term tax-exempt healthcare revenue bonds, bank-bought debt generally amortizes over long-term periods (20 to 30 years or possibly longer). However, the bank purchaser will require the right to demand that the borrower purchase the debt after a shorter period—usually in five, seven, or 10 years. At the end of the agreed-upon time period, the bank can accelerate principal or extend the financing to a new “put date” up to and including the maturity date of the debt. On the put date, the borrower can remarket the debt to another bank or different type of investor or refund the debt with a different bond offering if the initial bank purchaser does not extend.

Bank-bought tax-exempt debt bearing interest at a variable rate is usually prepayable without penalty. Fixed rate debt is prepayable either with a “make whole” provision at any time (similar to the structure present on taxable corporate bonds) or noncallable for a certain period of time with a “call premium” after the initial noncall period. Under the “make whole” prepayment scenario, the borrower has the right to make a lump sum payment to redeem the debt derived from a formula based on the net present value of interest payments that will not be paid because of the call.

Banks can provide a draw-down feature for the debt proceeds so that a healthcare borrower can obtain the borrowed funds from the bank as needed. This feature not only is convenient, but also can save a significant amount of money, because the borrower does not have to reinvest the construction funds in short-term low yielding investments during the construction period (and also avoids capitalizing a portion of interest payments on the debt during the construction period). Given today’s unusually low reinvestment rates, the savings are usually quite significant.

**Security requirements.** Even though most bank-bought debt will be on “parity” with the borrower’s other long-term debt (and thus will share in the security interest in hospital revenues and any other pledged property), a bank will require a few of its own financial covenants and different events of default and default remedies compared with a traditional fixed-rate debt issue sold to the investing public. In some instances, these default events and remedies can negatively affect bond ratings, and their potential impact should be considered. Any additional covenants will be similar in scope and level to the additional covenants found in the same bank’s letters of credit and standby bond purchase agreements.

Many banks also require healthcare borrowers to purchase noncredit banking services immediately or in the future. This new business requirement can make the financing more complicated, but the healthcare organization often concludes, as a result, that it should purchase all or a portion of its noncredit banking services from a bank that “lends its balance sheet” in support.

**An Option Worth Considering**

Seeing the $30 million bank-qualified and 2 percent de minimis exceptions eliminated was disappointing, but not-for-profit healthcare organizations should not dismiss banks as a source of tax-exempt financing. Non-bank-qualified debt is available at competitive interest rates, particularly when risk exposure and issuance costs are taken into account. Not-for-profit healthcare organizations should carefully consider the pros and cons of non-bank-qualified debt.

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