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(Volume 1 of 5)

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SAVING MEDICARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

September 22, 1995

Serial 104–55

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SAVING MEDICARE

FRIDAY, SEPTEMBER 22, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
September 14, 1995
FC-9

CONTACT: (202) 225-1721

Archer Announces Hearing on Saving Medicare

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on "Saving Medicare." **The hearing will take place Thursday, September 21, 1995, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.** The Committee will receive testimony from invited witnesses only.

BACKGROUND:

According to the Board of Trustees of the Federal Hospital Insurance Trust Fund, which includes three Clinton Administration cabinet secretaries, Medicare Part A next year begins spending out more than it takes in for the first time in the program's 30-year history. By the year 2002, the Trust Fund will be bankrupt.

If the program is insolvent, the Treasury cannot issue checks to pay hospital bills. If nothing is done, the health care of millions of current beneficiaries and millions more nearing retirement who have paid into the system all their working lives will be threatened. Bankrupting Medicare is unacceptable public policy.

"As we move forward with our plan to save Medicare from bankruptcy," Archer said, "I look forward to the nineteenth hearing that this Committee will have held over the past seven months on the issue of saving Medicare. It is vital that we proceed with preserving, protecting, and saving this important program."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, September 26, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

*****

NOTICE -- CHANGE IN SCHED'JLE

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
September 20, 1995
No. FC-9-Revised

CONTACT: (202) 225-1721

Schedule Change for Full Committee Hearing on Saving Medicare

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the full Committee hearing on "Saving Medicare," originally scheduled on Thursday, September 21, 1995, has been **rescheduled for Friday, September 22, 1995, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building**.

All other details for the hearing remain the same. (See full Committee advisory No. FC-9, dated September 14, 1995.)

******

Chairman ARCHER. We will begin just as soon as our guests and staff take seats.

Prior to the discussion and the hearing today, let me recite the Rules of the Committee and the House so there will be no misunderstanding for the rest of the hearing session. Under the Rules of the House and the Rules of the Committee, no demonstrations are permitted at hearings. The Chair will evenhandedly invoke the rule.

We are commencing this hearing today in an orderly fashion and it will continue to proceed through the day in an orderly fashion according to the Rules of the House and the Rules of the Committee.

In April this year, the board of trustees for Medicare reported that the trust fund that supports our Nation's Medicare Program would go broke in the year 2002. The underlying actuarial projection on which that report was based said that it could happen before 2002. The trustees, three of whom are Clinton administration Cabinet secretaries, reported that for the first time in the history of Medicare, the part A trust fund would spend more than it takes in beginning in 1996.

The report concluded that in just 7 years, the fund would be completely bankrupt. The fund has no ability to borrow under the law, and these hearings mark another important milestone in the efforts of this Congress to do two things: First, to keep our word because we said that we would save Medicare from bankruptcy, and we have offered a plan that does, indeed, save it. The plan is, yes, bold, innovative and, most importantly, it protects Medicare for today's retirees and it preserves it for the next generation of seniors.

Second, conventional wisdom said it was political suicide to touch Medicare. It has been called the third rail of American politics, touch it and you will die, but leadership requires us to challenge conventional wisdom, to rise above politics and to do what is right.

A long-term problem for the Congress should not be simply one that lasts between now and the next election and proposing we sweep it under the rug until after the next election. That will not be the hallmark of this Congress. At all of our townhall meetings, senior citizens have told us that they agree Medicare needs to be reformed if it is to survive. For too long, politicians in Washington hid from the real problems that our Nation faces. Our failure to face the bankruptcy problems presented by explosive entitlement spending has threatened the very solvency of these programs that we deeply cherish, not to mention the solvency of our Nation itself. So it is with Medicare.

The Medicare Trust Fund has been faced with insolvency before. Due to its unsustainable spending growth, it has teetered on the brink of bankruptcy. The solutions offered by the previous Congress were to raise taxes and to mandate fixes that save politicians through their next elections but they did little to save Medicare. Previous Congresses used up all the quick fixes.

Because of changing demographics, the crisis is out of hand. To protect and preserve Medicare, major reform is necessary. Republicans believe that the American people asked us to become the majority party to stop the quick fixes and they directed us to address the fundamental problems. That is why the solutions we offer will

save the trust fund for up to 12 years beyond the year 2002 and get us to the eve of the baby boomer retirement period.

Today's hearing is on saving Medicare. The Republicans have offered a plan and I have been informed that Ways and Means Democrats will also offer an alternative plan. The Republican plan has been developed as a result of 17 previous hearings on Medicare, 16 in Subcommittee, and one in the Full Committee. During this time, we took more than 2,500 pages of testimony from over 230 diverse witnesses chosen by both parties. This is the stack of testimony that has been heard by this Committee throughout all of those hearings. We have before us today a number of distinguished guests who will testify on saving Medicare, and I say, Sam, as we did throughout the previous 17 hearings, we have accommodated your requests and all the witnesses you requested today will appear before us.

But before we begin, I have one final message. These issues are truly difficult. They are important and they often become emotional. I would like to remind you, no one party or person holds a monopoly for compassion or dedication to the elderly. When it comes to saving Medicare from bankruptcy, it is easier to demagog and scare people than it is to move forward with meaningful solutions.

I know that both the majority and the minority care deeply about compassion and the elderly. In fact, our compassion has grown so large that it has driven Medicare to the brink of bankruptcy. We are on the verge of compassioning Medicare to death.

It is interesting to note that the growth of Medicare this year is anticipated to be more than three times the rate of inflation. We must find a plan that continues the growth of Medicare above the rate of inflation but not over three times the rate of inflation each year for the next 7 years, and our plan provides for an increase in Medicare spending, while saving, that is almost twice the rate of inflation over the next 7 years.

When the issues are important, they are not easy. That is why in this new day and age of the American government, it is important to keep our word and face our problems head on. The Republican plan to save Medicare empowers seniors with the ability to choose the health plan they like best and it breaks the government's monopoly over health care for seniors. It is exciting, bold, and it preserves, protects, and strengthens Medicare.

I look forward to hearing about the Democrat plan, and I now yield to the Ranking Democrat on the Committee, Mr. Gibbons, for an opening statement.

Let me say, Sam, before you begin your statement that every Member will be, without objection, permitted to enter a statement in writing in the record.

[The opening statements of Mr. Coyne and Mr. Neal follow:]

William J. Coyne

OPENING STATEMENT
CONGRESSMAN WILLIAM J. COYNE
SEPTEMBER 21, 1995

Yesterday, I received an outline of the Republican Medicare Preservation Act. While this document contains some details, it does not clearly describe how Republicans will reduce Medicare payments by $270 billion over seven years. It is difficult to draw thoughtful conclusions or develop informed opinions from the information provided in this document.

I strongly oppose cutting Medicare by $270 billion over seven years. I understand that we need to address the long-term solvency of the Medicare Part A hospital trust fund. However, it appears that this Republican solution does not deal properly with balancing Medicare Part A. Rather, this plan seems to jeopardize the security that Medicare has provided to beneficiaries for the past thirty years. I am particularly concerned because I represent one of the largest elderly populations in any Congressional district in the country.

It is not clear to me that beneficiaries will be protected from absorbing a good portion of the $270 billion in Medicare cuts. For example, if the Part B premium is held at 31% of the program's expenditures, beneficiaries will see their monthly Social Security check reduced by $93.00 per month -- that's $30.00 more a month than current law.

It also appears that beneficiaries will continue to pay more than 50% of the accepted Medicare rate for outpatient copayments. Present law is flawed and needs to be corrected -- particularly because patients are increasingly receiving care in this setting. If this plan was truly about Medicare reform, there would be a provision that would guarantee that patients pay a 20% copayment for services received in the outpatient setting.

Also, I am concerned about the impact that this proposal will have on providers -- and specifically, teaching hospitals. Teaching hospitals have the responsibilities of clinical education, biomedical research and highly specialized patient care. Additionally, they provide quality health care to distressed inner city populations. Should their payments be radically modified, workers will lose jobs, quality of patient care will be threatened, clinical research will be compromised, and Medicare beneficiaries could possibly face a disruption in the services they receive.

Mr. Chairman, from what I can glean from this document, it seems that no one benefits from the Medicare Preservation Act. I ask that we construct a bipartisan reform plan for Medicare that protects and improves patient care, limits seniors' out-of-pocket costs, and addresses the long term solvency of the Medicare Part A trust fund.

RICHARD E. NEAL
SECOND DISTRICT, MASSACHUSETTS
WHIP AT-LARGE

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON TRADE
SUBCOMMITTEE ON SOCIAL SECURITY

Congress of the United States
house of Representatives
Washington, DC 20515

September 22, 1995

Ways and Means Medicare Hearing
Congressman Richard E. Neal
Opening Statement

Good morning. This is an momentous day for all of us who serve on this prestigious committee. As we hear today's witnesses testify about their opinions of the Republican's Medicare plan, we should keep in mind the significance of the decisions we make in this room and how our deliberations here in Washington, D.C. affect the very security, health, and quality of life for America's families - especially our nation's senior citizens.

Since its creation thirty years ago, the Medicare program has become an integral part of the lives of America's senior citizens. Senior citizens need Medicare. It is not a luxury - an expendable social policy as many Republicans might lead you to believe. Instead, Medicare is the very reason why today's seniors are living longer than they did thirty years ago, why seniors can now afford to keep their family homes as they grow older, and why today's seniors are protected from falling into severe poverty in their most vulnerable years.

But Medicare is important in many other ways as well. My state of Massachusetts is home to many of the finest health care institutions and teaching hospitals in the world. Massachusetts' hospitals and academic health centers produce physicians and health care providers who continue on in their careers to serve the health care needs of the nation, and in many cases, the world. The Medicare program has been an integral ingredient in funding this quality and expensive education.

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I realize the complexities surrounding graduate medical education and the Medicare program, but I warn this committee today that the impact of any changes that we make affecting the education of our future physicians and health care providers won't be felt for many years to come. The Republican plan addresses the unique needs of teaching hospitals by creating a GME Trust Fund, but mind you, this plan we have before us today includes no specifics or funding levels for this fund. We need to give very careful consideration to the issue of medical education. The quality and future of health care delivery in America is at stake.

Jobs are also at stake. A recent study, which analyzed the impact of the Republicans Medicare and Medicaid cuts on employment in Massachusetts, found that more than 71,000 health sector jobs in Massachusetts alone are at risk if these cuts are allowed to pass. The layoffs and unemployment numbers associated with these cuts are huge, and would have a disproportionate effect on women and minorities. Slashing the Medicare program by $270 billion is an employment issue. The jobs that will be lost because of these cuts are good, well-paying jobs. And don't let the Republicans fool you. Once these jobs are gone, they are never going to come back.

$270 billion in cuts to the Medicare program is excessive. The summary of the Republican plan that we received yesterday glosses over the fact that this is by far the largest cut to Medicare since the program's creation. If the Republicans are confident that these Medicare cuts are as worthy as they say, then unveil the real details of the plan, let's debate these details, and let's have more than one day of hearings in this committee.

Creating good public policy takes time and careful consideration, and good public policy should be this committee's goal. Medicare serves more than 37 million seniors. Our focus in this committee should be to restore Medicare's solvency, and to ensure the program's integrity for the future. Our debate should be thoughtful and thorough. Today's hearing should be the beginning of a series of hearings so that we can truly comprehend the impact of the decisions we make. We owe this courtesy and our consideration to America's seniors.

I look forward to hearing the testimony of this morning's witnesses. Thank you Mr. Chairman.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. This pile of material that you see next to me presented here is absolutely useless. Let me repeat that. This pile of material that you see here is absolutely useless. No demonstrations, please.

Chairman ARCHER. We ask our guests, under the Rules of the Committee, the Rules of the House, not to have any audible or visible demonstrations. It is our desire to permit everyone in the public that wants to attend these meetings to sit in these meetings, but we must invoke the Rules of the Committee and the Rules of the House.

The gentleman may proceed.

Mr. GIBBONS. I will tell you why—it is absolutely useless. There is no bill before us. All the words that are stacked up here were uttered before there was any legislative piece or plan put together. They were commenting about dreams. They were commenting about aspirations. They were commenting about goals, but we are here talking about facts. So I would ask the staff to please remove these words.

Well, if the staff won't remove them, I guess I will have to remove them.

I appreciate the chance to speak, Mr. Thomas, and I am glad that our Republican colleagues have regained their sense of fair play which was so absent last Wednesday when I tried to speak. I have been in Congress a long time, Mr. Chairman, and I can only shake my head in dismay that you have allowed a process like this one to be employed in a matter that involves the life, and yes, perhaps even the death of so many of our seniors and disabled people.

Here we are just 5 days away from the time that we will start marking up a piece of legislation, one that we haven't seen and perhaps will not see until we get to mark it up, and let me tell all of you who are not familiar with what you will probably see, it will be at least that thick, perhaps thicker, and it will be full of all kinds of law. We are not talking about thoughts and desires. We are talking about law. That is what the Ways and Means Committee does, we make law.

We have no cost estimate as of this date, and perhaps we won't have an estimate until too late, as to what all of this will do in terms of money: Money from the pockets of the elderly, money from the pockets of the taxpayer, or revenue to this government. We do know that the goal is to take $270 billion out of Medicare and devote most of that to a tax cut for the very wealthy. That much we know. That much is incontrovertible.

Yesterday in this room, and what a desecration to this room that has seen so many historic events, we saw another press release paraded out as a piece of legislation. All of us in this room know you can't mark up a press release for a piece of legislation. You have got to have a bill. How can anyone be expected to analyze or to score a press release in place of legislation? It is just impossible.

Are you, Mr. Chairman, or any of you, prepared to tell me that these witnesses that we will be listening to today can talk about the plan or talk about the legislative language that you will hopefully be laying on the table finally 5 days from now? No. The witnesses that we are going to have today, with no disrespect to them

individually, will just be able to comment very generally about their hopes and aspirations, but that is not what we are here for. We are here to talk about making law, not just commenting on some vague press release document that was presented in this room yesterday.

Critical material, critical details, as deviling as they are, are important to what we have to do, and we have none. We simply have a press release document. Can you or anybody tell me or tell this Committee what the so-called "fail-safe provision" will do to doctors, to patients, to hospitals if all of your grand dreams, radical dreams go astray? Can you assure us that your limit on payments, which are far below anything that anybody has ever dreamed of, will not encourage doctors to turn Medicare patients away from their offices, or the hospitals to put up signs, "No more Medicare patients"? Of course, we will hear a great deal about goals and about lofty ideals, but we won't hear anything about what this Committee must eventually do, adopt or reject a piece of legislation.

I don't believe that Medicare needs saving, but I believe it needs saving from the Republicans. When we created this program, and I was here in Congress at that time, we set it up to be a pay-as-you-go program. We thought it would be wise to keep 1 year ahead of the bills that came in. Somewhere, without congressional direction or congressional authorization, you have changed this program to one that must be 10 years of reserves to pay bills. There were good reasons why we didn't set this program up to be in that kind of shape and we have never changed the design of this program.

The rhetoric on all of this amazes me. Almost one-half of the cuts which you have proposed in the Medicare Program come from part B, and you know as well as I know that none of these part B run programs go to fund any of the Medicare Trust Fund that you claim is in such dire straits. All of these funds will go into the general revenue fund to help pay for that rather enormous, and I think obscene, tax cut that you voted out earlier this year.

If you are so worried about the Medicare Trust Funds, why don't you take some $90 billion from that tax cut and put it back into the Medicare Trust Fund that you pretend to worry so much about? That will solve the so-called "insolvency" of the fund, the fund that was never designed to have more than 1 year's reserve in it, for 10 or 12 years in advance. That is the right approach if we have any crisis, and I think the crisis has been largely PR generated.

I will conclude, Mr. Chairman, with deep regret. This is a historic Committee, this is a historic responsibility, this is a historic program. The debate that we are entering into, we need a piece of legislation in front of us from which we can work, not just more PR documents. Ultimately, the American people will understand. Mr. Gingrich has been very successful in keeping from the American people those important parts of this program, and still it will be too late for the American people to understand what is about to happen to them.

Mr. Chairman, I would like to yield to Mr. McDermott who—Mr. McDermott.

Chairman ARCHER. Mr. Gibbons, the minority has been permitted, as the majority, to have one opening statement. If Mr.

McDermott wishes to enter a statement in writing in the record, he may do so. Without objection, that privilege is given to every Member of the Committee.

Mr. RANGEL. Parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. Mr. Rangel.

Mr. RANGEL. Mr. Chairman, exactly what bill are we marking up? Could you give me the number of that particular piece of legislation?

Chairman ARCHER. The gentleman's inquiry is—as to what bill we are marking up, and the response is, we are not marking up any bill. We are having hearings on how we should save Medicare, and the witnesses are going to be asked and invited to, in the first panel, take the witness table.

Mr. RANGEL. Correction, Mr. Chairman. Parliamentary inquiry as to the bill for which this hearing is being held, the number of the bill——

Chairman ARCHER. This hearing is being held on the subject of saving Medicare, as is generally true of most hearings before this Committee where a specific bill in statutory language is not before the Committee. The Chair does not wish to belabor for a long period of time procedural comments. The facts are, however, that this Committee over the years has operated over and over and over again with hearings where statutory language of a bill is not before the Committee.

In addition, to set the facts straight, when, in the last Congress, this Committee considered a very voluminous comprehensive proposal by the Clinton administration on health care, it was not in statutory language, even when presented to the Committee at the time of markup. So there is a great smokescreen that is being put before the public today to cover up the fact that this is simply an effort to delay the Congress from acting on saving Medicare.

Mr. STARK. If the Chairman would yield, I take exception to him. It was in parliamentary language before the Subcommittee markup.

Mr. RANGEL. Parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. It was not—it is a fact that what the Committee considered last year in Full Committee was not in statutory language, but we are not going to continue debate on that.

Mr. STARK. That is not true.

Mr. RANGEL. Further parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. The gentleman will state his parliamentary inquiry.

Mr. RANGEL. Mr. Chairman, will there be any witnesses from the administration to testify on this document that is before us today?

Chairman ARCHER. The Chair will say to the gentleman that every witness that was suggested by the minority has been accommodated and will be before the Committee today.

Mr. RANGEL. My last parliamentary inquiry, Mr. Chairman, is, do we have any reports from the Congressional Budget Office as to the cost of whatever is in this press release?

Chairman ARCHER. Is the gentleman suggesting that before we have a hearing, we must have a CBO analysis of the cost of printing a notice of the meeting?

Mr. RANGEL. Mr. Chairman, I am not.

Chairman ARCHER. That is highly, that is highly out of order.

Mr. RANGEL. I am fully aware, Mr. Chairman, that the Chair can proceed with any legislation you have votes for. I was merely asking whether or not there was any budget analysis before the Committee that we could use as we listen to the witnesses discuss your release.

Chairman ARCHER. The witnesses are not just going to discuss what you call a release, which is a notice of a meeting which is customary for the Committee. What they are going to talk about are methods to save Medicare, and the Democratic witnesses I am sure will put forward their suggestions as to how we should save Medicare, the ones that have been invited, at the suggestion of the minority, and that is the purpose of these hearings.

Mr. RANGEL. Thank you, Mr. Chairman.

Mr. MATSUI. May I ask a parliamentary inquiry, Mr. Chairman. My understanding was that originally we were going to have a hearing before the markup on a specific piece of legislation, or at least an outline of a piece of legislation. When the bill is finally completed, will we have the opportunity for a hearing in view of the fact that this is a general discussion on how to save Medicare?

Chairman ARCHER. We will continue to run this Committee in the way that it has been run in the past, according to the customary standards, I will say to the gentleman. Now, if the minority wishes to be dilatory and attempt to delay these hearings——

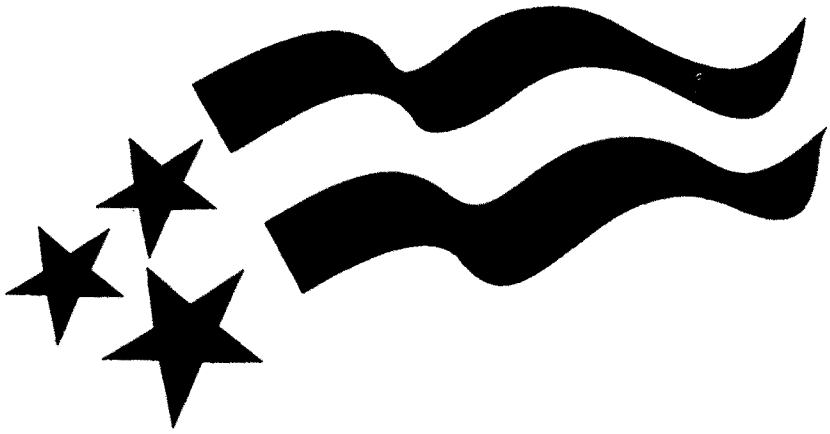
Mr. MATSUI. Not at all, Mr. Chairman.

Chairman ARCHER [continuing]. Then of course you can continue to ask parliamentary inquiry questions, you can continue to ask all the questions that you wish, but I think it is in the interest of this country that we proceed with the business of the country, as the notice for this meeting said when it was sent out.

The first witness before the Committee today is Mr. King.

Mr. King, if you will identify yourself for the record, we will be pleased to have your testimony. We would ask you, if you would, to limit your verbal comments to 5 minutes, but you may insert your complete written testimony for the record.

[A summary of the 1995 annual reports from the Social Security and Medicare Board of Trustees follows:]



Status of the Social Security and Medicare Programs

A SUMMARY OF THE
1995 ANNUAL REPORTS

Washington, D.C.
April 1995

Social Security and Medicare Boards of Trustees

A MESSAGE TO THE PUBLIC:

The Boards of Trustees are pleased to present this Summary of the 1995 Annual Reports of the Social Security and Medicare trust funds. The reports include extensive information about these important social programs and, we believe, fully and fairly present their current and projected financial condition.

In particular, we encourage current and future beneficiaries to consider what the reports mean for them as individual citizens. Based on the Trustees' best estimates, the reports show:

* *The Federal Old-Age and Survivors Insurance (OASI) Trust Fund, which pays retirement benefits, will be able to pay benefits for about 36 years. The Board believes that the long-range deficit of the OASI Trust Fund should be addressed. The Advisory Council on Social Security is currently studying the financing of the program and is expected to recommend later this year ways to achieve long-range actuarial balance in the OASI fund.*

* *The Federal Disability Insurance (DI) Trust Fund, which pays disability benefits, is projected to be exhausted in 2016. The Board believes that the long-range deficit of the DI Trust Fund should be addressed. The Advisory Council on Social Security currently also is studying the financing of the DI program and is expected to recommend later this year ways to achieve long-range actuarial balance in the DI fund.*

* *The Federal Hospital Insurance (HI) Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range. The Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.*

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* *The Federal Supplementary Medical Insurance (SMI) Trust Fund, which pays doctor bills and other outpatient expenses, is financed on a year-by-year basis and, on this limited basis, is adequately financed. The Trustees urge the Congress to take additional actions designed to more effectively control SMI costs through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.*

Public discussion regarding the financing of the Social Security and Medicare programs needs to take account of the critical differences among the four individual trust funds and, at the same time, the important relationships among them. A key aspect of thinking about future financing of these trust funds is recognition that under current law the timing and magnitude of the financing problems facing the programs are distinctly different. This summary presents the current and projected financial status of these four programs both separately and together in the hope that it will enhance public understanding of them and encourage necessary program reforms.

By the Trustees:

Robert E. Rubin,
Secretary of the Treasury,
and Managing Trustee

Robert B. Reich,
Secretary of Labor,
and Trustee

Donna E. Shalala,
Secretary of Health
and Human Services,
and Trustee

Shirley S. Chater,
Commissioner of
Social Security,
and Trustee

Stanford G. Ross,
Trustee

David M. Walker,
Trustee

STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS

A SUMMARY OF THE 1995 ANNUAL REPORTS

What Are the Trust Funds? Four trust funds have been established by law to finance the Social Security and Medicare programs. For Social Security, the Federal Old-Age and Survivors Insurance (OASI) Trust Fund pays retirement and survivors benefits; and the Federal Disability Insurance (DI) Trust Fund pays benefits after a worker becomes disabled. When both OASI and DI are considered together, they are called the OASDI program.

For Medicare, the Federal Hospital Insurance (HI) Trust Fund pays for hospital and related care (often called "Part A") for people over 65 and workers who are disabled. The Federal Supplementary Medical Insurance (SMI) Trust Fund pays for physician and outpatient services (often called "Part B") for people over 65 and workers who are disabled. These two trust funds are not usually considered together, because they are funded differently.

Who Are the Boards of Trustees? Six people serve on the Social Security and Medicare Boards of Trustees: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and two members appointed by the President and confirmed by the Senate to represent the public. The Boards are required by law to report to the Congress each year on the operation of the trust funds during the preceding years and the projected financial status for future years.

What Were the Trust Fund Results in 1994? Assets of all trust funds except SMI increased during calendar year 1994. At the end of the year, 42.9 million people were receiving OASDI benefits and about 37 million people were covered under Medicare. Trust fund operations, in billions of dollars, were (totals may not add due to rounding):

	OASI	DI	OASDI	HI	SMI
Assets (end of 1993)	369.3	9.0	378.3	127.8	24.1
Income during 1994	328.3	52.8	381.1	109.6	55.6
Outgo during 1994	284.1	38.9	323.0	104.5	60.3
Net Increase	44.1	14.0	58.1	5.0	-4.7
Assets (end of 1994)	413.5	22.9	436.4	132.8	19.4

What Were the Administrative Expenses in 1994? The cost of administrative expenses in fiscal year 1994, shown as a percentage of benefit payments from each trust fund, was:

	OASI	DI	OASDI	HI	SMI
Administrative Expenses (FY1994):	0.7	2.8	0.9	1.2	3.0

How Are the Trust Funds Financed? Most OASDI and HI revenue consists of taxes on earnings that are paid by employees, their employers, and the self-employed. The tax rates are set by law and, for OASDI, apply to earnings that do not exceed a certain annual amount. This amount, called the earnings base, rises as average wages increase. In 1995, the earnings base for OASDI is $61,200. Beginning with 1994, HI taxes are paid on total earnings. The tax rates for employees and employers each under current law are:

Year	OASI	DI	OASDI	HI	Total
1990-93	5.60	0.60	6.20	1.45	7.65
1994-96	5.26	0.94	6.20	1.45	7.65
1997-99	5.35	0.85	6.20	1.45	7.65
2000 and later	5.30	0.90	6.20	1.45	7.65

People who are self-employed are charged the equivalent of the combined employer and employee shares, but only on 92.35 percent of net earnings, and may deduct one-half of the combined tax from income subject to Federal income tax.

All the trust funds receive income from interest earnings on trust fund assets and from miscellaneous sources. The OASI, DI and, beginning in 1994, HI Trust Funds also receive revenue from the taxation of Social Security benefits.

The SMI or Part B program is financed similarly to yearly renewable, term insurance. Participants pay premiums that in 1994 covered about 30 percent of the cost; the rest is paid for by the Federal Government from general revenues. The 1995 monthly premium is $46.10.

In all trust funds, assets that are not needed to pay current benefits or administrative expenses (the only purposes for which trust funds may be used) are invested in special issue U.S. Government securities

guaranteed as to both principal and interest and backed by the full faith and credit of the U.S. Government.

How Are Estimates of Trust Fund Balances Made? Short-range (10-year) estimates are reported for all funds, and, for the OASI, DI, and HI Trust Funds, long-range (75-year) estimates are reported. *Because the future cannot be predicted with certainty, three alternative sets of economic and demographic assumptions are used to show a range of possibilities.* Assumptions are made about economic growth, wage growth, inflation, unemployment, fertility, immigration, and mortality, as well as specific factors relating to disability, hospital, and medical services costs.

The intermediate assumptions (alternative II) reflect the Trustees' best estimate of what the future experience will be. The low cost alternative is more optimistic; the high cost alternative is more pessimistic; they show how the trust funds would operate if economic and demographic conditions are better or worse than the best estimate.

What Concepts Are Used to Describe the Trust Funds? The measures used to evaluate the financial status of the trust funds are based on several concepts. Some of the important concepts are:

- Taxable payroll is that portion of total wages and self-employment income that is covered and taxed under the OASDI and HI programs.

- The annual income rate is the income to the trust fund from taxes, expressed as a percentage of taxable payroll.

- The annual cost rate is the outgo from the trust fund, also expressed as a percentage of taxable payroll.

- The percentage of taxable payroll is used to measure income rates and cost rates for the OASDI and HI programs. Measuring the funds' income and outgo over long periods of time by describing what portion of taxable earnings they represent is more meaningful than using dollar amounts, because the value of a dollar changes over time.

- The annual balance is the difference between the income rate and the cost rate. If the balance is negative, the trust fund has a deficit for that year.

- The actuarial balance is the difference between the annual income rates and cost rates summarized over a period of up to 75 years, and adjusted to include the beginning fund balance and the cost of ending the projection period with a trust fund balance equal to the next year's outgo; if the balance is negative, the fund has an actuarial deficit.

- The trust fund ratio is the amount in the trust fund at the beginning of a year divided by the outgo for the year. It shows what percentage of the year's expenditures the trust fund has on hand. For example, a trust fund ratio of 100 percent would reflect an amount equal to 1 year of projected expenditures.

- The year of exhaustion is the first year a trust fund is projected to run out of funds and to be unable to pay benefits on time and in full.

How Is the Financial Status of the Trust Funds Tested? Several tests, based on the intermediate assumptions, are used to review the financial status of the trust funds.

- The short-range test is met if, throughout the next 10 years, the trust fund ratio is at least 100 percent. Or, if the trust fund ratio is initially less, but reaches 100 percent within the first 5 years and stays at or above 100 percent, and there is enough income to pay benefits on time every month during the 10 years, the short-range test is met.

- The long-range test is met if a fund has an actuarial deficit of no more than 5 percent of the cost rate over the 75 years, and if the actuarial deficit for any period ending with 10th year or later is less than a graduated amount of 5 percent. If the long-range test is met, the trust fund is in close actuarial balance.

- The test for SMI actuarial soundness is met for any time period if the trust fund assets and projected income are enough to cover the projected outgo and there are enough assets to cover costs incurred but not yet paid. The adequacy of the SMI Trust Fund is measured only for years for which both the beneficiary premiums and the general revenue contributions have been set.

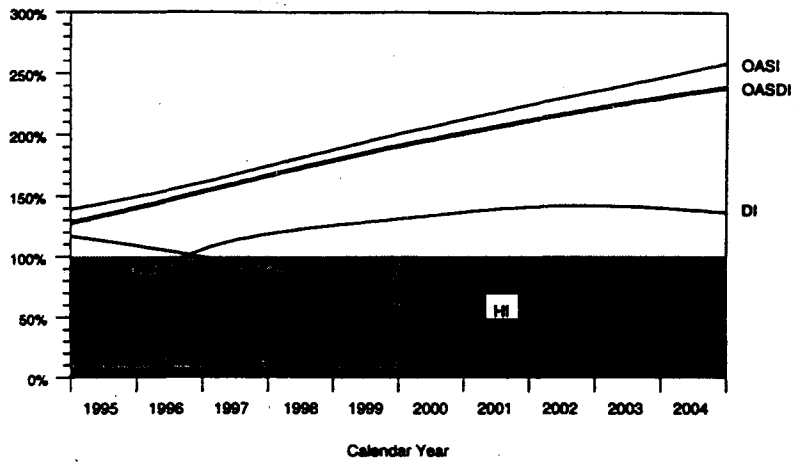
What Is the Future Outlook for the Trust Funds?

The status of the OASI, DI, and HI Trust Funds is shown together on charts because they are financed the same way. SMI is financed differently, so its status is described separately.

o THE SHORT-RANGE OUTLOOK (1995-2004)

Chart A shows the projected trust fund ratio under the intermediate (alternative II) assumptions for OASI, DI, and HI separately. It also shows the ratio for the combined OASI and DI trust funds.

Chart A.—Trust Fund Ratio and Short-Range Test of Financial Adequacy



The OASI trust fund ratio line is over the 100 percent level at the beginning of the 10-year period and stays over that level through the year 2004. Therefore, the OASI Trust Fund meets the short-range test of financial adequacy.

The trust fund ratio line for DI starts at 54 percent, reaches 100 percent in 1996, and remains above that level throughout the remainder of the period. Thus, the DI fund also meets the short-range test.

The trust fund ratio line for the combined OASI and DI Trust Funds begins above the 100 percent level and stays over that level throughout the 10-year period; therefore, the OASDI program, as a whole, meets the short-range test of financial adequacy.

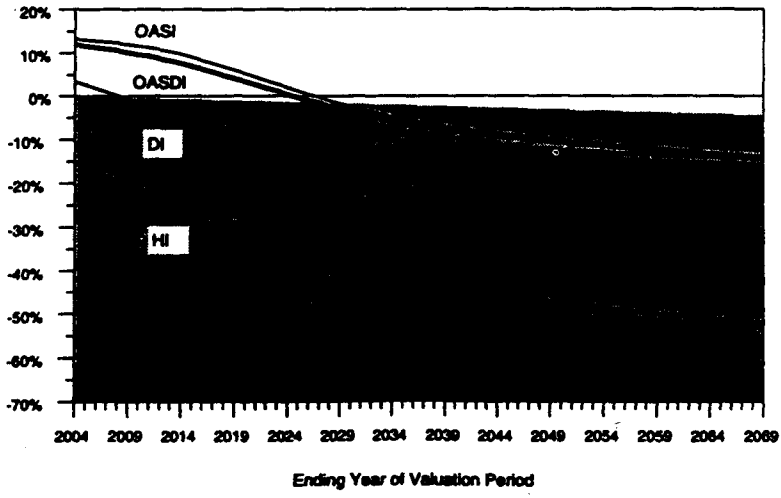
Although the trust fund ratio line for HI is over the 100 percent level at the beginning of the 10-year period, it falls below that level in 1995. As a result, it does not meet the short-range test. Under the intermediate assumptions, the projected year of exhaustion for the HI Trust Fund is 2002; under more adverse conditions, as in the high cost alternative, it could be as soon as 2001.

The financing for the SMI Trust Fund has been set through 1995, and the projected operations of the trust fund meet the test of SMI actuarial soundness.

o THE LONG-RANGE OUTLOOK (1995-2069)

Chart B shows the actuarial balance, as a percentage of the cost rate, for OASI, DI, and HI separately under the intermediate (alternative II) assumptions, as well as for the combined OASI and DI Trust Funds.

Chart B.--Actuarial Balance as a Percentage of Summarized Cost Rate and Long-Range Test of Close Actuarial Balance



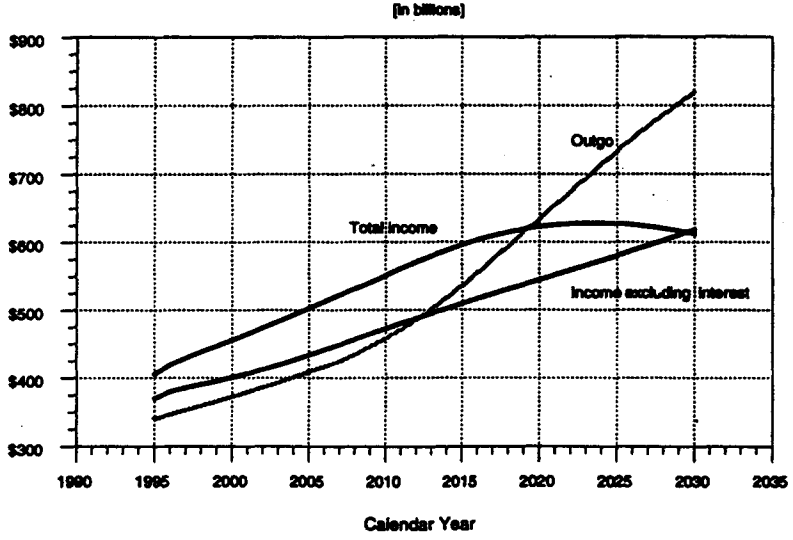
For a trust fund to meet the long-range test of close actuarial balance, the actuarial balance line for that trust fund must stay above the shaded area throughout the 75-year period. The triangle above the shaded area but below the zero percent level shows the range of allowable deficits a fund can have and still be in close actuarial balance.

None of the three trust funds is in close actuarial balance over the next 75 years. However, the chart shows that the actuarial balance line for OASI, as well as for the OASDI program as a whole, stays above the shaded area for many years to come.

The actuarial balance line for DI alone starts above the shaded area but declines below it in about 2009 and continues to decline significantly for about an additional 25 years before the rate of decline slows. The actuarial balance line for HI starts well into the shaded area and declines continuously over the long-range period.

The year of exhaustion for the OASI Trust Fund under intermediate assumptions does not occur until 2031--36 years from now. For the combined OASI and DI Trust Funds, the year of exhaustion would be 2030--in 35 years. However, combined OASDI expenditures will exceed current tax income beginning in 2013. Thus, as Chart C illustrates, current tax income plus a portion of annual interest income will be needed to meet expenditures for years 2013 through 2019, and current tax income, annual interest income, plus a portion of the principal balance in the trust funds will be needed for years 2020-2029.

Chart C.--Estimated OASDI Income and Outgo in Constant Dollars



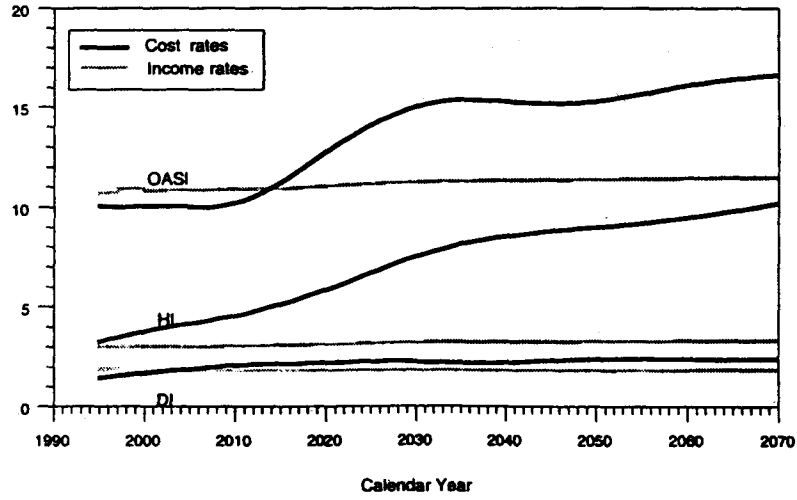
Another useful way to view the outlook of the trust funds is to compare the income rate for each fund with its estimated cost rate. Over the 75-year period the income rates for OASI, DI and HI remain relatively constant, while the cost rates generally rise steadily.

For OASI, the income rate is projected to remain significantly above the cost rate for a number of years. Starting in about 2010, however, the OASI cost rate will begin increasing rapidly as the baby boom generation begins to reach retirement age. In 2014 and later, the cost rate for OASI will exceed the income rate.

The income rate for DI is slightly higher than the cost rate only until 2004, after which the annual shortfall of tax income is projected to increase slowly over the entire 75-year period.

The cost rate for HI is higher than the income rate, by rapidly growing amounts, throughout the 75-year projection period -- by the end of the period, the HI cost rate is projected to be roughly 3 times greater than the HI income rate. Chart D shows the virtually level income rates and rising cost rates for OASI, DI and HI.

Chart D.—Income Rates and Cost Rates



An additional way to view the outlook for the trust funds as projected under current law is in relation to the economy as a whole. The table below shows the estimated outgo from each trust fund as a percentage

of estimated gross domestic product (GDP) from 1995 to 2069. OASI and DI increase at about the same rate over this period, while the increases in HI and particularly in SMI are much greater.

OASI, DI, HI AND SMI OUTGO AS A PERCENT OF GROSS DOMESTIC PRODUCT

Trust Fund	1995	2020	2045	2069	% Increase
OASI	4.18	5.05	5.72	5.98	43
DI	0.60	0.87	0.87	0.86	44
HI	1.62	2.83	4.05	4.46	175
SMI	0.99	3.18	4.01	4.29	333

CONCLUSIONS

The status of the Social Security and Medicare programs can be summarized by looking at the results of the tests used to evaluate the financial status of the trust funds and at the number of years before each trust fund is expected to be exhausted under the intermediate assumptions:

FINANCIAL STATUS OF THE OASI, DI, HI, AND SMI PROGRAMS

Trust Fund	Is the Test of Financial Adequacy Met: Short-Range 10 Years	Long-Range 75 Years	Years Until Exhaustion
OASI	Yes	No	36
DI	Yes	No	21
OASDI (combined)	Yes	No	35
HI	No	No	7

The SMI Trust Fund meets its test of actuarial soundness.

Based on the Trustees best estimates (alternative II):

The OASI Trust Fund is expected to be able to pay benefits for about the next 36 years while the DI fund will be exhausted in about 21 years. In view of the lack of actuarial balance in the OASDI program over the next 75 years, the Board believes that the long-range deficits in the OASI and DI programs should be addressed. Accordingly, the Board recommended last year that the 1995 Advisory Council on Social Security conduct an extensive review of Social Security financing issues and develop recommendations for achieving long-range financial stability for the OASDI program. The Council will submit its report later this year.

The HI Trust Fund will be able to pay benefits for only about 7 years and is severely out of actuarial balance over the next 75 years. Because of the magnitude of the projected actuarial deficit in the HI program and the high probability that the HI Trust Fund will be exhausted just after the turn of the century, the Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of broad-based health care reform.

The SMI program, though actuarially sound, has experienced rapid growth in costs: program outlays have increased 53 percent in the last 5 years and grew 19 percent faster than the economy as a whole. Because this growth shows little sign of abating, the Trustees urge the Congress to take additional actions designed to more effectively control SMI costs through specific program legislation as part of broad-based health care reform.

A MESSAGE FROM THE PUBLIC TRUSTEES:

This is the fifth set of Trust Fund Reports on which we have reported as Public Trustees. It is also, under the terms of our appointment, our last report, and we use this occasion to summarize our views on some major aspects of the Social Security and Medicare programs. As representatives of the public, our efforts have been to assure the American public of the integrity of the process and the credibility of the information in these reports. We feel privileged and honored to have been able to take part in this important exercise in public accountability, and want to provide our best advice on directions for change of these important programs in the years ahead.

The Need For Action

During the past 5 years there has been a trend of deterioration in the long-range financial condition of the Social Security and Medicare programs and an acceleration in the projected dates of exhaustion in the related trust funds. To some extent, this has been predictable because when doing annual 75-year projections, an additional deficit year in the 2060s is being added with each new projection. But to some extent, the increasingly adverse projections have come from unforeseen events and from the absence of prompt action in response to clear warnings that changes are necessary. These adverse trends can be expected to continue and indicate the possibility of a future retirement crisis as the U.S. population begins to age rapidly. We urge that concerted action be taken promptly to address the critical public policy issues raised by the financing projections for these programs.

Projections As A Guide To Action

We believe it is important for the public and the Congress to understand more about what the projections in the Trust Fund Reports really mean and how they are intended to be used. These projections represent the best estimates the Trustees can make based on the best available information and methodologies. We have, during our period of service, attempted to test assumptions, question methodologies and work with the Offices of the Actuary of SSA and HCFA and others in and out of government to seek improvements in the projections. We have also stimulated thought through a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. Action should be taken to continue and extend survey and

other data development efforts and to improve modeling capability regarding the income and health circumstances of future retirees. Such information is critical to the legislative and regulatory activity that will be required for both public and private income security and health care programs in future years.

However, with even the best data and models, projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. They are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. They are not helpful if ignored, or if used improperly, or if distorted. We hope that more policymakers will come to grips with the strengths and limitations of projections such as those in the Trust Fund Reports and how those projections can be used most productively.

Social Security Program

The Old-Age and Survivors Insurance Trust Fund shows a deficit of 1.87 percent of payroll in the long run. It is by far the best financed of the trust funds, and we believe strongly that the OASI program can and should be maintained over the long term. Yet even here reforms should be undertaken sooner rather than later to ease the transition to providing financial stability in the next century. We note the recent work of the Bipartisan Entitlement Commission and the current work of the Advisory Council on Social Security regarding the long-term financing of the OASI program. We hope that this kind of work will continue and that this problem will be addressed in a timely fashion.

The condition of the Disability Insurance Trust Fund is more troublesome. While the Congress acted this past year to restore its short-term financial balance, this necessary action should be viewed as only providing time and opportunity to design and implement substantive reforms that can lead to long-term financial stability. The research undertaken at the request of the Board of Trustees, and particularly of the Public Trustees, shows that there are serious design and administrative problems with the DI program. Changes in our society, the workforce and our economy suggest that adjustments in the program are needed to control long-range program costs. Also, incentives should be changed and the disability decision process improved in the interests of beneficiaries and taxpayers. We hope that this research will be completed promptly, fully presented to Congress and the public, and that the Congress will take action over the next few years to make this program financially stable over the long term.

Medicare Program

The most critical issues, however, relate to the Medicare program. Both the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

The Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A and Part B today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We feel strongly that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with OASDI, and making both Social Security and Medicare financially sound in the long term.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be urgently addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall.

Institutional Considerations

We have as Public Trustees tried over the past 5 years to provide continuity and improve the institutional framework surrounding the Social Security and Medicare programs. We have bridged two Administrations (one Republican and one Democratic), two Advisory Councils (one appointed by a Republican Administration and one by a Democratic Administration), and many changes in the ex officio Trustees. We have consulted with each of the Advisory Councils, as well as the working group of the prior Public Trustees, the Bipartisan Entitlement Commission, the Notch Commission and many other government entities. We have testified before both the House Ways and Means Committee and the Senate Finance Committee and held regular briefings for Congressional staff on the Trust Fund Reports. We know that with the advent of the new Social Security Administration as an independent agency, many of the institutional relationships in these areas will change. We hope that the Public Trustees in the future will continue to make a contribution towards a coherent institutional structure that serves the interests of the public.

Finally, we note that although the statute provides that one of the Public Trustees must be from each of the major political parties, we have operated as independent professionals on a nonpartisan basis. Every statement we have made over 5 years has been joint and consensual, and without partisan content or political dissonance. We believe these programs are too important to be politicized and urge that a highly professional, nonpartisan approach continue to be followed in future reports to the Congress and the public.

Stanford G. Ross
Trustee

David M. Walker
Trustee

Chairman ARCHER. Mr. King.

STATEMENT OF ROLAND E. "GUY" KING, CONSULTING ACTUARY, ERNST & YOUNG; AND FORMER CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION

Mr. KING. Thank you, Mr. Chairman, and Members of the Committee. I am an independent consulting actuary and I was chief actuary for the Health Care Financing Administration for 16 years up until 1994.

Before I start, let me commend the Members of this Committee for taking on headlong this very difficult issue. There has been much discussion recently of the need to reform the Medicare Program to bring the cost increases under control. And in particular, there has been discussion of the need to bring the cost of the Hospital Insurance Program under control in order to prevent the imminent depletion of the trust fund.

As you pointed out, Mr. Chairman, the 1995 trustees' report indicates that the fund will be depleted by the year 2002 if nothing is done. Both the congressional leadership and the President seem to agree on the need to reform the Hospital Insurance Program, but they have differing views on the magnitude of the savings needed during the next 7 years.

The House leadership has set a goal of $270 billion in Medicare, savings in Medicare during the next 7 years. And I estimate that the portion of the savings that would accrue to the Hospital Insurance Program would range from $145 to $167 billion based on the Hospital Insurance Program's share of total Medicare outlays.

The President has proposed net savings of $124 billion in Medicare with $89 billion in savings in the Hospital Insurance Program.

I have prepared projections on the impact of these proposals on the Hospital Insurance Trust Fund under the same assumptions used by the——

Chairman ARCHER. Mr. King, would you suspend for just a moment for a quick clarification.

Are the numbers that you just mentioned both by CBO scoring or is one by OMB and one by CBO?

Mr. KING. No. They are both by—the proposed savings I presume would be by CBO's scoring——

Chairman ARCHER. $89 billion in the Clinton proposal is scored by CBO?

Mr. KING. No. That was in the——

Chairman ARCHER. It was OMB, was it not?

Mr. KING. Yes.

Chairman ARCHER. And the $145 billion for the Republican proposal in the House was scored by CBO; is that correct?

Mr. KING. No, that wasn't scored by CBO. That was my best estimate of what the Hospital Insurance Program——

Chairman ARCHER. Is that based on the assumptions that were underlying the OMB analysis of the President's proposal or the assumptions underlying the CBO proposal?

Mr. KING. It is based on the goal of $270 billion in total savings in Medicare and then it brackets——

Chairman ARCHER. I didn't intend to belabor this and we can get into it in the question period.

Mr. GIBBONS. Let me belabor it a little, if you will, Mr. Chairman.

Mr. King, have you read the Republican bill to do what we are talking about here today?

Mr. KING. No, sir.

Mr. GIBBONS. Nobody has. And you haven't either?

Thank you.

Chairman ARCHER. Mr. King, you may continue, and we will restore the time that I took out of your 5 minutes by my inquiry.

Mr. KING. All of the projections of these proposals on the HI Trust Fund I have made under the assumptions used by the hospital insurance board of trustees, so all of my projections are under the trustees' report assumptions.

Tables 1 and 2, which the Committee Members have, display the estimated future operations of the Hospital Insurance Trust Fund for HI reform proposals that would save $145 billion and $167 billion, respectively, during the 7-year period from 1996 to 2002. The $145 billion level of savings would delay the depletion of the trust fund by 9 years, to 2011, which is the year when the post-World War II baby boom officially first begins to retire. The $167 billion level of savings would delay the depletion of the Hospital Insurance Trust Fund by 12 years, to 2014.

Table 3 displays the estimated future operations of the Hospital Insurance Trust Fund for the President's proposal for HI savings of $89 billion. The President's proposals would delay the depletion of the Hospital Insurance Trust Fund by 4 years, to 2006.

These projections show that the President's $89 billion package of savings does not satisfy the board of trustees' test for financial adequacy in the short-range projection period. The test that is described in the 1995 trustees' report requires that the trust fund ratio, which is the ratio of assets to expenditures, either be at least 100 percent throughout the 10-year period or reach a level of 100 percent within 5 years and then remain at or above the 100-percent level throughout the remainder of the 10-year period. Approximately $160 billion in HI savings would be required during this 7-year period to meet the trustees' short-range test.

I would like to point out two important caveats that arise from my not knowing the precise composition of any of the reform package. First, I am obviously assuming that the savings targets of all the proposals would, in fact, be achieved, even though it is not possible at this time to evaluate the effectiveness of the reforms that are contemplated.

Second, I assume only the savings initiatives that are taking effect during the 7-year period, 1996 through 2002. That is, I don't assume any reductions in the rate of growth in outlays beyond the period 2002. The savings initiatives that were implemented in the 7-year period ending in 2002——

Chairman ARCHER. Again, would you suspend for a moment?

The Chair has been advised that there is a group in the Committee room that has made inquiry as to what they need to do in order to be arrested. They have asked the police what sort of activity they would have to enter into in order to be arrested. I assume that they are commencing that activity now. It is in violation of the

Committee's rules and the Committee will be in order. This is a warning.

The Committee will stand in recess until the police can restore order.

[Recess.]

Chairman ARCHER. The Committee will come to order.

We must request that our guests take seats and that there be no audible conversation so that the Committee can continue with its business.

Mr. King, my apologies. Your testimony seems to have been disrupted a couple of times and you certainly will have adequate time to complete your verbal statement, and you may proceed.

Mr. KING. Thank you, Mr. Chairman.

As I was saying, I have not assumed any reductions in the rate of growth in outlays after 2002. The savings initiatives that take place in 1996 through 2002 would, of course, continue to produce savings in years after 2002. The program growth after 2002 is projected to be the same as under current law. Without knowing the precise nature of the reform package, it is not possible to determine the impact, if any, on growth rates after 2002.

This concludes my formal remarks, Mr. Chairman. I will be happy to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY BY
Guy King
Consulting Actuary and
Former Chief Actuary for HCFA
before the
House Committee on Ways and Means
September 21, 1995

Mr. Chairman, my name is Guy King. I am an independent Consulting Actuary. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994.

There has been much discussion recently of the need to reform the Medicare program to bring cost increases under control. In particular, there has been discussion of the need to bring the cost of the Hospital Insurance (HI) program under control in order to prevent imminent depletion of the Hospital Insurance Trust Fund. The 1995 HI Trustees Report indicates that the HI Trust Fund will be depleted by 2002 if nothing is done. Both the Congressional leadership and President seem to agree on the need to reform the HI program, but have differing views on the magnitude of the savings needed during the next seven years. The House leadership has set a goal of saving $270 billion in Medicare during the next seven years. I estimate that the HI portion of the savings would range from $145 to $167 billion. The President has proposed net savings of $124 billion in Medicare, with $89 billion in savings in the HI program.

I have prepared projections of the impact of these proposals on the HI Trust Fund under the assumptions used by the HI Board of Trustees.

Tables 1 and 2 display the estimated future operations of the HI Trust Fund for HI reform proposals that would save $145 billion and $167 billion, respectively during the seven year period 1996-2002. The $145 billion level of savings would delay the depletion of the trust fund by 9 years, to 2011, when the Post World War II Baby Boom begins to retire. The $167 billion level of savings would delay the depletion date for the HI Trust Fund by 12 years, to 2014.

Table 3 displays the estimated future operations of the HI Trust Fund for the President's proposal for HI savings of $89 billion. The President's proposals would delay the depletion date for the HI Trust Fund by 4 years, to 2006.

These projections show that the President's $89 billion package of savings does not satisfy the Board of Trustees' test for financial adequacy in the short-range projection period. This test requires that the trust fund ratio (ratio of assets to expenditures) either (a) be at least 100 percent throughout the ten year projection period, or (b) reach a level of 100 percent within five years and remain at or above 100 percent throughout the remainder of the ten year period. Approximately $160 billion in HI savings during the next seven years would be needed to meet the Trustees' short range test.

I would like to point out two caveats to these projections that arise from not knowing the precise composition of the reform packages. First, I obviously assumed that the savings targets would, in fact, be achieved, even though it is not possible to know at this time how effective the reforms will be. Second, I assume only the savings initiatives taking effect during the period 1996-2002. That is, no reductions in the rate of growth in outlays are assumed to take effect after 2002. The savings initiatives taking place in 1996-2002 would, of course, continue to produce savings in years after 2002, but program growth after 2002 is projected to be the same as under current law. Without knowing the precise nature of the reform package, it is not possible to determine the impact, if any, on rates of growth after 2002.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

TABLE 1: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE $145 BILLION OVER 7 YEARS

		Expenses			Income			Net increase in fund	Ending fund balance
Calendar year	Beginning fund balance	Benefits payments	Admin. expenses	Total expenses	Payroll taxes,etc	Interest income	Total income		
Actual data									
1994	127.8	103.2	1.3	$ 104.5	98.9	10.7	109.6	$ 5.0	$ 132.8
Projection									
1995	$ 132.8	112.7	1.2	$ 113.9	106.3	11.1	117.4	$ 3.5	$ 136.3
1996	$ 136.3	118.3	1.3	$ 119.6	113.0	11.3	124.3	$ 4.7	$ 141.0
1997	$ 141.0	124.3	1.3	$ 125.6	118.6	11.5	130.1	$ 4.5	$ 145.5
1998	$ 145.5	130.5	1.4	$ 131.9	124.7	11.9	136.6	$ 4.7	$ 150.2
1999	$ 150.2	137.0	1.5	$ 138.5	130.8	12.1	142.9	$ 4.4	$ 154.7
2000	$ 154.7	143.8	1.6	$ 145.5	137.7	12.4	150.1	$ 4.6	$ 159.3
2001	$ 159.3	151.0	1.7	$ 152.7	145.4	12.8	158.2	$ 5.4	$ 164.7
2002	$ 164.7	158.6	1.8	$ 160.4	153.6	14.4	168.0	$ 7.6	$ 172.3
2003	$ 172.3	171.1	1.9	$ 173.0	162.5	10.9	173.4	$ 0.3	$ 172.6
2004	$ 172.6	184.6	2.0	$ 186.6	172.1	10.6	182.7	$ (3.9)	$ 168.7
2005	$ 168.7	198.6	2.1	$ 200.7	182.5	10.2	192.7	$ (8.0)	$ 160.7
2006	$ 160.7	214.1	2.3	$ 216.3	193.6	9.6	203.2	$ (13.2)	$ 147.5
2007	$ 147.5	230.5	2.4	$ 232.9	205.3	8.7	214.0	$ (18.9)	$ 128.5
2008	$ 128.5	248.6	2.6	$ 251.2	217.7	7.3	225.0	$ (26.2)	$ 102.4
2009	$ 102.4	268.0	2.7	$ 270.7	230.9	5.4	236.3	$ (34.5)	$ 67.9
2010	$ 67.9	288.1	2.9	$ 291.0	244.9	2.9	247.8	$ (43.2)	$ 24.7
2011	$ 24.7	311.2	3.0	$ 314.3	259.9	-0.2	259.7	$ (54.5)	$ (29.9)
2012	$ (29.9)	336.2	3.2	$ 339.4	275.7	-3.9	271.8	$ (67.6)	$ (97.5)
2013	$ (97.5)	363.5	3.4	$ 366.9	292.4	-8.6	283.8	$ (83.1)	$ (180.6)
2014	$ (180.6)	393.0	3.6	$ 396.6	310.2	-14.3	295.9	$ (100.7)	$ (281.3)
2015	$ (281.3)	424.8	3.8	$ 428.7	329.0	-21.2	307.8	$ (120.9)	$ (402.2)
2016	$ (402.2)	459.0	4.1	$ 463.1	347.3	-29.4	317.9	$ (145.2)	$ (547.4)
2017	$ (547.4)	495.9	4.3	$ 500.2	366.6	-39.3	327.3	$ (172.9)	$ (720.3)
2018	$ (720.3)	535.7	4.6	$ 540.3	387.0	-51.0	336.0	$ (204.3)	$ (924.6)
2019	$ (924.6)	578.8	4.9	$ 583.7	408.5	-64.8	343.7	$ (239.9)	$ (1,164.6)
2020	$ (1,164.6)	625.3	5.1	$ 630.5	431.3	-80.9	350.4	$ (280.1)	$ (1,444.7)

TABLE 2: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE $167 BILLION OVER 7 YEARS

		Expenses			Income			Net increase in fund	Ending fund balance
Calendar year	Beginning fund balance	Benefit payments	Admin. expenses	Total expenses	Payroll taxes,etc	Interest income	Total income		
Actual data									
1994	$ 127.8	$ 103.2	1.3	$ 104.5	98.9	10.7	109.6	$ 5.0	$ 132.8
Projection									
1995	$ 132.8	112.7	1.2	$ 113.9	106.3	11.1	117.4	$ 3.5	$ 136.3
1996	$ 136.3	117.7	1.3	$ 119.0	113.0	11.3	124.3	$ 5.3	$ 141.6
1997	$ 141.6	122.9	1.3	$ 124.3	118.6	11.7	130.3	$ 6.0	$ 147.6
1998	$ 147.6	128.4	1.4	$ 129.8	124.7	12.2	136.9	$ 7.0	$ 154.6
1999	$ 154.6	134.1	1.5	$ 135.6	130.8	12.6	143.4	$ 7.8	$ 162.5
2000	$ 162.5	139.9	1.6	$ 141.5	137.7	13.2	150.9	$ 9.3	$ 171.8
2001	171.8	146.1	1.7	$ 147.8	145.4	14.0	159.4	$ 11.5	$ 183.3
2002	$ 183.3	152.6	1.8	$ 154.4	153.6	16.3	169.9	$ 15.4	$ 198.8
2003	$ 198.8	164.7	1.9	$ 166.6	162.5	12.8	175.3	$ 8.7	$ 207.5
2004	$ 207.5	177.7	2.0	$ 179.7	172.1	13.0	185.1	$ 5.5	$ 212.9
2005	$ 212.9	191.1	2.1	$ 193.3	182.5	13.3	195.8	$ 2.5	$ 215.4
2006	$ 215.4	206.0	2.3	$ 208.3	193.6	13.3	206.9	$ (1.4)	$ 214.1
2007	$ 214.1	221.9	2.4	$ 224.3	205.3	13.3	218.6	$ (5.7)	$ 208.4
2008	$ 208.4	239.3	2.6	$ 241.9	217.7	12.8	230.5	$ (11.3)	$ 197.1
2009	$ 197.1	258.0	2.7	$ 260.7	230.9	11.8	242.7	$ (17.9)	$ 179.2
2010	$ 179.2	277.3	2.9	$ 280.2	244.9	10.5	255.4	$ (24.8)	$ 154.4
2011	$ 154.4	299.5	3.0	$ 302.6	259.9	8.5	268.4	$ (34.2)	$ 120.2
2012	$ 120.2	323.5	3.2	$ 326.8	275.7	6.1	281.8	$ (45.0)	$ 75.2
2013	$ 75.2	349.8	3.4	$ 353.2	292.4	2.9	295.3	$ (58.0)	$ 17.2
2014	$ 17.2	378.2	3.6	$ 381.8	310.2	-1.2	309.0	$ (72.8)	$ (55.6)
2015	$ (55.6)	408.9	3.8	$ 412.7	329.0	-6.2	322.8	$ (90.0)	$ (145.5)
2016	$ (145.5)	441.8	4.1	$ 445.8	347.3	-12.5	334.8	$ (111.0)	$ (256.5)
2017	$ (256.5)	477.3	4.3	$ 481.6	366.6	-20.1	346.5	$ (135.1)	$ (391.6)
2018	$ (391.6)	515.6	4.6	$ 520.2	387.0	-29.3	357.7	$ (162.5)	$ (554.1)
2019	$ (554.1)	557.1	4.9	$ 561.9	408.5	-40.4	368.1	$ (193.8)	$ (747.9)
2020	$ (747.9)	601.8	5.1	$ 607.0	431.3	-53.5	377.8	$ (229.2)	$ (977.1)

TABLE 3: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE $89 BILLION OVER 7 YEARS

		Expenses			Income			Net increase in fund	Ending fund balance
Calendar year	Beginning fund balance	Benefits payments	Admin. expenses	Total expenses	Payroll taxes,etc	Interest income	Total income		
Actual data									
1994	127.8	103.2	1.3	$ 104.5	98.9	10.7	109.6	$ 5.0	$ 132.8
Projection									
1995	$ 132.8	112.7	1.2	$ 113.9	106.3	11.1	117.4	$ 3.5	$ 136.3
1996	$ 136.3	119.9	1.3	$ 121.2	113.0	11.2	124.2	$ 3.0	$ 139.3
1997	$ 139.3	127.6	1.3	$ 128.9	118.6	11.3	129.9	$ 0.9	$ 140.3
1998	$ 140.3	135.8	1.4	$ 137.2	124.7	11.3	136.0	$ (1.2)	$ 139.0
1999	$ 139.0	144.5	1.5	$ 146.0	130.8	10.9	141.7	$ (4.3)	$ 134.8
2000	$ 134.8	153.7	1.6	$ 155.3	137.7	10.3	148.0	$ (7.3)	$ 127.5
2001	$ 127.5	163.5	1.7	$ 165.2	145.4	9.6	155.0	$ (10.2)	$ 117.3
2002	$ 117.3	174.0	1.8	$ 175.8	153.6	9.5	163.1	$ (12.8)	$ 104.5
2003	$ 104.5	187.7	1.9	$ 189.6	162.5	5.9	168.4	$ (21.2)	$ 83.3
2004	$ 83.3	202.5	2.0	$ 204.5	172.1	4.3	176.4	$ (28.1)	$ 55.2
2005	$ 55.2	217.9	2.1	$ 220.0	182.5	2.3	184.8	$ (35.2)	$ 20.0
2006	$ 20.0	234.9	2.3	$ 237.1	193.6	-0.1	193.5	$ (43.6)	$ (23.7)
2007	$ (23.7)	252.9	2.4	$ 255.3	205.3	-3.2	202.1	$ (53.2)	$ (76.8)
2008	$ (76.8)	272.8	2.6	$ 275.3	217.7	-6.9	210.8	$ (64.6)	$ (141.4)
2009	$ (141.4)	294.1	2.7	$ 296.8	230.9	-11.3	219.6	$ (77.2)	$ (218.6)
2010	$ (218.6)	316.1	2.9	$ 319.0	244.9	-16.6	228.3	$ (90.7)	$ (309.3)
2011	$ (309.3)	341.5	3.0	$ 344.5	259.9	-22.5	237.4	$ (107.1)	$ (416.5)
2012	$ (416.5)	368.8	3.2	$ 372.1	275.7	-29.7	246.0	$ (126.1)	$ (542.5)
2013	$ (542.5)	398.8	3.4	$ 402.2	292.4	-38.2	254.2	$ (148.0)	$ (690.6)
2014	$ (690.6)	431.1	3.6	$ 434.8	310.2	-48.2	262.0	$ (172.7)	$ (863.3)
2015	$ (863.3)	466.1	3.8	$ 470.0	329.0	-59.8	269.2	$ (200.7)	$ (1,064.0)
2016	$ (1,064.0)	503.6	4.1	$ 507.7	347.3	-73.2	274.1	$ (233.6)	$ (1,297.6)
2017	$ (1,297.6)	544.1	4.3	$ 548.4	366.6	-88.9	277.7	$ (270.6)	$ (1,568.3)
2018	$ (1,568.3)	587.8	4.6	$ 592.4	387.0	-106.9	280.1	$ (312.3)	$ (1,880.6)
2019	$ (1,880.6)	635.0	4.9	$ 639.9	408.5	-127.8	280.7	$ (359.1)	$ (2,239.7)
2020	$ (2,239.7)	686.1	5.1	$ 691.2	431.3	-151.7	279.6	$ (411.6)	$ (2,651.3)

Chairman ARCHER. Thank you very much.

The Chair has just a brief question or two.

Since you are the former chief actuary of the Health Care Financing Administration, could you give the Committee the facts as to where the funds go that are saved by slowing the increased growth in Medicare, because the gentleman from Florida, to my left, commented in his opening statement, they all go into the general treasury in order to accommodate general tax reductions.

Can you, Mr. King, inform the Committee as to the facts of where the savings go by reducing the growth in Medicare?

Mr. KING. Yes, sir. The savings from reducing the rate of growth in the Hospital Insurance Trust Fund go back into the Hospital Insurance Trust Fund and earn interest that increases the reserves available for the payment of future benefits. They cannot, by statute, be used to go into general revenues.

Chairman ARCHER. Thank you very much.

Mr. Thomas may inquire.

Mr. THOMAS. Thank you, Mr. Chairman.

Mr. King, your career transcended political parties occupying the White House; is that correct?

Mr. KING. Yes, sir.

Mr. THOMAS. So as a career civil servant, your function as the head actuary was to be as accurate as possible in supplying data from a professional base. You were never a political appointee; is that correct?

Mr. KING. That is right.

Mr. THOMAS. And based upon your analysis of the numbers supplied to you, notwithstanding the difference of the base and the President's numbers obviously generated by the Office of Management and Budget, my understanding of what you told us was that the President's plan would keep the trust fund solvent to the year 2006; is that correct?

Mr. KING. That is right. The fund would be depleted in 2006 but it would not have adequate reserves as required by minimum financial requirements starting in the late nineties all the way to 2006.

Mr. THOMAS. So whose financial test does the President's plan not meet? Who determines that it is not adequate?

Mr. KING. It is the financial test that is described in the trustees' report and that means that the financial test is endorsed by the board of trustees.

Mr. THOMAS. The board of trustees then have said, according to the test they set up for financial soundness, that the President's plan is not financially sound. Who are the board of trustees?

Mr. KING. The ex-officio members of the board of trustees are the Secretary of Health and Human Services, the Secretary of the Treasury, the Secretary of Labor, and two public trustees, both of whom cannot be from the same political party.

Mr. THOMAS. So you have the public trustees not from the same party, the Commissioner of Social Security as a trustee, and three Cabinet secretaries who have been named to those Cabinet positions by the President of the United States and they say the President's plan is not sound; is that correct?

Mr. KING. They have not said that the President's plan is not sound.

Mr. THOMAS. The President's plan doesn't meet the criteria that the trustees have established which determines whether a plan is sound or not; is that correct?

Mr. KING. Yes, sir.

Mr. THOMAS. And on the other side of the coin, in your examining the structure that we have provided, would you say, then that the Republican plan meets those tests as determined by the President's appointed trustees?

Mr. KING. If the Republican plan were to achieve savings of approximately $160 billion over the next 7 years, it would achieve the financial requirements by the board of trustees.

Mr. THOMAS. Basically what you have done is created a target for us, and if we hit that target, we will then have achieved the criteria that the President's trustees said is appropriate?

Mr. KING. Yes, sir.

Mr. THOMAS. And based upon your analysis of the Democrats' plan, which they said they would have, or even the approximate numbers or the target of their plan, how does the Democrats' plan compare to what the President has offered? And of course when I say Democrats, I mean the Members of the Democrat party in the House led by Mr. Gephardt, or, for example, any plan offered by any Member on this Committee in conceptual form or otherwise.

Mr. KING. I haven't seen that plan. I haven't seen a description of the goals of the plan, but if I were given the goals of the plan, I would certainly be happy to offer projections on the impact on the HI Trust Fund.

Mr. THOMAS. So based upon the information and the tables you have in front of us, as a career civil servant and an actuary of HCFA, the Republican plan with its target figure will meet the criteria for soundness. The President's plan does not—and you await any kind of a plan that the Ways and Means Democrats might present to you—so you will do an analysis on that as well, is that where we are?

Mr. KING. Yes, sir.

Mr. THOMAS. I look forward to that third analysis.

Thank you very much, Mr. Chairman.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. Mr. King, can you point out to me any provision of the law that has ever directed you as an actuary to convert this program from a pay-as-you-go program to an actuarially funded program? Any provision of law?

Mr. KING. No, sir. The requirements of the board of trustees are precisely the requirements that you described earlier. They are setting up a criteria that requires the Hospital Insurance Trust Fund to retain a contingency reserve in the trust fund. It is still funded on a pay-as-you-go basis and it requires that it maintain a contingency reserve in that trust fund equal to the following year's outlay. So it is 1 year's worth of benefits, that is the minimum requirement to be retained in the trust fund.

Mr. GIBBONS. Thank you for reinforcing my recollection of this plan. This plan is now and always has been a pay-as-you-go program with a 1-year reserve, and now we have a 7-year reserve and

we are having a funeral? It sounds like we should be having a champagne party, we have 7 years of reserve.

I recognize that there are going to be problems with the baby boomers beginning to mature, but this program that has been outlined in releases to us, as I understand it, and correct me if I am wrong, Mr. King, does nothing about—directly about the baby boom population; is that right?

Mr. KING. It gets you to the baby boom population. It gets you to the point where the baby boom population is beginning to retire.

Mr. GIBBONS. But this plan, this press release that we have seen so far, does nothing about any problem that may arise in the baby boom generation; is that right?

Mr. KING. That is why I didn't make any projections beyond 2002 because I don't know what effect the plan might have beyond 2002.

Mr. GIBBONS. We have established from your testimony that this is a pay-as-you-go program that we were required to keep under law and that we have never changed here in the Congress, a 1-year reserve, and that we have that 1-year reserve and that the program is sound for 7 years out and that it does nothing about the problem of the baby boom generation.

Thank you, Mr. King.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Thank you, Mr. Chairman.

I am somewhat confused by Mr. Gibbons' statements about don't worry about it because as long as we are 1 year ahead of disaster, we are all right. That is like saying, Don't worry about jumping off the cliff because the fall isn't going to kill you, it is a sudden stop. That is amazing.

I would like to ask Mr. King, Do you know of any pension plans or anything in the private sector that only looks 1 year ahead, particularly when you see that there is a big balloon of employees that are coming out there that are going to be looking toward retirement?

Mr. KING. No, sir. In fact, that is why the board of trustees required us to make 75-year projections, because they felt that it was prudent to at least be able to look far enough ahead for the sake of generational equity to at least be able to look far enough ahead to see that the people who are paying into the program now could receive benefits under the program.

Mr. SHAW. Generational equity, you mean that the people that are going to be coming into the plan that are paying a lot of money into the plan and will pay actually more money into the plan by the time they retire than those of us who may be going into the plan a little earlier, you are saying that it would not be equitable or fair to them to have them pay into a plan that was going to be broke when they needed it; is that what you are saying?

Mr. KING. Yes, sir. I view the Hospital Insurance Program as a compact that the government forms between generations, and in return for paying for the benefits of the current generation the generation that is working now is promised this same level of benefits that the currently retired generation is promised.

Mr. SHAW. And the people who are in the plan now who plan to live for 7 years or longer, they would be out of luck if this Congress doesn't act; is that correct?

Mr. KING. That is right, sir.

Mr. SHAW. Now, the longer we wait to put the cure into the plan, aren't we looking at more severe consequences? In other words, if we didn't do something now, we would have to, in 4 or 5 years, we would have to change the plan in a dramatic way, which would be either a tremendous burden on the seniors that are in the plan or on the taxpayers whose payroll taxes would be increased at an astronomical level. Is that correct? Aren't those the only two choices that would be available to us if we don't do anything?

Mr. KING. That is correct. The longer you wait, the more difficult the issue becomes, and that is why the issue is so difficult now is because of the long time it has taken to attempt to do something about the problem.

Mr. SHAW. Mr. King, are you saying that if this Congress, when it was controlled by the Democrats, if they had done something several years ago, that the solution would have been even easier than it is today? Is that what you are saying?

Mr. KING. The earlier the action taken to address the problem, the more tractable the problem would be.

Mr. SHAW. I thank you.

You mentioned—in an offhand question that was presented by the Ranking Democrat Member, Mr. Gibbons, you said that you had not seen the bill. What did you base your actuary assumptions on?

Mr. KING. They were based on the assumption that since the Hospital Insurance Program constitutes about 60 percent of the Medicare Program, that roughly 60 percent of the savings would have to come from the Hospital Insurance Program, a little more, a little less. That is why I gave a range.

Mr. SHAW. And exactly what documents did you base your conclusions on?

Mr. KING. I based the projections for the congressional leadership on the goal that was pointed out in the press, the House leadership's goal of $270 billion in savings in Medicare over the next 7 years, and I based the $89 billion in savings from the President on a White House press release.

Mr. SHAW. Thank you. Thank you, Mr. King.

Yield back. Mr. Chairman.

Chairman ARCHER. Ms. Johnson.

Mr. Rangel.

Mr. RANGEL. Thank you.

Mr. King, thank you so much for your testimony. In following through with Mr. Shaw's question, did I understand you correctly in saying that the testimony you are giving this morning is not based on any legislation; is that correct?

Mr. KING. Yes.

Mr. RANGEL. You said in part it is based on reports that you read in the newspaper?

Mr. KING. Yes. The $270 billion goal is a goal that I read in the newspaper and was confirmed by staff.

Mr. RANGEL. And you also said that part of your testimony was based on the House leadership. Could you better describe what the House leadership told you? Did they give you a plan? Did they give you a document? What Mr. Shaw was asking was what document

are you basing your assumptions on? Do you have any document? Was a document given to you to study, to analyze, in order for you to testify, to give your assumptions?

Mr. KING. No. The projections were based on the Hospital Insurance Program's share of the $270 billion goal for Medicare savings.

Mr. RANGEL. But you had no materials given to you?

Mr. KING. No.

Mr. RANGEL. You have read nothing that has come from the House leadership to testify to this morning; is that correct?

Mr. KING. I don't have legislative language, that is correct.

Mr. RANGEL. I am not saying legislative language.

Are you familiar with a document that was distributed yesterday called the Medicare Preservation Act and in quotes called "A Better Medicare"? I am holding up this 60-page document. Are you able to see it from where you are sitting?

Mr. KING. Yes. I can't read it, of course, but I can see it.

Mr. RANGEL. Have you ever seen this document before?

Mr. KING. I haven't seen that document, no.

Mr. RANGEL. So the Republican leadership has given you nothing to read.

Mr. KING. That is right.

Mr. RANGEL. I have no further questions.

Chairman ARCHER. Mr. Bunning.

Mr. BUNNING. Pass.

Chairman ARCHER. Mr. Houghton.

Mr. HOUGHTON. Pass.

Chairman ARCHER. Mr. Herger.

Mr. HERGER. Just very briefly, Mr. King. I want to make sure I understand why you are here testifying and why we are having a hearing today.

Now, we heard a comment on the minority side just a few minutes ago that stated they didn't think Medicare needed to be saved. They feel that it was basically a partisan issue, that they felt that it needed to be saved from Republicans, that is close to a direct quote, and that the crisis was PR generated.

What is your comment on that? Is this the way you see this situation?

Mr. KING. I believe the report of the board of trustees, the 1995 report of the board of trustees, and previous reports of the board of trustees, show that this is a problem that is recognized both by the administration and by the Congress.

Mr. HERGER. Thank you very much. That is all I have.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I think, Mr. King, it is interesting that all of this testimony you gave us this morning shows that the Republican outline which you claim to be able to analyze without any numbers extends the date by 1 year if, in fact, you are correct. The problem seems to lie with the creators of this plan, however you may decide to interpret it.

It is obvious that the people trying to foist this scheme off on the public, first, don't understand the Medicare system. Second, they are rank amateurs at the business of drafting legislation, and in general are running a wish league operation with staff that largely

comes from lobbyists and the industry which is being rewarded in this piece of legislation. It wouldn't be so bad, if there wasn't a little humor in all this.

On page 18, they are going to encourage beneficiaries to report fraud and abuse. They say that Medicare provides little emphasis on educating beneficiaries, but obviously doesn't educate any Republicans, either.

If you look in the House Budget Committee report, on page 93, you will see Chairman Kasich says that there is a man in North Carolina who complains that the hospital billed his sister-in-law $49,435.67, and Mr. Kasich says that is a good reason to encourage beneficiaries to get into the act. But what Mr. Kasich and my Republican colleagues forgot, don't understand, or never took the trouble to learn is that Medicare didn't pay that. Medicare doesn't pay hospital bills.

We happened to call and check and we know that Medicare actually paid $19,000, $19,091.12 for a major surgical operation, and the difference between the charge that Mr. Kasich throws around so grandly and which these Republicans swallow without bothering to read the details is some $30,000.

I would hate to think that anybody on the other side of the aisle in this Committee would have to take a test and explain anything about this Medicare operation, because it is obvious from this silly outline that they don't know what they are talking about.

For many years, the Medicare plan was adjusted and improved every year on a bipartisan basis by people on both sides of the aisle who cared to improve the health care of seniors and devoted some conscientious effort to doing it. It is sad, as people have said, to see this charade being conducted, albeit under rather stern and strict rules.

I would like to further point out as a point of personal privilege that on March 23, the bill, H.R. 3600, was reported from Subcommittee. On April 15, 1994, it was drafted into legislative language by the legislative counsel, and on May 18, the Full Committee began markup and either the Chairman was misinformed or lied.

Thank you.

Chairman ARCHER. Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

Mr. King, I have to assume that you used something inflationary or inflation figures in your analysis for the future.

Mr. KING. Yes, sir.

Mr. HANCOCK. Did you analyze the difference between the amount that we are trying to control and the amount that has been proposed? Which one would be the most inflationary?

Mr. KING. I looked at the difference between the CBO baselines and the baseline projections in the trustees' report. What I found was that in terms of the rate of increase in costs of the Medicare Program between 1995 and 2002, the baselines were virtually identical. The difference in the projections lies in the fact that the CBO's estimates for 1995 are higher to begin with; and then they project essentially the same inflation assumptions off of a higher base, and that higher projection remains in the projections throughout the 7-year period.

The real difference in the baselines has to do with the higher estimates for 1995 and also the fact that CBO projects lower income growth in the latter years of the projection periods, and it makes the trust fund run out a little earlier. But the difference in the two baselines isn't significant enough to make a big difference in the projected year that the trust fund is projected to run out under current law. They are both projections; it is calendar year 2002.

Mr. HANCOCK. Thank you.

Chairman ARCHER. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. I note in your testimony, Mr. King, that you show the President's package, which has $89 billion of savings; you have testified that that does not satisfy the bipartisan board of trustees' test for financial adequacy in the short-range period.

Mr. KING. Yes, sir.

Mr. CAMP. Is that accurate? Was that $89 billion figure that you had based on any specific piece of statutory language that you received from the Clinton administration?

Mr. KING. No, it was based on a press release.

Mr. CAMP. And based on the estimates you have made regarding the numbers you received from the Republican proposals and the administration proposals, is it all that unusual for you to make estimates without statutory language?

Mr. KING. I think it serves a purpose in this case because it serves to create a goal for the impact of the legislation.

Mr. CAMP. All right. Thank you and I would be happy to yield to Mr. Thomas.

Mr. THOMAS. I thank the gentleman for yielding. You know, I guess we could go back and forth like a tennis match, but to try to put some definitiveness on what this Committee did with other bills that were before us before, I would like to tell the gentleman from California that in Mr. Gibbons' opening statement, he said we have got to have a bill. He said, "We need a piece of legislation in front of us." It didn't seem to bother him as Chairman, Acting Chairman, of the Ways and Means Committee on June 10. If you will examine the testimony from that time, he said:

> Any of the previous marks are not in use, we are dealing with the mark of June 9. This mark was made last night by me as Chair. This is what was presented to this Committee, notwithstanding whatever had been done in the Subcommittee, Mr. Stark.

This is not legislative language. This is not a bill. What this is is a concept paper, just like ours. How short the memories are.

I thank the gentleman for yielding.

Mr. CAMP. Thank you, Mr. Chairman.

Mr. STARK. Mr. Chairman, point of order.

I believe it is a violation of the Committee rules to read from an uncorrected manuscript of Committee proceedings, and particularly where it has not been corrected.

Mr. THOMAS. No, gentleman, I paraphrased from it.

Chairman ARCHER. Mr. Jacobs.

Mr. JACOBS. Thank you, Mr. Chairman. I am going to paraphrase from a couple of ideas, too. It was said that in previous Congresses the only thing that was done to help the Medicare and Social Security system was to raise taxes. If I remember correctly, the last

vote in Congress to raise taxes, FICA taxes, was 1983; and although, if I recall correctly, the Chairman himself opposed the bill, on final passage, generally, Republicans and Democrats in the House supported it. And what is more to the point, President Reagan signed it into law, along with the first tax on Social Security benefits.

I criticize neither party for doing it. Both parties held hands, looked at reality and dealt with reality.

Neither is it correct to say that the only efforts to save the program were on the tax side. In 1983 the Reagan administration came to me as Chairman of the Medicare Subcommittee at the time and asked if I would cooperate and in fact sponsor their proposal for DRGs, the diagnosis related groups, the prospective payment program. Had that not become law, I am sure Mr. King would agree, we would be in very, very bad shape with the HI Trust Fund long since.

The following year, it was the physicians' freeze adjustments for inflation, for reimbursements under part B had exceeded the actual inflation by 80 percent; in 10 years' time, we had a 15-month freeze.

I might say as far as political consequences resulting in the American Medical Association's coming to my town of Indianapolis and spending one-third of $1 million to get rid of me following that—following that episode, at the time—well, I guess they went after Pete, too, but they credit you with doing things I actually did. You happened to be the incumbent at the time, the Chairman at the time, but I think the record will show who actually did the things that honked them off.

I think I said in one interview, I thought they regarded me as an obstacle between them and the U.S. Treasury and, like tonsils, they thought I had to come out. But the good news was that doctors were not taking tonsils out much anymore.

I say all that to suggest that after all the fussing is over, my mother's favorite quotation is, "There is so much good in the best of us, and so much bad in the worst of us that it hardly becomes any of us to say very much about the rest of us." And once we have passed the emotions, I hope that that precedent of cooperation between a Democratic Congress and the Reagan administration can be reflected in the weeks and months ahead, that we can come together a little more quietly and see if we can work this thing out.

Mr. King, how much trouble is part B in?

Mr. KING. Part B is not in financial trouble because the revenues are redetermined each year at the level required to keep the program sound through the end of the following year. However, the board of trustees did take note of the fact that the rate of growth in the part B outlays of the part B trust fund had unsustainable growth rates and that the outlays of the trust fund were projected to triple as a percent of GDP.

Mr. JACOBS. I got your point. I got your point. In 1978 the premiums under part B paid what percent of the total cost of part B? Or let's just say in the late seventies. I know, and I suppose you know, too.

Mr. KING. At one point, the premiums paid 50 percent of the cost of part B.

Mr. JACOBS. I know that—I was here when it started in 1965. That was a requirement. Let's go to the late seventies. It fell to about 17 percent, didn't it?

Mr. KING. I believe that the lowest it ever fell that was—it is possible my recollection is 25 percent.

Mr. JACOBS. No, we had a bill that took great political courage to vote on about that time to raise the premiums from 17 percent to 25 percent; and that was considered sufficient at the time, the 25-percent portion under the realities that had occurred since 1965.

What percent do the premiums pay now in part B?

Mr. KING. A little over 30 percent.

Mr. JACOBS. Thank you.

Chairman ARCHER. Mr. Ramstad.

Mr. RAMSTAD. No questions, Mr. Chairman.

Chairman ARCHER. Mr. Zimmer.

Mr. ZIMMER. Mr. King, you have come here for the purpose of telling us what the impact of the President's proposal and the Republican proposal and the Democratic proposal, if they choose to give you one, would have on the trust fund under assumptions made by the board of trustees of the trust funds; is that correct?

Mr. KING. That is right.

Mr. ZIMMER. Do you need specific statutory language to do this?

Mr. KING. One of the caveats that I put in my testimony is that I had not received specific statutory language and that if these were—these projections were based on the goals of the two bills.

Mr. ZIMMER. Assuming that the legislation is going to be written to meet those budget targets that are set by the Budget Committee or explained in the President's press release, do you need statutory language to make your judgments?

Mr. KING. In order to make precise projections of the savings and the impact, yes.

Mr. ZIMMER. Within the range that you have given us?

Mr. KING. Yes.

Mr. ZIMMER. If the proportion is 60 percent to 40 percent, part A versus part B, what else do you need? You said that was one assumption you were making to perform your estimate; it might be a little more than 60 percent, it might be a little less than 60 percent. Do you need anything else in the statutory language?

Mr. KING. No. I think the—a set of assumptions in that we can make projections within the statutory language.

Mr. ZIMMER. So what you are saying is that to make these projections, you have assumed that the legislation, as finally drafted, will meet the $270 billion savings goal of the—established by the budget resolution, that the proportion of savings between part A and part B will be roughly 60 to 40 percent. Do you need pages and pages or any particular detail beyond that to justify the projections that you have given us today?

Mr. KING. No, not with the caveats that I have given.

Mr. ZIMMER. Thank you. Is there statutory language that the President has provided you that enabled you to make your projections based on his proposal?

Mr. KING. No, I haven't seen statutory language.

Mr. ZIMMER. Is there statutory language that the Members of the minority have given you that have allowed you to make any kind of projection whatsoever?

Mr. KING. No.

Mr. ZIMMER. When the Ranking Minority Member of this Committee closed his questioning of you, he made a statement which you did not have an opportunity to answer. He said the program—and I assume he is referring to part A, Medicare, is sound for 7 years. Is that a correct statement?

Mr. KING. No, that is not correct. The fact that the trust fund is not projected to be depleted for 7 more years doesn't mean that it is sound for the next 7 years. As the board of trustees points out in its report, the reserves in the trust fund are projected to get low enough, such that the trust fund could actually run out much sooner than projected because of the inadequacy of the reserves.

Mr. ZIMMER. Did not the trustees also state that the trust fund will start paying out more than it takes in, beginning next year?

Mr. KING. Yes, that projection is in the report.

Mr. ZIMMER. Do you agree with that projection?

Mr. KING. Yes, sir.

Mr. ZIMMER. Thank you very much.

Chairman ARCHER. Mr. Matsui. I am taking the Members in the order in which they were here at the time the gavel went down.

Mr. FORD. Mr. Chairman, Mr. Shaw wasn't here earlier, Mrs. Johnson was not here earlier; and you called on the two of them.

Chairman ARCHER. I would say to the gentleman that they were here when the meeting was called to order. I am following the customary procedure.

The gentleman will be recognized according to that customary procedure. Mr. Matsui.

Mr. FORD. Mr. Chairman, I sat here and listened to you.

Chairman ARCHER. Mr. Matsui is recognized to question.

Mr. FORD. I entered this room before Mr. Shaw and Mrs. Johnson both, Mr. Chairman.

Chairman ARCHER. The Chair recognizes Mr. Matsui for questioning.

Mr. MATSUI. Mr. Chairman, I hate to do this, but would it be appropriate if I yield my time to——

Chairman ARCHER. Of course.

Mr. MATSUI. But then will I be able to——

Chairman ARCHER. The gentleman will then have used his time if he yields. But perhaps he could get Mrs. Kennelly to yield her time to him.

Mr. THOMAS. Isn't there a concept to waive?

Mr. MATSUI. I tried. Thank you, Mr. Chairman.

Mr. King, you indicated you read in press reports and other reports about the $270 billion in the Republican plan, the savings over a 7-year period. Do you know as a matter of fact how much will be in part A when the bill is finally completed?

Mr. KING. No, you don't know for a fact how much will be in part A.

Mr. MATSUI. Do you know as a matter of fact how much will be in part B?

Mr. KING. No, sir.

Mr. MATSUI. Do you know how much of that will be for tax cuts?

Mr. KING. I am assuming that the split between part A and part B will be in the range of 60 percent, part A; 40 percent, and part B.

Mr. MATSUI. But you don't know that; is that correct?

Mr. KING. No. That is one of my assumptions.

Mr. MATSUI. That assumption is based upon the history breakdown.

Mr. KING. Yes, sir.

Mr. MATSUI. Right. But it is not based upon any document or any conversation you had with the Republican leadership who were drafting this plan.

Mr. KING. No.

Mr. MATSUI. Because in the press today there was a comment made in the Washington Post that, in fact, doctors will be kept pretty much whole. In fact, the President of the AMA indicated that he probably will be reasonably happy. That may alter your judgment of all this. It could; is that right?

Mr. KING. It is possible.

Mr. MATSUI. You obviously study trust funds. When President Reagan was President in 1982, the trustees had a report in January of that year. Do you know how long the solvency—the program would be before it became insolvent—the conclusion of the trustees' report in 1982?

Mr. KING. Yes. My recollection is that it wasn't very many years because at that point in time, the Social Security Trust Fund had just borrowed $10 or $12 billion——

Mr. MATSUI. It was 5 years.

Mr. KING [continuing]. From the Hospital Insurance Trust Fund and was projected not to be able to pay it back.

Mr. MATSUI. Let me ask you, so would 1987 be a reasonable number, from your recollection?

Mr. KING. Yes.

Mr. MATSUI. How about 1983, would the trustees' report at the conclusion of—the terms of the solvency under President Reagan, the insolvency would occur in the year 1990, 7 years, does that sound reasonable to you?

Mr. KING. Yes, sir.

Mr. MATSUI. Right. In 1984 the trustees' report said it would become insolvent in 1991, 7 years later. Does that seem reasonable to you, that number?

Mr. KING. It's possible, yes.

Mr. MATSUI. In 1985 because we did the DRG in 1984, if you recall the trustees said insolvency would occur 13 years later in 1998. That sounds reasonable, right?

Mr. KING. Yes, sir.

Mr. MATSUI. In fact, over the last 15 years, the lengthiest period, 1988, that we would find before it would become insolvent, was 17 years. Does that sounds reasonable to you?

Mr. KING. Yes, sir.

Mr. MATSUI. OK. Now, you do know over the eighties we made a number of incremental changes in the Medicare system, right?

Mr. KING. Yes, sir.

Mr. MATSUI. Now, let me ask you, I agree that we need to do something, but what should prevent us from doing this over the next 3 or 4 years? Why do we need to do it—is there any reason in your mind that we need to do it in the next 30 days?

Mr. KING. No, there is no reason why we have to do it in the next 30 days; but as I said, the sooner the problem is addressed, the less the problem is.

Mr. MATSUI. How about 1996; is that OK? I mean, would that create a major problem in your mind in terms of the insolvency issue?

Mr. KING. It is certainly better than not doing anything.

Mr. MATSUI. Right. Exactly.

Now let me ask you a question. Assuming you read some of the documents here, the Republican plan estimates that by the year 2002, the rate of growth of the Medicare Program will be what, 4.3 percent. You heard that number, right?

Mr. KING. I have heard——

Mr. MATSUI. In fact, you are basing a lot of your projections upon that, right?

Mr. KING. Yes.

Mr. MATSUI. OK. It would be a 1.378-percent growth in population and a 3-percent growth in CPI, the consumer price index. That is how you get the 4.37-percent, right, rate of growth?

Mr. KING. Yes, sir.

Mr. MATSUI. Do you know any industrialized country in the world that has had that low of a rate of growth over a period of years—England, Germany, the United States, any industrialized country—Canada?

Mr. KING. Actually, just recently the——

Mr. MATSUI. I am talking about over a period of years, over a period of years. Of course not. Of course not, right?

Mr. KING. Not that I know of.

Mr. MATSUI. OK, fine. Just say that the question that I want to ask you is, does that mean that we are going to have to cut benefits after the year 2002 in order to make this work?

Mr. KING. I don't believe that benefits have to be cut in 2002 if the reforms are done right. They can be done in such a way that the health care of the Medicare population will not suffer. I believe there is enough waste and abuse in the system now that if the reforms are done correctly, substantial waste can be removed from the system and health care won't suffer.

Mr. MATSUI. And that is how we are going to get it under the plan; is that right?

Chairman ARCHER. The gentleman's time has expired.

Mr. Nussle.

Mr. NUSSLE. Thank you, Mr. Chairman.

It is amazing to me the tone that I am hearing from my friends on the other side of the aisle today. It seems very clear to me that their message is that we don't need to fix Medicare. That is what Mr. Gibbons said, we don't need to fix it, we don't need to save it, we don't need to do anything about it. In fact, I haven't seen a plan yet from them.

We have a plan and it seems pretty clear that their attitude is that we don't need to fix it, and they continue to bring up these

arguments about, well, there has always been this worry about Medicare going broke and we put in quick fixes.

It reminds me of the story we have been hearing, as this has been analogized, that it is like a car that was purchased back in 1964. We repainted it a few times, we did a couple of tuneups, we got some new tires, it has been driving pretty well, but the Medicare trustees tell us that that car is going to break down eventually, and instead of just giving it another paint job or giving it another tuneup, we want a new car.

In fact I am referring right now to the trustees' report, and I—you said, Well, we don't have to do it in the next 30 days. Well, the trustees believe—this is right out of the report, right out of their conclusions. The trustees believe that prompt, effective, and decisive action is necessary.

Now, I have got two grandmothers, one is 92, the other is 87. They tell me we need to save Medicare. They tell me we need to fix it. I have my friend Sam Gibbons from Florida who tells me we don't need to save Medicare. Guess who I am going to listen to.

My two grandmothers tell me we need to save it. We are going to save it, and we have a plan. We are different. The fact that we can make a promise and keep it, the fact that the Democrats, who have controlled the House for 40 years, were not able to keep their promises in fixing Medicare does not dissuade me from the task ahead of us which is that we need to save it.

The question I have for you here today is that if it is true that we have got this car that is about to break down and they are looking for another tuneup, which—in the past, tuneups meant more taxes, more tax increases. The question I have for you, since you have had a chance to study this, is how high would we have to raise taxes this year, next year, over the course of the next 7 years in order to save Medicare, in order to fulfill the responsibility that the trustees gave us in this report to get us back on track? How high would we have to raise taxes, or more especially, would the Democrats suggest we would have to raise taxes in order to save Medicare?

Mr. KING. I haven't looked at the tax rate increase that would be required to save Medicare just over the next 7 years, but in the trustees' report, there is a statement that in order to put the Medicare Program, the Hospital Insurance Program, in balance over the next 25 years, would require I believe it is an increase in the FICA tax that goes to Medicare in excess of 40 percent.

Mr. NUSSLE. A 40-percent increase in taxes?

Mr. KING. Yes, I believe that is the number.

Mr. NUSSLE. So if we don't make the market reforms, if we don't make the fraud and abuse reforms, if we don't figure out a way to allow doctors and hospitals to network in a new and exciting way, if we can't figure out a way to give seniors choices, if we in fact cannot buy this new car that we want to call "MedicarePlus" or that we want to purchase that gives us the kinds of options so that we can save it without a tax increase and without copayments, without all of those things that are in our plan we want to be able to do, we would have to raise taxes on working Americans in this country by 40 percent in order to make sure that this fund is solvent, so that my two grandmothers and my father who is 57 years

old, who is going to be in Medicare here around the year 2002, would be able to have quality health care in this country. Is that what you are telling us here today?

Mr. KING. Yes, sir.

Mr. NUSSLE. Thank you.

Mr. KING. But the tax increase based on studies that I have done, the tax-rate increase that would save Medicare for the next 25 years wouldn't be a fair way with regard to generational equity to save the program because the people who would be paying that tax would be the people who would get the least out of the program when it came their time to retire.

Mr. NUSSLE. If that isn't the truest statement I have heard today about fairness—everyone wants to talk about fairness, but raising taxes on working Americans and keeping the same old car and giving it a new paint job certainly isn't fair. I would hope we would see a much better and more aggressive and exciting plan from the Democrats than just raising taxes on working Americans.

Thank you.

Chairman ARCHER. Mrs. Kennelly.

Mrs. KENNELLY. Thank you, Mr. Chairman.

Just so the record is kept straight, there are a number of Democrats——I think almost every Democrat on this Committee, in the 1993 reconciliation bill, voted to extend the Medicare Trust Fund, so it didn't go into bankruptcy, by an additional 3 years; and I believe every Member on the other side of the aisle—some of you weren't on the Committee then—voted no. So in our actions of the past we have shown that we are willing to vote to keep Medicare from going into bankruptcy.

Mr. King, rather than going into the huge numbers that we obviously can go into and will go into as we see the legislation, the number the American people are hearing is $270 billion; and in your testimony, you take $145 billion in part A cuts. If you subtract $145 billion from $270 billion, you get $125 billion. Where does that $125 billion go, in your opinion?

Mr. KING. That is the savings in part B of Medicare.

Mrs. KENNELLY. So in fact, those part B savings don't have anything to do with the part A trust fund.

Mr. KING. No, they have to do with the Medicare Part B Trust Fund.

Mrs. KENNELLY. Well, I thought that B was from general funds and premiums on people who belong to Medicare.

Mr. KING. There is a trust fund and the source of income to the trust fund is general revenues and premiums that beneficiaries pay.

Mrs. KENNELLY. It is an account, though, isn't it, sir?

Mr. KING. It is maintained as a trust fund.

Mrs. KENNELLY. But it isn't the trust fund that we keep saying, which I just said that we helped save in 1993, and there is a great concern by all of us that we want to make sure that it doesn't go bankrupt again. It is a different trust fund?

Mr. KING. Yes. It is financed differently than the HI Trust Fund.

Mrs. KENNELLY. It just leaves me to wonder if we have to do that additional $125 billion to save part A. Do you think we do?

Mr. KING. I haven't looked at the—I don't think that the savings in part B is necessarily associated with savings in part A.

Mrs. KENNELLY. That is what I think, too, Mr. King.

Thank you.

Mr. Chairman, I would like to request something. You had said that we all could enter into the record our own statements, opening statements.

Chairman ARCHER. Yes.

Mrs. KENNELLY. This morning there was another hearing on the Hill that Secretary of Labor Reich appeared at and some other witnesses. It is not a great, voluminous testimony. May I include in this hearing record an excerpt from that testimony?

Chairman ARCHER. Is there an objection? The Chair hears none.

Mrs. KENNELLY. Thank you, Mr. Chairman. Thank you, Mr. King.

Chairman ARCHER. Mr. Johnson.

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

Mr. King, you keep talking 60–40 and everybody calls it historic. You are an actuary; is that true?

Mr. KING. Yes, sir.

Mr. JOHNSON of Texas. And has our staff had contact with you to try to get you to help us develop the numbers that you are discussing today?

Mr. KING. Yes.

Mr. JOHNSON of Texas. And they did it for a specific purpose, did they not, so that we could come up with a Medicare proposal that would help the American people; is that true?

Mr. KING. That is right. I think the goals were to meet the criteria for financial soundness in the trustees' report.

Mr. JOHNSON of Texas. Right. Some of the numbers did come from our side, specifically from some of our staff, while they were working through the problem with you, I presume, and they asked you for some actuarial numbers; is that accurate?

Mr. KING. That is right.

Mr. JOHNSON of Texas. OK. Has there ever been a time in history when we have taken money from the trust fund, from the reserve?

Mr. KING. In 1982 there may have been times possibly when the reserves have declined, but in particular in 1982, there was money taken from the HI Trust Fund and placed in the OASDI Trust Fund, which was in trouble.

Mr. JOHNSON of Texas. But that was before it was removed from the Social Security Trust Fund; is that true?

Mr. KING. That is right.

Mr. JOHNSON of Texas. OK, so it is a real trust fund now and according to the trustees' report, that trust fund is going to go berserk next year; in other words, we would have to take money from it if we maintained the payout that we are achieving today?

Mr. KING. Yes, sir.

Mr. JOHNSON of Texas. And it has never been done and that is not the way you run a trust fund, so it is not solvent; is that true? Is that a true statement?

Mr. KING. Technically, the trust fund is not solvent now.

Mr. JOHNSON of Texas. Thank you. Now let me ask a question.

Somebody said that in 1993, Republicans refused to vote for—and I wasn't on the Committee—a proposal which blew the cap off of Social Security and taxed the poor, so that they could maintain 1 year more of solvency in the Medicare fund. Is that all we got out of that tax increase on the poor?

Mr. KING. My recollection was that raising the wage base to an unlimited wage base for HI got 1 or possibly 2 years of additional life for the trust fund.

Mr. JOHNSON of Texas. It didn't fix the problem, as Mr. Nussle said; it didn't even put a new coat of paint on it, much less a new engine, is that true?

Mr. KING. No, I would say it was a stopgap measure.

Mr. JOHNSON of Texas. Short term. According to the trustees' report, we need to fix it as expeditiously as possible; and before we go into that trust fund next year, it would seem to me that we have to fix it this year. Do you agree with that statement?

Mr. KING. I think we have studied the problem enough and we have enough knowledge so that we know what needs to be done to save the trust fund and there is a need to delay until 1996.

Mr. JOHNSON of Texas. Thank you, sir. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. King, earlier this year as part of the Contract With America, the Republicans cut taxes on upper income seniors to the tune of about $87 million. Had that not come about, would part A be relatively more solvent?

Mr. KING. I am not familiar with the change. Did they actually succeed in making the change?

Mr. COYNE. Well, it passed the House of Representatives.

Mr. KING. As I said, I think that the—that that tax was worth maybe 1 year of life to the trust fund.

Mr. COYNE. It would have provided the——

Mr. KING. I believe the tax you are talking about was the one that raised the taxability of Social Security benefits from 50 percent to 85 percent.

Mr. COYNE. If the tax cut for upper income seniors doesn't take effect, will that make the trust fund part A more solvent?

Mr. KING. I believe that repeal of that provision is worth 1 year at most, if that.

Mr. COYNE. But would it help the solvency of the funds that we are being told are going to become insolvent?

Mr. KING. Yes, it would have the minor effect on it.

Mr. COYNE. Under the proposal as you understand it, will seniors pay more under part B?

Mr. KING. Yes, they will pay more than they—it is not clear that they will pay more under part B until we receive the legislative language, but if the—if part of the plan is to raise the—to keep the percent of program expenditures that the part B premium covers the same as it is now, it is scheduled to drop to 25 percent under current law, then all other things being equal in the absence of any other legislation, the premium would increase.

Mr. COYNE. Will those savings go to the solvency of the part A section?

Mr. KING. No.

Mr. COYNE. Is there any reason for that? What is your judgment about a reason for that?

Mr. KING. Well, they go into the part—the savings from that would go into the part B trust fund.

Mr. COYNE. But it is in part A that we are having the financial difficulties.

Mr. KING. Yes.

Mr. COYNE. Wouldn't it be prudent then to use some of those funds for part A?

Mr. KING. That would be unprecedented to place premiums that a beneficiary pays in order to obtain eligibility for part B benefits and not use those funds for savings for part B benefits, instead use them for part A benefits. The programs are very separate and distinct programs.

Mr. COYNE. Fifty percent of all retirees in this country depend on Social Security as their only income, as their only source of income, and 50 percent of those who depend on Social Security earn less than $7,000 a year. As an actuary, do you think it is prudent for Members of Congress, and the administration for that matter, to have out-of-pocket expenses increased for people earning less than $7,000?

Mr. KING. I haven't dealt with issues regarding the solvency of the part B trust fund. That is not an area that I have been extensively involved with.

Mr. COYNE. Thank you very much.

Chairman ARCHER. Ms. Dunn.

Ms. DUNN. Thank you very much, Mr. Chairman, and thank you, Mr. King, for your testimony. I think you have clarified a number of points for people who are very interested in our Republican proposal on Medicare reform and how it compares to the press release that was given to you to work from by the President and the administration.

I also was interested in the testimony of Members on the other side who said that earlier reports from the trustees had said that at some time in the near future Medicare would go broke. What I want to make clear right now is that while the Democrat answer has consistently and always been to raise payroll taxes in order to solve the problem in very short term.

For example, in less than 1 year since the new majority was sent here to clean up the problem, I suspect that most would agree that we have used great courage and great common sense in coming up with a proposal to protect Medicare in the long run, to reorganize the system, to make it actuarially sound, at least according to your figures, through the year 2011, while still giving choice to senior citizens to whom this will become very important yet allowing them, if they choose, to remain on the Medicare plan.

I would like to ask you, Mr. King, because we have attempted to do a lot of things in the last 9 months, many of them relating to strengthening the economy here in the Nation, would you say that it is correct to assume that a reinvigorated economy would bring in more FICA revenues through greater employment?

Mr. KING. Yes, if the economy were to perform better, that would have a beneficial result on the HI Trust Fund, all other things being equal.

Ms. DUNN. And that as we seek to propose plans for strengthening the economy, leaving more money in the pockets of employers, for example, which would go to greater employment, would you therefore agree, Mr. King, that the policies that help the economy ultimately will help to strengthen and save Medicare for the future generations?

Mr. KING. Yes, if the policies are effective in strengthening and increasing the rate of growth in the economy, then they would have a beneficial effect on the solvency of the HI Trust Fund.

Ms. DUNN. Thank you, Mr. King.

And that will continue to be our effort.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Levin.

Mr. LEVIN. Thank you. Mr. Chairman, I don't think the question is whether there is a problem. The question is whether the medicine that you are proposing is going to damage and perhaps poison the patient and also use the proceeds for some other purpose, a tax cut for very wealthy people.

No one denies there is a problem of some sort in the short run and certainly the long run. But Mr. King, I agree very much with Ms. Dunn, I think your testimony has been very illuminating. I think it very much casts doubt on this effort to use part A to launch into a $270 billion program of cuts. I don't understand, why didn't you read this so-called plan before you made your estimates?

Mr. KING. I hadn't received it. I made these estimates before yesterday.

Mr. LEVIN. You didn't ask for this document?

Mr. KING. No.

Mr. LEVIN. It wasn't sent to you?

Mr. KING. No, sir.

Mr. LEVIN. So you base it on a rough calculation of 60–40.

Mr. KING. Yes.

Mr. LEVIN. There is a so-called fail-safe mechanism in here, you didn't look at that to see what the impact might be on your calculation?

Mr. KING. I don't believe that that document existed at the time that I made my projections.

Mr. LEVIN. Well, it was out yesterday.

Mr. KING. I made my projections several weeks ago.

Mr. LEVIN. You were still the actuary in 1994?

Mr. KING. Yes.

Mr. LEVIN. The projected years until insolvency were 7 years in 1994?

Mr. KING. That sounds about right.

Mr. LEVIN. Some of my colleagues have referred to the past and I just want to—it has moved me to try to make clear what has been said in the past. There is a quote from the Chairman, I wonder if you would put that up there for everybody to see.

We proposed in 1993 considerably less in Medicare cuts, all of which would have been plowed back into Medicare the first years.

This is what the now- Chairman of this Committee said about what Democrats were proposing:

Make no mistake about it for the elderly in this country, these cuts are going to devastate their program under Medicare. I just don't believe the quality of care and availability of care can survive these additional cuts and that is the price that is going to have to be paid for these cuts.

Again, Mr. King, the number of years until insolvency were the same in 1994 as they are supposedly today, right?

Mr. KING. Yes.

Mr. LEVIN. Just one other quote from another Member of this Committee. And I urge everybody to read this. It surely has a ring to it.

I would love to believe that we could achieve the level of cuts you have in this bill but history tells us that it isn't possible and I think we are just playing games, we are just making the numbers match. You have just estimated the number needed for Medicare to make the numbers match and I and the public understand that.

That was Mr. McCrery in June 1994. Let me just ask you, do you think it might be wise to take a look at legislative language before any firm conclusions are reached?

Mr. KING. Yes, I would like to, as I said in my testimony, these numbers have the caveat that I haven't seen the legislative language yet and therefore can't evaluate the effectiveness of the legislation.

Mr. LEVIN. Good. You can't evaluate the effectiveness of the legislation.

Thank you very much, Mr. King.

Chairman ARCHER. Since the gentleman has mentioned my name, I am going to interject briefly to say that the context of the statement that I made was that the Clinton proposal, in order to have comprehensive health care for all people in this country, was going to take $490 billion out of Medicare and Medicaid without restructuring Medicare and offering the choices and the alternatives that are a part of our program.

So to selectively pick a quote without relationship to what was happening leaves a false impression. So let it be clear that my quote was related to taking $490 billion out of Medicare and Medicaid without in any way reforming Medicare or restructuring it.

Mr. LEVIN. Mr. Chairman, there were no cuts.

Chairman ARCHER. Mr. Collins.

Mr. GIBBONS. Before Mr. Collins proceeds, I can understand the necessity for wanting to correct people who quote you, but my name has been mentioned many times here and I have been quoted from and I have never had an opportunity—can I have an opportunity to correct the people who quote me?

Chairman ARCHER. If the gentleman, if your name is referred to specifically, the Chair will grant you the opportunity to respond.

Mr. GIBBONS. Well, Mr. Nussle referred to me and a number of other people over there referred to me, quoting me. I think I ought to be entitled to as much response time as you take.

Chairman ARCHER. The gentleman—I will also say to the gentleman that the gentleman's comments today to me that relate to the specificity of the subject matter before us today certainly are a subject that can be debated. But when my name and a statement I made is not in context of today and is not even in context of what

occurred in 1994 is presented in writing to this Committee, then I certainly should have the right to respond. And should that happen to the gentleman, he will have the right to respond.

Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. King, we have all established and agree that the trust fund is insolvent but I want to move on to the part B and if I understood and understand the part B portion, the premiums—the funding for part B comes from premiums from Social Security checks and from general funds.

Am I right in that?

Mr. KING. Yes, sir.

Mr. COLLINS. You mentioned that in 1982, 1983, Social Security was heading toward insolvency. Do you see at any time in the future that Social Security will again become insolvent?

Mr. KING. Yes, I believe the trustees' report projects that Social Security will be insolvent, the trust fund will be depleted some time in the next century.

Mr. COLLINS. So that portion of part B funding does have solvency problems?

Mr. KING. Yes, sir.

Mr. COLLINS. And the part that comes from the general fund, is the general fund balanced today?

Mr. KING. No.

Mr. COLLINS. In other words, we are spending more than we take in in the general fund.

Mr. KING. Yes.

Mr. COLLINS. To the tune somewhere between $400 and $500 million a day, I believe, would be very close.

We have accumulated something like $4.9 trillion of debt that has to come from the general fund. Is that not true? Are you aware of those figures?

Mr. KING. I am aware of it, but not the precise figure.

Mr. COLLINS. We have established that part B from Social Security will eventually be insolvent, the budget is unbalanced and the debt is climbing. At what point or what level of debt will part B be in serious trouble?

Mr. KING. I haven't analyzed specifically at what point part B would be in trouble but according to the projections in the trustees' report, it is a major threat to the attempts to bring the Federal budget into balance because it is growing so fast as 1 percent of the Federal budget and as 1 percent of GDP.

Mr. COLLINS. In simple terms, part B does have its problems, too.

Mr. KING. That is right.

Mr. COLLINS. Well, that is not alarming from the standpoint that the same people who have been in charge of the public funds and have created and participated in the accumulation of $4.9 trillion of debt are very reluctant to address the fact that there is a cash flow shortfall beginning next year with Medicare part A which is going to lead to real problems for the Medicare system altogether.

Thank you, Mr. King.

Chairman ARCHER. Mr. McDermott.

I am sorry, Mr. Cardin is next.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. King, let me thank you for your testimony. If I understand it, if the goal is to have enough funds in the Medicare Trust Fund to pay for 1 year in advance, we are well ahead of that. If our goal is to have a 10-year solvency, an $89 billion amount would pretty much cover that, and if our goal is, as you described on short-term solvency, you believe $160 billion is necessary in the Medicare Trust Fund. Is that generally correct?

Mr. KING. No, that is not exactly correct. The differences between the amount that is required to maintain a 1-year contingency fund throughout the next 10 years versus just delaying the projected depletion of the trust fund for 10 years, if you delay the projected depletion of the trust fund through 2006, but during that period between 1995 and 2006, the trust fund is operating with balances that are below 100 percent in the following years' outlays, then it does not meet the test of financial adequacy.

Mr. CARDIN. I understand. Then for 10 years of solvency versus maintaining a 1-year contingency for 10 years, the difference is between the $89 billion and the $160 billion, correct? Or not?

Mr. KING. Yes, the $160 billion maintains reserves for the next 10 years.

Mr. CARDIN. Now, the $160 billion assumes the current tax policies on Social Security income remaining in the trust fund?

Mr. KING. Yes.

Mr. CARDIN. Let me go back to 1982 for 1 moment when with you as chief actuary, the trustees made a report indicating insolvency in 1987.

Mr. KING. That sounds about right.

Mr. CARDIN. Did the Medicare Trust Fund go insolvent in 1987?

Mr. KING. No, because reforms were made in the program, the implementation of the DRG program and also Social Security paid back the reserves that had been borrowed.

Mr. CARDIN. Changes were made, and in 1984 the report that was made while you were chief actuary indicated that the Medicare Trust Fund would go insolvent in 1991, is that right?

Mr. KING. Yes.

Mr. CARDIN. Did the Medicare Trust Fund go insolvent in 1991?

Mr. KING. No.

Mr. CARDIN. What happened?

Mr. KING. Some——

Mr. CARDIN. Reforms were made by changes in——

Mr. KING. Incremental changes.

Mr. CARDIN. Didn't Congress make some changes over that period of time?

Mr. KING. That is right.

Mr. CARDIN. In fact, for 5 years while you were chief actuary, the insolvency date was 7 years or shorter in the Medicare Trust Fund and during that period Congress made changes in the system in order to make sure that we extended the life of the Medicare Trust Fund.

Mr. KING. Yes.

Mr. CARDIN. And if you go back to 1982, the actions of Congress not only extended it beyond 1987, they extended it 15 years beyond that date. So is it fair to say that Congress has been responsive to

make sure the solvency of the trust fund has been maintained since you were actuary?

Mr. KING. I would say that Congress has been responsive in preventing the depletion of the trust fund, but it is not fair to say that the program was made solvent.

Mr. CARDIN. In 1982, would you have been satisfied with a 20-year solvency in the Medicare Trust Fund?

Mr. KING. No.

Mr. CARDIN. You wouldn't have been satisfied?

Mr. KING. No.

Mr. CARDIN. You wouldn't have been satisfied in 1982 to have a 20-year reserve?

Mr. KING. No, that——

Mr. CARDIN. Or a 20-year projected insolvency, you wanted more than 20 years?

Mr. KING. Yes.

Mr. CARDIN. I suppose I understand. And we have never ever in the history of Medicare had a report from the trustees that indicated 20 years of solvency, isn't that correct?

Mr. KING. Way back in the beginning of the program when the program first began, only 25-year projections were made and I believe that those projections showed that the trust fund would be solvent throughout the 25-year period.

Mr. CARDIN. I have figures dating back to 1970 and it shows 2 years solvency in 1970 with the Medicare Trust Fund.

Mr. KING. The program began in 1965 and the first trustees' report was issued, I believe, in 1966, and I believe that that report showed the trust fund was not in danger of insolvency.

Mr. CARDIN. In the few seconds that I have left let me just quote, if I might, from one of the trustees, the Secretary of the Treasury, Mr. Rubin, and this is dated yesterday and he says:

> Simply, no Member of Congress should vote for $270 billion of Medicare cuts believing that reduction of this size has been recommended by the Medicare trustees or that such reductions are needed now to prevent an immediate funding crisis. That would be factually incorrect.

Thank you, Mr. Chairman.

[The information follows:]

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

September 21, 1995

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

The Honorable Robert Dole
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Speaker and Mr. Majority Leader:

I understand the House Majority is releasing its plan to restructure Medicare today. I am writing to discuss the condition of the Medicare Hospital Trust Fund in the context of these reform plans.

As Managing Trustee of the Medicare Hospital Insurance (HI) Trust Fund, I am concerned by a growing number of statements by Members of Congress which appear to be based on a misunderstanding of what our annual report said. Because votes for significant changes in Medicare should not be cast without Members knowing the facts, I want to recount briefly what the Trustees reported about the funding status of Medicare.

Simply said, no Member of Congress should vote for $270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare Trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In the annual report to Congress on the financial condition of Medicare, the Trustees concluded that the HI Trust Fund will not be depleted until 2002, seven years from now. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then in the context of health care reform to make long-term changes in the system that would accommodate the influx of "baby-boomer" beneficiaries. At no time did the Trustees call the funding crisis "imminent." Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed.

Nonetheless, the Majority is asking for $270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance (Part A) Trust Fund for the next ten years. Moreover, I understand that the $270 billion of cuts proposed by the Majority includes increases in costs to beneficiaries under Part B of the Medicare program, even though increases in Part B do not contribute to the solvency of the Part A Trust Fund. In this context it is clear that more than $100 billion in Medicare funding reductions are being used to pay for other purposes -- not to shore up the Medicare HI Trust Fund.

By contrast, the President's proposal, by providing ten years of trust fund security, is consistent with actions by prior Congresses and would afford us far more than sufficient time to propose a bipartisan solution to the long-term fiscal needs of Medicare. Such a bipartisan solution will be needed regardless of whether the President's plan or Congress's plan is finally adopted.

To emphasize, the Trustees did not recommend $270 billion of Medicare cuts at this time nor state that the funding problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I hope this information can be provided to Members of Congress on both sides of the aisle as they review the significant changes in Medicare that are being considered so that Members can have a clear understanding of the facts.

Sincerely,

Robert E. Rubin

Chairman ARCHER. Mr. Portman.

Mr. PORTMAN. I thank the Chairman.

Thank you, Mr. King, for your testimony. It has been very useful for those of us who are interested in the actuarial projections.

I would like to make a point, and that is that most of those who have spoken today have addressed the very real fiscal crisis that the Medicare Program faces. I think that is the responsible thing to do.

A few have said it doesn't need to be fixed, but I think most acknowledge it needs to be fixed. The question of timing has come up.

Some have suggested we put this off until 1996, which I think we have seen the kinds of partisan atmosphere we have already in 1995. I am not sure that makes sense. Mr. Cardin just quoted a letter from one of the trustees. Let me quote from the trustees' report: "The Medicare Program is clearly unsustainable in its present form. It is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative." What I have found most useful about your testimony is that you took certain assumptions and I think it is fair that we Republicans, as we are drawing up a plan, should be held to those assumptions to the extent we are relying on your testimony.

And that was the $270 billion figure, that was the 60–40 ratio and using those assumptions, correct me if I am wrong, you made certain projections.

You have said in your testimony there are projections based on our assumptions that the program would be solvent until the year 2011 to 2014. You have also mentioned that these projections show the President's $89 billion package of savings does not satisfy the board of trustees' test for financial adequacy in the short-range projection period.

I think it is important for us to refocus on solvency, because it is why you are here this morning to explain to us that you have made certain assumptions. You don't need to see, frankly, the legislative language to make those assumptions.

Your analyses are based on what we have told you. We should be held to those to the extent we are relying on your testimony.

The previous speaker also mentioned a lot of changes that were made in the eighties and through the nineties, the prospective payment system, the DRGs, the physician fee schedules, and so on which were in my view fixes to get us through the next 3 or 4 years.

What you are telling us is that we are moving well beyond that period and I would ask you to confirm, based on these assumptions that we have given you—our goal for savings and the ratio you are using with respect to part A and part B, that in fact we are talking about solvency until the period 2011 to 2014.

Mr. KING. Yes, that is correct.

Mr. PORTMAN. I would also say that—and we will hear later from policy experts who will talk about the advantages of the Republican proposal to change Medicare, but I would also say that at this stage, I think it is very important that we focus on the fact that what we are talking about is going up to the baby boomer retirement time period.

Those in my generation who will be retiring after the year 2011, in 2014, will present an additional challenge to this Committee and to this Congress, and for those who say we are going too far, for those who say that 2011 or 2014 is too far down the track, I would just remind them that given the demographic trends, this is the least that we can do as a Congress to be fair to the coming generations, and again, Mr. King, I thank you for being here as an actuary to give us this data.

Mr. KING. Thank you.

Chairman ARCHER. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Being a patient person, I think Mr. Gibbons wanted me to talk about what I am now going to say, and I understand the Chairman says that the problem today is solving the problem of saving Medicare. I have spent 25 years in State legislatures and the U.S. Congress. In every instance, the responsibility for presenting solutions to problems is on the majority. First, they have to lay it out there. I was the Ways and Means Chairman in the State legislature. We had to put the budget out. The Republicans would say, Where is the budget, where is the budget. Well, we put the budget out there and then they made their comments on it. That is the way it operates. You people have to figure that out. You haven't put written language out here with specific numbers. When you put out releases, that doesn't work. You need to have specifics. Our poor actuary out here has made a lot of interesting statements about what he can and cannot do because he doesn't have the numbers. He is just guessing in the dark, and that is why I think you have to have specifics.

Now, there is no need to cut $270 billion to save Medicare. Every senior citizen who is watching this on C–SPAN should know that. It is not going to go over the cliff if we don't cut $270 billion. The trustees' report does not say that.

In response to the use of the trustees' report to support $270 billion in Medicare cuts, the four Clinton administration trustees put out an op-ed piece which I would ask unanimous consent to put in the record from the Los Angeles Times in which they say President Clinton has presented a plan to extend the fund's life.

[The information follows:]

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Los Angeles Times

August 28, 1995, Monday, Home Edition

SECTION: Metro; Part B; Page 5; Op-Ed Desk

LENGTH: 792 words

HEADLINE: PERSPECTIVE ON MEDICARE;
REHABILITATION NEEDED, NOT SURGERY;
THE TRUST FUND'S CRISIS ISN'T NEW; THE PRESIDENT OFFERED A SOLUTION TO INSOLVENCY.

BYLINE: By ROBERT E. RUBI; DONNA E. SHALALA, ; ROBERT B. REICH, SHIRLEY S. CHATER, Robert E. Rubin is secretary of the Treasury. Donna E. Shalala is secretary of health and human services. Robert B. Reich is secretary of labor. Shirley S. Chater is commissioner of Social Security.

BODY:

Our nation is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for $270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

* Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure it has adequate resources, the claim that the fund is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting President and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The President offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the President proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's Trustees Report that these members continually cite. The report found that predictions about the solvency of the

fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

* President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by $89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2006 -- 11 years from now.

* The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed $270 billion in Medicare cuts over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the President's plan. But a substantial part of the cuts the Republicans seek -- at least $100 billion -- would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of $1,650 per person or $3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of $2,825 per person or $5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the health care burden on all older and disabled Americans and their families. The President's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren. The President's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term plan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

GRAPHIC: Photo, ROBERT E. RUBIN ; Photo, DONNA E. SHALALA ; Photo, ROBERT B. REICH ; Photo, SHIRLEY S. CHATER ; Drawing, (Medicare), TOM TOLES, Buffalo News

LANGUAGE: ENGLISH

LOAD-DATE: August 29, 1995

Mr. MCDERMOTT. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue, but he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by $89 billion over the next 7 years to ensure Medicare benefits will be covered for up to October 2006.

Now, we will argue about how much money is going to be spent but they are projecting that $89 billion will get us to 2006. That is 10 years from now. What is important, I think, in this whole debate is that there is no work being done on what happens in 2010 when the baby boomers get into this system. There needs to be a blue ribbon commission that deals with that issue, just as we did with Social Security. Social Security was predicted to go broke. In 1983 the Congress dealt with that issue and Social Security is now solvent to somewhere around 2040. The $89 billion in cuts will clearly give us 10 years in which to figure out how we are going to deal with the baby boomers and Medicare. It is not something that we can put off any longer. The issue is in our face. We need to deal with it, but we are not going to go broke in the short run. For $89 billion, you can stabilize this thing for 10 years, which is longer than it has been predicted to be solvent in most every year that the Congress has dealt with this.

Now, any single Member of the U.S. Congress can come up with a proposal to save $89 billion from the U.S. Congress. I have a written draft in legislative language, 20 pages, that does it. And anybody who says there is not a proposal or there is not another proposal available is simply not correct, but I will not lay that proposal on the table until you people put a proposal out here with specifics. And I want to ask a question of Mr. King and I will show you why you need specifics.

In response to a question from Mr. Matsui, you stated you could not tell how much of the saving comes from part A or part B. There is no specific breakdown in this 60-page document that they passed out of that. So you have to make a guess about that. Mr. Portman says, Well, count on what we told you. So maybe they told you something that is not in the 60-page press release. But if you don't know how much comes from part A or part B, how can you know what the path of part A actually is? How do you make that judgment?

Mr. KING. I make that judgment on the basis of the 60–40 split between part A and part B and the caveat that this is the goal that—this is my interpretation of the goal for savings for part A, and if that goal is met, this will be the impact on the trust fund.

Mr. MCDERMOTT. So they are taking money—40 percent of the savings is going to come from part B and be put into part A. Is that what you are assuming?

Mr. KING. No.

Mr. MCDERMOTT. Explain it so that my mother, she is watching this, will understand what you just said.

Mr. KING. That if the Congress succeeds in saving $167 billion from the HI Program over the next 7 years, then the program will remain solvent, it will satisfy the solvency test, and it will delay the depletion of the trust fund until 2014.

Mr. CRANE [presiding]. The time of the gentleman has expired.

Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Mr. King, I want to talk to you about generational tax fairness. When you use that phrase, are you trying to say that the Medicare system, the benefits, and also the payments going into the fund ought to be fair to both the seniors and to the young people entering the work force who will be paying the payroll tax?

Mr. KING. Yes, sir.

Mr. LAUGHLIN. So when Mr. McDermott says his mother is watching C–SPAN, I suppose mine is, and to put it in terms, often we talk about figures and we talk about the senior citizens. Let me see if I can put it in a—my family terms so that my mother can understand it.

Next month she will be 76 years of age so I think we can easily put my mother into the Medicare senior citizen beneficiary age category, couldn't we?

Mr. KING. Yes.

Mr. LAUGHLIN. And when you talk about generational tax fairness, you are saying to my mother and to Mr. McDermott's mother and others, if they have grandchildren, my mother has six, that if we make no reforms to the current system but rely upon the current system as is, that we should say to my mother that she should expect her six grandchildren over the coming years to have about a 40-percent payroll tax increase in order to sustain the system as we have it today?

Mr. KING. That is right.

Mr. LAUGHLIN. So my mother should look at Mary, Brad, Valerie, Amy, Clark, and Michelle, and say to each of them, If your uncle, your father, and the other Members of Congress make no changes, when you enter the work force in the next couple of years, you should expect your taxes, your payroll taxes, to increase 40 percent to sustain the Medicare system as we know it today if they don't have the courage to make reforms and changes?

Mr. KING. That is right, sir.

Mr. LAUGHLIN. That is what you are telling us?

Mr. KING. Yes.

Mr. LAUGHLIN. Thank you very much, Mr. King.

Mr. CRANE. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. King, you are an employee of Ernst & Young?

Mr. KING. No. I am self-employed.

Mr. KLECZKA. You are self-employed. But you are a consultant to that corporation?

Mr. KING. Yes.

Mr. KLECZKA. Are you aware of Ernst & Young having as its clients any folks that are affected by the changes in Medicare? Do they represent hospitals or physician groups or things of that nature?

Mr. KING. They don't represent them. I would certainly expect they have them as clients.

Mr. KLECZKA. All right. They have them as clients. Do they have them as clients?

Mr. KING. I would expect they would, yes. It is a very large company.

Mr. KLECZKA. My question is, your purpose in testifying, are you testifying here as a former actuary for the Health Care Financing Administration?

Mr. KING. Yes. I am testifying as an actuary.

Mr. KLECZKA. And is your testimony today to indicate to us that the Republican cuts in Medicare will provide solvency not only to part A but also to part B?

Mr. KING. My testimony is to indicate the magnitude of the savings in part A that is needed in order to maintain solvency.

Mr. KLECZKA. You are saying that the Republican legislation will accomplish that?

Mr. KING. Yes. If the Republican legislation achieves the savings on the high side, it will accomplish that.

Mr. KLECZKA. But you are saying this without ever seeing a proposal. I think Mr. Rangel asked you some questions about whether or not you have seen the 60-page document that was distributed yesterday and you indicated no.

Mr. KING. That is right.

Mr. KLECZKA. And this is only an outline. This is not legislative language. There are a lot of unknowns as per this document. So you have never seen this. You have never seen a bill, but you are saying, as an expert actuary, that the Republican plan will restore solvency to the trust fund?

Mr. KING. No, I am not actually saying that. I am saying if the goals of the Republican plan are achieved.

Mr. KLECZKA. You don't know that because you haven't seen the legislation. So the goal could fall short and your testimony wouldn't be accurate.

Mr. KING. My testimony would still be accurate. It is just that I don't know whether those goals will be achieved, not having seen the legislative language.

Mr. KLECZKA. Basically, you are telling us we have problems with the trust fund and that is what your expertise is telling us today, is that——

Mr. KING. I am telling you that there is a solvency problem with the trust fund and that it will require $160 billion in savings over the next 7 years if that is the number of years over which savings are achieved.

Mr. KLECZKA. But you can't testify today that the Republican plan has $160 billion in savings for the trust fund, for the part A trust fund, right?

Mr. KING. No. I don't know that.

Mr. KLECZKA. OK. So if in fact you are telling us there is a problem in the trust fund, you are aware that we are knowledgeable on that fact. In fact, we were aware of that in 1994 when you were still an employee, correct?

Mr. KING. That is right.

Mr. KLECZKA. During that period in 1994, we had a lengthy discussion and legislative language on legislation to change the health care system of the country, which in part included changes in the part A trust fund. Are you aware of that?

Mr. KING. Yes.

Mr. KLECZKA. And that legislation of last year, did that provide solvency to the trust fund?

Mr. KING. I believe that it added a couple years. It didn't provide solvency for the trust fund but I believe it did add a couple of years of life to the trust fund.

Mr. KLECZKA. What do you mean when you say "solvency"? Forever and ever? Is that what you talk about when you talk about solvency?

Mr. KING. No. I am talking about both—yes, that is what I would call "solvency." But what I am talking about here——

Mr. KLECZKA. Does the Republican proposal provide for solvency forever and ever or does it extend it 7 years or 9 years or whatever the case might be?

Mr. KING. It meets the board of trustees' short-range solvency standards.

Mr. KLECZKA. So it is for a set period of time?

Mr. KING. Yes.

Mr. KLECZKA. And the proposal last year coauthored by the Democrats on this Committee did the same thing. Maybe not the same period, but it did extend it for a certain period of time; is that correct?

Mr. KING. I don't believe it met the board of trustees' solvency standards.

Mr. KLECZKA. No, but did we in that legislation extend the solvency of the HI Trust Fund?

Mr. KING. I believe it delayed the depletion date of the Hospital Insurance Trust Fund.

Mr. KLECZKA. Did it extend the solvency, yes or no?

Mr. KING. Yes.

Mr. KLECZKA. So there was a plan by the Democrats, even though we are accused of having no plan. We did address the problem. We were knowledgeable. So the point I am trying to make is the problem with the trust fund did not pop up this year. We were aware of it, and the Democrats on this Committee, without the help of any Republicans, did provide a legislative proposal to make that fund more solvent, and, as I indicated, there was no support from the other side.

So for those who say this magically appeared, we have been working on this long before the Republicans took over and will continue to work on it long after they are gone.

Thank you.

Mr. CRANE. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman.

Mr. King, I want to express my gratitude to you for taking the time to come and testify today. Obviously, you have been put under fire to some extent because you have come in as an independent actuary and told us what the trustees have already told us, what the two public trustees have already testified to before this Committee, that, in fact, the Medicare system is going bankrupt, that it does need saving, and that this crisis is not simply some sort of a PR stunt. So with that established, I wanted to ask you a couple of specific questions.

I believe that Mr. Matsui, in his comments, elegantly indicated that there had been over time some incremental changes that during the eighties had improved the actuarial position of the Medicare system. Correct me if I am wrong, you were at HCFA at the

time I think those incremental changes were primarily taxes; were they not?

Mr. KING. There were some taxes. There were also some reductions in payments to providers. It was a combination of those.

Mr. ENGLISH. It was a combination of the two, but there was certainly a very heavy reliance on tax increases at that time.

You may not be aware of this, you have been commenting on this trustees' report, which I know you have read, which is the primary object of your testimony here today, but you may not be aware of a study that was recently unveiled, I think in the last week by the U.S. Chamber of Commerce, and I have it here. It is entitled "The Medicare Crisis: The Tax Solution Is No Solution."

Several of the people here have commented on the fact that tax increases would have a substantial impact on people, but I don't think they have put it in human terms. This study demonstrates that in order to save the system long term purely through tax changes, you would have to more than double payroll taxes, and in human terms, what that means is a tax increase of roughly $1,100 for working families making $30,000 a year. Small businesses employing 25, the most dynamic sector in our economy, would have a $13,000 tax increase, and I think it is fair to say that would destroy at least one job in the business, and overall, the impact on the economy would be a 3-percent decline in growth, which from the growth projections we are seeing today suggests that it would push the economy into a recession.

Mr. Chairman, I would like this study included as part of the record of this Committee, if I could, and I would like to introduce it at this point.

Mr. CRANE. Without objection, so ordered.

Mr. ENGLISH. Thank you, Mr. Chairman.

[The information follows:]

The Medicare Crisis: The "Tax Solution" Is No Solution

Martin A. Regalia • Vice President and Chief Economist

Robert D. Barr • Deputy Chief Economist

U.S. Chamber of Commerce • Washington, D.C.

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

> For a worker making $30,000 a year, total Medicare payroll taxes paid would jump to $1,926 from the current $870.
>
> A small business employing 25 such workers would be liable for an additional $13,200 tax payment per year.
>
> When aggregated across the entire economy, the effect would be to lower real GDP by $179.4 billion within two years and hold GDP about $95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

Overview of Medicare: Why Reform Is Necessary

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible ($716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible ($100). About a quarter of the funding comes from monthly premiums ($46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held $132.8 billion.

Conclusions of the Trustees

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees -- four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater) -- reported the following conclusions:

> *Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years. . .* (HI Annual Report, pg. 2)

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

. . . the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they write:

Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. . . Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years. (SMI Annual Report, pg. 3)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

Where Medicare Stands Today

Medicare is a huge federal program. In 1994:

Medicare expenditures reached $160 billion, just over half the size of Social Security
Expenditures grew 11.4% from 1993
Eleven cents of every dollar spent by the federal government went to Medicare
Medicare represented one-fifth of total entitlement spending

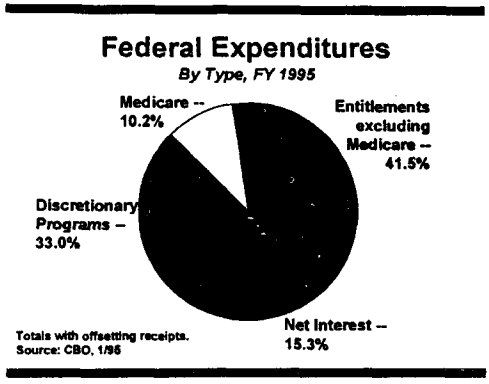
Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

Medicare and the Federal Budget

Medicare spending must be addressed as part of the solution to balancing the federal budget. That's because spending on federal entitlements -- such as Medicare, Medicaid and Social Security -- soared 8.4% annually on average between 1990 and 1994. Spending on

discretionary, annually appropriated programs -- such as defense, education and infrastructure -- increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Chart 1



Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. *If we are going to balance the federal budget -- and keep it in balance over the long term -- entitlement reform must be part of the solution.*

Where Medicare Is Headed If We Do Nothing

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach $344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust Fund, which at year-end 1994 held $132.8 billion, will have to be tapped to cover the projected $867 million difference.

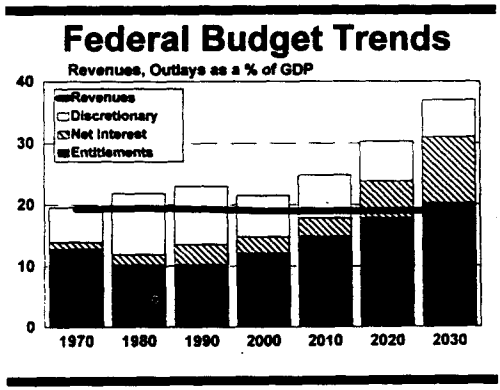
However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it

will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends, 1996 will be the first year of a hemorrhage that will deplete the entire trust fund by 2002 -- just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. *In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent -- unless we take action.*

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

Chart 2



Medicare's Impact on the Pay Stub

In addition to detailing the projected dissipation of the Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

Current Law

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning $30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or $435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another $435, resulting in **$870** of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that $36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

Table 1

Medicare Hospital Insurance Payroll Taxes

	Current Law	To Balance the HI Trust Fund Over the Next:					
		25 Years		50 Years		75 Years	
	Employee + Employer	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax
Tax Rates	2.90%	1.33%	4.23%	2.68%	5.58%	3.52%	6.42%
Percent increase over current law			*45.9%*		*92.4%*		*121.4%*
Payroll Earnings							
$10,000	$290	$133	$423	$268	$558	$352	$642
20,000	580	266	846	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,926
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,760	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,852
70,000	2,030	931	2,961	1,876	3,906	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source(for all tables): 1995 Annual Report of the Board of Trustees, Medicare Hospital Insurance Trust Fund, Table I.D3, page 22
Calculations and macroeconomic simulations by the U.S. Chamber of Commerce

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019):
According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our $30,000/year worker for whom $870 is currently provided to Medicare HI, this increase means an additional tax of $399, bringing total annual hospital insurance payroll taxes to **$1,269**. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044):
Balancing the trust fund over the next fifty years -- a span long enough to see most of the Baby Boomers through their lifetimes -- would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning $30,000 a year, the total HI payroll tax rises from $870 to **$1,674**, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069):
Balancing the trust fund over the next seventy-five years -- roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency -- would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning $30,000 a year would rise from $870 to **$1,926**.

Medicare's Impact on Business

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns $20,000 per year is currently liable for a $7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25

Table 2

Medicare Hospital Insurance Payroll Tax

Annual Employer Tax Liability

	Average Salary:	$20,000					
			Number of Employees				
	5	10	25	50	100	500	1,000
Current Law	$1,450	$2,900	$7,250	$14,500	$29,000	$145,000	$290,000
To Balance Medicare HI Over the Next:							
25 Years	2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 Years	2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 Years	3,210	6,420	16,050	32,100	64,200	321,000	642,000

	Average Salary:	$30,000					
			Number of Employees				
	5	10	25	50	100	500	1,000
Current Law	$2,175	$4,350	$10,875	$21,750	$43,500	$217,500	$435,000
To Balance Medicare HI Over the Next:							
25 Years	3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 Years	4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 Years	4,815	9,630	24,075	48,150	96,300	481,500	963,000

years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from $7,250 to $10,575 per year.

Medicare's Impact on the Economy

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of the short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

Table 3

Impact on Gross Domestic Product

Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Billions of 1987 Dollars			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-$68.4	-$30.1	-$36.1	-1.2%	-0.5%	-0.5%
50 Years	5.58%	-137.1	-60.5	-72.7	-2.4	-1.0	-1.1
75 Years	6.42%	-179.4	-79.4	-95.6	-3.1	-1.3	-1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase -- enough to keep the Medicare trust fund in balance for the next 25 years -- production in the economy would be 1.2%, or almost $70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline, amounting to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump from 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

Table 4

Impact on Employment

Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Millions of Jobs			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-1.2	-0.6	-0.8	-0.9%	-0.4%	-0.6%
50 Years	5.58%	-2.4	-1.2	-1.6	-1.9	-0.9	-1.2
75 Years	6.42%	-3.2	-1.5	-2.2	-2.5	-1.2	-1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first $61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a minimum measure of the economic impact of raising Medicare payroll taxes. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

Mr. ENGLISH. Mr. King, again, I appreciate your taking the time to come here and comment. As you know, the tax changes that were approved by this Committee earlier this spring included only one tax that actually affects the solvency of the fund, the Medicare fund. I think Mr. Coyne touched on that. But I believe it shows that it would only change by a matter of months the solvency of the fund, and of course what we did was actually cut the taxes passed in 1993 that had been imposed on Social Security, and I believe that tax cut that we passed was supported by AARP.

Thank you for your testimony, and we appreciate your being here.

Mr. CRANE. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. King, thank you very much for being here, for your testimony. Mr. King, I think many of us believe that Medicare is a sacred contract, I will call it a sacred trust with our seniors and with our families, and I know there are maybe some in this body who want to kill Medicare or destroy it in the name of saving it.

I know you are a very smart person and you are well read. Are you aware that back in 1965 when Medicare was passed during the summer of 1965, I was not here, that the great majority of the Republicans voted against it?

Mr. KING. Yes, I was aware of that.

Mr. LEWIS. And that there was a Democratic President by the name of Lyndon Johnson that signed the Medicare Act into law. Are you aware of that?

Mr. KING. Yes.

Mr. LEWIS. Now, I want to go to a line of questioning that Mr. Rangel, my colleague from New York, raised. Why do you feel so qualified to testify today? You haven't seen or read a bill. You told us you read about it in the paper. How can you be so confident when you haven't seen any detail?

Mr. KING. Well, I felt that I could clarify the question that has arisen over what is the amount of savings that is required in the Hospital Insurance Trust Fund in order to maintain solvency standards, at least in the short range, at the minimum, and that minimum level is $160 billion over the next 7 years.

Mr. LEWIS. Mr. King, are you aware, or is it true that the Contract With America takes $37 billion from the Medicare Trust Fund over 7 years, and $64 billion over 10 years?

Mr. KING. No, I wasn't aware of that.

Mr. LEWIS. If that is the case, that is the case of killing something in order to save it.

Mr. KING. Well, I think in this case I agree with your assessment that the—that the Hospital Insurance Program is a compact. It is a compact between generations, and there are participants in the program who are not yet drawing benefits from the program and those are the taxpayers, and when you view it as a compact between generations and the choice is to either raise taxes or reduce the rate of growth in benefits, what I found through my studies is that the fairest way to keep this compact intact between generations is to reduce the rate of growth in benefits.

Mr. LEWIS. Mr. King, I have an 81-year-old mother living in rural Alabama about 50 miles from Montgomery. Will you explain to her what is going on here?

Mr. KING. I think what I would tell her, Mr. Lewis, is that if the reforms in the Medicare Program are done right, it is not going to hurt the health care of the Medicare population. In fact, it could be beneficial on the rate of increase in health care costs, not only for the Medicare population, but for the entire population, and not only would the Medicare population be better off, but the underage 65 taxpayer would be better off as well.

Mr. LEWIS. Were these cuts that the Republicans are proposing to be put back into the health care delivery system?

Mr. KING. Yes. All of the savings in part A would be put back into the HI Trust Fund and saved and accumulated with interest to pay benefits for future beneficiaries.

Mr. LEWIS. It is the perception, whether it is real or not, that this is a search for revenue, for a $240 billion tax cut.

Have I been misled or has my mother been misled? Have the American people been misled or told something that is not the case?

Mr. KING. All I can say, Mr. Lewis, is that with regard to the savings in the Hospital Insurance Program, it is not possible to use those savings in order to pay for a tax cut for the wealthy. All of the savings that are achieved in the Hospital Insurance Trust Fund are required by statute to go back into the trust fund and to accumulate with interest to pay benefits for future generations of beneficiaries.

Mr. LEWIS. Thank you, Mr. King.

Mr. GIBBONS. Will the gentleman yield?

Mr. LEWIS. Yes. I yield to my friend from Florida.

Mr. GIBBONS. I think it is preposterous. The Republicans are crying about a distressed trust fund when their legislation, their tax cut they passed this year, out of this Committee, same people, took $87 billion out of the trust fund that they now say is going broke.

Mr. CRANE. The time of the gentleman has expired. Mr. Christensen—I am sorry. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

First of all, thank you for being here today and for your testimony. I want to make a brief statement.

I thought it was pretty interesting that one of my colleagues on the other side is talking about the President's plan. I would challenge anybody from the other side that has said that we don't have a plan to show me that the President has a plan when we haven't seen any statutory language from the President, but yet the other side is willing to call this the President's plan while saying that we don't have a plan.

I think that you should be fair when you are discussing our plan, and whether the President has a plan. Because it may not be in statutory language doesn't necessarily mean you don't have a plan. Something is being developed. It is a work in progress, and that is exactly what ours is. It is certainly quite a bit farther along than the President's so-called plan.

I would like to also thank Mr. Matsui. Mr. Matsui was the first person who actually started talking about some of the issues in-

stead of just playing politics with all of this, and he brought up I thought a very interesting point. He addressed the industrialized countries in Europe and he asked you if any of them had been able to maintain their inflation rates. I think it was 4.3 percent in medical costs, and my question to you would be, can you name me an industrialized country that, first of all, doesn't have a third party payer system, that has market forces truly working in the health care system, that is trying some of the innovative approaches that we are trying to bring to the marketplace in Medicare and in our health care system that would bring the patient back in to some accountability for what is going on, that would open up a whole system of choices and market forces? Are there any of those countries out there that have tried that?

Mr. KING. I am not an expert on the health care delivery systems of foreign countries, but I think I can say that the majority of them that I know about are experiencing the same problems with growth in health care costs that we are experiencing in the United States and that they have flaws in their systems just like we have in our system that haven't been addressed yet. And that is why they haven't been able to hold down their rate of increase in health care costs.

Mr. ENSIGN. One of our colleagues from the other side talked earlier about the system not needing savings, and that it is not in trouble. I held many townhall meetings in my district, as a matter of fact I have another one tomorrow morning, and virtually across the board, almost unanimously, people think that there is a tremendous amount of waste, fraud, and abuse in our Medicare system.

Do you feel, as Congress is the steward, we are to be stewards of the taxpayers' dollars? We are stewards of this whole Medicare system that provides so much for so many people that are so dependent on it, and I don't need to invoke my grandparents or my mother and father or anything like that, but so many people are so dependent on this system.

Is it a good use of tax dollars to just say, let's just let the system continue to waste billions and billions and billions of dollars in a system that does that? Are we being good stewards of the taxpayers' money?

Mr. KING. No. I believe that there are many billions of dollars of waste in the Medicare Program and that if reform is done correctly, it can get rid of that waste without damaging the health care of the elderly population.

Mr. ENSIGN. Just real quickly then, they mention that we have these trustees' reports and they made all these fixes over the last 15 years. During that time, did they adequately address the waste, fraud, and abuse by fundamentally changing the system? Did the other side when they were in charge do that?

Mr. KING. No. None of the changes in the system—probably the change in the system that did the most in the way of reform was the implementation of DRGs for the HI Program back in—with the 1983 legislation.

But for the most part, what has been done has been reductions in payment rates to providers that have had no effect on the incentives of the program. They have resulted in the rate of increase in

the Medicare Program going up at the same rate it has been going up just off of a lower base because of the lower payments to providers, and what needs to be done in order to reform the program is something that will change the incentives and that will actually bring about a reduction in the rate of increase in the cost of the system, not just a reduction in the base year.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman ARCHER [presiding]. The gentleman's time has expired. Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you, Mr. King, for your testimony. You mentioned earlier that there are needs for reform, and I certainly agree with that, and you stated that if it is done right, it would be beneficial to present and future beneficiaries, and I agree with that.

I am concerned that if it is not done right, however, it could have some devastating consequences. As one who represents a rural district, a district that 14 of the 17 counties are medically underserved, a number of the rural hospitals are dependent on Medicare for their survival, I want to make sure that we are, in fact, doing this right and it is in that context that I had some questions.

You started by saying that in order to achieve what the trustees tell us we need to achieve to ensure the adequacy of the HI Trust Fund, that we need to find savings of roughly $160 billion in the Medicare Program; is that correct?

Mr. KING. Over the next 7 years, yes, sir.

Mr. PAYNE. Over the next 7 years. A program then that puts full savings of $270 billion in would be using savings for something in addition to meeting the financial adequacy standards of the—that the trustees have put forth; is that correct?

Mr. KING. Well, if it has saved more than $160 billion in the HI Program, those savings could still be used to—the more the better up to a point. Those savings could still be——

Mr. PAYNE. The question is where is that point, though. That is what I am trying to get to.

Mr. KING. Well, the rest of the savings in excess of what is saved in the Hospital Insurance Program is saved in the supplementary Medical Insurance Program, part B of Medicare?

Mr. PAYNE. Right. But as you said earlier, those part B funds aren't addressing what the trustees asked us to address——

Mr. KING. That is right.

Mr. PAYNE [continuing]. Which is the HI Trust Fund. To address what they wanted us to address, roughly $160 billion is the amount that you stated that we would need to look at.

We will have before us something that suggests that we should be looking at $270 billion. I am assuming then that more than $100 billion could be used for other purposes, such as meeting the PAY–GO provisions of the Budget Act to pay for tax cuts or whatever those needs are; is that correct?

Mr. KING. I would expect they could be used for other purposes, yes.

Mr. PAYNE. Now, the next thing I was going to go to, and that is the standard by which we will be judged or the standard we need to meet that states that we have to find $160 billion in savings. That standard is, one, the financial adequacy standard for

short-range solvency says that we must either have at least 100 percent coverage through a continuing objection period or over 5 years reach that period and stay there for 5 years; is that correct?

Mr. KING. That is basically correct.

Mr. PAYNE. And as I look at the table end of the 1995 trustees' report, over what has happened historically, for the first 20-plus years, that standard was never met in a single year, including the first 10 years that you were the chief actuary; is that correct?

Mr. KING. I wouldn't be surprised.

Mr. PAYNE. So never in the history of Medicare have we ever met the standard of having an adequacy for a 10-year period; is that correct?

Mr. KING. The trustees' report—although this standard didn't exist when the program was first enacted, I would guess that the first trustees' report that was issued probably projected that that standard was met, even though——

Mr. PAYNE. But it was wrong?

Mr. KING [continuing]. It was wrong.

Mr. PAYNE. So there has never been a time in the history of Medicare, according to the chart in their report, where we have met this standard for 10 years. So what we are speaking of here is a very high standard, given the history of Medicare; and Medicare has continued to exist and function over that period of time.

Let me just read quickly in the few seconds I have left from a letter that Secretary Rubin wrote to the Speaker concerning this very matter we are discussing.

Secretary Rubin, who is a managing trustee of the HI Trust Fund says:

> Simply said, no Member of Congress should vote for $270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare trustees or that such reductions are needed now to prevent an imminent funding crisis. This would be factually incorrect.
>
> In an annual report to Congress on the financial condition of Medicare, the trustees concluded that the HI Trust Fund will not be depleted until the year 2002. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis, and then in the context of health care reform, to make long-term changes in the system that would accommodate the influx of baby boomer beneficiaries. At no time did the trustees call this funding crisis imminent.
>
> Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed. Nevertheless, the majority is asking for $270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance Trust Fund for the next 10 years.

And it goes on to say, to emphasize,

> The trustees did not recommend $270 billion of Medicare cuts at this time nor state that the financial problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I see my time has expired, and thank you very much, Mr. King.

Chairman ARCHER. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I yield to Mr. Thomas.

Mr. THOMAS. I thank the gentleman for yielding.

Briefly, I am quite sure that anyone who is watching this is now fairly confused, based upon the statements made by a number of

Members, and I want to try to pull them together very briefly and to thank the gentleman for yielding.

Mrs. Kennelly said several years ago that there was a program that was voted on to save this trust fund and all the Democrats voted yes and all the Republicans voted no. Mr. Kleczka then said that what we did was to stretch that program. We saved 3 years, didn't we?

Based upon the explanation from you, Mr. King, Mr. Lewis now understands that you can't take funds from the trust fund and use it for other purposes. But Mr. Gibbons' outburst was that Republicans are taking dollars out of the fund.

So how in the world can you reconcile all of these statements? I think it is very simple. What people need to know is that what the Democrats did in 1993 was to raise the income tax on seniors on their portion of Social Security earnings from a 50-percent tax after the threshold to 85 percent. That is what they voted for. That is what we voted against.

They also, in 1983, completely blew the lid off of the payroll tax amount subject to the part A trust fund. In the past, they had crept up on the amount that people earn to be subject to the tax. In 1993, they blew the lid off. All income is subject to the tax and they went after the seniors on the income tax to get their Social Security money. And what did that buy them? Just exactly what Mr. Kleczka said, 3 years. That is the way the Democrats have been trying to fix this fund year after year after year.

Let's remember what Mrs. Kennelly said, the Democrats all voted yes for that approach, the Republicans all voted no. Now that we are in the majority, we want to make sure we make fundamental, long-term, good changes. And I thank the gentleman for yielding.

Mrs. KENNELLY. Mr. Chairman.

Mr. CHRISTENSEN. Mr. King, reclaiming my time—reclaiming my time, Mr. King.

Mrs. KENNELLY. Mr. Chairman.

Mr. CHRISTENSEN. Reclaiming my time, Mr. King, isn't it true that when this program was formed in 1965, it was projected to cost $9 billion in 1965?

Mr. KING. Yes, I believe that——

Mr. CHRISTENSEN. In 1995. And what was the actual cost this year?

Mr. KING. The actual cost of the program in calendar year 1995, which isn't over yet, is $112.7 billion in benefit payments.

Mr. CHRISTENSEN. $112 billion. And so the projections back in 1965 were off just a little bit, projected at $9 billion and according to your figures, $112 billion. Likewise, I believe the average retired two-income-earning couple will take out over $127,000 more from the system than they paid in; is that correct?

Mr. KING. I don't know the exact figure, but I know that the average retiree in 1994 receives back in benefits about $5 for every dollar that they paid in in taxes.

Mr. CHRISTENSEN. $5 for every dollar they paid in in taxes?

There have been some Members on both sides, and I want to express my thanks for the constructive comments on the other side, and especially my friend Andy Jacobs, who I think represents a lot

of good that is going on in this country. People want to see a solution to this problem. They don't want people to ignore the problem, stick their heads in the sand, and demagog; and I think this week's Washington Post editorial describes some of the people that we are hearing from.

The Post—and Mr. Chairman, I would like to have this entered into the record; it was called "Medagogues" and, believe it or the or not, the Washington Post, which is not the most conservative paper in the country, stated that the Democrats are basing their campaign on distortion and on fear. The editorial continues, stating "They're engaged in demagoguery big time."

And then the Post finishes off its editorial, stating but the Republicans,

> They have a plan. Enough is known about it to say it's credible; it's gutsy and in some respects inventive—and it addresses a genuine problem that is only going to get worse.

And then the last paragraph declares:

> If the program isn't to become less generous over time, how do the Democrats propose to finance it and continue, as well, to finance the rest of the Federal activities they espouse? That's the question. You listen in vain for a real response. It's irresponsible.

And it is entitled "Medagogues," and I think in light of the Ranking Minority Member's comments, that he said a 1-year reserve is adequate for funding, I think the editorial fits his comments perfectly.

Thank you, Mr. Chairman.

[The information follows:]

House
REPUBLICAN
Conference

John Boehner, Chairman
8th District, Ohio

F.Y.I.

September 15, 1995

From this morning's *Washington Post*

Medagogues

NEWT GINGRICH and Bob Dole accused the Democrats and their allies yesterday of conducting a campaign based on distortion and fear to block the cuts in projected Medicare spending that are the core of the Republican effort to balance the budget in the next seven years. They're right; that's precisely what the Democrats are doing—it's pretty much all they're doing—and it's crummy stuff.

There's plenty to be said about the proposals the Republicans are making; there's a legitimate debate to be had about what ought to be the future of Medicare and federal aid to the elderly generally. But that's not what the Democrats are engaged in. They're engaged in demagoguery, big time. And it's wrong—as wrong on their part now as it was a year ago when other people did it to them on some of the same health care issues. Then, they were the ones who indignantly complained.

Medicare and Medicaid costs have got to be controlled, as do health care costs in the economy generally. The federal programs represent a double whammy, because they, more than any other factor, account for the budget deficits projected for the years ahead. They are therefore driving up interest costs even as they continue to rise powerfully themselves. But figuring out how to contain them is enormously difficult. More than a fourth of the population depends on the programs for health care; hospitals and other health care institutions depend on them for income; and you cut their costs with care. Politically, Medicare is especially hard to deal with because the elderly—and their children who must help care for them to the extent the government doesn't—are so potent a voting bloc.

The congressional Republicans have confounded the skeptics who said they would never attack a program benefiting the broad middle class. They have come up with a plan to cut projected Medicare costs by (depending on whose estimates you believe) anywhere from $190 billion to $270 billion over the seven-year period. It's true that they're also proposing a large and indiscriminate tax cut that is a bad idea and that the Medicare cuts would indirectly help to finance. And it's true that their cost-cutting plan would do—in our judgment—some harm as well as good.

But they have a plan. Enough is known about it to say it's credible; it's gutsy and in some respects inventive—and it addresses a genuine problem that is only going to get worse. What the Democrats have instead is a lot of expostulation, TV ads and scare talk. The fight is about "what's going to happen to the senior citizens in this country," Dick Gephardt said yesterday. "The rural hospitals. The community health centers. The teaching hospitals . . ." The Republicans "are going to decimate [Medicare] for a tax break for the wealthiest people, take it right out of the pockets of senior citizens. . . ." The American people "don't want to lose their Medicare. They don't want Medicare costs to be increased by $1,000 a person. They don't want to lose the choice of their doctor."

But there isn't any evidence that they would "lose their Medicare" or lose their choice of doctor under the Republican plan. If the program isn't to become less generous over time, how do the Democrats propose to finance it and continue as well to finance the rest of the federal activities they espouse? That's the question. You listen in vain for a real response. It's irresponsible.

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Mrs. KENNELLY. Mr. Chairman.

Chairman ARCHER. Mr. Neal is—Mrs. Kennelly, what is the purpose of your inquiry?

Mrs. KENNELLY. Mr. Chairman, I believe you said earlier in the hearing, if our names were mentioned and we were quoted, that we had a right to respond.

Chairman ARCHER. Let me explain to the gentlelady that whatever is said today, in context, in debate, I think is fair game for other Members to refer to in the debate today. But any quote that is taken out of context from a previous debate where the entire context of the debate is not before the Committee should be subject to a response.

Mr. Christensen—I am sorry. Mr. Neal.

Mr. NEAL. Thank you very much, Mr. Chairman, and let me begin by saying I think that Mr. Jacobs also approached this challenge from the right perspective today, and my sense is that at the end of the day, there are enough people of goodwill who wish to resolve this issue.

But let me call attention to the hearing today and call attention to your presence, Mr. King. You have impeccable credentials and you certainly have offered illuminating testimony here today, but let me ask you specifically, Have you seen the details of the Republican legislation?

Mr. KING. No, I haven't.

Mr. NEAL. You haven't seen any details of the Republican plan or legislation?

Mr. KING. No.

Mr. NEAL. And you are an actuary?

Mr. KING. Yes.

Mr. NEAL. And hold a fairly exalted position in this society? I mean, you can agree or disagree with that statement. This is your chance. Let me ask you this. How important are details to an actuary?

Mr. KING. At some point, they become important.

Mr. NEAL. At some point, they become important.

Mr. KING. Yes.

Mr. NEAL. But you are the leadoff witness here today to comment on a bill that you have never seen.

Mr. KING. I wasn't asked to comment on the bill that I hadn't seen. I was asked to comment on the level of savings that would be required in that bill.

Mr. NEAL. Let me go back to a specific question on details.

How important a detail is it that you can't yet tell how the so-called fail-safe rate of growth limit is allocated between hospitals, doctors, clinical labs, or home health agencies?

Mr. KING. That would be a detail that——

Mr. NEAL. A major detail?

Mr. KING [continuing]. In being able to establish how effective the legislation was going to be in achieving its goals.

Mr. NEAL. OK. So how are you able to tell what effect it will have on Medicare part A?

Mr. KING. The way I projected the impact on Medicare part A is taking the goals of the bill and analyzing what impact the goals of

the bill would have on part A financing if those goals were achieved, and I very carefully stated that caveat in my testimony.

Mr. NEAL. You said you haven't seen the bill?

Mr. KING. Yes.

Mr. NEAL. What do we know of the goals of the bill?

Mr. KING. Well, the goals of the bill are to——

Mr. NEAL. We haven't seen the bill.

Mr. KING [continuing]. Reduce the rate of growth in the outlays in the Hospital Insurance Trust Fund——

Mr. NEAL. But we haven't seen the bill.

Mr. KING [continuing]. And to save the program.

Mr. NEAL. That is a stated desire of every member of this panel. But let me ask you again, if I can, go back to the opening statements that were offered and to the questions that were asked. At this stage, you have not seen the details of the Republican measure?

Mr. KING. That is right.

Mr. NEAL. Thank you.

Chairman ARCHER. Mr. Crane.

Mr. CRANE. I have no questions of the witness, Mr. Chairman.

Chairman ARCHER. Mr. Ford.

Mr. FORD. Thank you, Mr. Chairman.

Mr. King, explain to me the savings in Medicare part B once again. I looked at the tables in your testimony and, one, two and three, I see how you make reference to the Republican plan and the plan that has been proposed by the administration as well. What about the Medicare part B premiums? Some questions have already come to you in reference to that on those savings. What happens to the savings? What are those savings in Medicare part B in this whole scenario?

Mr. KING. The savings, savings from Medicare part B reduce the rate of growth in the Medicare Trust Fund and the impact of those savings would be to reduce the rate of increase in future premiums paid by beneficiaries and, in general, revenue contributions to the trust fund.

Mr. FORD. But for some of those savings in Medicare part B, we will see some premium increases over the next 5 or 7 years; is that not true?

Mr. KING. As I said, I haven't seen the details of the bill. I have seen reports in the press that——

Mr. FORD. We know.

Mr. KING [continuing]. The proposal was to maintain the part B premium at 30 percent of cost instead of allowing it to go down to 25 percent of cost, so that the effect of—if that were part of the legislative package, that wouldn't be a proposal that would have the effect of increasing premiums. It would have the effect of preventing a decrease in premiums.

Mr. FORD. So you don't foresee, or are you suggesting that there will be no increase in Medicare part B premiums?

Mr. KING. I would have to see the legislative proposal and then I would have to evaluate the impact of that on the outlays in the part B trust fund in order to make that assessment.

Mr. FORD. Mr. King, who invited you here today to testify before this Committee?

Mr. KING. The staff of the Ways and Means Committee.

Mr. FORD. You received a letter or phone call from the staff?

Mr. KING. Yes. Well, I received a letter from the Chairman of the Committee. The staff invited me initially.

Mr. FORD. Did they invite you or did they invite Ernst & Young for whom you work for?

Mr. KING. No. They invited me.

Mr. FORD. You indicated to one of the other Members that you did not work for Ernst & Young, and that you were self-employed.

Mr. KING. That is right.

Mr. FORD. I called Ernst & Young and they told me you did work there. As a matter of fact, they connected me to your secretary at Ernst & Young.

Mr. KING. I left—at the end of July, I left Ernst & Young and became self-employed. I am a consultant with Ernst & Young, but I do not work for Ernst & Young.

Mr. FORD. Are you a Republican or a Democrat?

Mr. KING. I am a Republican.

Mr. FORD. You sound like one.

Thank you.

Chairman ARCHER. Mrs. Johnson.

The questioning has now been completed by Members who wish to question on both sides.

Mr. King, I am grateful for your coming to the Committee. Irrespective of your party affiliation, you have background as a professional, as a nonpolitical appointee in your job as an actuary of HCFA; and irrespective of the debate, which is appropriate, as to what happened in the past and what should be the alternatives for the future, which we spent a lot of time on, I think to recap where your professional input can be helpful to the Committee in general as an actuary.

What do you believe to safeguard and create stability and security for Medicare in the years ahead is a responsible action for the Congress to take at this time? Just from a numbers standpoint, not from the specificity of what might be in the approach or the alternatives, what would be the responsible action from an actuarial standpoint, numbers-wise, that the Congress, in your opinion, should take at this time?

Mr. KING. I believe that as a minimum, the savings in the Hospital Insurance Program should be achieved that would satisfy the short-range financial requirements of the board of trustees that would maintain the trust fund at 100 percent of the following year's outlays level at least for the next 10 years. If in fact reforms can be enacted that would reduce the rate of increase in outlays of the Hospital Insurance Trust Fund beyond 2002 and begin to address the problems that exist even beyond that, that would be so much the better. It doesn't all have to be achieved in the first 7 years, but a minimum of $160 billion has to be achieved in the first 7 years in order to maintain a viable reserve in the trust fund and to be reasonably assured that it is not going to run out sooner than expected.

Chairman ARCHER. In your opinion, how much can the amount of money per beneficiary increase annually in order to bring this about?

Mr. KING. I am not sure I understand the question.

Chairman ARCHER. From current levels, in order to accomplish the broader comments or goals that you just mentioned, how much can the payments by Medicare on behalf of beneficiaries increase over the forthcoming years above what they currently are annually?

Mr. KING. The one thing that I have looked at is that over the next 7 years, achieving savings over the next 7 years, the average—in order to achieve the $160 billion in savings, the average increase in payments per beneficiary has to be in the vicinity of 3 percent, assuming that the rate of growth in beneficiaries is about 1.5 percent, which is what it is projected to be during the next 10 years or so.

Chairman ARCHER. Thank you very much.

Mr. GIBBONS. Chairman Archer, I assume since you started back on the second round of questioning, that that applies to the rest of us.

Chairman ARCHER. I was merely recapping on my time that I did not use in the beginning, but certainly Mr. Gibbons, should you wish to question for a couple of minutes, you may do so.

Mr. GIBBONS. Very briefly.

Mr. King, you are the third Guy King I have known, and all of them are fine people; and I respect what you have said here today, and the goals of this program are to cut $270 billion out of Medicare. How much of that $270 billion is required to make, under your assumptions, the Medicare Trust Fund viable for 10 years?

Mr. KING. Well, $160 billion.

Mr. GIBBONS. $160 billion. So we have got $110 billion still lying on the table to be used for something else other than making the trust fund viable for 10 years?

Mr. KING. Well, yes. The $160 billion addresses the HI Trust Fund.

Mr. GIBBONS. And that is all you were talking about is the HI Trust Fund; is that right?

Mr. KING. That is right.

Mr. GIBBONS. Thank you very much.

Mr. FORD. Mr. Chairman, I want to recap on my time.

Chairman ARCHER. Mr. King, we thank you for your testimony and you are excused.

Mr. FORD. Mr. Chairman

Chairman ARCHER. Our next panel is composed of Gail Wilensky and Stuart Altman, if you would come to the witness table.

Ms. Wilensky, if you are prepared to proceed, the Committee would be pleased to have your testimony. We would encourage you to keep your oral presentation to 5 minutes and your entire statement can be entered in the record without objection.

Ms. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN LeROY

Ms. WILENSKY. Thank you, Mr. Chairman and Members of the Committee. As you have indicated, I would like you to have my detailed testimony and I would be glad to answer any questions.

What I would like to do is to summarize a few points that were contained in that testimony.

I am here as the chair of the Physician Payment Review Commission, and in that role, I see us trying to provide assistance in two general areas: First, trying to help the Congress understand broad implications of the proposed reforms; and second, try to provide technical assistance regarding some of the details of how these changes would be implemented.

I was pleased that there are many changes that over the years PPRC has been recommending which appear to have been included in the plan, as it has been described in documents that we have received, and let me mention just a few of these.

First, there have been the specific recommendations regarding the decoupling of payments to capitated plans from the fee-for-service, which we had discussed in numerous hearings, which are important to achieve.

We also think that it has been important to change the size of the geographical area that the capitated payment, the AAPCC, is referencing to a larger area because it will help to stabilize the payment.

A third specific that appears to be included is to change the nature of the spending target for physicians, the volume performance standard, and to have it become a more stable goal, to move to a single growth rate and an update factor that applies to all physician services, rather than the current three-part conversion factor and standard.

In addition, we think it has been very important to eliminate the size of the adjustments that can be made to the conversion factor and to put some restraints on it. But in addition to some specific changes that PPRC has recommended over the last several years, we think there are areas in which we can be helpful, as the Committee moves forward, trying to put specification on some of the broader issues that have been raised, and these relate to a fail-safe mechanism, to issues relating to risk adjustment, to issues relating to expanding choice, and also some changes in the graduate medical education. I just want to touch on these for a couple of minutes.

It has been important in terms of the fail-safe to look at exactly how you are going to apply the fail-safe to a number of sectors and to the adjustments that you will do. In the past, there has been some work done by the commission in relation to earlier attempts to put something like the fail-safe in place, and we hope that you will find it useful.

A second area I just want to touch on has to do with risk adjustment. Risk adjustment is an issue that has come up before the Committee in numerous ways concerning HMOs and whether or not they are being paid the proper amount.

As you go forward and expand the number of choices available to seniors, as has been described in documents that again have been made available to us—and especially including the use of a Medisave plan, but not limited to that—it becomes extremely important to be able to make some adjustments for potential risk selection. This is an area in which PPRC is doing work now with the highest priority. We hope to have some of the work available in the next month or two, and we will, of course, make it available to your

staff and to you as soon as it is available. But we would like to make the point that while we think it is important to go ahead with risk adjustment, we want to urge your consideration of using risk adjustment strategies as they are available, to not wait until there is the perfect risk adjustment strategy available to take on this very important problem.

We think that you can make improvements in this. It will become very important as you expand the number of options, and we urge your consideration in not waiting until the final, perfect risk adjustment mechanism is available.

In addition, as you expand options, there are a number of areas where we think you will need to consider, and we just want to touch on those: Coordinating the open season, making sure there is information available to seniors so that they can know how their choices should be made; to make sure that there is an adequate range of choices; and to make sure that there are consumer protections.

We at the PPRC, and I know as well my colleague Stuart Altman at ProPAC, stand ready to help you as you go forward in helping to assess the specific details as to how you will implement these plans and to how you will assure access and quality to the seniors of the country.

Thank you.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY, PH.D
CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I appreciate the opportunity to be here this morning to present the Physician Payment Review Commission's views on proposed reforms in the Medicare program. Since its creation in 1986, the Commission has devoted considerable thought to many of the issues raised by this proposal and has made recommendations in several key areas. In addition, we are now at work on several projects that will provide the Congress with information it can use as it seeks to broaden the array of choices available to Medicare beneficiaries.

As we speak, the U.S. health care system is undergoing major changes. Employers are fundamentally altering the way they purchase health services. Managed-care plans are growing rapidly and evolving toward more integrated systems of care. Physicians and hospitals are joining together in new types of organizations, transforming the way care is delivered. The design of the Medicare program, by contrast, continues to reflect the financing and delivery system that were in place at the time of its enactment thirty years ago.

Although managed care is now only a small part of Medicare, its rapid growth suggests that the time may be ripe for policy changes that will help guide this program into the next century. Much can be done to make changes in Medicare consistent with innovations in the private sector, and to ensure that the program acts as a prudent purchaser in responding to the changing health care marketplace. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost-effective providers, and to do so in ways that protect the fiscal integrity of the program and preserve beneficiaries' access to high-quality care.

As this Committee considers substantial changes in the Medicare program, it faces many tough decisions, some political, some technical. I see the role of the Physician Payment Review Commission as assisting you in two key tasks: understanding the broad implications of proposed reforms and providing technical assistance in developing the many details that will define how these changes would be implemented.

My testimony today reflects both these roles. First, I will present the Commission's views in several areas where it has done significant work over a number of years. These include setting payment rates for managed-care plans, constraining growth in spending for Medicare physicians' services, constraining overall growth in Medicare spending, and Medicare financing of graduate medical education (GME). In the second section, I will discuss a number of issues that the Commission has begun to consider more recently in context of expanding the range of choices available to Medicare beneficiaries. While we have not yet made recommendations in these areas, I can offer some insights about the questions that we will be considering and the analyses we plan to undertake.

In all of its work, the Commission has been guided by a series of goals, many of which it first elucidated when it began consideration of reforms in physician payment policy almost ten years ago. In assessing options for reforms designed to improve the performance of the Medicare program, the following goals have served as guideposts. Reforms should:

- ensure that all beneficiaries have access to medical care,
- maintain or improve the quality of care provided to Medicare beneficiaries,
- maintain financial protection for beneficiaries. Although some patient responsibility for the cost of care is appropriate, levels of responsibility should not be so high that they prevent beneficiaries from gaining access to care or impose significant economic hardship.
- slow growth in federal outlays for physicians' services (and more broadly, in other types of services financed by Medicare),

- make the program easier for physicians, providers, and the general public to understand,
- be orderly and coherent, with short-term changes consistent with long-term goals, and
- accommodate the various ways health care services are organized.

Setting Payment Rates for Managed Care Plans

As Members of this Committee are aware, current Medicare payment policies for managed-care plans are fundamentally flawed, and have contributed to problems of limited participation of health maintenance organizations (HMOs) (and thus low beneficiary enrollment rates), and higher costs per enrollee than their fee-for-service costs would have been. These problems include:

- the linking of managed-care payment rates to Medicare fee-for-service expenditures, so that the cost efficiencies achieved by HMOs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- highly volatile county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

The proposed Medicare Preservation Act would take some important steps toward correcting these problems. The establishment of payment rates for a baseline year, together with budgeted annual updates thereafter, will unlink HMO payments from Medicare fee-for-service expenditures. This will allow Medicare payment rates to be set for managed-care plans in a manner that better reflects the cost savings that can be achieved by participating plans. In addition, breaking the link eliminates the problem of payment volatility over time. More consistent and predictable payment rates should encourage participation in the Medicare program by risk contracting health plans and also help increase enrollment in those plans by beneficiaries.

Payment rates established for the baseline year will have a long-term influence on future payments. Although the proposal would reduce geographic variation in payment rates, it may not go far enough to modify those rates that are very high or low due to historical differences in patterns of service use for local counties.

The Commission has some suggestions to make to this Committee on how it could reduce the range of payment rates across the country; these methods include blends of national and local payment rates, differential updates for areas with high or low rates, and replacing counties with larger regional geographic areas. In its 1995 annual report, the Commission recommended blended payment rates as the most sound and administratively flexible approach. Although it would be desirable to develop baseline payment rates that are as correct as possible, the changes could be introduced over a transition period to ease financial dislocations for existing plans that now serve beneficiaries in markets where current Medicare capitation rates are very high.

Also at issue is the fact that teaching-related and disproportionate share (DSH) payments do not always reflect the actual costs incurred by managed-care plans, depending on their use of these institutions. Their inclusion in the calculation of managed-care payment rates has therefore led to both overpayment and underpayment in the current program. While the impact of retaining these special payments will diminish over time under the new approach to setting payment rates, they will have a lingering effect. If the Committee were to choose to remove them, one approach would be to provide direct payments to eligible hospitals when they provide services to managed-care enrollees.

As experience is gained with the new payment system, the Commission looks forward to working with the Congress to continue refining and improving the payment policy. Among the alternatives that could be explored are market-based payment methods that would enable Medicare payment rates to better reflect the costs of efficient health plans in competitive markets.

Mechanisms for Constraining Spending for Physicians' Services

The proposal would substantially improve the mechanism for constraining spending for physicians' services in the fee-for-service sector. As you know, the proposal would repeal the current volume performance standard (VPS) system and replace it with reasonable budgetary goals that fully account for all spending for physicians' services. This new system conforms to all of the Commission's recommendations for improving the VPS.

The proposed system has two components: a sustainable growth rate and a conversion factor update. A single growth rate and update would apply to all physicians' services.

The sustainable growth rate would be calculated to reflect changes in physicians' fees, enrollment, and law. It would also allow for reasonable and affordable growth in the volume and intensity of services by using projected growth in real gross domestic product (GDP) per capita plus two percentage points, instead of relying on historical growth rates used under the current system. Over the next decade, the expenditure targets under this proposed system would hold annual growth in Medicare spending for physicians' services to between 6 percent and 7 percent per year.

The second component of the system is an annual conversion factor update designed to hold total spending to its budget. The new system would eliminate the two-year delay, thereby increasing the timeliness of the adjustment to the conversion factor. It also has a better mechanism for addressing the inherent volatility in annual expenditure growth by limiting the size of the adjustments that would be made to the conversion factor each year. Unlike the current system, excesses and surpluses that are not made up in one year would be made up in subsequent years. Assuming inflation remains between 2 percent and 3 percent each year, conversion factor updates would hold increases or reductions to no more than 5 percent per year.

Currently, physicians face reductions in the conversion factor even if they hold volume growth to just 4 percent per year (Table 1). Under the proposed system, holding growth to 4 percent would actually lead to modest increases over the next decade. That is, the new approach would provide physicians the opportunity to receive increases in payment if volume and intensity growth is held to reasonable levels. If annual volume growth increases at unreasonable rates (10 percent or more), however, this system would provide maximum reductions of 5 percent per year.

Table 1. Comparison of Conversion Factors Updates Under Current Law and Under the New Approach Assuming 4 Percent Volume Growth (percentage)

Year	Current Law	New Approach
1997	-2.2	2.8
1998	-3.0	1.6
1999	-3.0	2.3
2000	-3.0	2.4
2001	-2.0	2.4
2002	-2.0	2.4
2003	-2.0	2.4
2004	-2.0	2.4
2005	-2.0	2.4

SOURCE: Physician Payment Review Commission analysis.

Another improvement is the adoption of a single conversion factor beginning in 1996, providing a single growth rate and update thereafter. This step would eliminate distortions to the Medicare Fee Schedule that have occurred under the current system. That is, a relative value for surgical services would once again be paid the same amount as a relative value for primary care services.

Finally, the proposal includes a "failsafe" provision which instructs the Secretary to reduce payments for each of ten sectors when overall budgetary goals are not met. This provision may conflict with the mechanism for constraining growth in physician spending. As this policy is further developed, it is important to consider the interaction between the failsafe and the mechanism for constraining growth in spending for physicians' services.

Mechanisms for Constraining Overall Growth in Medicare Expenditures

The House proposal includes mechanisms for constraining overall growth in Medicare expenditures. As now understood by the Commission, the so-called failsafe mechanism includes (1) fixed government payments and updates for Medicare Plus plans; (2) fixed fee-for-service prices, based generally on existing methods, set at a level designed to ensure that targets set in law for each sector of services are met; and (3) a lookback mechanism that would reduce spending by lowering provider payment increases in traditional Medicare if overall spending in a particular sector exceeds the targets. Both the setting of prices and the lookback may be necessary to account for increases in the volume of services

Based on its previous analyses, the Commission wants to comment on two issues. One is how the mechanisms to constrain spending are structured. In 1993, the Commission completed work for this committee that addressed similar mechanisms for constraining overall growth in Medicare expenditures. The second issue addresses how to account for differences in risk between beneficiaries enrolled in Medicare Plus and those selecting traditional Medicare. The Commission's ongoing work on risk adjustment provides a foundation for this discussion.

In its 1993 report to this committee, the Commission concluded that, if sector-specific methods were used to constrain spending growth, relatively few categories should be established. Doing so would give incentives to groups of providers while keeping most substitution of services within, rather than across categories. Where substitution occurs across categories of services, inequities may be created for certain categories of providers. For example, the substitution of lithotripsy for surgical treatment of kidney stones in the 1980s appropriately shifted services from hospital to outpatient settings. A process should be established for tracking substitution across categories.

A second issue is how to establish targets for each sector of services. Based on the Commission's experience with the VPS, it is important to set separate baselines for each category. Doing so recognizes that spending appropriately grows at different rates for different service sectors. The accuracy of baselines is also an issue, especially if they are derived from

current projections, because it may be difficult to anticipate accurately future trends in service delivery. Accordingly, a process may be needed to make corrections or adjustments over time.

Finally, given that the failsafe mechanisms in this proposal will "guarantee" a certain level of spending, any future policy initiatives on the fee-for-service side (e.g., case management) that produce savings for traditional Medicare would probably not be scored as savings. In fact, they may be scored as costing the program money if they add administrative costs even if those are more than offset by actual reductions in service use. This scoring situation would tend to reduce the incentive to find these savings. It may be useful to create some incentive to continue pursuing such improvements in traditional Medicare as under the proposed mechanism for constraining physician payments.

The Commission is also concerned that the failsafe mechanisms might be triggered if healthier-than-average people enroll in managed-care plans. This uncorrected risk selection (i.e., that due to factors other than those such as age, sex, and institutional status that have been included in Medicare's method for paying managed-care plans) would thus lead to increases in the volume of services and thus to provider payment reductions and potential reductions in beneficiaries' access to services. In fact, this could also be a complicating factor in efforts to constrain growth in spending for physicians' services.

Evidence published in 1993 showed that prior costs for HMO enrollees were lower than for nonenrollees in the same market areas, even after adjusting for the risk factors used in the current payment system. Enrollees were also less likely to rate their health as poor and to have a history of cancer, heart disease, or stroke. As a result, the Health Care Financing Administration (HCFA) has paid an estimated 5.7 percent more, on average, for Medicare HMO enrollees than it would have paid under fee for service. Changes in the market since this study was conducted have raised questions as to whether these results still apply today. The Commission is working on analysis of selection issues using recent enrollment and survey data and claims analysis.

Considerable research has been done on several different approaches to incorporating risk adjusters for health status. It seems appropriate that risk adjusters for health status could be incorporated in the short term, even as development of better methods continues. To do so would mean incorporating the best available risk adjusters instead of questioning whether risk adjusters are "good enough." Some form of reinsurance or partial capitation might also serve, either alone or alongside risk adjusters, as a way to reduce the effects of risk selection.

Financing Graduate Medical Education

Since the Commission's mandate was expanded in 1990 to include consideration of Medicare financing of graduate medical education, we have developed substantial expertise on these issues, particularly with regard to Medicare payments for the direct costs of medical education. As we understand them, the proposed reforms would make three key changes in current policy. Specifically, they would:

- freeze the number of residents supported by Medicare;
- limit Medicare payment to residents seeking their initial specialty certification; and
- limit Medicare payment to international medical graduates.

In addition, the proposal calls for reductions in the indirect medical education adjustment similar to those proposed in budget debates over the past several years. Moreover, the creation of a new independent commission suggests that these changes are short-term measures until broader changes in GME financing can be agreed upon.

The Physician Payment Review Commission has long noted the need for a link between decisions about GME financing and those affecting the number and mix of residents. These reforms begin to make such a step by setting limits on the type of training that the Medicare program will support.

While it is unclear how changes in Medicare financing will affect the actual number and specialty distribution of trainees, the Commission has estimated that they will have a substantial impact on Medicare-supported positions. Paying only for graduates of U.S. medical schools in their initial period of training will reduce the number of full-time equivalents (FTEs) supported by Medicare by one-third from the baseline under the Omnibus Budget Reconciliation Act of 1993 (OBRA93). While all specialties will experience reductions (including primary care with losses of 42 percent for internal medicine, 43 percent in pediatrics, and 25 percent in family practice), these range from about 11 percent of positions in orthopedic surgery to 100 percent of positions in medical and surgical subspecialties such as cardiology, gastroenterology, and thoracic surgery. At the state level, reductions range from just 8 percent of residents in South Dakota, 20 percent in Texas, 26 percent in California, to 42 percent in Connecticut, 47 percent in New York, and fully 59 percent in New Jersey.

The new independent commission that would be created by this legislation will face a number of important challenges. The first of these will be to evaluate whether the short-term solutions included in this proposal should be extended or modified. In addition, it should consider additional reforms such as moving from institution-specific per resident payment amounts to standardized rates, and mechanisms for shifting support to training in ambulatory settings. This commission will also face the fundamental question about the appropriate role of the federal government in financing physician training.

Issues Affecting Medicare Plus

In the past few months, the Commission has been working in a variety of areas related to development of a Medicare system which includes an expanded array of insurance options. These issues fall into three broad groupings: guaranteeing choice, ensuring access, and assuring quality.

Guaranteeing Choice. The proposal is designed to expand the array of choices available to Medicare beneficiaries by creating Medicare Plus as an alternative to traditional Medicare. Medicare Plus expands on the current Medicare risk contracting program by offering a wider variety of managed-care plans, as well as new types of plans referred to as provider-sponsored networks and medical savings accounts.

As the details of this multiple-choice system are worked out, it is important to consider provisions that would help guarantee that beneficiaries have a real ability to make choices. One is the establishment of a coordinated open season in which all options are made available to beneficiaries. The proposal creates such an open season and provides that all plans would be offered together on an annual basis.

A second factor is that beneficiaries have adequate information on available options to make an intelligent choice. The bill addresses this need by sending beneficiaries each year a booklet describing the approved plans available in their area. Such a booklet should provide information on (1) premiums in a form that allows comparisons to be made; (2) benefits offered, including a clear explanation of added benefits and network restrictions for obtaining these benefits; (3) quality, including disenrollment rates, consumer satisfaction, and performance reports; and (4) beneficiary rights and responsibilities, including grievance processes. Given the difficulty of comparing plans with different supplemental benefits, steps should be considered to make comparisons easier for beneficiaries. Because such information is so critical to the success of a multiple choice system, it is important to ensure that the resources will be available to develop and disseminate these materials.

A third component is to provide every beneficiary with an adequate range of choices. The proposal suggests that every beneficiary will be able to pick at least between traditional Medicare and medical savings accounts and expands the number of other private plan options open to them, including point-of-service plans. Combined with changes in the payment methodology, these steps should greatly broaden the range of options available to most beneficiaries. Nevertheless, it may be important to monitor how many plans become available, especially in areas where choices have historically been limited.

Finally are several important consumer protections. In the proposal, plans will be required to accept beneficiaries regardless of health status or other factors, and beneficiaries will apparently be able to switch back to traditional Medicare after a "cooling off" period. The Commission has spoken previously about the importance of these protections. In dropping the right to disenroll on a monthly basis, however, consideration should be given to options that protect beneficiaries in circumstances where access, quality, or continuity of care is threatened. In addition, given marketing abuses reported by the Inspector General and others, protections against inappropriate marketing will be needed. Finally, the Committee may want to include provisions to help those beneficiaries (such as those who are institutionalized or disabled) who may have special difficulties evaluating and making choices under this new system.

The creation of provider-sponsored networks, part of a strategy to increase the range of choices, raises two important issues. First, the rationale for creating different standards for access and quality for these plans is unclear. The second relates to antitrust policy. In last year's annual report, the Commission concluded that current laws and enforcement policies have not deterred the formation of provider-sponsored networks when they assume risk. Therefore, it found no compelling reasons for creating exemptions from the antitrust laws for such networks. It did suggest that enforcement agencies gather and make available to the public information on antitrust problems brought about by the evolving structure of health care markets. Changing current policy should be done with care because it may result in unintended increases in anticompetitive practices. In particular, even if a change applies only to the Medicare market, it may be difficult to keep potentially anticompetitive practices from spilling into other markets served by the networks.

Finally, the MediSave option -- a medical savings account for Medicare beneficiaries -- would be a new and very different option for Medicare beneficiaries and therefore one of the most uncertain. A number of recent studies show a wide range of predicted costs, and the Commission has only just begun its analyses of a medical savings account for Medicare beneficiaries. There are many design issues that will need thoughtful consideration including, among other things, the nature of the involvement of managed care with MediSave.

The impact of beneficial selection is a key policy consideration in designing medical savings accounts. As the American Academy of Actuaries has noted, medical savings accounts would provide the greatest monetary surplus to the healthiest beneficiaries. If indeed MediSave draws a healthier-than-average population, inadequacies of current risk adjustment techniques could lead to Medicare losing money on the MediSave option. Because selection is more likely the more frequently beneficiaries can switch into or out of the MediSave option, you may wish to consider setting a longer enrollment period for MediSave than for other options. For example, MediSave could be made available at five-year intervals or even only once in a lifetime decision, subject to some short cooling-off period after enrollment.

Ensuring Access. Previously when the Congress made significant changes in the Medicare program, it also established a process of monitoring to track the impact of such changes. Given the magnitude of changes in this proposal, it appears prudent to set up a strategy for monitoring beneficiaries' access to care in traditional Medicare, in Medicare Plus plans, and for those electing medical savings accounts. Monitoring would provide policymakers with information necessary to ensure successful implementation of structural changes in Medicare. It could be conducted by either HCFA or a Medicare commission, or both. One example is provided by

OBRA89 which required HCFA to monitor and report to Congress on access under the Medicare Fee Schedule, and this Commission to comment on HCFA's access report.

The Commission is ready to assist the Congress in this area. In response to its OBRA89 mandate, it has a track record of monitoring access under the traditional Medicare program. Now it is extending that work by developing a strategy to monitor access of beneficiaries enrolled in managed- care plans. First, it will assess which indicators measure access most effectively and efficiently in managed-care plans. This includes assessing the capacity of managed-care information systems to generate the data that would be needed to measure access. Second, the Commission will develop and test a questionnaire for use in surveying Medicare beneficiaries enrolled in or disenrolled from HMOs. This survey will develop baseline information on access issues and will generate information on how the Medicare Current Beneficiary Survey could be modified to permit the regular collection of information specific to Medicare managed-care enrollees.

Assuring Quality. Medicare reform presents a unique opportunity to accelerate the development and diffusion of tools to enhance quality of care, building on efforts of the private sector. In developing a quality assurance system, there are two major decisions that Congress has to make (1) what strategies of quality assurance will be adopted? and (2) what roles should different organizations play in quality assurance efforts?

Three basic strategies for ensuring the provision of high-quality health care have been adopted by innovative purchasers. The first consists of a process for measuring and reporting health plan performance. Report cards containing externally validated, comparable data on plans would empower beneficiaries to make informed decisions in choosing a health plan. The second strategy requires health plans to have internal quality assurance programs that meet specified standards. Health plans' internal quality assurance programs are important both in ensuring the quality of care provided and serving as a mechanism through which plans undertake quality improvement. The third strategy is an external quality assurance program which provides an independent check on quality.

These three strategies are not mutually exclusive. A mixed system might enhance the value of each approach. Such a system would facilitate consumer choice and provide the opportunity to improve quality, while guaranteeing at least a minimum threshold of quality for all plans.

The second question that the Congress needs to decide is who will be responsible for quality assurance. Government could play a role in oversight of quality. A decision about the degree of government involvement would have to be made. The government could run the quality assurance program, although, even in the current program, Medicare contracts that function to regional professional review organizations. At minimum the federal government could establish the framework and basic goals for quality assurance program, and oversee monitoring conducted by other bodies. Private accrediting organizations also could play a role in quality assurance. Today accreditation is voluntary, although an increasing number of employers and several states require it. A quality assurance program could involve a combination of government regulation and private accreditation. The federal government could give accredited plans deemed status that frees them from further quality review. This approach would simplify the review process for many plans, relieving them of multiple reviews for employers and the federal government.

While the Commission has never recommended which level of government should conduct oversight of the quality assurance process, it collected information on state regulations that may be helpful to Congress in making this decision. Eight states do not regulate the quality of care in any type of health plan. Of the remaining states, only a few regulate quality in health plans other than HMOs and there is a wide variation in approaches and requirements to their HMO regulation.

One last thought on quality assurance focuses on its tone. Previously, most quality assurance efforts rested on identifying the "bad" actors with utilization review programs. These traditional

efforts hassled physicians, were intrusive, and did little to improve the overall quality of care. By contrast, state of the art quality assurance programs emphasize continuous quality improvement and, therefore, should play a key role in any quality assurance system.

Medical Liability Reform

The proposal's provisions on medical liability reform are similar to the recommendations the Commission has previously made to the Congress. The principal difference is that the Commission recommends that the cap on noneconomic damages be replaced, when feasible, by a schedule that takes into account the severity of the injury.

The Commission sees enacting tort reforms as an important short-term goal. Over the longer term, however, steps should be taken to put in place a medical liability system that includes a fast, efficient administrative system to compensate patients and a complementary system to detect and prevent medical injuries.

Looking Ahead

In conclusion, Medicare cannot remain unchanged if the markets and organizations with which it deals are evolving rapidly. While the reforms included in this proposal will make new types of delivery systems available to Medicare beneficiaries, it is critical that the legislation include a strategy for assessing future changes in the marketplace. The health care system is likely to continue changing at a rapid pace, and Medicare needs to be able to adapt to both the current state of affairs as well as to any trends that are expected to continue.

Chairman ARCHER. Thank you, Ms. Wilensky.
Mr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Mr. Chairman, I want to first thank you and the Committee for the privilege of serving you for 12 years as chairman of ProPac, the Prospective Payment Assessment Commission, and make it very clear that my staff and I have worked very closely with your staff and they have given us as quickly as they can every bit of information that they have available. I would say, however, that with the changing plan, we don't know every aspect, but I have never found your staff or Mr. Thomas to be in any way holding back information. It is a privilege we have had with the Democrats and it has been shared equally with your staff. We have tried to do the best we can with what we have available, and we do know a lot about your plan thanks to the staff.

First, let me say that we at ProPAC support a lot of what is in this plan in terms of the restructuring of the home health benefits and the skilled nursing care. It is a very intricate—I don't have the time in 5 minutes to go through it. We think it goes a long way toward making the kinds of change that needs to be made in those benefits.

We also want to commend you with respect to restructuring the managed care emphasis of Medicare. We have long supported moving more forward in this area and expanding the availability of these benefits. I would point out, however, that we have some concerns. We don't believe that the change in the payment method for geographic areas as we understand it is enough. We would like to see more changes made. We think there is too much geographic variation. We think it leads to unfairness depending on what part of the country you are in. We would hope that you would give us the opportunity to work with your staff to make this plan better.

Finally, let me focus most of my time on an important area, the hospitals of this country. We have tried the best we can to estimate what would happen to the hospitals in this country if your plan was implemented. We have supplied you, and in the testimony, with several charts and graphs to do that. I will say that this is happening so fast that my staff changed their estimates last night at 11 p.m. I apologize. We have given you some new tables that revise it slightly, but let me try to summarize what we have found.

For the last 2 years, thanks in part to the pressure in the marketplace, hospitals have reduced their costs below inflation, for the first time in our history below inflation for 2 years at about 1 to 2 percent growth. Under your plan the Medicare Program would pay hospitals at inflation minus 2 percent. This is a very tough standard but we think it is doable. It would put pressure on American hospitals but it seems like the kind of pressure that they are now able to withstand.

Our concern, though, is with the look-back provision. To be honest with you, Mr. Chairman, that part of the plan is troubling. We don't know, and I would say with all due respect nobody knows ex-

actly what that look-back will look like. It depends upon how well the rest of the system works. If that look-back comes back and hits hospitals with 3-, 4-, and 5-percent reductions beyond the market basket minus 2, to be honest with you, Mr. Chairman, we cannot say that that will not have a significantly negative impact in accessing quality of care. The look-back is a troubling aspect of this plan. I know why it is there, but I cannot in good conscience say that in and of itself it will lead to the kind of care that everybody wants.

With respect to the teaching hospitals, I think Mr. Thomas and the staff have gone very far to address the needs of teaching hospitals. We have testified before him several times that we believe the Medicare payments were too high for teaching hospitals, but as has been pointed out by other Members, teaching hospitals are being hit from all sides. They are being hit from cutbacks from managed care and expansion in terms of research and so on. And as we understand it, the proposal now includes a substantial amount of extra funds for teaching hospitals. It is that change that we put in here in the—at 11 o'clock. If you include those funds into the proposal, then it is true that teaching hospitals ought to be able to maintain the quality of care and access that we now come to expect of our finest institutions. So that part we are supportive of.

What we don't know, though, is what is going to hit them on the private side and that is why our modeling is inadequate. It is not inadequate because of lack of information from your staff. It is inadequate because we are dealing with so much uncertainty out there. We have tried the best we can.

Our concerns are in other areas as well. We are concerned with this new medical savings account, not that it exists. That makes some sense. But what we are concerned with is that if you provide them with the same average payment rate as you do for the managed care part and these people are less sick and healthier and younger than the population, you could wind up hitting the fee for service with a disproportionate number of sick people while you let the medical savings account people receive payments that are higher than intended. That is troubling.

We suggest that you look hard at that medical savings account and adjust those premiums based on health status, as my colleagues talked about.

We also are concerned with health status when it comes to the managed care programs. I won't go into that; Gail has gone into that.

So there are important suggested changes. Overall, there are some very good features in here. As I said, the look-back provision is very troubling.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

STATEMENT OF STUART H. ALTMAN, PH.D
CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here again today to discuss the Committee's proposed changes to slow the growth in Medicare spending and to ensure the solvency of the Hospital Insurance Trust Fund.

For many years, public and private spending for health care in this country has been growing much faster than can be accounted for by increases in inflation and population growth. Recently, the private sector has experienced success in slowing the growth in its health care costs, especially in areas with extensive managed care arrangements. The Congressional Budget Office (CBO), however, forecasts that the growth in Medicare spending will average 10 percent a year between 1996 and 2002. There are large differences, however, in this rate of growth across hospitals, physicians, nursing homes, and other providers that must be considered. There now is wide agreement that this level of spending growth is not sustainable and that the Medicare program must control its costs.

The Committee's Proposals

The Committee's proposals would lower this growth to an average of about 6.4 percent per year between 1996 and 2002. During this time, inflation and increases in the number and age of Medicare enrollees can be expected to increase spending by about 5 percent annually, leaving about 1.4 percent additional growth each year for new technology, increases in the number or intensity of services furnished, and greater increases in the price of medical goods and services than those in the general economy.

To reduce spending growth by 35% requires new policies that will determine payments to providers and plans, or from Medicare enrollees, for the next seven years. This is not an easy task. It is especially difficult now, given the dynamic changes that are occurring in the financing and delivery of health care services. At the same time, however, it is these changes that are allowing the private sector to

control health care spending. Some of these changes also can be used by Medicare to control its spending.

As you requested, I will provide my general views on your approach and then focus on the effects of the proposal on hospitals, nursing facilities, and home health agencies. I must note, however, that there are a number of areas in which the effects of the proposal depend on specific details that I have not seen.

We have indicated to you in previous testimony that much of the rise in Medicare expenditures is due to continued increases in the number of Medicare enrollees obtaining services and the growth in the number and intensity of the services these beneficiaries receive. This growth in service volume and intensity has been aided by Medicare's traditional fee-for-service payment system. The continuing increases in fee-for-service spending also have driven up the cost of Medicare's risk contracting program, since the capitated payments to risk plans currently are based on fee-for-service spending.

Growth in Managed Care Plans

Although the number of beneficiaries enrolling in managed care plans is growing rapidly (Chart 1), many Medicare enrollees are likely to prefer the traditional system for some time to come. Further, in many areas of the country there is limited or no opportunity for individuals in the public or private sectors to enroll in competing capitated arrangements. Consequently, the Medicare fee-for-service payment system will continue for the time being to pay for the care furnished to many beneficiaries. Therefore, changes in this program also are necessary to achieve slower program growth.

Your proposal addresses both of these areas. Until now, Medicare enrollees' choice of capitated payment arrangements was limited. Your proposal would expand the type of plans and arrangements that are available and break the link with patterns of fee-for-service spending at the county level. Consequently, payments would be more stable and predictable over time. Nevertheless, payments would still be related

to historic patterns of spending that may not be an appropriate basis for future payments. I also encourage you to reduce the excessively wide variation in geographic payment rates, which generate substantially greater benefits for Medicare beneficiaries that live in geographic areas with high levels of fee-for-service spending and choose capitated plans.

Adjusting for Health Status

I share the concern of many analysts that we continue to lack a robust measure to adjust capitated payments to plans based on an enrollee's health status and the expected costs of furnishing appropriate care. This lack of a good risk adjustor financially disadvantages plans that enroll a disproportionate share of sicker individuals and could discourage plans in some areas from participating. It also provides undesirable incentives for plans regarding where they choose to locate and how they choose to market their services.

Also, younger and healthier Medicare beneficiaries are more likely to select capitated arrangements. One of the reasons for this is that many of the new plan enrollees are in managed care arrangements when they become eligible for Medicare, and they will continue in these plans, especially as you broaden the opportunities for them to do so. To the extent that plans do enroll a healthier than average Medicare population, the capitated rates will be higher than you intended. If this process of selection occurs, it will increase spending per beneficiary in the fee-for-service sector, since a sicker population will remain there. This will make it more difficult for the fee-for-service sector to function within the spending limits included in your proposal. I will return to a more detailed discussion of the fee-for-service sector in a few minutes.

As a result of these issues it is more important than ever to adjust the capitated payment amount and the fee-for-service limits to recognize differences in the health status and risk of costly illness across the populations covered under these two payment methods. The absence of such an adjustor has not been regarded as a major problem in the private sector. However, the variation in health status, and

particularly the number of individuals in the Medicare population with chronic, recognizable illnesses, creates a special problem, and the adjustments made as part of the current Medicare risk contracting program require improvements.

I should note, Mr. Chairman, that the improved enrollment policies and the process of averaging within geographic areas that are included in your proposal will help deal with this problem as it effects payments across plans. Such is not the case when a capitated payment is made to specific individuals, as with contributions to a medical savings account (MSA). If the contribution to the MSA does not recognize health status, then younger and healthier enrollees may choose this option because it is financially attractive at the time they make the choice. Again, this would increase spending per person in the fee-for-service program. In addition, over time, some of these individuals may develop costly, chronic illnesses that they did not plan for, and they may not be financially prepared to meet the out of pocket expenses required by their catastrophic coverage. The specific effects on Medicare beneficiaries, however, depend on policies regarding allowing individuals to revoke their decision to choose a MSA. I would caution you about allowing individuals too much choice once they have chosen this option.

I fully support your plans to offer Medicare enrollees the broad array of capitated payment and managed care choices available in the private sector. The major differences in health status between the general population and the Medicare population, however, create substantial problems. Ongoing modifications are likely to be needed to protect the financial integrity of the Medicare program and to ensure that Medicare's beneficiaries receive needed care.

Fee-For-Service Payment Policies

I would like to turn now to your proposals for changes in the fee-for-service payment system, especially those that affect hospitals and other providers. As I have described in previous testimony, the Medicare program has had some success in controlling its payment for each unit of service furnished. Spending increases for

inpatient hospital and other services, which slowed substantially in the late 1980s, again have accelerated. Much of this growth is due to increases in the number of services furnished, especially for hospital outpatient, nursing facility, and home health care. Unfortunately, placing controls on the price of individual services is not an effective way to control spending growth that is driven by volume increases. These controls also may introduce undesirable distortions in the medical market place as well as the practice of medicine.

Payments to Hospitals

Your proposals do adjust Medicare payments to bring them in line with the recent slowing in the growth of hospital costs. For many years, hospital costs per discharge have increased faster than the rate of inflation in the general economy. In the past two years, competition in the private sector, together with continuing payment constraints by the Medicare and Medicaid programs, have led to a large decline in cost growth (Chart 2). In the past year, hospital costs per adjusted admission have increased almost 2 percentage points less than inflation. Because of previous actions by the Congress, the increase in payments under the Medicare prospective payment system (PPS) in the last four years has been greater than the increase in hospital costs. Consequently, hospitals are now making a profit on their Medicare PPS patients. ProPAC estimates that hospital cost reductions will increase PPS margins from 0.3 percent in 1993 to 3.0 percent in 1995, their highest level since 1988 (Chart 3).

In anticipation of this testimony, we have attempted to estimate what PPS margins would be with the payment policies included in your proposal. To do so, we used two sets of cost increase assumptions. In the first, we assumed costs per discharge would rise slightly faster than the current level of increase, that is at about the level of hospital input price inflation (measured by the hospital market basket index) minus 1 percentage point. In the second analysis, costs were assumed to return to somewhat faster growth – at the level of the hospital market basket index. The payment policies

we used for this analysis include an annual PPS update factor equal to the market basket minus 2.5 percentage points for 1996, the market basket minus 2.0 for the next four years, and the market basket thereafter. We also assumed a gradual reduction in the level of the disproportionate share (DSH) adjustment to 70 percent of its current level. This reduction would return the DSH adjustment to the same percentage of total PPS payments that was in place in the early 1990s, shortly before Congress substantially increased DSH payments. For purposes of comparison, we also included Medicare's share as well as the general revenue share of indirect medical education (IME) payments that would be paid from the proposed Graduate Medical Education and Teaching Hospital Fund.

As shown in Chart 4-A, even with these policies, hospitals generally will maintain positive PPS margins if their costs per case grow at the market basket minus one percentage point. By 2002, the PPS margin would be higher than the current level. This financial performance, however, depends on the ability of hospitals to continue to restrain their cost growth. If costs per case increase at the level of the market basket, the PPS margin would be below zero in 2002 (Chart 4-B). The ability of hospitals to make a profit on their Medicare PPS business, therefore, is critically dependent on their ability to keep cost per case growth at current levels.

These are very tough policies, Mr. Chairman. Until the past year, hospitals have never kept their cost growth at the level your proposal requires. At the present time, I believe this level is appropriate. I am concerned, however, whether it will be appropriate as we move into the next century.

Of even greater concern to me, however, is the fail safe budget mechanism. While I am not aware of all of the details, as I understand it each major provider sector has a budget limit based on projections of the sector's share of the overall Medicare budget target. It is likely that achieving this budget target will require further reductions in payments per case beyond those you have already included in your bill. I am very concerned about the effect that would have on hospitals and the care received by Medicare beneficiaries.

It is important to note also that the effects of the proposed changes are not felt equally across all types of hospitals. In Chart 5-A, we display the simulated PPS margins for different groups of hospitals, assuming costs increase at market basket minus 1 percentage point. Major teaching hospitals do the best of all under PPS, with a PPS margin of 18.5 percent in 2002, compared with their 1995 margin of 14.6 percent. Disproportionate share hospitals also do slightly better on their PPS margins than they did in 1995. PPS margins for all groups, except major teaching and disproportionate share hospitals, become negative if average cost increases over this time return to the level of the market basket (Chart 5-B).

I continue to be concerned that the formula that we use to distribute disproportionate share payments is not targeting the funds to the hospitals most in need. Since the measure we use includes Medicaid hospital days, this problem is likely to worsen as states obtain Medicaid managed care waivers and Congress enacts fundamental changes in this program. During the summer, ProPAC conducted extensive analyses to attempt to devise a better formula. We concluded that improvements are not possible until new data become available to construct a better measure.

I would like to note also, Mr. Chairman, that your proposal breaks new ground in public support for teaching hospitals by creating a Graduate Medical Education and Teaching Hospital Fund that provides a new source of funding from general revenues. This fund continues, at a modestly reduced level, Medicare's support for both the indirect costs of caring for Medicare patients under the prospective payment system and the direct costs hospitals incur to maintain a graduate medical education program. It also authorizes important demonstration projects to test the feasibility of providing these payments to consortia of teaching hospitals and other entities with an interest in graduate medical education in the community. ProPAC supports such a fund and is pleased you have this provision in your proposal.

ProPAC also has attempted to assess the impact of your proposal on the overall financial condition of hospitals, as measured by their total margins. We are not able

to simulate total margins with precision, since they rely on trends in costs and revenues from private payers. We did, however, simulate what the effects of your proposal would be on hospital total margins under a set of very specific assumptions. We applied the same assumptions used in our analysis of PPS margins and factored in the proposed changes in Medicare hospital outpatient, capital, bad debt, and graduate medical education payment policies. We also assumed that other hospital revenues from all sources combined will increase in proportion to non-Medicare expenses. This method allows us to isolate the impact of Medicare's hospital payment policy changes on total margins in 2002, if other payers' policies did not change.

Using this approach, in 2002 the PPS and other changes contained in your proposal would result in total margins of 3.9 percent if hospitals hold their cost growth to market basket minus 1 percent (Chart 5-A). If costs increase at the level of the market basket, the total margin would decline in 2002 to 2.4 percent (Chart 5-B). Today, major teaching hospitals have the highest PPS margins but the lowest total margin of 2.6 percent. That pattern would continue, with total margins in 2002 of 2.6 percent under the market basket minus 1 cost growth scenario. If costs increased at the level of the market basket, the total margin for teaching hospitals in 2002 would be 1.3 percent.

It is important to note, however, that this approach is not intended to project what total margins actually will be in 2002. Depending on the numerous other potential changes that might be expected. these simulations may significantly overstate financial performance, particularly for teaching hospitals. It is likely that the growth in revenues that these hospitals receive from private payers will slow as more payers adopt managed care payment systems and become unwilling to recognize the extra costs these hospitals incur to maintain their teaching mission. I believe that the new contributions from general revenues to the Graduate Medical Education and Teaching Hospital are intended to help offset this likely decline in teaching hospital revenue growth as the number of individuals choosing managed care plans increases. We have included these new funds in our calculations, but we were not able to include

any estimates of the lower revenues from private payers. Consequently, the total margins that teaching hospitals face in the future may be lower than our analysis indicates.

Skilled Nursing Facilities

As ProPAC has reported, since 1988 Medicare spending for skilled nursing facility services has grown extremely rapidly (Chart 6). This growth has been fueled by increases in the number of persons served as well the number of days per person served. In addition, we recently have described large increases in skilled nursing facility reimbursement per day. Our analysis indicates that much of the increase is due to a substantial expansion in the utilization of ancillary services.

The Medicare program continues to reimburse skilled nursing facilities on a cost basis, with separate policies governing routine, capital, and ancillary costs. Currently, routine costs are subject to certain limits and your proposal would provide further incentives for SNFs to control their routine costs by extending the freeze on these limits for an additional year. In contrast to routine costs, where there have been some limits, capital costs have been fully reimbursed. In the late 1980s, Congress took action to reduce hospital capital spending. Your proposal would, for the first time, reduce capital spending for skilled nursing facilities. Consequently, these facilities now would have an incentive to carefully evaluate their capital spending.

The most important aspect of your proposal, however, is that for the first time it will place certain ancillary services under the routine cost limits. In addition, ancillary therapy services will be subject to aggregate payment limits. Facilities that are able to stay under the limit will share in the savings with the Medicare program. I believe the approach you have selected is a sound one. It is also an important first step in developing policies with financial incentives for nursing facilities to control the rapidly growing volume of SNF services. Nevertheless, these limits may not be may not be sufficient by themselves to bring the rapid growth in this sector in line with overall budget limits. While your proposal includes within the failsafe provision further limits

on spending growth in this sector, additional policy changes may be necessary to bring growth in this sector more in line with that in other sectors.

Home Health Services

Your proposal also makes a significant advance in Medicare's home health payment policies. Rather than imposing new cost sharing requirements on beneficiaries to control the volume of services furnished, you propose to establish prospectively determined per visit rates that are subject to aggregate limits per episode of care. Currently, the Medicare program pays home health agencies the costs they incur (subject to certain limits) to provide different types of visits to Medicare beneficiaries. This approach encourages agencies to increase the number of visits. It also fails to reward agencies for improving their efficiency. Consequently, over the past five years Medicare spending for home health services has grown an average of almost 40 percent a year (Chart 7).

The proposed policies would control this spending growth by providing incentives and rewards for agencies to improve their efficiency in providing each service as well as the total number of services over an episode of care. Agencies would have a strong incentive to keep their costs below the prospective per visit rate. In addition, a target payment limit would be calculated for an episode of 120 days of care for each home health agency. Consequently, agencies would have a strong incentive to keep their costs below the target limit. As a further incentive, they would share in the savings if they reduce their costs below the limit.

You have made a good start in providing the correct incentives to control the increase in the volume of skilled nursing facility, home health, and other post acute care services. We at ProPAC are continuing our analysis of this growth of services and their relationship to a prior hospital stay. I believe it is likely we can develop additional policies with the incentives to control volume growth. We also will be examining the changing patterns of service delivery to identify the modifications in

budget allocations across sectors that may be called for as the health care system continues to evolve and we improve our ability to control the growth in service volume.

Modifying Policies in the Future

As I noted earlier, Mr. Chairman, the financing and delivery of health care services is undergoing dramatic changes at the current time. Your proposals will continue the process of reshaping the Medicare program and allowing it to reap the benefits of a more competitive health care system. Your proposed changes in the capitated payment programs and in the payment policies for hospitals, skilled nursing facilities, and home health services do just that. Seven years in the rapidly evolving health care system, however, is a very long time. It is likely the changes we are witnessing in the private sector as well as other changes we can not anticipate now will require adjustments in these policies over time.

Your proposal sets updates for capitated and fee-for-service payment rates and addresses some of the unknown factors through a fail safe budget mechanism that is intended to provide incentives for providers to ensure that Medicare fee-for-service spending remains within the sector specific targets you have specified. I am not certain, however, that this kind of aggregate incentive, by itself, will result in the necessary behavioral change.

As I noted earlier, changes in Medicare's payment rates can control the price per unit of service. The problem, however, is the growth in the number of units of service being furnished. Controls on the prices paid for individual units of service will have only a small effect at best on reducing increases in the number of services. If this growth continues, the failsafe reduction mechanism could result in payments per unit of service that are actually lower than they are today.

A sector budget control also provides incentives for providers to shift services to other sectors to avoid penalties. Therefore, it is critical that the allocation among sectors be appropriate. In the past few years, spending for acute inpatient hospital care has grown more slowly than other sectors as the growth in admissions declined

and hospitals slowed the rise in costs and reduced lengths of stay. I am especially concerned that setting their future sector target based on this past improved performance may place them at a particular disadvantage in the future. We need to monitor carefully the effects of your proposal on access to quality care across sectors and be prepared at some point in the future to make the policy adjustments that I believe will be necessary.

As I described earlier, I also believe that the capitated payment rates should be adjusted to reflect the health status of the individuals selecting these options. The failure to do so will place those beneficiaries who choose to remain in the fee-for-service sector at a disadvantage if the average fee-for-service patient becomes sicker and the necessary costs to provide care to a sicker population triggers the failsafe budget mechanism.

In conclusion, Mr. Chairman, in the past several months the Commission has provided testimony and extensive background information and analyses concerning Medicare's managed care and fee-for-service programs to the Committee as you developed your proposal. We stand ready to provide you with additional assistance as the health care system changes and further adjustments to Medicare policies are called for. I would be pleased to answer any questions.

Chart 1. Medicare Risk Contract Enrollment and Payments, Fiscal Years 1990-1995

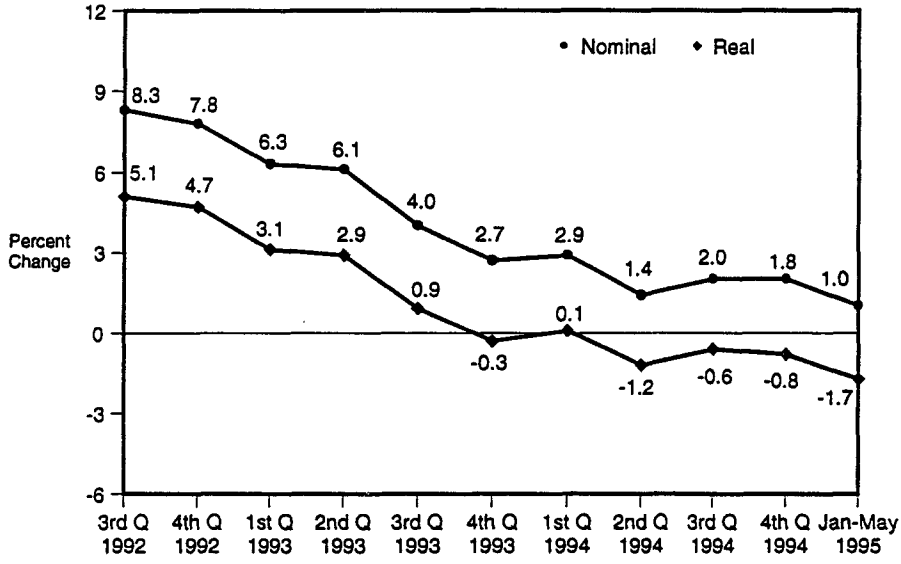
Year	Enrollees (In Millions)	Percent Change	Payments (In Billions)	Percent Change
1990	1.2	—	$4.2	—
1991	1.3	8.3%	4.9	16.7%
1992	1.5	15.4	5.7	16.3
1993	1.7	13.3	7.2	26.3
1994	2.1	23.5	9.1	26.4
October 1994 to June 1995	2.7	*	8.8	*

Note: Annual data are as of September for each year.

* Not calculated as 1995 data are not complete.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Managed Care.

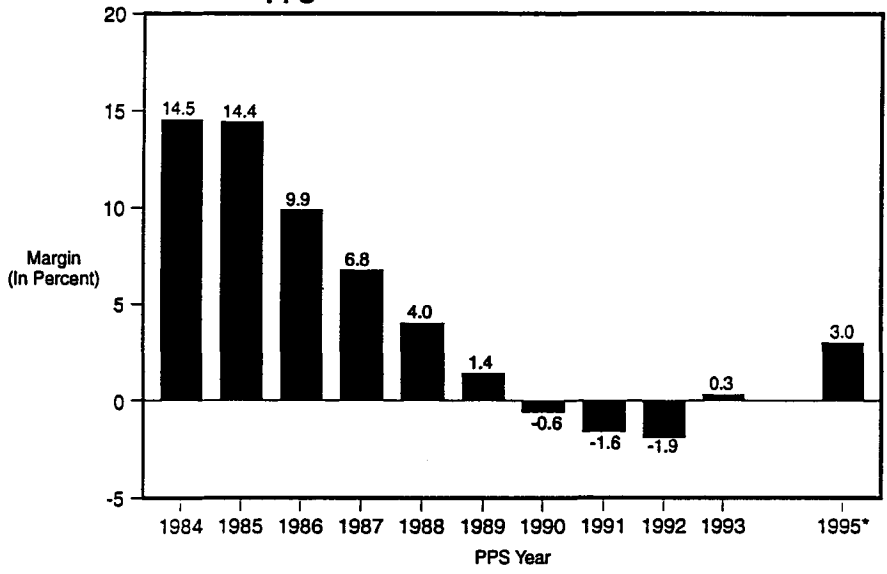
Chart 2. Quarterly Change in Hospital Cost Per Adjusted Admission



Note: Each period is compared to the same period the previous year.

SOURCE: American Hospital Association Hospital Panel Survey.

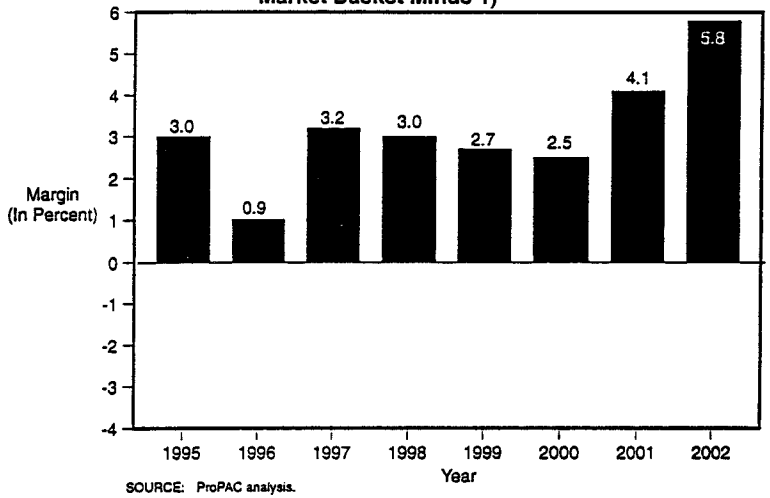
Chart 3. PPS Margins for All Hospitals, First Ten Years of PPS



* Estimated

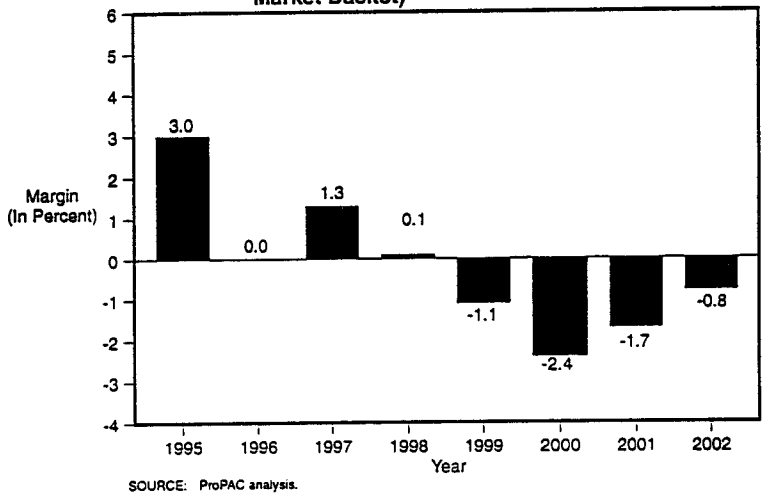
SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 4-A. Estimated PPS Margins for all Hospitals, 1995-2002 (With Costs Increasing at PPS Market Basket Minus 1)



SOURCE: ProPAC analysis.

Chart 4-B. Estimated PPS Margins for all Hospitals, 1995-2002 (With Costs Increasing at PPS Market Basket)



SOURCE: ProPAC analysis.

Chart 5-A. PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes (Market Basket Minus 1 Scenario)

	PPS Margin			Total Margin		
Hospital Group	Actual 1993	Estimated 1995	Simulated 2002	Actual 1993	Estimated 1995	Simulated 2002
All hospitals	0.2%	3.0%	5.8%	4.3%	4.3%	4.1%
Urban	0.6	3.1	6.0	4.2	4.2	4.0
Rural	-1.8	1.9	4.8	5.0	5.2	4.8
Major teaching	11.7	14.6	18.5	2.7	2.6	3.2
Other teaching	0.5	2.7	5.7	4.6	4.5	4.4
Non-teaching	-4.0	-1.0	1.3	4.8	4.9	4.3
DSH government	4.5	7.7	9.3	4.6	4.5	4.3
DSH non-government	4.7	7.4	9.3	3.9	4.0	3.6
Non-DSH	-5.1	-2.5	1.7	4.7	4.7	4.6

Note: The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues.These assumptions include: Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to one percentage point less than the PPS hospital market basket index, or an average of 2.6 percent per year. Medicare operating payment growth according to current law. Other hospital revenue growth at a rate equal to one percentage point less than the PPS hospital market basket index. The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here: PPS Operating--Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0, with new funding added; DSH reduced by 15 percent/10 percent/15 percent/ 20 percent/ 25 percent/ 30 percent. Capital--Reduced 15 percent from baseline. GME--Reduced 25 percent from baseline, with new funding added. Bad Debt--Reduced 50 percent from baseline. OPD/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment.

SOURCE: ProPAC analysis.

Chart 5-B. PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes (Market Basket Scenario)

	PPS Margin			Total Margin		
Hospital Group	Actual 1993	Estimated 1995	Simulated 2002	Actual 1993	Estimated 1995	Simulation 2002
All hospitals	0.2%	3.0%	-0.8%	4.3%	4.3%	2.6%
Urban	0.6	3.1	-0.6	4.2	4.2	2.5
Rural	-1.8	1.9	-1.9	5.0	5.2	3.2
Major teaching	11.7	14.6	12.8	2.7	2.6	1.9
Other teaching	0.5	2.7	-1.0	4.6	4.5	2.8
Non-teaching	-4.0	-1.0	-5.6	4.8	4.9	2.7
DSH government	4.5	7.7	2.9	4.6	4.5	3.2
DSH non-government	4.7	7.4	3.0	3.9	4.0	2.1
Non-DSH	-5.1	-2.5	-5.2	4.7	4.7	3.0

Note: The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues. These assumptions include: Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to the PPS hospital market basket index, estimated by the CBO to average 3.6 percent per year. Medicare operating payment growth according to current law. Other hospital revenue growth at a rate equal to the PPS hospital market basket index. The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here: PPS Operating--Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0, with new funding added; DSH reduced by 15 percent/10 percent/15 percent/ 20 percent/ 25 percent. Capital--Reduced 15 percent from baseline. GME--Reduced 25 percent from baseline, with new funding added. Bad Debt--Reduced 50 percent from baseline. OPD/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment.

SOURCE: ProPAC analysis.

Chart 6. Medicare Skilled Nursing Facility Utilization, 1980-1994

Year	Persons Served		Days	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

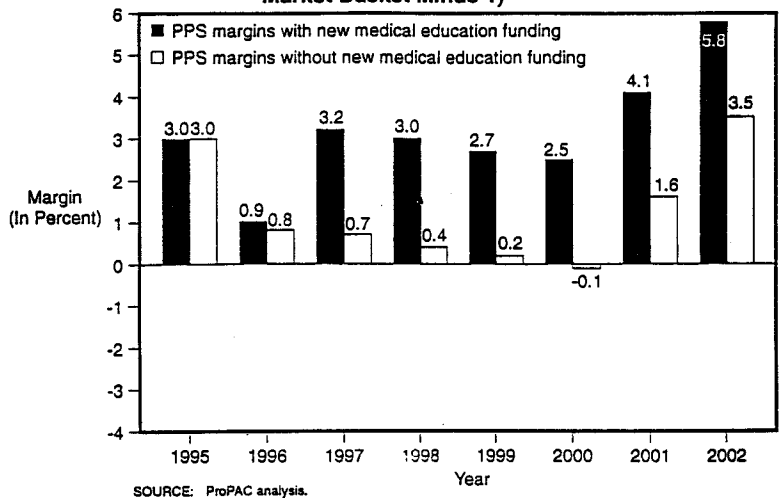
Chart 7. Medicare Home Health Care Utilization and Payments Per Visit, 1983-1994

Year of Service	People Served		Visits			Payments Per Visit	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per 1,000 Enrollees	Per Person Served	Amount	Percent Change
1983	1,318	45	36,898	1,234	28	$43	—
1984	1,498	50	40,422	1,330	27	46	7.3%
1985	1,549	50	39,449	1,274	25	49	6.5
1986	1,571	50	38,000	1,204	24	51	3.3
1987	1,544	48	35,591	1,104	23	54	5.5
1988	1,582	48	37,132	1,130	23	56	4.1
1989	1,685	50	46,199	1,379	27	56	-0.5
1990	1,940	57	69,565	2,038	36	57	1.7
1991	2,223	64	100,044	2,875	45	57	0.3
1992	2,523	71	134,844	3,796	53	59	3.5
1993	2,900	80	173,953	4,804	60	61	4.3
1994*	3,220	87	209,149	5,765	65	62	1.6

* Estimated.

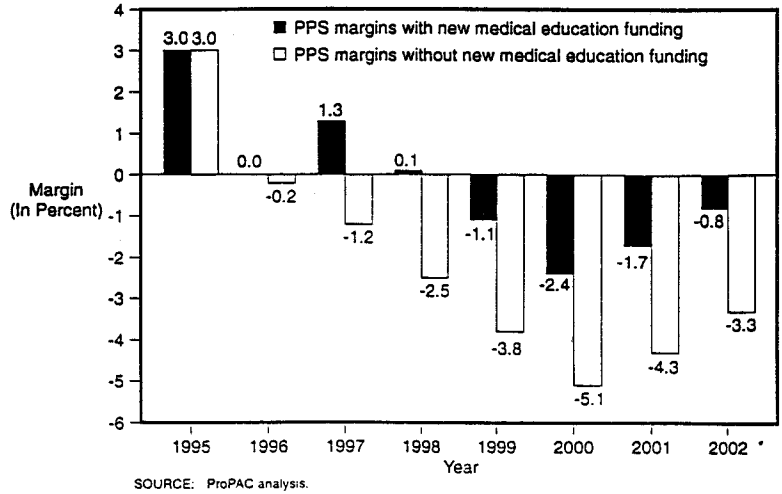
SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 4-A. Estimated PPS Margins for all Hospitals With and Without New Medical Education Funding, 1995-2002 (With Costs Increasing at PPS Market Basket Minus 1)



SOURCE: ProPAC analysis.

Chart 4-B. Estimated PPS Margins for all Hospitals With and Without New Medical Education Funding, 1995-2002 (With Costs Increasing at PPS Market Basket)



SOURCE: ProPAC analysis.

PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes, With and Without New Medical Education Funding
(Market Basket Minus 1 Scenario)

	PPS Margin				Total Margin			
	Actual	Estimated	Simulated 2002		Actual	Estimated	Simulated 2002	
Hospital Group	1993	1995	With	Without	1993	1995	With	Without
All hospitals	0.2%	3.0%	5.8%	3.5%	4.3%	4.3%	4.1%	3.3%
Urban	0.6%	3.1%	6.0%	3.3%	4.2%	4.2%	4.0%	3.1%
Rural	-1.8%	1.9%	4.8%	4.6%	5.0%	5.2%	4.8%	4.7%
Major teaching	11.7%	14.6%	18.5%	10.8%	2.7%	2.6%	3.2%	0.6%
Other teaching	0.5%	2.7%	5.7%	3.2%	4.6%	4.5%	4.4%	3.5%
Non-teaching	-4.0%	-1.0%	1.3%	1.3%	4.8%	4.9%	4.3%	4.3%
DSH government	4.5%	7.7%	9.3%	5.3%	4.6%	4.5%	4.3%	3.3%
DSH non-government	4.7%	7.4%	9.3%	6.4%	3.9%	4.0%	3.6%	2.5%
Non-DSH	-5.1%	-2.5%	1.7%	0.3%	4.7%	4.7%	4.6%	4.1%

The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues.

These assumptions include:

- Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to one percentage point less than the PPS hospital market basket index, or an average of 2.6 percent per year.
- Medicare operating payment growth according to current law.
- Other hospital revenue growth at a rate equal to one percentage point less than the PPS hospital market basket index.

The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here:

- PPS Operating--Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0; DSH reduced by 15%/10%/15%/20%/25%/30%.
- Capital--Reduced 15% from baseline.
- GME--Reduced 25% from baseline.
- Bad Debt--Reduced 50% from baseline.
- OPD/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment.

PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes, With and Without New Medical Education Funding
(Market Basket Scenario)

	PPS Margin				Total Margin			
	Actual	Estimated	Simulated 2002		Actual	Estimated	Simulated 2002	
Hospital Group	1993	1995	With	Without	1993	1995	With	Without
All hospitals	0.2%	3.0%	-0.8%	-3.3%	4.3%	4.3%	2.6%	1.8%
Urban	0.6%	3.1%	-0.6%	-3.5%	4.2%	4.2%	2.5%	1.6%
Rural	-1.8%	1.9%	-1.9%	-2.1%	5.0%	5.2%	3.2%	3.1%
Major teaching	11.7%	14.6%	12.8%	4.5%	2.7%	2.6%	1.9%	-0.6%
Other teaching	0.5%	2.7%	-1.0%	-3.6%	4.6%	4.5%	2.8%	2.0%
Non-teaching	-4.0%	-1.0%	-5.6%	-5.6%	4.8%	4.9%	2.7%	2.7%
DSH government	4.5%	7.7%	2.9%	-1.4%	4.6%	4.5%	3.2%	2.2%
DSH non-government	4.7%	7.4%	3.0%	-0.2%	3.9%	4.0%	2.1%	1.0%
Non-DSH	-5.1%	-2.5%	-5.2%	-6.7%	4.7%	4.7%	3.0%	2.5%

The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues. These assumptions include:

- Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to the PPS hospital market basket index, estimated by the CBO to average 3.6 percent per year.
- Medicare operating payment growth according to current law.
- Other hospital revenue growth at a rate equal to the PPS hospital market basket index.

The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here:

- PPS Operating--Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0; DSH reduced by 15%/10%/15%/20%/25%/30%.
- Capital--Reduced 15% from baseline.
- GME--Reduced 25% from baseline.
- Bad Debt--Reduced 50% from baseline.
- OPD/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment.

Chairman ARCHER. Thank you, Dr. Altman.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I want to thank both of you, and it probably would be useful to whenever I ask a question if either of you feel you want to respond, do, although it appears as though it is divided between physicians on one commission and hospitals on the other.

As you well know, in all of those hearings that we have had, we kind of carry on a discussion about desired changes and wishes. In fact, I remember when we were in the minority there was the discussion about whether or not this managed care trend was going to stay, whether it was a permanent adjustment in the system.

Mr. ALTMAN. Right.

Mr. THOMAS. You and I agreed that it probably was and that was a couple of years ago and it is moving even more rapidly than we thought.

First of all, thank you in terms of the nice comments that you made, and as you might expect, I have some concerns about the very areas that you have some concerns about. We are making change. We are making change because we need to make change.

I personally think the prospective payment structure we put in for home health care was kind of elegant. I think we have done a pretty good job there. I would say we couldn't do as good a job in the skilled nursing facility area, but we just didn't have the data and, of course, that is always troubling, as you know. We would like to have more. We are going to try to get more.

Your concern about the medical savings accounts and the risk adjustment method, which was a point that Dr. Wilensky focused on, we know that under the managed care type payment tied to fee-for-service which is adjusted by age, sex, geography, and institutional condition there are problems. We are looking for some assistance in working on a risk adjustment mechanism that is far better than what we have now.

If any of you could give us an update as to where you are in providing us with that. Obviously, we are anxious to get any newer model that you might have, but I agree with Dr. Wilensky that if you waited for that perfect risk adjustment model, you would be waiting forever.

We are moving forward with the understanding we have some problem areas, but we are going to focus on them and we are going to resolve them as rapidly as we can. So, let me give you the mike for a minute or two if you have any response to where we are now on risk adjustment mechanisms.

Ms. WILENSKY. There are activities going on at HCFA and, obviously, you should follow through with the administration, but PPRC has some studies that are underway. The first of them should be completed within 1 month. Some additional studies looking at claims data and trying to assess the status of people before they go into HMOs and those that leave HMOs so that we understand both, whether there is self-selection in but maybe there may be favorable or unfavorable selection out, should be available over the next several months.

Again, let me urge you that if you look at the notion of risk adjustment as looking at distributions of people who choose plans and

making an adjustment after the fact, it will be far easier than if you try to be able to predict beforehand at an individual level. I think many of the analysts on PPRC and commissioners as well as others believe that that after-the-fact adjustment will be far easier.

Again, to the extent that you can make some improvement, let me urge you to do so and to improve as you go along. As you open up greater choices, point-of-service, PPOs, other types of flexible managed care in addition to Medisave, it will become more and more important to make adjustments for health status so that you don't send some of the plans in death spirals.

Mr. THOMAS. Stu, on the adjusted average per capita cost formula, we obviously agree that we have big problems, and one of the big ones is the geography is by county. We are going to move to a metropolitan statistical area, which is an easy fix and it starts us moving.

I believe you know that in the bill we have a commission to look into some kind of a new formula, and we are going to rely on the expertise that is embodied in you folks as the core of that commission and then bring additional folk in to work on some kind of a fair allocation under a formula dealing with a number of different models. I think we are behind the curve on that, and I look forward once again to any input that you folks can give us on a fair formula.

But I hope you understand that at the beginning we have to take what we have been given and make whatever adjustments we can to live with it until you give us a better model.

Mr. ALTMAN. I appreciate that. Mr. Thomas, we testified before you regarding our concern that in certain parts of the country, the current payment rate is so far in excess of what it costs the managed care plans to provide the services that some beneficiaries are getting $140 per month of extra benefits. Now you might say, well, they are getting extra benefits, that is fine. But in another county right around the corner or around the block or halfway around the country, they are getting none of those benefits, and I think over time if you don't fix this problem quickly, you are going to have a very different Medicare Program depending upon where you live.

Mr. THOMAS. Once again, you understand we are aware of the problem. We have what we believe to be current adjustments that are possible. We have a commission to look into it. We inherited this problem and we have set up a structure I think that will resolve it.

I want to thank both of you for your testimony, not just today, but for all those other times we enjoyed having a discussion about the way in which Medicare ought to be reformed.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. Dr. Altman, the last witness testified that to make this part B trust fund sound, it would take $160 billion, not $280 billion.

Mr. ALTMAN. The part A trust fund, sir?

Mr. GIBBONS. That is right. The trust fund, the thing that they are all weeping and wailing over, it would take $160 billion. So we have still got $110 billion that is coming out of this program more than what is needed to make the trust fund sound. That is their witness. They called him. He identified himself as being a coworker

of theirs and a member of their own political party, and he is a fine fellow and he has had lots of experience so I trust his figure of $160 billion.

I am not going to ask you why the other $110 billion is coming out of this program. But I am intrigued with what both you and Ms. Wilensky said about the problems you are having with the Republican draft that none of us up here and the public has ever seen. Can you elaborate a little more for me about the problems you are having?

Mr. ALTMAN. Well, as I tried to say, we have tried to model the implications of the cuts mostly in the part A trust fund. And as I said, most of the reductions in the rate of increase—and that is what they are—seem to us to make sense. The hospitals, much of the cuts in the growth rate in the hospital payments are in line with where the market is today; they are not unreasonable. Where we get uncomfortable is in the look-back provision, if it is necessary, and also in the fact that it is sector by sector.

We had a long discussion with Mr. Stark about that and I understand why it is done. I think the government is pushed into that by the scoring mechanism that sits on high. From an economic point of view, it is bad business because it lacks flexibility; therefore, you have to give the flexibility back to somebody else.

Now, I think I understand that when we see the legislative language it will say that the secretary will have the authority to change those sector allocations. I encourage you to have those words in there because there is no way we can anticipate 3, 4, 5 years down what those sectors ought to look like. You could wind up wiping out the hospital industry while the home health benefits go berserk or the other way around. So those look-back provisions to the extent they are sector specific and they are earmarked can lead to serious problems to our health care delivery system. That is our concern.

Ms. WILENSKY. I would like to add a comment with regard to that. PPRC, in response to some earlier requests to something that was like a look-back in previous years, had suggested trying not to have too many sectors, again because of the concern that Stuart Altman raised as to whether or not you will put very difficult burdens. To the extent there is some flexibility allowed to the Secretary, that would, I think, alleviate that concern.

The staff at PPRC have worked closely with the staff of the House Subcommittee in trying to provide technical assistance and have felt that that working relationship has continued as it has in the past, and we have not felt a difficulty other than the fact that not all of the details have been finalized and therefore changes occur over time.

Mr. GIBBONS. But as I interpret your testimony, both of you professionals are uncomfortable with the program that you know of that none of us have ever seen.

Thank you.

Ms. WILENSKY. Well, I think that there are aspects in there that incorporate changes that relate to our specific recommendations, and we are very pleased to see that, and there are other aspects that are not finalized or don't go as far as we would like to see and as we think the Committee or at least the Committee staff would

like to see because we don't have the technical information. Risk adjustment is one of them. We know we need to get better.

But I think all of us encourage the Committee not to wait until you have the perfect adjustment. We know the AAPCC needs to become more equal across the country, but you have to move from where you are to where you want to be, and I think there seem to be some signs that that is being built in.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Mr. Chairman, I would like to ask the witnesses to clarify something Mr. Gibbons asked in quoting the actuary as to $160 billion being all that was necessary, and I believe the question was phrased as to the—as to one part of the Medicare plan and for 10 years. The question then comes up what is done with the extra $110 billion because the total package is—creates a savings of $270 billion. Can either one of these witnesses respond, Dr. Wilensky?

Ms. WILENSKY. Well, let me respond as an economist rather than a PPRC chair with regard to that answer. Right now the Medicare Program is growing at about 10.5 percent per year. It is about 9-percent growth per person, 1.5 percent reflecting the aging of the population.

The issue, in addition to the fact that there is a trust fund that has a funding problem which has gotten a lot of attention, has to do with the question of how fast does the program need to grow in the aggregate or per person in order to provide the services we have promised the elderly. It is important to get a sustainable spending level per person. I think many of us think 9 percent per year is too much, is too fast, not just because of current budgetary concerns but because we all know the boomers are coming along and that even when we get a sustainable level of spending per person, we are going to have to worry about the bulge in the population. So that while you may need a certain amount of money, and I will trust Guy King's estimate as to what that is, to solve a certain funding problem in the trust fund, it begs the broader issue, which is how fast does Medicare need to increase per person each year in order to deliver the services, and that the present rate of increase I believe is too fast and unsustainable. What the right rate is is obviously a more difficult question that people can argue about.

Mr. SHAW. But in the plan, the so-called Republican plan or the MedicarePlus Program, the growth is still approaching 6 percent per year so there is still a growth pattern and there are no actual cuts.

Ms. WILENSKY. It is about 5 percent per person, 6½ percent per person in the aggregate. It is 2 percent above inflation, maybe 2.5 percent depending exactly on what is inflation in terms of real growth. It is growth per person. It is obviously slower growth per person than we have seen in the past. The question is is it enough, is it fast enough?

Mr. SHAW. And the payments that are made go into a trust fund under part A and part B; is that correct?

Ms. WILENSKY. Well, there is technically a part B trust fund. It works in a different manner. It is funded each year out of the general fund and out of premiums. There is a very well-known part A

trust fund that comes from 1.45 percent of the wage tax by the employer and employee and goes directly into a trust fund for hospitals.

Mr. SHAW. Thank you, Mr. Chairman.

Chairman ARCHER. With the balance of the gentleman's time, would he yield to me?

Mr. SHAW. I yield to the gentleman the balance of my time.

Chairman ARCHER. I think this gets into some very important areas for us, for the understanding of the American people. Currently, Medicare is growing at over 10 percent per year; is that correct?

Mr. ALTMAN. That is right.

Ms. WILENSKY. That is right.

Chairman ARCHER. That is more than three times the rate of inflation; is that correct?

Ms. WILENSKY. Approximately.

Chairman ARCHER. In order to save Medicare, if we let the growth approximate roughly twice the rate of inflation, we can get the job done; is that a fair statement?

Mr. ALTMAN. That is true, yes.

Chairman ARCHER. All right. So any plan necessary to save Medicare under the projections and assumptions of the actuaries—we just had one in front of us today—that will let Medicare grow at roughly twice the rate of inflation and will still get the job done; is that a fair statement?

Mr. ALTMAN. I think it is a fair statement, although I would caution that we need to talk about per beneficiary as opposed to the program.

Chairman ARCHER. No, I understand. But even per beneficiary, it can continue to grow at a figure that I believe Ms. Wilensky said was 2.5 percent above the rate of inflation.

Mr. ALTMAN. That is right.

Chairman ARCHER. And accomplish the job.

Mr. ALTMAN. That is right.

Chairman ARCHER. I think that is very, very important.

And the question that Mr. King was not permitted to answer by the questioner when he began to say, actually, could it be that he was referring to what has actually occurred in the private sector in this country relative to the growth of the rate of spending on health care as a model that shows that we can do better, would that be a fair statement, than we are doing currently?

Mr. ALTMAN. Since the early nineties, the rate of growth in the Medicare Program has been 2 to 3 percentage points faster than in the private sector. Much of it, though, has been because of volume, which I think Mr. Thomas tried to get at, and I think we need to focus on that because I think that volume growth needs to be dealt with more in a managed care environment. It can't be dealt with in a price environment. But you are absolutely correct.

Chairman ARCHER. Thank you very much.

Mr. Rangel.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Stuart, I think the assumption is that hospital admissions have a rate of increase, I don't know what it is, but this can vary be-

cause of disasters and other things, and I also believe that the baseline growth in this proposal is based on an inflation rate of about 3 percent. I don't know that but that is a guess.

Under this bill, we are now limited in hospital payments to exact dollar amounts. We have never been limited that way in the past. We have always adjusted by population or inflation growth.

Would it not have a serious effect and possibly result in payment decreases if the inflation rate was 4 or 5 percent or if we had an additional 1 or 2 percent in a certain area of hospital admissions, without any ability to correct? Could you not, because of the specific dollar amounts, end up cutting payments to hospitals?

Mr. ALTMAN. I am very troubled by the box that I think this Committee is in in terms of the scoring mechanism by having to live with an artificial growth curve built into the CBO estimates where they have estimates they have no idea what will actually happen, not because they are not smart, because nobody knows. I would have felt much better if this was tied to inflation.

The idea that we have absolute dollar amounts could be very troubling. If—and I can't say anything else—if inflation were to double and you wind up with a situation where you have an absolute dollar amount and you have to come back with this look-back, you could actually, yes, you could have absolute reductions in payments to hospitals. I think everybody would be better protected if we could do this in real terms.

I understand the problem the Committee gets into. They don't have any choice. But from a public policy point of view, I would feel much more comfortable if it was in real terms.

Mr. STARK. Gail, on your side, after 2002, you are limiting the cuts—I mean, the increases to 4.3 percent. The figure you gave us is good until 2002. But after that, your fail-safe cuts will always be lower than the recommended updates and you are going to, in this bill, limit those increases.

Now, that may be good, but it may be bad and there is nothing you can do about it. Would you share Stuart's concern that we ought to build some kind of indexing or flexibility into the program?

Ms. WILENSKY. I think the need for flexibility is important. Frankly, if the situation that Stuart described arose, I suspect you would change this legislation in a hurry. That if in fact the presumptions about inflation were to change dramatically, you could not withstand these set dollar amounts.

Mr. STARK. Could we not achieve what one would anticipate the Republican outline wants to achieve and still use some guidelines or indexing? Now, this may cause a budget scoring problem, I am not sure. And it was my feeling that this could be done.

Let me ask Gail one more question. You didn't summarize your testimony on Medisave. But if I could paraphrase your testimony, you suggest that because we don't have accurate risk selection programs, that we ought to require Medisave enrollment for at least 5 years and possibly make it a once-in-a-lifetime decision. Can you elaborate?

Ms. WILENSKY. Yes. I actually have said this, I believe, to at least the Subcommittee before. I am a strong supporter of the option of Medisave. It exacerbates the problem of risk selection, if it

occurs, and until we can get a reasonable risk adjustment mechanism, one way to try to protect the rest of the choices would be to have a longer term choice pattern, to have a cooling off period of at least a couple of years, maybe 5 years. Initially, I had advocated a once in a lifetime. I think I have changed my mind since then that that may be excessive. But to have an annual enrollment at this point in time with the sophistication of our risk adjustment ability I think is asking for trouble. But I do think it is an important option and I think it can be worked out. I am anxious to see what CBO does with regard to the scoring of this as to whether they think it will cause increased expenditures to occur elsewhere.

Mr. STARK. Just one question. Do either of you belong to an HMO?

Ms. WILENSKY. I belong to a PPO, a network.

Mr. STARK. An HMO?

Ms. WILENSKY. No.

Mr. ALTMAN. Fee-for-service.

Mr. STARK. So do all the Democrats. I have not asked the Republicans. I have a hunch that nobody in the room belongs to an HMO, but I am going to find that out later.

Chairman ARCHER. The gentleman's time has expired.

Mr. ALTMAN. All my children work for HMOs, though. I think that is the future.

Chairman ARCHER. I think if we took a poll, most of us up here on the Committee are covered by a PPO. I know that I am. But let me just quickly say this. What Ms. Wilensky said is so very important for all of us to understand, irrespective of our persuasions on this. We cannot lock in a program for 7 years that will not be adjusted and changed as we move along.

Mr. ALTMAN. Absolutely, yes.

Chairman ARCHER. That has got to be assumed. Every year the Congress is going to be looking and adjusting whatever program is put in place.

Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman.

In regard to your foregoing comment, I think it is appropriate also to remind the Committee, as well as to remind the listening public, that should there be a sudden rise in costs for any reason, whether it was because of inflation or some other factor, Congress would respond. Every time there is a serious rise in unemployment, this Committee meets, reports out new legislation, and alters the program and extends the benefits. So whenever there is a significant aberration in our economic circumstances that affects the lives of the people, we respond. And if there is any significant change from the assumptions that we are operating on in the real world, we will certainly respond.

It is also true that of course as inflation rises so do contributions to the Medicare Trust Fund as a percent of wages and so more money does come in without increasing taxes and that helps to offset the inflation of the medical costs. So I don't worry about what happens during the 7 years because we will all be here together deciding what is going to happen if we are under those circumstances.

But I do want to ask you both to comment on an issue that you have raised that is at the heart of what we are doing. To me, it is the core cost driver in Medicare. Of course we have more seniors and of course there are things like that. But it is our extraordinary ability to diagnose and treat illnesses that are driving rising costs in health care for every group in the population.

Now, in Medicare we have tried to control the costs of volume, that is, the number of new visits, the amount of new tests, the number of specialists, the use of specialists. We have tried to control all of that by regulating rates. We have a long history of price controls, some of which were put in place explicitly for the purpose of controlling volume.

Now, I have anecdotal evidence that we are at the point where prices in some areas are so low that there is diminishing access to the service to the physician or to the product. I am interested in whether there is yet, since our data is 2 years behind or 1 year behind reality, whether you are seeing any evidence in your data of reduced access to service as a result of price controls. And then I would like you to comment on the mechanism of volume control through price control versus the mechanism of volume control through integrated care systems.

Mr. ALTMAN. Well, Mrs. Johnson, first in the areas that we have focused on, hospital care, nursing home care, and home care, quite the opposite is true. The payment rate on the part of the government has gotten quite generous and what we see is exactly the opposite.

Mrs. JOHNSON of Connecticut. You mean so the rates are encouraging use?

Mr. ALTMAN. Hospitals—the rates have been held fairly constant. Their costs have come down. For the first time in several years, hospitals are making quite substantial profits on Medicare and they are making very substantial profits when we go to the skilled nursing and home care. So it is the opposite. We are seeing tremendous increases in volume.

Now Gail may have a different picture on the physician side, but in our side, the opposite is true.

Ms. WILENSKY. The interesting thing is that while Medicare has been relatively constant in its treatment, the private sector has been very aggressive, and the upshot is that our worries which in principle are very appropriate and should be remembered in the future, in fact there is absolutely no indication that there is an access difficulty. In fact, when I go around and speak, physicians are now telling me that Medicare is frequently the best payer in town. So while it is something that could happen, it is not happening at the moment.

Now, there is an issue with regard to volume price tradeoff, and in the past, Medicare has tried through a direct control system to limit spending, focusing on prices, except for physicians where they link prices and volume. In general, it doesn't work very well because volume is what has driven expenditures for the most part in this country. It is why a lot of people think integrated delivery systems, the whole range of managed care and Medisave accounts which have people using their own money for the noncatastrophic, is a way to try to go after this volume problem by either having

the individual or the plan at risk rather than trying only to control through price controls. We haven't had in general in our history as much success as we have liked. That is why you are facing the difficulty you are facing.

Mrs. JOHNSON of Connecticut. Thank you. Thank you, Mr. Chairman.

Chairman ARCHER. The gentlewoman's time has expired. The gentleman from Kentucky.

Mr. BUNNING. Thank you.

My good friend, Mrs. Johnson, has said that she will be here in 7 years. I don't know if any of us will be here in 7 years, but I congratulate her on winning her next three elections.

Let me get to the point of what the present law says. If we get to the year 2002 and we don't alter what we have in front of us and the projections show the funding continuing to spiral downward, what does the present law say in regard to paying benefits? I want this on the record because I want everybody to understand what the alternative is. Anyone on the panel?

Mr. ALTMAN. My sense of the law is that if the trust fund is out of money, Medicare will not pay its bills.

Ms. WILENSKY. There is no legal authority. You have two economists speaking.

Mr. ALTMAN. We don't know anything about the law.

Ms. WILENSKY. There is no real authority to spend money out of the trust fund when it has depleted the funds.

Mr. BUNNING. In other words, if we fail to act, then there will be no money at all, by your projections, in the trust fund in the year 2002. I want to just make sure that that is on the record because I don't believe it has been brought out.

Look-back provisions. If we do run into a problem where inflation erodes the increase that we are building into the projection—in other words, the 6.5-percent increase—I suspect that whoever is sitting on this Committee at that time will listen to the Secretary of Health and Human Services as we have this year and say, We have to do something to correct that.

Do you all feel that that is not going to be the case?

Mr. ALTMAN. There are two parts to the look-back provision. One is that the look-back provision could be implemented even without inflation.

Mr. BUNNING. Correct.

Mr. ALTMAN. One aspect of this that I do not know—and I have never seen added up—will all the savings reach the goals. So I don't know whether you will need the look-back without inflation. If you need the look-back without inflation, then what we are talking about are reductions that are going to be greater than we have modeled. Now, as I said, I haven't seen them. They are by sector. It may be that the hospitals are fine, the nursing homes. I don't know that. I would hope that when we see the final proposal, the dollar growth reductions that are in place will be adequate to meet your goals and that the look-back provision will not be necessary.

Ms. WILENSKY. Let me say I believe the look-back will be necessary because the fee-for-service system has the same lack of incentives to moderate spending it has always had, and, therefore, in

all likelihood the growth in spending in that sector will be greater than what is presumed in the budget.

The question of whether or not the look-back mechanism provides enough flexibility will depend on exactly how you write that language. I presume that if what you have put in place produces reductions that are intolerable and that can't be accommodated by the flexibility, the Members of this Committee will meet and make some changes.

Mr. ALTMAN. But I want to add something. We see different sides of this animal. I think the proposals that are in this plan in terms of home health care and skilled nursing will reverse much of the pressure points that fee-for-service generates.

Ms. WILENSKY. That is true.

Mr. ALTMAN. It is also the hospital care. Hospital growth has not been the driver of inflation. So the driver has been in the home health and skilled nursing, and as I said earlier, those proposals do have a crack at making significant restructuring. And so, therefore, there is a reasonable shot that you might see the savings. But I don't know, I have never seen the addup. And the look-back, if it is needed, could cause real problems.

Ms. WILENSKY. But again I think—while there are some behavioral changes that may help, I believe that it is in place not only because you need it for scoring purposes, but it is prudent to expect that you might not have quite the slowdown in spending that is presumed.

Again, I think the real issue is, do you have some flexibility in how the look-back is implemented? It may be that as we can look at the legislation and have the two commissions' help, we may be able to offer some assistance to make sure the least harm is done if you have to invoke the look-back. So I think we are both offering help to try to make this as easy a system as we can.

Mr. BUNNING. Thank you both.

Chairman ARCHER. The gentleman's time has expired.

Does the gentleman from Indiana wish to inquire?

Mr. JACOBS. Did somebody just misspeak now and say if no action is taken there will be no money at all for Medicare part A in 2002?

Did you mean to say that?

Ms. WILENSKY. No. I think what we said, based on what we understand of the actuary's projections, is that the trust fund will be depleted, the surplus will be depleted by the year 2002.

Mr. JACOBS. The surplus, but the tax would still be in place. There won't be enough money, it is not that there will be no money at all.

Ms. WILENSKY. The problem is that the incoming funds are smaller than the outgrowth, and it is only the surplus that keeps us out of difficulty.

Mr. JACOBS. Well, Mr. Chairman, as my contribution to the progress of this hearing, I have no other questions, only one comment.

Gail, it is nice to see you again.

Ms. WILENSKY. Thank you. Nice to be here.

Chairman ARCHER. I thank the gentleman from Indiana.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, thank you, Mr. Chairman.

We have had a series of hearings and this is the last one, and it is a very important hearing. And what I would like to do is to get your judgment rather than a litany of figures.

If I understand, Ms. Wilensky and Mr. Altman, what you have been saying is that you do not expect people to react to the new product line the way we might like them to; therefore, you are worried that we will have to go back into a thing called a fall-back or the look-back.

I guess the question I want to ask of you is this: Do you think that there are sufficient incentives or motivations in this system, if they are properly orchestrated, to make this plan work? Because it is only because people believe in it and feel that they are going to get something new out of it that it will work. I would like your reaction.

Mr. ALTMAN. Well, I have not read the specifics. I did read the document that came out yesterday; I have not worked with it.

I don't see a significant number of new incentives. They are to expand managed care. I think managed care is growing and is going to continue to grow rapidly under the existing incentives. So don't get me wrong, I think we are going to see a substantial growth in managed care under the Medicare Program, to a large extent because you get much more benefit out of it. The legislation helps it along by—my sense is, by making it clearer what kind of benefits, making it easier for people to join.

But what I haven't seen, and maybe it is in your legislation, are the financial incentives that I was hoping to see to make it even more attractive for people to go into. Maybe it is there. So I think we are on a growth path, and as we see more plans come in and more areas with plans, you are going to see more and more growth.

But I don't know whether in the foreseeable future, clearly in the next 7 to 10 years you are going to see 50 percent or anywhere near 50 percent of the Medicare population in managed care. So, therefore, I think you need to recognize that for the foreseeable future, the majority of spending in Medicare will be in what we call the fee-for-service plan.

Ms. WILENSKY. Let me respond. I don't fundamentally disagree, but I think that the introduction of new options, more flexible options of managed care—including however it is arranged, the use of a Medisave—will attract seniors who have previously not been attracted to go into managed care. What would have been necessary, if you wanted to complete the circle, to change people faster, would be to have seniors face higher prices, higher costs. If the fee-for-service system, the classic Medicare, is more expensive, as we expect over time it will be, the way to have made that other part of Medichoice—or MedicarePlus, I guess is what it is now called—more attractive would have been to have seniors face the additional prices and costs of being in the classic Medicare. For a series of very understandable reasons, that is not the mechanism in place.

I think you will get substantial growth in the choice plans. But even under the most optimistic assumptions, you are going to have at least 50 percent of the population in the fee-for-service system in all probability at the end of the decade. And therefore the issues

about how you keep spending in line with projections, or for the fee-for-service world, the look-back, the fail-safe mechanism becomes relevant. I think it is there. Maybe it will be 35 percent, maybe it will be 50 percent that goes into the choice plan, but in all probability, there will be a big number that is left in classic Medicare.

Mr. HOUGHTON. Well, it obviously takes a tremendous amount of time to turn a battleship around, and that is what we are trying to do now.

Ms. WILENSKY. Yes.

Mr. HOUGHTON. But it seems to me we are trying to reach for those same incentives that the private sector has used to keep its costs under control. Do you agree with that?

Ms. WILENSKY. Well, sort of. I mean, the fact is, there are a lot of different strategies the private sector has used. Some companies pay a fixed amount. The employee can choose whatever plan they want, sort of like the Federal Government's plan and the choice part of Medicare.

Sometimes employers go and drive the best bargain they can with a single plan, and that is the only choice that people have. There are some companies that are using old-fashioned indemnity schedules where they set the reimbursement at the 50 percentile, and if you want to go more expensive, you pay the difference. And some companies have used Medisave kinds of accounts.

So what companies are trying to do is to be aggressive purchasers, and that underlies a lot of what Medicare is doing, but there isn't one strategy that they follow.

Mr. ALTMAN. I want to emphasize what Gail said, although I think—in retrospect, I think the Committee, the proposal came out right. I don't think you can get away with, and I don't think it is good public policy to have expected Medicare to follow completely what the private sector does.

Let's face it, in more and more companies around the country, they are being economically pressured to go into managed care. I think to do that as quickly as the private sector has done for Medicare would have been very dangerous. And so, in retrospect, I think going slowly is probably the better movement.

Ms. WILENSKY. Certainly dangerous politically.

Mr. THOMAS [presiding]. The gentleman's time has expired.

Will the gentleman from Michigan yield very briefly?

Mr. CAMP. Yes, I will yield.

Mr. THOMAS. I thank the gentleman. I want to make the point you just made and I want to underscore it.

Obviously, we are talking about trying to modify a program in a political context. Had we, as Dr. Wilensky said, increased the side on fee-for-service so that people would be forced to make a choice, we would be accused of driving people out of the fee-for-service and herding them into managed care.

Ms. WILENSKY. Right.

Mr. THOMAS. Had we created a bunch of incentives on the managed care side, as I said, toasters, microwaves, big cash-back arrangements, we would have been accused of setting up systems which would have induced people to go into a program that wasn't very good for them. What we did do was examine what options we

could make, and clearly the reason beneficiaries select these options as you said, Dr. Altman, in large part is because of the additional health care that they do receive—paid prescriptions, vision, dental.

But in our plan—and you may not have picked it up yet—what we do say is that since we continue the part B premium at the 31.5-percent rate, which is currently $46.10 a month, that amount could be——

Mr. ALTMAN. I did see that.

Mr. THOMAS [continuing]. Part of the managed care. So you at least, in essence, get a rebate of the premium you would have already paid, along with those other benefits.

You are going to be criticized no matter what you do, and I believe we have the mix about as right as you can get it right now. Hopefully, if we could enter into a bipartisan examination of the area without the worry of the partisan attacks, we could have done something slightly different; but given the environment that we have now, I think your final analysis is correct.

I thank the gentleman for yielding.

Mr. CAMP. Thank you, Mr. Chairman. I want to thank Dr. Wilensky and Dr. Altman for coming here and testifying, and I appreciate your testimony.

Dr. Wilensky, you mention that when Medicare was enacted some 30 years ago that basically the current medical financing and delivery system was placed into law and pretty much froze there for the last 30 years. Yet you also mentioned, in the marketplace or in the private sector, we are seeing our health system changing and undergoing dramatic reform.

I just wondered if you could briefly state for the record what are some of the options that are available now that aren't available to seniors under a basic fee-for-service plan?

Ms. WILENSKY. Basically, seniors now have two choices. They can stay in the a la carte fee-for-service direct control system that characterizes Medicare, or they can choose a classic HMO with very little variation in between. They can go into an individual practice association, which is not quite as tightly organized as the group staff model, but that is the only variation.

In the private sector, you have seen much more flexible arrangements develop: Preferred provider organizations, other network plans where you get a good buy in the network but you can leave at any point, pay a little more, and go outside of the network.

There are indemnity schedules where the insurance is paid at a specific level. The person can leave and pay the difference if they go to a more expensive physician or facility.

There are some plans that incorporate the Medisave principle where there is an amount set aside to be under the control of the individual along with the catastrophic insurance to try to encourage people to be more cost conscious in the noncatastrophic part.

There is a lot of variety that the private sector has been developing in trying to find ways to constrain spending, almost none of which is, by law, available to seniors.

Mr. CAMP. Thank you. That is very helpful.

I yield back.

Mr. THOMAS. Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you, Mr. Chairman. I would like to ask Dr. Altman a couple questions.

The medical inflation today is 10 percent—I think both you and Dr. Wilensky had indicated that—6.4 percent will be what we are projecting under this proposal, what the proposed proposal is for the next 6, 7 years, from this year to 2002. After that, the projection is 4.3 percent.

Do you believe that that is a credible number, perhaps we are looking 7 years away?

Mr. ALTMAN. I am sorry, I am having trouble. Where did the 4.3 percent come from?

Mr. MATSUI. Apparently from what we understand.

Ms. WILENSKY. I haven't heard that, either.

Mr. MATSUI. From what we understand—maybe this was in the document that we received earlier this week—after the year 2002, the 6.4 percent will change to 4.3 percent in terms of Medicare growth. That is, 3 percent CPI growth and 1.3 percent growth in population.

That is not your understanding?

Ms. WILENSKY. That is——

Mr. ALTMAN. I have never seen that, sorry, sir.

Ms. WILENSKY. I have not seen that. That sounds like a Medicaid number rather than a Medicare number. I may be wrong, Mr. Matsui. I haven't seen the number.

Mr. MATSUI. In fact, I believe Mr. King had verified that with me.

Ms. WILENSKY. I will—I guess I am willing to make a comment with regards to the numbers I know, maybe in the spirit of that, but I don't know.

Mr. MATSUI. I understand. Dr. Altman, are you reading from a——

Mr. ALTMAN. I—we have not modeled anything beyond 2002 and——

Mr. MATSUI. I notice that in your statement, because you do go up to 2002 and that is why I am——

Mr. ALTMAN [continuing]. And it is—I would have to go back and look. I have just never—I am having enough trouble figuring out what is going to happen in 2002.

Mr. MATSUI. If I may just have a moment—OK, it is on page 58 of the document.

Mr. ALTMAN. I have just been shown it, and it is the first time I have seen it.

Mr. MATSUI. That being the case, however, is that a realistic number 7 years from now?

Mr. ALTMAN. It is a tough number.

Mr. MATSUI. It is. The 6.4-percent number is a tough number.

Ms. WILENSKY. It is.

Mr. MATSUI. You indicated that is possible to achieve?

Ms. WILENSKY. I think my comment to you is going to be, the number that I was aware of, which is 6.4 percent, I think, is a reach, a stretch.

Mr. MATSUI. Right.

Ms. WILENSKY. But not beyond the pale.

Mr. MATSUI. Right.

Ms. WILENSKY. The issue of whether we can go to zero real growth would again—I have just looked at this very briefly; the enrollment and inflation only is something less than I have contemplated and that I have seen experienced.

Mr. MATSUI. I guess what troubled me a little bit is that if you combine the reach-back with the 4.3 percent, that does create an interesting problem, I believe, for whomever happens to be in the administration in the year 2003. Do you have any comment on that? Because I think if we are serious about solving this problem for 14, 18, or 20 years—20 years, I guess it is—7 years from now we had better know exactly what we are looking at.

Mr. ALTMAN. I do. I think we need to take a broader view about this program.

We are talking about our health care system. Medicare is not a trivial part of our health care system, and I—and the reason why I was supportive of many parts of the Republicans' plan, when they realized they had a problem with the teaching, they dealt with it.

I think we are going to have 7 years to deal with a very tough set of numbers, maybe even impossible to get to even in themselves. I would hope that this Committee and every other Committee in the Congress would take a hard look way before then, and I hope you would do that and say, what are we doing—forget about the Medicare Program. Is this viable for our hospitals and our doctors and our home care?

And so, therefore, I do believe that we—you know, as you get out beyond the year 2000, quite frankly, we are dealing with a world that——

Mr. MATSUI. Stuart, hold on 1 minute now, wait 1 minute. Because that is exactly what has been happening over the last 15 years. We have been going 7 years, 8 years, up to 14 years in terms of the solvency of the system. So, I mean, we have been doing that.

Now, if you are suggesting that all of a sudden you can't go beyond the year 2002, then why are we into this debate?

Mr. ALTMAN. I think you need to—well, first of all, actuaries are actuaries.

Mr. MATSUI. So you are refuting——

Mr. ALTMAN. I realize they have a higher claim to the economy.

Mr. MATSUI [continuing]. So you are refutiating the last testimony.

Mr. THOMAS. The gentleman's time has expired. We need a succinct answer.

Ms. WILENSKY. I think that as I understand it, what is being proposed are specific proposals with regard to the 7-year period.

Now, I will be honest, I have not seen this before. I have not heard this. I think a proposal that has zero real growth, I would like to understand what was driving that rationale.

I do want to make it clear to the Committee that what is being contemplated now in the 7-year proposal is getting sustainable spending per person and that the other shoe to drop, that I think most of you expect to be facing, is what we do to face the population bulge that comes at the end of the next decade. Because even if you get sustainable spending per person at, say, 5 percent per

person under Medicare, that is not going to solve the problem of the boomers starting to retire at the end of the decade.

Now, I don't understand what is behind this, so I guess I would feel—I will say I am uncomfortable with the notion of no real growth. I have never heard it as part of this plan, so I just would like to know more about it.

Mr. MATSUI. Thank you.

Mr. THOMAS. Thank you. The gentleman's time has expired.

Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you.

First, Dr. Wilensky and Dr. Altman, I want to thank you both for participating in this process. Certainly your intellect, your pragmatism and your expertise are refreshing, especially when your input is contrasted with some of the unfortunate political posturing and political bickering that has characterized this debate. And I, as one Member, truly hope we can work in a spirit of bipartisanship, in a pragmatic way to craft the final legislative package, and we will get into that next week.

I would like to focus, Dr. Wilensky, on your written testimony and also your exchange briefly, Dr. Altman, with Mr. Thomas.

In your written testimony, you outline concerns about the inequitable Medicare reimbursement rates for managed care. We have discussed this many times in the past, Dr. Wilensky, and I appreciate your counsel on this. We all know that the current system, which is based on fee-for-service payments, fails to capture the savings generated by managed care. It penalizes those counties that have historically provided cost-effective fee-for-service care.

And of course, a State like Minnesota, which has historically delivered very cost-effective fee-for-service medicine, in fact, one of the most efficient delivery systems with some of the highest quality medicine in the country, is hit hard by this inequitable formula.

Senator Durenberger used to tell us, you get 2½ surgeries at the Mayo clinic for every similar procedure in Miami or some of the other places, and, in fact, all but two counties in Minnesota received less than the national average payment.

My question is this, Ms. Wilensky. What methodology would you suggest to correct this disparity? I mean, how, once and for all, can we get at this problem?

Ms. WILENSKY. The specific methodology I would recommend is to use a blended rate between the average payment and the local payment so that you get closer to accounting for differences in prices and only some, but not all, of the differences in volume, which is why the spending is so much higher per person in Florida as opposed to Minnesota.

But I would caution. It is easier to make a leveler playingfield across the country for these capitated payments, but if the payments in the fee-for-service remain as unequal as they had been, which is how we got into this problem in the first place, you will make going into the capitated system less attractive than staying in the fee-for-service. That is why, if you don't address that part of the problem as well, you will make it more equitable across the country, but you will drive people out of the capitated system and into the classic Medicare if you don't address that at the same time. So that is my one caution.

Mr. ALTMAN. Let me add, we at ProPAC have just completed a study which demonstrates that even if you accept differences in spending between different parts of the country, it is still true that the higher spending areas get even more money, and areas in Minnesota and Portland and others, Oregon, wind up getting much tighter reimbursements under the AAPCC, which gives you much less flexibility if you run a managed care plan in those areas to provide the extra benefits. That is what we have been working on with the staff.

And I personally would like to see us begin to move, not so much in the artificial blended—not blended, but I think we ought to make it more even around the United States, that the level of extra benefits needs to be more even in all parts of the country and not related to where you live.

Mr. RAMSTAD. Well, thank you both. I couldn't agree more. It is unbelievable when you look at the Medicare payment rates to HMOs now, the variances from a low of $176 per month in the lowest county to a high of $647 per month in the highest. That is a difference of about 370 percent.

As I said, in Minnesota, all but two of our counties receive less than the national average payment. So I truly hope we can address this problem in the final package and I thank you both for your important counsel and expertise on that point particularly.

Thank you, Mr. Chairman.

I yield back.

Mr. THOMAS [presiding]. Does the gentleman from New Jersey wish to inquire?

Mr. ZIMMER. No, I do not. I just want to make one comment about the remarks of the gentleman from Minnesota who said that you can get 2½ surgeries in the Mayo Clinic for every one surgery in Miami. I would just hope I would not be the recipient of the half surgery.

I yield back.

Mr. RAMSTAD. Mr. Zimmer, I can assure you our doctors never quit.

Mr. THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Thank you, Mr. Chairman.

Dr. Wilensky, as you well know and you remember when you were at HCFA, a number of us put in our own health reform care bills, and we had a terrible time with risk adjusters. It would just stymie us. I remember calling your office and it was very difficult. We look at this Medicare population and roughly 10 percent of the people in Medicare spend 70 percent of the money.

Now, you say to us, don't expect to get the perfect risk adjuster. Now, I don't know if there is a perfect risk adjuster, but I know it is very hard to come to the conclusion of what it should be. Aren't you worried if we don't get it right Medicare will suffer? You said roughly at the end of the decade, 50 percent of the Medicare population would still be in the fee-for-service. We know that 10 percent, the older, frailer, sicker will be in the fee-for-service.

Aren't you afraid if we don't get it at least close to right that you are going to end up with the sicker beneficiaries in the Medicare

traditional fund, making costs rise, while the healthier, younger are in new choices?

Our Subcommittee Chairman, Mr. Thomas, said we are going to do it. Are we going to do it?

Ms. WILENSKY. I am worried and I want to say that this is not—it is probably the single most serious issue in the proposal and the reforms that are being considered. PPRC, both in their staff and with one of their commissioners in particular, Professor Newhouse from Harvard, is spending a lot of time on this issue.

I talked to him about this and with the staff and I believe that by concentrating on looking at the distribution of people in a plan at the end of the year and looking for health diagnoses that are associated with high expenditures, we can, in fact, make adjustments not today, but within the next few years, that will keep the worst of this problem from happening.

I actually don't agree that they will all be in fee-for-service, but I think the concern is a very legitimate one that they will more than proportionately stay in fee-for-service because they are older or sicker.

If we can't do it, we are going to have to come back and struggle with this, but I wish to caution you that any choice, any kind of a choice plan requires us to be able to do this and that in the Federal Employees Health Benefit Program, which not only has a large distribution, but has a substantial number of retirees, there has been less of a risk selection with no attempt to adjust than you might have expected.

So I regard it as very serious, I don't think we can put too many resources to resolve it. But to not think that you can solve this problem means basically no choices for the seniors. Any amount of choice for the seniors and for the under 65 population requires a risk adjustment or you can get into a death spiral.

Mrs. KENNELLY. I know from experience you have to have it right, but here we are, you are talking about 1 year, another year. We are going to do this legislation next week. How does this work in that we haven't gotten the right risk adjuster at this point.

How does this fit in with the process as we see it today in passing a Medicare reform bill this year and moving on?

Ms. WILENSKY. Well, the fact of the matter is this year we are at 7 percent in the non-fee-for-service and next year we are going to be at some growth, but not—you know, may be small, two digits. It will take a couple of years to put a lot of these plans in place, to have the offerings.

If by the end of 2 to 3 years we aren't ready to make some adjustments, then I think the potential for a real problem will be there. And again, you meet each year and if there isn't some evidence, I think that is going to force some reassessment of what is happening to the plan because it could become very expensive.

Mr. ALTMAN. Let me make a suggestion here. And I think it goes back to the idea that we are going to have to watch this. When we introduced the DRG system in 1983, you gave me a very part-time job that has taken up most of my time and I am very pleased to be part of this system, because we were moving into areas that we didn't completely understand.

I would strongly urge that there be a constant monitoring. The biggest concern about these risk adjusters is that you unfairly reward one sector and unfairly penalize the other sector. You are going to be able to watch that. We are going to be able to—whoever is here doing that is going—if you have good monitors in there, and you may, and hopefully you will decide to reallocate the dollars, push down the dollars that are going into the sector that is getting the healthier population and give more of the dollars to ones that have the sicker population. That is the key.

Mrs. KENNELLY. Thank you, but let me remind you. We had a terrible time in health care reform when we had the whole population. We are now dealing with a population 65 roughly to 90, so this is going to be hard, and I just hope——

Mr. ALTMAN. But we can see where—we can see the diagnoses of the people who stay in the program. We have the capacity now to do a much faster and better job of knowing, and if all of a sudden we can watch the tilting of the system——

Mrs. KENNELLY. Mr. Altman, that is what worries me. Mr. Gibbons had said that at one point this week, you know by the time you have gotten to 65, you have records—not you, but companies have records. The word is out there what your health care situation is, and as a result, we are going to have some plans that might avoid that risk. Thank you very much. Take it seriously, as I know you all will.

Mr. THOMAS. Does the gentleman from Iowa wish to inquire? Would you yield briefly?

Mr. NUSSLE. I would be happy to yield.

Mr. THOMAS. Since we are now in the process of asking questions and trying to understand the plan, just a couple of comments in this area.

Our problem is that this is a government program and that most of the real knowledge, in my opinion, about adverse risk selection is in private hands, and that managed-care companies with their knowledge in terms of how they deal with preventive care are way ahead of us. We need to look at outcomes, based research. We need to do these exit examinations so that we can begin to get a better understanding. We haven't had any real world input and that is going to occur.

Very briefly, I tell the gentleman from California, Mr. Matsui, on the page 58 question that you had, since we do have a commission that we have asked to look at the baby boomer question and that we want to deal with it in the outyears, rather than trying to run an exhaustive number of dollar amounts. What you have on page 58 is the Consumer Price Index for urban, and that will be an automatic adjustment, plus whatever else is adjusted for the simple purpose of scoring through the Congressional Budget Office, rather than running an exhaustive number of years that may or may not apply.

The assumption is that the Baby Boomer Commission will come in and make suggestions about the changes that will occur on a prospective basis after 2002. So if they do their job, we don't need it, but if they don't do it right away, you have a fail-safe mechanism to carry you on the Consumer Price Index. And I didn't want

to interject myself in that conversation, but once you understand that, I think you will see the nodding heads out there.

Mr. MATSUI. It makes more sense.

Mr. ALTMAN. But let that commission deal with that problem.

Mr. MATSUI. Mr. Thomas, the only problem is, though, that becomes a baseline and the 4.3 percent is part of that baseline, and somehow you have to deal with that.

Is that correct?

Ms. WILENSKY. As I understand, the formal part of this program goes to 2002. If, in fact, you find yourself in the position after 2002 of actually living with that amount, you will have a big struggle.

Mr. MATSUI. And you are going to have a problem, obviously. You are going to have to deal with this problem. But you can't say you will have the problem solved until the year 2014 and not deal with it.

Mr. ALTMAN. That is going to be a small part of the problem. The problem is the numbers, too. I mean, it is—we all know it is a serious problem that needs to be dealt with.

Mr. THOMAS. I thank the gentleman for yielding.

Mr. NUSSLE. If I could reclaim my time, I just wanted to ask a couple of questions.

One of the—there are a couple of side—I realize, believe it or not, there are side issues to all of this. Maybe we are not aware of that, but it is not just Medicare from what my providers back home tell me, and let me give you a for instance and then I would like to get your comments on this, because it seems to me that solving—or saving Medicare is part of a bigger picture in health care and health care economics right now, because of what is happening in the area of cost shifting. I may be making this way too simple. It is probably because my understanding of it may still be simple. I am learning like I think many Americans are.

But it is my understanding that because we have not had a holistic solution to Medicare in the past, that the ways we have tried to reduce cost have been ratcheting down of reimbursements and payments to providers, and so forth, and as they have found less money for similar services and their expanding costs, they have tried to figure out ways to shift those costs elsewhere.

My question to you would be: If in fact—and this is for the non-Medicare public—you and me and others that end up paying for them from an economic model, what we are not—it is just like a tax increase again on somebody else.

Mr. ALTMAN. That is exactly what is going to happen.

Mr. NUSSLE. What would happen if we are not successful in dealing with this problem, in saving Medicare, what would it mean for a family out there? What would it mean for the rest of health care economics?

I would invite both people to—both my respected friends and witnesses here to respond.

Mr. ALTMAN. Let me try to respond the best I can. We at ProPAC have been estimating the so-called cost-shifting numbers and our estimates are that for the year 1992, the private patient paid about 31 percent more than the cost of care in the hospital to make up for a $26 billion shortfall that hospitals incurred in providing care to Medicare patients, and they felt they didn't get adequately reim-

bursed, Medicaid patients and for the uninsured. $26 billion they got.

Now, what happens as we move into the future? You have two things happening. First of all, the private sector itself is getting a lot tougher and they are saying, we have had it, we are not going to be patsies anymore. We are going to come in and we are going to aggressively push down on what we pay.

Whether they do that or not is up for grabs because, interestingly enough, in the last few years, I mentioned to Mrs. Johnson, Medicare has become a relatively better payer, and so the pressure on the private sector has actually been reduced.

One of the concerns you have to have, and I hate to tell you this but you have got to have it, is that as Medicare squeezes down on what it is willing to pay, hospitals are not going to lay over and die. They are going to try to get money where they can and I think they are going to go after the private payers.

And so the private payers are going to be faced with a tougher onslaught than they have ever been faced with before. If they succeed in holding back that onslaught, then the hospitals are in trouble.

This is an interconnected system, and that is what I was trying to say. Medicare is a critical part now of the delivery system of health care and how Medicare pays affects your health care too. It does.

Ms. WILENSKY. Let me also—I don't——

Mr. THOMAS. The gentleman's time has expired.

Mr. NUSSLE. Mr. Chairman, I asked both witnesses to respond.

Mr. THOMAS. Brief response. Brief response.

Ms. WILENSKY. There is overcapacity in the health care system. If the private sector doesn't cave in, what you will see is some downsizing in this overcapacity health care system. You should want that but the people who are being impacted won't like it.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from New York wish to inquire?

Mr. RANGEL. Thank you so much, Mr. Chairman.

Am I to assume that all of the testimony we hear today is not based at all on the document that was distributed by the Republican leadership yesterday? This testimony has nothing to do with any legislation, which of course we don't have either, but you are not basing—I mean, have all of you had an opportunity to study this?

Ms. WILENSKY. Yes.

Mr. ALTMAN. Yes.

Mr. RANGEL. And are all of you familiar with this?

Ms. WILENSKY. We have been working with the Committee staff as part of our commission's work, while we have not had a chance to study every line, but more or less.

Mr. RANGEL. You are just the people I want to talk with. Having read this, can you share with me how the plight of the inner-city hospitals works out? Because the people that I had read this for me, they said, with the disproportionate share hospitals, that they don't do too well under the better Medicare plan that is before us.

Has anyone addressed that issue?

Mr. ALTMAN. We looked very—Mr. Rangel, we at ProPAC are very concerned about inner-city health care and have been watching the plight of inner-city hospitals from our inception, and it is fair to say that it is difficult to completely understand all aspects of the plan from that document, and as Gail——

Mr. RANGEL. Let me interrupt. You keep saying we. Am I talking to you as someone that has studied the plan or am I talking to the author of the plan?

Mr. ALTMAN. You are not talking to the author—not from me. We are on the other—

Mr. RANGEL. I just——

Mr. ALTMAN. When I say we, I mean the staff and the commissioners at ProPAC. I do not mean a collective we that goes beyond that.

Mr. RANGEL. Well, so many people have brought in their mothers and their grandmothers, and of course everyone is concerned about the trust fund, but most of the people that have looked at this are concerned about the inner-city hospitals, the doctors that have been—come from other countries but they service the poor, the poor patients.

There is a lot of concern, too, about the inability for older people to bargain for their health maintenance organizations. There is concern that they may not know where to go or to take advantage of the great savings that are here. But specifically as it relates to hospitals, it is my understanding that the doctors are very pleased with this plan as it relates to their reimbursement, but my phone is ringing off the hook.

New York City is a hospital town and I am not returning the calls because I knew you experts would be here to tell me, Should they be worried about this new Medicare plan? Are they treated fairly in your opinion?

Mr. ALTMAN. As a former New Yorker and as someone who spends a lot of time in New York, I have had more than a few discussions with them myself, and I think as of 2 or 3 weeks ago, New York was in a panic.

New York and New York hospitals have been the largest benefactors, I think very appropriate, I might add, of the teaching adjustments and the disproportionate share adjustment. I have to go back there. My mother lives there so——

Mr. RANGEL. Come on. It is the best stop in the world.

Mr. ALTMAN. Now, as of 2 or 3 weeks ago, they were in a panic because it looked like the teaching adjustment was taken down, the disproportionate share was being cut back, but I will tell you this. In the last, I don't know, 48 to 62 hours, there have been substantial improvements in the money that flows back to disproportionate share and teaching hospitals, and as of my understanding, I can—as of——

Mr. RANGEL. What page? To what page are we referring? You see——

Mr. ALTMAN. It is in my testimony, but——

Mr. RANGEL. No, it is not in your testimony.

Mr. ALTMAN. I didn't write that document.

Mr. RANGEL. I am not being critical of you. I just want to be certain we are reading from the same page.

Mr. THOMAS. Page 32.

Mr. RANGEL. Page 32? This is the better bill, or whatever you call it, the better Medicare?

Mr. THOMAS. Will the gentleman yield?

Mr. RANGEL. Sure.

Mr. THOMAS. Yes. In the document on page 32 under subtitle E, reform of payment for graduate medical education and teaching hospital payment.

Mr. RANGEL. I am talking about disproportionate share, what page would that be on?

Mr. THOMAS. What you will find is that we have separated disproportionate share from teaching hospitals. It is long overdue. We have created a whole new funding mechanism for teaching hospitals while maintaining disproportionate share and not using it as an excuse for funding hospitals.

Mr. RANGEL. Where will the disproportionate share hospitals—how, under this bill, and on what page would it be? And that is why we enjoy working from a bill but I will work from this. In places where hospitals have more than their share of sick people and older people and therefore have more illness and more expenses, where is that taken care of in the better Medicare plan? That is what I want to know.

Mr. THOMAS. The gentleman's time is expired, but we do need an answer for this. The disproportionate share hospital formula has been adjusted. Basically, I believe it was a ProPAC recommendation, and we followed the recommendation of ProPAC while maintaining the disproportionate share.

You want to react to that?

Mr. ALTMAN. Well, it wasn't our—as much as I would like to get credit for that——

Mr. RANGEL. Just 1 minute. Mr. Chairman, I appreciate your trying to help me out, but you are referring to some discussions that you and Mr. Altman had, and I can't make all of the meetings, not even the Democratic meetings, much less the Republican meetings.

Now, if I wasn't——

Mr. THOMAS. If the gentleman would yield, it was a Health Subcommittee hearing. It wasn't some private meeting. It was those 16 hearings that we held on the subject.

Mr. RANGEL. Let me apologize to you because since this Committee has had no hearings at all, some of the things that the Acting Chairman is talking about, I haven't the slightest idea where the meeting took place.

Mr. THOMAS. In this room.

Mr. RANGEL. But not with the Ways and Means Committee. That is my problem.

Mr. THOMAS. With the Health Subcommittee of the Ways and Means Committee.

Mr. RANGEL. I am willing to concede that the Health Subcommittee has done a wonderful job, but I haven't the slightest idea what that has to do with the Full Committee when I am just trying to find out what went on in the Subcommittee.

So just—I beg your indulgence because Mr. Nussle on television said that we are 14, 20, 30. We on the Ways and Means had hearings, and I assume because he is new to the Committee——

Mr. NUSSLE. Will the gentleman yield?

Mr. RANGEL [continuing]. The Subcommittee, the Full Committee.

Mr. THOMAS. The Chair will indicate, the light is——

Mr. RANGEL. For whatever happened in the Subcommittee, if you can kind of get a little memo out and share it with us so that the next time I have any questions, I will refer to the Subcommittee paper or something.

Mr. THOMAS. I tell the gentleman, what he has in front of him is the accumulation of the 16 hearings of the Health Subcommittee which is what we are now discussing in Full Committee.

Mr. RANGEL. And I am asking what happened to the disproportionate share, and you asked Mr. Altman, what did we do in our discussions?

Mr. THOMAS. Now we are back to square one. Would either of you like to discuss the disproportionate share?

Mr. ALTMAN. Yes, I would like to take a shot.

Mr. RANGEL. I don't want to take the Committee's time. All I want is the page. Could you give me the page and then you two can talk about your previous discussions?

Mr. THOMAS. Excuse me. It goes 32, 33, 34 and then 35. Those are the pages that cover this.

Mr. RANGEL. Very good. And now I will listen to Mr. Altman and I will have the document in front of me.

Thank you.

Mr. ALTMAN. I think it is on——

Mr. RANGEL. Thirty-five. Do I hear 36? 35. Why don't you just go ahead. I will catch up with you. Go ahead, really. You couldn't have done a better job. It is the page after 30.

Thank you.

Mr. Chairman, when you have another hearing at another time, maybe we will have something better so we can follow the good work that you have done in the Subcommittee.

Mr. THOMAS. The gentleman has the material in front of him. Would he like an answer to his question? His time has expired.

Mr. RANGEL. Yes.

Mr. THOMAS. Go ahead. The gentleman's time has expired.

Does the gentlewoman from Washington wish to inquire?

Does the gentleman from Georgia wish to inquire?

Ms. DUNN. I do want to, thank you.

Mr. Altman, I do want you to answer the disproportionate share question but I also want to get into my 5 minutes—which seem to expire very quickly—my question to Dr. Wilensky, because I would like her to comment on the medical malpractice liability reform that we have included in this bill. So why don't we do disproportionate share. That is important in my district.

We have a hospital called Harbor View and we are in daily contact with them and I was beginning to get the indication that you are much more comfortable with how we have handled disproportionate share since we have taken the teaching, medical education funds out of that and put them into a trust fund.

Mr. ALTMAN. First of all, from the hospital's point of view, you cannot separate out the dollar flows that come from disproportionate share and that come from teaching. Many of our teaching hos-

pitals are the ones that also provide large numbers of care to the disproportionate. They are the same hospitals that get much of the disproportionate share payment, which according to the plan, is reduced by 25 percent. However, the teaching part is now higher.

We have modeled, and in my testimony, I show what we expect the margins to be for the disproportionate share hospitals and they grow. So if you combine the total impact of the disproportionate share payments and the teaching payments that go to those types of hospitals, they will be better off, and the New York hospitals will not be in the dire straits that they thought they would have been in 2 weeks ago.

Ms. DUNN. Great. That was a great precise answer and exactly answered our questions. Right, Charlie?

Mr. RANGEL. I want to thank you Ms. Dunn, and Mr. Chairman, for pursuing that, because it is the pages between 44 and——

Ms. DUNN. No, I haven't yielded, but I think he is absolutely right.

Dr. Wilensky, could you take a look at the liability reform that has been put into this plan and comment on it, please?

Ms. WILENSKY. The plan's liability reform is very similar to the recommendations that PPRC has made previously to the Congress. The main difference is that the commission has recommended that rather than just have a cap on noneconomic damages, that when it is feasible, you include a schedule that takes into account the severity of the injury rather than just putting a flat cap on the limit of noneconomic damages.

But this is a short-term reform. We think it is an important reform, but it is one in the short term. We think that in the long term what we need to do is find a way to compensate patients faster and to also detect and prevent medical injuries.

And whether that is through outcomes analysis or using a very different system such as one that allows an agreement to occur between the patient and the provider that settles the economic damages but puts any other issue off the table, as has been proposed in the late eighties as a strategy, is something we think needs to happen. But this is a good, short-term start on malpractice reform.

Ms. DUNN. Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentlewoman.

Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. I pass.

Mr. THOMAS. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you, Bill.

Dr. Altman, let me ask you a few questions getting back to what I think has become the nub of this part of the hearing, and I only wish that we had had a chance to do this before the Republican proposal was drafted. Because I think if we had had this discussion and we could have moved some of the political charge out of this, there might have been some opportunity to work together, and I am afraid because we were not in the process, that chance has been blown. I hope not for much, much longer. At some point, we are going to have to try to come together.

So let's talk about the—we are talking about the cost factors here for A and B. We are talking about a system where there would be specified amounts that could be expended under the fee-for-service

the next 6 years, 7 years, and then a percentage after that, a CPI urban, nothing beyond it. A CPI at zero-plus growth in the numbers in the plan. And you have a so-called fail-safe, a trigger throughout this period, both the first 7 years and then thereafter. And you were saying you were very troubled by the box.

Take the worst case scenario and that these figures can't be met, aren't met. Look at it from the point of view of the Medicare beneficiary for 1 minute, the person who is supposed to be the one who has worked for this program and helped.

What could happen if these targets prove to be very unrealistic? From their point of view, what can happen?

Mr. ALTMAN. Well, I think we need to focus on the implications for the hospital industry and for the other industries, and what they do to meet these targets.

Mr. LEVIN. Quickly, because we are going to run out of time.

Mr. ALTMAN. If they can bring about the efficiencies that these numbers require without affecting quality of care, I think that there is the potential—Gail pointed out, we have 40, 45 percent excess capacity. We can reduce that substantially if you can bring down the inefficiencies, as they seem to be doing.

Mr. LEVIN. The CPI plus zero is——

Mr. ALTMAN. I don't want to comment on that because I just—it hasn't sort of seeped in yet. That is a very tight number. I need to know more about that. So all I can comment about is up to the year 2002, which is more than CPI, but it is still a very tight number.

Don't get me wrong. The 6.4 percent as opposed to 10 is a reduction of 35 percent of the rate of growth, so we are not talking about a——

Mr. LEVIN. So what happens to the beneficiary? This plan calls for something beyond 2002 at zero plus zero. Now, tell us from the point of view of the beneficiary, what happens?

Mr. ALTMAN. I think the key here is what I said. It is the impact on the delivery system and how the delivery system responds. If it responds by efficiencies without generating serious reductions, that is one thing, but if it winds up closing its doors, having no nurses, reducing quality, it could have a deleterious effect. That is why I am urging this Committee not to go to sleep.

You have got to—this is—this program is as significant a program as I have ever seen, and its implications for the delivery system and, therefore, for the beneficiaries could be good or bad depending upon how the delivery system responds.

Mr. LEVIN. But if it can't respond to meet these targets, what happens?

Mr. ALTMAN. Then you are going to see a health care delivery system that squeezes itself back because it won't have the money, and it is going to have negative implications in access, in quality.

Mr. LEVIN. I think what has happened, for the first 7 years and thereafter, it is kind of an iron box. And then the suggestion is, we can come back and fix it. However, the worst time to try that is during a recession. Contrary to what has been said here, we have not always been able to respond to recessions. And so this is, I think, in addition to the part B premium increase, the reason sen-

iors are most concerned, access and quality of care. That means choice, right, Doctor?

Mr. ALTMAN. Yes.

Mr. LEVIN. Thank you.

Mr. THOMAS. Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

I want to thank my friend from New York City, Mr. Rangel, for asking about the problem with inner-city hospitals, and while I don't have any inner cities—because I don't have any cities, I represent a very large rural area—the problems, I think, from all I have heard, are very similar.

Mr. ALTMAN. Very similar, yes, sir.

Mr. LAUGHLIN. I guess, first, I ought to say, since you are from New York and have assured Mr. Rangel that the inner-city hospital's worries have been cured in the last few weeks, tell me what you see for the rural hospitals when, in fact, many of us represent large counties that don't even have one hospital in the county. What do you see for the rural hospitals?

Mr. ALTMAN. Let me make it clear that ProPAC has spent more time on the rural delivery system than any other part of the system because in the beginning of the DRG system, it did adversely affect them. So do not be misled by my upbringing in terms of where I have been spending my time.

Rural hospitals, as we understand it, would go as follows: In 1995 the Medicare margins, which are the funds above their costs, are slightly less than 2 percent; that under the 2002 simulation, their margins would grow to about 4.8 percent; so this plan does provide funds, as we see it, for the rural system to survive.

Mr. LAUGHLIN. Mr. Altman, over the years I have become a strong believer in home health care and its benefits, particularly to the senior citizen, and I think back to the many that I have visited in hospitals over the years. One of the first things they want to talk about is when they are going to go home.

In your statement you have talked about over the last 5 years, Medicare spending for home health services has increased an average of 40 percent per year. Realizing the importance of home health care services, will that same percentage of increase in spending exist or can it be sustained if we make no reforms?

Mr. ALTMAN. Well, you start multiplying 40 times 40, and what started out as a very small part of the Medicare Program can very quickly become and is already becoming a major part. As I indicated in my testimony and in previous statements, the big growth items of home care and skilled nursing care are where the Medicare Program has blown out of control; it has not been on hospital payments and physician payments. I don't think it is sustainable.

I, too, am a supporter of home care, but I think the current reimbursement system has no incentives for anything but spending money. I personally would like to see home care put much more into a managed care environment. I realize that in the short run we can't do that, and therefore there are a number of changes that are proposed here that bring about—change the incentive structure by putting in rates of services more related to how sick the patient is and holding the home health agency accountable for not only providing extra services.

Mr. LAUGHLIN. In the remaining time, can you tell us some of the incentives you support? Because as I interpret what you are saying, those incentives are part of the reforms that you recommend to the Medicare system.

Mr. ALTMAN. Well, we have seen in a managed care environment where a deliverer has complete flexibility between services. When they use the home care benefits, they reduce the hospital services, or vice versa. Under the current situation, you have a very tight limit on the hospitals, but you have a fee-for-services system on the home care benefits; and there is more and more evidence, much as we would like the opposite, that a lot of the service that is being provided in home care is, let's say, marginal benefits compared to other uses of that money, and therefore, you need to put into that side of the sector the same kind of incentives as you have on hospital care. This plan goes part of the way there; my own view is, it doesn't go far enough.

Mr. LAUGHLIN. What would you do to go far enough?

Mr. ALTMAN. I would like to see it put into a managed care environment with a budget. But I know it is very difficult to do that.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Yes. Thank you, Mr. Chairman.

Mr. Altman, I appreciated your insights as provided by a line of questioning, originating with Mr. Rangel, regarding disproportionate share payments.

It is my understanding that the Medicare Preservation Act calls for a 25-percent reduction in disproportionate share payments. I believe your testimony anticipated a 30-percent reduction. I have a strong interest in this because I have three fairly significant urban hospitals in my congressional district. I forwarded to the Health Subcommittee a proposal supported by the Heritage Foundation that called for the targeting of this reduction.

In your view, is what is in the legislation fairly close to what Heritage proposed?

Mr. ALTMAN. I am sorry, sir. I don't know the Heritage—I know Heritage generally, but I don't know the specifics of the disproportionate share.

Mr. ENGLISH. Then I appreciate it. I will move on.

With regard to indirect medical education, will the institutions that bear the cost of running the IME or the graduate medical education programs receive this funding, or as you understand it, will it be diverted to a third or intermediate party such as a medical school dean and distributed to those affiliated from there?

Mr. ALTMAN. My sense is that part of it will go—maybe Dr. Young may want to comment on this. He has been spending more time on that part than I have.

Dr. YOUNG. Under the standard fee-for-service Medicare Program, it will continue to be directed to the hospital. The Committee's proposal, however, includes a demonstration for consortia to develop a better mechanism to pay communities and to let the community work together to decide how they want teaching to function, and their manpower needs, so that the money traditionally—under the traditional fee-for-service system, goes to the hospital.

The consortia is a new mechanism. Under managed care, the managed care entity negotiates.

Mr. ENGLISH. Thank you.

Ms. Wilensky, the Medicare Program has been growing, as we know, by 10 percent yearly in the aggregate. How does this growth translate to actual payment increases received by a physician, hospital, long-term care organization, or home health care provider?

Ms. WILENSKY. Well, the growth for those various sectors varies in terms of how the pricing works. In hospitals, it has been through a DRG mechanism, which is an admission payment per hospital. The rate is set, but there has been some increase because of increase in coding and increase in severity.

It is set in Congress, though, how much the per-case increase goes up. For physicians, we have a relative value scale. It is still a fee schedule, but it was changed to try to help the primary care physicians relative to specialists, and the rural relative to urban to try to reweight some of the relative payments. Again, the structure, once set in place, is increased according to the schedule that Congress puts in place.

That is, for the most part, generally true of the other major sectors. In fee-for-service medicine, usually they have cost limits. Clinical labs have cost limits; home care has cost limits, so it is a blend between what the charges are, subject to a limit.

The difficulty has been that while Congress targets its sights on prices, in Medicare, as in all of health care—most of health care in the United States, there has been a large volume growth; and so there is a tendency to focus on what you can control directly, prices. But what determines expenditures is prices and quantity, and it has been much harder to control quantity.

Mr. ENGLISH. How has that volume growth been distributed through the system? Who have been the biggest winners and who have been the biggest losers?

Ms. WILENSKY. Well, for awhile it had been physicians and hospitals, but because they have been the subject of considerable congressional oversight, we are seeing smaller growth in terms of—hospital admissions have initially declined and now increased at a very slow rate. The physician spending right in this particular window is very low, although it is projected to grow higher. There has been very substantial growth in home care, in skilled nursing homes, in both volume, prices, and number of services provided per person. Clinical labs and durable medical equipment has also grown very quickly.

So the smaller spending areas of home care, skilled nursing, clinical labs, durable medical equipment have grown very rapidly in the nineties.

Mr. ENGLISH. Thank you very much. Thank you, Mr. Chairman.

Mr. THOMAS. I thank the gentleman.

Does gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Altman, you were very kind in your opening comments about both the Democrats and Republicans and working with us. I want to thank you for your help over the years that I have been on this Committee in trying to analyze what we can do in order to try to bring down the cost, particularly of hospital care, under Medicare.

I must tell you, though, I am concerned that the proposal that will be coming forward by the Republicans could have a very damaging effect on the viability of hospitals in our community and the access to care for our seniors, whether in fact they are going to be able to obtain quality health care services with the types of recommendations that are being made. The prior witness indicated that the goal of the Republican proposal is to save $160 billion over the next 7 years in part A. When you add to that the $30 billion that has been taken out of part A under the Contract With America, that means basically we need to do $190 billion in part A cuts in the next 7 years. If, in fact, private health insurance rises at 7.1 percent, which is the projection, can we do those types of cuts?

Can you tell us how we can do those types of cuts while trying to give me some security as to my concerns as to whether that won't mean hospitals are going to close in our communities and that our Medicare beneficiaries are not going to be denied access to care?

Mr. ALTMAN. Mr. Cardin, as you know, I don't shrink from answering many questions. What I don't know is how all these things add up. I haven't seen that table, whether it adds up to $160 or $190 billion.

I think I have tried in our testimony to make several points. One is that market basket minus 2 is a very tough goal, which I think is possible given the fact that hospitals have been controlling their costs much better over the last 2 years, and if they keep that up through this 7-year period, their financial situation would not be such that we would see the concerns that you raise.

Mr. CARDIN. But that is more than $30 billion dollars over 7 years or something like that. I think it is $35 billion.

Mr. ALTMAN. It is at that point—I haven't seen—we haven't seen the scoring from CBO and I don't know whether it is 35 or it is 35 to 50. I don't know what that number is. I think it is closer to between 35 and 50. I think it may get that far.

Mr. CARDIN. How do we get the other——

Mr. ALTMAN. But there are other things in there. There is the reduction in the capital payment. There is a whole bunch of——

Ms. WILENSKY. Skilled nursing and home care.

Mr. ALTMAN. It adds up to significantly more than 30. But the issue is when you go beyond that, and I think I—if hospitals don't control their costs to that level, then we are talking about serious problems, and the concern that I have raised, and I would like to see the numbers, is that if that does not take you all the way to where the plan says it has to go and you need that fail-safe to come back and do that, and this goes to market basket minus 3, 4, 5 percent, we have never seen reductions of that magnitude, and at that point I do get concerned, yes, very concerned.

Mr. CARDIN. And by getting concerned, what could happen? Are we talking about hospitals closing?

Mr. ALTMAN. Absolutely. Now, as Gail pointed out, we are going to see, and should see, substantial closing of hospitals to bring about efficiency and probably better quality care.

Mr. CARDIN. I understand that, but there is a point to efficiency. Are we talking about rural America being without hospitals? Are we talking about urban centers being without hospitals? It is more

efficient to run an urban hospital than an inner-city hospital for some very obvious reasons. Are we talking about only having hospitals located in certain communities? I mean, is that a real risk if the Republicans are wrong and you can't get that savings and you start to get minus 3, minus 4, minus 5 percent?

Mr. ALTMAN. You could have that kind of cut in different ways. You could have a lot of hospitals with fairly shallow staffs. We have only begun to see the efficiencies, so that there is a possibility that that minus 1 could go to minus 2. I don't want to paint the blackest picture that you could paint.

Mr. CARDIN. My time is running out, so let me just make the point. Minus 2 is going to be in the $40 to $50 billion range. The proposed cuts, if my percentage of $160 billion is correct, plus $30 billion, $190 billion, we are not even close.

Mr. ALTMAN. Let's be fair, that 30 to 50 is just on the hospital side. Then you have to add the skilled nursing care, the home care, capital part.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I just want to toss out a few numbers here on Medicare. People toss around the goal of $270 billion in savings over the next 7 years. Total Medicare spending is projected on the CBO baseline to be close to $2,100,000,000 over the next 7 years, just quick arithmetic, that is about an 11-percent decrease, the $270 billion out of total Medicare spending over 7 years.

My question is, is Medicare a system that is so efficient today that 11 percent of its growth or 11 percent out of that total spending package could not be achieved?

Ms. WILENSKY. Well, neither of us think that Medicare is a particularly efficient system. It has had a very unhelpful incentive structure attached to it. What we see proposed is not undoable. I think both of us would say it is a reach, it is a strand so forthh, but it is not undoable.

As we see the specifics laid out about exactly what happens if more people stay in fee-for-service classic Medicare rather than taking advantage of the options and some of these fail-safe mechanisms start kicking in place, how would it work, those are the kinds of answers that could help us.

But I think the notion of, can you achieve the kind of savings that are laid out and have a high-quality system providing services to the seniors, the answer is yes, although it is a reach. It is a reach because now we are growing at 9 percent per person and this suggests being able to grow at 5 percent per person, which is real growth of at least a couple percent, but certainly not an unreasonable growth when you think about what is going on elsewhere in the Federal budget. The rest of the Federal budget, except for health care and interest on the debt, is, due to growth, 3.5 percent per year. So what we are seeing is twice that in the Medicare Program. But again, relative to where we have been, it would be saying we expect you to get a lot more efficient.

Mr. ENSIGN. Let me ask a question. If there are not major fundamental changes made in our Medicare system, is there virtually any way to save it when the baby boomers retire?

Ms. WILENSKY. I think the impact of the boomers hitting, if we haven't gotten to a sustainable spending per person covered, it will be impossible to achieve. We must get this first step.

Mr. ENSIGN. My other question along those lines is, if we don't test some of these market forces, even though there is disagreement whether some of the things we are going to introduce into the market, whether those will be able to control costs, whether some of the inefficiencies can be eliminated, whether some of the waste and the fraud and abuse can be gotten out, whether some of these market forces will bring in such competitions that prices will be much lower than they are currently projected. If we don't answer those questions in the next 7 years, with 7 or 8 years after that before the baby boomers start retiring, if we don't have those questions answered, is there any possible way, with the huge demographic shift that will take place, unless you make taxes skyrocket or cut benefits dramatically to save Medicare?

Ms. WILENSKY. I think that what we need to be sure of, as we are trying all of this change, is that we are monitoring the effects on access and quality, as Stuart Altman suggested.

Mr. ALTMAN. Let me take a different twist because I think we can get lost. Medicare has been asked to take on a lot of social values. For example, it has become the major protector of our teaching hospitals. One of the things that I like about this new proposal is it breaks that nexus. I am sorry Mr. Blaun isn't here. Medicare now is sustaining many of our rural hospitals. Medicare is being asked to take on very good, in my view, social values. My preference would be to disentangle them. It also is supporting a lot of basic research. In a way, you are blaming Medicare unfairly. This is an absolute——

Mr. ENSIGN. Let me make one comment.

Mr. ALTMAN. My sense is it ought to be separated. Medicare ought to be run like a business, you are right.

Mr. ENSIGN. Let me make one comment on that. How do you think that the vast majority of senior citizens in this country would react to a plan that the previous majority had set up—undergraduate medical education that was basically subsidizing noncitizen medical graduates educated in other countries, who come to this hospital, do residencies, and that money was coming out of their Medicare system? Fundamental question.

I think that the vast majority of Medicare recipients would be outraged that people from other countries are coming to this country and their Medicare Program is subsidizing them.

Thank you, Mr. Chairman.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. I would just remind the gentleman that health care delivered by those foreign-born medical graduates—they are people who have passed all the exams in this country. You can't practice medicine in an American hospital if you haven't passed the exams.

But let me ask both Mr. Altman and Ms. Wilensky what you think of CBO's analysis, generally speaking, about health care costs? Do you generally trust them?

Ms. WILENSKY. Well, I sometimes—the answer is I think they are nonpartisan. I occasionally think they are too staid in their thinking not allowing for behavioral changes, but I believe they are nonpartisan in their errors. Bipartisan in their errors.

Mr. MCDERMOTT. Is that what you are saying, CBO's numbers are too conservative?

Ms. WILENSKY. I think they are too conservative in terms of how they take on behavioral change.

Mr. MCDERMOTT. I have had the staff put up a graph and I have given you a copy of it and I would like to talk to you about it. We will make some assumptions because right now you have both said at various points you don't have a single number and so you have had to make a lot of guesses in your testimony today, and so I want you to assume a couple things.

In the chart before you, which is being distributed to the Members, we assumed from the numbers on page 58 of the Republican press release the dollar amount that will be given to senior citizens for health care from 1996 to the year 2002, and we asked CBO, What are the health premiums going to be in the private sector during that same period?

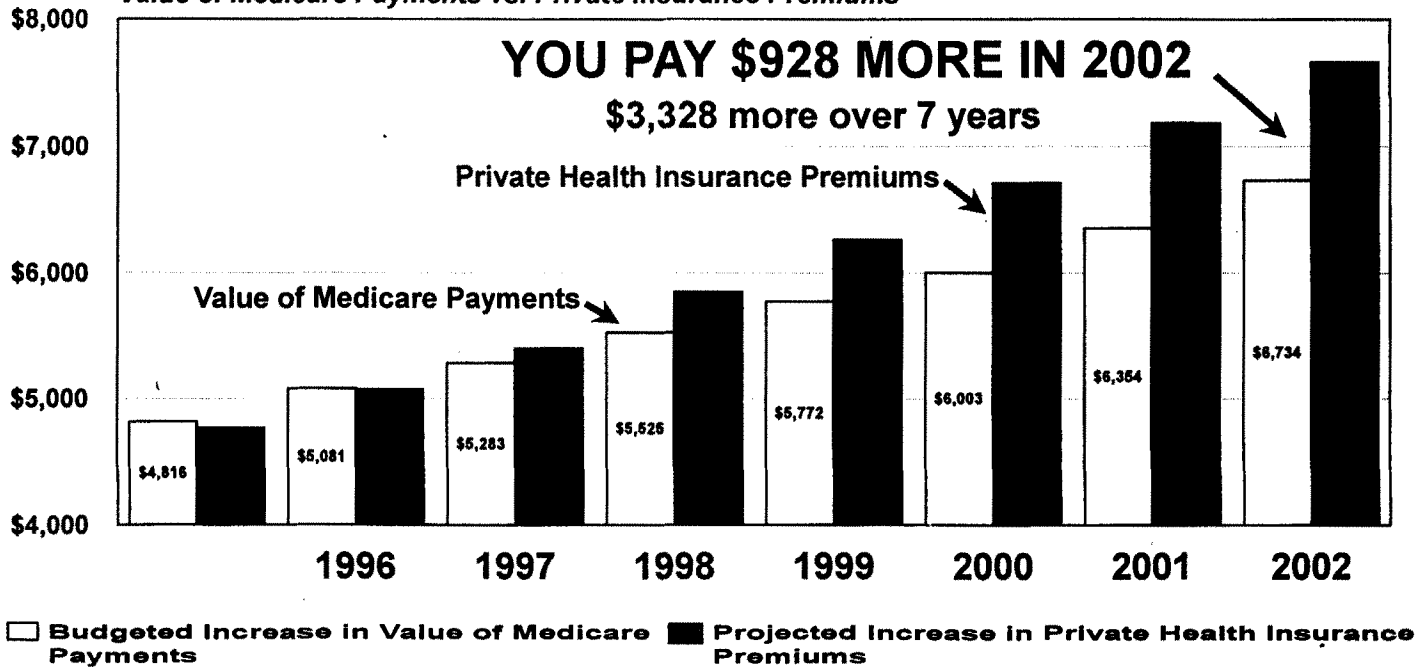
If you look at this graph, in 1996, you start about at the same amount of money, but by the year 2002, private premiums for a comparable health care plan are almost $1,000, $928 more.

Now, I want to know from you if this graph is correct, and we will make the assumption it is. If it is correct, where will that money be made up? How will the health care system get that $928? Will it be from the pockets of senior citizens or from changes in the law in the Congress? What will happen to make up that difference?

[The information follows:]

REPUBLICAN PLAN ERODES SENIORS' MEDICARE COVERAGE

Value of Medicare Payments vs. Private Insurance Premiums



Source: Republican press release on "The Medicare Preservation Act" compared with actual Congressional Budget Office NHE projections of private health insurance, adjusted by HCFA age and enrollment projections.

Ms. WILENSKY. Well, the presumption, and I am glad I made the statement, not knowing that you were going to distribute this because it really goes to the heart of CBO's projections for the private sector, which I think are far higher than I believe will occur and they have just reestimated them downward over what had been a few months before.

Mr. MCDERMOTT. When did they reestimate them?

Ms. WILENSKY. They reestimated them in March or April to lower the growth of private spending over the even higher rates. I still think that they are projecting too high a growth in the private sector. They have too little change that is going on because of the aggressive changes by employers. I have shared that thought with them. I think that their—I think that the shaded bar is higher than what will occur, but it is what they project. I am not questioning that.

Mr. MCDERMOTT. And so what would you say we should do? I mean, what kind of guess would you put in there for 10 percent less; 20 percent less than they estimate——

Ms. WILENSKY. Well, if you look at the differential growth in the early nineties.

Mr. MCDERMOTT. We are talking about hospital payments now. They have been squeezing hospitals for the last 10 years since DRGs came in.

Ms. WILENSKY. But the issue of hospitals is that they are running on average at 40 percent empty beds, and in some areas of the country, their occupancy is in the neighborhood of 30 and 40 percent. These are very high-fixed cost institutions. If we don't try to downsize, I guess some people call it "rightsize," to get rid of some of that excess capacity, it will be very hard to have spending grow at lower levels.

Mr. MCDERMOTT. So you are expecting that there will be a lot of hospitals closed. Mr. Cardin's question is absolutely correct. Rural hospitals that are running at 30 percent are going to close. That is basically what you expect, right?

Ms. WILENSKY. I think that rural hospitals, because they tend to be very small, tend to be easier to keep around. Some rural hospitals will, in fact, close, as some rural hospitals have been closing. But you look in this area and you look in Washington, DC, and a 15-minute ride from Sibley Hospital to Columbia Hospital, there are four hospitals that are like 12 minutes apart by car.

Mr. MCDERMOTT. I could take you to parts of the State of Washington where the hospitals are 150 miles apart so——

Ms. WILENSKY. We have to make sure, as I believe there is a——

Mr. MCDERMOTT. But how is that money going to be——

Mr. THOMAS. The gentleman's time has expired.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Just briefly, these numbers that the doctor has passed out are based on the old CBO numbers and would not be truly accurate of the current projection that the CBO has come out with, isn't that correct?

Ms. WILENSKY. It is—it is not based on any projections that CBO will be doing. It was, I believe, the baseline TV estimates they put out in March.

Mr. MCDERMOTT. If the gentleman would yield?

These are the updated numbers.

Mr. CHRISTENSEN. I was under the understanding that the CBO will be coming out with revised numbers and that this chart would not be accurate at that time; is that correct?

Ms. WILENSKY. Yes.

Mr. CHRISTENSEN. Thank you.

Chairman ARCHER. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Chairman and Members, I have two concerns I would like to raise at this point, and the panel has alluded to one or both of them. The first is the idea of medical savings accounts.

I know, Gail, you had some portion of your testimony dealing with that. My fear is if in fact this proposal in total is to retain and restrain costs for the program, this is one item that might have a lot of political sex appeal, but I think once people get this scam down, it is going to be abused and it is going to be a costly abuse. And the abuse I envision is if I am retiring at age 65 and I am in relatively good health, what I am going to do is I am going to roll the dice for 5 years. I am going to take the high deductible plan plus the medical savings account, which although taxable, I can make some money on it, and I am going to say that for 5 years, between 65 and 70, I should be OK, maybe. However, what I am going to do as soon as I turn 70, I am going to go into the fee-for-service plan, knowing full well it is going to take 12 months to get into that plan. Is that scenario that I have just painted totally off base?

Ms. WILENSKY. Well, I mean, I think the issue of——

Mr. KLECZKA. Briefly, because I want one more point.

Ms. WILENSKY. OK. If it is only the healthy people who go in and if there is not an adjustment to the payment to reflect the fact that they are a healthier risk, you will end up putting pressure on the fee-for-service market. Frankly, I think most seniors won't want to do it. They don't like big deductibles.

Mr. KLECZKA. Stu.

Mr. ALTMAN. I am concerned. I think you need to adjust and really push the rates down that they get because they are good risks, they should get a lot less money and, therefore, they won't have a lot of extra money to put into those medical savings accounts.

Mr. KLECZKA. What I am hearing and again, it is only rumor because there is nothing solid before us, is they are going to the per capita payment, whatever it is, and we are looking at $4,800.

Ms. WILENSKY. It is the payment that says they will get a risk-adjusted premium. What that means and how they will do it, I don't know. But there is the term risk-adjusted premium. Somebody understood that they had to use that phrase.

Mr. KLECZKA. OK.

The other concern which has been mentioned is the fee-for-service program. I think that, first of all, if this should pass, the bulk of the seniors are going to stay in fee-for-service so we are going to start off with a big group in that service.

For those who start shopping around for an HMO which has maybe better benefits through the selection process, the sicker of those seniors are not going to be permitted or accepted into the HMO. They are going to have to stay into the fee-for-service. So not only are we going to get a high volume of people in fee-for-service, but after a period of time, the sickest of the seniors are going to be in fee-for-service.

Mr. ALTMAN. I think that is a real concern unless we adjust the payment better. It is not that sick people are necessarily losers. It is only in relationship to what they—the plan gets paid. So if you paid the plan a decent amount of money for the sickest members, I think you potentially can save more money with the sickest members than you can with the healthiest members. The key is the payment.

Mr. KLECZKA. Given the scenario that these folks are going to be stuck in or decide to stay in the fee-for-service, again I haven't seen any part of the plan or a plan. But reading the Wall Street Journal today, they indicate that each fee-for-service program would be permitted to consume a preset sum of money, if that is capitation or whatever, and if in fact the spending is higher than projected, Medicare payments naturally would be reduced automatically.

My question is what happens at that point? If in fact a per capita or this preset dollar amount is expended, do the providers have the option to shift the additional cost to the patient or do they have to accept the liability themselves and what do they do, stop accepting patients?

Ms. WILENSKY. The pressure will be on reducing payments for providers. I think we both agree that if there is not a risk adjustment and healthier people go in one type of plan or the capitated plan, there will be artificial reductions in the fee-for-service over what should occur.

Mr. KLECZKA. And I agree with all that. But what happens to the beneficiary?

Ms. WILENSKY. They cannot charge more. It will only be a question of whether they will have trouble getting access.

Mr. KLECZKA. Do the physicians fail to accept any new Medicare patients?

Ms. WILENSKY. It is always the right of a physician. There is again the—right now, Medicare is.

Mr. KLECZKA. This is like a balloon. If you keep punching it, it is going to come out somewhere. I am wondering when it pops out, that one side of the balloon, who is going to be affected by the big pop?

Ms. WILENSKY. Probably what will happen is those physicians who will feel they are being punched will go find managed care plans to join and take their patients with them. If there is not risk adjustment and risk selection occurs, there will be a problem, absolutely.

Mr. THOMAS [presiding]. The gentleman's time has expired.

Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Wilensky, the current Medicare system is funded by a payroll tax.

Ms. WILENSKY. For part A.

Mr. COLLINS. Part A. Well, when you get down to the bottom line for America——

Ms. WILENSKY. For part B it is from the Treasury.

Mr. COLLINS. That is right. But they pay into the Treasury, too. How many workers do we have today per beneficiary?

Ms. WILENSKY. I think it is about 3½ or 4 to 1. When the program started it was closer to 5 to 1.

Mr. COLLINS. And that will continually get closer and closer in ratio?

Ms. WILENSKY. Right.

Mr. COLLINS. I have seen the figure somewhere, but based on a couple, a two-income couple that would retire in 1995, what is the estimated benefit cost to Medicare for that couple in their retirement age versus the amount of funds they paid in through a payroll tax as premiums?

Ms. WILENSKY. As I recall the numbers, they would receive about $100,000 more than what they put in. I think Mr. King indicated that for an individual who is retiring in 1990, he can expect to get out five times what he himself or she put into the trust fund. If you count the employer's contribution, it is 2½ times more than what they put in. So there is a substantial increase in terms of what you get vis-a-vis what you put in.

Mr. COLLINS. Based on those numbers, there is no way that the system can survive.

Ms. WILENSKY. Well, it is the problem of having started with a large number of workers supporting a small number of retirees and moving into a system where that is getting closer and closer to a 1-to-1 ratio.

Mr. COLLINS. It is kind of like Mr. Laughlin said, the farther you go, the more it is going to cost.

Ms. WILENSKY. Right.

Mr. COLLINS. The younger people today who are possibly looking forward to having Medicare in their retirement age.

Ms. WILENSKY. Right. And of course compounded by Social Security.

Mr. COLLINS. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Georgia Mr. Lewis wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman.

Dr. Wilensky, does this plan help or hurt this fight against waste and abuse? If so, can you describe that?

Ms. WILENSKY. I believe there are several measures to try to go after waste and abuse, so I think it attempts to reduce waste and abuse.

Mr. LEWIS. Have you read the plan?

Ms. WILENSKY. Yes, I have read it, although I have obviously had a limited time to read the document that was distributed yesterday.

Mr. LEWIS. When did you first receive the plan?

Ms. WILENSKY. Well, I received the document that was distributed yesterday. There was an earlier distribution on Monday that was of a more general nature.

As Dr. Altman has said, the PPRC and ProPAC staffs have been working with the Committee staff, so there are some parts that we have known about for a longer time.

Mr. LEWIS. Thank you very much.

Dr. Altman, would teaching hospitals like Emory and Morehouse in Atlanta be hurt by this proposal?

Mr. ALTMAN. As I indicated, the current numbers suggest that teaching hospitals like Emory and Morehouse will actually be big benefactors of the plan but that is because of this new fund that has been established. So they do not lose.

Mr. LEWIS. Could you tell me, I notice on page 33, a new fund would be established. Could you tell me how it would be funded? Is there an ongoing source of funding?

Mr. ALTMAN. My reading of it--Don, you may want to correct me—is that it is made up of several sources of funds. Part of it will be the traditional funds that flow into the indirect medical education adjustment and to the direct medical education adjustment, and part of it will come from general revenues to be established which will flow both into the indirect medical education fund and the direct medical education fund, and then the direct one will be split into two parts, some of which will go the more traditional way and some into this demonstration. Don, is that——

Mr. LEWIS. Dr. Altman, I think you told Ms. Dunn, and maybe Mr. Rangel, that the New York hospitals were doing OK under Medicare, everything was all right, they don't have anything to worry about, but I am concerned about the safety-net hospital in my district. What would happen, combined with the large cut in Medicaid, at a place like Grady?

Mr. ALTMAN. Well, I think we need to look at the total impact of the three forces: One is Medicare; two is Medicaid; three is what is happening to the number of uninsured; and the fourth factor of course is to the extent that they have any private patients. We haven't modeled the implications of the Medicaid because we don't know what that looks like. It has only been recently put out in terms of the numbers.

You start worrying about block grants and what the States choose to do with the money, at some point we need to look at the totality of it and it is quite possible that some safety-net hospitals could be in trouble. I think the proposal for adding this extra money for teaching will help that, make it less of a problem, but it is something to look at hard. I don't think we can be assured that all those safety-net hospitals are going to do fine.

Mr. LEWIS. So are you suggesting that some of these safety-net hospitals may not survive, they may close in the inner cities, in rural areas and small towns?

Mr. ALTMAN. I think we are already seeing the problem in Los Angeles County, and I think the issue is developing. Part of the issue, though, is that we have built up in some areas a fair amount of excess capacity and a fair amount of waste. But I am concerned about the safety net and I think everybody should be concerned about it, that we don't do harm to what is really needed. And I am also concerned that the number of uninsured in this country could grow substantially and——

Mr. LEWIS. Under this proposal?

Mr. ALTMAN. No, it is not related to this proposal. This is what I was trying to say before, there are bigger, there are other forces. This proposal helps those institutions.

Mr. LEWIS. I thought you indicated, Dr. Altman, that this would maybe increase the tempo of closure for some of these inner-city safety-net hospitals.

Mr. ALTMAN. No. I said when you combine the potential impact of Medicaid and the growing number of uninsured and the reduced number of people willing to pay on the private side, some could close. That goes way beyond this proposal.

This proposal is part of a mosaic, and I for one cannot—I would never say that our safety net is secure. I think there are potential problems down the road for our safety-net institutions. But this proposal in and of itself does not, under the current form, it will actually help inner-city teaching hospitals that also are a disproportionate share because of the new money that has been put in.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Ohio wish to inquire?

Mr. PORTMAN. I thank the Chair, and I thank both of our panelists for their excellent testimony today. And I think this has been a good dialog among us. I learned a lot and I think it was the kind of hearing that we needed on the proposal.

I would just say as many members of the panels have, I have a Medicare as well as a health care task force back home. I represent Cincinnati, which I view as a relatively sophisticated and progressive health care community, both on the provider side and the business side, frankly. Our health care costs in the private sector now are well below inflation. In fact, our hospital costs, including outpatient last year, increased about 1.9 percent.

Many of our companies are now putting request proposals at zero percent health care increase and primarily that has come from increased competition, more managed care, many of the factors you have talked about. So I guess I have to put myself down as a believer that in fact the market forces can work, and that is why I am excited about this proposal. I probably would have gone further—and we talked earlier about your views as to the blends here and how far we went or didn't go in terms of providing incentives and disincentives for fee-for-service as compared to various coordinated care options.

I guess I would just ask you sort of a summary question. Do you believe, Dr. Altman, that this plan goes too far in terms of encouraging people who are currently in the fee-for-service option, which is 90 percent of Medicare beneficiaries, to move into some coordinated care option?

Mr. ALTMAN. No, I don't think it goes too far. As I said in answer, I think it continues a set of incentives that are in place today. It does not add some of the others in terms of extra cash benefits. It depends on what part of the country you are in, though, and I would have to take a look at Cincinnati relative to its AAPCC, relative to its costs, whether it is a winner or loser under this game. My sense is that the current Medicare badly needs to change or over the next 10 years you are going to see very different Medicare Programs in different parts of the country.

Mr. PORTMAN. Do you think, Dr. Wilensky, that the so-called "look-back" provision, as I understand it, do you think that that mechanism is properly adjusted given what you think will happen in terms of the managed care options and the other coordinated care options so that it will not create an undue problem for providers in the system?

Ms. WILENSKY. Well, I think that the specifics and the flexibility that may be in there needs to be looked at.

I would hope that the reasons why you did not go perhaps farther in terms of encouraging the choice structure that seniors pay is something that you might be willing to reconsider in 2 or 3 years. I agree, the realistic and political assessment, it would have been an error, but I would have liked to have seen you go farther. I think especially if that happens in 2 or 3 years, the likelihood of engaging the fail-safe mechanisms becomes less and therefore it is less of a concern.

I think you can accommodate these concerns by putting in some flexibility, and again monitoring each year what is going on and if there are sides of access problems, quality problems, intervene as you can as a Congress.

Mr. PORTMAN. I thank you both very much.

I think there is a general consensus on the monitoring and the ability to look at outcomes and look at the data over time so that we can be flexible.

Thank you for your testimony.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Thank you, Mr. Chairman, and thank you Dr. Wilensky.

Dr. Altman, I think your testimony has been very, very helpful, and I do appreciate it. Dr. Altman, you began by saying that you had an opportunity to look at some of the details and consequently were able to comment on some specifics of the plan. My perspective on this issue is as someone who represents an area that is medically underserved.

I am from a rural area, out of 17 counties, 14 have been deemed medically underserved. Our hospitals are all disproportionate-share hospitals. Many are sole community-provider hospitals, and we have rural referral centers there as well. And I am concerned because a very high percentage of their revenues come from Medicare and to some extent Medicaid. You mentioned that you thought that the provision, the market basket minus 2 provision, was one that could be sustained by the hospitals in general. Does that mean that there will be some that will and some that won't, or do you think that hospitals, such as the ones I have just described, would be able to sustain themselves in that kind of environment?

Mr. ALTMAN. Well, there have been a number of special provisions that have been added to the DRG system over the last 10 years to help out rural hospitals in your district in terms of treating them more like urban hospitals, allowing the update to be adjusted. So—and as a result of that, the rural hospitals have been able to do much better after those adjustments were made. To the extent that they stay in place, I think it will be OK.

I want to modify my answer to Mr. Lewis. My comments are without regard to that fail-safe. If that fail-safe comes in and comes

in big, substantially beyond what we have seen in the market basket minus 2, I can't make the comments I have made in terms of that. That is why I, if it was up to me, I wouldn't have a fail-safe—unless you found behavior changes on the part of institutions that were making money on the other side. There a fail-safe is OK. But if that fail-safe is needed to cut and make it market basket minus 3, 4 or 5 percent, then all bets are off.

Mr. PAYNE. So when you say you wouldn't have a fail-safe, then you wouldn't recommend that we cut $270 or——

Mr. ALTMAN. I don't know. I haven't seen that part so I can't say. I don't know what the programs add up to because there are many—we had a pretty good sense of what the basic ideas were, but I have not seen them added up, so I do not know how far the specifics take you to the $270 billion and how much is needed beyond that for the fail-safe.

Mr. PAYNE. So at this point you couldn't comment on the appropriateness of the $270 billion number.

Mr. ALTMAN. I can't. I honestly cannot.

Mr. PAYNE. As you look at market basket minus 2——

Mr. ALTMAN. Yes.

Mr. PAYNE [continuing]. And thought about that and decided that it is pushing it to the edge, and did you factor in the fact that Medicaid also is being looked at and likely those payments may be reduced as well?

Mr. ALTMAN. We did not and that is something that needs to be done. We could not because we have no idea what this will look like under the revised system.

I mean, the States may turn out, if you were to block grant it, they might give more money to these institutions and less to the others. And besides, we just found out the numbers—we knew the overall numbers. We, in our modeling effort, we have pretty much kept Medicaid where it was. So if we have time, we are going to go back and redo those models. But even at best, we are going to be guessing a lot because there is much more uncertainty on the Medicaid side in terms of its impact on institutions.

Mr. PAYNE. Well, like you, I will be very interested in seeing those numbers or the numbers of this bill, the Medicare bill, to be able to make some judgment about what the impact might be, and particularly this look-back or fail-safe mechanism and how that is proposed to work and what that might do in the event that——

Mr. ALTMAN. Well, that is why I have been cautioning about the need for constant vigilance on the part of the Congress, because there are many unknowns that have nothing to do with this proposal, by the way, in terms of how efficient the system is, how many uninsured become available, what happens. And you can't just write this legislation and decide you are now retired—it would be a big mistake.

Mr. PAYNE. Well, this is critically important to many of us because this is not only a health issue, this is an economic development issue, if we don't have our hospitals.

Mr. ALTMAN. This is a health care system issue.

Mr. PAYNE. It is the health care system, but it is also whether we would be able to attract new businesses and expand the ones

we have. So this is critically important, and I think we need to get it right.

Thank you.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Massachusetts wish to inquire?

Mr. NEAL. I do.

Thank you, Mr. Chairman.

A question for Dr. Altman.

Massachusetts, as you know, is heavily dependent on the health care industry.

Mr. ALTMAN. I do know.

Mr. NEAL. Massachusetts is the perfect microcosm of the best things that take place in American health care every single day. You indicated in your opening statement that you thought there had been some change of heart during the last 60 or 72 hours.

Mr. ALTMAN. Yes.

Mr. NEAL. On the part of the teaching hospitals.

Mr. ALTMAN. Yes, substantial. As a resident of Massachusetts, I am well aware of the issues and I was very pleasantly surprised to learn that the proposal now includes this new graduate medical education fund which would be partially funded by general revenues. It is an area where I have long believed we need to be establishing the recognition that graduate medical education should be shared and should not be the sole burden of the Medicare Trust Fund and I think this is a big step forward.

We have tried to estimate what that would do to teaching hospitals. One of the things we couldn't figure out, though, is while we are adding money on one side, if the private sector is going to pull it out on the other side, is it going to be a wash; is it going to be a net plus or a net minus?

We did the best we could but I think our estimates that are in your testimony are too high in terms of the impact on teaching hospitals because they don't take account of the potential reduction on the private side. But I applaud the proposal and I hope that it becomes the basis of any new legislation that we move to the recognition that teaching and research should be a shared responsibility, and then let the market work.

I believe in that market. I think that those market forces should work, but you can't count on the market to fund social goods. It—what little economics I remember, that is what I was taught, and I believe it.

Mr. NEAL. Well, thank you for the last sentence you offered.

Mr. ALTMAN. The little economics I remember?

Mr. NEAL. No, no, that you can't depend upon the private sector sometimes to properly finance social goods.

Mr. ALTMAN. It should be financed socially.

Mr. NEAL. Exactly. Keep going, you are doing fine.

My point is I was caught by the description you said over the last 2 or 3 days because I thought last night while I watched Speaker Gingrich and Chairman Archer on the rerun of C–SPAN that Speaker Gingrich indicated that that issue was more than 1 year away from being resolved.

Mr. ALTMAN. What?

Mr. NEAL. Graduate medical education.

Ms. WILENSKY. Because I think it is proposed that there will be a special commission set up to look at the longer term issues, so the question of what ultimately is the role of the Federal Government for graduate medical education, there are other issues but the change in the funding occurred because of the setup of the separate fund and the infusion of new funds. So it is something that will be revisited.

Mr. ALTMAN. The issue that I think the Speaker was referring to is a second complicated issue about how—should we give more money for a certain kind of training than others. Should we impose any kind of top-down restrictions on our medical schools in terms of what specialties they fund? And that is a very complicated issue. I was referring to the dollars that flow to the teaching hospitals. And I think that is automatic. That is fair.

Mr. NEAL. I know the panelists don't need any reminder, but when Raisa Gorbachev was ill, she came to Massachusetts, and when Elizabeth Dole was ill, she came to Massachusetts. And we want to ensure that that high quality is maintained. And that the point that you raised in your concluding sentence about not being able to look to the private sector to fund some of those social goods is terribly important. I thank you for at least that aspect of your testimony.

Thank you, Mr. Chairman.

Mr. THOMAS. I believe that all Members who wish to inquire have inquired.

I want to thank both of you once again. You have done an excellent job. We look forward to hearing from you again as we continue to remodel this sector.

It is not going to be something that, as you said, Mr. Altman, you do once and then just walk away from it. We are going to be at it for a while, but I think we are at least moving in the right direction, and I want to thank you.

The next panel, Peter J. Ferrara, National Center for Policy Analysis; Joyce L. Hansen, assistant vice president, Reliastar Financial from Minnesota; and Karen Davis, who is the president of the Commonwealth Fund, New York, New York.

And if I might, I would yield to our colleague from Minneapolis, Minnesota.

Mr. RAMSTAD. Mr. Chairman, I thank you for yielding for the opportunity to introduce a constituent who is truly an expert witness. I am glad to see Joyce Hansen here today from Reliastar Financial, which is a major company in Minneapolis, Minnesota, specializing in health and life insurance. Joyce will testify on a critical component of the Medicare Preservation Act, the provisions designed to combat fraud and abuse.

Mr. Chairman, as all of us know, fraud and abuse currently consume literally billions of taxpayer dollars. We are fortunate to have Joyce Hansen here today because she is an expert in this area. As assistant vice president of Reliastar, with 18 years of experience, she is a certified fraud examiner. She designed and established the Special Investigations Unit at Northwestern National Life. Joyce is a cofounder and president of the Midwest Insurance Fraud Prevention Association and she serves as the 1995 chair of the National Health Care Antifraud Association.

So it is a real pleasure to welcome you, Joyce, to today's hearing. I look forward to your important input on the Medicare Preservation Act as well as to the other witnesses.

Thank you, Mr. Chairman.

Yield back.

Mr. THOMAS. Certainly.

And I do want to indicate that added to this panel, Dr. Mullins, who is the executive vice chancellor for Health Affairs, University of Texas System, and I should mention out of Austin. And Dr. Cohen, who is the president and chief executive officer of the Association of American Medical Colleges.

Each of you has 5 minutes to inform the Committee as you see fit, and your written statements will be made a part of the record.

And I will just start with you, Mr. Ferrara, and move across the panel.

STATEMENT OF PETER J. FERRARA, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. FERRARA. Thank you very much, Mr. Chairman.

I would like to focus today on a study that we did at the National Center for Policy Analysis along with the actuarial firm of Milliman and Robertson. They are the top actuarial firm in the country. These are one of the firms that insurance companies go to when they want to find out how to structure their insurance plans or what they should charge and that type of thing, and our study was on medical savings accounts.

And what we did was we looked to see what kind of medical savings account you could purchase with the money that you would be able to withdraw from Medicare under the Republican proposal. What kind of features would it have?

We discussed this matter with the staff, Committee staff, to obtain the estimates of what these funds would be. And in the charts over here, we have the main conclusions of the study.

In the first chart, this is a medical savings account with a fee-for-service plan. And what Milliman and Robertson does is that with the funds you could withdraw from Medicare you would be able to purchase a fee-for-service catastrophic plan covering all expenses above $3,000 and you see the blue part. That is the catastrophic plan covering all expenses above $3,000 and still have $1,500 left to put in the medical savings account to cover expenses below the deductible.

Now, what is fascinating about this is this benefit structure is better than the benefit structure of Medicare in at least five ways: First of all, it provides complete catastrophic coverage, all expenses above $3,000. Medicare, as you know, does not provide complete catastrophic coverage.

Second, it provides a cap on out-of-pocket expenses. An elderly beneficiary with this cap, with this plan would never have to spend more than $1,500 out of pocket, which is the difference between the amount in the medical savings account and the amount of the deductible. As you know, Medicare has no cap on out-of-pocket expenses. In fact, an elderly recipient can be liable for tens of thousands of dollars each year in costs for services that are supposed

to be covered by Medicare. That is why 70 percent of the elderly purchase private Medigap insurance. These are all 1996 numbers.

The average premium for that insurance will be $1,200. You wouldn't need to buy that at all with this medical savings account plan or you could put the $1,200 in the plan and you—into the medical savings account and you would have $2,700 and that would almost be equal to the deductible itself.

A third way in which it is better is that the funds in the medical savings account can be used for any health expense, not just health expenses covered by Medicare. So, for example, if you have a constituent that has a high cost for prescription drugs, maybe that constituent doesn't have too many other costs during the year but it is $500 to $600 to pay for, say, medicine for a heart condition, they could use the funds in the medical savings account to pay for that, whereas Medicare would not pay for that. In addition, whatever funds are left in the account at the end of the year above a certain threshold, they could withdraw those funds and use them for any purpose. This is a reward to the elderly for helping to control health costs within the budget targets, and so this is another benefit.

In addition, in the private market they would not be subject to any of the payment restrictions, the payment limitations, the delays in approval of new technologies and other matters that, in my opinion, are reducing the quality of care under Medicare.

Now, what is fascinating also about these medical savings accounts is they are already in use in the private sector. Over 1,000 employers nationwide have these medical savings accounts. They are getting bigger cost reductions with these medical savings accounts than is targeted for the budget under Medicare, targeted for Medicare under the budget. Instead of reducing costs just from 10 percent to 6.5 percent, the private employers are reducing costs with medical savings accounts that are increasing at a range of 15 to 20 percent down to zero percent and even less. That shows that these medical savings accounts will stay within the budget-limited voucher amounts over time. The elderly will be able to buy these benefits that are better than Medicare with the amounts that they get out of Medicare.

The second chart shows what would happen if you bought a managed care plan covering all expenses above $3,000 and put the rest in the medical savings account. In that case you would have $2,100 left over in the medical savings account which provides even more funds to pay for health expenses.

Now, one key point to make out of this: This shows the medical savings account is more attractive for sick people than Medicare. If you were sick, you would rather be—have the catastrophic coverage. You would rather have the cap on out-of-pocket expenses. You would rather be able to use the funds in the account to pay for the expenses you—whatever expenses you want and all these other factors.

Because it is more attractive for the sick people than Medicare, this addresses many of the concerns we have heard up until now. This data has not been available to many of the people, to people who have been testifying up until now. But this greatly reduces the risk selection problem because I would argue that the majority of

people, it is more attractive for sick people than Medicare, and Milliman and Robertson will back this up.

The actuaries at Milliman and Robertson also agree the medical savings account plan will be more attractive to sick people than Medicare. So the risk selection problem, the sick are going to stay in Medicare, is greatly reduced as a result of this.

It reduces the concern over risk adjustment. You don't have the same concern. It reduces the concern about—in fact provider—the limitation, once providers—Milliman and Robertson estimates that by 2002—I will finish on this sentence—that 80 percent of the people in Medicare will have chosen the private options.

Now, I tell you again this is the top actuarial firm in the country and because this is more attractive for sick people as well as healthy people, that is the key reason why they assume that. So most of the people in Medicare today will be in the private sector where they are—where the hospitals and doctors are not subject to these provider limitations and thereby greatly easing that problem as well.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF PETER J. FERRARA
SENIOR FELLOW
NATIONAL CENTER FOR POLICY ANALYSIS

Better Than Medicare

The Republicans have now accomplished what no one in the Washington establishment contemplated when the Republican budget blueprint was adopted by Congress earlier this year. They have proposed a Medicare reform plan that actually offers the elderly a better system than Medicare, while still meeting the budget targets.

The essence of the plan is that it shifts power and control over Medicare and its funds away from the government, the hospitals and the doctors, to the elderly themselves.

The key features of the plan are:

- The elderly would each have the freedom to take their share of funds out of Medicare and use it to buy any of the full range of private alternatives for their health coverage.

- The proposal is not based on HMOs or managed care. Managed care is only one option on a level playing field with all of the others.

- Other options include Medical Savings Accounts (MSAs), traditional fee-for-service insurers, preferred provider networks, provider service networks (where doctors and hospitals in an area organize to provide health coverage directly), and plans offered by associations such as AARP, or unions, or employers.

- The elderly would each be perfectly free to stay in the current Medicare system if they prefer, foregoing the private options entirely.

- The private plans must provide at least the same benefits as Medicare, and can provide more. They must accept all Medicare-covered retirees who choose them during an annual open enrollment period, regardless of health condition.

- The share of funds the elderly can each withdraw from Medicare to pay for these private plans would vary depending at least on age, geographic location, and certain health factors. So the older and sicker would get more and the younger and healthier would get less, reflecting what they would each have to pay for the private coverage.

- If a chosen plan costs less than the amount withdrawn from Medicare, the beneficiary can keep the difference, up to a maximum limit equal to the Medicare Part B premium, which will be around $600 per retiree next year.

- The amounts that can be withdrawn from Medicare for these private options are limited to grow no faster than the budget targets. So these targets will be automatically met to the extent that retirees choose the private options.

- Medicare premiums would be kept at their current level of 31.5% of costs for Medicare Part B. So they would increase over time at the rate at which costs for Medicare Part B grow, which is the same rate as they have grown in the past. By 2002, this would leave premiums $7 - $10 per month higher than if the target percentage for the premiums had dropped to 25% of Part B costs. While such a decline to 25% was putatively scheduled under current law, with the Medicare financing crisis and the drive to balance the budget, this decline was never going to happen anyway.

- Premiums would be raised substantially more for high income retirees with incomes over $150,000 per year for couples and $75,000 per year for singles.

- As of this moment, the plan includes no increase in Medicare deductibles and co-payments, even though Part B has a ridiculously low deductible of $100 that should have been raised substantially.

- To offset higher costs for those who choose to stay in Medicare, expected increases in payments to doctors and hospitals would be reduced to the extent necessary to ensure that budget targets are met.

- Overall, these changes will reduce the rate of growth of Medicare from about 10% per year to 6.4%. This lower growth rate will be sufficient to cover benefits because that is about the rate at which costs have been growing in private health plans.

- This reduced growth rate means Medicare would spend approximately $270 billion less over the next 7 years than it would have otherwise. But total Medicare spending would still grow sharply over that time. By 2002, Medicare would be spending over 50% more than today. Medicare spending per retiree would grow by about 40%, from $4,800 per person today to $6,700 per person in 2002.

The key to this plan is that it allows the elderly to take advantage of the incentives, competition, efficiencies and innovation of the private sector. Because of these factors, many of the private plans will be able to provide even better benefits than Medicare, while still staying within the budget targets.

For example, the NCPA study done by Milliman and Robertson, the nation's top actuarial firm, shows that with the funds retirees can withdraw from Medicare, they will be able to buy an MSA plan that provides full insurance coverage for all expenses over $3,000 per year, with $1,500 left in the MSA to pay for expenses below $3,000. This plan provide better benefits than Medicare in at least 5 ways.

- It provides complete catastrophic coverage for all expenses over $3,000, while Medicare does not. Medicare coverage runs out after various caps and limitations.

- It provides a maximum cap on out-of-pocket expenses by the elderly themselves of $1,500 per year (the difference between the $3,000 deductible and the $1,500 in the MSA). Medicare has no cap on out-of-pocket expenses. The elderly can be liable for tens of thousands in expenses themselves with Medicare and more. That is why 70% of the elderly pay almost $1,200 per year on average for private insurance to supplement Medicare. With the MSA, the elderly can keep that $1,200 per year. Or they could put it in the MSA, providing a total of $2,700 to cover expenses below the $3,000 deductible, virtually eliminating any further out-of-pocket expenses.

- The funds in the MSA can be used for health care, often preventative in nature, which are not covered by Medicare, such as prescription drugs.

- Unspent funds in the MSA at the end of the year would belong to the retiree, and could be saved for future expenses, or withdrawn for any purpose, subject to certain minimum balance requirements in the House bill. This allows the elderly to share directly in the reward for controlling health costs.

- MSAs would not be subject to the payment and reimbursement limitations of Medicare, or the outdated limitations on what new services and treatments the program covers. These limitations and controls are reducing access to care and quality of care under Medicare, effectively rationing health care for the elderly.

Experience with HMOs and other managed care options shows that they can provide better benefits than Medicare as well, while also staying within the budget limits. They will likely be able to add catastrophic coverage and prescription drugs to the Medicare package for what the elderly will be able to withdraw from Medicare each year.

The elderly can consequently get better benefits from a range of private plans. They can benefit directly from controlling costs through cash rebates from the MSAs and other private plans. They can gain complete control over their health care through the private

plans, escaping the rationing that is increasingly occurring under Medicare. They would have freedom of choice to pick the health plan best suited to their needs and preferences, with complete choice as well over doctors, hospitals, treatments and services. The Medicare financing crisis would be averted for today's retirees, while their premiums in fact would continue to increase at the same rate as in the past (except for the highest income retirees). These are the reasons why the Republican reform plan offers the elderly a better system than Medicare.

For the rest of us, all of this is accomplished without any increase in taxes. To the extent retirees choose the private options, the insurance function of Medicare would be shifted to the private sector. Medicare would become an innovative voucher system that classically minimizes government interference in the health care market. And the new system includes a very strong MSA that will likely lead the way in creating a real health care market. Finally, this freedom of choice system creates a powerful precedent for future entitlement reform. This is a proposal, therefore, that conservatives and free market reformers, as well as the general public, can and must ardently support.

Some fret that the proposal relies too heavily on reducing reimbursements for doctors and hospitals to reduce costs for those who stay in Medicare. But this is looking at the proposal out the back window of the train. Overall, instead of effectively tightening overly restrictive reimbursement limitation further, the reforms are a means for abolishing the controls altogether. That is because the reforms allow the elderly options and choice in private alternatives where the reimbursement limitations do not apply.

You heard it here first. Within 5 years, 80-90% of the retirees will be in the private options. Among other implications, that will effectively nullify the reimbursement limitations.

Mr. SHAW [presiding]. Thank you.
Ms. Hansen.

STATEMENT OF JOYCE L. HANSEN, ASSISTANT VICE PRESIDENT, RELIASTAR FINANCIAL, MINNEAPOLIS, MINNESOTA

Ms. JOYCE HANSEN. First of all, I would like to thank the Members of this distinguished Committee for the opportunity to speak with you today on issues relating to fraud and abuse in the Medicare system. I commend this Committee for its willingness to confront this important and costly matter.

I developed the fraud and abuse detection program for Reliastar over 10 years ago and today I would like to share some of our tools and techniques that have proven effective in reducing the amount of money lost to fraud and abuse for our clients.

Health insurance fraud has been hitting the public programs and private industry hard over the last 5 years. To place this debate in its proper context, this Committee is charged with the daunting task of achieving $270 billion in savings within the next 7 years in the Medicare Program.

Recently, the HHS Office of Inspector General estimates over the next 7 years if nothing changes, Medicare will lose $138 billion to fraud. Members of the Committee, that figure represents over one-half of the total savings this Committee plans to achieve. In order to address the fraud problem, efforts must be made to aggressively pursue those who perpetrate fraud.

The proposed legislation is a good first step. It displays a viable effort by the Committee to address the issue of fraud in Medicare. The education efforts and Antifraud and Abuse Trust Fund are important elements. But there are additional steps that could make this proposal even more truly proactive.

At Reliastar our approach to detecting and preventing fraud and abuse centers on a proactive approach. We achieve success by identifying problematic providers and thoroughly investigating their claims prior to payment. By placing the claims in a pending status and ensuring a thorough audit of the claims, we have reduced the number of fraudulent claims that would otherwise get paid. As a result, we saved our clients, we have 400 clients, millions and millions of dollars.

The most effective fraud prevention program is to identify the fraudulent claim before it is ever paid. It is a two-step process. It is screening the claims and having well-trained staff to investigate. We also employ the use of sophisticated technology designed to detect fraud and abuse through a retrospective analysis of claims data. Let me give you a couple of examples.

We looked specifically at chiropractors in the Los Angeles area and we found—this was during 1993—we found a chiropractor who 100 percent of the claims he had submitted to Reliastar were for patients who lived 50 miles or more from his office. Well, after we looked into it, we found out that he had moved his practice but he kept billing for those same patients.

We found another chiropractor in the Los Angeles area, through this systematic technology. Twenty-five percent of the claims he submitted to our company in 1993 were for services on Sundays and holidays, but he didn't have office hours on Sundays and holi-

days. These claims went undetected before we had this technology. Fraud and abuse technology is able to detect these aberrant practices.

We have been using sophisticated technology for just over 1 year because it has just been brought into the marketplace in the last 18 to 24 months. In that time, we have seen an increase in savings of over 500 percent for some of our internal clients and an overall increase in savings of 41 percent in the last year for our whole block of business.

By implementing effective training, investigation and system identification programs, I would estimate that the total medical expenditure could be reduced by one-half of 1 percent within 24 months. For example, if total expenditures in 1995 are 177 billion, the amount that could be saved due to fraud prevention measures would be $885 million. Please keep in mind this is a very conservative estimate. The percentage of savings would likely increase to 2 to 4 percent of the total annual expenditures in the following years.

Through years of experience in a program where we have seen increases in savings every year, I can assure you in order to stay on top of this sophistication of schemes, you have to have effective tools. Sophisticated schemes take sophisticated approaches to solve.

I hope I was able to provide additional insight on how to address this problem with my suggestions and comments.

Thank you.

[The prepared statement follows:]

STATEMENT OF JOYCE L. HANSEN
ASSISTANT VICE PRESIDENT
RELIASTAR FINANCIAL

INTRODUCTION

I would like to thank the members of this distinguished committee for the opportunity to speak on the issue of Medicare fraud. I commend this committee for its willingness to confront this important, and costly, matter.

I am Joyce Hansen, Assistant Vice President, Reliastar Financial. I oversee the investigative area of the Employee Benefits Division of Reliastar. We provide investigative services, training, and system identification of questionable providers for our group-insurance customers, as well as for external clients.

Reliastar Financial is headquartered in Minneapolis and has been in the insurance business since 1885. We were known formerly as Northwestern National Life (NWNL). The Employee Benefits Division provides products and services that include life, health, disability, long term care insurance, claim administration, national and regional managed care programs, and, as previously mentioned, health care fraud detection and investigation services.

I have been with Reliastar for 12 years. I started the company's anti-fraud program in 1985, becoming the first special investigator in the Employee Benefits Division. We presently have 8 full time investigators. Our goal is to identify providers, participating in both indemnity and managed care plans, who are engaged in questionable practices and to ensure thorough and timely review of their claims prior to our payment of benefit dollars. Through the comprehensive review of questionable claims, we are able to prevent the expenditure of company and clients' funds on ineligible charges.

In 1990, I was instrumental in the formation of a regional fraud prevention association. The Midwest Insurance Fraud Prevention Association draws insurance representatives in health, life and disability markets from Minnesota, Wisconsin, and North Dakota. We hold quarterly meetings to discuss fraud investigation techniques, to network on a regional basis and to involve regional law enforcement personnel in our activities. I am currently President of the Association.

In addition, in 1990 Reliastar became a corporate member of the National Health Care Anti-Fraud Association (NHCAA). This association has furthered our commitment to improve the detection, prevention, and prosecution of health care fraud. The NHCAA, with approximately 70 corporate members and over 700 individual members representing both the private and public sectors, plays a critical role in public education and in directing the resources of the insurance industry's fraud detection efforts. I am currently serving as Chairperson of the NHCAA.

NHCAA was established in 1985. It is not a trade association, nor is it a lobbying organization. Rather, it is an issue-based cooperative association whose member organizations account for most of the private and public health insurance benefits paid in the U.S., and whose objective is to improve the private and public sectors' ability to detect, investigate, prosecute (both civilly and criminally) and, ultimately, prevent health care fraud.

My discussion today will focus on:

- Reliastar's approach to the identification, prevention and detection of health care fraud;
- The use of technology to enhance the detection of questionable providers; and
- Anticipated savings through fraud prevention.

OVERVIEW OF FRAUD IN MEDICARE

Although most providers supplying services to Medicare beneficiaries are honest, it is the minority of dishonest providers that have created a massive and expensive problem. Approximately 20 years ago, the Health and Human Services Inspector General indicated that 10% of Medicare expenditures were lost to fraud and abuse. At the time, that translated into $3 billion to $4 billion annually. That 10% statistic still holds true today. However, the monetary loss is now nearly $17 billion. Further, the Office of the Inspector General estimates that within the next seven years, Medicare will lose $138 billion to fraud.

In order to address this problem, subsequently reducing the amount of Medicare dollars lost to fraud each year, efforts must be made to aggressively pursue those who make concentrated, intentional attempts to abuse the system or bend the rules for financial gain.

The sources of fraud and abuse in Medicare come from a variety of places which include: providers such as physicians and hospitals, suppliers of medical devices, home health care agencies, laboratories, and pharmacies.

FRAUD PREVENTION

Our focus at Reliastar is a proactive approach. We believe in preventing the benefit dollars from being paid on questionable claims. We achieve this goal by identifying problematic providers and thoroughly investigating their claims prior to payment. By placing those claims on "pending" status and ensuring complete review of the providers' submissions, we have successfully reduced the likelihood of our paying fraudulent claims. Although this practice does not guarantee the elimination of fraud, it has helped to save our clients several million dollars.

The practice of pending questionable claims is an effective tool in fighting health care fraud and would be advantageous to reducing Medicare's expenditures. Why should Medicare pay for claims to a provider known to bill for services not rendered until those claims can be scrutinized? Why should Medicare be charged for a more costly procedure if a less expensive procedure was actually administered? Is it fair that Medicare beneficiaries are continually subjected to procedures that are not medically necessary? Obviously, the answer to those questions is that Medicare should not pay for inappropriate practices. Unfortunately, the questions represent scenarios that occur daily and are costing taxpayers billions.

To prevent the payment of fraudulent claims, three things need to occur. First, claims data need to be analyzed to identify those providers that have suspicious practices. This will be discussed in more detail later. Second, future claims from those providers identified as questionable should be reviewed and investigated to determine the validity of the claims. This must occur prior to payment of the benefits. The investigation needs can be met internally, if the claims payer has a

Special Investigations Unit, or through an external organization that would conduct the investigation. Third, claims examiners and adjusters need to be trained in fraud detection, in various types of fraud, and in characteristics of specific fraud schemes. Again, this can be conducted with internal special investigators or referred to an external training entity.

Through the implementation of claims-data analysis, investigation of pended claims, and the training of examiners and adjusters, Medicare expenditures could be reduced by several billion dollars annually. This reduction would be completed prospectively, thus minimizing the less efficient practice of trying to recover fraudulent claims that have already been paid.

USING TECHNOLOGY TO DETECT FRAUD

As previously stated, technology should be used to identify those providers that have questionable practices. Specifically, at Reliastar we review providers by specialty and geographic location, and we compare them to each other through the analysis of their utilization, diagnosis, radiology, and billing practices. In addition, we look at "suspect provider practices"—which include, for example, the percentage of claimants that live more than XX miles from the provider's office and the percent of patients to whom the provider administers services on Sundays and/or holidays. We do not use medical management or billing thresholds to determine the results. Instead, we rely on the practices of peers to establish scores.

This comparison of providers to their peers based on submitted claim data and measured against practice patterns that were designated to detect fraudulent and abusive practices allows us to compare "apples to apples." It further identifies providers whose professional behavior warrants prospective review. In a sense, we use retrospective data to prevent future losses. By systematically analyzing an entire population of providers and statistically measuring them against the practices of their peers, the perception of a "witch hunt" is eliminated. A provider whose practices are inconsistent with his colleagues has only his own claim submissions to blame.

ANTICIPATED SAVINGS THROUGH FRAUD PREVENTION

We have been using sophisticated technology for approximately one year. In that time, we have seen an increase in savings of over 500% to our internal clients that have purchased our services, due to our ability to detect and identify more questionable providers. Further, we have seen an increase in savings of 41% for all of our group-insurance clients over last year.

By implementing effective training, investigation and system identification programs, I would estimate that the total annual Medicare health care expenditure could be reduced by one-half of one percent within 24 months. For example, if total expenditures in 1995 are $177 billion, the amount that could be saved due to fraud-prevention measures would be $885 million. The percentage of savings would likely increase to 2% to 4% of the total annual expenditures in the following years.

FRAUD IN MANAGED CARE

The managed care evolution is occurring rapidly, and many people are of the opinion that managed care will eliminate fraud and abuse in the health care field. This is a very common misconception.

The NHCAA analyzed this subject over a one-year period and determined that fee-for-service transactions continue to figure significantly in virtually any managed care system; there are few "pure" managed care models, in which every patient service is delivered on a pre-paid and/or fixed-cost basis.

Managed health care delivery still features many incentives and opportunities for unscrupulous health care providers to commit fraud. The same questionable providers in our fee-for-service system are the ones participating in managed care networks. For example, most HMO's still exclusively offer point of service plans.

HMO members, given incentives to obtain services from providers in the network, seek out the appropriate specialty. The provider in turn still bills the payer on a

claim basis. Even though the claims are "repriced" by the payer based on the agreed amount for the service, the provider can still commit many of the same fraudulent misrepresentations—such as billing for services not rendered, and falsification of the diagnosis—that one sees in the traditional indemnity business.

As you can see, even in the managed care environment certain indemnity fraud indictors will remain valid. However, other indicators of potential fraud in managed care dealings may be more subtle. This is especially true as you move into a fixed "capitated" environment where a provider is paid a fixed payment for potentially unlimited treatment of a given patient. In these instances, it is our opinion that the incentive for the unscrupulous provider is to provide less care in return for the payment—i.e., to under-serve the patient.

The most important issue to remember with respect to fraud in managed care is that much of the system still manages under point-of-service products that give participants choices within their respective health plans. This meets a critical customer issue, but it also means continued vulnerability to unscrupulous providers.

CONCLUSION

Fraud will continue to escalate and to create negative repercussions in Medicare unless it is forcefully confronted by effective detection and prevention techniques. I hope I was able to provide additional insight on how to address this problem with my suggestions and comments. Again, it was my pleasure to be here with you today. As the Chairperson of the NHCAA, an officer of Reliastar Financial, and a concerned taxpayer, please accept my heartfelt appreciation for your interest in this subject.

Mr. THOMAS [presiding]. Thank you very much, Ms. Hansen. Dr. Davis.

STATEMENT OF KAREN DAVIS, PRESIDENT, COMMONWEALTH FUND, NEW YORK, NEW YORK

Ms. DAVIS. Thank you, Mr. Chairman, for this opportunity to testify on the importance of the Medicare Program during its 30th anniversary.

Today we have heard a lot about money, we have heard a lot about providers, we have now heard about fraud, private insurance, and medical savings accounts. I would like to focus on the beneficiaries of this program and how they would be affected by the changes under consideration by the Committee.

I would like to, in the interest of time, just turn to some charts at the back of my testimony.

The first chart reminds us that one in five Medicare beneficiaries is either under age 65 and disabled or over age 85 and frail. Most Medicare beneficiaries have modest incomes; 83 percent of Medicare dollars go for services to people with incomes under $25,000; only 3 percent of Medicare outlays go for services to beneficiaries whose incomes exceed $50,000.

Most of Medicare in fact goes for essential services, hospital and physician services, and a small fraction for home health and outpatient care, although that has been growing rapidly. Because of Medicare's noncovered services and deductibles, Medicare only pays 45 percent of the expenses of the elderly; 12 percent is paid by Medicaid for certain low-income, elderly and disabled beneficiaries. The rest is paid out of pocket or from private insurance.

This comes about because Medicare has a hospital deductible that currently exceeds $700, a physician deductible of $100, a physician annual premium of $550. So to avoid these large payments, most Medicare beneficiaries buy private coverage at over $800 a year to pick up their deductibles and coinsurance. In fact, about 43 percent of Medicare beneficiaries have retiree health care coverage, another 38 percent buy private coverage. But despite this coverage we know low-income Medicare beneficiaries already pay one-third of their incomes out of pocket on health care. In fact, on average, Medicare beneficiaries today spend over $2,000 per person on health care expenses, far more than younger adults.

The other important thing to know about Medicare beneficiaries is that there are some who are healthy and some who are sick; 10 percent of beneficiaries account for 70 percent of outlays. For the 10 percent of beneficiaries who are the sickest, the average expenditure in 1993 was $28,000. For the 90 percent who are healthiest, the average expenditure was $1,300. This has tremendous implications for medical savings accounts, creates incentives for marketing to healthier people, and with an average voucher, making money for insurance companies but costing the Medicare Program and taxpayers additional costs.

Medicare is a popular program. In fact, in a survey the Commonwealth Fund did, it is the most popular of all forms of health insurance coverage; 52 percent of beneficiaries are very satisfied, compared with 44 percent of people in employer plans, and only 30 per-

cent of people in individual plans like the one that Mr. Ferrara would have the elderly buy.

Medicare has a good record on efficiency. It has 2 percent administrative costs, well below that of private coverage. It has a good system of physician payment that is better than most managed care plans. Despite some testimony we have heard today, chart 14 points out the fact Medicare's costs are not growing faster than private insurance.

How would the changes affect Medicare beneficiaries? Chart 16 indicates that if you are going to have beneficiaries pay more, premiums are more evenly spread, but it is important Medicaid be there to pick up cost sharing and premiums for low-income Medicare beneficiaries and that that is protected in any type of block grant legislation. If provider payments are too tight, you run the problem of financial instability of hospitals, but you also run the risk that eventually physicians and others will not participate in the program. While information on choices is good, expansion to loosely organized managed care plans will run into this favorable selection problem, and cost the Medicare Program.

Vouchers are an even greater problem for people that go into medical savings accounts. They are likely to cost the Medicare Program, skim off the healthiest beneficiaries and leave beneficiaries with bad debts when they cannot pay a $3,000 deductible on top of $2,000 of out-of-pocket expenses, and it opens beneficiaries to marketing abuses.

Thank you.

[The prepared statement and attachments follow:]

MEDICARE BUDGETARY SAVINGS: IMPLICATIONS FOR BENEFICIARIES
Before U. S. House of Representatives Committee on Ways and Means
Hearing on Medicare, September 22, 1995

Statement of Karen Davis
President, The Commonwealth Fund
One East 75th Street
New York, NY 10021

Thank you for this opportunity to testify on the importance of the Medicare program and the implications of Medicare budgetary savings for elderly and disabled beneficiaries. This year marks the 30th anniversary of the Medicare program. When it was enacted thirty years ago, most elderly people were uninsured. They lost their health insurance coverage when they retired. Medicare has brought health and economic security to some of the nation's most vulnerable citizens for three decades.

Medicare beneficiaries differ in important respects from the working population. It is important that changes to Medicare be grounded in a clear understanding of the nature of the health and economic status of beneficiaries, and that the gains in access to care and quality of life that Medicare has helped bring about are not lost in a short-sighted effort to obtain budgetary savings. Health care for the elderly and disabled is expensive for Medicare and it is expensive for beneficiaries. Understanding why this is the case is fundamental to any attempt to modify the program.

Who and What is Covered by Medicare?

It is particularly important to keep in mind an accurate picture of the people Medicare serves. Among the 37 million Medicare beneficiaries are those with limited financial resources, those with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. One in five Medicare beneficiaries is disabled and under age 65 or over age 85 (see Chart 1).

Despite popular views that older Americans enjoy high incomes and standard of living, most elderly Americans have modest incomes. Over three-fourths of Medicare beneficiaries have incomes below $25,000. While poverty rates of older Americans are somewhat lower than for the non-elderly population, many elderly people have been lifted barely above the poverty level by Social Security benefits. For important subgroups, such as elderly people living alone poverty rates exceed 20 percent—comparable to poverty rates for children.

The high concentration of low-income elderly, and the fact that such elderly are more likely to be in poor health and need more health care services, means that Medicare outlays are concentrated on relatively low-income beneficiaries. Eighty-three percent of Medicare outlays go to beneficiaries with incomes of $25,000 or less. Only 3 percent goes to elderly individuals or couples with incomes in excess of $50,000 (see Chart 2).

Low-income elderly and disabled beneficiaries have increasingly relied on the Medicaid program to supplement their Medicare benefits. The Qualified Medicare Beneficiary (QMB) program entitles all poor Medicare beneficiaries to supplemental Medicaid coverage for cost-sharing. Beneficiaries with incomes up to 120 percent of the poverty level are eligible for Medicare Part B premium subsidies from Medicaid. Today, more than two-thirds of all Medicaid outlays are for the elderly and disabled.

Only about half of aged Medicare beneficiaries with incomes of under $5,000 are enrolled in Medicaid. A Commonwealth Fund study in the late 1980s found that the most common reasons why elderly poor are not covered by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible. Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

Medicaid and Medicare have also been important financers of long-term care for the frail elderly and those suffering from chronic and disabling physical and mental conditions. Together, the two programs account for half of long-term care expenditures; private health insurance coverage for long-term care is negligible. Medicaid is the only significant source of coverage for nursing

home care or for personal care such as that provided by a home care aide, but to qualify an elderly person must become destitute. Medicare nursing home benefits are restricted to skilled nursing care, although Medicare does pay for about one-third of home health services for older Americans.

Medicare's benefits go largely for hospital and physician services needed by this high risk population (see Chart 3). In the last 15 years home health and hospital outpatient care have been relatively rapidly growing parts of Medicare, while hospital inpatient outlays have grown more slowly.

Financial Burden of Health Costs on Medicare Beneficiaries

It is not well understood that the elderly pay far more for their own health care than the non-elderly—even with important coverage from Medicare. This happens because Medicare pays only 45 percent of the health care bills of the elderly (see Chart 4). Beneficiaries incur substantial out-of-pocket costs for Medicare cost-sharing and for services not covered by Medicare.

As shown in Chart 5, the hospital deductible under Medicare is $716, the Part B deductible is $100 per year, and the Part B premium is $550 per year. The average Medi-Gap premium is now $840. Given non-covered services such as prescription drugs, premiums and out-of-pocket costs for Medicare beneficiaries averages over $2000 per year. For a elderly woman with an income of $10,000, this is clearly an excessive and burdensome cost.

Cost-sharing requirements by their very design mean that those who are ill and use services bear the burden. The chronically ill and other high utilizers of care are most likely to incur large individual liability for Medicare cost-sharing and uncovered services and charges. A Commonwealth Fund study, *Medicare's Poor*, found that thirty percent of Medicare beneficiaries rate their health as fair or poor. For those who are poor, members of minority groups, or over age 85 even higher numbers have poor health. For example, over 60 percent of poor elderly have arthritis. Half suffer from hypertension and need counseling about diet and exercise, and many require physician monitoring and prescription drugs to control their condition. Twelve percent of poor elderly people have diabetes and many require insulin treatment as well as medical care for the many conditions that arise as complications to diabetes.

Out-of-pocket costs can pose a serious financial burden. About 9 percent of Medicare beneficiaries have no health insurance to supplement Medicare—either from Medicaid or from private coverage through a retiree health plan or through individually purchased Medi-Gap coverage (see Chart 6). These beneficiaries are concentrated in incomes under $10,000.

As shown in Chart 7, poor elderly households spend over a third of their incomes on health care. The average for non-elderly households is 8 percent of income, while the average for the elderly is 21 percent.

The financial burden of health care costs for Medicare beneficiaries is very unevenly distributed. Some elderly enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. Because Medicare beneficiaries have very different needs for health care, health expenditures are very skewed. In 1993, 10 percent of Medicare beneficiaries accounted for 70 percent of outlays (see Chart 8). One-fourth of beneficiaries accounted for 91 percent of outlays.

The average expenditure in 1993 for all Medicare beneficiaries was $4,020 (see Chart 9). For the ten percent of Medicare beneficiaries with the highest outlays, the average expenditure was $28,120. This is contrasted with $1,340 for the 90 percent of Medicare beneficiaries with the lowest outlays.

Understanding this variation in outlays is particularly important in any discussion of expanding capitated managed care coverage under Medicare. If capitation payments are not appropriately adjusted for health status, over or underpayments can be quite serious. Plans can make considerable profit at an average capitated rate if they can avoid enrolling those beneficiaries likely to be in the most costly 10 percent. The incentives to enroll only healthier enrollees or encourage less healthy enrollees to disenroll are formidable.

For those elderly with long-term care needs, costs can be even higher. About 40 percent of all nursing home expenses are paid directly by patients and families. For those elderly with functional impairment living at home, costs can also be high. Over one-third of poor elderly people living at home report being restricted in one or more activities of daily living compared to 17 percent of those with moderate or high incomes.

Inadequate Medicare benefits not only mean financial burdens, but also barriers to needed care. The significant deductible and coinsurance provisions in Medicare deter some of the elderly poor and near poor from obtaining care. Low-income and minority elderly are less likely to get preventive services such as Pap smears and mammograms, in part because of the financial barrier posed by out-of-pocket costs. A recent study supported by The Commonwealth Fund found that elderly women without Medicaid or supplemental private health insurance were much less likely to get mammograms. The financial barriers posed by deductibles and copayments for cancer screening contribute to failure to detect cancer in an early stage when recovery chances are higher. Rates of ambulatory sensitive hospital admission rates are particularly high for poor and minority elderly—indicating inadequate access to primary care.

In sum, poor and near-poor elderly are more likely to be experiencing health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes. For those who do get care large out-of-pocket medical expenses can lead to impoverishment.

Beneficiary Views of Medicare

Medicare enjoys a high degree of support from both the elderly and non-elderly. Medicare beneficiaries report high rates of satisfaction with the plan. The Medicare Current Beneficiary Survey finds that 89 percent are satisfied or very satisfied with the overall quality of medical care. A Kaiser-Commonwealth Fund 1993 health insurance survey found that 52 percent of Medicare beneficiaries are very satisfied with their Medicare insurance, compared with 44 percent of families covered by employer-provided private coverage, 39 percent of Medicaid beneficiaries, and 30 percent of those who purchase private health insurance individually (see Chart 10). It is particularly important to note that Medicare is far more popular than individual health insurance coverage.

Medicare's Record of Performance

Medicare has opened the door to health care and greater economic security for the nation's elderly and disabled populations for three decades. Particularly striking has been the program's success in improving access to care for low-income and minority elderly Americans. Racial disparities in care for elderly Americans have largely been eliminated, and Medicare has been instrumental in spurring desegregation of medical facilities for all minority Americans.

Medicare has also contributed to the development of research and innovation, through its funding of medical education and allowances for teaching hospitals. Technological innovation such as cataract surgery, joint replacements, and treatments for coronary artery disease, financed by Medicare, have improved the quality of life and functioning of millions of elderly people.

As the American population ages and lives longer, Medicare has financed the care of an ever older and frailer group of beneficiaries. Admittedly, the cost of covering this high risk group has grown rapidly over time. Yet the underlying cause is primarily health care cost inflation in the system as a whole, not inefficiency by Medicare.

Medicare in fact has an excellent record of low administrative costs. Medicare's administrative costs average 2 percent of program outlays, compared with 25 percent in small group market plans and 30-50 percent in individual insurance plans (see Chart 11).

Medicare has also been an innovator in provider payment. Its system of physician payment has been increasingly accepted by physicians as payment in full (see Chart 12). It has also formed the basis for managed care plan payment to physicians. A survey of managed care plans finds that Medicare still obtains the best "discounts" from physicians -- with most managed care plans paying physicians in excess of Medicare rates (see Chart 13).

Most significantly, Medicare outlays per enrollee for a similar package of services have grown more slowly than private health insurance outlays for these services in the decade from 1984 to 1993 (see Chart 14). Spending on inpatient hospital and physician services have moderated considerably. Certainly the new methods of paying hospitals and physicians introduced in 1984 and 1992 respectively have had an impact. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches--particularly home health and skilled nursing facilities services. When long-term care services are excluded from the Medicare benefit package and prescription drugs are excluded from private insurance packages, even in the most recent 1991 to 1993 period Medicare expenditures per enrollee for a similar set of services have increased more slowly than private insurance.

Why then is Medicare so costly? The simple answer is that Medicare is costly because it covers very sick people, and because health care costs for all Americans--whether privately insured or covered by Medicare or Medicaid--have risen rapidly over the last two decades. Until more effective approaches for containing health care costs in the health system as a whole are developed, the program is likely to be caught in the dilemma of high costs for both taxpayers and beneficiaries.

Medicare Budgetary Changes

Medicare does face genuine short run and long run financial problems (see Chart 15). The Hospital Trust Fund will be insolvent by 2002. Medicare is one of the most rapidly growing components of the federal budget. When the baby boom generation reaches retirement beginning in 2010, the program will face even greater challenges.

Preparing Medicare for the next century, however, requires an in-depth, thoughtful examination of a full array of policy options. It is important that changes made now to address Medicare's short-run problems not set the program on the wrong course, or inflict harm on vulnerable beneficiaries.

Higher Beneficiary Payments

Beneficiaries already bear substantial out-of-pocket costs for Medicare premiums, cost-sharing and noncovered services. If additional payments from beneficiaries are required for budgetary reasons, care should be taken to see that those costs do not fall on those already most heavily burdened -- the poor and chronically ill. Premiums are the fairest type of beneficiary payments, in that they are spread across all 37 million beneficiaries. Cost-sharing such as increased deductibles or copayments on physician services fall more heavily on sick beneficiaries. Copayments on home health services are targeted on the most seriously ill, who already typically face large payments for such noncovered services as prescription drugs.

It is particularly important that Medicaid supplementation to pay Medicare premiums and cost-sharing for low-income beneficiaries be assured if beneficiaries are required to pay a greater portion of Medicare costs. A block grant to states could leave over 4 million low-income beneficiaries without financial access to care. Federalizing this portion of the Medicaid program could be an important complement to any provision to increase beneficiary payments.

Tighter provider payments

Another budgetary option is to curtail payments to Medicare providers. Presently nearly all hospitals, physicians, and eligible health care providers participate in the Medicare program. Medicare pays physicians at 68 percent of the rate of private insurers. Yet, surveys of physicians indicate a continued willingness to see Medicare patients.

Medicaid's experience, however, has been that once payments fall markedly relative to payment rates of private insurers many providers are no longer willing to serve beneficiaries or do not provide quality services. There are limits, therefore, on how much and how quickly Medicare provider payment rates can be tightened further. The financial stability of hospitals and other providers heavily dependent on Medicare--such as rural hospitals and academic health centers--could be undermined by major reductions in Medicare payments.

Medicare's prospective payment methods for hospitals and physicians have been remarkably successful in providing incentives for efficiency and slowing growth in costs. One possibility is to extend these methods to other services including home health care where rates of increase have been

very rapid. Other techniques such as profiling, appropriateness guidelines, high cost case management may also generate further savings.

Managed Care

Medicare has been criticized for not promoting aggressively enough managed care alternatives for its beneficiaries. Yet, Medicare is itself similar to a preferred provider managed care plan. With the recent reforms in provider payment, Medicare sets prospective prices for hospitals and physicians at a substantial "discount" to usual charges. Medicare's physician payment fees, for example, average 68 percent of fees paid under private health insurance plans. All providers who are willing to participate at these rates are permitted to enroll. Physicians who agree to take "discounted" payments as payments in full become participating physicians and are listed in directories of preferred providers. This has worked remarkably well, to the extent that 92 percent of all Medicare physician services are now on assignment.

In addition Medicare makes HMO options available to beneficiaries. Three-fourths of beneficiaries live in areas where managed care plans are available. Seventy percent of HMOs now offer or plan to offer shortly a Medicare product marketed to Medicare beneficiaries. Despite the reluctance of many elderly to give up their personal physician to join an HMO, HMO enrollment has increased from 1 million in 1985 to 3 million in 1995—about 9 percent of all Medicare beneficiaries.

Some expansion of Medicare's managed care options seems warranted. Medicare could systematically make information available to beneficiaries about choices in their geographic area, and conduct a formal annual enrollment process. HMOS with a Point of Service feature could be added. It is important, however, that plans be held to high quality standards, and that information on plan performance be provided to beneficiaries. Starting slowly is important. Expanding coverage to loosely organized managed care plans such as preferred provider organizations or to indemnity insurance plans does not seem warranted, until many of the problems with current capitation payment are resolved and adequate quality standards established and an enforcement mechanism instituted.

Even if enrollment were to expand more markedly, it is unlikely that there would be savings to the program, and in fact might cost the Medicare program. A recent study finds that the actual cost of serving Medicare beneficiaries who opt for HMO enrollment is 5.7 percent more than Medicare would have had paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage. Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.

Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries which they have very strong incentives to do, Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Managed care plans have the option of switching to a fee-for-service method of payment from a capitated risk contract if they experience adverse selection and would receive higher payment under
Medicare's fee-for-service provider payment rules. Monthly disenrollment by Medicare beneficiaries also means that managed care plans can encourage sicker patients to leave the plan and be cared for on a fee-for-service basis. In the case of network-model HMOs the same physician might even continue to care for the patient when he or she disenrolls.

The current method of paying managed care plans for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status seems years away.

The current method of Medicare HMO payment includes allowances for the direct and indirect costs of medical education even though managed care plans do not incur these costs; The payment rate also includes an allowance for disproportionate share payments even though managed care plans do not cover the uninsured, and in general are open only to those who can afford the premium or have employers or public programs that pay the premium on their behalf. These factors

represent about a four percent overpayment to HMOs with Medicare risk contracts.

If budgetary savings are required, serious consideration should be given to lowering the Medicare HMO payment rate. It is currently set at 95 percent of Medicare projected expenditures for beneficiaries with average health status. Given the favorable selection that occurs, reducing this to 85 to 90 percent could be considered.

The extent of managed care abuses could be curbed by lowering capitation payment rates and imposing penalties on plans for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. Nor has the long-term success of managed care in controlling costs (aside from getting provider price discounts) yet been demonstrated.

Vouchers, Medical Savings Accounts, Catastrophic Coverage

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare on first examination has appeal as a policy option. Vouchers or giving beneficiaries the actuarial value of Medicare to invest in medical savings accounts and purchase private catastrophic coverage represent mechanisms for capping and limiting growth in budget outlays, shifting financial risks to beneficiaries, and creating incentives for individuals to control costs.

Vouchers would provide more choices for beneficiaries, including wider choices among benefit packages, but also shift more financial risk to individuals. Vouchers to purchase catastrophic health coverage with the balance invested in medical savings accounts raise particular concerns.

First, such provisions are likely to be costly to the Medicare program. While a mandatory voucher system could be designed to guarantee savings, a voluntary voucher program is almost certain to be attractive only to relatively healthier beneficiaries. Setting the voucher at an average level could result in very substantial overpayments. Medicare currently spends very little on the healthiest 50 percent of Medicare beneficiaries. If they were to take vouchers, the cost to the program could be extraordinary. For example, if 18 million beneficiaries collected vouchers of $5,000, the cost would be $90 billion -- yet these beneficiaries currently cost the Medicare program virtually nothing. Skimming off the healthiest Medicare beneficiaries undermines the advantages of risk pooling that Medicare as a universal program now achieves.

Nor is there reason to believe that the private sector will be successful in holding down costs as compared to the current Medicare program. First, private insurers will almost surely have higher administrative overhead costs than does Medicare. Medicare's administrative costs average less than 2 percent of outlays, while individual insurance administrative costs for the elderly often runs 30-50 percent. Insurers will need to advertise and promote their plans. They will face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. They will not have the advantage of Medicare's scale and governmental authority in imposing steep provider price discounts. For example, Medicare's physician payment rates are 68 percent of those of private insurers, and lower than managed care plans that use the Medicare system to pay physicians. These plans expect to return a profit to shareholders. All of these factors work against private companies performing better than Medicare.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries--those in poor health and with modest incomes at particular risk. If vouchers or other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs due to the market segmentation. A two tier system of care could result in which modest income families are forced to choose less desirable plans.

Catastrophic coverage is unlikely to be attractive to many beneficiaries. After all 90 percent of Medicare beneficiaries now obtain supplemental coverage to avoid the $716 Part A deductible and $100 Part B deductible. Few beneficiaries who truly understand that a plan has a $3,000 or $4,000 deductible are likely to find it attractive. Nor is it affordable for the three-fourths of Medicare beneficiaries with incomes below $25,000. If beneficiaries were to experience a serious illness, they could face financial bankruptcy and bad debts to providers. Providing financial protection for beneficiaries was the major rationale for creating Medicare. It should not be abandoned now.

PHYSICIAN FEE SCHEDULE CONVERSION FACTORS FOR MANAGED CARE PLANS USING A RESOURCE-BASED RELATIVE VALUE SCALE, 1994

Conversion Factor	% of Plans
• Lower than Medicare	0
• Same as Medicare	20
• Up to $14 Higher than Medicare	44
• $15 to $29 Higher than Medicare	28
• Greater than $29 Higher than Medicare	8

13

Source: Physician Payment Review Commission, 1995 Annual Report to Congress

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Per Capita Outlay Growth Rates for Services Covered by Both Medicare and Private Insurance 1976-1993

14

Source: M. Moon and S. Zuckerman, July 1995
Are Private Insurers Really Controlling Spending Better Than Medicare?

The Commonwealth Fund

MEDICARE:
SHORT RUN AND LONG RUN PROBLEMS

Short Run:
- Hospital Insurance Insolvency in 2002
- Federal Budget Deficit

Long Run:
- Retirement of Baby Boom Generation

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Medicare Budget Options:
Considerations and Concerns

- Higher beneficiary payments
  - Premiums pose less burden on sick than increased deductibles and coinsurance
  - Medicaid supplementation is essential to protect low-income beneficiaries
- Tighter provider payments
  - Magnitude of change important in assessing impact on financial stability of hospitals and willingness of providers to take Medicare beneficiaries
- Managed care
  - Choice, formal enrollment, information, quality standards useful
  - Some expansion to HMO/point-of-service may be warranted; premature to expand to loosely organized managed care plans or indemnity plans
  - Likely to cost Medicare not save money
  - Could lower AAPCC to 85-90% if want savings
- Vouchers/medical savings accounts/catastrophic coverage
  - Likely to cost Medicare program
  - Likely to skim off healthiest beneficiaries; undermines benefits of risk pooling
  - Private coverage less efficient than Medicare
  - Could leave beneficiaries with bad debts, excessive financial burdens
  - Opens beneficiaries to marketing abuses

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BUILDING ON MEDICARE'S STRENGTHS

- Improving Medicare's Fee For Service Option
- Expanding Medicare's Managed Care Options
- Minimizing Risk Selection
- Financing Options

17

The Commonwealth Fund

Further, the experience with sale of private MediGap coverage to beneficiaries is that without stringent safeguards marketing abuses are likely. Confused or scared, some beneficiaries could take options which are not in their best interests -- nor genuinely preferred by them.

On balance, vouchers offer little in the way of guarantees for continued protection under Medicare. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those largely rejected by the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a universal benefit would be seriously undermined.

Building on Medicare's Strengths

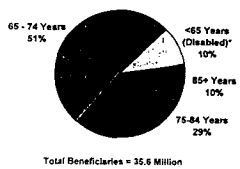
At present, too little attention is being focused on how to improve the functioning of the basic Medicare program, rather than departing radically from its basic structure. The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; capitated managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme.

Major issues include: 1) how to improve the fee-for-service option within Medicare; 2) how to expand Medicare managed care choices while assuring quality standards; 3) how to minimize the difficulties posed by risk selection; and 4) what financial contribution Medicare beneficiaries and taxpayers can reasonably be expected to make (see Chart 17).

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should not be hastily jettisoned in an ill-conceived and short-sighted effort to obtain federal budgetary savings. Instead a full array of options needs to be carefully analyzed, critiqued, and debated.

Thank you.

COMPOSITION OF THE MEDICARE POPULATION, 1992
One Out of Five is Disabled or Over Age 85

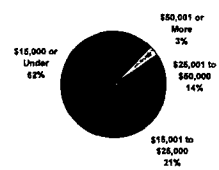


Total Beneficiaries = 35.6 Million

1

The Commonwealth Fund

MEDICARE EXPENDITURES BY BENEFICIARIES' INCOME, 1992
83% of Medicare Expenditures Are for Beneficiaries With Annual Incomes Under $25,000



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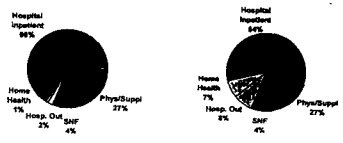
The Commonwealth Fund

WHERE THE MEDICARE DOLLAR GOES, 1980 and 1993



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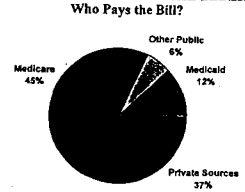
The Commonwealth Fund

HEALTH CARE SPENDING FOR THE ELDERLY, 1987
Who Pays the Bill?



4

The Commonwealth Fund

MEDICARE COST SHARING, 1995

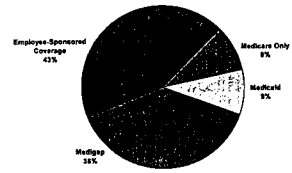
- Inpatient Hospital Deductible = $716 per benefit period
- Part B Deductible = $100 per year
- Part B Premium = $553 per year
- In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier, and hospital outpatient services.
- Average Medigap premium (1992) = $840 per year

5

The Commonwealth Fund

MEDICARE BENEFICIARIES BY TYPE OF SUPPLEMENTAL COVERAGE, 1992

One in Ten Have No Supplemental Coverage

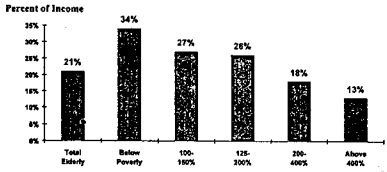


6

The Commonwealth Fund

PERCENT OF INCOME SPENT ON OUT-OF-POCKET COSTS, ADULTS 65 AND OLDER, 1994

Poor and Near Poor Older Americans Spend High Percent of Income on Out-of-Pocket Costs



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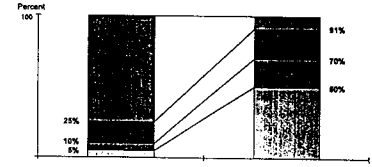
The Commonwealth Fund

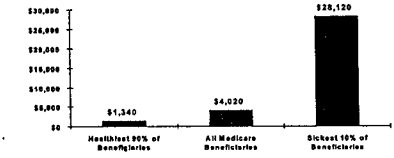
DISTRIBUTION OF MEDICARE EXPENDITURES BY TOP PERCENTILES OF ENROLLEES, 1993



8

The Commonwealth Fund

AVERAGE MEDICARE OUTLAYS PER BENEFICIARY BY HEALTH STATUS, 1993

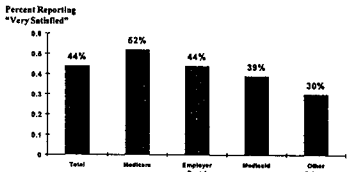


9

The Commonwealth Fund

PERCENT OF POPULATION VERY SATISFIED WITH HEALTH INSURANCE, BY TYPE OF INSURANCE, 1993

Medicare Beneficiaries Most Satisfied With Coverage



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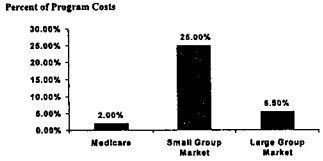
The Commonwealth Fund

ADMINISTRATIVE COSTS

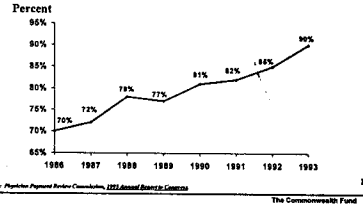
Medicare vs. Private Plans



11

The Commonwealth Fund

ASSIGNMENT RATES FOR PHYSICIAN SERVICES, 1986-1993



12

The Commonwealth Fund

Mr. THOMAS. Thank you very much, Dr. Davis.
Dr. Mullins.

STATEMENT OF CHARLES B. MULLINS, M.D., EXECUTIVE VICE CHANCELLOR FOR HEALTH AFFAIRS, UNIVERSITY OF TEXAS SYSTEM; ACCOMPANIED BY JORDON J. COHEN, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. MULLINS. Chairman Thomas and Members of the Committee——

Mr. THOMAS. Doctor, I would say that these microphones are very unidirectional and you will just need to talk directly into it.

Dr. MULLINS. Thank you.

I am Dr. Charles Mullins, executive vice chancellor for Health Affairs for the University of Texas System, up here with Dr. Jordan Cohen, who is the chief executive officer and President of AAMC, the Association of American Medical Colleges.

The AAMC welcomes the opportunity to comment on the Medicare Preservation Act, subsection E, the reform of payments for graduate medical and teaching hospitals.

The AAMC represents all of the Nation's 125 accredited medical schools, 300 major teaching hospitals, and 160,000 medical educators, students, and residents.

The University of Texas System is a large academic medical and teaching system that will be significantly impacted by changes in the national health care financing. The UT system includes 6,300 faculty, 1,100 medical residents in training, 3,200 medical students, and 10 primary care teaching hospitals.

Last year, the University of Texas faculty cared for over 2 million outpatients and provided 500,000 inpatient hospital days and delivered over $700 million in charity care services. The AAMC is pleased that Chairman Archer and the Committee along with Chairman Thomas and Representatives Nancy Johnson and McCrery have recognized that teaching hospitals and medical schools face unique and serious problems in maintaining their crucial mission in a rapidly changing health care environment. We thank you for your efforts.

This Committee has devised an innovative plan to establish a trust fund intended to assist teaching hospitals and medical schools in the meeting of special costs associated with medical education. The AAMC has long endorsed the need for an approach to finance equitably the clinical training for future health care providers and we believe that the proposed trust fund is a real step forward in the direction of a true sharing of this societal responsibility.

We would like to express our appreciation of the Committee's leadership in recognizing that teaching hospitals face unique and potentially devastating problems in maintaining their crucial missions in the new and fiercely competitive market, health care marketplace.

The AAMC understands the difficulty Congress faces in reducing the rate of growth in the Medicare Program to protect the Medicare Trust Fund. The proposed magnitude of the reductions and projected expenditures for Medicare and as well Medicaid is likely to have a major impact on the Nation's teaching hospitals and medi-

cal schools. Teaching hospitals serve large numbers of poor and elderly and depend heavily on Medicare patient payments for direct graduate medical education and indirect medical education and disproportionate share of funds.

For members of the AAMC Council of Teaching Hospitals, Medicaid and Medicare payments on the average of 1993, constituted 48 percent or almost one-half of their net patient revenue. AAMC believes the Committee's trust fund for graduate medical education would open up the way for shared responsibility by all parts of the health care delivery system to participate in the financing of clinical training.

The AAMC has long endorsed the need for an all-payer system, equitable financing and clinical training for future health care providers, and we believe that the proposed trust fund is a real step forward in the development of a true sharing of this societal responsibility.

In reviewing the summary of the Medicare Preservation Act, we were encouraged to learn that the proposal includes the creation of a legislative commission to study and make recommendations on alternative broad-based sources of graduate medical education financing and including the urgent need to determine the dependence of schools on service-generated income.

The same economic challenges entertained by teaching hospitals also affect the ability of medical schools to maintain their essential infrastructure for education and research and to reorient their educational training programs for managed care. The AAMC agrees that among other responsibilities, the new commission should examine the Federal policies regarding international medical graduates and the feasibility and desirability of reducing payments for high-cost residency programs.

The intermediate termination of Medicare support for specialty training and in the 4-year phasing out of Medicare support for non-U.S. residents would have an untoward effect on certain specific institutions and their ability to provide care to Medicare beneficiaries and others. Our review of subtitle E indicates that there are a number of specific issues and details which will need to be addressed, and we look forward to working with the Committee on these details.

The AAMC is concerned about the omission in the House proposal to carve out the indirect medical education, direct medical education, and the disproportionate share payments from adjusted average per capita payment for Medicare risk contractors. The AAMC believes that the education-related payments should be maintained for the specific purposes mandated by Congress and should be removed from the calculation of the per capita cost rate and paid directly to teaching hospitals when they provide services to Medicare risk plan enrollees.

In conclusion, the AAMC appreciates the efforts of the Chairman and the Committee in the difficult task of designing a plan to sustain the Medicare Program, providing support for graduate medical education in the face of many competing priorities. The academic medical community looks forward to working with you on ways to strengthen the medical care program and ensure that the American health care delivery system remains the best in the world.

Thank you.

[The prepared statement follows:]

STATEMENT OF CHARLES B. MULLINS, M.D. EXECUTIVE VICE CHANCELLOR FOR HEALTH AFFAIRS UNIVERSITY OF TEXAS SYSTEM; AND JORDON J. COHEN, M.D. PRESIDENT AND CEO, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the Committee, I am Dr. Charles Mullins, executive vice chancellor for health affairs at the University of Texas System. I appear with Dr. Jordan Cohen, president and chief executive officer of the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to comment on the Medicare Preservation Act, Subtitle E--Reform of Payments for Graduate Medical Education and Teaching Hospitals. The AAMC represents all of the nation's 125 accredited medical schools; 300 major teaching hospitals that participate in the Medicare and Medicaid programs; the faculty of these institutions through 92 constituent academic society members; and the more than 160,000 men and women in medical education as students and residents.

The University of Texas (UT) System is a large academic medical and teaching hospital system that will be affected significantly by changes in national health care financing. The UT System includes 6,300 faculty; 1,110 medical residents in training; 3,200 medical students; and 10 primary teaching hospitals. Last year, the UT faculty cared for over 2 million outpatients, provided 500,000 inpatient hospital days, and delivered over $700 million in charity care services.

Before commenting on the specific proposal, we would like to express our appreciation to the Committee for recognizing that teaching hospitals face unique and potentially devastating problems in maintaining their crucial missions in the new, fiercely competitive health care marketplace. We would like to give special thanks to Chairman Bill Archer and Representatives Thomas and Johnson for their leadership and concern.

The AAMC understands the difficulty Congress faces in reducing the rate of growth in the Medicare program to protect the Medicare Trust Fund. The proposed magnitude of the reductions in projected expenditures for Medicare, as well as Medicaid, will have a major impact on the U.S. health care system. Moreover, the changes contemplated would have especially profound effects on the nation's teaching hospitals and medical schools. Teaching hospitals serve large numbers of the poor and the elderly, and depend heavily on Medicare payments for direct graduate medical education (DGME), indirect medical education (IME), and disproportionate share (DSH). Many teaching hospitals also serve large segments of the Medicaid population. For members of the AAMC's Council of Teaching Hospitals (COTH), Medicare and Medicaid payments on average in 1993 constituted 48 percent, or nearly one-half of all their net patient revenue.

The Ways and Means Committee has devised a novel plan to assist teaching hospitals in meeting the special costs associated with their education mission. The AAMC recognizes that the creation of a trust fund for graduate medical education, which includes non-Medicare revenue, is designed to ameliorate the impact of anticipated reductions in Medicare DGME and IME payments. A trust fund also would open the way for shared responsibility by all parts of the health care delivery system to participate in the financing of clinical training. Shared responsibility for clinical education is an essential ingredient in a competitive delivery environment. The AAMC has long endorsed the need for an all-payer approach to finance equitably the clinical training of future health care providers. We believe that the proposed trust fund is a real step forward in the development of a true sharing of this societal responsibility.

In reviewing the summary of the Medicare Preservation Act, the AAMC was pleased to learn that it includes the creation of a legislative commission to study and to make recommendations on alternative broad-based sources of graduate medical education financing, including the urgent need to determine the dependence of schools of medicine on service-generated income. The same economic challenges encountered by teaching hospitals also affect the ability of medical schools to maintain their essential infrastructure for education and research and to reorient their educational programs.

The AAMC agrees that, among other responsibilities, the new commission should examine federal policies regarding international medical graduates and the feasibility and desirability of reducing payments for "high cost" residency programs. The immediate termination of Medicare support for specialty training and the four-year phasing out of Medicare support for non-U.S. citizens would have untoward, adverse effects on specific institutions and their ability to provide care to Medicare beneficiaries and others. The commission should examine immediately the impact of these provisions.

The AAMC is pleased that this plan retains the structure and methodology of the current Medicare payment system for graduate medical education, namely the continued formula-driven contributions of separate DGME and IME payments. The AAMC has long held that these two payments with an educational label serve separate and distinct purposes and should continue to be paid as individual contributions to a new trust fund.

Our review of subtitle E indicates that there are a number of specific issues and details that will need to be addressed. We are prepared to work with the committee to clarify issues ranging from the appropriate base year to the definition of "non-U.S. citizen medical graduates." We look forward to additional information on the magnitude of the non-Medicare revenue funding that would be placed in the trust fund.

As noted above, the AAMC is concerned about the ability of teaching hospitals to maintain their missions, faced with expected reductions in Medicare payments and being unable to capture the IME, DGME, and DSH payments embedded in the Adjusted Average Per Capita Cost (AAPCC), the payment rate for Medicare risk contractors. The AAMC believes that these mission-related payments should be preserved for the specific purposes mandated by Congress and should be removed from the calculation of the AAPCC rate and paid directly to teaching hospitals when they provide services to Medicare risk plan enrollees. A recent analysis by the Prospective Payment Assessment Commission (ProPAC) showed that, on average, excluding teaching-related and DSH payments from the rate would have resulted in a decrease of $21 in the U.S. per capita cost, or 5.3 percent, in the AAPCC in 1995. In the aggregate, this means teaching hospitals lost $545 million in mission-related payments in 1995, and ProPAC's estimate is based on only 2 million risk plan enrollees. As Medicare beneficiaries increase their participation in managed care plans, or exercise other options such as Medical Savings Accounts (MSAs), and fee-for-service payments decline, the mission-related dollars lost by teaching hospitals will increase substantially. Over time, it will become more difficult to "carve out" these payments and redirect them, as Congress originally intended, to teaching hospitals. We hope that this important issue will be a priority of the new commission.

In conclusion, the AAMC appreciates the efforts of the chairman and the committee in the extraordinarily difficult task of designing a plan to provide support for graduate medical education in the face of many competing priorities. The academic medical community looks forward to working with you on ways to strengthen the Medicare program and to ensure that the American health care system continues to provide the best health care in the world.

Mr. THOMAS. Thank you, Dr. Mullins.

The Chairman asks unanimous consent to place in the record at this point a letter from the University of California, from Dr. Cornelius Hopper, who is the vice president of Health Affairs, referencing the teaching hospital portion of the bill.

[The information follows:]

UNIVERSITY OF CALIFORNIA

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SANTA BARBARA • SANTA CRUZ

J.W. PELTASON
President

CORNELIUS L. HOPPER, M.D.
Vice President—Health Affairs

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(510) 987-9697
FAX: 987-9715

September 21, 1995

Honorable William B. Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The University of California has expressed its concern to you and your staff over the last several weeks regarding the overall impact sharp reductions in the rate of growth in the Medicare program could have on California's teaching hospitals. We have also expressed our concerns about the critical importance of ensuring that funds designated for sustaining our crucial missions in Medicare's present method for calculating the adjusted average per capita cost (AAPCC) be addressed as part of the budget reconcilliation process. We would like to take this opportunity to express our appreciation to you for your leadership and your willingness to work with us in an effort to address many of these concerns.

We believe the Medicare Preservation Act includes a unique and novel approach in establishing a trust fund that is intended to assist teaching hospitals in meeting the special costs associated with our education mission. We further believe, that with adequate protections, the trust fund concept could help us to sustain our unique missions. The University of California hopes that this innovative proposal will be a first step toward establishing an all-payer approach to finance clinical training.

We continue to have concerns about the AAPCC calculation and hope that as the Medicare proposal moves through the legislative process in the House and the Senate, we can work with you and your staff to attempt to resolve a situation that continues to have significant impact on teaching hospitals in California.

The University of California would like to thank you for your strong commitment to the clinical training of future health care providers.

Sincerely,

Con Hopper

Cornelius L. Hopper, M.D.
Vice President, Health Affairs

Mr. THOMAS. Does the gentleman from Illinois wish to inquire? Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. Oh, absolutely.

Ms. Davis, I want to say that I have listened to witnesses on this subject for 26 years and I have listened to hundreds of different witnesses on this subject, and you are the best and most understandable that I have ever heard in all this time. You hit the points. So I am going to take your testimony home with me tonight and read it.

Mr. Ferrara, last year I insisted that we put the medical savings account in the program that we put forward. I—of course, that program was rejected by my Republican friends entirely. But let me ask you some things about your medical savings account.

I assume that once you choose a medical savings account, you have got to stay in that for the rest of your life, is that right?

Mr. FERRARA. No.

Mr. GIBBONS. Oh, oh?

Mr. FERRARA. There would be an annual open enrollment program.

Mr. GIBBONS. The insurance companies want to get out of it, every year, is that right?

Mr. FERRARA. No, the beneficiaries would have the choice. The insurance companies would have to continue to insure the beneficiaries if they wanted to stay in the plan.

Mr. GIBBONS. Well, at what rate would they insure?

Mr. FERRARA. They would have to continue to insure them under a guaranteed renewability policy, which means that they would have to—they could not raise rates selectively for the people who were insured. They would have to have the same rate increase for everybody. They could not say, well, you are sick so we are going to massively increase your rate, and so forth, and so forth. They would have to continue to insure them if they wanted to stay and they would have to continue to insure them at a standard rate rather than a selective rate.

Mr. GIBBONS. And standard for what?

Mr. FERRARA. In other words, everybody in MSA, the medical savings account plan, has to be charged the same rate. You cannot say, well, this person here is sick, I am going to charge them 10 times what I am going to charge somebody else.

Mr. GIBBONS. You mean the standard rate in Tampa, Florida, it would be the same rate as the standard rate say in Los Angeles or New York——

Mr. FERRARA. Let me try to take it, answer your question this way. Under the study that we did with Milliman and Robertson, what we have here, the medical savings accounts you see on the charts here are what would be financed from the funds that would be withdrawn from Medicare. The beneficiary wouldn't be paying anything to get the medical savings accounts. The Medicare system would be paying for this. And so just with those funds alone, this is what Milliman and Robertson calculates you could get.

Mr. GIBBONS. You are not answering my question. My question is, Are you going to guarantee them for a lifetime that you will insure them, but at what rate will we be paying or they be paying?

Mr. FERRARA. The beneficiary?

Mr. GIBBONS. Yes.

Mr. FERRARA. Zero. The beneficiary wouldn't pay anything. These are the benefits that are going to be financed out of the funds that would be withdrawn from Medicare.

Mr. GIBBONS. So the Medicare Trust Fund would be picking up any rate differential, is that right?

Mr. FERRARA. What do you mean by rate differentials?

Mr. GIBBONS. Well, if I contracted bone marrow leukemia or something like that, where I would have to have a bone marrow transplant.

Mr. FERRARA. OK, I understand.

Mr. GIBBONS. You would continue to insure me just like you insure everybody else.

Mr. FERRARA. Yes. The answer to that question is the medical savings accounts get the same voucher amounts, if I could use that term, as any other plan. Medicare is going to set out in the beginning, here is the amount we are going to pay for the private plans and we are—it will be risk adjusted according to age and according to geographic location, whatever else it is, but it would be the same for MSAs as for anything else. So when the elderly person picks an MSA plan, they get the amount that Medicare has designated for that elderly person regardless of which option they choose.

Ms. DAVIS. If I could pick up on that.

Mr. GIBBONS. Yes, Ms. Davis.

Ms. DAVIS. I think what is guaranteed under the medical savings account is that the beneficiary would face an upfront deductible of $3,000 or $4,000. There is no guarantee over time under this proposal that the Medicare voucher would even be enough to cover the catastrophic health insurance plan. There is no control, as I understand it, on the premium that an insurance company could set for a catastrophic health insurance plan while the value of the voucher would be tightly squeezed over time.

Mr. FERRARA. There is no control, that is——

Ms. DAVIS. The beneficiary knows they are out the deductible because they are buying into a policy with $3,000, $4,000 out of pocket, plus they have got to pay any noncovered services, like prescription drugs, nursing home care, dental care, dentures, hearing aids, so that the beneficiary is not protected under this scheme. There is not a ceiling on the total amount they have to pay, and many of them, particularly those who are ill, if they are misled into buying a plan like this, are going to have ruinous out-of-pocket medical expenses.

Mr. FERRARA. Our study shows that everything you just said, Ms. Davis, is completely wrong, as a matter of fact. I wish you would read the study, because Milliman and Robertson is the top actuarial firm in the country. These are not just some professors making this up off in a closet.

Mr. GIBBONS. You are speaking so fast, I can't understand you. Would you talk a little slower like Ms. Davis does? I can understand her.

Mr. FERRARA. Well, under the plan, they calculated what benefits you would be able to buy with the funds that you can withdraw from Medicare each year over 7 years, and they calculated that after you pay for the cost of the catastrophic insurance out of that

voucher amount withdrawn from Medicare, you would have $1,500 left over if you bought a fee-for-service plan, you would have $2,100 left over if you bought a managed care plan. This is what the real insurance actuaries calculated, not some think tank person making up some numbers.

These are the people who advise the insurance companies and tell them what to charge and how to design their plans. They projected it out over 7 years and they showed what the benefits would be.

Under this chart, these charts right here, you have a cap on out-of-pocket expenses of $1,500 under the fee-for-service plan and $900 on the managed care plan. This is what the real actuaries have calculated and these are better benefits than Medicare for the five reasons I described.

Mr. GIBBONS. You are not just going to cherrypick the elderly in Medicare?

Mr. FERRARA. No, they cannot cherrypick. They have to accept everybody from Medicare who chooses them no matter what their condition. If they want to play and participate, they have to accept everybody who chooses them.

Mr. GIBBONS. And Medicare, the government won't pay any more for the insurance while it is in force, no matter how sick that person is?

Mr. FERRARA. Medicare will pay the risk-adjusted amounts that Medicare determines that they will pay for any private plan, whether it is medical savings accounts or anything, and Milliman and Robertson took all that into account when they did their actuary calculations as to what would be covered.

Mr. GIBBONS. I am interested in the taxpayers' point of view. Is the taxpayer going to have to pick up more of the cost from your insurance companies as they have to pick up sicker and sicker people in those Medicare savings accounts?

Mr. FERRARA. It is going to be the same for all the plan. Let me try to explain, answer your question this way.

Mr. GIBBONS. I am talking about what are the ground rules here.

Mr. FERRARA. Let me try to answer the question this way.

Medicare will say in the beginning we are going to spend this much on average and then we are going to risk adjust it, and if the person is of a certain age we are going to pay this much more, and if they are a certain—and they may adjust it for health status as well, and if they got this illness we will pay this much more and they will specify that for everybody at the beginning regardless of what they choose. So Medicare will determine all that so that the total amount is consistent with the budget targets.

They will set an average and then they will set risk adjustments around that average, taking into account health status and age, so that when you total it all up, it is no more than the total budget targets, and then regardless of which private plan the beneficiary picks, that is the amount that goes to that plan. If it is an MSA, they get the amount that Medicare has determined in the beginning they are going to pay for everybody that is—so that it will cost no more than the budget targets.

Mr. CRANE [presiding]. The time of the gentleman has expired.

Mr. GIBBONS. I wish somebody would explain to me what he said. I tried to listen to him.

Ms. Davis, can you explain to me what he said?

Ms. DAVIS. There is a concern here about risk selection, will the government save money on Medicare. Can you think about a sales person going bed-to-bed in a nursing home and marketing to the 1.5 million elderly in nursing homes?

If not, the average amount that is being paid in this voucher is going to be overstated and the government is going to be paying $5,000 for people who take this voucher, for people whose expenses on my chart in my testimony were $1,300. The government will lose $2,000 or $3,000 on every person who does that because no sound insurance company is going to try to market to people who are bed-bound, who are in nursing homes.

They are going to market to people who come down and get free coffee at the coffee shop, who are ambulatory, cognizant of what the options are.

Mr. FERRARA. That is all wrong. That is not what the plan is going to do.

Ms. DAVIS. It is going to cost the Medicare Program money.

Mr. CRANE. The time of the gentleman has expired.

Mr. Shaw.

Mr. SHAW. Just very, very briefly, Mr. Chairman. I would point out to my friend from Florida that if it is not in the bill that it is guaranteed renewable, he certainly would be able to offer an amendment to that effect, and I think it would be a good amendment. So I mean, we could sit here and have a fight or argument over whether it is going to be guaranteed renewable or not, but if we put it in the bill that that is the condition of the issuance, then that is the condition of the issuance and the argument is over and I would support such an amendment.

And I yield back.

Mr. GIBBONS. Good.

Thank you.

Mr. RANGEL. It is always good to see you, Ms. Davis. Could you amplify the voucher aspect of this suggestion that is coming from the Republican leadership? With Medicare dealing with the problems of the older citizens and with younger people that do not know the options of health plans that we have now, it is hard for me to see these dramatic savings where people must leave their doctors to join the HMOs to find out which HMO is the best for them.

And the older you get, I just assume with exceptions like Mr. Ferrara's organization, but the older you get, I assume that the for-profit organizations would rather be dealing with younger people, and the more sick you are, I would gather that they would not encourage sick old people to join up with them, not because they don't like them, but because it is just more expensive.

How do you see this dramatic reduction in cost as outlined in this proposal by using the voucher system? Is the voucher system a practical tool to use to reduce the cost of Medicare in your opinion?

Mr. DAVIS. Well, I will look forward to the Congressional Budget Office's estimates of things like Medisave and also the expansion

of managed-care options. I am concerned that both Medisave and the expansion of many managed-care options will cost the Medicare Program.

It is particularly a concern with the Medisave because no one who expects to hit that deductible is going to sign up for a policy that is going to make them pay $3,000 or $4,000 every year. But with regard to the managed care plans, I think some of the provisions that I understand are in the proposal to give people information, that there be an annual enrollment process, the Health Care Financing Administration explain the HMOs that are available, that is good.

I think what we will need to work on is getting quality standards for the HMOs and getting information to patients so that they can actually know what they are signing up for.

In studies we supported at the Commonwealth Fund, we just found a lot of variability from one plan to another. Some consumers were satisfied, whereas others weren't, and certainly I think your concern about the plans preferring to enroll healthier people has been Medicare's experience with HMOs to date, and it is one of the reasons that HMOs cost the Medicare Program 6 percent for every beneficiary who joins an HMO.

Mr. RANGEL. Let me just ask one question of the panel. I guess most all of you have read in the newspapers or have had an opportunity to read the document that has been distributed by the Republicans, and most all of you, one way or the other, are experts in the fields that you testified.

Based on what you know now, would you be prepared to vote aye just on this package just based on the knowledge? Or in your opinion, would it be necessary for you to get additional information before you decided one way or the other? How about you Mr. Ferrara?

Mr. FERRARA. I have been working closely with several people working on this plan so I have a lot of information on what it will be, but I vote aye on this plan.

Mr. RANGEL. Ms. Hansen.

Ms. JOYCE HANSEN. I think I am pretty pleased with what we have seen proposed so far.

Mr. RANGEL. Oh, no. I mean a lot of people are. But Mr. Ferrara, he just speaks from what he knows, what he has seen, this is the way to go. You don't need any more information, no more hearings, no nothing. You are ready to go, right?

Mr. FERRARA. I am ready to go.

Mr. RANGEL. Especially with the sure amendment.

Ms. Hansen, are you ready to go, ready for an aye vote? Ms. Davis.

Mr. DAVIS. I would like to know the price tag of anything I am buying, so the first thing I want are cost estimates.

Mr. RANGEL. Have you seen anything, Mr. Ferrara, from the Congressional Budget Office?

Mr. FERRARA. No, I haven't, but I have a good idea what this is going to cost. While we have our study done by Milliman & Robertson, they have cost estimates and they estimate that these vouchers would reduce spending by over $200 billion over 7 years, and the reason they reached that conclusion is because, based on their actuarial judgment, they estimate by 2002, 80 percent of people

will choose the private options. And I greatly concur with that. I think a lot of these places where they have allowed private options to people to opt into private systems, you get that same result.

Mr. RANGEL. I think you are the only person I have met that talks faster than I do.

Mr. Mullins, are you ready to go with this?

Mr. MULLINS. I think I would like to have some more information. The truth about it, I haven't read the entire document that was distributed yesterday.

Mr. RANGEL. Mr. Cohen.

Dr. COHEN. I think we also need to have more information. I think the issues that we are concerned about in terms of the trust fund for graduate medical education are targeted to relieve some of the blows on academic medical centers, but there are a whole lot of other aspects to what is being proposed that have a complex set of facts. We would need more information.

Mr. CRANE [presiding]. The time of the gentleman has expired. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

To Mr. Cohen and Mr. Mullins, I would say thank you for your testimony and I look forward to your input in the next week and the week thereafter.

In terms of the graduate medical education proposal, we have now our first real study from a program done in a short period of time, showing that you do very well under our proposal the first 3 years, because of the fund that we have put in place to make up any losses due to migration into managed care plans.

We weren't able at this point to deal with the AAPCC issue, but we do understand it and we have put money in place so that where there is migration, we have substituted cash. But during that time, we have a commission that is going to look at how we capture our ME and DME into a general fund and develop a broad-based separate flow of dollars for medical education which also can be distributed, not through the Medicare patients' reimbursement, because as you get fewer and fewer of those into the hospital and they save less and less time and so forth, this is not going to work in the long run.

And so the kinds of reforms that the Committee has known we needed and that we know we needed, we have a way to develop. But in the short term, while philosophically I agree, American taxpayers should not be subsidizing 6,000 to 7,000 foreign medical graduates, most of whom are also noncitizens; nonetheless, the disparate institution of withdrawing support for foreign medical graduates is a significant problem. We look to you to help us identify the institutions that would be most affected and how we can spread that until we have the input from this commission to help us look at, over the long run, how we withdraw that subsidy from the system, reduce the number of doctors whose education we are subsidizing since we are actually turning out too many now anyway. How do we do this in a way that preserves our centers of excellence and our strong training facilities?

There will be some mergers of training facilities. They are already going on. There will be reduction in the number of plans. We

want that to happen right, not as the result of irrational reimbursement policies.

So we are aware of refinements that have to go on and will look carefully at the mandate of that commission. And as the preceding panel said, this is not legislation we can pass and forget tomorrow. It is going to be an ongoing involvement and endeavor.

Ms. Davis, thank you for being here. I heard well the testimony of the other two and agree with you. I do want to talk to Ms. Davis a little bit about her comments in regard to MSAs particularly. One of my fears about the MSA, and I share the concerns about risk selection that both you and the preceding panel brought up. This is a great deal for a very sick elderly person, because for the cash portion, you can deduct anything eligible for a medical deduction under the Tax Code. So you can deduct a great array of things that no health care plan currently offers.

If you are going to spend $3,000 on Medicare deductibles and Medicare copayments anyway and on prescription drugs, which many people end up doing, you are much better off doing it under a medical savings account because you can do things that are very user friendly, and then in the end the policy picks up everything.

Now, I have no question but that the Medicare premium will be capable of buying some catastrophic care, but I think we are going to have to watch very carefully who buys it. Because in the first studies of Medicare Select, we are beginning to see that Medicare Select actually is attracting the sicker, not the less sick, which we feared, and I just add that we are interested in your thoughts on governance of these plans.

At this point, we are adopting all the governance of the current risk contract plans. We will watch how they advertise. We will publish and advertise for them so that they won't be able to select to where they market.

But given that ability to put on the market plans that can't discriminate, and you are perfectly right, Mr. Ferrara, we will not allow anyone to participate who won't take all Medicare recipients, given that, and the governance that the government has been able to develop over plans assuring that you offer the benefits that you say you are going to, that there is quality assurance, that there are consumer protections, that there is marketing equity. Given those things, we think a Medicare Choice Program has the opportunity to offer to seniors better benefits than Medicare can, and you have been a longtime observer of this Committee.

You know it took us 4 years to even get mammograms. It will be forever before we modernize the benefit structure of Medicare.

So I hope you work with us and with your friends on the other side of the aisle and help us refine the Medichoice option and expand it at a far more rapid rate than HCFA has been willing to expand it or able to expand it in recent years.

Mrs. KENNELLY. Will the gentlewoman yield?

Mrs. JOHNSON. I would be happy to.

Mrs. KENNELLY. I have been listening to your statement, Mrs. Johnson, and I share your concerns, but I just wanted to get in the mix that I believe—I think Connecticut has 42 percent international medical students.

Mrs. JOHNSON. International what?

Mrs. KENNELLY. I think it is a little higher than you think about having international medical students in our mix. I just wanted to add that to your—that we do have a number of medical students that are——

Mrs. JOHNSON. Absolutely. Fifty-five percent of our residents at University of Connecticut and it is institution-specific. I am very concerned about it, but it is in the bill the way it is because it sends the philosophical message that the issue here is that out of our 25,000 residencies that we are subsidizing, 7,000 are for the training of non-U.S. citizens and we do have to raise that issue. It is a legitimate issue, but how we are implementing it right now has some temporary defects.

Mrs. KENNELLY. Thank you.

Mr. DAVIS. I look forward to working with the Congresswoman, but I think you can't just extrapolate from the working population to the elderly population, so tax breaks for the working population mean a different thing than most elderly people at the lower end of the range who aren't paying taxes because of various kinds of treatment of Social Security and other income.

So with three-fourths of Medicare beneficiaries with incomes below $25,000, to subject these people off the top to $3,000, $4,000, it is not going to help them much to say, But the amount you pay out of pocket for prescription drugs is tax deductible.

Mrs. JOHNSON. Reclaiming my time, we are subjecting no one to anything. This is totally voluntary. They can stay in the current Medicare plan without signing a paper, making a telephone call. And furthermore, low-income people get their premiums paid by the government.

Mr. THOMAS. The time of the gentlewoman has expired.

Mr. DAVIS. Medicaid payment of Medicare premiums for low-income beneficiaries is not protected in the future under the block grant. So one of my concerns is that the cost sharing for Medicaid dual beneficiaries will no longer be guaranteed to be paid by States for 4 million low-income Medicare beneficiaries. So I think we can't extrapolate from the working population to the elderly population.

Mr. THOMAS [presiding]. The gentlewoman's time has expired.

Does the gentleman from California wish to inquire? No questions.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

I have got a couple of questions. The first involves the State. You know, this is not just a Federal, but a State program. For example, New York has its all-payer system, which I understand is going to sort of expire next year, and what it has done is drive a lot of these hospitals into public funding, and I guess the question I have is that we are concentrating on Federal moneys and Federal programs, but is anybody working with the Governor of New York—I happen to come from New York—on this issue? Because it is very, very critical.

Mr. DAVIS. You are referring to the Medicaid block grant?

Mr. HOUGHTON. I am talking to the New York all-payer system.

Mr. DAVIS. Certainly, I think the all-payer systems, particularly in Maryland, I know Congressman Cardin is particularly familiar with the system there, has worked reasonably well and I am not

sure exactly what the provisions in this proposal would be as they would affect States that have their own system of paying hospitals under Medicare.

Mr. HOUGHTON. I think it is part of the overall package that we have got to look at because I think in New York State, which I am associated with, there have been very, very tight restrictions, and some of these financing obligations have driven people in certain ways, and if this program is going to end, obviously it is going to be a problem for us.

Let me just ask my second question and I guess it rides on questions that have been asked previously. If I understand it, the alien international medical graduates, that program is going to stop. There are wide disparities in New York.

For example, a hospital for special surgery has no alien international medical graduates. The New York Methodist Hospital, 78 percent of their population is international. As far as the north-central Bronx hospital, they have got zero, but 50 percent are in the United States, medical graduates, people who are already citizens.

Again, there is such wide variety here. Tell me again, will you, how we are going to get through this period of adjusting to a different system? I don't know whether you would like for Mr. Ferrara——

Mr. COHEN. I will take a crack at that, if I could, Mr. Houghton. I think it is going to be a difficult transition and I think, as has been pointed out, the particular problems are in those institutions that are serving vulnerable populations and are, because of the way the system is currently structured, are dependent heavily on foreign medical graduates, whether they are U.S. citizens or non-U.S. citizens as the case may be.

I think the point that has been made by Mrs. Johnson is that we currently have a system where we have at least 40, perhaps 45 percent more entry level positions in our graduate medical education system than we have graduates of our own medical schools, and all of the evidence clearly suggests that we are heading for a very large oversupply of physicians.

So the near-term savings that occur by using doctors that are educated abroad to solve these local acute medical service problems is compounded by all these physicians who are in practice in this country, adding further to the impetus for raising health care costs.

So I think the issue is trying to balance the long-term problems against the short-term issues, and other providers of those services, it seems to us, it would be a more intelligent way in the long run to deal with that service delivery problem than to depend upon foreign-trained physicians.

Mr. HOUGHTON. Well, I think it is particularly critical in New York because—and I hate to be parochial here, but this is the State I represent. Since I understand it, over 40 percent—upward of 50 percent of all the foreign residents are in New York City. So it is going to be a very difficult adjustment period.

Dr. COHEN. I think there is no question about it and I think any system that would attempt to try to change that in a hurry would lead to very great dislocations. I think we have to be sensitive to

the institutions that are serving these social missions and we have to find ways to solve their problems.

Mr. HOUGHTON. Fine. I will yield.

Mr. JOHNSON of Texas. Thank you. The States obviously control most of the students that come into the process because most of them are State-run institutions, at least in Texas. Are they in New York as well?

Dr. COHEN. It varies there. It is certainly not exclusively a problem of government-sponsored institutions, but even—I mean, the States are not the ones that are permitting these individuals to come into the country to train.

Mr. JOHNSON of Texas. I guess what I am asking is, is there a way to control the influx of foreign graduate students through the systems at the State level?

Dr. COHEN. No way that I am aware of other than if the State chose to reduce the number of trained positions that it offered available to the foreign medical graduates.

There are, in this country, certified to be trained a large excess of foreign graduate physicians who are eligible for training for whom there are no positions even now available. So the issue is not a question of allowing foreign-trained physicians who were well-qualified and pass all the examinations to gain entrance to the country. The question is how many positions are there for them to—it depends on how dependent the institution is on the funding for Medicare. There is funding for these institutions as well.

Mr. THOMAS. Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Mullins, in the district I represent, we have 22 hospitals. Some of them are teaching hospitals. We are going to be returning to our districts after this hearing today for a few days and I am sure the people back in our districts are going to want to know, particularly people from the teaching hospitals, how teaching hospitals reimbursed under this plan are going to be able to treat charity cases. What would you respond to them if you were asked that question?

Mr. MULLINS. As I understand it, in the document I read yesterday, there will be a reduction in the indirect medical education funding from about 7.7 percent down to 6.5 to 6 percent between 1996 and 1997, I believe. So there will be some reduction there.

The direct medical education doesn't change except it puts restrictions on funding foreign medical graduates over a period of 4 years.

The disproportionate share portion—and all these funds go to hospitals. The disproportionate share funds are about $3 billion a year right now and will be reduced in the plan by 25 percent over a 7-year period of time. Then there is an additional fund from non-Medicare funds that will supplement the Medical Education Program.

So I don't have the details of it, but it looks as if it might well be a wash in terms of where we stand right now, or pretty close to it. The disproportionate share hospitals under Medicare are a little different than under Medicaid, but there is an approximation.

Most of the money that comes from disproportionate share comes from the Medicaid Program and not from the Medicare Program.

Mr. THOMAS. Will the gentleman yield briefly for a correction and then we will go forward?

Mr. COYNE. Sure.

Mr. THOMAS. In terms of the direct medical education, it would apply to all foreign medical graduates. It will be for noncitizens, and there will be a phaseout of 25 percent a year over 4 years. It will be taxpayers' dollars not funding noncitizens rather than foreign graduates.

Mr. COYNE. Do you think the administrators of these hospitals ought to be concerned, that is, the teaching hospitals, about the fact that there is no dedicated source of revenue to pay for the obligation of the teaching hospitals to teach doctors?

Mr. MULLINS. The separate trust fund proposed in here is a dedicated fund, very similar, and it does incorporate the current IME, DME funding, as well as adding to it an additional funding that comes from general revenue as I understand it.

Mr. COYNE. So the general revenues will make up any shortfall for those teaching hospitals?

Mr. MULLINS. I don't have that detail, but there will be a fund.

Mr. COYNE. So detail is not a part of the proposal as you understand it?

Mr. MULLINS. Well, not what I have read. It may be there.

Mr. COYNE. Thank you.

Mr. THOMAS. Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman.

I would like to thank all the witnesses for your helpful testimony. Ms. Hansen. Your testimony corroborated what the General Accounting Office has told us, that if we don't go after the fraud and abuse, it is going to cost taxpayers, beneficiaries of Medicare, about $138 billion over the next 7 years. That is how much will be lost to fraud and abuse, as you testified and the GAO's study shows.

Your results certainly in terms of fraud detection and prevention techniques have been very impressive. I was wondering if you could briefly describe—you didn't get a chance within the limits of your testimony—if you could briefly describe for the panel the programs you developed to detect and eliminate fraud, and then tell us if you believe the antifraud technology that you have used and developed could be applied more generally to the Medicare system to identify providers with questionable practices and make some of those savings in terms of fraud and abuse.

Ms. JOYCE HANSEN. We actually developed our program 10 years ago so it has evolved greatly. There is a lot of change in the industry today as well as in terms of perpetrators of fraud. We have found the most effective tools and techniques—and we have had a lot of successes—is to use training, training those people that are looking at claims every day.

We have sophisticated investigators that have backgrounds in law enforcement, medicine and claims working together, but what makes a big difference is the technology piece. Two years ago I went to our senior management and said, "The schemes have be-

come so sophisticated that if you do not have technology to detect fraud, you might as well give up on what you are doing." And there are some great systems out there. There are some great services that can be employed. I definitely think that it could be applied toward the Medicare system, absolutely.

The perpetrators of fraud that are hitting the system today are hitting public programs as well as the private programs. The providers are not saying, Well, you know, this is a private carrier so I am going to bill them differently, or this is a carrier that was rendering services for a Medicare patient. And so, the bottom line is we have to look at what is happening here and technology has just proven to be fantastic. It is something that Medicare and the public program should really think about seriously.

Mr. RAMSTAD. Well, certainly that is helpful. We need to bring those kind of advancements into the system and certainly we can't afford to lose $138 billion to fraud and abuse over the next 7 years. Certainly the seniors of America and the taxpayers deserve much better.

I would also like to ask you about a statement in your written testimony. I know that there are some people around here who believe that somehow magically managed care will eliminate fraud and abuse in health care. You state in your testimony that that is a very common misconception. Could you expand upon that?

Ms. JOYCE HANSEN. Certainly. There is a real misconception out there that now that we have got managed care, we are not going to have any more fraud and abuse. But if you look at it, many of the HMOs and the managed-care entities are offering point-of-service plans where patients are allowed to go to that particular provider and they are billed on a claim-specific basis. So anyone perpetrating fraud can add whatever they want into that claim, billing for services not rendered and falsifying the diagnosis.

In addition, with the HMOs and when you are looking at capitated plans, we strongly believe, and are now starting to find specific evidence, that there is a real problem with underutilization, not having convenient office hours for patients within the plan, not having convenient locations, and that is going to be something that we are going to have to start looking at in the future.

Mr. RAMSTAD. Thank you again, Ms. Hansen, and to the other witnesses as well. I yield back, Mr. Chairman.

Mr. THOMAS. Thank you very much.

Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. I do. I am just going to ask a question of Mr. Ferrara and Ms. Davis because your testimony is in such contrast.

So, Mr. Ferrara, you say the essence of the plan is that it shifts power and control over Medicare away from the government, hospitals, and doctors to the elderly themselves.

Ms. Davis, you say that this plan places beneficiaries at enormous risk. So sum up for us, if you would, we get 1 minute sometimes on the floor, how you would respond to the other on this?

Mr. Ferrara, why don't you take a crack? Why are you at 180 degrees?

Mr. FERRARA. These private options like the medical savings accounts reduce the risk that the elderly face. Under Medicare, they are subject to a lot of out-of-pocket cost. They don't have complete

catastrophic coverage. They have unlimited out-of-pocket coverage, and you can see that the elderly believe this themselves because 70 percent of them shell out a lot of money to get additional coverage to cover that exposure they have under Medicare.

Under this medical savings account, which again, this is Milliman & Robertson's numbers. They are the actuaries. They are like the Harvard of actuarial firms. The most out-of-pocket expenses they would have to pay if they got a fee-for-service plan would be $1,500 because they have got insurance paying for everything over $3,000. They have got $1,500 in the savings account to pay for expenses below $3,000, so that leaves at the most $1,500. That is less risk exposure than they have under Medicare, and that is why it is a better program, particularly for the sick, and once you recognize that, there are so many implications that come out of that.

It reduces the dangers of risk selection, for one. It reduces the pressure that you would have on the risk adjustment mechanism so it doesn't have to be as perfect as it might be otherwise, and so that is why I disagree with her statement that it puts them in enormous risk.

Mr. LEVIN. Let her respond. Ms. Davis, tell us why you think there would be an enormous risk for beneficiaries.

Mr. DAVIS. I think if beneficiaries understand what they get when they get into a Medisave account——

Mr. LEVIN. Do you think this whole plan places Medicare beneficiaries at risk?

Mr. DAVIS. I think any time you are fixing what the government is paying and you are not controlling health care costs, the person who is vulnerable to the difference is the beneficiary. So I guess my fundamental concern is savings to the program that are proposed cannot be achieved and without doing anything about the health care system the beneficiaries will be harmed. So that is the broad point.

The specific point on medical savings accounts is that I don't think people want plans with $3,000 deductibles. Now they have a $700 hospital deductible, $100 physician deductible. It is why 80 to 90 percent of beneficiaries go out and buy supplemental coverage. They don't want those deductibles.

But I think we have seen with Medigap policies, you can find an elderly person who, before some of the reforms there, were buying 30 or 40 policies. They just didn't understand what they were getting, and so I am concerned that we could open up to a lot of marketing abuses, get people inadequate coverage, and undermine the whole reason Medicare was started in the first place, which was to make sure that nobody had to worry about bills, nobody was bankrupted by bills, that Medicare was there to provide health and economic security.

Mr. FERRARA. May I respond to that?

Mr. LEVIN. Well, my time is up basically. Thank you.

Chairman ARCHER. The gentleman's time has expired.

Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman. Dr. Mullins, as the vice chancellor of the medical schools at the University of Texas,

could you tell us why teaching hospitals and academic health centers are at risk now when they have been so successful in the past?

Mr. MULLINS. Well, it is because of managed care and the intensity of the managed-care market, which under contract is moving some of their traditional patients away from many of the safety-net hospitals that are in our University of Texas System by group contracting, and potentially can group contract large segments of the Medicaid population which our teaching hospitals have traditionally cared for under the supervision of our faculty.

Mr. LAUGHLIN. Why should Medicare be solely responsible for paying the cost of graduate medical education?

Mr. MULLINS. Well, I personally don't think it should be solely responsible. I would think it should be an all-payer system in which all insurance companies, both public and private, help fund the medical education expense of the country rather than having it just on the Federal tax roll.

Mr. LAUGHLIN. Ms. Hansen, I missed part of your testimony, but I heard part of it where you were talking about managed care. Is there any fraud in managed care? And if so, could you briefly explain the problem?

Ms. JOYCE HANSEN. As I mentioned earlier, there is fraud in managed care. What we see is overutilization and underutilization. Most HMOs and managed-care entities today still offer plans where everything is submitted on a per claim basis, so, you know, it is an open checkbook basically at that point in terms of what kinds of things can be billed for.

From the capitated standpoint, there is a lot of concern about underutilization. Those of us in the detection industry are trying to beef up our staff and beef up our technologies so that we are able to attack fraud from that perspective. It is a real different perspective from what we have worked on for the last 10 years, and I think it is critical that Medicare stay on top of that. HCFA must be able to respond to both types of fraud.

Mr. LAUGHLIN. Could you elaborate on your proactive approach to fighting fraud and what makes your program so unique?

Ms. JOYCE HANSEN. Well, we have been extremely successful over the last 10 years by applying different tools and techniques. Our savings have increased considerably year after year, and it has been such a successful program that we are actually doing these services for other insurance companies, third-party administrators, HMOs, and managed care entities. We are currently discussing some of our services with the State of Georgia in their Medicaid assistance program and trying to help out some of the other payers in the industry today.

I think once we went in and talked about what our savings are and what we can do for people, there has been a lot of interest in applying our techniques so that people aren't reinventing the wheel.

Mr. LAUGHLIN. As I listened to you talk about the examples of chiropractic fraud in Los Angeles, it occurred to me that some of the people involved in paying for the services are more involved in paying for the services than they are in looking for the fraud. Sometimes doctors are more involved in treating patients than they are in looking at their expenses or whether they are getting paid.

Is part of your success the fact that you are specialized at looking for the fraud in the program and paying for patients' service on Sunday when their office isn't open on Sunday? And you had another example, and do you suggest that there ought to be more antifraud specialists within the system rather than expecting the person writing the checks to look for the fraud?

Ms. JOYCE HANSEN. Absolutely. It is a cost-management tool, and our approach has been that we have to put the right tools and techniques in place in order to detect the fraud. So it has got to be at the point that the claim is being reviewed from a payment standpoint or the point prior to that. You have to have the right tools and techniques in place to review the claim at that early point. To pay and chase is not the way to go.

Mr. LAUGHLIN. Just the last 10-second answer to the question. How much money do you estimate your program saves, and where you have investigated or would save in the system?

Ms. JOYCE HANSEN. This year our programs are going to save $3 million. I did a quick estimate for the Medicare system, and over the next 7 years, applying the tools and techniques I talked about, it is about $18 billion in savings.

Mr. LAUGHLIN. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Certainly.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I do indeed. First, Mr. Mullins, let me thank you for mentioning the all-payer needs for graduate medical education. Mr. Cohen, I compliment you for the work you have been doing on behalf of the academic centers. As a Congressman that represents Maryland, with an all-payer hospital rate system, I have been trying my best to educate the Committee on the merits of all-payer rate system. Clearly, the example of Maryland and how we finance our hospital reimbursement system is one that offers a lot of merit for other uses, and I strongly support an all-payer revenue source for graduate medical education.

I want to compliment Mr. Thomas, the Chairman of our Subcommittee on Health Care, for recognizing the need to change the way that we finance graduate medical education in our country. I would have hoped we would have had an all-payer revenue source in the Republican bill, but there is an acknowledgment that we need to set up a separate type of funding source for graduate medical education, and I am glad to see that at least in that direction the bill moves us, I think, in a positive step. Enough with the compliments. I now go to some areas of concern.

Ms. Davis, you have helped us in Maryland and always have been extremely forthcoming, I think, on good advice. I am concerned by something in your testimony. You point out something that maybe my constituents don't fully understand, and that is that our elderly pay more for their own health care out of pocket than any other group of Americans. They are the only group that has comprehensive insurance, and yet they have more out-of-pocket costs. You point out that 45 percent of their health bills are paid by Medicare, and that the average out-of-pocket cost is $2,000 a year.

I guess my question to you, bottom line, if we do $270 billion in Medicare cuts over the next 7 years, what is likely to happen? If we get that number, if we do $270 billion, what is likely to happen to seniors' out-of-pocket costs? That is, how much out-of-pocket cost are seniors likely to incur in order to meet their health care needs. Is that number going to go up? Is it going to go up slightly, radically? What is likely to happen?

Mr. DAVIS. Well, I think it will go up just because we aren't doing anything to solve the underlying problem of health care costs, so the hospital deductible at a minimum is going to go up every year. That means Medigap premiums are going to go up. Out-of-pocket costs for prescription drugs are going to go up as well.

One of the things it would be nice to get from the Congressional Budget Office are the premium increases in this bill, how much of the Social Security increases over the next 7 years will be eaten up by that Medicare premium.

The way the Medicare premium works, it is deducted from the Social Security check. So every year there is a slight increase for the cost of living in the Social Security check, but if you are increasing that premium every year pretty substantially, how much of that increase or more is being picked up in the increase in the Medicare premium? So there is some additional information on that that I think is important to get.

Mr. CARDIN. So our seniors are going to receive a larger reduction from their Social Security checks. The Senate Finance Committee Republicans released their plan today and they have higher deductibles and they start the premium increases at lower income levels than the Republicans here. I think they are trying to fill the black box in a more direct way. I guess my point is, you are likely to see our seniors not only pay more of a deduction on their Social Security income, but they are going to have higher out-of-pocket cost either because of copayments and deductible increases or services that are no longer covered or supplemental insurance that they now feel obligated to purchase.

Is that a reasonable assumption? Am I correct in that?

Mr. DAVIS. I haven't had an opportunity to look at the Senate proposal, but I think one of the nice characteristics of the Committee proposal is that it focuses on premiums and not deductibles.

When you increase deductibles, when you increase copayments on home health services, you are targeting your budgetary savings on increased payments from a smaller group of beneficiaries who are already paying the most out of pocket. So it is $2,000 and average, but if you are a person who is very sick, has heart disease, cancer, you are in and out of the hospital, you may be paying $3,000 out of pocket. Then, if you have to pay 20 percent of the cost of the home health aide, if you have to have a higher $150 physician deductible, it is increasing costs on the sick.

So if you are going to have beneficiaries pay more, the question is how much more is it reasonable to ask, spread it over all beneficiaries through premiums, protect the poor beneficiaries by making sure that Medicaid remains to pick up Medicare premiums and Medicare cost sharing for the 4 million poor beneficiaries covered by both programs.

Mr. CARDIN. We don't have Medicaid before our Committee, but the cuts there will also come down. Thank you.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I appreciate the opportunity. Ms. Hansen, I appreciate your being here and your testimony. I was the first Member of the House to drop in a bill going after Medicare fraud. I think this is a very serious component in this solution because these are costs going out that are simply not received by the beneficiaries. So they are a dead loss to the system.

I don't know if you are aware of it, but the GAO just came out with a new study that I think addresses this, talking about the unnecessary Medicare payments, describing Medicare as an appealing target for abuse, indicating that Medicare does not adequately check claims and does not adequately screen providers for credibility.

One of the examples they use, and I don't know if you have had experience along these lines, a therapy company added $170,000 to its Medicare reimbursement over 6 months, providing no additional services, by creating a paper corporation.

Medicare, under this report, is scored for its slow and bureaucratic response to problems. And I wonder, looking at the broad sweep, given the fact that the Medicare proposal before us does provide for an exclusion for fraud as my bill does, does not go as far as my bill does in increasing the monetary penalties for fraud. Do you feel we could go further in this bill in cracking down on fraud?

Ms. JOYCE HANSEN. Oh, absolutely. But I think my approach is that there is a lot more that can be caught if you put proactive measures in place versus the reactive penalties. I think it is very—I like the idea that even in this bill the penalties were increased from, I believe, $25,000 to $250,000. That is important.

My concern is at the same time we not concentrate so much on the back end, kind of the pay and chase, because in the meantime, there are hundreds of thousands of dollars being lost in the system today that are continuing to flow right through the system. So I think the approach has to be a real balanced approach with an emphasis on the proactive.

Mr. ENGLISH. And I agree with you and again, I appreciate your expertise on this.

Mr. Ferrara, it is a delight to see you here and as always, your testimony is powerful.

Mr. FERRARA. Thank you.

Mr. ENGLISH. You argue that under MedicarePlus, you feel confident that premiums are going to go up only $7 per month by 2002 for Medicare part B relative to where the President's proposal roughly would put them, and that copays and deductibles are not going to be increasing. You are fairly confident that this system will work and constrain costs within those parameters.

Mr. FERRARA. Let me make a point about that, that in fact, under the proposal from the Republican side on premiums, they will go up in the future at the same rate as they have gone up in the past. They won't go up any faster because it is 31.5 percent of

the part B costs. Premiums are going to go up at the same rate as part B costs.

Medicare premiums have always gone up at the same rate as part B costs. It will be $7 more per month than if you had reduced the 31.5 to 25 percent, which would be an irresponsible thing to do in the midst of current crisis, but the fact is, the rate of increase will be no greater than in the past.

Mr. ENGLISH. Very good. Let me do a quick followup because I am running out of time. I know that under the MedicarePlus plan, limited enrollment plans, the inclusion of unions and associations being able to participate and offer their own networks and provider-sponsored networks in communities is considered an important part of the solution, and I would like you to amplify on that.

Also, can you say with these networks, should they be regulated in any way at the State level under conventional insurance regulation?

Mr. FERRARA. Well, these other options you describe are important options. They give people the freedom to choose what is best suited to them, and that is why I started out in my comments here—I didn't talk about some of the written points. I think that the plan that the Republicans are offering offers a better system in Medicare for several reasons.

Many of the options are going to offer better benefits than Medicare. The medical savings account option will. As Ms. Davis says, their out-of-pocket costs will go up. Quite to the contrary. Medical savings accounts, out-of-pocket costs will go down.

With many HMOs and managed care plans, out-of-pocket costs will go down, and yet they can get additional benefits from many of those plans as well, such as catastrophic coverage and prescription drugs, and these other options you are talking about are other parts where people have the freedom to choose what best suits them.

Now, I think that most people, in fact, are going to end up picking the medical savings accounts. Ms. Davis says they don't like them. Well, let's just allow people the freedom of choice and we will see who is right 5 years from now.

Mr. ENGLISH. I am out of time. But again, if you could speak to the last part of my question. As part of the oversight of these networks, do you think——

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Mr. Chairman, I have no questions of the panel except to thank them for their testimony. However, I do want to caution the Members of the Committee on this whole question of medical savings accounts.

I mean, if you sat and listened to the experts in the previous panel, all that glitters is not gold, and here we have the National Center for Policy Analysis coming forward today. Who funds them, I don't know, but this is a walking commercial for MSAs, and if, in fact, you think they are a good thing, you have a right to say they are a good thing. But, the caution to the Members is, what I see happening here, and the panel has somewhat agreed with me, is that the younger senior, the healthier senior will go into the MSA, will stay there for a period of time, knowing full well that

once age advances, health deteriorates. At that point they are going to opt to go back to the fee-for-service or look around for something else.

So these things are flashes in a pan, and to say that this catastrophic insurance underwriter just wants all these risks, all these unhealthy people in there, that is baloney. I worked for an insurance company years ago before my legislative days. Insurance companies are in it to make money and they don't want risk, an avalanche of risk.

So to think that these folks are just going to have an open door policy to every sick senior in the country, you are full of baloney. They don't want those folks. They want the healthy ones. Once they start popping off in the later years some of the medical costs, they are not going to make money.

So let's not buy this commercial we are hearing from the National Center for Policy Analysis on MSAs because I think we can get burned on them, and clearly in application, we might find out they are expensive and not cost saving for the whole Federal scheme.

Mr. FERRARA. Mr. Chairman, may I respond to that briefly?

Mr. KLECZKA. There wasn't a question, Mr. Chairman.

Mr. THOMAS. The gentleman from Wisconsin says he didn't ask a question. He knows that he didn't ask a question.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Ferrara, how long have you been working on this MSA idea?

Mr. FERRARA. I have been working on it for over 10 years, and no matter where I have worked, I have worked in the National Center of Policy Council for 1 year, but I have been working on this study for over 10 years.

Mr. CHRISTENSEN. What companies out there have had an experience with MSAs and are currently using them?

Mr. FERRARA. There are 1,000 accounts. I produced a paper about medical savings accounts which discusses over a dozen examples. One of the best examples is Golden Rule Insurance Co., which uses medical savings accounts for their own employees. And where they have allowed them the choice there at Golden Rule, they have over a thousand employees at Golden Rule, ninety percent of the workers have chosen the medical savings account plan.

They can choose the typical fee-for-service plan instead, but over 90 percent of the workers, sick or healthy or whatever, have chosen the private—the medical savings account plan. And one of the reasons they do this, and that is in answer to this gentleman over here, is that as these studies show, people are not going to stay in medical savings accounts for 5 years and then shift to the HMOs or to Medicare because the medical savings accounts are better for the sick than Medicare plan.

That is what these studies show, and it is not just the NCPA doing this. That is why we had Milliman & Robertson do these calculations for us. They are the actuaries that do these things for the insurance companies. That benefit structure that you see up there on the chart is better for sick people than Medicare for the five reasons I discussed. And that is why when they choose them, they are going to stay with them, and that is the experience, according to

Golden Rule and these other places, sick as well as healthy people have chosen them and stayed with them.

Mr. CHRISTENSEN. Do you think there will be any difference between the private market under age 65 and the emerging MSA for the senior market? Will there be any difference in—did the studies show any kind of difference as far as Milliman & Robertson?

Mr. FERRARA. You see, Milliman & Robertson examined this in the context of seniors, and they have the cost data under Medicare and they have the—they know the incidents of the illness and the cost. And so they were able to calculate this.

There is no fundamental difference in the way MSAs work. The reason why they have such a big impact in cost is because people have control of this money. It is their money in the account. They don't want to waste it. So they have a new cost incentive now that they don't have under traditional insurance. Because they have this incentive, even more importantly, the doctors and hospitals will start to compete because the patients will now be concerned about cost as well as quality.

Mr. CHRISTENSEN. You have studied this for over 10 years. There are over a thousand companies using this. In your opinion, is there any area of the MSA idea that could be gamed in the system, either by insurance companies or by individuals? Where do you think we need to focus if there is an area of weakness in the MSA approach?

Mr. FERRARA. Well, there is no danger, gaming it under the rules that I know the Committee staff has sort of developed, to apply this option. The rules you need to say is that the company has to accept everybody who comes out of Medicare who chooses them. They can't just take the healthy and refuse the sick. The company has to accept guaranteed renewability, which means if they want to stay with the plan, they have to stay with the plan, that whatever premium they set for people who are in their plan already from year to year cannot be different for some people than for others.

As long as you have these basic rules that the Committee staff has developed, then there is no risk of gaming the system.

Mr. CHRISTENSEN. I wanted to follow up on Representative English's last question about the State regulations and the provider-sponsored networks complying with them or not complying with them. Where do you see the problem there? If the insurance companies have to comply with State regulations and the provider-sponsored networks don't have to comply, will there be a problem or potential problem there?

Mr. FERRARA. Well, I am not as expert on PSNs as on the MSAs. What I could say is that I think you should examine the degree to which the provider service networks are different than the insurance companies, so that where regulation is not necessary to apply to them, that they not be burdened unnecessarily with the same regulation.

On the other hand, you don't want to give them an unfair advantage over other providers in the market. You want to put all the providers on a level playingfield. So within those two principles, I would have to examine the details more to give you a definitive answer.

Mr. CHRISTENSEN. Ms. Davis, were you one of the members of the task force last year on health care?

Mr. DAVIS. No, I was not.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Georgia want to inquire? Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Ms. Davis, earlier this week, the Republican proposal eliminated Medicaid. They are replacing it with block grants. How would that affect senior citizens, the elderly?

Mr. DAVIS. Two-thirds of Medicaid spending goes for the elderly and disabled. So first of all, if you have on average 30 percent cuts in Medicaid funding in the year 2002 relative to what it otherwise would have been, two-thirds of that is coming out of benefits for elderly and disabled people.

The provisions in Medicaid that are particularly important for Medicare beneficiaries are, first of all, anyone below the poverty level is eligible to have their full Medicare premium, their Medicare hospital deductible, their physician deductible and coinsurance picked up by Medicaid. As I understand it, that is not protected, particularly the cost-sharing provisions, in the block grant as the Commerce Committee has considered it.

In addition, Medicaid picks up prescription drugs for low-income elderly and disabled beneficiaries. That wouldn't be protected specifically. It has provisions which are called spousal impoverishment. If your spouse goes into a nursing home, people in the past were driven into poverty because it ate up all of their own income and assets. There is protection for that in the Medicaid law. I don't believe that has been protected in the new block grant provisions.

There are quality standards on nursing homes. Those aren't being protected in the new block grant. There is no guarantee that the funding is actually there for nursing home and home health and other long-term care services.

So I think there are a lot of interconnections between Medicaid and Medicare that people don't realize and that a block grant will affect it.

On the provider side, if you are cutting payments to hospitals for disproportionate share and you are squeezing the DRG payment rate and the States are forced to cut as well because they have got less money to work with, the payment rates to hospitals, and you have got a growing number of uninsured, who are going to certain kinds of public hospitals or others for care, you are going to have real financial problems to have all of these things hitting public hospitals, community health centers, and other institutions that serve low-income communities all at once.

Mr. LEWIS. Thank you very much, Ms. Davis.

Mr. Ferrara, could you tell me, I know you think this is a good deal. You came across as a believer. Do you believe there is a strong role for the National Government to play in the delivery of health care to all of its citizens?

Mr. FERRARA. Yes. I think that the government, Federal and State working together, should develop policies that will assure that all citizens will have access to health care, and we have writ-

ten on this in how you can have universal—effectively what we call universal coverage through a private market system.

Mr. LEWIS. What are your feelings about delivering health care using block grants?

Mr. FERRARA. Well, in terms of Medicaid, we support block granting Medicaid to the States because we think that the—in Medicaid, you have a special—the greatest difficulty, because you have got a conjunction of health care problems and welfare problems, so you have got a tremendous mix of problems.

We think the welfare system as a whole needs to be revised from the ground up, and that Medicaid is a central part of that system, and that it ought to be integrated with the entire system. We think the States ought to have the freedom—we think all the major welfare programs ought to be block granted to the States: AFDC, food stamps, housing, and so forth, and allow the States to redesign integrated programs, taking all those factors into account.

What I would do if I was Governor of a State with a Medicaid block grant, my program would be a voucher program. I would give all the people at the lowest income level a voucher that they could use to buy any plan in the private sector that they chose. This would be much better for low-income beneficiaries because they would be free to participate in the same middle-class health care system as everyone else.

Under Medicaid today, because assistance reimbursements are so low, they are often shunted off into second-class health care. They don't have the same access to care and quality of care as the middle class.

If they had a voucher system, they could go to Blue Cross, they could go to a medical savings account, they could go to a managed care plan if they want, the same ones as the middle class, and participate in the same system.

This is one area where—I am very fiscally conservative as you might guess, but this is one area where——

Mr. THOMAS. The gentleman's time has expired. One sentence.

Mr. FERRARA [continuing]. This is just one area where I would try to assure that there were enough funds so that no one would have inadequate financing to purchase essential health coverage.

Mr. LEWIS. Mr. Chairman, since the witness went on so long, let me just have another question, another minute here.

Mr. THOMAS. Without objection, Mr. Lewis gets to ask the last question.

Mr. LEWIS. You do believe in certain national standards. You wouldn't want the people in Alabama, Mississippi, or Georgia to have a different quality of health care than the people in California or New York?

Mr. FERRARA. Well, I would not want them to have a different quality of health care, but I don't believe the Federal Government is able to deliver that. I believe that the same people who are electing Congressmen and Senators are also electing State legislators, and if they can be trusted to elect Congressmen and Senators who will take into account the interests of all the people, they can be trusted to elect State representatives who will take into account the interests of all the people, and, therefore, I believe that these

State governments will adopt sound policies with the block grant program.

Mr. LEWIS. Mr. Ferrara, in another period of our history, we had a concepts of States' rights, and some people were mistreated during that period and weren't treated so well.

Mr. THOMAS. And the gentleman's time has expired.

Mr. FERRARA. I support national civil rights standards.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Thank you very much, Mr. Chairman, and I want to thank these witnesses for their testimony.

Mr. Chairman, I wanted to thank you as well for the work that you have done on graduate medical education and the concept that is being put forth now, and I look forward to seeing the bill and the details at some early time, but I do appreciate the work you have done.

And I yield back the balance of my time.

Mr. THOMAS. Since I didn't take any time earlier, I wanted to say several things.

Miss Davis, I was pleased to see that there is at least one portion of this plan you like. That is, that we focus on the premiums and put in prospective payment structures for home health care and others and stay away from the deductibles and the copays that others had suggested.

Ms. DAVIS. I also mentioned the importance of information. I think it is important as choices are given to Medicare beneficiaries to make sure that there are quality standards and good information. So I think that is an important provision.

Mr. THOMAS. We are going to an educational program. That is one of the reasons we didn't go to a voucher program, because we wanted to maintain that contract relationship with the Federal Government for our seniors. But today you can turn over a program every 30 days.

What we want to do is provide a model, using the Federal employees health benefit program, which would give you a layout of what it is that is offered. In that context, I think you will find Mr. Ferrara's program as an option. There are a number of asterisks in the various categories where programs would offer benefits with an explanation for what it was.

Right now, seniors are signed up for the fee-for-service program by doing nothing in essence. We don't even educate them about coordinated care and managed care options. That, I think, is the fault of the current system. We are going to make sure that we have adequate information for our seniors. I know you are concerned about those folk, and I just hope you will focus on some portions of this new program which emphasizes I think some things that in prior hearings we have talked about that you had concerns about.

Ms. DAVIS. I did mention I do like the formal annual enrollment process. I think it is important we are talking about a benefit package that is as good as the Medicare package, that we are talking about a real delivery system like a health maintenance organization and not an indemnity or a catastrophic health plan.

But I think the notion of letting people know what choices there are, giving them information on how consumers feel about those HMOs, what they have experienced with them, that those would be

good measures. But I think we ought to move slowly about expanding what is an eligible managed care organization under Medicare. I think there is some merit to expanding it to the point-of-service option for HMOs, but as for very loosely organized managed care plans, I think until we have better quality standards, better enforcement mechanisms, and a better way of setting the capitation rate that we shouldn't move too quickly in that direction.

Mr. THOMAS. And you heard the previous panel in terms of their concerns, and we are working together to make sure that we try to coordinate them.

Dr. Mullins, in your testimony I heard some fairly good comments and then in terms of responses I was concerned. I would ask unanimous consent to submit for the record a letter from the Association of American Medical Colleges signed by Dr. Cohen which says, in part, the AAMC, the Association of American Medical Colleges, endorses the trust fund concept and applauds the House Ways and Means and Commerce Committees for their commitment to the clinical training of future health care providers.

[The information follows:]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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Jordan J. Cohen, M.D., President

September 21, 1995

Honorable William B. Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives
2208 Rayburn House Office Building
Washington, D. C. 20515-0521

Dear Mr. Chairman:

The Association of American Medical Colleges (AAMC) understands the difficulty Congress and the Administration face in their efforts to preserve and protect the Medicare Trust Fund. We continue to be concerned that sharp reductions in the rate of growth in the Medicare program could have a major impact on the U.S. health care system. Moreover, the changes being contemplated would have especially profound effects on the nation's medical schools and teaching hospitals.

Proposals now being advanced in the House of Representatives have been designed to attenuate some of these effects by recognizing that teaching hospitals face unique challenges in maintaining their crucial missions of patient care, education and research in the new, fiercely competitive health care marketplace. Indeed, Medicare's present method for calculating the adjusted average per capita cost (AAPCC) to establish rates for Medicare risk contractors includes the graduate medical education and disproportionate share payments intended for teaching hospitals under Medicare fee-for-service. Diverting these payments away from teaching hospitals accentuates the competitive disadvantages they face.

The Republican Leadership, the Ways and Means Committee, and the Commerce Committee have devised a plan to establish a trust fund that is intended to assist teaching hospitals in meeting the special costs associated with their education mission. The AAMC endorses the trust fund concept and applauds the House Ways and Means and Commerce Committees for their commitment to the clinical training of future health care providers. Our hope is that this innovative proposal will be a first step toward establishing the principle of shared responsibility and toward creating an all-payer approach to equitably financing clinical training.

Sincerely,

Jordan J. Cohen, M.D.

Mr. THOMAS. Do you like what we are trying to do in terms of getting away from Medicare being the funder for medical education and trying to move to another system or should we just kind of not spend more time in that area and leave it the way it is?

Dr. MULLINS. No, sir, I think it is a wonderful concept, and I support it 100 percent.

Mr. THOMAS. That is sufficient. I thank you very much.

Any additional questioners?

I want to thank all of you for your testimony.

The Chair has been informed that several of our witnesses are beginning to bump into transportation concerns, based upon the amount of interest Members have shown in each of the panels in their discussion. So, without objection, the Chair would suggest that we combine the next panel of senior citizens and the panel after that so that we would have one panel. Is there any objection?

Mr. GIBBONS. Reserving the right to object, Mr. Chairman.

Mr. THOMAS. The gentleman from Florida.

Mr. GIBBONS. And I don't want to prolong this any longer than we have to. But I can't help feeling a little resentment toward Chairman Archer and the Republicans on the Committee for having tried to cram all of this in 1 day. We took 5 hours to hear three witnesses. We have 20 witnesses scheduled here. I don't know where Chairman Archer is. The rumor is he has taken off and gone to Texas. If so, I hope he has a nice trip.

Mr. THOMAS. Does the gentleman object to combining the panels?

Mr. GIBBONS. Reserving the right to object, Mr. Chairman, and I may object if I get pushed too hard.

Mr. THOMAS. Well, it is your call.

Mr. GIBBONS. Reserving the right to object. I think it is ridiculous that these hearings were scheduled like this and planned like this. This is an imposition upon the witnesses. It is an imposition upon the American public because——

Mr. THOMAS. The gentleman is taking additional time from the panel so that we can question them. Does the gentleman object?

Mr. GIBBONS. The gentleman may object if you keep pushing me too far, Mr. Thomas.

Mr. THOMAS. Your point is being lost by the time that you are consuming. I thought we wanted to move on.

Mr. GIBBONS. Chairman Archer—Mr. Thomas, if you push me too far I am going to object. I am using this time to express my indignation for the way you, the Republicans, and Chairman Archer particularly arranged this hearing and jammed it down our throat. We are not examining any legislative material. Everybody is coming here with a wish list. And the only thing they have to go off of is some press release statement that some public relations firm put out for you all.

This is a ridiculous hearing. It has been drawn to the ridiculous extreme. The best testimony of that is that the Chairman, who called all this, has taken off and gone somewhere. It doesn't make any sense. It is not good government. It is not what ought to be done for the American people. We have got 40 million people whose life and whose health depends on this program. This is a serious, serious matter, and these hearings are just a farce.

Mr. THOMAS. The Chair will renew its request. Is there any objection to combining the two panels because of the witnesses scheduled?

The Chair hears no objection. The first panel then was to be Mr. Lehrmann, president of the American Association of Retired Persons; Mr. Hansen, vice president, Government Affairs, Seniors Coalition; and Hon. Beau Boulter, former Member of Congress, Legislative Counsel, the United Seniors Association.

If the Chair might then request Mary Nell Lehnhard, senior vice president of Blue Cross & Blue Shield Association; Karen Ignagni, chairman and chief executive officer of the Group Health Association of America; and John Troy, executive vice president, Health Insurance Association of America, if they would come to the table as well.

Thank you all for attending. I believe every one of you, perhaps with one exception, have been in previous health care Subcommittee meetings. We welcome you in front of the full Ways and Means Committee. Any written testimony that you may have will be made a part of the record, and you will have 5 minutes in which to inform the Committee in any manner that you see fit.

And I guess the most appropriate way would be, Beau, to start with you, and then we would move across the panel.

STATEMENT OF HON. BEAU BOULTER, LEGISLATIVE COUNSEL, UNITED SENIORS ASSOCIATION, INC.; AND FORMER MEMBER OF CONGRESS

Mr. BOULTER. Thank you very much, Mr. Chairman.

I just want to thank Members of the Committee and especially your Subcommittee for this Republican proposal. I mean it is a Republican proposal. I don't know what else to call it. I do thank you for allowing the United Seniors Association to participate in the process so far.

I look back to the time that started last July, and it seems like since then through the August work period and up until now that the understanding of the American people and especially the senior community has been raised by your effort in spite of a lot of attacks. And so I just think in the weeks ahead that it is going to be important for you and all of us to keep educating people.

I don't think that they used to know, for example—and I think this is important to understanding the senior community. They didn't know that an average couple retiring in 1995, for example, would take out of the Medicare system $117,000 more than were paid in in premiums and taxes. They didn't know that. They didn't know that Medicare expenses were growing at 10.5 percent, but Medicare population only grows at 1.5 percent. That is a 9-percent-per-year increase on each beneficiary. That simply is not sustainable.

And so facts like these have been coming out, and I think it has helped the cause a lot. I think a lot of people now understand that Medicare is not being cut, that the growth is being reduced because it is simply unsustainable. So, to me, the only other choice that you had, given the trustees' report and given the fact that the baby boomers are going to be retiring in 2010 or so, the only other choice

you had was to raise taxes or reduce benefits drastically, and that was not a good choice.

So I want to thank you for the United Seniors Association. We have had our plan; and I hope, Mr. Chairman, if there is no objection that it might be made a part of the record. It is written by Dr. Peter Ferrara.

I am pleased to say that while we do not agree by the way with everything in your proposal, I mean we think it could be improved and hope it will be, still the fundamentals of our plan coincide with the fundamentals of your plan. And mainly it gives control of funds to the seniors. It gives them choice.

We were a big supporter of the medical savings account. I cannot talk as fast as Dr. Ferrara, being as I am from west Texas, but he wrote this and would like it in the record if there is no objection.

Mr. CRANE [presiding]. Without objection, so ordered.

[A Proposal for Reform: Resolving the Medicare Crisis is being held in the Committee's files.]

Mr. BOULTER. We think it will be a good deal.

We participated in many of your townhall meetings and focus groups. We have a national television show. We are in contact with seniors is what I am trying to say, and I believe that because of the work that is being done that seniors will give you very strong support.

We thank you. We are pretty pleased and appreciate the opportunity to participate.

[The prepared statement follows:]

Testimony of The Honorable Beau Boulter on behalf of United Seniors Association, Inc.

Before the House Ways and Means Committee

Hearing on Saving and Reforming Medicare Friday, September 22, 1995

Chairman Archer and Members of the Committee, I am Beau Boulter, Legislative Counsel for the United Seniors Association (USA,Inc.). I want to thank you for the opportunity to testify today on the critical issue of saving and reforming Medicare.

As we all know, the Medicare system faces an impending financial collapse. Indeed, Medicare Part A starts going bankrupt next year, with outlays exceeding revenues collected from the 2.9% payroll tax. The Medicare Trust Fund is expected to be exhausted in 2002.

While some individuals have questioned the seriousness of Medicare's financial condition, the conclusions by the program's Board of Trustees, including three members of President Clinton's cabinet, are exceptionally clear and unambiguous. In order to save Medicare it must be reformed now. To fail to do so will result in a fiscal catastrophe, and only make the future changes that much more painful and severe.

As a former Congressman, I know that it is difficult dealing with issues such as Medicare. One only has to recall the fight over the Balanced Budget Amendment and the efforts by many to scare seniors, claiming that if passed, their Social Security would be endangered.

It has taken courage to make the hard decisions needed to begin a systematic reform of Medicare because there are those who will attack any changes for political reasons. Such as it is, there are those who see political advantage in scaring seniors.

Those who do this - who do it in the full knowledge that a failure to act now could doom this system to bankruptcy - are cynically exploiting the fears of those they claim to be protecting. The facts are the long term impact of your reforms will effectively rebut and eventually discredit such attacks.

I believe that adopting reforms to strengthen, and yes, improve Medicare will ultimately give you the credit you deserve from America's seniors. To do nothing now would simply be irresponsible and a disservice to seniors as well as their children and grandchildren. Our members, and I believe seniors in general, weren't born yesterday. They know that to really protect their legitimate interests we have to recognize these problems and work with you to find solutions to them.

That is why in June of 1994 USA,Inc. put forth a comprehensive and responsible plan to deal with Medicare's financial crisis. Our plan had several key components, many of which appear to be in the House Republican proposals. Our plan would implement market-oriented reforms that would fundamentally change Medicare's structure and improve seniors' access to high quality, affordable health care.

The essence of the House Republican plan is that it shifts power and control over Medicare and its funds away from the government, the hospitals, the doctors, the politicians and the bureaucrats to the elderly themselves. By doing so, you give seniors the best of all worlds through a wide range of choices, including: staying in the traditional fee for service Medicare; various manage care arrangements; and other private options, including a Medical Savings Account. The advantage of giving Medicare recipients additional choices is that by doing so you will generate competition, which will help slow the growth in Medicare's costs. With Medicare's costs rising 10.5% a year, it's the only alternative to the current command

and control system.

Just as important, you allow the elderly to take advantage of the incentives, competition, efficiencies and innovation of the private sector. Because of these factors, it is likely that many of the private plans will provide better benefits than Medicare. While opponents might question this assumption, we believe that if the plan is implemented, millions of seniors themselves will opt for choices not open to them today.

For those who stay in the traditional fee for service Medicare, the House Republican plan calls for no changes in copayments, deductibles or the rate paid by beneficiaries for Part B premiums, which is currently 31.5%. While the latter point is appropriate, considering Part B's exploding costs, USA,Inc.'s Medicare reform plan called for raising deductibles as opposed to premiums.

Today, Medicare encourages over-consumption of medical services through low deductibles and coverage of routine care. Our approach would replace the current benefit structure with comprehensive coverage of all listed benefits once beneficiaries have satisfied a reasonable deductible.

No one wants to pay more for anything, but most seniors will pay more for better coverage if they know that by doing so, they are saving the system on which they rely.

Raising deductibles should not be a hardship on the elderly. Considering the premiums that seniors pay for Medigap policies, combined with capping future Part B increases, seniors would have significant cash reserves to pay the higher deductibles. However, you should know that we also advocate special assistance to help low income seniors handle these higher payments.

Our proposal would also allow the Medicare deductible to increase in the future to cover real cost increases. While none of us want to see this happen, we see it as necessary to real reform. We also propose expanding current IRAs to allow baby boomers and younger workers to save now in preparation for the deductibles they will pay after retirement.

There are several other components of the House Republican plan that we enthusiastically support. One is the fact that it deals with Medicare's financial problem without raising taxes. Already the 2.9% payroll tax is a disincentive to hiring workers and onerous to those who are employed. Raising taxes is the escape door to be used by those who refuse to implement market-oriented reforms. And it is a dangerous door to open.

While these increases do not directly affect retired seniors, imposing an unreasonable tax burden on younger working Americans has serious political as well as economic consequences. We are concerned about anything that increases inter-generational tensions, which are good for neither our country nor for our seniors.

The other area of great concern is waste, fraud and abuse. As USA,Inc. testified before the Commerce Subcommittees on Health and Environment and Oversight and Investigations, this problem poses a clear and present danger to the Medicare program.

It is clear that tougher penalties and additional resources for law enforcement and auditing are desperately needed to combat fraud. In addition, doctors, labs and equipment providers found guilty of fraud should be permanently disbarred from participating in the Medicare program.

In addition to the steps outlined above, a system must be established whereby Medicare's beneficiaries are rewarded for rooting out waste, fraud and abuse. It is evident that the government can't solve this problem alone. Rewarding beneficiaries who expose waste, fraud and abuse will go a long way toward eliminating this problem.

In conclusion, we believe that the House Republican plan is a giant step in the right direction. It allows us to avoid the otherwise certain bankruptcy of Medicare in 2002, provides choices and control for seniors over their health care plans and benefits, and will greatly improve the quality of care available to them.

Through our town hall meetings, newsletters, national television show and letters we get from seniors, we know that seniors are concerned not only about their benefits but for the world their children and grandchildren will inherit. Many also know that Medicare needs to

be fixed, that something is wrong, and that they will bear the burden if the system collapses under its own weight.

In this town, Mr. Chairman, the conventional wisdom is that seniors are unreasonable when it comes to dealing with "their" programs. Well, we also know that the conventional wisdom is often wrong. Your plan is one that we believe will garner support from seniors around the country.

Thank you.

Mr. CRANE. Thank you both.
Mr. Hansen.

STATEMENT OF JAKE HANSEN, VICE PRESIDENT, GOVERNMENT AFFAIRS, SENIORS COALITION

Mr. JAKE HANSEN. Well, thank you, Mr. Chairman.

My name is Jake Hansen, and I am vice president of the Seniors Coalition, an organization representing over 2 million older Americans.

I want to take this opportunity to thank the leadership of the House for the work and effort that has gone into developing the Medicare Preservation Act. It is a dramatic step which will improve the health care and lives of older Americans throughout the country. It took a great deal of courage on the part of those who drafted this bill, courage to face head on the impending catastrophe that Medicare's bankruptcy would cause and the courage to tackle the mammoth bureaucracy and reshape it into a system that is both flexible and responsive.

Our members and supporters, Mr. Chairman, want and need real change in the way Medicare operates. They demand that Medicare be saved and not through some quick-fix or hocus-pocus cost shifting that merely puts off the disaster until after the next couple of elections.

Seniors are real people. They are not an objectified population group. They are extremely diverse in their opinions, habits and needs, more different perhaps than they are all alike, and no one group or organization, not even the Seniors Coalition, speaks for all of them. We recognize and honor such diversity among younger people, yet we have not tolerated it among the Nation's elderly. We have told them that they must adopt their needs to a one-size-fits-all plan regardless of their health status, geographic location, financial acumen, or personal wishes and values. We have disenfranchised them as consumers of health care, and they are fed up.

We celebrate the introduction of a bill which restores full citizenship to America's elderly.

We are particularly pleased to see real, substantive, and positive change in the following areas:

One, providing real choice to seniors for the first time ever.

Two, using competition to control costs and encourage the addition of more benefits such as coverage for prescription drugs and eyeglasses.

Three, restoring to seniors the power of the purse in their health care expenditures.

Four, safeguarding the health of seniors through reasonable, not burdensome regulations of health care providers.

Five, offering complete consumer protection and creating a health care buyers' market, for the first time, through the provision of annual open seasons.

Six, empowering and rewarding Medicare beneficiaries for policing their bills and establishing stiffer penalties for those who would take advantage of them.

Seven, creating a solution that will force no one to leave traditional Medicare unless they so choose.

Eight, resisting the easy way out by refusing to increase copayments or deductibles.

Nine, boldly increasing Medicare spending per senior by nearly $2,000 over the next 7 years.

And, 10, making all participants in the Medicare system, patients and providers, responsible for addressing the skyrocketing costs of health care and giving them the tools to do something about it.

The Medicare Preservation Act is the most important development in health care for seniors since Medicare was enacted 30 years ago, and it will no doubt be a legislative landmark in health care reform. We welcome the opportunity to participate in the advancement of this extraordinary measure.

Thank you.

[The prepared statement follows:]

STATEMENT OF JAKE HANSEN
VICE PRESIDENT, SENIORS COALITION

Mr. Chairman,

Thank you for inviting me to speak today. I am Jake Hansen, Vice President for Government Affairs of The Seniors Coalition, an organization representing over 2 million older Americans.

Mr. Chairman, I want to take this opportunity to thank the leadership of the House for the work and effort that has gone into the development of the Medicare Preservation Act. It is a dramatic step which will improve the healthcare and lives of older Americans throughout the country. It took a great deal of courage on the part of those who drafted this bill -- courage to face head on the impending catastrophe that Medicare's bankruptcy would cause and courage to tackle a mammoth bureaucracy and reshape it into a system that is both flexible and responsive.

Our members and supporters, Mr. Chairman, want and need real change in the way Medicare operates. They demand that Medicare be saved, and not through some quick-fix, hocus-pocus cost shifting that merely puts off the disaster until after the next Presidential election or two.

Seniors are real people Mr. Chairman, they are not an objectified population group. They are extremely diverse in their opinions, habits and needs... more different, perhaps than they are alike, and no one group or organization, not even my own, speaks for all of them. We recognize and honor such diversity among younger people, yet we have not tolerated it among our nation's elderly. We have told them that they must adopt their needs to a one-size-fits-all plan regardless of their heath status, geographic location, financial acumen or personal wishes and values. We have disenfranchised them as consumers of healthcare and they are fed up.

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2) Using competition to control costs and encourage the addition of more benefits such as coverage for prescription drugs and eyeglasses;

3) Restoring to seniors the power of the purse in their healthcare expenditures;

4) Safeguarding the health of seniors through reasonable, not burdensome regulations on healthcare providers;

5) Offering complete consumer protection and creating a healthcare buyers market -- for the first time -- through the provision of annual open seasons;

6) Empowering and rewarding Medicare beneficiaries for policing their bills and establishing stiffer penalties for those who would take advantage of them;

7) Creating a solution that will force no one to leave traditional Medicare unless they so choose;

8) Resisting the easy way out by refusing to increase co-payments or deductibles;

9) Boldly increasing Medicare spending per senior over nearly $2000 over the next seven years;

10) Making all participants in the Medicare system, patients and providers responsible for addressing the skyrocketing costs of healthcare -- and giving them the tools to do something about it.

The Medicare Preservation Act is the most important development in healthcare for seniors since Medicare was enacted 30 years ago and will no doubt be a legislative landmark in healthcare We welcome the opportunity to participate in the advancement of this historic measure.

Mr. CRANE. Thank you, Mr. Hansen.
Mr. Lehrmann.

STATEMENT OF EUGENE LEHRMANN, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. LEHRMANN. Thank you very much, Mr. Chairman.

Good afternoon. I am Gene Lehrmann from Madison, Wisconsin. I am the president of AARP, the American Association of Retired Persons.

I appreciate the opportunity to testify on the restructuring of Medicare. Today's hearing provides an important opportunity to learn more about the House leadership's proposal.

Because the plan is still unfolding and there is much detail that we do not have, I will focus on what we know so far. AARP will continue to analyze the proposal as more details are made available.

The stability of Medicare and its ability to offer quality, affordable health care to older and disabled Americans is of premier importance to AARP and our members. Our previous testimony has underscored our conviction that $270 billion in Medicare spending reductions is too much, too fast. We are deeply concerned that it is more than the program can absorb. Moreover, according to the trustees' report, it is far more than is necessary to keep the trust fund solvent for the next 10 years.

We are also troubled by how the $270 billion would be achieved. The proposed cap on Medicare fee-for-service spending raises serious concerns about how much savings would be generated through this mechanism and what the effect would be on beneficiaries. We caution you about adopting a cost containment structure that would create hidden costs and access problems for Medicare beneficiaries.

AARP continues to believe that the long-term strength and stability of Medicare would be best preserved and protected through a two-stage approach. First, we could trim roughly $110 billion from part A spending, then move to the second step of making changes in the program to address the needs of the soon-to-be-retiring baby boomer generation.

With respect to specific reforms, we are pleased to see that the House leadership proposal takes some steps to limit direct increases in beneficiary out-of-pocket costs, maintain the current Medicare benefit package, and continue the current fee-for-service option. We are concerned, however, about what protections would be in place for low-income Medicare beneficiaries, particularly those who now rely on Medicaid's QMB protection.

AARP also urges you not to overlook indirect beneficiary out-of-pocket costs which also jeopardize the financial security of older persons. We are particularly concerned about the additional costs that could result from relaxing or eliminating the Medicare balanced billing limits, and we are troubled by the fact that the proposal does nothing to fix and, in fact, it worsens the problem with beneficiary hospital outpatient coinsurance.

The leadership proposal suggests that Medicare beneficiaries would have a greater range of coverage options. While AARP supports a broader range of coverage, Medicare choices, we need to

know much more about how these new plans would work and the long-term effect on beneficiaries. We have included specific questions in our written statement.

Over the course of the next few weeks, as we learn more about the House leadership plan, we will educate our members about what the changes would mean to them as we seek their input. Medicare beneficiaries need to know what changes are being proposed, what they are designed to build upon, not erode promise of financial protection and solid health care coverage now and in the future.

It is in everyone's interest that we take the time to explain this proposal to the Medicare beneficiaries and their families. Rushing forward will not yield good policy. Ultimately, AARP wants to ensure that we achieve a stronger, healthier Medicare for current and future generations.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF EUGENE LEHRMANN
PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning. I am Gene Lehrmann from Madison, Wisconsin. I am President of the American Association of Retired Persons (AARP). I appreciate the opportunity to testify before the Committee on the restructuring of Medicare.

Today's hearing provides an important opportunity to learn more about the House Leadership's proposal. Since no bill language is available and we have only had an opportunity to review the summary of the plan, many questions about what the proposed changes will mean to the Medicare program and to beneficiaries remain unanswered. Medicare beneficiaries need all of the facts -- and adequate time to consider them -- in order to make informed judgments about the proposal.

Members of the Ways and Means Committee, along with the House Commerce and Senate Finance Committees and the President, are the elected "Trustees" of the Medicare program. Older Americans, our members and your constituents, will look to you to make sure that any changes to Medicare are made cautiously, carefully, and in the interest of strengthening Medicare for current and future beneficiaries and their families.

When AARP testified before this Committee in July, we raised several issues and questions about proposed changes to Medicare. Our testimony today revisits many of these issues based on what we now know about the House leadership proposal.

Trust Fund Solvency

Before I comment on specific program changes, I want to reiterate the Association's position on the proposed Medicare spending reductions. AARP continues to be concerned that the $270 billion in Medicare spending reductions -- whether they are called "cuts" or "slowing the rate of growth" -- is beyond what the program can absorb without jeopardizing quality and access and without endangering the ability to achieve real program reform. It is also more than is necessary to keep the HI Trust Fund solvent for the next ten years. In short, it is too much, too fast.

The spending cuts needed to hit the $270 billion Medicare target -- along with the $182 billion Medicaid target -- are also a serious threat to our national health care delivery system. We should move with caution in our efforts to slow the growth of health costs in ways that do not jeopardize access, quality or affordability.

Ensuring the stability of Medicare remains a high priority for AARP. We recommended in previous testimony that Congress address the solvency issue in a two-stage process -- first, assuring solvency for the next decade; and second, proceeding on a separate track to deal with the longer-term financial stability of the program.

The first step -- assuring solvency in the program for the next ten years -- would return Medicare to its historic average term for solvency as reported in the annual Trustees' Report. The 1995 Trustees' Report indicates that Part A savings of approximately $110 billion over the next seven years would improve the near-term status of the fund by delaying until 2001 the date when the program has to begin dipping into reserves. This spending reduction would extend the life of the Fund through 2005 -- a decade from now -- and even with some Part B savings would be far less than the $270 billion in Medicare spending reductions in the Budget Resolution.

Extending the near-term solvency of the Trust Fund would provide sufficient time for Congress to move to the second stage. This second stage includes engaging the public -- particularly the baby boom generation -- in a discussion about Medicare's future and then crafting the best policy for longer-term financial stability. The public needs time to understand how proposed changes in Medicare could affect them and their families. Public opinion research conducted by DYG, Inc. for AARP, clearly demonstrates that Medicare is as vital to financial security in retirement as Social Security.

For the average older person, the fact that Medicare helps to provide affordable health care ensures that they don't have to be dependent on their children.

Fail-Safe Mechanism

The size of the spending reductions in the Budget Resolution also raises the question of how these reductions are to be achieved. The proposed "fail-safe" mechanism included in the plan is more than a means to assure "scorable" savings which might otherwise occur from increasing the number of beneficiaries enrolling in managed care plans. It now appears to be an outright cap on spending in the traditional fee-for-service program with little apparent relationship to actual movement into managed care. As we understand it, the fail-safe mechanism has serious potential for eroding traditional fee-for-service Medicare.

Formula-driven approaches to budget cutting have always concerned AARP, in part, because of the rigidities they build into the system and their inherent potential for error and misestimation. For example, the Committee proposal requires the Secretary to estimate how much will be spent on "Medicare Plus" each year and subtract that from the benefit budget. This seem to put the fee-for-service program at risk under the "fail-safe" if the Secretary overestimates the shift into Medicare Plus. Does the Committee bill contain any mechanism for correcting such mistakes?

Allocating the benefit budget among various sectors of the fee-for-service program -- inpatient hospital, physicians' services, etc. -- can also produce distortions. Allocations based on current spending patterns fail to reflect the rapid changes occurring in the health care delivery system. On the other hand, allocations based on a five-year trend line -- while less static -- will often lag behind what the current trend actually is. How does the Committee bill address these problems?

Direct Beneficiary Out-of-Pocket Costs

We are pleased to see that the House Leadership proposal takes an important step to limit direct increases in beneficiary out-of-pocket costs. According to the outline, as well as statements by the Speaker, the average beneficiary would not pay additional Medicare deductibles or coinsurance. Beneficiaries would pay a monthly Part B premium equal to 31.5% of program costs -- roughly $90-$93 per month or $1100 per year -- in 2002. Given that the average beneficiary already today spends $2,750 out-of-pocket for health care costs, limiting additional expenses is a key element of Medicare reform.

Low-income Medicare beneficiaries, in particular, are affected by higher out-of-pocket costs. Currently, Medicare beneficiaries with incomes below 120 percent of the federal poverty level are eligible for Medicaid coverage of their Medicare premiums. Those with incomes below the federal poverty level can get Medicaid coverage for deductibles and coinsurance as well. The proposed increase in Medicare premiums, combined with substantial cuts in the program, will dramatically reduce funding in the Qualified Medicare Beneficiary (QMB) program in Medicaid and leave low-income Medicare beneficiaries without the ability to pay Medicare's premiums and cost-sharing.

As we understand it, the House Commerce Committee's Medicaid proposal would require that states spend a minimum share of Medicaid dollars on Medicare premiums for low-income beneficiaries, but this amount would fall well below what is needed. Moreover, the current requirement that the Medicaid program pay Medicare's deductibles or coinsurance for poor beneficiaries will be scaled back, if it remains at all. The goal of Medicare and Medicaid reform must be to provide access to quality, affordable care. "Reform" will be a step backward if it costs the federal budget less but diminishes access, quality and affordability.

The Leadership proposal's treatment of the Medicare home health benefit could also mean higher out-of-pocket costs for beneficiaries. It is our understanding that after 120

days, payments to home health agencies would cease. Almost one-third of Medicare home health users have episodes of illness longer than 120 days. If Medicare would no longer pay for care over 120 days, what kind of out-of-pocket costs will over one million beneficiaries, most of whom are lower-income women over the age of 75, face?

The Leadership proposal also suggests an "affluence test" for higher income Medicare beneficiaries -- with thresholds set at $75,000 for singles and $125,000 for couples. What is not clear is whether this higher premium would mean the complete elimination of all general revenue financing of Part B services for these beneficiaries.

We believe this "affluence test" raises an issue of equity -- particularly since federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies are direct for federal employees -- including Members of Congress -- or indirect in the form of the tax deduction for employer-provided health insurance and the exclusion of health benefits from individual taxes. If higher income Medicare beneficiaries are going to be asked to pay more for their health care, a parallel obligation to reduce these federal health care subsidies should also apply to individuals under the age of 65.

Indirect Beneficiary Costs

The House Leadership proposal indicates that Medicare's Part B premium would be set at 31.5 percent of program costs and a new "affluence test" premium would be imposed on higher income beneficiaries, as discussed above. The outline goes on to say that there would be no change in Medicare copayments and deductibles. AARP is pleased that the proposal would limit these direct increases in beneficiary out-of-pocket costs, but we urge members of the Committee not to overlook the potential of indirect beneficiary out-of-pocket costs that would jeopardize the financial security of older persons.

In addition to the potential out-of-pocket increases from a fee-for-service fail-safe mechanism, we are concerned about the additional out-of-pocket costs that could result from relaxing or eliminating the Medicare balance billing limits. The proposal does not appear to indicate whether the Medicare balance billing limits would remain in place in the fee-for-service program, nor does it indicate whether these limits would be applied to the other Medicare Plus coverage options as well. Failure to maintain the balance billing limits set in current law would be an invitation to providers to shift higher costs onto beneficiaries and violates one of the principle objectives of this year's debate -- restraining the growth of health care costs.

Prior to the enactment of the physician payment reform law in 1989, Medicare beneficiaries spent over $2 billion out-of-pocket costs for physician balance billing charges. Congress sought to relieve this burden by limiting the amount beneficiaries could be "extra billed" to 15 percent. Physicians who do not accept Medicare assignment can now collect Medicare's payment amount, the beneficiary's 20 percent coinsurance, plus an additional 15 percent from the beneficiary. Some in the physician and provider community have proposed lifting the current balance billing limit. This could occur at three levels:

- doctors could "negotiate" fees directly with patients so they are able to charge beneficiaries additional amounts over and above Medicare payments;
- Medicare Plus plans -- whose payments are ratcheted down under the new Medicare caps -- could accept the "cuts" but insist on the right to charge beneficiaries higher premiums and/or copays; and
- practitioners who provide care as part of a Medicare Plus plan could balance bill beneficiaries in excess of the health plan's payment.

Absent these limits, beneficiaries will end up shouldering the burden of provider payment reductions. AARP is also concerned that the Leadership proposal does not correct -- and in fact worsens -- the inequity that exists in beneficiary coinsurance for hospital outpatient services. Because beneficiary coinsurance for hospital outpatient services is based on the amount the hospital charges, older people are now paying more than 50 percent in coinsurance rather than the standard 20 percent. We believe that this problem needs to be corrected.

Because so many older Americans view Medicare as vital to their financial security, limiting out-of-pocket expenditures -- both direct and indirect -- is crucial to any Medicare reform package. AARP urges the Committee to keep this in mind as the proposal continues to evolve.

Benefits Package

According to the Leadership proposal -- the Medicare benefits package would be maintained in Medicare fee-for-service and in Medicare Plus plans. The Association welcomes this decision to maintain the fundamental principle of a defined benefits package in Medicare, with leeway for plans to offer additional coverage. We would further urge that any changes in Medicare's reimbursement policy reinforce this decision by guaranteeing that Medicare payment also be adequate to pay for the Medicare benefits package in fee-for-service and Medicare Plus plans. Together, these steps will help to ensure that the program remains a health care plan on which older and disabled Americans can rely now and in future years.

Older Americans view Medicare as a cornerstone of their financial security in addition to relying on the program for health care coverage. If Medicare were transformed from a program that provides a guaranteed package of benefits to a system where government "contributions" no longer paid for needed health care and costs were simply shifted onto beneficiaries, then we would be violating a fundamental tenet of Medicare. At the same time, we are concerned that erosion in the benefits package not be the ultimate result of the greatly reduced growth rate in the program. The 6.1 percent growth rate provided for in the Budget Resolution, provides very little room for Medicare program growth, considering a projected 3.4 percent rate of general inflation and 2 percent growth in the older population. The growth rate does not recognize or leave room for factors that could have a direct bearing on Medicare spending, such as unpredictable trends in health care needs, the development of new technology and a rise in general inflation.

Beneficiary Choice

AARP believes that genuine choice is critical. Many older persons have forged long-standing relationships with providers who understand the breadth of the patient's health care needs. The Leadership proposal suggests that efforts have been taken to initially protect beneficiary choice of plan and provider. The fee-for-service option has been maintained and the outline indicates that Medicare beneficiaries who remain in traditional Medicare will not be required to pay higher deductibles or copays.

This is certainly a step in the right direction, but Medicare's payment policy in both fee-for-service and Medicare Plus could have a powerful influence on beneficiaries' choice and quality of care in the future. AARP continues to be concerned that the cap on Medicare fee-for-service spending could, in time, force beneficiaries -- who prefer fee-for-service -- to leave the coverage option of their choice and sever physician-patient relationships because they could no longer afford to remain in that plan. As we understand the proposal, annual fee-for-service spending would be capped. If spending exceeds the cap, the Secretary would change the payment rates for fee-for-service. It is not clear whether the Secretary could increase beneficiary copayments as well. If so, or if balance billing does not continue to be capped at 15 percent, then the fail-safe mechanism could mean higher out-of-pocket costs for beneficiaries. It could also prove to be a disincentive for providers to treat Medicare beneficiaries in a fee-for-

service setting. In this way, the fail-safe mechanism could result in less beneficiary choice since many beneficiaries would no longer be able to afford fee-for-service. Those that could might well have difficulty finding physicians willing to treat Medicare fee-for-service patients once reimbursement is cut severely to accommodate the Medicare spending reductions required in the Budget Resolution and enforced by the fail-safe mechanism.

Coverage Options

Under the Leadership proposal, Medicare beneficiaries would have a greater range of coverage options -- including expanded managed care, medical savings accounts (MSAs) and provider service networks (PSNs) -- through the creation of a new Medicare Plus program. While AARP supports a broader range of coverage choices for beneficiaries, we need to know much more about how the new coordinated care plans, MSAs and PSNs would work. Who would oversee the administration of the various options? Who would negotiate on behalf of beneficiaries?

We are also concerned about the standards and quality criteria that would apply to Medicare Plus plans and how these standards would be enforced. We have appended to this statement a set of recommendations on quality and consumer protection standards.

It appears from the proposal that federal quality standards would be established but that certification, oversight and enforcement would be left up to the states. What is not clear is what the specific standards would be and whether there would be federal oversight of state certification and enforcement activities.

We are also interested in knowing how a beneficiary would navigate this new system. Could beneficiaries move back and forth between fee-for-service and the various Medicare Plus plans? Would they be expected to "negotiate" payment rates with their providers? Would there be a month-to-month enrollment option to assure that beneficiaries are not locked into a plan that is providing poor service or quality care? What changes, if any, would affect Medicare beneficiaries' ability to purchase Medigap policies? What plans would be in place for data collection and monitoring activities to assess the program? In general, we believe that to the extent that the legislation facilitates movement by beneficiaries between fee-for-service and Medicare Plus, it will promote beneficiary willingness to consider Medicare Plus options.

Because some of the new plan options are relatively untested, there are a number of questions about the specific proposals that need to be raised as well.

Medical Savings Accounts (MSAs): We are pleased that the proposal indicates that a beneficiary who chooses an MSA option would not be expected to pay coinsurance in addition to the premiums for the catastrophic policy and would have a capped deductible. We are concerned, however, about the potential for risk selection within this option.

What is unclear from the proposal, and deserves further attention, is whether Medicare's payment amount for beneficiaries would fully cover the catastrophic insurance policy, how much of the deductible it would cover, whether all beneficiaries choosing this option would pay community-rated premiums for a given plan, and whether the Medicare payments to plans are risk-adjusted. The Leadership proposal indicates that it is possible that beneficiaries who choose this option could find themselves with considerable out-of-pocket expenses if the cost of the plan and the deductible exceed Medicare's payment.

Other questions include: Will plans guarantee issue and renewal to all beneficiaries? How would Medicare's contribution to an MSA be determined? What would the deductible be and what expenses would count toward it? Who will make these administrative decisions?

Given that MSAs are relatively untested in the private market, we believe it is imperative to determine how the catastrophic plans that are part of an MSA option would be structured and whether plans would be subject to state insurance laws.

Expanded Managed Care: The Leadership document also states that several new managed care plans would be available to beneficiaries. We believe that the Medicare program could benefit from some of the innovations occurring in the private health care market, but we also recognize that Medicare's payment structure for managed care needs to be changed in order to make these new options viable for the program and for beneficiaries. The Leadership outline does not address how Medicare's managed care payment system would be changed. Such changes will, of course, be fundamental to the availability of new managed care plans and their success in serving Medicare beneficiaries.

We are pleased that managed care plans will be required to offer the minimum Medicare benefits package but may also offer beneficiaries more generous coverage. Given current trends, however, it is uncertain whether after a few years many plans -- if any -- would be able to offer additional benefits without charging extra for them. For example, fewer Medicare risk contracts now cover prescription drugs. We would caution against marketing coordinated care to beneficiaries on the basis of their ability to get additional benefits for little or no extra cost when this promise may be difficult to keep within a few short years. While reform or complete replacement of the AAPCC is clearly in order, it is as yet unclear how the "proxy premium" system the plan proposes using for payment to managed care plans.

Provider Service Networks: The third option outlined in the Leadership document is the Provider Service Network. AARP is particularly interested in how these entities would be structured and what specific consumer safeguards -- particularly solvency, capital and marketing requirements -- would apply. The proposal is also unclear about whether these entities would be required to be licensed by states.

Union or Association Sponsors: The Leadership proposal would allow health plans sponsored by unions or associations to offer coverage to their Medicare eligible members. The plans would be eligible to contract with Medicare and assume risk for providing health care coverage to beneficiaries who are members of the union or association. While this provision may provide an additional avenue of coverage for some beneficiaries, AARP's concern and focus will continue to be Medicare reform in the broader context.

Fraud and Abuse

AARP is pleased that the proposal addresses fraud and abuse. It is important to note that fraud and abuse prevention activities generate only limited savings, and that improved enforcement will add up-front costs. But left unaddressed, fraud and abuse within the Medicare and Medicaid systems have a corrosive effect on the program and on the public's view of government stewardship generally. Moreover, signaling to the public that this issue is being pursued more aggressively is a necessary first step before the public will be willing to consider other, more contentious strategies to reduce program spending and the deficit.

Conclusion

There is concern and even skepticism on the part of many Medicare beneficiaries about how proposed changes in a program that they have come to depend on will affect them. These beneficiaries and their families need time to understand the changes and assess whether the proposal would build upon -- not erode -- Medicare's promise of financial protection.

AARP and its members also want to ensure that we strengthen Medicare for current and future beneficiaries and their families. To fully achieve this, we need to look beyond the Medicare program to ways in which we can improve our health care system as well by: exploring new approaches and ideas, such as outcomes research that offer the prospect of better medical and program management in the future; establishing mechanisms that assure that the market, with its competing plans, works; and last but not least, that we are able to lower the projected cost of health care while preserving access, quality, choice and affordability.

We believe continued dialogue is critical and we look forward to working with all members of the Committee and other Members of Congress in this effort.

Mr. THOMAS [presiding]. Thank you very much, Mr. Lehrmann. Miss Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, POLICY AND REPRESENTATION, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, Members of the Committee, I am Mary Nell Lehnhard, senior vice president of the Blue Cross & Blue Shield Association. I am here representing the 67 independent Blue Cross & Blue Shield programs. Collectively, our plans provide health benefits for 65 million Americans, including 7 million Medicare beneficiaries with Medicare supplemental coverage and 200,000 Medicare beneficiaries in our Blue Cross & Blue Shield HMOs.

The Medicare Program faces a troubled future. The combination of relentless increases in health care costs and the aging of the population make it imperative to take action. The program needs to be made secure for the future. The leadership's proposal moves us in the right direction. It builds on the proven ability of health care—private health plans to offer high quality, lower cost coverage through formal relationships with physicians, hospitals and other types of health care providers.

The leadership's proposal addresses the need to control the cost of the program. It wisely retains the basic program and the historic mission to assure that all senior citizens have access to a comprehensive range of medical care.

Given the complexity of the issues before us, we will want to examine the legislative language. However, we believe that the leadership has charted a course that is simultaneously incremental and innovating and will be reassuring to senior citizens.

The proposal, first of all, leaves in place the traditional program as an alternative available to all beneficiaries. Second, it expands the private health care options that are available to beneficiaries as a voluntary alternative. Third, we believe it succeeds in harnessing the innovative energy of the private sector to improve the quality and affordability of coverage for seniors.

We believe that competition among health care plans that meet high standards of quality of care and financial stability is the best way to secure the future of the program.

A recently completed survey of Medicare beneficiaries in Blue Cross & Blue Shield HMOs confirms that private health plans can offer more comprehensive benefits at lower cost and with a high level of satisfaction. According to our survey, more Blue Cross & Blue Shield HMO members are very satisfied with their health care coverage than those enrolled in the traditional program, 72 percent compared to 62 percent. And, importantly, satisfaction is high regardless of the individual's health status. But those in poor health, according to the survey, are more likely to be satisfied with their care if they are enrolled in the HMO coverage than in the traditional program, 87 percent versus 81 percent.

In addition, beneficiaries enrolled in HMOs are more satisfied than those in the traditional program when it comes to overall quality of care, access to the latest technology, quality of special-

ists, and their ability to get to specialists when they feel they need them.

We highly support the direction of the proposal, but there are areas we would like to continue to work on with you.

First of all, we believe a broad range of health care options is essential to a healthy, competitive market. However, we believe that all the options should meet the same standards for quality and financial stability. A competitive market strategy won't work if there are different rules for participants.

We find the argument of the National Association of Insurance Commissioners compelling, the urging that all entities engaged in the insurance risk of accepting a Medicare capitation payment in exchange for the promise to pay future benefits to be licensed by the State and meet the quality and financial stability standards for HMOs.

In addition, we urge that current antitrust rules that protect the consumer and, importantly for this proposal, a healthy, competitive marketplace not be changed. We agree with the Physician Payment Review Commission that the existing antitrust law and rules allow the development of any modified health plan.

In conclusion, we commend the leadership for assembling a proposal which is a serious attempt to address the pressing problem of the Medicare Program. We believe this proposal is the first one that will bring Medicare into the mainstream of private health care coverage where every senior citizen can choose their own health care program and, second, one that offers a framework as long as everyone meets the standards. Again, we urge to reward health plans that keep their subscribers highly satisfied.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. Chairmen, and members of the committees, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 67 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 65 million people — including more than 7 million Medicare subscribers with supplemental (MediGap) insurance coverage and 200,000 beneficiaries enrolled in Blue Cross and Blue Shield HMOs. I appreciate the opportunity to testify before you on the House Republican Leadership's Medicare proposal.

The Medicare program faces a troubled future. The combination of relentless increases in health care costs and the aging of the population make action to secure the future of the program imperative. The Leadership's proposal moves in the right direction by building on the proven ability of private health plans in offering millions of Americans under the age of 65 a choice of innovative, high value coverage options.

The Medicare program extends to virtually all seniors the security of knowing that they will always have coverage for needed acute medical care. This security is particularly important to people over the age of sixty-five for whom serious illness is a virtual certainty and not merely a remote possibility. The Leadership has wisely charted a course that renews this commitment.

The Leadership's proposal enables the 104th Congress to reaffirm the goal that was embraced by the 89th Congress thirty years ago: providing the nation's seniors with access to mainstream health care and health care coverage. As we noted in our testimony last July, since 1965 the mainstream of health care coverage has shifted, but Medicare has not. The Leadership's proposal returns Medicare to the mainstream by bringing the program into the 1990s and preparing it to face the 21st Century.

We strongly support the general direction taken in the extensive outline of the Leadership package. Obviously, given the complexity of the issues, we will want to examine the actual legislative language before providing more specific comments and endorsements. However, in general we believe that the Leadership has wisely pursued a strategy that is simultaneously incremental and innovative:

- It leaves in place the existing program as an alternative that will be available to all current and future beneficiaries.

- It expands the private health plan options that are available to Medicare beneficiaries as a voluntary alternative to coverage under the traditional program.

- It strives to harness the innovative energy of private enterprise to continuously improve both the quality and affordability of the coverage available to the nation's seniors.

We believe this is the right way to go. We believe that competition among participating health plans on a level playing field is the best means of securing the future of the Medicare program and meeting the needs of Medicare's current and future beneficiaries. As we review the details of the plan in the days ahead, we will be most concerned in seeing that these goals — which we share with the Leadership — are achieved.

Medicare should expand the range of private health plan options that provide a high value alternative to traditional coverage.

We believe that private health plans can offer Medicare beneficiaries a high value option that may better meet the needs of many beneficiaries than the

combination of traditional coverage with MediGap coverage. We reported in our July testimony that private health plans offer consumers a more comprehensive set of benefits, lower out-of-pocket costs, and a lower premium than the combination of traditional coverage supplemented by a MediGap policy. A recently completed survey comparing Medicare beneficiaries enrolled in Blue Cross and Blue Shield sponsored HMOs to beneficiaries enrolled in the traditional program dramatically confirms this.

- More Blue Cross and Blue Shield Medicare HMO members are 'very satisfied' with their health coverage and medical care than traditional Medicare recipients: 72 percent compared to 62 percent.

- Satisfaction is high regardless of the individual's health status — but those in poor health are more likely to be satisfied with the care and coverage if they are enrolled in an HMO: 87 percent of HMO members in poor health are satisfied, compared to 81 percent of those enrolled in traditional Medicare.

- Subscribers with chronic medical conditions are more likely to be very satisfied with their care and coverage if they are enrolled in an HMO than if they are enrolled in traditional Medicare.

Even more telling are the results for beneficiaries' satisfaction with specific aspects of their care and coverage. Compared to beneficiaries enrolled in traditional Medicare, beneficiaries enrolled in HMOs are:

- 70 percent more likely to be very satisfied with the amount of paperwork they have to cope with;

- 60 percent more likely to be very satisfied with the overall cost of their care and coverage;

- 44 percent more likely to be very satisfied with the cost of preventive care and routine office visits; and,

- 29 percent more likely to be very satisfied with coverage of prescription drugs and education on preventive services.

In addition, beneficiaries enrolled in HMOs are more satisfied than beneficiaries enrolled in traditional Medicare when it comes to the overall quality of care, access to the latest technology, coordination of care, the quality of specialists, the quality of their personal physician, the time they spend with doctors and other staff, and their ability to see specialists. In fact, over 76 percent of HMO enrollees reported being very satisfied with the overall quality of their care — compared to only 66 percent of those enrolled in the traditional program.

We believe that these findings conclusively demonstrate the value that private health plans can deliver — and are already delivering today. They are also strong evidence that the existing requirements of section 1876 for Medicare HMOs are an appropriate framework for assuring quality that should be extended to all health plans that want to enroll Medicare beneficiaries.

We applaud the direction outlined in the Leadership's proposal that would expand the range of health plans available to beneficiaries to include some of the most popular options available to the under-65 population today but denied those enrolled in Medicare: Preferred Provider Organization options and Point-of-Service health plans.

All private health plans should meet the same high standards.

Section 1876 of the Social Security Act establishes a comprehensive set of standards that all (non-supplemental) health plans offered to Medicare beneficiaries must meet. These standards are extensive. The most important of them include:

- ❒ coverage by the private health plan of the services that are covered by Parts A and B of the traditional program;
- ❒ access to health care "24 hours a day, 7 days a week";
- ❒ coverage of emergency services from any provider when it is not reasonable to delay treatment until the patient can reach their health plan provider;
- ❒ clear explanation of benefits, utilization review procedures, and requirements to use network providers;
- ❒ procedures for resolving consumer complaints and grievances;
- ❒ solvency and other financial standards, including state licensure, that assure beneficiaries that their health plan will be able to provide benefits tomorrow as well as today;
- ❒ open enrollment that allows any beneficiary to choose any participating health plan — or to leave that health plan if it does not meet their needs; and,
- ❒ oversight of health plan marketing to prevent health plans from offering coverage only to the healthy.

We believe that all health plans offered to Medicare beneficiaries should meet these same high standards. We believe that the administrative procedures for approval of new health plans can be streamlined, but that the standards that are applied to all health plans should be the same. We do not believe that additional requirements are necessary. The extraordinarily high level of satisfaction revealed by our recent study demonstrates that the existing standards are working to protect vital consumer interests.

In particular, we applaud the efforts that have been made to streamline and simplify the requirements governing the calculation of health plan premiums and contributions. Medicare contributions will be adjusted for geographic and risk factors. The level of Medicare contributions will be 'decoupled' from costs in the traditional program, and instead increase by a defined percentage each year. We believe that this could both simplify the administration of the program and increase predictability for beneficiaries and health plans.

In examining the provisions implementing these changes, we will be particularly concerned to make sure that Medicare's contribution to private health plans increases at the same rate as payments under the traditional program. We also believe that it is particularly important to implement changes in the contribution formula in a way that (1) increases the predictability of payment amounts, and (2) reduces the magnitude of geographic variations in Medicare contributions without disrupting the ability of HMOs to offer the benefits that they offer today.

While we support the direction of the Leadership proposal, we would raise three areas of concern.

While we heartily support the general direction of the Leadership package, there are three areas that we believe need to be closely and critically examined. We believe that these provisions could, if not appropriately structured, cause problems for Medicare in the future.

Unlicensed Health Plans

The Leadership's proposal would allow two new types of entities that would be able to offer coverage: Provider Sponsored Networks and Limited Enrollment Plans. We welcome these new enterprises — as potential customers, partners, colleagues, and — yes — rivals. We believe that they should meet the same high standards that we and other competitors in the market have to meet, including the requirements designed to assure quality and financial stability. We believe that we share with beneficiaries and the Leadership a common commitment to applying the same contracting and quality standards to all entities offering MedicarePlus coverage. Where we may differ with the direction outlined in the proposal is in the application of financial and other standards that are designed to ensure the financial stability of the products that are available to beneficiaries.

We believe that the best, simplest, and most efficient means of achieving this goal of financial stability is to require all health plans to be offered by licensed HMOs or insurers. The fact is that all organizations participating in Medicare will bear risk — which is the hallmark of insurance. That is, they will all accept a capitation payment from Medicare in exchange for a promise to pay future benefits. The fact that they are sponsored by providers does not alter their need for reserves and adequate capital resources.

The National Association of Insurance Commissioners has noted with respect to Provider Sponsored Networks that

> "The states have had a wealth of experience with the effects of similarly unregulated entities, and the experience has not been a good one for consumers... [T]here does not appear to be any regulatory reason to treat these entities differently than their close relatives, health maintenance organizations (HMOs). In fact, in appearance, structure, and services provided, many of these entities are virtually identical to HMOs. Any difference in the appropriate capital and solvency requirements for these entities due to the unique structure of their assets can be accounted for through risk-based capital requirements for the diverse health care organizations in today's market."

There is little question that the financial standards that are applied to insurers must be appropriate to the types of entities offering coverage and the risks that they bear. This is the reason that many states have adopted separate standards for Health Maintenance Organizations. This is also the reason that we have actively supported the development of new 'risk-based capital standards' by the National Association of Insurance Commissioners that would be applied to health companies — a process in which organizations representing providers are active participants. These standards have been under development for over a year, and we expect that they will be completed next year. They are designed to reflect the risk that is assumed by all types of health plan sponsors, including HMOs. The standards specifically are designed to acknowledge that an organizations need for capital may be lessened by adopting different types of provider payment methods.

While we support state licensure for all MedicarePlus options, we recommend three modifications to the Leadership's proposal.

First, the interim standards applied to PSNs — including standards for financial stability — must be equivalent to the requirements that are defined by the NAIC's Model Act for Health Maintenance Organizations.

Second, PSNs must be required to be fully at risk for the costs of the benefits they promise to beneficiaries. That is, the PSN must accept a capitation

payment out of which it will cover the cost of covered services. Medicare should not act as a stop-loss reinsurer for these plans.

Third, there should be a firm sunset on the federal process of certification of these health plans with states assuming ultimate responsibility for regulatory oversight of them.

Medical Savings Accounts

We do not believe that the new options to be made available immediately should include Medical Savings Accounts. Both PPO health plans and POS health plans have a proven track record in the private market. The same cannot be said about MSAs. We believe that the appropriate course is to conduct demonstration projects, as has been done with other significant 'new ideas' such as Medicare Risk Contracting, Social Health Maintenance Organizations, Medicare Hospice Benefits, and Medicare Select.

An evaluation would allow Congress to assess the extent to which these products would offer an option that meets the real needs of beneficiaries and the impact that these products would have on both the traditional program and on competition among private health plans available to beneficiaries. It would allow, for example, a careful assessment of the impact of allowing beneficiaries to use funds deposited in the MSA for non-medical purposes as would be allowed under the Leadership's proposal.

Changes in Anti-trust Guidelines

We believe that anti-trust law is vital for the development of a truly competitive market place that is responsive to consumer demands.

The Department of Justice and Federal Trade Commission have issued interpretive guidelines in both 1993 and 1994 to clarify how the anti-trust law applies to the health care industry. These guidelines recognize that the competitive structure of health care financing and delivery is evolving rapidly and allow for the development of a wide range of innovative arrangements among providers or between providers and health plans. They would allow the formation of virtually any PSN that agrees to accept a capitation payment.

Consequently, we believe that current law and regulation does not present a barrier to *bona fide* efforts by health plans to develop innovative arrangements that will benefit consumers. The Physician Payment Review Commission concluded in their 1995 report that there is no evidence to support contentions that changes are needed in the current anti-trust laws.

Conclusion

In closing, we commend the House Leadership for assembling a proposal that seriously attempts to address the pressing problems of the Medicare program without threatening the characteristics that have been the source of the program's strength. We strongly support efforts to expand the choice of options available to Medicare beneficiaries as consistent with the original goal of the program: to provide seniors with access to mainstream health care and health care coverage.

Mr. SHAW [presiding]. Thank you.

Miss Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. Thank you, Mr. Chairman.

Mr. SHAW. Please correct me if I mispronounced your name. It is a bit unusual.

Ms. IGNAGNI. No, you did very well. Thank you very much.

My name is Karen Ignagni. I am president of GHAA, the Group Health Association of America. We represent 385 HMOs and other managed care organizations providing services to almost 50 million people around the country. We also represent virtually all of the current participants in the Medicare HMO Program.

I would like to say on behalf of GHAA, Mr. Chairman, that we recognize that the proposal before us is a work in progress. We have attempted to offer our comments in that spirit.

I would like to indicate as a beginning point that we believe that the fundamental principle that the proposal advocates, which is building on the best of what the private sector offers and what working Americans have access to now, is a fundamental starting point that deserves to be commended. There is quite a track record out there with respect to performance of plans, with respect to satisfaction, quality, particularly with respect to the point that we are, in many cases, now providing better opportunities for seniors in terms of comprehensiveness and performance of health plans, broader benefits to seniors and particularly with respect to the accomplishments with respect to what our plans have done in terms of driving down overall health care costs in the Medicare Program.

I would like to raise some specific comments which I believe, in listening to previous panelists, in many cases reiterates points that were made before, but I would like to go through them quickly and itemize them for you.

I think choice is a very important principle for our members. The notion of putting in beneficiaries' hands the information that they are going to need to fully evaluate what is out there in the market is a principle that we believe is fundamental and fully support.

Standards are very important, we believe, in terms of moving forward to truly establishing a level playingfield in a competitive market that works where consumers can compare one plan to another. We have in previous testimonies indicated and testified on the importance of a level playingfield across the entire system. There has been major discussion about that principle. And I do concur with Miss Lehnhard's observations that we, too, have concerns about setting up a new structure with respect to regulating new entities. On the other hand, we are encouraged that you are looking to HMO standards as a model.

So we look forward to learning more details, but we do want to flag that as an issue that we would like to continue to talk with you about and provide whatever assistance we can.

In terms of the much debated antimanaged care initiatives that have surfaced both last year and this year and at the State level, we are delighted that the proposal recognizes that antimanaged

care provisions are not a step forward in the debate and would only turn back the clock on the progress that has been made. We hope that that principle will be upheld, and we would like to continue to provide assistance to the Members of this Committee about the implications of those provisions.

On payments, we are very encouraged that the proposal seems to not try to attempt to take a piecemeal approach to payment and to imbue the principle across the delivery system about a level playingfield and the importance of a level playingfield on the fee-for-service side and the so-called managed care side and everything in between.

We do commend the attention to a technical issue which seems small but has been long discussed with respect to current payment methodology which is the notion of moving from a county basis for payment methodology to metropolitan statistical areas. Again, it seems like a technical point, but we believe it is terribly important in terms of dealing with issues that have been raised.

The Metropolitan Statistical Area, or MSA adjustment, is indeed different from the MSA proposal that the last panelist spent so much time talking about; and we would like to flag that, but from the perspective of potential unintended consequences, and would like to engage in continued discussion on that issue as well. We believe as the proposal is further developed that—and the details are fleshed out—there is quite a lot to be encouraged about, quite a lot that takes the accomplishments from the private sector that have worked so well for working Americans. We look forward to commenting on those details and look forward to working with each and every one of you.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF KAREN IGNAGNI
PRESIDENT AND CHIEF EXECUTIVE OFFICER
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. Chairman and members of the Committee, I am Karen Ignagni, President and CEO of the Group Health Association of America. GHAA is the principal national association of health maintenance organizations. Our 385 member plans serve 80 percent of the more than 50 million Americans receiving health care through HMOs today. We represent most of the largest HMOs in the country and many of the very smallest plans.

I very much appreciate your invitation to comment on the proposed Medicare Preservation Act. Recognizing that the Act is a work in progress, we propose to comment in that spirit. Many details, some of them very important, are being ironed out; we look forward to working with you as this process continues.

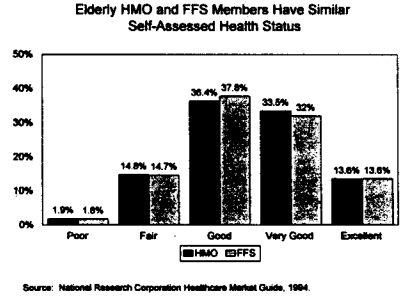
The Medicare Preservation Act is built on a foundation of expanded health plan choices that brings to beneficiaries the best of what the private sector has to offer by recognizing the strengths of the current program -- and adding to it by providing beneficiaries the opportunity to choose the plan that best meets their needs from an array of coverage options.

The Strength of the Current Medicare HMO Program

Over the past two years, the number of beneficiaries enrolled in Medicare HMOs has grown by twenty-five percent. Today, over 3 million Medicare beneficiaries have chosen to enroll in Medicare HMOs.

HMO Medicare enrollees benefit from the many advantages offered by our plans, including an emphasis on preventive services and early intervention when health conditions arise, affordable and predictable out-of-pocket costs, little or no paperwork, and access to a coordinated care system. These advantages for beneficiaries are the foundation for the success of the present Medicare HMO contracting program. This success has been demonstrated in a number of ways -- through its broad enrollment base, member satisfaction, documented quality and savings.

Broad enrollment base: The National Research Corporation found that seniors enrolled in HMOs and in fee-for-service Medicare are very similar in terms of overall self-reported health status and incidence of chronic medical conditions. As shown below, 47.1 percent of HMO members reported that they were in "excellent" or "very good" health, compared with 45.6 percent of fee-for-service enrollees. The percentage in both populations reporting "poor" health was the same, slightly less than 2 percent.



Source: National Research Corporation Healthcare Market Guide, 1994.

Satisfaction: Medicare HMOs attract a broad mix of enrollees, and those enrollees are satisfied with their care. During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers overall are more satisfied with their health plan than fee-for-service subscribers. A recent study on American attitudes toward managed care looked at the numerous enrollee satisfaction surveys and concluded that managed care participants are "overwhelmingly satisfied with their health care."

Quality: Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely

to be diagnosed at an early stage than those in the fee-for-service sector. This is due to coverage of and improved access to preventive care under comprehensive HMO coverage, which is also highlighted in a study by the Centers for Disease Control (CDC) and the National Center for Health Statistics that showed that women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams than those in the fee-for-service sector. Another study, comparing care for patients age 65 and older with acute myocardial infarction (heart attack), concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.

Savings: One important way HMOs lower the rate of increase in spending is by producing savings in the marketplace as a whole (the so-called "spillover" effect).

By promoting competition in an area, HMOs lead to reductions in fee-for-service Medicare costs. A recent study by Price Waterhouse showed that for every 10 percent increase in Medicare HMO penetration there is a 7.6 percent reduction in fee-for-service Medicare costs. Based on the findings of this study, if the percentage of beneficiaries receiving care in Medicare risk HMOs were to increase from its current 6 percent to 20 percent, Medicare would save about $17 billion. This initial decline would be followed by additional yearly savings over current projected costs.

Other studies support this finding. W.P. Welch of the Urban Institute estimated that for metropolitan statistical areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Studies by Glenn Melnick and James Robinson found that hospital costs increased less rapidly in areas of California where HMOs had a larger market share. Jack Hadley and Darrel Gaston of Georgetown University report that hospital costs per admission increased 69 percent in high HMO penetration markets from 1984 to 1993, compared with 96 percent for low HMO penetration markets.

GHAA's Comments on the Medicare Preservation Act

GHAA agrees with the fundamental premise of the Medicare Preservation Act, that Medicare can be strengthened by giving beneficiaries the same kinds of choices that already are available to millions of working Americans both in the private sector and in the federal government. To this end, GHAA agrees that Medicare ought to be reoriented toward a model in which beneficiaries have the opportunity to choose from a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable accountability standards.

When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector. As GHAA has testified previously, Medicare reform should embody the following principles:

- **Beneficiary choices**: Medicare reform should be consistent with the promise of providing access to basic Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population.

- **Comparable standards**: All organized systems of care, as well as providers under the fee-for-service Medicare program, should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.

- **Equitable payments**: To foster an expanded array of choices for Medicare beneficiaries there should be parity among payments to all options available to Medicare beneficiaries. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the traditional fee-for-service Medicare program.

We have reviewed the outline in light of these principles and would like to make the following preliminary comments:

Expanding choices for Medicare beneficiaries. The expansion of choices through the addition of MedicarePlus plans envisioned in the proposal is critical for improving the current program and enhancing the delivery of care provided to beneficiaries. GHAA fully supports the principle that Medicare beneficiaries be given the opportunity to choose the coverage option best suited to their individual needs. Moreover, the private sector market has done much to lower the growth of health care costs and improve quality of care by allowing employers and employees to select among different coverage options on the basis of cost and quality. Many employers and employees have benefited from the ability to choose among different types of coverage options and have been increasingly turning to HMOs and other managed care arrangements to obtain comprehensive, cost-effective, quality care.

Standards for options participating in Medicare. The Act recognizes the need for standards to safeguard the interests of beneficiaries and to ensure that all coverage options remain viable. It also contributes to the establishment of a well-grounded, competitive marketplace by stipulating that all options available to beneficiaries must cover the full range of Medicare Part A and Part B services and assume full risk for providing such coverage. Moreover, we are encouraged that the Act references existing HMO Act standards as a basis for standards for all options.

However, we believe that as the infrastructure of offerings to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for *all* options. Medicare beneficiaries need to be assured that all of the plans they are choosing from meet the same standards regarding access, quality of care, solvency, and grievance procedures. Failure to address these kinds of problems in advance could lead to an erosion in public confidence and a backlash against reform.

Historically, states have performed the function of ensuring that entities entering the market are able to provide adequately as well as to finance the delivery of health care. Meanwhile, HCFA has provided an overall regulatory framework to oversee participation in federal public programs. This current two-tiered regulatory scheme -- federal standards with state oversight responsibility -- has proven effective in ensuring that Medicare beneficiaries are receiving promised benefits and services from viable entities, no matter where they are in the country. The Medicare Preservation Act appears to weaken this structure by allowing selected entities to bypass state licensure. In addition, we are concerned that the existing federal regulatory framework cannot absorb the additional burden of overseeing all aspects of regulation of provider-sponsored options.

Anti-managed care: Expansion of the array of HMOs and other organized systems of care available to Medicare beneficiaries is at the heart of the Medicare Preservation Act. We are pleased that the sponsors of this Act have recognized that the inclusion of provisions that limit choice by inhibiting the development of such systems of care, such as anti-managed care provisions, are counterproductive and undermine the delivery of high quality, cost-effective care through HMOs. However, we believe that provisions that preempt state anti-managed care laws and preempt clinical mandates should be included to ensure that barriers at the state level do not hinder efforts to broaden the choices available to Medicare beneficiaries and to allow all options to compete on the basis of cost and quality.

We are concerned, however, with the Act's inclusion of provisions that weaken current antitrust laws to encourage the development of provider-sponsored networks. Current antitrust laws have proven successful in protecting the interests of consumers. Weakening or eliminating the current structure will create an unlevel playing field, having a negative impact on the quality of health care, and increasing overall program costs. The increasing number of provider-sponsored health plans and physician-directed provider networks is clear evidence that the current structure does not restrict the establishment of such ventures.

MSAs: Medical savings accounts that are linked to catastrophic coverage with very high deductibles merit scrutiny to determine whether, when offered as a health care coverage choice, they could have unintended consequences. Although such an option may appeal to individuals who want to take charge of their own health care finances, it may leave beneficiaries with significant financial obligations. People who choose MSAs may postpone needed checkups and other preventive care in order to "save" money, and may end up with a much more severe

condition, requiring much costlier treatment. Moreover, to the extent that healthy beneficiaries opt out of more comprehensive coverage arrangements, they create an adverse selection problem for the Medicare program as a whole — increasing its costs for everyone else.

GHAA recommends that the Committee consider introducing the Medicare MSA option as a demonstration program in certain areas. This would provide an opportunity to study the actual effects of the design elements of this option on the Medicare marketplace and allow Congress to develop an option that mitigates any negative consequences of the availability of MSA/catastrophic options.

Payment methodologies: The Medicare Preservation Act provides important payment improvements. These include establishing the principle of comparable rates of growth between fee-for-service and MedicarePlus plans, providing predictability in the future rate of growth in plan payment, changing the rating areas from counties to larger geographic areas, building on the current methodology for reimbursing HMOs and competitive medical plans, and beginning to comprehensively address graduate medical education reform, rather than disaggregating the AAPCC. The proposal also recognizes the need to narrow the variation in payment across urban and rural markets. It is important as specifics are developed that the payment policy ensure that the program will be viable on a national basis while not disrupting existing markets in which significant numbers of beneficiaries rely on plans for Medicare services.

Conclusion

The Medicare Preservation Act provides a significant opportunity to increase choices for Medicare beneficiaries, while providing information to beneficiaries to ensure that they can make appropriate choices for themselves. GHAA supports the proposal's fundamental premise of choice and look forward to working with the Committee to help refine the proposal to ensure that a well-structured, competitive market will be established to provide high quality, cost-effective choices for Medicare beneficiaries. We would be pleased to answer any questions that you may have. Thank you.

Mr. THOMAS [presiding]. Thank you, Miss Ignagni, and I appreciate your contributions in the past.

Mr. Troy.

STATEMENT OF JOHN F. TROY, EXECUTIVE VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. TROY. Thank you, Mr. Chairman.

I am John Troy, executive vice president of HIAA, the Health Insurance Association of America. I am delighted to participate in this important hearing on the future of Medicare.

As it turns 30, Medicare is in financial trouble. It needs reform if it is to provide security into the next century. We applaud Congress for taking on this task. We believe you have achieved a balanced and responsible approach to reform.

Medicare is in trouble because it hasn't changed with the times. In its reliance on fee-for-service medicine, it has denied beneficiaries access to newer forms of health care delivery. One way to rejuvenate Medicare is to return to the original vision of ensuring that all seniors have access to health plan options enjoyed by working Americans. Your proposal adopts that concept.

Options available to beneficiaries should include HMOs, point-of-service plans, PPOs, and managed fee-for-service plans. Reform should encourage development of additional alternatives. Beneficiaries should be able to choose the traditional fee-for-service program as well as products that supplement Medicare coverage, including Medicare Select. Over 26 million Americans now have purchased some form of Medicare supplement insurance.

Regarding managed care options, in a recently released survey of Americans' attitudes toward managed care, 5 well-known pollsters combined data from 40 different public opinion studies. They concluded, "Americans in managed care are satisfied with their health care coverage." They went on, "Overwhelmingly the weight of evidence indicates that those enrolled in managed care plans are as satisfied with their health care arrangements as are other Americans."

Obviously, it is difficult to comment on the specifics of a bill when we have not seen legislative language. We are still reviewing the outline in detail.

We are pleased to know, as Karen Ignagni has said, that antimanaged care provisions are not generally included. We hope you will continue this position. These proposals undermine the ability of managed care organizations to deliver high-quality care. The private market is already addressing many of the act's concerns as employers and consumers demand higher quality.

HIAA is extremely pleased that the proposal contains malpractice reform. Malpractice reform would reduce health care costs and improve consumer access.

We are also supportive of the initiatives to eliminate health care fraud and abuse. The overwhelming majority of insurers have developed successful antifraud programs. We are supportive of your proposals which increase beneficiary awareness and your incentives which will complement the increased awareness efforts.

Health care plans have traditionally been marketed and delivered at the local level. Health insurance agents have an under-

standing of people's health insurance needs. Under a reformed Medicare, seniors are going to need help in understanding the plans being offered. Congress should encourage agent participation in the new program.

We welcome competition in the marketplace from provider-sponsored networks. We do understand the need to recognize legitimate differences between PSNs and insurance companies. Currently, there are over 500 PHOs operating in the country, with as many as 1,000 in the process of being formed. While we welcome competition, the public interest will not be served by an unlevel regulatory environment.

Currently, health plans for Medicare beneficiaries conform to Federal and State requirements designed to protect beneficiaries. States have established standards for plan solvency, marketing, quality assurance, and consumer protection. The industry has voluntarily supplemented regulations with effective private accreditation programs.

We believe that all entities that assume risk should be subject to the same standards. The experience of California two decades ago with Prepaid Health Plans, which had minimal operating requirements and profited at the expense of tens of thousands of consumers, teaches us that all entities should be held to the same high standards that are in place today in the marketplace.

Concerning application of antitrust laws, marketplace competition results in lowering cost. The market is constantly changing, with new types of entities forming to provide health care services. Current antitrust law has allowed hundreds of organizations, including many developed by providers, to integrate financially to form networks that are successfully competing in the marketplace. Changing antitrust laws to benefit any new or existing health care entity could allow those entities to circumvent valid protections in place under current law.

We are pleased to see recognition of the need to base government contributions on legitimate risk factors and that the contribution structure is based on the current AAPCC system. We support study of further refinement to the AAPCC methodology. The gradual approach taken to controlling long-term costs by restraining the annual rate of contribution growth is superior to a one-time cut in plan reimbursement rates, which could disrupt markets.

We are also pleased that the MedicarePlus Program recognizes the dangers of beneficiary risk selection between high deductible plans and managed care programs. This recognition, along with appropriate pricing based on beneficiary risk, is vital to ensuring the stability of the program.

Reforming our Medicare system is a monumental task. The Medicare Preservation Act works to achieve a balance between new horizons and maintaining a secure health care system for our Nation's senior citizens. We look forward to working with Congress as it refines its proposal through the legislative process.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF JOHN F. TROY
EXECUTIVE VICE PRESIDENT
HEALTH INSURANCE ASSOCIATION OF AMERICA

I am John F. Troy, Executive Vice President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the nation's leading health insurers, covering 55 million Americans. I am delighted to have the opportunity to participate in this important hearing on the future of the Medicare program.

HIAA member companies are involved in all aspects of Medicare: as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO, CMP and Medicare Select managed care options that have been available to beneficiaries in many parts of the country.

Among the HIAA member companies involved in Medicare managed care are Bankers Life and Casualty, Healthsource, Humana, Intergroup, New York Life, Principal Health Care, Sierra Health and Life, and Wellpoint. Outside of Medicare, our member companies have enrolled over 25 million of the 100 million Americans estimated to be in the private managed care plans. Their record in Medicare is similar. They have enrolled nearly 700,000 of the 3 million seniors covered by plans under contract with Medicare. HIAA member companies provide needed Medicare Supplemental Insurance to nearly 2.5 million Americans.

As it turns 30, Medicare is in financial trouble. It urgently needs reform if it is to provide medical security to its elderly and disabled beneficiaries into the next century. HIAA applauds the Congress for taking on this monumental task. We believe you have acheived a balanced and responsible approach to reforming this critical program.

Medicare is in trouble because it hasn't changed with the times. In its almost exclusive reliance on fee-for-service medicine, it has denied beneficiaries access to newer forms of health care delivery. While Medicare has been stuck in the 1960s, the private sector has moved forward, coming up with innovative ways to provide affordable, quality health care. Thus, one way to rejuvenate Medicare is to return to its original vision: while preserving current options, ensure that all the nation's seniors have access to the same range of health plan options enjoyed today by working Americans. "The Medicare Preservation Act of 1995" does just that.

Taxpayers and beneficiaries alike will be better off if spending for Medicare can be slowed down. To bring cost increases in Medicare in line with those in private sector health care, program options must incorporate both provider and beneficiary incentives for the cost-conscious selection of services. In addition, private sector initiatives to improve quality (while controlling costs) must be applied throughout.

The key to reforming Medicare is harnessing the price and quality competition that has helped to stabilize the cost of coverage and enhance the quality of services in private sector health care.

We agree that Medicare beneficiaries should have access to the full range of health plan options that are available to working Americans. These options should

include HMOs, point-of-service plans, PPOs, and managed fee-for-service plans; reform should also encourage future development of additional creative alternatives. Beneficiaries must also be able to choose the traditional fee-for-service Medicare program as well as private products that supplement Medicare coverage, including Medicare Select.

Harnessing private sector creativity and innovation is the best way to reform Medicare. We can do that by giving beneficiaries broader plan choices - both of comprehensive plans that replace traditional Medicare and of supplemental plans that enhance it and by giving them a financial stake in the choices they make.

Clearly, no single change can solve all of Medicare's problems. Taken together, however, the steps outlined in the proposal will go a long way toward accomplishing the goal of restoring Medicare's financial viability, so that beneficiaries can continue to be assured of coverage that will provide quality services to meet their medical needs.

As managed care networks and Medicare risk contracting becomes more common, and as MediSave emerges, consumers will be faced with more choices. HIAA supports giving consumers more flexibility and additional choices to meet their changing needs. At the same time, we appreciate the fact that this outline recognizes that consumers also want the ability to choose the familiar. That is why we support efforts to give seniors a choice of keeping their Medicare Supplemental insurance policies or Medigap policies. Over 26 million Americans have purchased some form of Medicare Supplemental insurance to protect themselves from rising medical expenses.

For some years, the Medicare Supplemental insurance industry has had additional regulation at the state and federal level to ensure that consumers are protected and claims are paid. These important consumer protections have worked well to ensure that seniors receive value for the premiums they pay.

HIAA believes that seniors will want choices to meet their changing needs. Flexibility and consumer protection are key in this debate. Just as consumers seek to find new benefits at better values, the Medicare Supplemental insurance market also should have an opportunity to have more flexibility and latitude to enter the managed care arena, while ensuring that quality health care services are delivered with proper consumer protections.

One final thought on the supplemental insurance side of the Medicare reform package, we want to express our thanks for the Committee's willingness to work to resolve confusion in the supplemental insurance and long-term care insurance markets as it relates to Medicare nonduplication rules. Although we have not seen the details of the proposal, we believe that corrective legislation is necessary to ensure that all consumers, including those on Medicare, have the option of purchasing supplemental insurance that pays benefits regardless of other coverage and long-term care insurance products that coordinate against Medicare.

Obviously, it is extremely difficult to comment on specifics of a bill when we have not seen legislative language. The outline we received is general in nature, and we have not had time to review it in detail.

The HIAA is extremely pleased that the bill expands options for seniors to mirror those available in the private sector. In a recently released survey of "American Attitudes Toward Managed Care" five well-known pollsters pulled together data from approximately 40 different public option studies from the beginning of 1993 to the present. Their conclusion was "Americans in managed care are satisfied with their health care coverage. Overwhelmingly, the weight of evidence indicates that those enrolled in managed care plans are as satisfied with their health care arrangements as are other Americans." We agree that it is time for Medicare beneficiaries to have expanded access to these types of plans.

It is also important to note that beneficiaries who choose to do so can remain in traditional fee-for-service Medicare. Change is difficult for all Americans, particularly our senior population. We are pleased that remaining in fee-for-service Medicare will be an option in the reformed system.

We also believe that the Medisave plan or Medical Savings Accounts (MSAs) for Medicare beneficiaries will provide another important health care option for seniors. The Medisave plan will help make funds available to seniors for routine care when needed, and empower seniors to make choices that best suits their needs.

In designing the Medisave plan, we applaud the Leadership for recognizing the potential dangers of adverse risk selection and the need for special rules for opting in and out of Medisave plans in order to minimize selection problems. In order to protect the underlying MedicarePlus system and taxpayers from the problems associated with adverse risk, the Medisave plan should go further to discourage individuals from switching back and forth between Medisave and another MedicarePlus plans. Finally, Medisave plan option could be strengthened to protect taxpayers by ensuring that Medisave plans are only used for medical needs.

We were also pleased to note that onerous Patient Protection Act (PPA) standards or other anti-managed care provisions were not included in the outline. We hope that you will be vigilant in keeping anti-managed care provisions from being attached to the bill as it moves through the legislative process. Patient Protection Act proposals compromise patient protection by undermining the ability of managed care organizations to deliver high quality care. Most of the Act's provisions are designed to protect providers, not consumers. The private market is already addressing many of the Act's concerns as employers and consumers demand higher quality health care.

Managed care organizations ensure delivery of quality care by choosing providers who are best qualified and most suited to serve the needs of their members. These providers are willing to have the quality of their care measured to ensure continuous quality improvement. Proposals such as the PPA, however, are anti-competitive and hinder managed care organizations from ensuring the high quality of providers in their networks.

HIAA is extremely pleased the proposal contains malpractice reform. We have served for several years on the Executive Committee of the Health Care Liability Alliance. Enacting malpractice reform is essential to reduce health care costs and improve consumer access to health care services. Effective federal health care liability

reform will enhance the fairness, timeliness and cost effectiveness of the civil justice system in resolving health care injury disputes. Everyone bears the burden of high malpractice costs. These costs are reflected in higher insurance premiums, increasing defensive medicine, and high costs for health products and services. Further, health care liability costs do not result in productive use of our health care dollars. Only 43 cents of every dollar awarded in lawsuits actually goes to the injured party. Even a meritless lawsuit can tie up a physician in court for years, directly taking away from the physicians' ability to provide care to patients.

The bill's provisions would place a statute of limitations on filing claims, limit non-economic damages to $250,000, limit defendant liability for non-economic damages to a proportionate amount, cap punitive damages, and allow periodic payment of non-economic damages, rather than in a lump sum. Many of these provisions build on the "Cox liability amendment" contained in the tort reform bill previously passed by the House. HIAA strongly supports malpractice reform and its application to all defendants, for all claims, under Medicare or otherwise, in claims arising from an injury incurred in the delivery of health care.

HIAA is very supportive of efforts to combat health care fraud and abuse and supports initiatives to eliminate health care fraud and abuse in the government and private sectors. HIAA maintains statistics about fraud in the private health insurance system. As you may know, the overwhelming majority of private health insurers have developed anti-fraud programs, which have been very successful in achieving savings through their anti-fraud activities.

HIAA is supportive of proposals which increase awareness of health care fraud such as the proposal to increase beneficiary awareness of fraud and abuse. This will enable us to educate beneficiaries so that they may become better consumers and be better able to detect fraud and abuse in the health care system. Beneficiaries should be the most informed individuals regarding the types of health care services which they receive and their increased participation is crucial to eliminating fraud and abuse in the health care system. Proposed beneficiary incentives will complement the increased awareness efforts.

HIAA also supports the proposed Medicare Integrity Program, which requires the use of private sector companies, technologies, and software best suited to performing anti-fraud and abuse activities. As I noted before, the private sector has been very successful in developing anti-fraud programs to decrease health care fraud and abuse. HIAA believes that the federal government will benefit by following the lead of the private sector in this area.

According to a report released by the General Accounting Office (GAO) in May, 1992, medical fraud and abuse cost the nation as much as $70 billion, equaling 10 percent of the money the nation spends on health care annually. The GAO estimates that this year the loss could rise to $100 billion. The GAO report concluded that "only a fraction of the fraud and abuse committed against the health care system is identified," and of those abuses that are discovered, fewer still are prosecuted.

Health care fraud affects every citizen because each of us pays the price for health care in the United States: taxpayers who pay for public programs such as Medicare and Medicaid; persons who pay health insurance premiums; and organizations who buy health care coverage for their employees. Every one of us pays higher premiums because of fraud.

According to an HIAA survey, anti-fraud programs implemented by health insurance companies saved $112 million in 1992. These savings represent a cost/benefit ratio of 1 to 9. This is an example of a "good" administrative cost expenditure by the health insurance industry; one that will help keep health insurance premiums low.

The proposal envisions a 2-year transition period before 12-month enrollment becomes the norm. From a practical standpoint, allowing beneficiaries to disenroll and enroll monthly could entail substantial administrative costs to HCFA and private plans. It would also greatly increase uncertainties related to establishing premiums, as MedicarePlus plans could experience significant shifts in the risk-mix of their enrollees during the course of a year.

Health care in this country has traditionally been developed, marketed, regulated, and delivered at the state and local level. Health insurance agents, in particular know people personally and have a good understanding of their health needs and the insurance that would most appropriately meet those needs. Under the reformed Medicare plan, seniors are going to need help in understanding the maze of different and competing plans being offered The health insurance agent is best situated, has the most knowledge, and is the most appropriate individual to provide such assistance. Congress should encourage agent participation in the new program.

HIAA welcomes additional competition in the marketplace from provider sponsored networks (PSNs). We understand the concerns raised in the draft about recognizing legitimate differences between PSNs and insurance companies. Currently, there are 500 PHOs operating in today's market, with as many as 1,000 in the process of being formed. While we welcome competition, we do not welcome competition in an unlevel regulatory environment. If these new entities are not required to operate in the same regulatory environment as others in the market, and can operate under different or perhaps less stringent rules, they will have a market advantage. The National Association of Insurance Commissioners (NAIC) stated in a letter dated September 19, 1995, that the unlevel playing field created by an exemption from state regulation "would likely have unforeseen and potentially negative consequences on the health care market." "A dangerous precedent would be set by such an exemption. Medicare beneficiaries deserve the same protections which state laws affords to other citizens of the states."

Currently, health plans providing health care delivery to Medicare beneficiaries conform to federal and state statutes and regulations designed to protect these beneficiaries. All states have established standards affecting health plan solvency, plan offerings, marketing activities, quality assurance, consumer protection, and other important consumer safeguards. The managed care industry has voluntarily supplemented these statutes and regulations with national, private accreditation programs that have had a significant effect on the way the industry evaluates itself. Medicare managed care plans are required to offer adequate access to services, monitor the quality of care, respond to consumer grievances, and evaluate outcomes.

The HIAA believes that all entities that assume risk for the payment and provision of health services to the public should be subject to the same kind of consumer protection standards. We are concerned that in the eagerness to implement Medicare restructuring, these hard won consumer protection standards, including requirements relating to capitalization, solvency, financial reporting and disclosure not fall victim to the experience of California two decades ago with Prepaid Health Plans, or PHPs. PHPs, which had minimal operating requirements, profited at the expense of tens of thousands of consumers. If the PHP experience teaches us anything, it is that all entities taking on risk to provide services should be held to the same high standards that are in place for insurers and HMOs in the Medicare marketplace.

HIAA recognizes that market based competition between health care financing and delivery systems results in the lowering of health care costs to consumers. The market is constantly changing, with new types of health care entities constantly forming to provide a range of health care services to all consumers, including Medicare beneficiaries. Current antitrust law has allowed hundreds of organizations, including ones developed by physicians, hospitals, and allied health professionals, to integrate financially to form networks that are successfully competing in the market place. However, changing antitrust law to benefit any new or existing health care entity, including those seeking to provide health care services to Medicare beneficiaries, would allow those entities to circumvent protections in place under current law.

We would like to continue to work with the Committee and the Leadership to modify the provisions as they are drafted into legislative language.

We are pleased to see that the need to base contributions on legitimate beneficiary risk factors such as age and geographic location has been clearly recognized. We are particularly pleased to see that the MedicarePlus government contribution structure is based on the current, well-established AAPCC system. We support efforts to study further refinement of the current AAPCC methodology to better reflect beneficiary health care needs. The gradual approach taken to controlling long term costs by restraining the annual rate of contribution growth is superior to an arbitrary, one time cut in plan reimbursement rates, which could disrupt markets, damage the existing managed care infrastructure, and reduce beneficiary access to managed care alternatives.

We are also very pleased that the MedicarePlus program implicitly recognizes the dangers of beneficiary risk selection between high deductible plans and managed care programs. This recognition, along with appropriate pricing based on beneficiary risk, is vital to ensure the stability and cost effectiveness of the total Medicare program.

We agree with the notion that Part B premiums will be set to maintain the portion of Part B costs covered by beneficiaries at 31%. This provision will preserve cost consciousness among beneficiaries while at the same time preserving the affordability of Part B coverage.

The industry recognizes the need to control costs throughout the Medicare program and applauds the drafters' efforts to embrace private sector cost containment

techniques like managed health care. However, the changes to the Medicare Volume Performance Standard and the Hospital Outpatient Formula, and the caps on reimbursement for durable medical equipment, orthotics, prosthetics, and clinical laboratory services could have a significant impact on the supplemental coverage policies seniors purchase to cover costs that Medicare does not reimburse. While it is not possible to quantify this impact at this time, we intend to study the extent of this impact and will provide further analysis to the Committee.

Reforming our Medicare system is a monumental task. "The Medicare Preservation Act of 1995" works to achieve a balance between new horizons and maintaining a secure health care system for our nation's senior citizens. It also attempts to look to the future and deal with the retiring baby-boom generation. HIAA looks forward to working with the Congress as it refines this proposal through the legislative process.

Mr. THOMAS. Thank you, Mr. Troy.

I thank all of the witnesses for their testimony.

I would say, Mr. Troy, that as we looked at new ways in which to provide health care delivery service to seniors approximately two decades ago, the whole concept of managed care HMOs was a new concept; and at that time there was a plea not to be treated like the folk who had been there in the past because you are different.

Notwithstanding the obvious comparison in terms of today's structure, I do want to seriously underscore our commitment, I think, as you have seen in this and you will see later, to make sure we have consumer protection, quality standards, and adequate resources. And we look to you folks to assist us in examining this new structure. It may not be exactly the same, but we want to know your growth experiences during your early days so that we would not commit any of the obvious mistakes that you folks had lived through. It would be a good idea, because I think you are very sound now. You understand what you are doing. You are a very mature operation. And I cannot conceive of a choice structure for Medicare that would not make you folks a major component in it.

Mr. Lehrmann, I want to thank you for your testimony where you say you are pleased to see that we are trying to hold down the direct cost to beneficiaries. As opposed to other projects in town right now, who are examining options on increasing copays and increasing the deductible, we thought it was more important to reform the programs, to put them in a prospective payment structure where they look for savings within a fixed structure rather than trying to get additional funds from beneficiaries. And I appreciate your recognizing our focus in that area.

Mr. LEHRMANN. We did see it, and we wanted to recognize it and let you know that that was one of the targets we had to work on.

Mr. THOMAS. Thank you very much.

Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. Mr. Troy, I am skeptical of your association. I think you are just going to go out and cherrypick the Medicare people. You are going to insure all the healthy ones, and you are going to dump all of the unhealthy ones back on the government. Now, what is to prevent you from doing that?

Mr. TROY. Of course there will be the requirements, the guarantee issue to all comers. And I think we have acknowledged that the subject of risk selection——

Mr. GIBBONS. But at what rate? What will they have to pay?

Mr. TROY. The marketplace we believe is the best place to set the premium rates for the products.

Mr. GIBBONS. In other words, you will be able to cherrypick them because you all are a collusion anyway. You have no antitrust laws. You can put—get together on prices. You can cherrypick the market. You have got all of—you have got the health records of every senior in the United States, and you could go out and cherrypick the market, and you can charge them different rates. That is what you are telling me.

Mr. TROY. The program includes risk adjustors now. We have indicated favorable——

Mr. GIBBONS. Risk adjustment means cherrypicking to me. What is it? What is going to stop you from cherrypicking the market?

Mr. TROY. Well, the guaranteed issue requirements plus the application of any appropriate risk adjustment. In other words, where you adjust premiums to the plans based on the risk of the beneficiaries that they assume. There are risk adjustors in the program now, and we have indicated that there—that subject should be studied and refined further.

Mr. GIBBONS. You are going to risk adjust on the basis of age, aren't you?

Mr. TROY. Yes, sir, that is appropriate.

Mr. GIBBONS. That means that all of the really sick people in Medicare won't get in, because your premium will just be too high on them. Sure, you don't want them. I don't blame your industry for not wanting them. You won't insure some 90-year-old man for anything near a reasonable price that everybody else pays, will you?

Mr. TROY. Mr. Gibbons, I don't think the record shows any favorable risk selection in favor of the HMOs that are in the marketplace now, surely, with respect to the under-65 market.

Mr. GIBBONS. I am not talking about HMOs. People in my area that are in HMOs, most of them are anxious to get out, get out as quickly as they can.

Mr. TROY. The demographic profile of people in HMOs matches the demographic profile of people not in HMOs across the country. There is no indication at all of risk selection on a broad basis in favor of HMOs.

Mr. GIBBONS. Aren't most of the people in HMOs today young and healthy?

Mr. TROY. No. I think, broadly speaking, the profile of the under-65 market pretty much matches.

Mr. GIBBONS. Aren't most of the people who are in HMOs much healthier, much younger, than all the people as a whole that are covered by insurance?

Mr. TROY. I don't think so, Mr. Gibbons.

Mr. GIBBONS. Well, yes or no? Are they? I think they are. I have been told that they are, that the young and healthy people pick an HMO if they have any choice. You all are just going to cherrypick the market. You might as well admit it. Tell me I am wrong. Tell me how I am wrong.

Mr. TROY. I don't think the record supports it with respect to—

Mr. GIBBONS. I am not talking about the record. I am talking about what is in this legislation. What in this legislation is going to stop your insurance companies from cherrypicking the market and leaving the Federal Government, the taxpayers of the Federal Government, to pick up the bill for all the sick people? Tell me what is in there.

Mr. TROY. The ability to apply an appropriate risk adjustment factor if, in fact, a healthier population is going to one plan versus another or with respect to the people remaining in the Medicare fee-for-service program. The plan provides for that.

Ms. IGNAGNI. Mr. Gibbons, perhaps I could add some data to the discussion with respect to your question about who is in HMOs and who are we serving presently.

There is a study that we submitted to the Committee during our last testimony about 1 month ago. I would be delighted to send it

to you. It is based on 1994 data. It is the most comprehensive survey that has been done about the question you posed—14,000 households. It looked at elderly people over 65 in HMOs versus fee-for-service, and it showed on a disease basis, and on a chronic condition basis, they disaggregated by very specific conditions, and they showed that it was an equal match in HMOs and fee-for-service.

Mr. GIBBONS. What—did you all survey yourselves?

Ms. IGNAGNI. No, sir. It was done by the National Research Council, I think, a very respected organization in Wisconsin, 14,000 households; and I would be delighted to provide it to you for the record.

Mr. GIBBONS. Send it up, I will be happy to read it.

Ms. IGNAGNI. Thank you, sir.

[The following was subsequently received:]

Enrollment/Disenrollment Patterns for Medicare Risk Plans

I. Findings

This study provides an analysis of 1994 enrollment/disenrollment patterns for Medicare Risk plans. The results show that 90 percent of members continued in an HMO plan in their area, with 84 percent remaining in the same plan and six percent switching to another area plan. An additional six percent disenrolled due to beneficiary-related factors, and four percent disenrolled to join another fee-for-service plan in the area. These results are consistent with other research studies.

II. Background

Currently, 2.5 million Medicare beneficiaries receive their care through the Medicare Risk program. As the government considers alternative approaches to ensuring the future financial viability of the Medicare program, expanded use of HMOs is one potential option. Therefore, the ability of HMOs to meet the needs of the elderly is an issue of major interest.

Actual experience in the Medicare program provides the best basis for assessing managed care's potential to effectively serve the Medicare population. Accordingly, this study uses 1994 data to look at disenrollment patterns for Medicare HMOs. In contrast to participants in many private-sector plans, Medicare Risk members are permitted to leave the program at any time. The choices they make provide one indication of their satisfaction with the care they are receiving.

Below, the study methods and results are discussed. Then, the findings are compared to those of previous studies.

III. Methods

To determine the overall disenrollment rate for the Medicare Risk program, the study uses data from the Health Care Financing Administration's (HCFA) "Disenrollment Rates Report: National -- Risk HMOs" for the full year 1994. The disenrollment rate is calculated by comparing the total number of disenrollments over the year to the average of beginning of the year enrollment and end of the year enrollment.

To break down the disenrollment further, data were collected from four large risk plans. These plans represent about 40 percent of the risk enrollees nationwide and have a combined disenrollment rate that is similar to the nationwide rate. HCFA Regions 4 and 9 (Atlanta and San Francisco) account for about 93 percent of the enrollment of the sample plans. In comparison, the two regions account for about 68 percent of enrollment for the overall

Medicare Risk program.

The plan data reflect information collected as part of ongoing plan operations. Therefore, the exact approach and organization of the data varies across plans. To aggregate the data, disenrollments were classified into three groupings:

- "Involuntary" disenrollments due to such factors as failure to pay premium, ineligibility, a move out of the service area and death. These disenrollments are beneficiary-related, not plan-related.
- Disenrollments to move to another risk plan in the area.
- Disenrollments to move to fee-for-service care in the area.

For each category, the plan data were used to derive a weighted average rate.

IV. Results

Overall Enrollment/Disenrollment Pattern

As shown in the attached figure, the HCFA data and plan data can be combined to look at the overall enrollment/disenrollment pattern for all enrollees in a year:

- Eighty-four percent of risk plan enrollees remain in their plan.
- Six percent of risk plan enrollees leave their plan to join another risk plan in the area.
- Another six percent of risk plan members leave their plan due to "involuntary" causes, including change in Social Security status, relocation out of their plan's service area, failure to pay plan premiums, and death.
- About four percent of risk plan enrollees leave their plan to switch to fee-for-service care in the area.

Background Analysis

HCFA data shows that 16 percent of Medicare beneficiaries disenrolled in 1994. Based on the plan-specific data, the enrollment/disenrollment pattern for the year can be further broken down:

- About 38 percent of disenrollees leave their plan to join another risk plan in the area.

- Another 37 percent of disenrollees leave their plan due to "involuntary" causes, including change in Social Security status, relocation out of their plan's service area, failure to pay plan premiums, and death.

- About 25 percent of disenrollees leave their plan to switch to fee-for-service care in the area. Thus, looking at voluntary disenrollments, about 60 percent switch to HMOs and 40 percent switch to fee-for-service care.

As noted above, the plan-specific data principally reflects enrollments in HCFA Regions 4 and 9, areas where most Medicare Risk enrollment is concentrated. In other regions, patterns may differ.

V. Comparison to Other Studies

The plan-specific data can be compared to other studies of disenrollment from Medicare risk plans:

The Office of the Inspector General (1995) studied a sample of 1,915 beneficiaries who had disenrolled from Medicare Risk plans. The sample is based on the 87 risk HMOs participating in the program in February 1993. HMOs were stratified into three categories according to disenrollment rate. A sample of beneficiaries from 15 HMOs was then selected randomly from each category. Sixty-one percent of the sample, 1,177 disenrollees, responded to the survey. The study excluded beneficiaries who had died.

The study results are consistent with the findings presented in *Section III*:

- Excluding deaths, the Office of Inspector General study (OIG) finds that 29 percent of disenrollments are for involuntary reasons such as moving and clerical errors. This figure is consistent with findings presented in *Section III* which reports 37 percent of disenrollments are involuntary when deaths are included.

- The OIG study finds that 58 percent of disenrollments involve a switch to another HMO and 42 percent involve a switch to fee-for-service care. These figures are consistent with the findings presented in *Section III* which reports that 60 percent of voluntary disenrollments involve a switch to another HMO and 40 percent involve a switch to fee-for-service care. It should be noted that the OIG figures are not adjusted for involuntary enrollments other than death.

A HCFA-funded Brandeis study (1992) looked at a sample of 17,400 beneficiaries who disenrolled between December 1988 and May 1989. The survey was stratified to reflect the geographic distribution of disenrollments. Disenrollments due to death, administrative error, and termination of Medicare coverage were excluded. For most survey questions, there were over 5,600 respondents.

The study results are consistent with the findings presented in *Section III*:

- The Brandeis study finds that 46 percent of disenrollees switched to another HMO and 54 percent switched to fee-for-service. For beneficiaries with an option of switching to another HMO, however, 62 percent switched to another HMO and 38 percent switched to fee-for-service. These figures are consistent with the findings presented in *Section III* which reports that 60 percent of voluntary disenrollments involve a switch to another HMO and 40 percent involve a switch to fee-for-service care.

HCFA's "Disenrollment Rates Report: National -- Risk HMOs" breaks down disenrollments into three broad categories: switch to another HMO, switch to fee-for-service, and selected involuntary factors (e.g., death, ineligibility).

For 1994, the HCFA adminstrative data shows 33.4 percent of enrollees switch to another HMO, 51.2 percent switch to fee-for-service, and 15.4 percent leave involuntarily. Compared to the survey findings presented in *Section III*, these results show a higher share of disenrollment involving a shift to fee-for-service care and a lower share involving involuntary disenrollment.

Two factors may contribute to the difference. First, in the HCFA study, disenrollments due to some beneficiary-related factors such as a move out of the area appear to be included in the shifts to a new plan rather than in involuntary disenrollments. Second, in the HCFA study, the death-figures are lower than those reported by the plans. This discrepancy may reflect the time lag for noting deaths in the HCFA information system.

SOURCES

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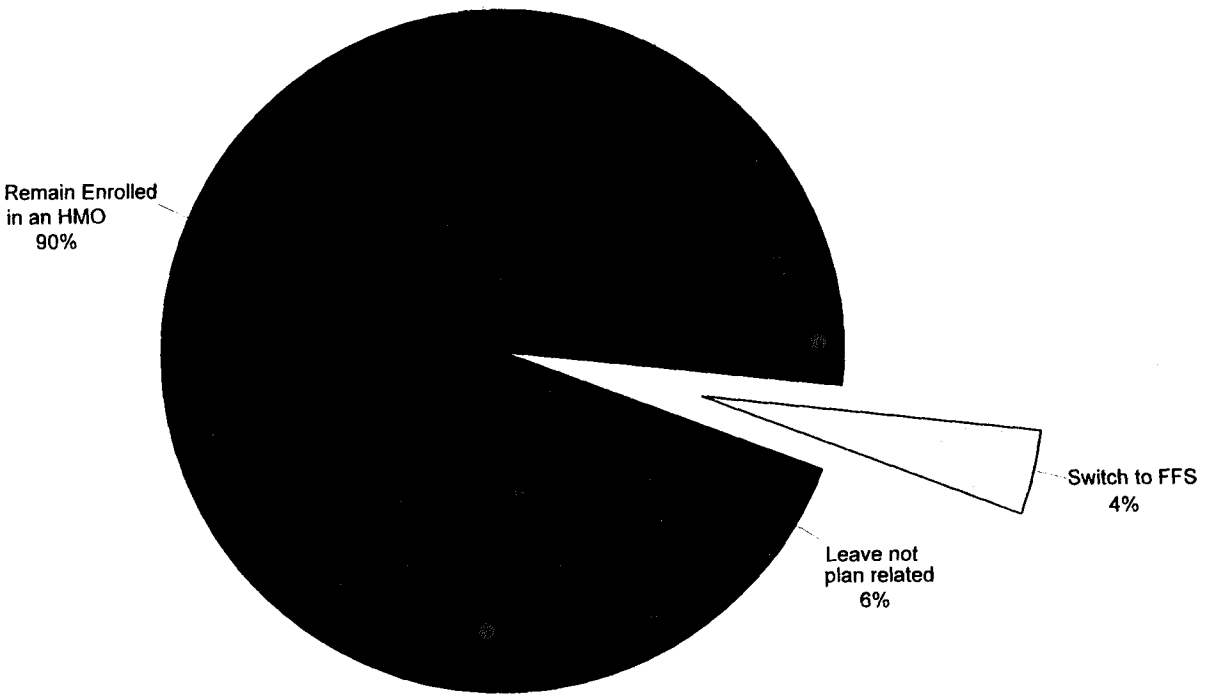
Office of Inspector General, Department of Health and Human Services, "Beneficiary Perspectives of Medicare Risk HMOs", March 1995.

Porell, Frank W., Carolyn Cocotas, Peter J. Perales, Christopher P. Tompkins, and Mitchell Glavin, "Factors Associated with Disenrollment from Medicare HMOs: Findings from a Survey of Disenrollees", July 1992.

Enrollment Patterns In Medicare HMOs*



* 1994 "Disenrollment Rates Report: National -- Risk HMOs" (HCFA)
1994 Data from four large Medicare risk plans

April 27, 1995 RH 6-95

Chronic Illness in the Medicare Population:
Study Finds No Difference Between HMOs and the FFS Sector

Analysis of unpublished data from a National Research Corporation (NRC) survey reveals that elderly individuals are similar in terms of self-assessed health status and the prevalence of chronic medical conditions regardless of health plan type; whether HMOs or fee-for-service (FFS) plans.

I. Background

As part of its Healthcare Market Guide V Survey, the National Research Corporation (NRC) gathered data on health status, service utilization, and plan satisfaction from 200,000 households, a representative sample of the 48 contiguous states. The number of responses was 132,014; a response rate of 66 percent. NRC did not follow up with nonrespondents. The households were balanced to match the U.S. Census percentage distribution in total and within each geographic division with regard to market size, age of household head, annual household income, and household size.

Respondents reported the name and type of their health plan; NRC categorized the plans as HMOs, PPOs, or FFS plans. The primary health care decision maker for each household was asked a series of satisfaction questions and evaluated the performance of the household's primary health care plan. In addition, the survey collected data on up to five household members regarding thirteen specific chronic medical conditions and overall health status.

II. Methods

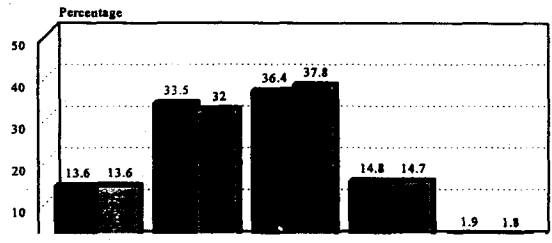
The results reported here focus only on respondents who are primary health care decision makers over age 65. In order to more accurately compare characteristics of this population group across HMOs and FFS coverage, the analysis examines only those metropolitan statistical areas (MSAs) where there were responses for both types of plan. MSAs with respondents enrolled exclusively in an HMO or FFS plan were excluded. Of the 318 MSAs sampled in NRC's survey, 230 MSAs had elderly, primary decision makers enrolled in an HMO or in FFS coverage (72.3% MSAs represented). This resulted in a sample size of 14,695 observations or approximately 11.1% of the total responses for the NRC survey.

III. Results

The study found that in terms of overall self-reported health status and incidence of chronic conditions, HMOs and FFS populations were very similar. The differences between HMOs and FFS plans were not statistically significant. Some of these comparisons are illustrated in the attached table:

- Elderly members in HMOs and FFS coverage have similar perceived health status:
  - + 16.7% of HMO members reported they were in excellent or very good health, compared to 16.5% of FFS enrollees. The percentage in both populations reporting poor health was the same, at 13.6%.
- Individuals with chronic health conditions also look similar in HMOs and FFS coverage:
  - + 19.5% of HMO members reported chronic back pain, compared with 18.3% of FFS members;
  - + 49.2% of HMO members reported arthritis, compared to 49.1% of FFS members;
  - + High blood pressure was reported by 38.6% of HMO members and 39% of FFS enrollees; and
  - + Diabetes was reported by 11.2% of HMO members and 10.4% of FFS enrollees.

Elderly Members in an HMO or FFS Have Similar Perceived Health Stati



Mr. THOMAS. Will the gentleman yield back?

Mr. GIBBONS. Yes.

Mr. THOMAS. Does the gentleman from Florida wish to inquire?

Mr. SHAW. I have no questions except to congratulate the panel of witnesses for a very enlightening testimony. Thank you.

Mr. THOMAS. Does the gentleman from Kentucky wish to inquire?

Mr. BUNNING. Yes, thank you.

I want to ask Hon. Beau Boulter and Jake Hansen, do you have anybody in your groups that are in alternative health care plans rather than Medicare?

Mr. BOULTER. Well, I mean, I know that the United Seniors Association does. You mean among the membership?

Mr. BUNNING. Among your membership, yes.

Mr. BOULTER. Yes, I can; but I can't give you how many.

Mr. BUNNING. In other words, is everybody, 100 percent of your membership, in Medicare? Or do people who continue to work after 65 have employers' sponsored plans and they stay in there?

Mr. BOULTER. The vast majority are in Medicare, but not everybody is in Medicare. Some are in HMOs.

Mr. BUNNING. Mr. Hansen.

Mr. JAKE HANSEN. I would say that is accurate. A lot of people are taking advantage of Medicare Select.

Mr. BUNNING. Of course. Mr. Lehrmann.

Mr. LEHRMANN. We certainly would say about the same thing as far as AARP is concerned.

Mr. BUNNING. Do all three of you have any idea how many people in your organizations also have what are called Medigap Programs?

Mr. BOULTER. Nearly everybody.

Mr. JAKE HANSEN. Over 80 percent.

Mr. LEHRMANN. I would say it is very high, yes.

Mr. BUNNING. Let me ask, how many people in Medicare have anything but fee-for-service? In other words, where the provider would have the ability of an HMO or PPO or whatever it might be.

Mr. BOULTER. Currently?

Mr. BUNNING. Currently.

Mr. BOULTER. About 10 percent.

Ms. IGNAGNI. Ten percent.

Mr. BUNNING. Ten percent. Is that the answer? There is only 10 percent in anything but fee-for-service nationwide?

Ms. IGNAGNI. That is right.

Mr. BUNNING. Mr. Lehrmann, do you think we should have a program that has more options than just Medicare part A and Medicare part B for senior citizens?

Mr. LEHRMANN. Senior citizens——

Mr. BUNNING. Sixty-five and older.

Mr. LEHRMANN. Seniors and older people want to have some choices, and if there are choices that they can utilize appropriately they certainly would take a look at it. We certainly don't object to proposals that include HMOs and other approaches. If they can be appropriately documented and it is a good choice for our members, that is certainly the direction that we would like to move in.

Mr. BUNNING. Wouldn't it be nice if prescription drugs were available to those that are in Medicare?

Mr. LEHRMANN. It has always been a target of ours to include prescription drugs, because prescription drugs create a special problem for older persons.

Mr. BUNNING. Not only for older persons but for anyone who has a maintenance problem.

Mr. LEHRMANN. Yes, yes, persons with diabetes and the like. Absolutely, that is a serious problem.

Mr. BUNNING. There are some provisions, obviously, in this mark, this proposal, that would address prescription drugs in some manner; and I think that we ought to take a strong look and see if it is positive for those that would be covered by Medicare.

Thank you all for your testimony.

Mr. THOMAS. Does the gentleman from New York wish to inquire?

Mr. RANGEL. Just a few questions.

Mr. Hansen, who is the president of your group?

Mr. JAKE HANSEN. A gentleman by the name of Jim Aldige.

Mr. RANGEL. Where is your headquarters?

Mr. JAKE HANSEN. We have headquarters in Fairfax, Virginia. We have our legislative office here on Capitol Hill.

Mr. RANGEL. Outside of those two offices, do you have other offices?

Mr. JAKE HANSEN. No, we do not.

Mr. RANGEL. But your membership is two and a half—how many in your membership?

Mr. JAKE HANSEN. It is 2 million members and supporters. One million people who have paid dues.

Mr. RANGEL. They pay dues?

Mr. JAKE HANSEN. One million who have paid dues, and 1 million who may not be able to afford to, but they want to support and believe in what we believe in.

Mr. RANGEL. Are you organized under the laws of Virginia?

Mr. JAKE HANSEN. Yes, we are.

Mr. RANGEL. Is it a 501(c)(3)?

Mr. JAKE HANSEN. It is a 501(c)(4).

Mr. RANGEL. Do you have a letterhead or post office box or anything?

Mr. JAKE HANSEN. Yes, we have all of those things.

Mr. RANGEL. How long have you been with this Seniors Coalition?

Mr. JAKE HANSEN. I have been with them pretty much since its inception, so about 5 years.

Mr. RANGEL. It is a coalition of many, many different senior groups?

Mr. JAKE HANSEN. It is a coalition of many individual members. Just citizens and people who believe and care.

Mr. RANGEL. No offices in Chicago. If I wanted to find out who from New York was in your coalition, where could—what would I have to do?

Mr. JAKE HANSEN. You would have to contact our office. Either our Washington, DC, or Fairfax office.

Mr. RANGEL. Would it be a problem to send to me the members who come from the New York area?

Mr. JAKE HANSEN. We—as a general rule, we don't just basically make that available; but we would certainly be willing to talk with you about it. You have heard from thousands of our members, and I assume——

Mr. RANGEL. I have?

Mr. JAKE HANSEN. I am sure you have. I can—and that would be easy enough to check.

Mr. RANGEL. They identified themselves as a part of your coalition?

Mr. JAKE HANSEN. Yes, they would.

Mr. THOMAS. Would the gentleman yield? Would you like him to have all those people in New York send you a letter?

Mr. RANGEL. No, I really—if it is on a letter—listen, if seniors are excited about it, and it has just been 60 pages about something I don't know about, and they come from my district, then maybe they can tell me as well as you have testified how great this thing is. So I hope, though, there would be a letterhead or something other than what I have here, because there is not even a telephone number here.

Mr. JAKE HANSEN. I will tell you what. I will send you a package of information about our organization, and I will see if I can find some people——

Mr. RANGEL. Let me add, though, there is not a name or telephone number on their package, either, so we are in good company. Thank you.

Mr. THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Mr. Chairman, I would like to ask the panelists a question, all of you, if you could listen just a second.

There have been a lot of informational questions, specific things that come up, and I am not going to do that. But I have been sort of keeping a list of the general morals that have come out of this session all day.

The first is, don't go to sleep. Let Congress keep on top of this issue. It is important. It is not just a 1-day or a one-bill issue. Second is, go slow, be careful. Third, hinder those who try to play the system. And, fourth, communicate, communicate, communicate.

Would you like to add a moral to that list? Yes, Beau.

Mr. BOULTER. I would. I think it is included in everything you are saying but is just let the marketplace work, give it enough flexibility, keep enough flexibility in there to make sure that the incentives have a chance to work as people experiment, enroll, get out and join these various plans.

Mr. JAKE HANSEN. I would say, believe in seniors. They are a group of people who have had more experience than most and, being consumers, they know what they want. They know what works for them. They will find a way to make sure that they get a product that meets their needs.

Mr. HOUGHTON. Thank you.

Mr. LEHRMANN. I would certainly add that we want to make certain that we protect the people that we are working with, the beneficiaries of Medicare.

Ms. LEHNHARD. I would say follow through on the framework of using the competitive forces of the private sector and create a healthy marketplace, a level playingfield.

Mr. HOUGHTON. OK.

Ms. IGNAGNI. I would say build on what works.

Mr. TROY. I would just underscore letting the marketplace work. It is just starting to work in the last few years, and I think it can bring great benefits to society here.

Mr. HOUGHTON. Thank you very much.

Mr. THOMAS. Thank the gentleman. Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you. I would like to—Mr. Hansen, you say you support the proposal that is advanced by the Republican leadership?

Mr. JAKE HANSEN. Yes, what we have seen so far we are quite happy with.

Mr. MATSUI. What have you seen?

Mr. JAKE HANSEN. We have seen the 60-page plan that has been——

Mr. MATSUI. This document, the Medicare Preservation Act, a better Medicare, right?

Mr. JAKE HANSEN. That is correct.

Mr. MATSUI. OK. You have been able to base your support on these 60 pages?

Mr. JAKE HANSEN. Yes, we can.

Mr. MATSUI. I see. Well, could you tell me what the rate of increase will be from 1996 to the year 2002?

Mr. JAKE HANSEN. I guess in part it depends—I have seen and talked——

Mr. MATSUI. No, do you know what it is?

Mr. JAKE HANSEN. Not exactly.

Mr. MATSUI. Do you know what it will be from the year 2002 beyond and in the indefinite future?

Mr. JAKE HANSEN. No.

Mr. MATSUI. Do you know what the premium increase will be for the average senior citizen when this plan is in effect?

Mr. JAKE HANSEN. Well, let me tell you——

Mr. MATSUI. No, do you know, just yes or no?

Mr. JAKE HANSEN. No.

Mr. MATSUI. Do you happen to know—that is interesting. Do you happen to know how many seniors currently receive Medicare?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. How many?

Mr. JAKE HANSEN. 37 million people are on Medicare.

Mr. MATSUI. OK. So I am glad you know that number because that at least shows me that you have some knowledge of this issue.

Do you know how much will be taken out of part A in terms of the savings?

Mr. JAKE HANSEN. I don't believe that the savings are coming out of part A. I think the savings are coming out of giving people choices and introducing the market.

Mr. MATSUI. You say there are no savings out of part A, that is your understanding? Is that your understanding?

Mr. JAKE HANSEN. Well, I don't think——

Mr. MATSUI. No, it is a yes or no question. Is it or isn't it? Is that your understanding? I am trying to get an answer. Are you saying there is no money being taken out of part A or no cut in the rate of increase out of part A, let me say that?

Mr. JAKE HANSEN. There will definitely be a cut in increase.

Mr. MATSUI. OK. Do you know how much that is?

Mr. JAKE HANSEN. I don't think we can project that.

Mr. MATSUI. OK. Do you know what the cuts in the rate of increase will be out of part B?

Mr. JAKE HANSEN. We can't entirely project that.

Mr. MATSUI. You don't know that, either? Do you know, if I gave you the number 4.3 percent, that that will be the rate of growth for Medicare beyond the year 2002, that will be the new baseline? Do you know what baseline means?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. OK. That will be the new baseline. Can you tell me what impact that might have? Does that give it a 2-percent rate of growth, real rate of growth or zero or minus four or six or what?

Mr. JAKE HANSEN. I think you are going to come up with a very low rate of growth. I can't tell you an exact number. I think it is going to be very good.

Mr. MATSUI. Let me ask you, of your 2 million members, how many are senior citizens?

Mr. JAKE HANSEN. Nearly all of them.

Mr. MATSUI. How many, percentagewise?

Mr. JAKE HANSEN. Sixty-nine percent of our members are over 69 years of age. Eleven percent of our members are under 65 years of age.

Mr. MATSUI. Now, you have—I am assuming you must have a staff that has analyzed this 60-page document so that there is a knowledge base. That is why you came here. You are testifying before the Committee that next week is going to make a decision on cutting $270 billion out of the rate of growth of Medicare, so I am assuming that you at least took the time on behalf of these 69 percent of the 69-year-olds or older, the 2 million people you represent, to analyze this, right?

Mr. JAKE HANSEN. We have taken a lot of time to look at this, yes.

Mr. MATSUI. Right. But you don't know how much is going to be taken out of part A, how much is going to be taken out of part B, you don't know what the actual rate of growth will be over the next 7 years or beyond that.

Mr. JAKE HANSEN. We know that Medicare will be bankrupt in 2002, we know that Medicare has significant problems.

Mr. MATSUI. Have you read the trustee report?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. Oh, good.

Mr. THOMAS. Does the gentleman relinquish the rest of his time?

Mr. MATSUI. I yield.

Mr. THOMAS. Yield back, thank you. Does the gentleman from Iowa wish to inquire?

Mr. NUSSLE. Thank you, Mr. Chairman. I am kind of puzzled. I think maybe America has been watching the O.J. Simpson trial too long. I thought this was a hearing.

Is there a witness at the table who is under subpoena? Are any of you here under subpoena? I think you are all citizens of this country and I don't think any of you are hostile witnesses that I am aware of. Is anyone aware of a hostile witness? You all came here to give us your best advice.

I listened to your testimony, and I learned from it. For 1 minute there I thought I was going to hear the gentleman from New York ask you if you have now been or if you have ever been a member of a senior organization. I thought we were going to go into double jeopardy there for 1 minute just 1 minute ago, can you answer this question, can you answer that question. I mean, we are here to learn, to listen to the seniors and to the country about what to do to save Medicare, and we are getting—you know what is interesting about this, one of the questions that was asked, I am going to ask you the same question, they said have you seen this plan, have you seen the 60-page document?

Is there anyone here that has seen the plan that the Minority Leader said the House Ways and Means Democrats were going to present to us today? Has anyone seen the Democrat plan, an alternative plan? Could you raise your hand if you have? No one has seen a plan? The Democrats don't have a plan, is that what you are telling us?

You have seen our plan, at least some of you have had a chance to look through it. Some of you are going to continue to look through it, but not one of you has seen a plan. Has anyone seen a plan? No one has seen a plan. Well, it is interesting to me that—you know, I have got a statement here from the Minority Leader, Representative Gephardt, on McNeil-Lehrer on September 15, 1995, saying we are going to have an alternative in the Ways and Means Committee, and there is still no plan from the Democrats.

Now, let me turn to our plan, and I would like to ask in particular from Mr. Lehrmann, and this is only a little small nuance, and I guess my first observation, let me say, is that I am very happy, I have met with my AARP members back home in Iowa. They came and they gave me their list that you provided us here today and we talked through it and had a great discussion. I learned a lot; hopefully they learned a lot, but I am sure I learned more.

The thing that impressed me is that they are keeping an open mind, and what I am hearing from you today in your testimony, sir, and what I am hearing from the other senior organizations here today is that you are keeping an open mind, you are looking at the plan, you are studying it, you want to see it continue to develop, but you understand it is a work in progress and you are keeping an open mind; is that correct?

Mr. LEHRMANN. Obviously, we are following what is going on. Truly I haven't had a chance to read the 60-page plan that you are talking about. I am aware of it, and as we go through this process, we are going to analyze the points that I raised each step of the way.

Mr. NUSSLE. The comments I have heard in the newspaper that your organization has made, maybe not through you, and I am not trying to say it was you, personally have been, I would say, surprisingly positive about our efforts so far, and if I am not characterizing it correctly, please characterize it for me, but I didn't hear as

in past efforts—I know your organization in particular has come out when there was a senior issue, and if it was not something you liked, boy, you just—you laid on it right away. I get the impression that that is not the case this time, that you are either happy with our efforts or, you know, you want to at least give us a chance to look through this; is that right?

Mr. LEHRMANN. Well, we are certainly open minded about it. We want to see what is developing and we told you what some of the limitations are, and we are going to pursue those questions with you, not only here, but our members in Iowa will be talking to you I am sure.

Mr. NUSSLE. I have no doubt. They are very good at making sure I know exactly what we need to do. One thing I just wanted to ask, you mentioned that you would be willing to consider $110 billion, what you said trimming the growth. You called our $270 billion a cut.

Now, I just want to—I am not trying to quibble with you, don't get me wrong, but $110 billion trimming the growth and $270—if we only trimmed the growth at $110 billion, would that be the same trim growth or would that be a cut? I just want to make sure that we are talking about the same thing.

Mr. LEHRMANN. We are certainly, if we are reducing the amount that is available to the Hospital Insurance Trust Fund, then on the basis of what we have been having, there will certainly be some adjustments which you could refer to as cuts, yes.

Mr. NUSSLE. OK, so you would be supportive of cutting Medicare at $110 billion is what you are suggesting?

Mr. LEHRMANN. We obviously know that something has to be done. We read the trustees' report, just as you read the trustees' report, and we know that we have to do something in order to keep the program solvent for the next 10 years. You noticed our second statement was that we would go slow as we take the next step, though, because we are looking out many years into the future as we deal with the issues of the baby boomers coming on line, so, yes, we realize that that is a reduction or a cut, whatever you want to call it.

Mr. NUSSLE. We have a plan. We want to get moving, but when you don't have a plan time may not be quite as much a factor, but we have got a plan we want to get moving and we appreciate all your testimony here today.

Thank you.

Mr. LEHRMANN. You're welcome.

Mr. THOMAS. Thank you. Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman. I would like to address this question to any of the panelists who care to respond. Presently we have 11 million beneficiaries of the Medicare Program who earn income under $8,000 a year, mostly they are widowed women or single women. This plan that is being proposed here seems to double the part B premium by the year 2002.

Do any of you think it is fair to ask people who have an income of $8,000 or less per year to absorb a doubling of the part B premium for doctors care?

Mr. BOULTER. If I may, one thing that we were sort of looking at at United Seniors Association is we were hoping that there would be no premium increases. I don't think it is so much an issue of fairness as it is, I think, to create market incentives. You have got to give people an incentive to make a different choice. They don't have to make a different choice, but it is not quite the question you are asking, but I wanted you to understand that that is one thing that we don't like about the plan, although we do think it is a good plan. But it would be better, I think, if it didn't rely on increased premiums.

Mr. COYNE. Anyone else care to comment on that?

Mr. LEHRMANN. Well, we were supportive of the Medicare, qualified Medicare beneficiary plan to help relieve that problem for lower income people, and we certainly believe that is an important part of this.

Mr. JAKE HANSEN. I agree with that, the QMB Program is very important for lower income seniors.

Mr. COYNE. Maybe the better question is do you think people who have incomes of less than $8,000 a year are in any position to absorb a doubling of their premium? Anyone believe that?

Mr. LEHRMANN. Frankly, I don't see how these people can.

Mr. COYNE. Thank you.

Mr. THOMAS. Thank you. Does the gentleman from Ohio wish to inquire?

Mr. PORTMAN. I thank the Chair. I appreciate all the witnesses being so patient with us today and for your good testimony. I have a number of questions.

First of all, with regard to the conversation you had with Mr. Bunning and Mr. Gibbons on managed care, do you have any information—anyone can jump in—as to the level of satisfaction among those 10 percent of seniors who are in some kind of coordinated or managed care?

Ms. IGNAGNI. We do. We have quite a lot of information that has been gleaned by particular plans as well as impartial surveyors, which is quite compelling in terms of a real testimonial for the satisfaction.

The other piece I think that is very relevant that you haven't asked about, but it is the question of whether people stay in HMOs in particular, which is the option now available under Medicare, and what we are finding is that 96 percent of the individuals that have made the choice remain in the HMO environment, which seems to me a real vote of confidence about the satisfaction and the accomplishments of the plans.

Mr. PORTMAN. I have a Medicare task force at home as well. In fact, of our 33 members, 2 are representatives of the local AARP. They have been very constructive. We have had a good dialog over the last few months. One thing they tell me is that although in Cincinnati we don't have an active managed-care option available under Medicare, in Cleveland there is one, and the approval rates, in fact, are slightly higher, one point higher for HMOs with Medicare than they are for HMO for those under 65, which I thought was interesting because I thought although the approval rates were relatively high nationally, I thought perhaps they would be just the opposite with regard to those in Medicare.

Ms. LEHNHARD. Yes, we just completed a survey of Blue Cross & Blue Shield subscribers in our Medicare HMOs in 13 States, and we surveyed both the beneficiaries in HMO and people who are in the traditional program, and we found the satisfaction rate higher among those in HMOs, but the most important thing we found was that those with chronic illnesses had a higher satisfaction rate with the HMO.

In all this talk about whether you have access to specialists or not, the chronically ill in the HMOs were highly satisfied at an 87 percent versus 81 percent of the traditional program, so the sicker they were, the more they liked their HMO.

Mr. PORTMAN. Mr. Lehrmann.

Mr. LEHRMANN. I would just comment there was some question, I thought I heard earlier today, that there aren't very many people in an HMO. I have been in a cost HMO for the last 11 years in Madison, Wisconsin, and for me it has worked quite well. Having said that, I would not say it is for everybody, but it has worked out all right as far as I am concerned.

Mr. PORTMAN. That is fascinating. I wonder why—and I know there is some availability or access issues here—but why we are only at 10 percent then among the Medicare-eligible population in terms of HMOs? Could someone give us an answer to that?

Ms. LEHNHARD. I think they don't know about the availability. There is no organized effort to get out information about HMOs. I would go back to the earlier point about adverse selection. We think the best way to make sure that adverse selection doesn't occur, and we don't think it occurs now, but the best way to protect against that is to have a very organized effort to inform beneficiaries that they have these choices.

If you put a program, we know this with the Federal employees program, we have 4 million Federal employees in our coverage. If you put a scale, a chart in front of them and say these are your extra benefits in an HMO, and it includes prescription drugs, we know we are going to enroll people who will use prescription drugs. We welcome that kind of mass merchandising to Medicare beneficiaries to let them know it is available.

Mr. PORTMAN. Let me ask one more question with regard to the affluence test that we haven't touched on in this hearing. I read the AARP testimony. It is interesting a lot of seniors with whom I have talked at town meetings and even in my task force support affluence testing. Mr. Lehrmann, you seem to be saying that as long as there isn't affluence testing among those under 65 in the health care area, it wasn't fair for seniors to be subject to it under Medicare. I wonder what your personal thoughts are on it and whether there has been some discussion of that within your organization.

Mr. LEHRMANN. Yes, our organization has talked about it, and we believe that in fairness if you are going to use the affluence test for Medicare beneficiaries, then what about those who are wealthier in the rest of society, shouldn't they be put to the same test because they are getting their health care benefits paid for and are not paying any taxes on that benefit?

Mr. PORTMAN. You suggest that the subsidy should be changed with regard to income?

Mr. LEHRMANN. That is right.

Mr. PORTMAN. I would say in some respects the affluence testing is the flip side to Mr. Coyne's concerns, and I think the two actually go well together. I have many more questions, but I want to thank you all for being here and thank the Chair.

Mr. THOMAS. Thank the gentleman. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Yes, thank you. Thank you, Mr. Chairman. Mr. Boulter, does your organization support the portion of the Republican plan that would increase the premiums?

Mr. BOULTER. Well, as I have said earlier, Mr. Levin, if you just isolate that, no, we do not. We are not for increasing the premium.

Mr. LEVIN. All right, that is a straight answer. So you oppose that part of the proposal?

Mr. BOULTER. Maybe that will get changed. It is a work in progress, it probably won't. It won't stop us from supporting the plan, but we have been on record for a long, long time in opposing premium increases, and we do oppose them.

Mr. THOMAS. Will the gentleman yield? I don't know where in our plan there is an increased premium. The premium remains the same.

Mr. LEVIN. It does over current law, under current law the premiums go back to 25 percent and then to the cost of living.

Mr. THOMAS. Is that in effect now?

Mr. LEVIN. That is the current law.

Mr. THOMAS. It is 31.5——

Mr. LEVIN. The premium works out to 31.5. Under current law it reverts to 25 percent and then to the COLA.

Mr. BOULTER. If I may, just to complete the answer, we think that is appropriate, that you maintain it at 31.5.

Mr. LEVIN. That is the increase, Mr. Boulter. I don't quite understand that. Under current law the premium in 2002, this is an estimate, would be about $61. Under the Republican proposal the estimate is, this depends in part on the overall cost of part B, it would be $93 to $95 to $97. That is an increase of $32, $33 over current law.

Mr. BOULTER. What I am trying to say is that we can understand if you are wanting to reduce cost why the Committee or Members of Congress might want to maintain it at 31 percent. However, our position would be that in the best of all worlds what we would rather see, frankly, is raising, you won't like this either, raising copayments or raising deductibles.

Mr. LEVIN. I take it that you don't support the premium portion, but let's leave your testimony as it is. Let me just ask you then about raising deductibles. You say in your statement that it should not be a hardship on the elderly. However, you should know that we also advocate special assistance to help low-income seniors handle these higher payments.

Are you aware that the majority proposal on Medicaid would eliminate those Federal supports?

Mr. BOULTER. I am sorry, I am not hearing you. Say that again, please.

Mr. LEVIN. Are you aware that the majority's Medicaid proposal would eliminate Federal support for the payment of those premiums for low-income seniors, are you aware of that?

Mr. BOULTER. I am not an expert at this Medicaid reform, but my understanding is that I believe in the block grant program that the States will be required to maintain a certain level of funding for those people.

Mr. LEVIN. There weren't hearings on that bill, either, so it is hard to tell.

Mr. BOULTER. If I am right.

Mr. LEVIN. I am not sure, it just came out of Committee. Mr. Hansen, let me just ask you quickly, does your organization receive its moneys only from individuals?

Mr. JAKE HANSEN. That is correct. Ninety-eight percent of our money comes from individuals.

Mr. LEVIN. You receive no organizational——

Mr. JAKE HANSEN. A small amount we have received money from, we have advertising in our newspaper and there have been a few corporations that have made small contributions to us, relatively small.

Mr. LEVIN. Mr. Boulter, does your organization?

Mr. BOULTER. One hundred percent.

Mr. LEVIN. Let me just ask, I understand the Senate majority bill would raise the eligibility age for Medicare so that it would be in 19—2003, it would start increasing from 65 to 67. This is for Medicare now. Paralleling the Social Security old age cash benefits. Does your organization support that?

Mr. BOULTER. United Seniors Association does support that.

Mr. LEVIN. Mr. Hansen.

Mr. JAKE HANSEN. I would think it makes a great deal of sense to have the eligibility age track along the Social Security.

Mr. LEVIN. Mr. Lehrmann.

Mr. LEHRMANN. We haven't decided exactly what our position would be on Medicare. It is one of the components in the long-term correction of this problem that would have to be taken into consideration.

Mr. LEVIN. OK, thank you very much.

Mr. THOMAS. The gentleman from Texas.

Mr. LAUGHLIN. Thank you, Mr. Chairman. Mr. Lehrmann, as president of the American Association of Retired Persons, does your organization discuss or have any position on the generational tax fairness that Mr. King testified about this morning? Were you here when he testified?

Mr. LEHRMANN. I didn't hear all of his testimony.

Mr. LAUGHLIN. Are you familiar with that terminology?

Mr. LEHRMANN. No, I am not.

Mr. LAUGHLIN. Can you tell us whether your organization has taken any position on whether the senior citizens are receiving benefits and the younger people entering the work force are paying a disproportionately higher payroll tax to support the benefits? That hasn't entered into your organization's discussion?

Mr. LEHRMANN. We haven't taken a position on that.

Mr. LAUGHLIN. All right. In fairness I won't ask you any more on that. Mr. Hansen, has your organization discussed generational tax fairness?

Mr. JAKE HANSEN. We have discussed that, and we have asked our members what they feel about that.

Mr. LAUGHLIN. What are your members telling you?

Mr. JAKE HANSEN. That there is definitely concern. They want to leave a better world for their children. They aren't particularly interested in leaving their children massive amounts of debt. They are concerned about what type of life their children are going to have. There is definitely that awareness and concern about that.

Mr. LAUGHLIN. What is the general age range of your membership? Is there a minimum age that you have to achieve before you can join?

Mr. JAKE HANSEN. We suggest that people have to be interested and concerned about the issues, and that generally translates to people over 65, and the majority of our people are over 69 years of age, but we were surprised to find out that we have got, you know, a big chunk of people who are under 65.

Mr. LAUGHLIN. Well, Congressman Boulter, does your organization take any position on generational tax fairness?

Mr. BOULTER. No. We have discussed it a lot. We haven't polled our members, but we have discussed it a lot. It just makes sense to us that you have got to have the support of the younger working Americans for this program, and if you just keep raising the payroll tax, you will lose that support. We think it is an important issue. That is one reason we do like your plan because it does not do that.

Mr. LAUGHLIN. I would just ask Mr. Lehrmann, Mr. Hansen, or Congressman Boulter, if you have an opinion as to whether it would be a major concern to your senior citizen membership if Congress were to make no changes and it became necessary to have a 40-percent payroll tax increase to support the current system with no reform. Would that be of concern to your membership?

Mr. LEHRMANN. Oh, yes, yes. Certainly if there was substantial increase of that magnitude, we certainly would be concerned about it.

Mr. JAKE HANSEN. That would be tragic.

Mr. LAUGHLIN. Congressman Boulter.

Mr. BOULTER. It would destroy the program.

Mr. LAUGHLIN. That is all the questions I have.

Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Yes, thank you, Mr. Chairman.

Looking at this group before me I can see they have very intergenerational interests. I wonder if any of you would like to comment on the $270 billion of Medicare cuts and the $180 billion of Medicaid cuts we are looking at.

I read a Lewin study not too long ago that suggests that this could result in higher premiums for individuals not involved in the Medicare Program and could possibly impact on wages because we are having this—really $450 billion is a huge shift in dollars. So I wonder if any of you had read that account or if not, if you thought that when we are facing this number of dollars in shifts

that we might see some things that we might not want to see down the line.

Mr. Troy, you were with an insurance company, so you understand cost shifts.

Mr. TROY. Yes, Congresswoman, I guess that the general concept of the proposal which involves applying marketplace forces fully to the Medicare Program, we feel that that will have a very favorable long-term effect on the rates of increase of health care costs, so that——

Mrs. KENNELLY. Could you just explain that just a little bit more. A favorable impact? The Lewin report said there might be a negative impact on wages and on cost shifts from Medicare patients to younger sick people.

Mr. TROY. We believe that long term that the changes that are involved in this will reduce the overall rate of inflation on health care costs from what it would have been without offering these kind of options to the Medicare beneficiaries, so long term it has positive effects I think both on the Medicare costs and on the cost of private insurance premiums for those not on Medicare.

Ms. IGNAGNI. Mrs. Kennelly, to amplify what Mr. Troy has just observed, we have just submitted to the Congressional Budget Office a study that was done for us by Price Waterhouse, which I believe is one of the most comprehensive studies on the so-called spillover effect which is the impact of what is happening in managed care and the impact that it has on total Medicare costs, which definitely shows a significant downward pressure, and I would be delighted to submit it for the record here.

[The Price Waterhouse study dated September 11, 1995, is being held in the Committee's files.]

Mrs. KENNELLY. Well, thank you, and I certainly hope that is the results that we see, and I guess there is a difference of opinion in some of these reports, but certainly we all would hope that the costs would be lower for people.

Thank you very much.

Mr. THOMAS. The gentlewoman relinquishes her time. Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I appreciate that opportunity.

Mr. Lehrmann, Mr. Hansen, Congressman Boulter, I am delighted to find you here because we have been having this day-long hearing, and you are here as the representatives of the beneficiaries more than any other witnesses that we have had here today.

I am not sure every person on this Committee is delighted you are here, but I certainly am, and I appreciate your taking the time to represent your constituents. A couple of features of the MedicarePlus Program that I would like you to comment on.

I think, Mr. Lehrmann, you have already commented on the affluence test, but for all three of you, I would like you to comment on the affluence test for Medicare beneficiaries who already have an upper income and, second of all, the feature that there is no increase in deductibles and copays over the 7-year period.

Mr. Boulter.

Mr. BOULTER. I personally don't think there is anything philosophically wrong or unfair about the affluence test, but having said that, I just think it is not a good reform. I don't think it is what is needed to reform the Medicare system, and I don't think you get that much money out of it, either, and as I have said, I think it is better to rely on an increase in the deductible, for example, and I think maybe if there needs to be, that some assistance could be given to lower end people, lower income people, but I would rather go that route. So I don't object on a fairness basis personally, but I don't think it is a significant reform.

Mr. ENGLISH. Mr. Hansen.

Mr. JAKE HANSEN. I think you have to take it as a part of the whole, and as a part of the whole of saving Medicare. It is something that is probably needed to be done. It is important to keep in mind that Medicare part B comes out of the general treasury. It is not part of a trust fund. We would not look very kindly on means testing of a trust fund.

Mr. ENGLISH. Mr. Lehrmann.

Mr. LEHRMANN. Well, you heard my comment before on that. As far as raising deductibles and copayments, we certainly think that that is not a route to go because you really, if you do that, target those who are the most vulnerable, those who are the sickest and neediest in the whole process.

Mr. ENGLISH. I agree with you, and I think most of the seniors in my district agree as well. I have been out and I have had myself a Medicare task force which, by the way, also has the representative of your organization for our congressional district involved, and I think she has played a very valuable role in our deliberations.

Mr. Lehrmann, in commenting on fraud and abuse, which I think is part of the solution to this problem, you raised the concern that fraud and abuse enforcement might raise up front costs. In my bill I use additional fines to finance the fraud and abuse effort. Would your organization find that acceptable?

Mr. LEHRMANN. Well, we certainly agree that we ought to do what we can to deal with this issue of fraud and abuse, and I don't know that we have actually taken a position on what you suggested, Mr. English, but we certainly would take a look at it, but by all means we believe we ought to address this issue.

Mr. ENGLISH. Thank you. I appreciate your comments. They have been thoughtful and responsible.

Ms. Lehnhard, Ms. Ignagni and Mr. Troy, a question for you. Given that in the MedicarePlus proposal there is the option of limited enrollment plans and provider-sponsored networks, could you comment on what is the appropriate level of regulation of those sorts of organizations?

Ms. IGNAGNI. To state it very simply, we believe there should be a consistent level of regulation, a uniform level of regulation across the spectrum of participants in the health care arena to assure consumer protection, adequacy of performance within the system, and to assure that we can compare as consumers one plan to another.

Ms. LEHNHARD. I would agree with that, and I would note that the—I think NAIC, the National Association of Insurance Commissioners, has recognized this. They have done a great deal of work

on what they call the risk-based capital adjustments and very simply in lay persons terms this would mean that you could apply this risk-based capital test to any type of entity. A big insurance company would have to have a lot of reserves. A PSN wouldn't have to have very many reserves, but the State could apply this across the board, and apply the same quality and contracting standards to everyone, but the solvency test would fluctuate.

That is what we think should be done, the State should do it all, but recognize that not everybody has to have the big reserves of an insurance company.

Mr. TROY. I think where the plan is heading and where the proposal is heading is trying to create a competitive marketplace, as much of a competitive marketplace as possible, and I think that absolutely requires a level playingfield in terms of the regulations in order to make the marketplace work properly, and that will result in the savings that you are looking for.

Mr. ENGLISH. Thank you so much.

Mr. THOMAS. The gentleman's time has expired. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I think all of us understand that the Medicare system is going to change. It is not only going to change over the next 7 years, it is going to change over time, and all of us hope that there are more opportunities and choice for our seniors and more participation and types of plans the seniors can participate in.

We are at a disadvantage at this hearing because we don't have the specifics of the Republican proposal, but one of my major concerns is whether seniors under that proposal will have more choice or whether they are going to be forced into plans that will give them less choice of their health care provider than they want. They may be, in effect, required to go into that type of plan because the fee-for-service option is going to erode so much that health care providers won't participate in the fee-for-service plans, doctors won't participate, or the cost factors will become such that seniors will be forced into a managed care plan because of cost, not because of additional benefits coming into that plan.

I guess that is my major concern about the parameters of trying to implement a $270 billion cut, and we have been talking in rather abstract terms, and I agree that there is a lot to be gained by more competition and more opportunities from the private sector.

My question is, if we could just agree or assume for purposes of this question, you start with the same base. Is it reasonable to assume that Medicare can grow at a slower growth rate than private insurance can grow? If we start with the same base, is there something about the elderly that we can assume that their health care needs can grow at a slower growth rate than the under 65 population, again, assuming we start at the same base?

We can argue whether Medicare has performed or outperformed private insurance. It has worked differently than private insurance, but let's assume we can start at the same base and go forward. Is there something about our seniors that their health care can grow at a slower growth rate than the people under 65?

Ms. LEHNHARD. Mr. Cardin, I can't give you the specific numbers, and I can't even tell you that you can grow Medicare at a

slower rate than the private sector, but I would make the observation, and our Blue Cross & Blue Shield plans have told me this, that Medicare hasn't had the exposure to market competition. There is very little energy from managed care in Medicare and they make the observation constantly that you could maintain a very high level of quality in Medicare, reduce the length of stay, reduce the use of services, increase the satisfaction.

Mr. CARDIN. I want to start at the same base. I don't mean to interrupt you, but——

Ms. LEHNHARD. The base is very high.

Mr. CARDIN. Some of the best witnesses we had before our Committee were some of the people who testified from the private employment marketplace and how well they were doing in their private companies. The question I asked at that time was, Is there anyone here from a private company who would take their employees or retirees once they reach 65 at what they are spending, and we will give you the same growth rate that is in the Republican bill here, would they take that employee and keep that employee in their private health care plan at a growth rate of about 4 percent, and I didn't have any takers.

For purposes of my question, I want to assume we start at the same base because we could argue whether we are at the same base or not. Can you keep senior health care at a slower growth rate than those under 65 if we start at the same base? Someone who is in your plan today turns 65, can you manage their health care at a slower growth rate than someone under 65?

Mr. TROY. I would assume that the growth rates would be fairly similar between the over and under 65. However, as Mary now said, if you currently have a higher base because you haven't introduced as much competition into that market, then there would be a short-term lower rate of growth expected under that scenario.

Mr. CARDIN. I acknowledge that. I tried for purposes of assumption to assume that we are at the same base. I understand your arguments.

Ms. IGNAGNI. Mr. Cardin, one of the observations I would make that has long been discussed throughout the last several years about Medicare in particular, we have not yet moved forward on the following agenda, is the notion of marrying part A and B, the efficiencies that would result, the many aspects of the private sector plans that have been incorporated into whether it is HMOs, PPOs, other kinds of alternative delivery systems or coordinated care where you are doing case management, where you are looking at the appropriate utilization of services, where you are concentrating on bringing people in at the earliest stage.

There are a lot of things, and actually to acknowledge the statement that I believe Bruce Vladeck made rather recently, I know HCFA is moving and beginning to move in this direction, and I believe that there are considerable savings to result directly related to your question of getting at the base before we begin in terms of looking at the profiles on both sides, and I think that initiative that puts us on the same footing and that is to say that looks at rate of growth across the spectrum of alternatives, fee-for-service and managed care, whatever that might be in that block of managed

care would be very much relevant and very much the same sort of strategy that——

Mr. CARDIN. My time has expired, but the bottom line is if we start at the same base there is no reason to expect seniors' health care to grow at a slower growth rate than private insurance, if we start at the same base?

Thank you, Mr. Chairman.

Mr. THOMAS. Certainly. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Yes, thank you, Mr. Chairman. I also want to thank the panel for their time today and waiting until this late hour. Mr. Lehrmann, I also want to thank you for your help because it has been a constructive addition to this whole dilemma that we have been faced with this past year.

I also had a Medicare Advisory Council this year and one of the members on the Medicare Advisory Council was Mary Jane O'Gara, who represents the AARP in the Omaha area. She had a lot of constructive input. We didn't always agree, but we worked together and we are still working together, and that is a part of this whole process.

I wanted to ask Miss Lehnhard, Miss Ignagni, and Mr. Troy about the PSN provision and how you thought it would impact the rural area. Even though I don't represent a rural area, I come from rural Nebraska and so I am very concerned about where we are moving in that area as well.

I think PSNs, provider-sponsored networks, may be something that can be very, very attractive for the rural area as well as medical savings accounts. Do you have a favorite of those two or which one do you think might be a better approach for rural America?

Ms. LEHNHARD. We welcome the competition from PSNs, and, in fact, we are partnering with them in many places, including rural areas. We always cover the entire State, and often have managed-care arrangements in the rural areas, and again, as we have said, as I have said earlier, we welcome their participation in Medicare. We just want the same rules applied to them.

I would say that I think PSNs are probably one of the options for rural areas. I can't comment so much on medical savings accounts because, again, that is going to be, we believe it is going to be very difficult to manage the risk selection in MSAs, and we have suggested that there be demonstration projects and perhaps rural areas are an ideal place to start with those demonstration projects.

Ms. IGNAGNI. As you know, Mr. Christensen, there is quite a lot of activity now with respect to plans to develop alternative delivery systems in rural areas. A number of our plans have moved and have plans to move very directly into rural areas to offer the benefit package that has worked so well in other areas. We also welcome the competition, but do believe that there is a matter of fair play here, uniform standards, and that is the principle that we are advocating, that, indeed, that there be a multiplicity of players in the system.

The point is that we would hope that the Committee might consider standards that would ensure that there is fair play, and there is no competitive advantage that would be associated with one delivery system versus another. I was very encouraged to hear the

Chairman's observation that he is interested in some feedback from us, and I think speaking for my colleagues, we plan to provide assistance with respect to the definitions of particular elements of those standards, and we look forward to working with you on that.

Mr. CHRISTENSEN. Mr. Troy.

Mr. TROY. Yes, I would underscore the fact that managed care is very active in many rural areas. I think some of the Members of Congress have traveled out to New Mexico to see the extent of managed care in that State, which is one of the most rural States. Also, there are, of course, many HMOs today which are provider-sponsored plans which are what you would call the PSNs in this bill which have become licensed in the States and are fully competitive with HMOs that aren't sponsored by providers.

Mr. CHRISTENSEN. Thank you. And thank you again for your testimony here today.

Mr. THOMAS. The gentleman from Georgia, Mr. Lewis, does he wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. Mr. Chairman, I yield to Barbara Kennelly, my colleague from Connecticut.

Mrs. KENNELLY. Thank you. I will try to be quick. Thank you very much, Mr. Lewis.

Mr. Troy and some of the other members who have experience in this, Dr. Gail Wilensky was with us today and as you know she has a strong background in health care. She cautioned us the most difficult thing that will be before us is to find a risk adjuster for these new choices if we don't want to find all the older, sicker, frailer people in the traditional Medicare Program and the healthy people in the other choices.

Mr. Troy, I know you have had a long number of years in insurance. Now, you should understand that risk adjuster concept very well. Could you share with us how we might meet this challenge?

Mr. TROY. Thank you, Congresswoman, and I appreciate the comments previously made by Mr. Gibbons on this same subject. We do agree that an appropriate risk adjustment mechanism between the options, including the fee-for-service option is needed, necessary for the long-term viability of the program. There are risk adjusters that apply, that are applied now, and further study should be made.

With respect to Medicare, you would have the health history, for example, of all of the beneficiaries, their permanent health histories. This could be applied as a prospective risk adjuster. There are also fairly simple retrospective risk adjusters that could be applied if it turned out that a plan, for example, based on specified diagnoses—categories ended up with much more or much less numbers of these categories of high cost or low cost cases than the average would call for.

These have been tried, for example, in New York with some success where New York has a combination of a risk adjuster, which includes a specified disease mechanism and a reinsurance program with some other demographic adjustments built in, so it is a very important subject. No one would downplay it, but I do not consider it an Achilles heel of going forward with the choices.

Mrs. KENNELLY. Thank you, Mr. Troy. Thank you very much, Mr. Lewis.

Mr. LEWIS. Thank you.

Mr. Hansen, you said earlier that about one-half of your members couldn't afford to pay dues, yet my colleague from Pennsylvania, Mr. Coyne, pointed out that this plan would include higher premiums for seniors, that combined with the end of help for seniors through Medicaid would hurt seniors. Don't you think this would hurt your membership?

Mr. HANSEN. Well, we are concerned and we will watch that, but we are more concerned about what would happen if Medicare just wasn't there. We think it is imperative to have a Medicare and we think the way to control the costs of Medicare is to try to get the market to help push that down.

We think that some of the alternatives that are going to arise will actually end up helping the poorest seniors more. Some of the managed-care options are going to make it unnecessary to purchase Medigap-type policies and I think there are going to be a lot of powerful and positive things to come from it. And it is certainly far more important to do something and do it now and start moving down the track than to get to the point where we are at 2002 and we have nothing to turn to.

Mr. LEWIS. Mr. Hansen, I don't know much about your organization, but let me just—I received some cards in my office in Atlanta and some cards here in Washington, maybe a few hundred. Did you poll your membership about this plan?

Mr. JAKE HANSEN. We have had extensive communications with our membership. We have done polling, we have done focus groups, we have had questionnaires in our newspaper.

Mr. LEWIS. Have you polled them since yesterday? You just got this 60-page——

Mr. JAKE HANSEN. What we have done is we have talked to our members about the basic ideas that we know, the basic set of ideas.

Mr. LEWIS. Before my time expires, how many members do you have in the State of Georgia?

Mr. JAKE HANSEN. I can't tell you off the top of my head.

Mr. LEWIS. Let me ask you another question, is it true that this organization was investigated by the attorney general of the State of New York for involvement in a pattern of fraud and abuse?

Mr. JAKE HANSEN. It is true that there were investigations and nothing came of them.

Mr. LEWIS. Were you fined by the State of Pennsylvania?

Mr. JAKE HANSEN. There were fines right as we were founded because we were several days late with——

Mr. LEWIS. Were you also prohibited from soliciting forms in the State of Maryland?

Mr. JAKE HANSEN. For about 2 days, then the Attorney General apologized.

Mr. LEWIS. And you feel that you are qualified to come here and testify on behalf of the senior citizens of America?

Mr. JAKE HANSEN. Absolutely.

Mr. LEWIS. Thank you, Mr. Hansen.

Mr. THOMAS. Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. No.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Thank you very much, Mr. Chairman.

When we were back home in August, I spent a number of days with some of Mr. Lehrmann's members in AARP and to talk about how they felt about Medicare and Medicare changes and so forth, and one of the issues that continued to come up was the issue of choice, and the plan that is before us is in some ways dealing with the issue of choice.

However, in an area like mine, which is a medically underserved rural area that generally has very low reimbursement rates in terms of the AAPCC, it seems that it is probably unlikely that there will be more choices available for the citizens that I represent as a result of this plan or I should say perhaps there will be. This is a question. And so I was interested in what Ms. Lehnhard or what Ms. Ignagni might say concerning that particular observation on my part and do you think that is correct, and what has been done in this plan to perhaps improve choice for rural underserved areas, like the one that I represent?

Ms. IGNAGNI. Two points. I believe that what struck us as we read the document, the first is the technical change that I referred to that sounds small, but can have some major impacts in areas such as yours, which is the change from a countywide basis to a metropolitan statistical area, point number one.

Point number two, the notion of looking at the variation in payment and trying to deal with the challenge that exists for rural areas, and we were very much interested in the observation in the paper with respect to that principle and point of view and plan to work very closely with all Members of the Committee to provide whatever assistance and help we can to get on to that job.

Mr. PAYNE. So the change that occurs here is the change from the county to the MSA generally, do you think? You said it is small, but it may be significant. Is that significant enough that in an area like mine—and I know you don't know the demographics in the area I represent—but areas that are rural underserved, do you think it is likely there will be some immediate differences as a result of this or is this more likely to be looked at in the second phase as the AAPCC amounts are generally looked at and hopefully try to make it more uniform across the country?

Ms. IGNAGNI. I think you have asked a very important question, and there are a series of answers to it. The technical observations I made with respect to the basis for payment as well as the way we compute payments and look at dealing with the challenges of rural areas. The second is expanding the choices and seeing the trend toward more participants and more entities, whether they be HMO, PPO, PSN, or physician-operated delivery systems offering services and providing some real interest in offering services in those areas.

The third is to put in the beneficiaries' hands the information they need to compare the spectrum of plans in particular areas, so I think it would be wrong to conclude from anything certainly I have observed that there is just the technical issue that would solve this problem, that would be terribly presumptuous.

I see it as a package of initiatives that were referred to in the paper that I think are very encouraging in terms of dealing with many of the challenges that you have raised, and indeed actually

put together some of the proposals that have been discussed over the last several years, which we think is very encouraging.

Ms. LEHNHARD. I would also say since we cover the entire State in all cases that the products that we have found most popular and most feasible to put in place in rural areas aren't allowed under Medicare, and that is the point-of-service option and the PPO option, and we think our plans would have immediate interest in those, particularly in rural areas.

Mr. PAYNE. You are saying they are not allowed under Medicare today?

Ms. LEHNHARD. Right now the only option is the closed panel HMO, and that is one of the things we are excited about is that we would be able to introduce the most popular product on the market, which is the point-of-service option.

Mr. PAYNE. But don't you think those areas that have the lowest reimbursement rates likely will be the last ones to find that they have the most choices?

Ms. LEHNHARD. I think you have to couple what I said about the product with the technical—not only the technical but the important changes in the move from county to metropolitan, statistical metropolitan area calculation, and those two things combined you will see some action.

Mr. PAYNE. And, beyond that, don't you think we need to continue to look at some of these reimbursement rates to make sure that they are more equitable across the country?

Ms. LEHNHARD. Absolutely. It is not only the counties to city issue, it is the State to State issue, and you may be running into that in your State, also.

Mr. PAYNE. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. If no other Member wishes to inquire, I want to thank the panel.

Just as a footnote, obviously, we are searching for that formula which would allow us to determine what portion of risk. If we had that, that would make our lives a lot easier. Good luck in trying to find it. And I am hopeful that these are the kinds of structures that we will have in the future that will allow us an honest relative assessment so that we can maximize the number of options available to seniors. I want to thank those representing the seniors as well.

I will ask the last panel of the day to come forward. The last panel consists of Gail Warden, chairman, Board of Trustees, American Hospital Association—good to see you again; Dr. John Seward, chairman, Board of Trustees, American Medical Association; Tom Scully, president and chief executive officer of the Federation of American Health Systems; Sister Carol Keehan, president and chief executive officer, Providence Hospital and the Carrol Manor Nursing Home in Washington, DC; and Dr. Gerald Thomson, president, American College of Physicians.

I want to welcome all of you to the Ways and Means Committee hearing on Medicare, and I would say that your written statement will be made a part of the record in its entirety and that you will have 5 minutes to enlighten and inform the Committee in any way you see fit.

Gail, if you would like to begin.

STATEMENT OF GAIL WARDEN, CHAIRMAN, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. WARDEN. Thank you, Mr. Chairman.

I am Gail Warden, the president of the Henry Ford Health System in Detroit and the chairman of the American Hospital Association. On behalf of America's hospitals I want to thank the Committee for inviting us to testify today as we have had an opportunity to do on a number of occasions about the future of Medicare.

As we approach this subject, I suppose one way to put it is we have both some good news and some bad news about the Medicare spending proposal, and I will start with the bad news and then go to the good news.

We feel that hospitals and health systems are facing a double whammy. Providers, including hospitals, are going to bear the brunt of reductions made in the overall program and then hospitals will bear the brunt of most of the reductions that are made to providers. Quite frankly, this is not what we had understood it would be. We have throughout the budget process maintained that the burden of Medicare reductions should be shared by everyone with a stake in Medicare.

Based on a quick estimate of the Medicare Preservation Act, hospital reductions are in excess of $75 billion over 7 years, and we are still counting. This does not include the reductions that may be made as a result of the look-back mechanism, as pointed out by Mr. Altman this afternoon. In fact, the reductions in Medicare payments to hospitals may be so steep that they won't even keep up with general inflation, because Medicare spending for hospitals is already growing much slower than the rest of the program, about 6.9 percent a year over the next 7 years, compared to 10 percent for the program overall according to CBO.

Deep reductions in hospital payments could lead to such small rates of increase that they do not even cover inflation, which is projected to average 3.3 percent annually as measured by the CPI. In economic terms, this means a real cut. And as a health care provider, not a lobbyist, I can assure you that in health care terms they do mean a cut.

What do these reductions mean to a typical 150-bed hospital? They mean about $11 million less revenue between 1996 and 2002; for a 250-bed hospital, it is $17 million; and for the typical hospital with 300 or more beds, it is $49 million less revenue. For my own organization, it is $234 million over 7 years. For all types of hospitals, these reductions, obviously, are threats to access and service, to their ability to form networks in many areas, to their very existence.

We strongly urge the Committee to keep its promise that hospitals would not be cut in this budget process. We support restructuring the health care system, and we certainly support restructuring Medicare, but to do it we need strong hospitals and health systems.

We also need the tools to do the job right, and this is where I get to the good news. The package included provider-sponsored networks as an option for Medicare beneficiaries, and you have talked

about them throughout the day. This is a key tool, and we congratulate you for recognizing it as such.

These networks, PSNs as we call them, are local affiliations of providers organized and operated to provide health care services in their communities. They provide a good opportunity to ensure patient choice, to give a patient more choice of plans, an opportunity to avoid disruption of the relationship between the patient, the physician, the hospital, and the community. PSNs offer an opportunity to provide choice in areas that do not have a coordinated care plan. And they also are important to us because in many States it takes as much as 2 years or more to get an HMO license. We are pleased to see that these are included in the budget plan. However, of course, the devil is in the details.

We also believe that PSNs can offer us a solid middle ground for seniors somewhere between fee-for-service and full-fledged HMO, and we are concerned that the PSNs may be treated more like insurance companies than health care providers. Obviously, clarification needs to be made about these programs and how they might work and how they would be regulated.

We are also pleased with the effort you have made to remove barriers to network building, such as modifications to self-referral and the antikickback law. We were particularly pleased about the changes that were made in liability reform.

But we do have one other concern and that relates to the concept of the look-back mechanism. We understand that it would apply to all Medicare spending in excess of targets. We feel that it should only be applied to those programs that relate to managed care. The total amount that can be recaptured should be capped at the targeted savings for managed care, which we believe is $60 billion—an amount the program could reasonably expect managed care to save over 7 years.

Beyond that, we believe an independent commission like that proposed by Representative Phil English is best suited to objectively determine how to allocate—among all stakeholders—the spending reductions a look-back may call for.

Mr. Chairman, hospitals and health systems share this panel's goal of restructuring Medicare. Given the right tools, we believe we can help you get the job done; but the ability of hospitals to provide even basic care could be jeopardized by what we see as real spending cuts. We urge you to consider the important changes we have outlined as the plan is debated in the Committee and on the floor.

Thank you.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
Committee on Ways and Means
of the
United States House of Representatives
on
Saving Medicare

September 22, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit, Michigan, and chairman of the American Hospital Association. AHA includes in its membership 5,000 hospitals, health systems, networks and other providers of care. I am pleased to testify today on their behalf.

America's hospitals and health systems are at the forefront of change in the way health care is being delivered. In communities all across the country, hospitals and health systems are looking for new and better ways to do their job. They are forming partnerships and creating integrated systems of care that are designed not just to treat illness and injury, but to make the communities they serve healthier.

This is health care reform at its finest -- and Congress should be commended for recognizing that it is time for Medicare to take part in this progress. There has been a lot said about restructuring the Medicare program, and we understand there are some positive steps being considered that move toward that goal in the Medicare Preservation Act. That's the good news. The bad news is that the plan apparently does not go far enough to help us continue those reforms. More importantly, we have to question the Congress' commitment to those reforms when, in the same plan, it appears that a level of spending reductions in Medicare is proposed that could affect quality and access to care for millions of Americans.

THE BAD NEWS -- MEDICARE SPENDING REDUCTIONS

Although the proposed reductions have been referred to as a slowdown in the rate of growth of Medicare spending -- from 10 percent annually to 6.4 percent annually -- the fact is that for hospitals and health systems, they could translate into real cuts if payments don't keep up with general inflation.

How could this happen when the budget resolution would allow per-beneficiary spending to increase 40 percent over the next seven years, from $4800 to $6700? Because Medicare spending for hospital services is growing much more slowly than the rest of the program. CBO projects that, under current law, Medicare spending for hospital services will grow 6.9 percent a year over the 1996-2002 period, compared with about 10 percent for the Medicare program overall. On a per-beneficiary basis, under current law, payments to hospitals are projected to grow by only 5.5 percent each year, compared with more than 8 percent for the program overall.

The deep reductions in payments for Medicare hospital services that are being considered could, therefore, lead to such small rates of increase for hospitals that they do not even cover

general inflation -- which is projected to average 3.3 percent annually, as measured by the Consumer Price Index. Payments that do not at least cover inflation will force hospitals to try and provide the same range and quality of services with fewer and fewer resources, an extremely difficult if not impossible task -- and one that most hospitals are already struggling with in the current market.

Based on a quick estimate of the Medicare Preservation Act, the specific hospitals reductions are in excess of $75 billion over seven years -- and we're still counting. This does not include further reductions that would be made in hospital payments as a result of the fail-safe, or "look-back," mechanism.

What do these reductions mean to the typical 150-bed hospital?
- $11 million less revenue between 1996 and 2002.

What do these reductions mean to the typical 250-bed hospital?
- $17 million less revenue between 1996 and 2002.

What do these reductions mean to the typical hospital with 300 or more beds?
- $49 million less revenue between 1996 and 2002.

While this committee deals with Medicare and not Medicaid, I must point out that proposed Medicaid reductions, when added to the Medicare reductions being considered, will increase these losses substantially.

For all types of hospitals, these reductions could:
- Threaten the very future of hospitals in the neediest communities. Large cuts in Medicare spending hit the most financially vulnerable hospitals hardest, often the ones that need to remain open to ensure access and coverage to underserved populations.
- Restrict access or availability of important services often offered at a financial loss -- including trauma care, burn units and neonatal intensive care.
- Limit the ability of hospitals to focus on the health of their community. Prevention, health promotion, community outreach and education may be scaled back or sacrificed in cost-cutting efforts.
- Jeopardize the local economy through forced layoffs and cutbacks in purchasing. As major employers and purchasers of goods, hospitals are a vital part of the economic fabric of their communities.
- Stymie their efforts to collaborate within the community to provide cost-effective and patient-friendly networks of care.

Shared responsibility

America's hospitals and health systems have urged throughout this budget process that shared responsibility should be the guiding principle behind any reductions in Medicare spending. It has been our understanding that Congress agreed. However, the reports that we are getting about the realities of the Medicare Preservation Act concern us. Hospitals face a double-whammy: a disproportionate share of the overall Medicare reductions would be borne by providers -- including hospitals and health systems; and a disproportionate share of provider reductions would be borne by hospitals and health systems. In fact, we estimate that hospitals face in excess of $75 billion in reductions through traditional means -- a figure that does not include potential reductions from a look-back mechanism, but is already disproportionately higher than reductions to others with a stake in Medicare.

Hospitals and health systems are willing to work to both reduce the budget deficit and ensure that the Hospital Insurance Trust Fund remains solvent. But both goals must be arrived at through shared responsibility.

Initiatives that move Medicare toward our vision of coordinated health care can serve patients better *and* save money. But, saving the current goal of $270 billion over seven years should mean a financial effect on everyone with a stake in Medicare -- hospitals and health systems, physicians, other providers, and beneficiaries. Doing business the old-fashioned way -- just

cutting provider payments -- is not the answer. To address Medicare's long-term problems, everything must be on the table: program structure, benefits, beneficiary cost-sharing, eligibility, and program revenues, as well as provider payments.

In the past, hospitals coped with Medicare spending reductions by passing the difference on to other payers, like non-Medicare patients and their employers. That's called cost-shifting. But those days are fast disappearing, and these reductions are unprecedented. The market is shutting down the cost-shift option. Managed care contracts and a growing number of employers and private insurers who negotiate discounted prices are making it a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or, ultimately, shut their doors altogether. Any one of these options takes us further from our mission of providing the highest-quality care to the people we serve, including America's elderly, poor and disabled. At the same time, deep reductions to provider payments could stifle the local innovation and progress that are key to restructuring the Medicare program.

THE GOOD NEWS: EXPANDING COORDINATED CARE OPTIONS

Hospitals and health care systems have a great deal at stake in expanding coordinated care options under the Medicare program. First and foremost, we believe that locally based coordinated care systems hold great promise in improving the quality and continuity of care, as well as improving the efficiency of health care delivery. The document released yesterday suggests that the Medicare Preservation Act recognizes that promise, at least conceptually.

However, we need to ensure that Congress provides the specific tools needed to make coordinated care options available to beneficiaries, and to encourage beneficiaries to select those options.

Provider-Sponsored Networks

Medicare beneficiaries who want to choose coordinated care rather than fee-for-service coverage have just two choices: a health maintenance organization (HMO) or a competitive medical plan (CMP). These plans are important elements in a restructured health care delivery system, but Medicare must look beyond these two options.

The Medicare Preservation Act recognizes the benefits and savings that can be achieved through locally based networks of care -- what we call provider-sponsored networks. PSNs are formal affiliations of health care providers, organized and operated to provide health care services. These networks commonly take the form of physician-hospital organizations or independent practice associations, and are often called integrated delivery systems.

Many PSNs have formed HMOs, or have become partners with insurers to do so. But still more have not become HMOs. Some serve populations that are too small or too sick to support the full risk of an HMO. Some are in states where it reportedly takes up to two years to get an HMO license. Others are in areas where Medicare's HMO payment is simply too low to provide adequate care. Others are in areas where it could be economic suicide to compete with local insurers for private enrollees.

The Medicare program should take full advantage of the health care innovations and efficiencies offered by PSNs by allowing them to contract directly with Medicare. Medicare will need many new entrants into the coordinated care market in order to give seniors a wide range of health plan choices.

We agree that any entity delivering care to Medicare beneficiaries must meet high standards. But current regulatory thinking could limit the ability of PSNs to serve Medicare beneficiaries.

We propose that PSNs would have to meet all the same consumer protection standards as currently required by Medicare for other risk contractors, except that PSNs would meet

higher quality standards and different but comparable solvency standards, and they would not be required to have at least as many private enrollees as Medicare and Medicaid enrollees (Medicare's so-called "50/50" rule).

A modified solvency standard is important because PSNs directly provide, not buy, most of the services that are covered. As a result, the standard should recognize that most of a PSN's assets need to be invested in its capacity to deliver health care services, not in the more liquid assets needed by insurers to pay claims to providers. It is their receipt of capitated payment that many insurance regulators equate with an insurance function, which triggers the perceived need for insurer-like solvency requirements. PSNs are actually paid in many ways, not just capitation, so it is important to put this in context with the rest of their operation. The solvency standard we have proposed is generally equivalent to the national model HMO act (which is actually higher than some state HMO requirements), with changes to reflect the primary PSN function of health care delivery and avoid any unreasonable financial barrier for rural PSNs.

A key difference between our proposed PSN direct contracts and other Medicare risk contractors is that PSNs would not be required to directly enroll private individuals. In the private sector, PSNs contract to deliver coordinated care to enrollees of HMOs, self-insured employers, and other health plans. They do not generally engage in enrolling individuals. Medicare's current "50/50 requirement" forces PSNs to directly compete for the private enrollees of the same plans with whom they have contracts to deliver services -- a step that generally disrupts those contractual relationships.

PSNs, while required to meet federal standards, should not also be required to be licensed by the state in order to direct contract with Medicare. State HMO licensure is a process that can be burdensome, slow and unsuitable for PSNs -- blocking the availability of a broader range of options for America's seniors. And we fear that the state regulatory process will become more problematic, as state insurance regulators try to force new and evolving health care delivery structures into existing regulatory structures.

Thus far, we have seen only a conceptual description of the budget plan's approach to provider-sponsored networks. We greatly appreciate that PSNs are included in the Medicare Preservation Act, but we continue to have real concerns that the promise of provider-sponsored networks may not be realized under the Medicare program.

For example:

- **Timeline that provides a jump start for insurers.** The description indicates that insurers would be allowed to offer expanded options to Medicare beneficiaries well before PSNs would be allowed to do so (as much as 11 months), allowing them to corner the market before PSNs are allowed to compete. To ensure a level playing field, all new Medicare private plan options should be required to become available simultaneously to Medicare beneficiaries.

- **Timing of PSN standards.** In an earlier draft document made available to AHA, the framework of regulatory deadlines and effective dates indicated that PSNs would be subject to a set of transitional standards that would take six months to issue, even though they are based predominantly on the current HMO/CMP standards, and another six months to apply in the certification process -- only to be supplanted two years later by a permanent set of standards, the development of which would be turned over to state insurance regulators under the auspices of the National Association of Insurance Commissioners (NAIC). The secretary of Health and Human Services (HHS) would not have any authority to reject or modify NAIC's standards. This would tie up PSNs in a process of constantly changing regulatory requirements for the first three to four years. PSNs need a lengthy period of stable federal oversight (preempting state regulation) to ensure substantial PSN participation in markets around the country; NAIC's role should be limited to an advisory one. PSN standards should be issued on a fast-track basis (by April 1, 1996).

- **Solvency standard.** The description also indicated that the American Academy of Actuaries (AAA) would be given the open-ended task of developing a PSN solvency standard, again without any apparent ability on the part of the HHS secretary to reject or modify it. The provision that AAA develop the PSN solvency standard should be significantly altered. AAA should modify the current NAIC model HMO solvency standard only to the extent necessary to conform to the provider service delivery environment of a PSN, and to avoid any unreasonably high financial hurdle for rural PSNs. It also should be clarified that the role of AAA is advisory to the HHS secretary.

- **Shared-risk payment arrangements.** We understand that some in Congress may be unwilling to allow a shared-risk as well as full-risk payment option for PSNs. We believe that is unfortunate, because shared risk may be the only means of bringing coordinated care arrangements to some rural and chronic care Medicare populations. If Congress insists on excluding shared-risk arrangements for PSNs at the outset, we urge that HHS be given explicit demonstration authority to develop and demonstrate such arrangements.

Barriers to integration

There are other barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation -- the heart of coordinated care.

For instance:

- The provision of health care services has long been considered a charitable and, therefore, tax-exempt activity. However, current tax exemption guidelines for non-profit providers have not kept pace with the trend toward coordinated care. Tax policy should create opportunities for non-profit health care providers to integrate and provide coordinated care services. Not-for-profit HMOs currently enjoy tax exemption, and should continue to do so. In addition, we support including in the budget plan a provision giving statutory tax exemption to provider-sponsored networks that meet vigorous community benefit requirements.

- We are pleased to see modifications to the physician self-referral law, which prohibits referrals when a financial relationship exists between the physician and the entity to which the physician refers a patient. For example, the Medicare Preservation Act removes from the law's jurisdiction referrals based on compensation arrangements, which are already covered under anti-kickback law, and pares back the list of services to which the law applies. However, it is unclear whether the modification that expands the exception for prepaid plans would cover the variety of risk-sharing arrangements, including PSNs, that can be developed with incentives to prevent excessive and inappropriate utilization of services. This issue needs to be addressed.

- Modifications to the "anti-kickback" law, which prohibits payment in exchange for referrals of Medicare and Medicaid patients, are heartily welcomed. The federal government is actively--and properly--working to ferret out waste, fraud and abuse. However, a vague law, broad interpretations, and expansion of the law's reach and sanctions without clarification, have combined to create confusion over what kinds of arrangements providers may establish. We're very pleased that the Medicare Preservation Act provides for an advisory opinion process and calls for various clarifications in the enforcement of the anti-kickback law. Again, however, we need to be certain that the exemption for certain managed care arrangements adequately covers the variety of risk-sharing arrangements, like PSNs, that ensure appropriate utilization.

- The Medicare Preservation Act indicates that current antitrust law is a barrier to the formation of PSNs. Because we do not know the details of how PSNs will be defined, we cannot speak to whether the proposed relief is necessary, adequate or anti-competitive. However, we continue to believe that a process for getting specific

approval for appropriate provider arrangements could offer protection from expensive and time-consuming antitrust challenges.

- Although it may not necessarily be a barrier to integration, the threat of liability lawsuits is felt heavily by hospitals and health systems and can certainly be a barrier to the efficient delivery of health care. We are very pleased to see that a number of liability reforms are planned in the budget proposal. These include limiting a defendant's liability for non-economic damages to its proportionate share of fault; limiting non-economic damages to $250,000; modification of the collateral source rule to allow defendants to introduce evidence of insurance payments to a claimant; modifying the statute of limitations so that claims can not be filed more than two years after an injury is discovered or five years after the initial injury occurred; and allowing non-economic damages of more than $50,000 to be paid periodically rather than in a lump sum.

The look-back

If the budget plan provides the tools we feel are necessary, then we are confident that the program will save money by moving Medicare toward coordinated care. That is why we supported the concept of a "look-back" mechanism during deliberation of the budget to ensure the savings anticipated from moving more Medicare beneficiaries into coordinated care. But the "look-back" should not be used to overpromise savings that can be reasonably achieved through coordinated care in seven years. The specific amount of targeted savings we had suggested from a look-back mechanism is $60 billion through 2002. However, we are concerned that the budget plan may go well beyond this. All Medicare spending in excess of specified target amounts would be recaptured through the look-back, triggering future reductions in payments to providers. This would effectively turn the entire Medicare program into a capped entitlement.

Under this approach, factors beyond the control of hospitals and other providers could cause budget targets to be exceeded and trigger a look-back sequester: unanticipated inflation in the prices of goods and services hospitals must purchase (inflation is currently projected to average a relatively low 3.3 percent over the next seven years); unanticipated admission increases (for example, as the result of a flu epidemic); and errors by the Congressional Budget Office in estimating the savings associated with specific proposals.

The look-back should be limited to its original purpose: guaranteeing savings that can be reasonably achieved by moving Medicare beneficiaries into coordinated care plans. Therefore, the total amount that can be recaptured from hospitals and other providers in a look-back should be limited and capped at the targeted savings -- our suggestion of $60 billion over seven years. All stakeholders should play a role in contributing to the look-back if it becomes necessary. And an independent commission -- like the one proposed by Rep. Phil English (R-PA) in his Commission to Save Medicare Act of 1995 (HR 2152) -- would be best-suited to objectively and efficiently determine how to allocate among the various stakeholders the automatic spending reductions a look-back would call for.

CONCLUSION

Mr. Chairman, America's hospitals and health systems share this committee's goal of restructuring Medicare. But the current budget plan as we understand it won't bring some of the key changes needed to achieve this result. We urge you to consider the very important changes we've outlined in this statement as the plan is debated in committees and on the floor.

We continue to be concerned about the impact of reductions of $270 billion on quality and access. At the same time, given the right tools, America's hospitals and health systems are confident that the Medicare program can be restructured in a way that increases efficiency and improves access and quality. The millions of Americans who rely on Medicare, and those who will rely on it in the future, deserve no less.

Mr. THOMAS. Thank you, Mr. Warden.
Dr. Seward.

STATEMENT OF P. JOHN SEWARD, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. SEWARD. Thank you, Mr. Chairman and Members of the Committee.

My name is John Seward. I am a practicing family physician in Rockford, Illinois. I am also chairman of the board of AMA, the American Medical Association.

While the legislative language must still be seen and analyzed before any definitive judgment can be rendered, overall, the Medicare Preservation Act appears to be an important step toward fulfilling the promise of protecting and strengthening the Medicare Program for present and future beneficiaries.

We appreciate that both physician and patient input has been considered in putting together this legislative outline. We believe the outline supports the AMA's long-term concerns, the preservation of patient choice and the sustaining of quality medical care in a changing marketplace.

We are pleased to note the Committee's emphasis on choice. This is reflected in provisions calling for patient information and protections in dealing with managed care plans. Informed patients are empowered patients. This also serves to enhance the patient-physician relationship which the AMA believes is the core of good medical care.

In addition, the MedicarePlus option begins to introduce seniors to a variety of health plans available in the private sector. We believe the Committee has been sensitized to incentives that could encourage patients to choose a broad range of options. As long as the choice that we are talking about is informed and truly voluntary, then we won't cross the line from financial incentives to financial coercion.

The AMA is particularly pleased to see the medical savings account as one of the choices that will be available to seniors. Chairman Archer and Representative Jacobs have long supported this option, and we commend the Committee's efforts to extend this valuable health financing option to all Americans.

The outline of the Medicare Preservation Act includes significant health care liability reforms which we understand will apply to the entire health care system, including a $250,000 cap on noneconomic damages which the House passed overwhelmingly early this year. This has our enthusiastic endorsement, as piecemeal reforms of the system would only shift liability to other sectors.

The outline also reduces unnecessary and burdensome government regulations. Physician self-referral law, for example, would continue to prohibit inappropriate referral practices but will be modified to remove those provisions that have not only failed to protect patients, but have actually impeded their ability and access to appropriate care. We applaud these changes.

We also support modification to CLIA which would relieve the onerous administrative burdens placed on physician office clinical laboratories. We commend Chairman Archer for taking the lead on this important issue.

We are pleased that the outline reflects many of the antifraud and abuse measures AMA has advocated in its proposal "Transforming Medicare." We will look forward to continuing our efforts with Congress and law enforcement to prevent and detect fraudulent activity.

We believe the outline makes a measured approach to graduate medical education funding. Limiting Federal residency funding to the first board certification of 5 years is a fair one. We are particularly excited to see the exception for geriatric training, recognizing the importance of this particular kind of training in serving the Medicare population.

While we have not yet seen the details, we are concerned about potential reductions to physician payments in the legislation. However, we are extremely pleased to see several corrections of policy from the past that also just haven't worked. This includes a repeal of the MVPS and a move to a single conversion factor. We want to work with the Committee and HCFA on the appropriate and timely implementation of these changes. We believe the fail-safe provision could take a constructive approach by isolating high-growth services within the Medicare Program.

However, Mr. Chairman, physicians do have limited control over the number of times a fee-for-service patient can access the Medicare system. We believe individuals are much more prudent consumers of medical care when they have a financial interest in that care.

Finally, we are pleased that the outline supports the formation of the provider-sponsored networks. Federal standards must allow for all providers to compete in a revolving health care marketplace. The AMA looks forward to seeing the specific legislative language on this important issue.

Again, I want to thank you, Mr. Chairman, for this opportunity to testify. The AMA looks forward to continuing working with the Committee Members and Congress as this historic legislative initiative unfolds.

I thank you, Mr. Chairman.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Committee on Ways and Means

RE: MEDICARE SOLVENCY AND BUDGET RECONCILIATION

Presented by: P. John Seward, MD

September 22, 1995

Mr. Chairman and Members of the Committee, my name is P. John Seward, MD, and I am a practicing family physician from Rockford, Illinois. I am also the Chairman of the Board of Trustees of the American Medical Association (AMA), representing over 300,000 physicians and medical students.

Thank you for inviting the AMA to come before you today to respond to the outline of the "Medicare Preservation Act of 1995" distributed yesterday. We appreciate that both physician and patient input has been a vital element in your deliberations and hope that we can continue to provide counsel and feedback as the budget reconciliation process continues.

While the legislative language must be seen and analyzed before any definitive judgment can be rendered, overall, the Act's outline is one which the AMA believes fulfills the promise of protecting and strengthening the Medicare program for present and future beneficiaries. Many elements of the outline appear to be in concert with physicians' concerns regarding the preservation of patient choice and the sustaining of quality medical care in a changing marketplace.

CHOICE FOR PATIENTS

The AMA is pleased to note the emphasis on choice in the outline and the multiple strategies presented to preserve choice throughout the Medicare program. This is reflected in provisions calling for patient information and protections in their dealings with plans offered under the "Medicare Plus" portion of the outline. The AMA endorses the idea that informed patients can make informed choices about their health care; it is this vision which we believe is the foundation for true and meaningful choice in the Medicare marketplace. While we have not seen the specific legislative language, we are pleased to note that the Act's outline includes several patient protections such as disclosure to patients of plan information; rights and responsibilities; access to all medically necessary services for all covered benefits; qualification of utilization review programs; and a requirement for plans to provide written policies on notice and appeals processes for terminated physicians.

Clearly, the issue of patient choice and autonomy is a key issue to Medicare beneficiaries. The broad range of options available to seniors under the proposed "Medicare Plus" is a progressive step toward employing private sector cost savings mechanisms in the Medicare program. A system premised on choice and individual responsibility can offer savings to the Medicare program. The outline we have reviewed appears to allow everyone the right to choose, without forcing anyone to choose.

We believe the Committee has been sensitized to the range of incentives available to encourage patients to choose managed care plans, understanding that the line beyond which incentives become financial coercion can become blurred. As long as "choice" is informed and truly voluntary, the patient can become a more prudent user of limited health care resources and

physicians can increase their efficiency. In short, the marketplace can work without the burden of previously imposed distortions.

MEDICAL SAVINGS ACCOUNTS

The AMA is very pleased to see the inclusion of Medical Savings Accounts (MSAs) as an option for seniors in the financing of their health care needs. Coupled with a catastrophic policy, MSAs will undoubtedly prove attractive to many beneficiaries because they could provide funds for purchase of items and services formerly not covered by Medicare, such as prescription drugs or extended long-term care. For almost a decade, the AMA has been on record as supporting adoption of MSAs as an option in our health care system. We believe MSAs not only represent a cost effective approach to providing health care, but also strengthen the market for medical care by assuring patients more freedom of choice and promoting competition among health care providers. We are extremely pleased that MSAs were made a part of the Committee's tax package passed Tuesday, making this valuable health financing option available to the non-Medicare population, as well.

LIABILITY REFORM

We applaud the inclusion of health care liability reform, including a $250,000 cap on non-economic damages and other provisions that have proven effective in the States that have tried them. These reforms are a very significant step forward that clearly will play a part in stabilizing the cost of health care services. The cap on non-economic damages will ensure that Medicare beneficiaries who may be injured in the course of receiving health care services would receive full and fair compensation for all out of pocket losses, yet it places a needed control on the few cases that fuel the lawsuit "lottery" mentality. These reforms should also promote faster settlement of claims, an important issue for elder Americans, who are particularly disadvantaged by the backlog in the civil justice system.

The AMA supports the decision to include all parts of the health care community, including medical product manufacturers and the biotechnology services sector, under the same umbrella of common reforms. The AMA is always concerned that piece-meal reform may have unintended consequences. This more comprehensive approach should help reduce the growing incentives among different parts of the health care community to inappropriately attempt to shift liability through onerous indemnity or "hold harmless" arrangements.

We understand that this section of the Act is not confined in application to Medicare beneficiaries, but applies to all claims for personal injury arising from the delivery of health care services. The AMA supports this approach, which ensures that the basic reforms included in the Act truly will apply nationwide. It is important, however, that States be left with the flexibility to craft additional civil justice reforms or implement alternative approaches that are equally effective in promoting access to health care services, reducing their cost and expediting the resolution of health care liability claims. Some states have already implemented alternative or more extensive reform programs, and these should not be disturbed.

PHYSICIAN SELF-REFERRAL AND REGULATORY RELIEF

The AMA is very pleased that the outline of the Act includes major improvements to the federal law on physician self-referral as well as regulatory relief provisions. The Act would remove barriers to arrangements between and among providers in the developing health care marketplace where there is little or no evidence that increased volume is due to inappropriate referrals. In particular, the Act would eliminate the prohibition on referrals based on compensation arrangements, would reduce the categories of designated health services subject to the law, and would repeal the site of service and direct supervision requirements for the in-office ancillary services exception. The AMA has long supported two of the new exceptions outlined in the Act, the first of which would allow for the legitimate use of shared office facilities by physicians, and

the second of which would create a "community need" exception for communities that are without access to designated health services facilities. In addition, we strongly support the Act's provisions that would require the Secretary of HHS to provide advisory opinions on physician ownership and referral arrangements, and which would prohibit the Secretary from enforcing the physician self-referral provisions passed in OBRA 93 until regulations are promulgated.

Finally, the AMA strongly supports the modification of the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) to relieve the burden of onerous regulations imposed on physician office clinical laboratories. Many physicians have eliminated all or some types of in-office testing because the administrative burdens and costs of complying with CLIA-88 outweigh the benefits. Consequently patients have had to suffer the inconvenience of going to outside laboratories and hospital emergency rooms to have laboratory specimens obtained and analyzed. We commend Chairman Archer for taking the lead on this important issue by introducing the Clinical Laboratory Improvement Act Amendments of 1995, H.R. 1386.

FRAUD AND ABUSE

The AMA strongly supports measures to intensify efforts in tracking and punishing fraudulent abusers of the system. We particularly appreciate the apparent distinction emphasized between intentional fraud, which is a fair target for punishment, and inappropriate use of the system, which is generally a quality issue that is more properly addressed through educational rather than punitive measures. Again, while we have not seen the specific legislative language, we are pleased to see that the outline includes so many of the anti-fraud and abuse provisions advocated in the AMA's Transforming Medicare proposal. This includes the establishment of a coordinated Fraud and Abuse law enforcement effort in which the AMA hopes to continue its role as a private sector partner in the prevention and detection of fraudulent activities. The outline earmarks fines and penalties to directly fund some of these activities. As a footnote, we would request that the Committee consider requiring an appropriations process for the use of Trust Fund monies, so as to minimize the potential for the creation of inappropriate incentives.

We also appreciate the inclusion of a patient protection for which the AMA has advocated for some time: authorizing HCFA's Office of Research to contract for a study of health plan quality assurance systems currently in place to assure that utilization control features do not result in the inappropriate denial of care. Review mechanisms must be established to assure that physicians are not offered incentives to limit care inappropriately.

GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

Our review of the outline's Graduate Medical Education (GME) provisions reveals a measured approach to what will certainly be sizeable shifts of funding over time for GME programs. We believe that the provisions limiting residency funding to first board certification or five years is fair. We are particularly excited to see the exception retained for up to three years additional funding for specialists in geriatrics, reflecting the Committee's recognition of the importance of geriatrics training for physicians who will be serving the Medicare population.

Another element of the GME proposed language that is gratifying to note is the ability for "Direct Account" monies to go to consortia, allowing GME payments to "follow the services" to the place where they are provided. This will clearly encourage residency training at needed non-hospital sites previously disadvantaged by payment policies. The legislative commission designated in the outline to study and make recommendations on a broad array of GME issues is laudable. This commission requires high public credibility. To this end, the AMA hopes that the formal membership on this commission will reflect all the major parties that have a stake in the redesign of GME financing, including medical professional and trade associations, private payers and representatives from state and local governments.

PHYSICIAN PAYMENTS

The AMA is very pleased with a number of provisions included in the outline of the Act which

affect payments to physicians under the traditional Medicare program.

Repeal of the Medicare Volume Performance Standard (MVPS)

The outline provides that the Act would repeal the MVPS and instead adopt the Physician Payment Review Commission's (PPRC) recommendation that physician updates should be set by a formula linked to the projected growth of real domestic product per capita increased by two percent annually as well as changes in enrollment and inflation. The AMA strongly supports this change to the current flawed MVPS formula. Because of changes to the MVPS made by the Omnibus Budget Reconciliation Act of 1993, Medicare physician payments, without modification, are projected to drop by 2-3% annually through 2002 and beyond. According to the PPRC, projections based on current MVPS formulas show that within the next ten years, the conversion factor could fall below $31, the level established when the Medicare Resource-Based Relative Value Scale (RBRVS) system was first implemented. The AMA applauds the Committee for addressing this important issue and eliminating the flawed MVPS formula.

Move to Single Conversion Factor

The outline also states that the Act would implement a single conversion factor for all Medicare physician fee schedule services (i.e. surgical, primary care, and non-surgical). The AMA's Transforming Medicare proposal, along with longstanding AMA policy, calls for the Medicare payment schedule to utilize a single conversion factor. Because of past differential updates, the primary care conversion factor is currently 14 percent lower, and other non-surgical 8 percent lower, than the conversion factor for surgical services. The AMA is concerned that this divergence undermines the original intent of the Medicare physician fee schedule. The AMA would welcome the opportunity to work with the Committee and HCFA to discuss how best to design a transition from the current multiple MVPSs that take appropriate account of the potential disruptions for physicians who provide a large proportion of services in the surgical MVPS, as well as consider changes due to the five-year review of the RBRVS payment system. In its recent proposal for Medicare transformation, the AMA proposed a timetable that would achieve implementation of a single conversion factor by 1998. We look forward to working with the Committee and HCFA on an appropriate, timely, and carefully considered implementation of a single conversion factor.

Physician Payment Reductions

While the AMA strongly supports the physician payment changes discussed above, we are nevertheless concerned about potential reductions to physician payments which are not described in the Act. Year after year, physicians have contributed their fair share to the budget deficit effort. Physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. According to the PPRC, Medicare's physician payment rates are currently only 68% of those of private insurers. Further reductions to Medicare physician payments would only increase the gap between Medicare's rates and private rates, limiting physicians' willingness to accept Medicare beneficiaries and limiting Medicare beneficiaries' access to health care.

PROVIDER SERVICE NETWORKS

We are pleased that the outline of the Act reflects consideration of an evolving marketplace that would include the formation of "Provider Sponsored Networks" (PSNs). As noted in the outline of the Medicare Preservation Act, it is crucial that special consideration be given to the major differences between insurance companies and PSNs, especially in the areas of financial solvency, definition of risk-based capital and issues of reinsurance. In addition, given the acknowledged precedent at the federal level for promoting an environment in which competition should be allowed to flourish in an evolving health care marketplace, the AMA looks forward to working with the Committee in developing specific legislative language that will fulfill the intent of the outline's promise.

"FAIL SAFE" PROVISION

The AMA believes that the "fail safe" provision in the Act takes a constructive approach by setting spending growth rates for separate provider categories, such as inpatient hospital services, physician services, home health care, durable medical equipment and laboratory services. If services within a category exceed designated spending growth targets, the Secretary of Health and Human Services would be required to change the payment updates for that category for future budget years. We believe this properly isolates high growth services and better identifies sources of growth within the Medicare program. At the same time, we are disappointed that the outline does not more directly address Medicare's basic lack of price competition. We appreciate and understand the goal of reducing growth, however, physicians have only a limited control over the number of times a fee-for-service patient can access the Medicare system. Individuals are much more likely to be prudent consumers of medical care if they have a financial interest in their care.

In addition, the limited cost-sharing in the current Medicare program has been largely nullified by the widespread purchase of Medigap coverage which transforms Medicare into first-dollar coverage. As a result, some beneficiaries consume more medical services than they otherwise would. We believe it is inappropriate to penalize physicians for providing medical services sought by seniors, as well as basing the fee-for-service option on what is a de facto expenditure target.

CONCLUSION

The AMA recognizes the fact that Medicare has been a great success in meeting its originally declared mission of improving the health status of our elderly Americans. The goal to protect and strengthen the Medicare program for present and future generations of beneficiaries is paramount. The AMA looks forward to continuing our work with the Committee and the Congress as this historic legislative initiative moves forward.

Mr. THOMAS. Thank you very much, Doctor.
Mr. Scully.

STATEMENT OF THOMAS SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. SCULLY. Mr. Chairman, thank you very much for having us testify today. I am president of the Federation of American Health Systems, which represents 1,700 investor-owned hospitals and health systems nationwide.

We also have kind of a mixed message today. We still haven't seen all the details, but our initial reaction is that the Committee's package does a very good job of restructuring the health care system and puts us on a road toward what we think will be a much more dynamic and better health care system 7 years from now.

In the interim, we have some pretty serious concerns. I guess that is where the mixed message comes from.

We very much like the restructured package. We very much like a lot of the changes you have made in giving seniors the ability to choose private sector health plans. But that excitement is tempered by the fact that we are not exactly happy about the level of reductions.

We certainly still think, as we have stated all year, that the $270 billion in the package is large, is excessive on local community hospitals; and we certainly hope, through the course of the debate that the level of reductions, the level of budget savings will come down. If the reduction is more reasonable, I can say that our hospitals would certainly be out leading the brass band in support of this plan, because we do think it is very well structured and will significantly improve the performance of the health care system.

Let me comment additionally beyond the generic comments on four very specific issues. The first one, the two previous witnesses have mentioned, is provider-sponsored networks. This is an enormous, enormous issue for hospitals.

Just to clarify what this issue is, essentially, the Committee package would open the new market in the next year to 33 million new seniors into a new, competitive health care system. How you get access to that system for your local community hospitals to offer a comprehensive health care package is very, very important.

Our concern is that we not be left at the starting gate. The insurance industry would tell you what we should do is go back to every State and get an HMO list. What is going to happen there, basically, is we are going to be left 1 year, 2 years behind. If we have to go back, if a community hospital and community health system have to go to its State to get an HMO license, the reality is the market may be completely gone and the game will be over long before the hospitals get in to compete for the new beneficiaries.

So while we are very supportive of the new plan, we are, I would say, very strong in our efforts to make sure we gain fair access; and we don't want to be wandering around State capitals getting HMO licenses 2 years from now when every local senior signed up for private choice.

Second is fraud and abuse. We are very supportive of what the Chairman put in the mark for the fraud and abuse package. We

think a lot of the current fraud and abuse laws are very helpful in the fee-for-service environment, but they are very detrimental if you are trying to put together an integrated service network, and that is what we all hope to do in the next 7 years. The incentives are just totally different. When you are looking at managed care networks and integrated environments, I think there should be two totally different sets of standards.

Third, liability reform. We have strongly supported liability reform for years. We believe the public support for that is very strong nationwide. We worked very closely with the AMA and the AHA on that for the last couple of years. We are very excited to see that in the package, and we hope it will stay in. We also think we will have significant savings, probably much more than CBO, OMB, what everyone else will ever acknowledge.

Fourth and finally, one thing I would like to focus on most is the fail-safe mechanism. We have—certainly the AHA and the federation have worked a lot in the last 6 months to try to find a way to help develop a fail-safe mechanism or look-back, as it is sometimes called. We think it is a very good idea. We are concerned how it is structured. We haven't seen the details. We think it could help make for a much more flexible and rational way to reduce the spending in the Medicare Program by $270 billion if it is crafted correctly. We think it would be a disaster if it is crafted incorrectly.

We would very much like to work with you on this in the coming couple weeks. And we believe if it is crafted—and I attached some numbers in the back.

I had the fortune—or misfortune—of being the associate director of OMB for 4 years and oversaw the Medicare Program. I can tell you that I think a lot of this and how it is done has to do with what the various assumptions are for the next 7 years. There is a right way to do it, and I think if it is done right it will be an enormous help in making your package work in a way that can make this survivable for hospitals, physicians, and the rest of the health care community.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY
of
Thomas Scully, President & CEO
Federation of American Health Systems
before
The House Ways and Means Committee
hearing on
Medicare Reform: "Medicare Preservation Act"
Friday, September 22, 1995

Mr. Chairman and Members of the Ways and Means Committee: Thank you for giving the Federation of American Health Systems, which represents 1700 investor-owned and managed hospitals, the opportunity to comment on the essential changes and restructuring that you are undertaking in the Medicare program.

The Committee and House leadership should be commended for putting forth a proposal that appears to be a thorough effort to restructure the Medicare system. The Republican plan, if followed for the next seven years, is a blueprint that can ensure a stronger Medicare health care delivery system that will offer beneficiaries more choices in a more efficient market.

Not having seen the final legislation, I feel a little like a diner at an expensive restaurant. Much of the menu looks appealing, but there are no prices listed and I'm a little afraid that I may not be as happy when the bill arrives. As you know, we still do not know the specific amount of the hospital reimbursement changes in the package.

As a result, the Federation has a mixed message today. Despite the positive aspects of restructuring, the Federation remains very concerned about the size of the budget reductions Congress has proposed for Medicare. These reductions are unprecedented in their size and appear to have a disparate impact on the average community hospital. As the Medicare debate continues, the Federation hopes that the overall target of $270 billion will be reduced, and that the specific reductions will be more equitably distributed.

If the reductions were more reasonable, or showed a better balance between hospitals, physicians, other providers and beneficiaries, the Federation might be leading a brass band in support of the plan. However, we are concerned that budget reductions of this magnitude will contribute to a cumulative effect that will accelerate the existing trend of hospital employee layoffs, and cause quality to deteriorate.

Let me briefly comment on four issues that are most sensitive to our hospitals. These are areas where the committee seems to be heading in the right direction toward creating an environment where true restructuring can eventually be accomplished.

ISSUE ONE Provider sponsored networks: If you are to open a truly competitive market--one that can best serve the 33 million seniors--all new market participants, whether insurance carriers, HMOs or provider sponsored networks, must be given fair access to develop service

networks. Fair access requires putting all of these competing systems at the starting line at the same time. If the new Medicare market opens next spring, all worthy participants should be admitted at the same time.

ISSUE TWO Fraud and abuse: Many of these laws serve a purpose in the fee-for-service market, but will hinder the development of integrated networks. Modifying the anti-kickback and so-called "Stark" laws would remove a number of roadblocks in the health care market that prevent health care organizations from providing more efficient and cost-effective care. Because the Medicare proposal will open the door to many new and hybrid health care relationships, it is vitally important that risk-sharing arrangements that include incentives for appropriate utilization be allowed under these statutes. We also recommend establishing an advisory opinion process that would provide more guidance than the broad and general statutory language and regulations currently allow.

ISSUE THREE Liability reform: The bill contains a proposal limiting liability for health care providers. These reforms are overdue, enjoy strong public support, and have long been advocated by hospitals nationwide. We urge the Congress to include these reforms in the legislation.

ISSUE FOUR Finally, your "fail safe" budget mechanism, or what has also been called a "lookback," is an important part of creating a budget package that will allow Congress to lock in absolute spending limits for seven years. $270 billion is a very large number. The fail safe gives Congress the flexibility of reaching this number with a guarantee that you will not exceed spending caps. The better Congress and the public understand how completely this insurance policy guarantees savings, the more support it will garner. (See attached chart). As a former Associate Director of OMB, who oversaw Medicare, I can assure you that these savings are not only real--they are absolutely certain.

However, for this to work, there must be a fair balance between providers and beneficiaries, and there must be a rational limit on the amount of savings that can be achieved through this mechanism. Furthermore, the fail safe should contain clearly defined targets by category of service. Groups operating efficiently within the new Medicare rules should not be subjected to balancing the budget for less efficient groups.

CONCLUSION: From what the Federation has seen, the restructuring contained in your proposal, if the details are handled correctly, will allow the Medicare program to utilize private-market competition to lower costs and improve quality. But the package would be far better if savings targets were more reasonable.

The Federation would urge members from both parties to embrace the restructuring elements of this proposal and begin working out the differences they will understandably have, given the size and scope of this legislation. The reforms contained in this plan are long overdue.

The Federation looks forward to working with the committee in completing this important restructuring of the Medicare program.

Mr. THOMAS. Thank you very much, Mr. Scully. I know we will receive input from you as we move forward.

Sister Keehan, thank you for coming.

STATEMENT OF SISTER CAROL KEEHAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVIDENCE HOSPITAL; AND CARROL MANOR NURSING HOME, WASHINGTON, DC

Sister KEEHAN. Thank you. Good evening, thank you very much for the opportunity to be here. I am Sister Carol Keehan, president and chief executive officer of Providence Hospital here in the District of Columbia.

We must preserve Medicare, the program itself and the quality of it. We must assure that the health security of elderly Americans of all socioeconomic levels remains intact. The cuts in this bill are entirely too large and will significantly undermine the quality of the program, especially for the most vulnerable.

I applaud your desire to balance the budget. I also acknowledge that there are real opportunities to improve Medicare and realize some savings. There are inefficiencies to correct and, sadly, some fraud to eradicate as there is in almost any business, school system, military or government operation, but there is not $270 billion to be saved.

In truth, a number of the measures outlined could increase some of the inefficiencies. The savings goal in this bill is not derived from quality studies that have demonstrated specific dollar savings tied to program modifications that have no detrimental effect on the accessibility and quality of the Medicare Program. It is an arbitrarily determined dollar savings needed.

Those who will most suffer are the poor and those of multiple, severe, chronic illnesses. These are the elderly who most need the safety nets that now exist in Medicare, the ability to get care, tests, and services when and where they need it is critical.

Many of the gatekeeper functions and other market-driven characteristics of managed care as we know it are not compatible with the needs of the elderly. There is no argument that coordinated care systems are best for all Americans. That is different from systems of care that are designed by the market.

We also have no evidence that the managed care industry can render the same level of care and produce savings to the Medicare Trust Fund from those patients whose care constitutes the bulk of Medicare expenditures.

It is also not fair to assure Medicare recipients that they can keep the current program if they want. The current program is lost with this proposal. The fee-for-service option retained is not the same program from many points of view.

While the poor and seriously ill will suffer most from these changes, make no mistake, all Medicare patients will feel their effect. The dramatically reduced reimbursements in major areas will change the character of many of our health care services. When you factor in the significant cuts proposed in Medicaid, this phenomenon is guaranteed.

Many aspects comprise the wonderful health care enjoyed by most elderly Americans. Whether you look at medical education programs, the mix of professionals rendering care versus on-the-job

trained care workers, or the multiple programs aimed at the special needs of the elderly, it is obvious we have made great strides in developing quality programs for the elderly.

Medicare deserves much of the credit for this. Make no mistake. These changes will undermine those gains in significant ways. An additional $7 per month will be the most minimum change recipients will feel. With the growth of managed care, we have seen diminishing community service programs, significant shifts in the number and educational level of staff caring for patients, and marketing away from the poor.

You must understand that meeting patients' needs, especially the elderly with multiple problems, cannot simply be programmed. Patient and family education, obtaining services and equipment is time consuming, whether it is getting a diabetic a glucose monitor, supplies, diet education, transporting, or evaluating the compatibility of the myriad of drugs a patient is on. It takes time and educated staff.

Patients with multiple complex problems may find themselves avoided and/or a portion of their problems not addressed because they consume so much time. If they are poor as well, the supports of social services to arrange transportation, assistance in housing, food stamps, outpatient dialysis will be hard for providers to afford to offer.

These concrete examples may seem naive in these great chambers, but I assure you they are the everyday life of the elderly and their primary concerns. Whether these needs are better met after you change Medicare or not is how they will judge the outcome of your decision.

I urge you to look at a more courageous and compassionate approach to this issue. Put this draconian approach on hold this year and put in more modest cuts. Fund some high-quality studies for the next 2 years focusing on multiple delivery systems and how well they meet our most challenging Medicare patients. This will give you accurate information to use in designing the long-term strategy. You will know what works best, what is essential, what is not compatible with meeting the needs of the elderly.

It will also give you time to focus on regulations that fail the cost-benefit test, make health care more expensive, structure malpractice laws, and to structure laws that make it possible for not-for-profit providers to set up delivery networks that retain any profit for community benefit.

I urge you to take the time to do this well. A balanced budget and/or a tax cut will be no credit to you if it has cost elderly Americans their health security.

Thank you.

[The prepared statement follows:]

STATEMENT OF SISTER CAROL KEEHAN
PRESIDENT AND CEO
PROVIDENCE HOSPITAL AND CARROL MANOR NURSING HOME

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I applaud your desire to balance the budget.

I also acknowledge that there are real opportunities to improve Medicare -- and realize some savings. There are inefficiencies to correct and sadly some fraud to eradicate as there is in almost any business, school system, military or government operation.

But there is not $270 billion to be saved, and in truth, a number of the measures outlined could increase some of the inefficiencies.

The savings goal in this bill is not derived from quality studies that have demonstrated specific dollar savings tied to program modifications that have no detrimental effect on the accessibility and quality of the Medicare program. It is an arbitrarily determined dollar savings needed.

Those who will most suffer are the poor and those with multiple severe chronic illnesses.

These are the elderly who most need the safety nets that now exist in Medicare -- the ability to get care , tests and services when and where they need it is critical.

Many of the gatekeeper functions and other market driven characteristics of managed care as we know it are not compatible with the needs of the elderly.

There is no argument that coordinated care systems are best for all Americans. That is different from systems of care that are designed by the market.

We also have no evidence that the managed care industry can render the same level of care and produce savings to the Medicare Trust Fund from those patients whose care constitutes the bulk of the

Medicare expenditures.

It is also not fair to assure Medicare recipients that they can keep the current program if they want. The current program is lost with this proposal. The "Fee for Service" option retained is not the same program from many points of view.

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Make no mistake -- these changes will undermine those gains in significant ways. An additional $7 per month will be the most minimal change that recipients will feel. With the growth of managed care, we have seen diminishing community service programs, significant shifts in the numbers and educational level of staff, and marketing away from the poor. The diminishment of medical education programs is something we will all pay for in the future.

You must understand that meeting patient's needs, especially the elderly with multiple problems, cannot simply be programmed -- patient and family education, obtaining services and equipment is time consuming. Whether it is getting a diabetic a glucose monitor, supplies, diet education, transportation or evaluating the compatibility of the myriad of drugs a patient is on, it takes time and educated staff.

Patients with multiple complex problems may find themselves avoided and/or a portion of their problems not addressed because they consume so much time. If they are poor as well, the supports of social services to arrange transportation, assistance in housing, food stamps, outpatient dialysis, etc., will be hard for providers to afford to offer.

These concrete examples may seem naive in these great chambers but I assure you they are the everyday life of the elderly and their primary concerns. Whether these needs are better met after you change Medicare or not is how they will judge the outcome of your decision.

I urge you to look at a more courageous and compassionate

approach to this issue.

Put this draconian approach on hold this year, put in more modest cuts, fund some high quality studies for the next two years focusing on multiple delivery systems and how well they meet the needs of our most challenging Medicare patients. This will give you very accurate information to use in designing a long term strategy. You will know what works best, what is essential and what is not compatible with meeting the needs of the elderly.

It will also give you the time to focus on regulations that fail the cost benefit test and make health care more expensive, to structure reasonable malpractice laws and to structure laws that make it possible for not-for-profit providers to set up delivery networks that retain any profit for community benefit.

In this regard, the current ambiguous tax laws and IRS policies severely limit the kinds of integration that can qualify for tax exemption. As a result, many providers join for-profit managed care arrangements out of necessity.

There is concern that, over time, integration into for-profit structures will threaten the original charitable mission of the not-for-profit hospitals, which have served communities across this country well.

We need provisions which:

- allow not-for-profit hospitals to form tax exempt IDNs; and
- require tax exempt IDNs to meet strong statutory requirements regarding their charitable purpose, including an annual report on charitable activities.

This would include the concept of intermediate sanctions as a strong protection against private inurement and private benefit in tax exempt organizations.

I urge you to take the time to do this well. A balanced budget and/or a tax cut will be no credit to you if it has cost elderly Americans their health security.

Thank you.

Mr. THOMAS. Thank you very much, Sister.
Dr. Thomson.

STATEMENT OF GERALD E. THOMSON, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. THOMSON. Mr. Chairman, Representative Gibbons, and Members of the Committee, I am Dr. Gerald Thomson. I am president of the American College of Physicians, and we are pleased to have the opportunity to share with you the college's very serious concerns about proposals to cut deeply into Medicare.

The American College of Physicians is the Nation's largest specialty society group, with over 85,000 members, almost all trained in internal medicine. This group of physicians, internists, who provide more care for Medicare patients than any other physicians, are not on board with the proposed budget reductions in the public insurance programs.

We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many but not nearly all Americans. The college opposes Medicare restructuring that starts from a target number driven by the demands for a balanced budget and tax cuts, and then tries to engineer changes that meet that target.

We believe in the opposite approach. Start with changes that derive from health care system goals, then estimate the savings that would be produced within the context of what is best with a rationale health care system. Neither Medicare patients nor their health delivery system can absorb the magnitude of budget cuts proposed, even if one assumes a large-scale transition of Medicare patients to managed care plans.

Medicare patients already spend as much as 21 percent of their incomes on out-of-pocket costs, and the vast majority of patients are in relatively low incomes. With a median income of about $18,000 a year, most Medicare patients cannot afford higher out-of-pocket payments.

Health care providers have paid more than their fair share toward deficit reduction. To ratchet down reimbursement further will threaten the ability of both doctors and hospitals to treat current and especially new Medicare patients. Particularly vulnerable are the poor with disproportionate numbers of minorities, the very old and disabled. Those living in rural and urban poverty areas, all groups whose access and health problems have been so well documented.

Another significant impact of the proposed cost-cutting effort will be increases in out-of-pocket expenses and lost wages for all Americans. A recent study by Lewin VHI, commissioned by the National Leadership Coalition on Health Care, showed that more than $90 billion in costs would be shifted to the private sector from the $450 billion in cuts proposed for both Medicare and Medicaid.

This $90 billion cost shift will fall on America's employers and America's families. An even higher price will be paid by those least able to afford it. There will be an increase in the projected number of uninsured. The Lewin VHI study projects an additional half a million people will lose coverage as a result of the cost shifting.

Just over 1 year ago, the American College of Physicians appeared before this and other Committees to support efforts to bring America closer to universal coverage, a goal that had universal support.

Today, we struggle to avert a cost-cutting proposal that will move the country backward from the goal of health care for every one.

I must say that the proposed cuts in Medicaid, while not within the jurisdiction of this Committee, are also of grave concern. We do not believe that a 4-percent growth rate can be achieved in the near term as proposed. Cuts of this size will force States to move ahead with poorly conceived managed care plans instead of implementing a careful transition that early experience suggests is essential.

We also oppose block grant proposals that eliminate the guarantee of coverage for patients who meet eligibility criteria, and without a guarantee, a recession of even minor proportions will force waves of additional people out from the umbrella of employer-provided health care coverage.

In sum, Mr. Chairman, the American College of Physicians cannot support short-term budget cuts that target patients, physicians, hospitals, and others and risk serious harm to patient care.

We urge you to forgo the inclusion of these programs in this budget cutting exercise and explore and eventually enact Medicare and Medicaid reforms that are consistent with and indeed may lead the way to more fundamental health care system changes.

The American College of Physician's recommendations are summarized in our written statement but I would simply indicate that—by listening to our suggestions.

First, the college supports managed care plans that are comprehensive and assure coordinated, quality care.

Second, recognizing that Medicare patients now have complete and open choice of physicians and hospitals, a point sometimes lost in these discussions. The college supports the gradual transition of Medicare and Medicaid to systems which offer beneficiaries, on a volunteer basis, a variety of options among different types of health care plans, including additional plans.

Third, the American College of Physicians believes that a national discussion should be undertaken to address the very difficult issues surrounding prioritization of health care, prioritization of health care services for all populations, not simply the elderly, not simply the poor. A national consensus must be reached on how to decide when care becomes futile at any age and when other care options should be chosen to preserve individual dignity and comfort.

Fourth, the potential for savings through administrative simplification remains to be exploited.

Fifth, Medicare and Medicaid should evaluate and adopt, as appropriate, prudent private sector purchaser initiatives, such as quality indicators and service performance standards, the use of standards of excellence, specialize services contracting, and case management for high-cost services.

Now, we recognize that the changes that we recommend may not be as quantifiable for short-term deficit reduction. We hope, though, that Congress and the administration will establish the private-public mechanisms to plan for long-term reforms in these vital public programs.

Thank you for the opportunity to share our views with the Committee.

[The prepared statement follows:]

Statement of Gerald E. Thomson, MD
President, American College of Physicians
Committee on Ways and Means
U.S. House of Representatives
September 22, 1995

PROPOSED MEDICARE BUDGET REDUCTIONS

Good morning Chairman Archer, Representative Gibbons and members of the Committee. I am Dr. Gerald E. Thomson, President of the American College of Physicians. I am pleased to have the opportunity to share with you the College's very serious concerns about proposals to cut deeply into Medicare.

Let me first remind you that the American College of Physicians is the nation's largest medical specialty society with 85,000 members trained in internal medicine and its subspecialties. We are dedicated to continuing medical education -- we publish the *Annals of Internal Medicine* -- and to advocacy of responsible public policy.

Let me say in all seriousness that this group of physicians -- internists who provide more care for Medicare patients than any other physicians -- are *not* on board with the proposed budget reductions in the public insurance programs. We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many, but not nearly all, Americans. Further, these cuts move us away from, not towards, assuring health care for all Americans, which remains an overarching goal of the American College of Physicians.

The College is concerned about an approach to Medicare restructuring that starts from a target number driven by the demands for a balanced budget and tax cuts, and then tries to engineer changes to meet that target. We believe in the opposite approach: start with changes that derive from health care system goals, and then estimate the savings that would be produced. The College was one of the first physician organizations to commit itself to cost containment, but we have insisted that cost containment not be the starting point for proposed changes. Rather, well conceived and carefully implemented reforms, designed to reduce excess capacity and utilization of services, promise savings based on a real reduction in costs rather than arbitrary budget cuts. In sum, we have to change the growth curve in health care costs and forego budget cuts that produce short term savings but no lasting cost containment or reform.

Neither Medicare patients nor the health delivery system can absorb the magnitude of budget cuts proposed, even with a large-scale transition of Medicare patients to managed care plans.

Medicare patients already spend as much as 21 percent of their incomes on out-of-pocket costs, and the vast majority of patients are at relatively low incomes. The median income of Medicare beneficiaries is about $18,000. Nor do the elderly have substantial assets. The typical household in pre-retirement years has assets of $17,300; the comparable figure for African-American and Hispanic households is $500. Income-related premiums may make sense for the small number of beneficiaries at higher income levels, but that will produce only modest revenue.

It is proposed that reimbursements to health care providers be reduced through both government caps and market forces. There is a limit to what can be taken from the health care system in a given period of time. We suggest that proposed approaches to cost containment may prove to be very costly in terms of access to care and impact on the private sector.

Health care providers have paid more than their fair share towards deficit reduction. Physicians have absorbed 32 percent of recent budget reductions while they account for only 23 percent of Medicare spending. Medicare payment to physicians averages fully one third less than private sector payment. To ratchet down reimbursement further will threaten the ability of both doctors and hospitals to treat current and especially new Medicare patients. Particularly vulnerable are the poor, with disproportionate numbers of African-Americans and other minority groups, the very old, the disabled, and those living in rural and urban poverty areas -- all groups whose access problems have been documented (Physician Payment Review Commission, 1994, 1995).

Another significant cost of the proposed 'cost-cutting' effort will be steep increases in out-of-pocket expenses and lost wages for all Americans. A recent study by Lewin/VHI, commissioned by the National Leadership Coalition on Health Care -- a nonpartisan group that includes large corporations -- showed that more than $90 billion in costs would be shifted to the private sector from the $450 billion cuts proposed for both Medicare and Medicaid. This cost shift takes place even under assumptions of large numbers of Medicare patients moving into managed care plans and sizable reductions in

reimbursement to providers; significantly, only a portion of the reimbursement reduction is included in the cost-shift amount.

This $90 billion cost shift is a tax increase. What's worse, it is a hidden tax increase, and it will fall on America's employers and families.

As distasteful and harmful to the economy as the cost-shift is -- it is not the greatest cost of proposed budget cuts. The highest price, paid by those least able to afford it, will be an increase in the number of uninsured. Already, one-sixth of the non-elderly population lacks health coverage. The Lewin/VHI study projects an *additional half-million people* will lose coverage as a result of the cost -shift. Just over a year ago, the American College of Physicians appeared before this and other committees to support efforts to bring America closer to universal coverage -- a goal that had bipartisan support. Today, we struggle to avert a cost-cutting proposal that will move the country backward from the goal of health care for everyone.

As in Medicare, the proposed cuts in Medicaid also are of grave concern. We do not believe that a four percent growth rate can be achieved in the near term, as proposed. People have claimed -- but no one has shown -- how the states, "freed" from federal requirements, can save that amount of money. Cuts of this size will force states to move ahead with poorly conceived managed care plans, instead of implementing a careful transition that early experience, such as TennCare, suggests is essential. We also oppose block grant proposals that eliminate the guarantee of coverage for patients who meet

eligibility criteria. Without a guarantee, a recession of even *minor* proportions will force waves of additional people out from the umbrella of employer-provided health coverage.

In sum, Mr. Chairman, the American College of Physicians cannot support short-term budget cuts that target patients, physicians, hospitals, and others, bring about no meaningful change, and risk serious harm to patient care.

We urge you to forego the inclusion of these programs in this budget cutting exercise and explore and eventually enact Medicare and Medicaid reforms that are consistent with, and indeed may lead the way to, more fundamental health system changes. We must reduce excess capacity and utilization if we are to achieve meaningful, lasting cost containment. I will summarize briefly the ACP recommendations for long term reforms.

First, the College supports managed care plans that are comprehensive and assure coordinated quality care. We think that this approach to delivery of services potentially can improve access and quality for Medicare and Medicaid patients and, at the same time, control spending by reducing excess capacity and utilization. Federal standards for high quality care are essential, and the ACP's Task Force on Aging has made recommendations on what Medicare managed care should look like. We have also proposed standards for Medicaid managed care.

Second, recognizing that Medicare patients now have complete and open choice of physicians and hospitals -- a point sometimes lost in the current debate -- the College supports the gradual transition of Medicare and Medicaid to systems which offer beneficiaries, on a voluntary basis, a variety of options among different types of health care plans, including traditional plans. We have real concerns about the ability of more vulnerable elderly patients to adjust to such a system, and believe that an administrative mechanism such as a purchasing pool is a necessary component of this approach. However, we have reservations about the medical savings account option. This approach contradicts the principles served by quality managed care. MSAs may discourage comprehensive care. Moreover, they have the potential of draining the healthier and wealthier beneficiaries from the rest of the Medicare risk pool, undermining the ability of Medicare to survive. The College recommends MSAs be tried on a demonstration basis to gather more information about their effects on the health status of those who use them and on the health coverage of those who do not.

Third, ACP believes that a national debate should be undertaken to address the difficult issue of prioritizing health care services for all populations, not simply the elderly or poor. A national consensus must be reached on how to decide when care becomes futile, at any age, and when other care options should be chosen to preserve individual dignity and comfort. Alternatives to acute care treatments are critical, so that patients are not forced to choose between high tech care and no care.

Fourth, the potential for savings through administrative simplification remains to be exploited. Strategies for savings include uniform claims forms and electronic processing, utilization review based on patterns of care rather than case-by-case review, and incentives to promote economies of scale.

Fifth, Medicare and Medicaid should evaluate and adopt, as appropriate, prudent private sector purchaser initiatives such as quality indicators and service performance standards, use of centers of excellence, specialized services contracting, and case management for high cost services.

To summarize, the American College of Physicians believes that the goal of Medicare and Medicaid changes should be quality care for those in need and the long-term solvency and viability of those programs. Restructuring must be considered in light of its effects on the larger health care system. We recognize that the changes we recommend may not be quantifiable by CBO for short-term deficit reduction, and we know we are bucking the tide to insist that deficit-reduction is not the appropriate goal for changes in these programs. Many proposals which are so easily scored by CBO are arbitrary program cuts that harm patients, health care professionals and institutions, and the larger health care system. We hope that Congress and the Administration establish the private-public mechanisms to plan for long-term reforms in these vital public programs.

Thank you for the opportunity to share our views with the committee.

Mr. THOMAS. Thank you, Doctor.

I thank the panel.

Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. First, I want to thank the whole panel and all the others, the four Republicans and the eight Democrats that are still here. I regret that the Chairman had to fulfill a social engagement down in Texas. I thought these hearings were more important than that, but, Sister Keehan, I am glad that you and Mr. Thomson both put a human face on what we are talking about here.

We too often here in Congress tend to talk in budgetary terms rather than human face terms. Now that I have condemned myself for talking too much in budget terms, I want to say to Mr. Warden and Mr. Seward, most of this is going to come out of your folks and the hides of human beings that are going to be affected by this.

Mr. Thomson, you mentioned the cuts in Medicaid. It used to be before the unfortunate reform around here we handled the Medicaid Program. The Medicaid Program started right here at this dais. And when you take the Medicaid cuts and the Medicare cuts, they amount to almost $½ trillion, $½ trillion.

Now, assuming—and I don't, but assuming that $160 billion is needed to put the Medicare Trust Fund in balance, that still leaves roughly some $390 billion that is cut out of Medicare and Medicaid and out of people's benefits, a large part of it for a tax reduction for very wealthy people. When you compare the fact that we are talking about what is coming out of the pockets or the services to the sick, the elderly, to the disabled, it just doesn't make any social sense or economic sense or political sense to do that.

We can vastly reduce the burden on you, which is largely being driven, $390 billion of it, just by budget figures alone; $390 billion is being driven by budget figures alone, if we took out the 250 billion dollars' worth of tax cuts that will go to very limited upper income people.

So I think you begin to see the injustices and why at times I get very disturbed about what I am seeing happening here. I have left out the $23 billion that these folks voted yesterday or the day before yesterday to take out of the pockets of the working middle-class families here in America.

So this is an assault upon working middle-class families, upon sick people and elderly people; $1½ trillion.

Sister Keehan, I am eternally grateful for the human face you put on all this. I know where your Providence Hospital is. I know the kind of people that you end up treating and I just regret that the Chairman didn't stick around for this, that we don't have a piece of legislation to talk about. We are just talking about concepts and ideas and releases. No way to run a government.

I yield back the balance of my time.

Mr. THOMAS. The gentleman yields back the balance of his time.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. I have a question, but you know, I would just like to say something.

Mr. Gibbons, I know how deeply you feel about these issues. I respect you tremendously and you have led the way for many of us, but the way I look at this, this is not an assault on the working-

class people, the middle-class people. I think we are all trying to struggle with getting something accomplished and saving a system.

The degree to which we save the system may be different in your estimation than it is in mine, but you know, the question is how much and how fast, and it is not a metallic issue. It is a people issue.

I just wanted to say that because I just don't want to constantly be put in the position of ignoring whole groups of people with which I grew up and work every day.

Now, let me get to my question. A lot of us have been interested in these provider service networks. From my standpoint, representing a rural area, they are very, very important, and I understand that Mr. Warden, Seward, Scully all think these are pretty good ideas and maybe Sister and Mr. Thomson, you think that they are also.

From a practical standpoint, since they are so important—I mean, they tend to resolve the issue between the provider and the insurance company. They tend to knock down some of these problems of financing from the outside, profits going elsewhere and would instead leave them in the community. How fast, practically, if we were to say go now, would these things be able to get up and going? Do you see a reasonably short period of time or do you see us struggling?

Mr. WARDEN. Mr. Houghton, I think that in many places around the country, these networks have already been formed. In a very short period of time, as little as 6 months, I think that other provider-sponsored networks could be formed, arrangements could be made with HCFA for the Medicare population and it could move forward. And a good example, for instance, in rural America might be the Laurel Health System which is in Wellsboro, Pennsylvania.

Mr. HOUGHTON. I know it well.

Mr. WARDEN. That particular network came together over the last several years. It is a case of a community working with the providers and the social agencies, and is a good example of what could be done. Laurel Health is a network, for instance, that could move ahead very quickly.

That is the case throughout the country in many, many communities. And the problem is that in many, many communities, there isn't a managed care alternative; and if we provide a more flexible approach to contracting for Medicare, there have got to be entities ready to put that approach into place. We are not asking for special privileges in terms of the regulatory mechanisms. We believe that we can meet the same kind of regulatory requirements that HMOs and insurance companies have had to respond to in terms of quality and consumer protection and solvency.

What is important is the understanding that the capital requirements and reserve requirements should be somewhat less because most of the capital of a provider-sponsored network is reinvested in the delivery system—and is being used to take care of those people who are enrolled in it. And the other thing that is necessary, of course, is in many States, to have a less hostile regulatory environment—because the State insurance commissioners have such strict approaches to the development of anything that has an insur-

ance mechanism. And we have seen this in Blue Cross plans for years.

Mr. HOUGHTON. Anybody else?

Mr. SEWARD. Yes. I will be quick, Mr. Houghton.

I agree with what my colleagues said here, but there is one other thing that has to be—many of our providers are literally waiting to do this, but there are certain impediments in the law that have to do with antitrust, not that you need an exemption, but—

It would be in conflict with antitrust rules. So that if we could address some of those areas, not to give absolute exemptions from doing illegal business practices, but to help take away that impediment would increase the validity at how fast these come up.

Mr. HOUGHTON. Mr. Scully, would you like——

Mr. SCULLY. Yes, just quickly.

I would say the issue for us is clearly market access. There are lot of HMOs; I know Gail has one in Detroit—lots of hospitals that have HMOs. They could get in right away. Many hospital systems have chosen not to get HMO licenses and the issue for us is, do we have to spend 2 years getting one.

We have one system, Columbia HCA, that is a $17 billion a year operation. They clearly are more solvent than probably any insurance company in the country. They don't have an HMO license that I know of anyplace.

There are a lot of places, for instance, Houston, where they have 40 hospitals. They could put together a network tomorrow but they have to get a license first. Down in Charleston, in Mr. Payne's district where I went to school, the University of Virginia, which I don't believe has an HMO license, could probably put together a local provider network there in about 1½ hours, but they would have to get a State HMO license first. For us it is purely a matter of timing and varied success as far as the time.

Mr. THOMAS. The gentleman's time has expired.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Thank you, Mr. Thomas.

The previous panel, when I asked them about taking $270 billion cuts in Medicare or $180 billion cuts in Medicaid, which would add up to $450 billion, a staggering amount of money, kind of gave me a not-to-worry answer.

Sister, I would like to ask you the same question. If Providence Hospital in fact had to, over the next 7 years, deal with $450 billion of cuts in Medicaid and Medicare, what is the future of Providence Hospital?

Sister KEEHAN. Providence Hospital was established at around the time of the Civil War when Abraham Lincoln signed our charter, so when we were established, we weren't sure we were going to have a country, so I have to continue to believe in God. But I can tell you that we are testing that at Providence quite a bit with these. We have looked at the impact.

If we survived those cuts, we would survive with the character of the institution dramatically changed. All the safety-net programs we have that help our citizens and that help our elderly who don't—who are not the grandmothers of Congressmen. I smile when I hear Congressmen talking about worrying about their grandmothers. Don't worry about your grandmother. Worry about

the people that don't have grandchildren, those people who, when you tell them they need dialysis or they need wound care, we have to provide that. We have to provide every bit of education, have to provide every bit of the social support, have to provide their transportation to the physicians.

We will not be able to do that. We will not be able to provide things like palliative care. We will not be able to keep the same level of registered nurses. We will have to resort to much more of on-the-job training, lesser skilled people, if we can still afford the graduate medical education program.

There are multiple, multiple changes. People will not be able to come to the doctor with the increased costs out of pocket. They will not be able to meet the market-driven kind of structures that HMOs—that the market-driven HMOs impose on them. We will have to have more safety net and we will be able to afford less.

Mrs. KENNELLY. Thank you, Sister.

The panel seems almost unanimous in their acceptance of these new provider networks, and I have a hospital similar to your hospital, St. Francis in Hartford, Connecticut. My grandfather helped found the hospital. They are under a lot of stress and they are doing a very good job, but it is a constant struggle, things that they have to do with being an urban hospital, and that is how your hospital sounds, and I know it is the same thing.

Now, these new provider networks, will you have time—now, Mr. Scully says, hey, get a license, everything will be good. Somebody can do it in 1½ hours. Will you have time to set up these provider networks?

How much time do you have when you have got these changes coming, these stresses that you have got on your system? Explain to me—and I want to know, it is a good idea, you said?

Sister KEEHAN. Absolutely. I cut that portion of my testimony because of the lights that were flashing, but yes, I think that it is.

Mr. THOMAS. Tell the gentlewoman that she can go ahead and give us that part of the testimony.

Sister KEEHAN. I believe that is going to be a very important piece to allow provider service networks. Again, the devil is in the details. If the requirements for developing provider service networks are kept reasonable and are balanced, we can do that very quickly.

We have adjusted to multiple new systems, new delivery methods. We can do that very quickly.

But if they are so onerous and if they replicate some of the capital requirements that are free and simple, we will not be able to do it. What we have to remember in looking at capital requirements, the hospitals are not going to be paying out themselves. They are bringing that to the table, and so that is going to be a very important piece.

Mrs. KENNELLY. Thank you, Sister. I am glad to hear that from you.

Mr. Scully, you talked about the look-back, the fail-safe. We have called it two things today, the possibility down the line, if the cuts—or if what should have happened doesn't happen, if HHS or somebody is going to have to look back, and you seemed more or less content with this. Yet I hear many of the providers worried

about this, afraid that they will get a double hit if in fact the bill is $80 billion short.

Mr. SCULLY. I think it depends on how it is structured. I think again the details are important. I attached a chart to the back of my testimony. The issue for us is if you are going to take $270 billion out of the system, that there are a number of ways to do it, and we believe that—we have advocated along with the AHA for some 6 months now, that you should determine some amount of money you should take out of the system. And we suggested somewhat less than is being taken out, but the point is, there should be—the chart suggests that if you took, say, $200 billion, roughly, out of the system in specific cuts, nobody knows 7 years out what is going to happen and Congress is trying to hit specific budget targets.

What we have basically suggested is take out 80 percent of the amount with specific budget targets and leave the rest flexible on a year-by-year basis, and if the move to managed care works, you are going to save the money. If the OMB's baseline, which is a little lower, happens to be more right than CBO's and inflation doesn't go up, you are not going to need to save the money. In the alternative, you could have a little sequester to take the rest.

But the likelihood is, there is no reason to go out and say specifically $270 billion on specific provider cuts off a baseline that is not certain because it is going to change over the next 7 years, so we have suggested you have a more flexible chunk for the last 20 percent of the savings, and if it turns out that OMB is more right than CBO, great, it won't happen.

If the managed care changes happen, you won't need the money. And the alternative is a backup mechanism to make sure CBO can score it. We suggested putting in the sequester mechanism to save the last 20 percent, but in any case, just from a provider's point of view, we are not happy about the reductions but it is either pay me now or pay me later, and we would rather roll the dice on maybe managed care will work, roll the dice on maybe OMB is right, not CBO, and then as a third alternative, do a sequester.

Mrs. KENNELLY. I want to thank the panel.

We have all spent 9 hours together in this room and I am so glad you stayed and your testimony was excellent, and I just appreciate your being here and staying with us.

Mr. THOMAS. Thank the gentlelady.

Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. Thank you, Mr. Chairman.

I, too, want to say thank you to those of you for staying this long length of time just to testify before this Committee, and all the others that have been here today. Your testimony, your advice, your comments are all very helpful.

My colleagues on the other side of the aisle, their comments, too, are very helpful. In fact, I recall back earlier this year I had an opportunity to spend some time with the President. We were traveling together in Georgia and the first thing that I told him, because I wanted to spend some time and I wanted to get right into some issues, was that, Mr. President, we have a difference of philosophy. We will just get that out to start with. But that is not bad because the difference in philosophy means that we will be bring-

ing different ideas to the table, and the more ideas we bring to the table, the more debate we have, the better solution we will come up with for the problems that we face. I fully believe that that is what is happening here, is what has happened in the past, is what has happened in a lot of the meetings that we have held in this room this year.

Mr. Gibbons said that the way we are going about this is not the way to run a government. Well, I reckon, again, the proof will be in the details down the road, the results. But when I go back home, I hear people tell me that they like what we are doing because we are doing something. They may not know exactly what, but they know we are doing something and they know we are doing something different than has been done in the past.

And what has been done in the past? We sat here in this town as a Congress and we have spent taxpayers—$5 trillion into debt. We are spending from $400 to $500 million a day more than we take in in revenue from those taxpayers. However, when taxpayers pay their bills at the end of the month, when they run out of money, they have to stop writing checks. They can't do what we do with their money, continuously putting them in debt as taxpayers.

So is it irresponsible to address the problems of this country? I think not. I think it would be irresponsible to sit here and do the same old thing over and over and over again.

Sure, we are reducing the growth of spending in the area of health care. We must. We are reducing the growth of spending in all areas of government and we must.

We are reducing taxation, and we must, because we are putting moneys back into the budgets of families who are writing those checks at the end of the month to pay their bills. They need those funds, just like you need your funds.

I know, Sister, you need your funds and you are doing a good service and we don't want that service disrupted. But we know that if we keep doing the same thing that has been done in the past here continuously, you won't be able to provide that service and look to us for help, because it won't be here.

If we keep spending the money in the way and the rate that we have been spending it, this government will go bottom-side up. It can't exist. What will we do then?

We may not be doing everything to satisfy everyone, but at least we are doing something and we are addressing a problem and we are addressing it head on.

Thank you for your time.

Mr. THOMAS. Thank the gentleman.

Doctor, I understand you may have a time constraint on an airplane, so if you feel you have to leave, no one will think it is because you either don't want to answer a question or that you don't like them. We will understand.

Mr. SEWARD. Thank you, Mr. Chairman. I do have a speaking engagement in your State, but the trouble is, I do have to stop in Illinois to pick up some clothes.

Mr. SCULLY. We will represent the AMA.

Mr. SEWARD. I think I will stay then, Mr. Chairman.

Mr. THOMAS. Smart decision.

Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you, Mr. Chairman.

I would like to thank all five members of the panel as well. I thought your testimony was very thoughtful, very helpful, and I particularly would like to thank Sister Keehan for her testimony. Certainly Providence Hospital is one of the outstanding hospitals in the United States, and please give my regards to Dr. Simmons who is a friend of mine and certainly one of the outstanding physicians.

I would like to ask Mr. Scully, if I may, in the testimony, the second panel we had today, Dr. Wilensky and Dr. Altman testified basically that over the next 7 years the rate of growth will be 6.4, 5 percent for inflation and population growth and 1.4 percent for technology and other needs for the hospital and health care industry. They both testified that it will be very, very difficult, but doable, to meet that goal, and obviously we have the fail-safe with the look-back to deal with that.

In addition, in the document that we were handed out, the 60-page document, after the year 2002, instead of 6.4, as you know, the rate of growth will become 3 point—excuse me, 4.3 percent, which is 2 percent below even what they say will be very, very difficult.

And the reason I am asking you, Mr. Scully, is because you are familiar with the congressional budget process, not to say the others aren't, but you certainly are. That will be built into the baseline in the year 2002 and beyond, or as soon as we begin the 5-year projection and we hit the year 2002.

Being in the baseline, that means either taxes will have to be raised, fees will have to be raised, or more cuts in programs in the area of Medicare. I would like your thoughts on that because, 7 years seems like a long ways, in fact, Dr. Altman said, that is a long ways from now.

It is hard for me to make that projection, but it is built into the year 2014 in order to get those long-term savings and in order to make sure that the system is stable. I mean, that is the biggest selling point of this plan that is being—hopefully, we will receive next week, and I think of the DRGs. That has been in existence now for 13 years and——

Mr. THOMAS. Will the gentleman yield?

Mr. MATSUI. Let me just finish. And at that time, of course, we certainly—well, 7, 8 years, but now it has been in place for 13 years. Perhaps you could comment on that, if you would.

Mr. THOMAS. Will the gentleman yield briefly?

Mr. MATSUI. Sure, I will be happy to yield.

Mr. THOMAS. Based upon the gentleman's emphasis on that point, and one of the nice things about a conceptual document, rather than legislative language, I think the gentleman will find that when the legislative language is presented to us, that that number will change. It was a number that was put in assuming that the commission would change it, and I think the gentleman's point has been made several times and is a well-taken point and that number will change.

Mr. MATSUI. Do you know what the number will be?

Mr. THOMAS. It will be more than it is.

Mr. MATSUI. What will that—do you know the number?

Mr. THOMAS. I don't know. I know that the Consumer Price Index on the urban rating now, and it will be more than that when we make an analysis, assuming the commission doesn't do its job as outlined in this structure.

Mr. MATSUI. I hope I will be able to maintain my time.

Mr. THOMAS. Certainly. I just thought the gentleman would like to know.

Mr. MATSUI. I appreciate that. But it would help, because you see, this is an important issue to me and I think it is going to be an important issue to the hospital, the doctors, all the providers. I think we should know what that number is. It is going to be built into the baseline of it. If it isn't 4.3——

Mr. THOMAS. If the gentleman wants to work with us in terms of cooperatively structuring the bill and is on board, I would love to have him in the room when we make that decision.

Mr. MATSUI. In other words, that decision isn't made; we just know it is going to be increased?

Mr. THOMAS. I am going to carry back the gentleman's arguments and I believe will carry the day in making that number larger, just as we did in terms of the teaching hospitals and the structural changes that we have made there.

Mr. MATSUI. It would be my hope then that after we see that, because that number obviously has been built into this 60-page document, that maybe we can get these witnesses back and ask them the impact on the new number because that number is going to be built in for the next 20, 30 years, or whatever the year 2014 is.

Mr. THOMAS. I think you will find that the testimony that is given today will reflect the structural changes that will be made. But I thank the gentleman for yielding, and Mr. Scully, if you want to respond to his question.

Mr. SCULLY. I am much happier with the Committee's new position. It was one of the first things—I think you are right—CPI–U after 2002 is extremely, extremely tough. We raised those, one of the first things we raised when we saw the document. I think we raised it with the Subcommittee Chairman and we have raised it with the leadership and we were told it was going to be looked at, but I think you are right; it will be beyond tough.

Mr. MATSUI. Let me ask you this. This will be my final question. I know everybody is absolutely exhausted at this time. But under the 6.4 percent, do you believe that there will be additional cost shifts?

It would be very difficult, I suppose, because obviously that is what the private sector is, but where will the cost shift occur if, in fact——unless hospitals will close. That is an option. I know that Dr. Wilensky suggested that that could happen.

Mr. SCULLY. We hate to cry wolf and say hospitals will close down.

Mr. MATSUI. She said that was an option obviously.

Mr. SCULLY. There is definitely going to be a squeeze and I think our concern is—the argument is Medicare is growing at 10 percent a year. Well, the average growth total hospital spending this year for all hospital spending is about 5.5 percent, and if you ratchet

down the growth to 6.4, we think the hospital spending is probably closer to 3 percent or less.

There is going to be a squeeze. Hospitals are closing already because managed care is squeezing, the market is squeezing. We think it is increasingly much more difficult, especially in urban markets, to cost shift. It has almost disappeared. So there isn't anyplace else left to shift the cost.

I think in most major cities, you will find that hospitals are laying people off and cutting back staff. That is not so bad. We are trying to become more efficient and adapt and do what you all want us to do, which is to save money. This is obviously going to speed it up. We are obviously concerned it might speed it up too quickly. So I think the market is squeezing us and we are concerned that this might be going too far too fast.

Mr. MATSUI. I appreciate that. My only hope would be that hospitals like Providence will remain open. You see, that is the real frustration because I think that is the one that becomes—could become vulnerable in this process, and obviously they are the ones that are taking, uncompensated, those people that are really at the edge of life.

I do appreciate the testimony of all of us, and certainly, Mr. Chairman, I look forward to seeing what that new number is because that will help us determine perhaps what the long-term projections will be.

Thank you.

Mr. THOMAS. I do know, and I know he may not be pleased. He will be closer to pleased than he is now.

Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Thomson, the document that Speaker Gingrich made public yesterday and which has been the subject of discussion here today tends to steer people, elderly people, beneficiaries, into managed care programs. In your judgment, is that the most efficient way to give care to seniors who tend to need more care, more medical care in their elderly years?

Dr. THOMSON. I am not sure we know the answer to that completely, Congressman. It certainly appears to be on the surface a more efficient way to deliver care. What we need to do, though, is apply standards to the way in which managed care is applied to the elderly to be certain that the decisions that are made are not purely cost directed and have quality and standards as a basis for those decisions. So we are not certain what the—what managed care, what impact managed care will have on the elderly, but it is certainly worth an effort.

Mr. COYNE. Well, would one of those requirements possibly be more flexible choices in choosing your health care professional? Would you recommend that they have more flexibility in choosing their health care professional if they are steered into managed care programs?

Dr. THOMSON. Certainly, yes.

Mr. COYNE. Thank you.

Mr. THOMAS. Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Dr. Thomson, I want to ask you about your fifth recommendation because I represent a very large rural area, and your recommendations, I visualize how that will work in the big cities, but when you talk about Medicare or Medicaid should evaluate and adopt through private sector purchaser initiatives, and I would like you to explain what that is in the concept of small rural hospitals, such as quality indicators, service performance standards, use of centers of excellence, specialized services, contracting and case management; how do you visualize that will work in the small hospitals in rural America?

Dr. THOMSON. We are talking about the use of centers of excellence, for example, in which patients could be referred, although it is much more difficult in a rural area admittedly, to a center, a regional center, as opposed to developing that service within the institution.

Mr. LAUGHLIN. Would you establish a liaison or other relationship?

The gentleman from Washington State on the Democratic side this morning was talking about out in his district or in the eastern part of his State, that some areas are more than 150 miles from hospitals. I have heard that same figure in the western part of my State, but how did they get those type relationships where they get the excellence you are talking about and the cost-saving factors?

Dr. THOMSON. Well, they need to have a relationship with a major academic medical center in the region to which they could refer patients.

Mr. LAUGHLIN. And this will—I still don't figure.

Dr. THOMSON. This would obviate the need for the local institution to develop the expertise, to expend the funds to develop the capacity to care for very complicated patients as opposed to having them referred to a center in the region for care.

Mr. LAUGHLIN. I was hoping you were talking about some of the cost problems that some of our hospitals have because they don't have a big purchasing base. When I saw your purchaser initiatives, I was hopeful that you were coming with some idea. I don't know the size of the Sister's hospital, but we have some in Houston some miles from my district that are very large, and they have a substantial purchasing power and they get things at a substantially lower cost than the much smaller hospital purchasing. You didn't have any ideas along that line that you would recommend for cost saving for small hospitals?

Dr. THOMSON. As a network of hospitals together that could then purchase services at a lower rate, yes, that certainly could be done.

Mr. LAUGHLIN. Mr. Scully, do you——

Mr. SCULLY. We do have a couple hospitals in your district, and I believe Columbia has two; I am not sure. Yes, I think the market for rural hospitals is just totally different. I think it helps to get in the purchasing networks, you know, one of our chains with a voluntary a hospital association, or MHS. There are a lot of opportunities that many rural hospitals are getting in purchasing cooperatives to get the same purchasing power and kind of a joint venture mode that they might have in an urban area.

But I also think the reality is, a lot of these things are going to hit rural hospitals much harder than everybody else. I hope Congress is sensitive to that. It is just a different system.

If somebody has a 40-percent occupancy rate in an urban area, that is a problem, then they may well consolidate and someone else would help them out. In a rural area, nobody wants to close the hospital and have somebody drive 150 miles to the next hospital. So we are certainly concerned about the impact on rural hospitals.

Mr. LAUGHLIN. Were you going to add to that, Dr. Thomson?

Dr. THOMSON. Just that the use of quality indicators and service performance standards also would hold out some hope for containment of costs as well.

Mr. LAUGHLIN. In your fifth recommendation, did you have any transfer of technology to rural areas in mind when you were talking about service performance standards? One program they are experimenting with in my area is, I think they call it telemedicine—where they have the hookups to the big hospitals where they have specialty advice. Is that something that you had in mind in your fifth recommendation?

Dr. THOMSON. That is certainly a coming technology that is going to help a great deal. We are now able to transmit all sorts of images back and forth between institutions, so it is no longer necessary to send a patient from a rural institution, for example, to another institution for an imaging procedure, like an x ray, an MRI, or a CAT scan.

We also are looking forward to the opportunity or the possibility of having consultations done by telemedicine as well, that patients might actually be seen in their local setting by a consultant in a center of excellence that is at some distance from that patient.

Mr. LAUGHLIN. I wanted to raise those points with you because, as I listened to your testimony and looked through your written testimony, it appeared to me that the American College of Physicians was certainly far more focused on the big city areas than the rural area and so I appreciate your comments.

Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman.

Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you. Thank you very much.

This has been an excellent panel. I wish in many respects you had been the first. I think it would have been better for you, and I think it would have been better for us. You know, the four of you who are left I think have said what, Mr. Scully, you said too far, too fast.

Mr. Thomas, I would hope you might take a look at it before the year 2003 as well as after it.

Mr. THOMAS. Will the gentleman yield?

One to a customer.

Mr. Matsui got to me first.

Mr. LEVIN. No. But you responded post the 7-year period.

Mr. THOMAS. I didn't look at it.

Mr. LEVIN. This testimony is that that relates to the period now through 2002.

Mr. Warden, I especially welcome you. You specifically say you are concerned about the impact of reductions of $270 billion on quality and access. That is this first period of time, not the period of time after 2002, and I hope that you might take another look.

This issue has become, I think, frightfully polarized and maybe hopelessly so. But the testimony of this panel is that you should take another look.

Mr. Scully, you were with OMB. When were you there?

Mr. SCULLY. From the first day of the Bush administration to the last of the Bush administration.

Mr. LEVIN. So you don't come here as a partisan Democrat, I take it?

Mr. SCULLY. Some people who are Republicans might take issue, but——

Mr. LEVIN. Your experience was in the Bush administration, not the Clinton or the Carter?

Mr. SCULLY. In the Bush administration.

Mr. LEVIN. I don't say that except I think it adds to your credibility when you say the package would be far better if saving targets were more reasonable, and I think that is a frightfully reasonable statement, as yours are, Mr. Thomson.

If I might just ask you, Sister, I had the privilege of serving on the advisory board of Providence in Southfield, and I knew one of your predecessors in Washington, but you know, I am afraid there may be a tendency to say, Well, what you have said is just true of your hospital in Washington. Your powerful testimony that I hope everybody in this country will read, you say, "While the poor and seriously ill will suffer most from these changes, make no mistake, all Medicare patients will feel their effect." Are you talking about Medicare patients just at Providence Hospital in Washington?

Sister KEEHAN. Oh, no. No.

Mr. LEVIN. So tell us a bit more about the universality, in your judgment, of your statement if it isn't only about your hospital.

Sister KEEHAN. This country could go on well without one hospital, even as great a hospital as Providence, so there would be no need for me to be here if that was the issue.

The issue is, for the poor and the vulnerable, most of the hospitals that serve them have set up wonderful safety nets. It is one thing to say you have Medicare and you can go to the doctor you want at Providence or at any other hospital. But we run three buses a day picking up senior citizens.

We have to be the person who provides for many of the social service things. We have to deal with their housing. We have to deal with them with palliative care. We have to deal with them with home care and the supplies.

You just can't tell senior citizens who have no income, or are very low income and have no supportive families, that your wound needs to be redressed every day and come on into the wound care center, we will take care of it because Medicare covers it. You can't.

In addition, you are going to have, and you are already seeing with the squeeze of the lack of reimbursement in managed care, you are going to have fewer and fewer people at the bedsides of these patients in the emergency room, in the health centers who

are trained professionals. You are going to have more on-the-job trainees because you have to substitute to live with this $270 billion cut, plus the Medicaid cut.

How long will hospitals run transportation, will run stroke clubs, will run health screenings and wellness programs for the elderly with these cuts? I don't think it is going to be very long. I think that those things are going to be impacted at all the major hospitals, particularly those who have high percentages of people on Medicare who are poor, and so I don't think that it is a Providence phenomenon. It is going to be a phenomenon all across the country.

Mr. LEVIN. When you say poor, 87 percent—and I will finish with it—of the seniors in Michigan have incomes under $25,000, and 70 percent under $15,000.

Thank you.

Sister KEEHAN. Those are the people that need the screenings, they need the transportation, they need all the safety-net services that made Medicare work.

Mr. THOMAS. Thank you.

The gentleman's time has expired.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Let me follow up with Mr. Levin for 1 moment and say that I found this panel to be extremely helpful. All of your testimonies have been, I think, enlightening as to what the plan before us—when we finally get the details—will mean.

Four of you remaining all agree that $270 billion over 7 years, it is too much. You represent provider groups and they are just not going to be able to do that without some dramatic consequences.

And I personally don't think we should be beating up on you, Mr. Chairman, on that number. The $270 billion is in the budget resolution and this Committee is instructed to come in with $270 billion. I find that wrong.

I think the testimony earlier has pointed out that that is not needed as far as the solvency of the trust fund. In fact, a large part of the $270 billion has nothing to do with the Medicare Trust Fund, as has been pointed out by previous testimony. A significant part is necessary in order to bring about the tax cut that the Republicans have in their budget resolution. So I think that is pretty clear.

I find that the testimony here, though, of this panel points out the tragedy of that $270 billion number. It is clearly going to mean that hospitals are going to close. It is clearly going to mean that less physicians are going to be willing to treat Medicare patients. It truly means that some people are going to go without care, as the sister has pointed out, particularly when you combine these cuts with the cuts in the Medicaid Program.

But let me, I guess, quote from the sister, if I might, one line that you put in the letter, and I think you know better than just about any of the other people who have testified or commented because you deal on a day-to-day basis with people who must rely upon Medicare in order to get their health care needs met. You know what it is going to mean if the system is not there to provide the type of care that they get today. And I just want to quote you one line that I think is the most disturbing, because I think you

are more likely to be correct than the other people who have voiced their views, including both the Democratic and Republican Members of this Committee when you say, "It is also not fair to assure Medicare recipients that they can keep the current program if they want. The current program is lost with this proposal." I think that is the fear that I think my constituents have.

I thank you very much for your testimony.

I yield back my time.

Mr. THOMAS. Thank the gentleman.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you.

I would also like to congratulate this panel because I know all of you are out in the trenches. All of you I think care very deeply about this, and I think all of you appreciate perhaps more vividly than anyone involved in this Committee the consequences if the system were to actually go bankrupt in 7 years, and I think we have all seen the trustees' report. I think we all understand its significance, and my hope is that we could rise above partisan politics and check maybe a little bit of our philosophy at the door, come up with a way of addressing this problem.

I think that the majority in the leadership have offered a proposal that tries to get at the core of this problem, but I think in the long run there is also a terrible need for the whole Medicare issue to be addressed long term. I don't think we can allow this program to remain on the brink of insolvency on an ongoing basis. And that is why, Mr. Warden, I appreciate your comments in support of my independent commission bill that would create a commission above politics to assess the Medicare Program on an annual basis, and like the BRAC Commission, send recommendations directly to the floor of the House and Senate for action.

Now, having said that, Mr. Warden, I would like to visit with you how you feel this commission idea could be integrated with the notion of a look-back or fail-safe provision as appears in this legislation and to what extent you think they might be compatible or one might be a replacement for the other.

Mr. WARDEN. I think they could be very compatible. The look-back mechanism or fail-safe mechanism is obviously aimed at recovering the reductions if they do not occur through the other approaches that have been designated in the proposal. And the reason why the commission could be very important is because it would be in a position to take into consideration the kinds of things that would make the look-back mechanism so problematic for providers.

For instance, a misprediction by CBO on what the costs are, or, more likely an increase in inflation that is greater than what was projected, or even the fact that nobody decides to enroll in all these new kinds of alternatives that we provide for them in managed care plans. Each one of those kinds of things could have an impact on what the look-back amount is going to be and what will need to be done with it.

And I think that the commission would be the best approach to looking at those kinds of issues on an annual basis and then being able to make some judgment about why the problem occurred, how much money there is available, how many beneficiaries have to be

covered, what differences there are in different regions around the country, and then make some judgment about what the best approach is for the look-back mechanism for that year.

Mr. ENGLISH. I feel that in today's hearing we have seen some validation for the notion that we need to bring this whole process a little bit above the partisan political fray. Some of those validations perhaps were inadvertent. But I think, clearly, we need to bring this whole process of tying resources to services very much above the fray; and I appreciate your comments.

One last question. I know that many of your comments have focused on the need for hospitals to restructure. Why is this so important? And, Sister, I would like to follow up on that, too.

Mr. WARDEN. Well, the restructuring is important because the real way to reduce the cost in the system is to develop a continuum of care that integrates the system, integrates the services into a continuum instead of having them fragmented. Because it is the problems in the pass off from one level of care to another that creates additional costs, sometimes ruins quality, impacts patient satisfaction. And the coordination is essential, particularly when we have not only pressures of Medicare but also the pressures of the marketplace; and we, obviously, have got to reduce the cost of health care while maintaining the quality.

Mr. ENGLISH. Sure.

Mr. WARDEN. And by having coordinated services we are able to do it much more effectively.

Mr. ENGLISH. Sister, would you like to add to that?

Sister KEEHAN. I can only echo it, to tell you the truth.

The one thing I would like to tell you, your notion for a commission would be very, very helpful. I would hope the first thing it would look at would be some type of experiment with the most costly Medicare recipients, that very small percentage, and take the largest percent and see how the different level or different method of delivering care could be as effective, more effective or less effective before we change the whole thing and drop the safety net.

Mr. ENGLISH. Thank you very much.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you very much, Mr. Chairman.

Like my colleagues, Mr. Chairman, I want to thank members of this panel for their wonderful and moving testimony. I want to agree with Mr. Gibbons and want to be associated with his words.

Sister, you and Dr. Thomson put a human face on what this debate is all about. Sister, you in particular reminded me of the words of Hubert Humphrey, who said that the moral test of a government is how we treat those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadow of life, the needy and the handicapped. I think if we fail to meet this moral test during the next few weeks and months and maybe the years to come, the judgment of history will not be kind to any of us.

So I thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman from Georgia.

Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Yes, thank you very much, Mr. Chairman.

And I, too, want to add my word of thanks and appreciation for this panel. I think it has been excellent. You all have been here a very long time. We have been here since 10 o'clock this morning, and I do appreciate the fine job that you have done.

I just want to recap just a little bit of what I have learned here today. We started this morning with a plan, and this plan begins by saying that the board of trustees of the Medicare Hospital Insurance Fund has urged the Congress to take some action to ensure that the fund is solvent. And I agree with that, and I think we need to do that, and I think most of the people who have been here today have said the same thing.

We have learned that if we, over 7 years, look at ways to save $90 billion that we can prolong the life of that fund by 3 years, give us some time then to have a commission to study many of the factors that will be facing us as the baby boomers become Medicare recipients, and that would then give us an opportunity to make some good, long-term decisions.

The standard that was set out by the actuaries says that if you want to have 100 percent coverage of assets to the annual expenditures for each year over a 10-year period, then you would have to reduce the cost by $160 billion. This is a very tough standard, a standard Medicare has never met since it has been in existence, but this is a standard that was set out in the trustees' report. And to meet this tough, relatively new standard, the savings would be $160 billion.

What we are looking at today is a plan that goes far beyond either of those, and it is a $270 billion plan which we must then assume not only deals with Medicare and the things that need to be done to deal with the trust fund but over $100 billion is used for other purposes, for tax cuts and things that, in my judgment, in the judgment I think of others, don't need to be done at this particular time.

Mr. Scully says we are moving too far and too fast. I think he is exactly right about that. We are taking on a great deal of risk for Medicare, a great deal of risk I think for our whole health care system as we take on risk for Medicare. And for areas like mine, rural areas that are so dependent on health care and dependent on having good health care systems in order to be able to attract new people, to have our businesses grow and so forth, we are putting at risk our whole way of life.

So I think while we need changes and we need reforms, and I think there are some good ones in the plan that has been put before us today, this $270 billion is much too great. That is what we need to examine. And I look forward to working with the other members on this panel as we move forward to find an acceptable way to make sure that we get this right.

I realize I am the only thing standing between us and us being able to leave for the weekend, and so I will yield back the balance of my time.

Mr. THOMAS. Thank you. Thank the gentleman for yielding, and I want to thank all of the Members, and I do want to thank this panel as well. In fact, I want to thank all of the people who participated today.

It is kind of a culmination of those 16 Subcommittee hearings that we held with many of the same folk meeting time after time. It is a kind of a culmination because we discussed these issues repeatedly, and now we have pulled them together in a single structure.

But underlying all of the discussion today, notwithstanding the concern about particulars, is the fact that entitlements are the single largest area of the Federal Government. They are the single fastest growing area of the Federal Government. Medicare is the second largest entitlement, and we do have to deal with it. Even if we are not going bankrupt, the growth rate is unsustainable with the demands that it would make on the Treasury. But it is also going bankrupt, as the trustees clearly indicated.

I was pleased that after the initial discussion we got to some particulars. The gentleman from New York began looking at page 32, 33, 34, 35; and there is contained an effort in this bill to rethink the way in which we finance graduate medical education. It made no sense to me at all to use Medicare as the vehicle to meet a broader societal need and that we ought to change that. We are beginning the process of doing that with the downpayment of a large amount of general fund money to begin the shift.

The gentleman from California—in examining the mechanism that we have set up that Mr. Scully explained allows us to watch the managed care choices made by seniors and that if more choose than the Congressional Budget Office believes, the fail-safe mechanism is not needed. That is why it is called a fail-safe. If the fail-safe is needed, then we want to make sure that the structure of that fail-safe is a good one; and I am pleased that the gentleman from California and several panels focused on that number. I had not focused on it in the way that he presented it. As I indicated to him, we would change. We will then debate the legislative language, and you will look at the particulars as well.

But what we are doing, as the gentleman from Georgia indicated, is what the American people want us to do. They want to make sure that Medicare is there. A lot of the discussion is over needs and wants. Change is hard. It is very difficult. Sometimes when we are challenged we are able to do things we never thought we would be able to do and that coming out the other side we say we are better for it.

Our plan took the problem of community hospitals and doctors not seeing a bright future, of not knowing where they are going to go, waiting to be swallowed up by a managed care plan, going out of business, and we have created now a new opportunity in these provider service networks.

I was pleased, Sister Keehan, that you see this as a real opportunity in restructuring so that you might be able, in the savings of that restructuring, to direct some money to the very support-needed services that you indicated. And you are nodding. Is that one of the things that you would be looking at, to make sure that the money was directed to those things that you wanted to do?

Sister KEEHAN. Yes.

Mr. THOMAS. That is the kind of thing we need to do, rethink the way in which we have operated. The idea of having seniors provided with choice, not forced into programs but letting them choose,

I think, will be a very healthy operation in which seniors with adequate information and support and education can choose between a more historical managed care structure, HMOs or others, the provider service networks, medical savings accounts. I think it is an exciting part of this plan.

Because what it does is it says that Medicare will now be shaped by the marketplace, that the marketplace will help the government keep the cost down. That is how we are going to make sure that, first, Medicare doesn't go bankrupt; but, second, in this one change, we will make sure that Medicare is sound until we need to examine it again when the baby boomers retire.

In this same plan, we have a commission to examine how we should adapt. It makes no sense at all for us to come occasionally together in this Committee and clash over what we should do. We have decided to build in a commission way ahead of its needed findings so that we can plan for the future, 1 day at a time or 1 year at a time.

Staying ahead of the piper is not the way to deal with a program like this. To say that we are going to have a 1-year solvency test and that if you made it this year then you are doing a good job I don't believe is an approach that the American people, once they know that is the way it had been operated, would approve of.

What we want to do—and we are looking for cooperation, if not support—is to make sure that in this examination of a restructuring of Medicare, notwithstanding the concerns my colleagues on the other side of the aisle have, is that we make those fundamental changes in the program that guarantee that seniors through choice and through the marketplace will assist us in making sure that Medicare is there for them.

Sister Keehan, I would also say that one of the things that we have to make sure of is that in this society, having witnessed the largest resources shift in the history of any generation in the world from one to the next, that this current senior generation has to make sure that in the way in which they consumed the resources of this society that there is something there for the younger generation coming along. And we are going to try to make sure that that occurs as well.

And all Members having used their time——

Mr. GIBBONS. No, Mr. Chairman, I——

Mr. THOMAS. This was my 5 minutes that was allotted to each Member.

Mr. GIBBONS. The rules of this Committee don't just require us to talk when we have used—stop when we have used our time, and I don't intend to.

Mr. THOMAS. Is the gentleman requesting——

Mr. GIBBONS. I am not requesting. I am just using my constitutional prerogatives here.

Mr. THOMAS. Well, the Chair recognizes the gentleman.

Mr. GIBBONS. Thank you. It is now 9 hours and 28 minutes since—or, excuse me, 10 hours and 28 minutes since we started this meeting. Three Republicans, eight Democrats survived. Four witnesses survived. We even lost one of them in all of this.

I am sorry that the Chairman sought to fulfill a social engagement in his district rather than staying here and listening, particularly to this last panel. That was a mistake on his part, I believe.

I think, Mr. Thomas, you thoroughly failed to establish that, first, the Medicare Trust Fund is broke. Your first witness didn't do that. He hedged around at it, admitted in his opening testimony that the law requires a 1-year reserve and that we have a 7-year reserve. That is the law today.

Second, your first witness said that it would—in his estimate, it would take $160 billion to correct the trust fund; and you are taking out of medical care for aged and for poor and for elderly $450 billion—I mean, your party. That is unconscionable. That leaves some $320 billion laying on the table to cut taxes with, that you have already taken $250 billion of that $310 billion off the table to cut taxes.

And you know what I think of that. When the American public understands what is in that tax cut they will think the same thing.

I just think it is unconscionable that you would take the most vulnerable part of our population, the old and the sick and the poor, and use that much for a rich people's tax cut. I don't understand it. All of the wonderful things that you are advocating and have been in your mind for some time can all have been done without this kind of retribution against the sick. We could have tried them all without any kind of retribution against the sick and the elderly. I wonder where justice has gone. I wonder where the social contract in America has gone.

I yield back the balance of my time.

Mr. THOMAS. Any other Member wish to be heard at the end of this hearing?

Without objection, the hearing is adjourned.

[Whereupon, at 8:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

American Association of Clinical Endocrinologists

Testimony before the Ways and Means Committee

on the Republican 1995 Budget Reconciliation proposal

by the American Association of Clinical Endocrinologists

September 22, 1995

INTRODUCTION

The American Association of Clinical Endocrinologists provides a unified voice for clinical endocrinologists on issues affecting health care and the practice of endocrinology. As advocates for our patients, we are deeply concerned about maintaining necessary access to an endocrinologist for people with endocrine disorders, including diabetes, thyroid disease, cholesterol disorders, osteoporosis and other metabolic disorders.

The Medicare proposal submitted to the Committee for consideration today provides an excellent guideline for discussion with other congressional leaders and health policy makers on how best to reform Medicare, in light of increasing demand for deficit reduction and limitations in expenditures on federal entitlements. The proposal includes several provisions long-supported by the AACE. AACE strongly supports the plan's clarification of the self-referral law that will allow physicians to provide Durable Medical Equipment to their patients from their offices. AACE supports the CLIA provisions found in the plan. AACE is pleased that the proposal contains language mandating the use of a single conversion factor within the Medicare Fee Schedule. AACE is appreciative of the proposal's reform of medical liability issues. Further, AACE believes the addition of Physician Sponsored Networks in the marketplace will provide additional competition with health plans for Medicare beneficiaries business. There are, of course, some provisions in the Republican proposal which give us cause for concern. We are concerned over how the "Look Back" mechanism could arbitrarily reduce physicians fees. Additionally, AACE is concerned that the proposal does not include language mandating that a Point-of-Service option rider be attached to all Medicare managed care plans. A POS is critical to ensuring that patients have the choice to see the physician best trained to treat their diseases. We will elaborate on these issues below.

The AACE would like to thank the Ways and Means Committee for this opportunity to provide written testimony. We offer the following comments on the Republican proposal and hope that you will keep our views in mind as the budget reconciliation process goes through the inevitable refinement process.

MANDATORY POINT-OF-SERVICE

The AACE notes that the Republican proposal did not contain a mandatory Point-of-Service provision. AACE has long advocated for this provision and we hope Congress will agree to mandate a POS in all Medicare managed health plans.

AACE's longstanding concern has been the provision of optimal, cost-effective health care to patients with endocrine disorders, including diabetes, thyroid disease, cholesterol disorders, osteoporosis and other metabolic disorders. As an example of these endocrine disorders, diabetes is a complex metabolic disease that often leads to devastating health consequences. It is the sixth leading cause of death in the United States and its annual cost to society in terms of medical care and lost productivity is estimated between $20-25 billion. It has also been proven in a National Institutes of Health (NIH) sponsored study that intensive regulation of blood sugar levels results in better outcomes for diabetes patients. This type of regulation is best done by a specially trained endocrinologist; it is, therefore, critical to insure the right of patients with diabetes to have access to an endocrinologist.

To insure that this access is available, AACE supports a Point-of-Service (POS) rider be attached to all Medicare managed care plans. The POS allows endocrinology patients to obtain the most medically effective and cost effective way to combat this disease. Furthermore, AACE has developed a proposal to strengthen the POS option. In order to guarantee access to an endocrinologist for all chronic endocrine patients, we believe that legislation is necessary that would allow low-income endocrine patients to waive the co-payments and co-insurance payments typically found in the POS option if they choose to go out of a network plan to receive care from an endocrinologist. This would ensure that <u>all</u> endocrine patients who need specialized care from an endocrinologist could obtain it. Otherwise those who can not afford a POS option plan must accept their care from a "gatekeeper" who may or may not refer them to a specialist best trained for the patient's medical needs.

We note that in surveys of public attitudes about health care, choice of physician appears consistently among the top priorities of patients and consumers. A POS is responsive to patient's desires for freedom in selecting their caregivers. It also ensures that all health plan enrollees will enjoy that choice, not just those who can afford a higher priced fee-for-service.

FEE SCHEDULE IMPROVEMENTS

AACE is very pleased that the proposal includes a budget neutral single conversion factor for the Medicare Fee Schedule and replacement of the current volume performance standard with growth targets based on the gross domestic products plus two percent. As the Committee knows, the MVPS and separate conversion factors for surgery, primary care and non-surgery have served to severely distort the original intention of resource-based relative value system. We note however, that the proposal does not specify an implementation date for this change and makes reference only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to reduce volatility." AACE urges the Committee to clarify that the implementation date for the single conversion factor will be January 1, 1996 and also to specify a lower limit on annual updates to the conversion factor to assure that the updates remain reasonable.

AACE also expresses its support for the replacement of the VPS with updates based on GDP plus two percentage points. This move has been endorsed by the Physician Payment Review Commission.

MEDICAL LIABILITY

The AACE is very pleased to see the inclusion of health care liability reform in the Republican proposal. As the Committee is well aware, our tort system is ladled with excessive attorney costs, potentially huge punitive damage costs, and increased filing of non-meritorious claims against physicians. Further, the current tort system inadequately compensates deserving plaintiffs and imposes unnecessarily high litigation costs on all parties. The cost of these judgements are then passed on to the consumer in the form of increased prices, and decreased productivity of the work force. Fear of suits has lead many physicians to practice "defensive medicine" adding between $20 to $25 billion dollars per year to the health care system. Physicians pay an estimated $10 billion in liability premiums per year. By reforming the medical liability laws, with limits on how much juries can award for non-economic damages and providing guarantees that most of the monetary awards will go to patients rather than their trial attorneys, the Republican proposal offers real liability relief to the medical community. Such relief will result in more efficient and less costly care.

PHYSICIAN SELF-REFERRAL AND OWNERSHIP

AACE applauds the Proposals improvement of the Physician Self-Referral and Ownership provision of OBRA 93. The proposals treatment of that burdensome law will allow endocrinologists to provide blood glucose monitors to their patients and ensure their proper use.

As you know, Stark II prohibits physician referral of Durable Medical Equipment. This provision would effectively prohibit situations where an endocrinologist supplies his or her patients with blood glucose monitors in the physician's office. As a matter of practice, clinical endocrinologists diagnose and treat a significant amount of diabetic patients through the control and management of blood glucose levels. Frequently, the endocrinologist supplies the blood glucose monitor to the patient and then provides patient education activities related to the specific patient requirements for blood glucose monitors to ensure accurate, understandable, and timely results.

Vendors of blood glucose monitoring devices cannot provide the level of instruction necessary to properly educate the patient with respect to the intricacies of his or her condition. The enforcement of Stark II will disjoint the patient education process and leave patients to decide upon the choice of monitor without the technical background to make an informed choice. Patients who do not receive physician education on these monitors often find themselves back in the physician's office, realizing too late that their choice of equipment may have been either less than required or too elaborate for their condition.

Permitting physician practices to deliver blood glucose monitors and other DME within the office would recognize that these services are often an integral part of the physician's treatment of their patient, and are frequently dispensed to the patient in the physician's office at the time the physician services are provided. Restricting the provision of DME in physician practices may diminish quality of care, inconvenience patients, and increase rather than reduce health care costs.

We again thank the leadership for the positive way in which they have dealt with the Stark II law. These improvements in the law will allow endocrinologists and all other physicians to provide their patients with the best quality care possible.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 RELIEF

AACE applauds the inclusion of CLIA relief in the Republican Medicare proposal. The AACE has been concerned by the large number of physicians' practices that have sharply limited or discontinued essential patient testing because of burdensome CLIA requirements. As a result, patients are referred to outside laboratories for routine patient testing which could be done during the office visit for far less cost and would enable the physician to treat the patient immediately. AACE believes it is critical that the regulatory burdens imposed by CLIA on physicians and other health care providers be eased so they can return to providing the laboratory tests that they are trained to perform as a part of their clinical examination. These tests are the basic tools used by the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has unintentionally caused many physicians and other health care providers to stop offering the routine laboratory tests they need to provide patients with high quality care in an efficient and cost-effective manner.

CLIA has resulted in significantly higher costs for those physicians operating physician office laboratories. The government concluded that CLIA will add approximately $1.3 billion annually to the cost of health care. Despite this cost of complying with CLIA, there is little, if any, documentation that CLIA has resulted in improved patient care. The provision included in the Republican proposal will provide much needed relief for physicians who want to offer their patients laboratory testing in a timely and cost-conscious manner.

THE "LOOK BACK" MECHANISM

AACE urges the committee not to subject the Medicare program to a "look back sequester" if spending under the program exceeds estimated budget targets. Budget targets may be exceeded for various reasons such as the availability of new expensive technologies, increased use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the program. Indiscriminately cutting reimbursement rates to providers are likely to result in access problems for beneficiaries as physicians find it financially impossible to participate in health plans accepting Medicare vouchers. AACE recommends that if spending is higher than projected because of new useful technologies or increased patient utilization of services deemed medically necessary, Congress should provide the funds necessary to reimburse for these services.

CONCLUSION

The AACE commends the leadership for drafting their proposal on transforming Medicare. The document contains many provisions which AACE has long supported and we applaud your goal of preserving and strengthening Medicare for present and future beneficiaries. We are aware that this year's budget process is just underway and that this proposal will undergo change. The AACE looks forward to working with Congress on this crucial issue as the debate over Medicare continues.

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STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING AND AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

STATEMENT ON USING EXISTING MEDICARE SUPPORT FOR NURSING EDUCATION TO PREPARE ADVANCED PRACTICE NURSES

The American Association of Colleges of Nursing (AACN), representing 472 baccalaureate and graduate nursing institutions, and the American Association of Nurse Anesthetists (AANA), representing 26,000 certified registered nurse anesthetists, urge that existing Medicare funds presently going mostly to undergraduate nursing education be redirected for graduate nurse education. This innovation would help Medicare support for nursing education be more relevant to the Medicare population, and provide a stable, on-going revenue source to expand the production of advanced practice nurses (APNs), a vital resource for meeting future Medicare population needs. A graduate nurse education (GNE) program is one that educates nurse practitioners, nurse midwives, nurse anesthetists, or clinical nurse specialists. These APNs are prepared as expert clinicians to deliver primary care and services supportive to primary care. They also manage chronic medical conditions and other concerns typical of Medicare beneficiaries. GNE programs are post - baccalaureate, advanced practice nursing programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state and/or regional accrediting body, and award a graduate degree.

In order to educate adequate numbers of skilled APNs who provide high quality and cost-effective services to Medicare recipients and others, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. Medicare monies support provider operated nursing and allied health programs. AACN urges that these nursing education monies be redirected to educate APNs.

We suggest the following Medicare changes regarding support for professional education at Medicare facilities:

1. Changing eligibility to include jointly operated graduate programs.

Medicare reimburses hospitals for a portion of the costs of eligible hospital-owned or operated nurse education programs. In fiscal 1991, hospital operated undergraduate programs received $174 million from Medicare, according to Health Care Financing Administration data. Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed; educational cost of these new providers are, with one exception (nurse anesthetists), not covered by Medicare. **Consequently, eligibility requirements should be changed to those "jointly-operated" (provider-academic) programs incurring costs for support of APN education.** Providers eligible to receive reimbursement would have to meet all of the following criteria: must be eligible to receive Medicare Part A, incur clinical costs for the support of graduate nurse education programs, and have a written contractual agreement with the program's academic institution. Cost allocations for determination of Medicare's share of reimbursement would include student stipends, costs of nursing clinical faculty and supervision at the clinical site, and program expenses, all limited to that portion of the education taking place at the Medicare provider facility. Determination of the specific cost of education would be based on an appropriate ratio of faculty to students, and faculty and supervisory salaries.

2. Clarifying of "provider" definition to include out - patient facilities.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery evolving beyond acute care to community based sites, ambulatory care facilities as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. It is critical to support these settings, because students must be exposed to a variety of places where people are getting care. **The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers,**

ambulatory care facilities, health maintenance organizations, and public health departments. A broad definition of eligible training facilities is necessary to facilitate clinical training of the largest number of APNs in those sites serving Medicare patients that have the greatest need for these practitioners.

Most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are part of the cost of providing patient care because patients receive the benefit of the care delivered by graduate students and their faculty. The cost of nursing education is that of any student receiving a master's degree. The average debt burden is low because most graduate nursing students work full time, go to school part time on the "pay as you go" plan, and do not accumulate large debts.

A brief description of the APN student follows: She (most are female) goes to graduate nursing school part-time for an average of 3.9 years and is a primary earner for the family. She goes to school to become an expert practitioner and a stable health care resource to the community. Stipend support from Medicare funds would provide opportunities for the APN student to attend school full-time, reduce the need to work while going to school, and allow the completion of a graduate degree more quickly.

Under this proposal, all entities that incur clinical costs for support of APN education would have access to GNE funding for the portion of the cost attributable to the Medicare patient population. GNE funding would allow the allocation of resources for added clinical faculty to expand the number of APNs in training. This would help eliminate the waiting lists which all graduate nursing programs are experiencing. Support of preceptors in the clinical sites would allow them to provide teaching and direct clinical supervision to the APN students as a planned component of their job responsibilities, rather than as an additional responsibility to their current workload. GNE support would also provide incentives to the practice sites to agree to take on students for clinical training. It would allow the clinical site to focus on training activities while having a positive impact on patient care. It would also provide reimbursement to the sites for a portion of training costs.

Due to limited resources in many of these settings where patients are receiving care, most can only take on one or two APN students at any one time. This forces programs of nursing to contract with numerous sites in order to provide clinical training for students. In addition, reimbursing clinical sites for training APN students recognizes the value of their services to patient care. With the number of specialty resident physicians likely to be reduced, these APNs will be delivering many of the services and care formerly performed by resident physicians. Acute care nurse practitioners who have graduated from programs such as these, are already assuming roles in a number of clinical sites.

APNs are precisely the type of health professional the Medicare populations will need for primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization or nursing home care. The APN can be a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment.

At present, Medicare reimbursement for nursing education programs is limited by the "provider - operated rule," which directs most of the funding to diploma programs that produce entry level nurses. There are data indicating that the number of entry level nurses is adequate. There is a large gap, however, in the supply of advanced practice nurses. There have been five demonstration projects funded by Medicare to educate various types of advanced practice nurses. These projects ended in July 1994 and a report on the demonstration projects will be sent soon to Congress. These projects show that Medicare dollars increased the recruitment and retention of advanced practice nurses at the facilities running the programs, and improved the provision of nursing care. One project created a skilled nursing facility, and another implemented a management teaching/counseling program for cardiac rehabilitation. These programs suggest that more Medicare support

for advanced practice nurses will greatly benefit the Medicare population and could help reduce Medicare costs through replacement of more costly professionals.

This is the time to shift Medicare funding toward the recognized great need for advanced practice nurses. Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Though the redirection of these funds for support to APN education requires no new Medicare expenditures, it is imperative that funding levels should not be reduced for those APN programs currently receiving Medicare support. Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of the changing health care workforce.

COSTS FOR USE OF MEDICARE SUPPORT FOR NURSING EDUCATION

Initial estimates indicate that a proposal which reimburses for the clinical training of advanced practice nurses would cost Medicare no more than $66 million, as opposed to HCFA's estimate of $248 million for nursing education (which reimburses hospitals for the costs of educating mostly diploma nurses) in 1994.

1994 total number of full time APN students (AACN and AANA enrollment data)	8461
1994 Average cost per APN student (Division of Nursing data)	x $15,591
Total cost of educating full time APN students in 1994	$131,915,451
50% of the total reflects that 50% of education is spent in clinical training	x 50%
Total cost of clinical training of full time APNs	$65,957,725 million

**(reduced by the percentage of Medicare patient load, which varies by institution patient profile)

1994 Estimated Medicare nursing expenditure	$248 million
Total Projected Savings	**$182 million or more**

** Example: If costs reported for nursing education at one hospital are $200,000 and the Medicare patient load was 20%, Medicare reimbursement to the institution for nursing education would equal $40,000.

AMERICAN ASSOCIATION of Preferred Provider Organizations

AMERICAN ASSOCIATION OF PPOs

601 13th Street, N.W. * Suite 370 South * Washington, D.C. * (202) 347-7600 * FAX (202) 347-7601

September 21, 1995

The Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organizations (AAPPO) has enthusiastically supported the development of much-needed legislation to restructure Medicare, rescue it from looming bankruptcy, and bring to it the managed-care successes that have been so notable in the privately-insured health care market. To this end, we have been pleased to work with members of this Committee and to offer our vision of the role that PPOs can play in accomplishing your goals. We are gratified to hear that PPOs will be included as one option in an expanded menu of plan choices, and we hope that you will make the best use of PPOs' unique abilities to control cost and preserve choice.

AAPPO understands the Committee's enthusiasm for a 21st-century Medicare program that promotes risk-bearing private health plans. Naturally, cost predictability as well as containment is of critical importance in the budget process. However, some seniors may opt for one form of managed care over another, and there is general agreement that they cannot all be channeled into the most restricting forms of managed care (e.g., staff-model HMOs). AAPPO is concerned that Medicare legislation not attempt this indirectly by making all managed care plans behave like HMOs.

Most PPOs operate in a **managed fee-for-service** environment. They are not set up to accept risk, i.e., capitation. Yet non-risk PPOs are able to return eight to ten times their administrative fees in savings to payors through utilization management and negotiated fee schedules. PPOs are more geographically dispersed than other managed care networks, giving them a greater capacity to respond to beneficiary enrollment. They offer provider selection and credentialing, quality as well as utilization management -- and beneficiary satisfaction rooted in the ability to choose, each time service is needed, whether to see a network doctor or to consult one outside the network.

Preserving a degree of flexibility is an important part of encouraging beneficiaries to make the transition to managed care. PPOs are well equipped to provide this comfort level in addition to providing quality care and cost savings. But this can only happen if PPOs are not themselves forced into a too-precipitate transition. If required to bear full risk, the majority of PPOs will stay out of Medicare. Others will say, accurately, that they cannot bear responsibility for services performed out of network; being charged with full responsibility will mean a sharp reduction in choice.

AAPPO asks you to look at a range of risk options that will maximize PPO effectiveness in Medicare. A summary of the association's proposal for risk and non-risk contracting is attached. If you or your staff have questions, or if AAPPO can provide additional information, please call me or Director of Legislative Affairs Lisa Sprague. Thank you for your attention to our concerns.

Sincerely,

Gordon B. Wheeler

Gordon B. Wheeler
President and Chief Operating Officer

AMERICAN ASSOCIATION OF PPOs

601 13th Street, N.W. * Suite 370 South * Washington, D.C. * (202) 347-7600 * FAX (202) 347-7601

PPOs IN MEDICARE: RISK AND NON-RISK OPTIONS

The American Association of Preferred Provider Organizations (AAPPO) agrees with legislators that Medicare choices should be expanded, giving beneficiaries the same options available to those insured in the private market. We are concerned by proposals that would limit those choices to state-licensed, risk-bearing entities.

Most PPOs are not licensed as insurers or HMOs, and do not bear insurance risk. To require them to do so is to bar most PPOs from Medicare participation, thereby barring beneficiaries from an option that would offer both cost savings and provider choice.

AAPPO believes strongly that Medicare must build on the successes of the private sector, including PPOs. PPOs have charted impressive growth and popularity not by trying to replicate HMOs' structure, but by applying utilization and quality management to a fee-for-service base. In essence, PPOs represent *managed fee-for-service*. Given that 90% of Medicare beneficiaries currently are enrolled in a fee-for-service arrangement, it clearly would be advantageous to encourage this population to move into a more efficient and cost-effective variation. PPOs have the capacity to enroll large numbers of beneficiaries quickly -- but not if they must first undergo the laborious process of obtaining state insurance licensure.

AAPPO by no means suggests that PPOs seek to escape oversight and accountability. Indeed, we have proposed the development and implementation of federal-level standards to demonstrate PPOs' ability to deliver high-quality care and to protect beneficiary interests. Under the current scenario, we are prepared to work with Congress and the Health Care Financing Administration to develop standards appropriate to PPOs' unique structure; however, we would also suggest that private accrediting organizations could fulfill the role of arbiter.

PPOs seek direct contractor status under the Medicare program. As we envision the process, an interested PPO would first demonstrate its qualification by complying with formal standards. It then would contract with Medicare just as it now does with a self-insured employer, i.e., the employer bears the insurance risk, and compensates the PPO via an administrative fee for network access, provider credentialling, quality and utilization management, etc. AAPPO has suggested that negotiated performance targets could form part of this contract, and that non-risk PPOs put their administrative fees at risk as a form of performance assurance. In addition, PPOs would retain the option to participate as full-risk contractors by obtaining the necessary license or in partnership with a licensed carrier.

September 18, 1995

AMERICAN COLLEGE OF RHEUMATOLOGY

SPECIALISTS IN ARTHRITIS CARE & RESEARCH

Testimony before the Ways and Means Committee

on the Republican 1995 Budget Reconciliation proposal

by the American College of Rheumatology

September 22, 1995

INTRODUCTION

The ACR is the professional organization of rheumatologists. It includes practicing physicians, research scientists, nurses, physical and occupational therapists, and other associated health professionals who are dedicated who are dedicated to preventing disability, healing and eventually curing more than 100 types of arthritis and related disabling and sometimes fatal disorders of the joints, muscles, and bones.

As Congress and the public make increased demands for deficit reduction and a concomitant reduction in expenditures on federal entitlements, the proposal submitted to the Committee for consideration today provides an excellent guideline for discussion with other congressional leaders and health policy makers on how best to reform Medicare. The proposal includes several provisions long supported by the ACR. ACR strongly supports the plan's clarification of the self-referral law to allow physicians to share facilities and be in compliance with the Stark II law. ACR also strongly supports the CLIA provisions found in the plan. ACR appreciates the proposals' provision on medical liability. ACR is pleased to see the proposal also provides language mandating the use of a single conversion factor within the Medicare Fee Schedule. The leadership's provision regarding Physician Sponsored Networks will provide increased competition for health plans for beneficiaries business.

There are, of course, some provisions in the Republican proposal which give us cause for concern. We are concerned over how the "Look Back" mechanism could arbitrarily reduce physicians fees. ACR believes that a Point-of-Service rider should be mandated to ensure patient choice of physician is provided. Additionally, ACR is concerned that there is no provision which calls for a risk-based methodology when calculating the federal contribution to private health plans for those seniors who choose them. We will elaborate on these issues below.

The ACR would like to thank the Ways and Means Committee for this opportunity to provide written testimony. We offer the following comments on the Republican proposal and hope that you will keep our views in mind as the budget reconciliation process goes through the inevitable refinement process.

Risk-Based Methodology for Calculating the Defined Contribution

As you are well aware, Congress and health policy makers are coming to the conclusion that the existing Medicare structure must be transformed from a defined benefit program to a defined contribution program. Several policy makers have espoused the concept of providing "vouchers" to Medicare beneficiaries and allowing them to purchase their own health insurance with these vouchers. Although the Republican proposal does not advocate the use of vouchers per se, beneficiaries could elect to participate in MedicarePlus plans, which would be paid through a defined federal monetary benefit.

If such a system is to be a part of a long-term restructuring of Medicare, the ACR believes it is imperative that a proper risk-based methodology be used to calculate the voucher amount. As you know, the average expenditure per Medicare beneficiary in 1993 was $4020. However, for ten percent of beneficiaries, the average cost for care was $28,120 and for the remaining ninety percent the average expenditure was $1,340. The ACR is concerned that patients with chronic conditions, such as arthritis and related arthritic diseases, whose health expenditures exceed the value of the voucher may be "left behind" as insurance companies look to enroll healthier beneficiaries. In addition, because of the high costs of providing care to these patients, their out-of-pocket costs may be so high that they could be forced into purchasing the lowest-cost health plan available. Such plans will likely restrict them from accessing the physician best trained to treat their chronic condition.

The ACR believes that a proper risk-based methodology will help alleviate these problems. The methodology should be based on known variables established by medical literature accounting

for the co-morbid conditions affecting patient survival and quality of life. Prior patient utilization of health care services, though complex to administer, could be used to calculate a correct voucher value. In addition, it is clear that a detailed monitoring system would be necessary to ensure that providers and health plans did not adversely select against certain patients (ie. those with chronic, expensive conditions) and did not under-utilize resources associated with the improvement of morbidity and mortality of these patients. This monitoring system should not be used to alter diagnostic and procedural-related services; rather it should be focused on whether patients are receiving services when medically appropriate. ACR also believes that health plans should be required to include co-morbid and severity of disease data in their patient acceptance rates. This will ensure that health plans are appropriately spreading medical risk to all potential enrollees.

The "Look Back" Mechanism

ACR urges you not to arbitrarily subject the Medicare program to a "look back sequester" if spending under the program exceed estimated budget targets. Budget targets may be exceeded for various reasons such as the availability of new expensive technologies, increased use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the program. Indiscriminately cutting reimbursement rates to providers are likely to result in access problems for beneficiaries as physicians find it financially impossible to participate in health plans accepting Medicare vouchers. ACR recommends that if spending is higher than projected because of new useful technologies or increased patient utilization of services deemed medically necessary, Congress provide the funds necessary to reimburse for these services.

Mandatory Point-of-Service

The ACR notes that the Republican proposal did not contain a mandatory Point-of-Service provision. ACR has long advocated for this provision and we hope Congress will agree to mandate a POS in all Medicare managed health plans. Unlike more restrictive plans, the POS option allows enrollee who pay somewhat more the option of receiving services outside of the plan's network, thus broadening patients' freedom of choice in provider selection.

Under a POS, a health plan could charge an additional premium and higher coinsurance for services provided outside the plans' provider networks. Plans would be prohibited from reducing benefits or imposing excessive coinsurance on individuals who elect this option. The POS mandate strikes a balance between creating incentives to obtain services within a provider network and allowing people to go outside the network without prohibitive financial penalties.

A voluntary approach would not prevent health plans from imposing restrictions on choice. The sad truth is that many of the POS option arrangements now offered on a voluntary basis offer choice in name only. By imposing high cost-sharing when such services are provided outside the plan's provider network, they typically permit choice only for well off Americans for specialty services. For middle income Americans who wish to select a rheumatologist not on the plan's list, this is no choice at all.

Since some health policy makers have stated their concern that seniors may not be well suited to receive services in a capitated setting, it is extremely important that people be guaranteed the right to choose their own doctor. Medicare reform will not be credible if it promises choice, but then allows health plans to impose unacceptable restrictions on choice. ACR urges you to support enactment of a POS mandate in the budget reconciliation bill.

Fee Schedule Improvements

ACR is very pleased that the proposal includes a budget neutral single conversion factor for the Medicare Fee Schedule and replacement of the current volume performance standard with growth targets based on the gross domestic products plus two percent. As the Committee knows, the MVPS and separate conversion factors for surgery, primary care and non-surgery have served to distort the original intention of resource-based relative value system. We note however, that the proposal does not specify an implementation date for this change and makes reference only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to reduce volatility." ACR urges the Committee to clarify that the implementation date for the single conversion factor will be January 1, 1996 and also to specify a lower limit on annual updates to the conversion factor to assure that the updates remain reasonable.

ACR also expresses its support for the replacement of the VPS with updates based on GDP plus two percentage points. This move has been endorsed by the Physician Payment Review Commission.

Physician Self-Referral and Ownership
Shared In-office Ancillary Services Facilities Exception

ACR appreciates the Republican proposal's improvement of the federal law on physician self-referral. As the Committee knows, the current self-referral law includes an exception that allows solo practitioners and group practices to provide in-office testing services (e.g., clinical labs and x-ray services). However, it does not provide an exception from the ban for in-office testing services provided by an in-office facility shared by two or more physicians located in the same building but who are not in practice together. The absence of a "shared" in-office ancillary service exception has been a problem since the original 1989 law was enacted.

Shared arrangements are a cost-effective and practical way for physicians in solo or small group practices to provide in-office ancillary services to their own patients, without unnecessarily duplicating facilities in the same office building. For example, it is practical for physicians who are already sharing office space to share a single in-office laboratory between them rather than setting up two laboratories. Shared arrangements are especially common among the primary care specialties. In most cases, it is not a viable alternative for physicians in shared arrangements to become a group practice. Becoming a group practice involves much more than sharing the cost of providing in-office testing services, e.g., sharing legal and financial liability. Physicians involved in the shared arrangement may have nothing in common other than the fact that they share office space with each other. Understandably, they may not want to become a group just so they can provide in-office testing services to their patients. That leaves them with two options; set up two laboratories in the same office or stop providing in-office testing services. ACR thanks the leadership for eliminating this major problem.

Clinical Laboratory Improvement Amendments of 1988 Relief

ACR appreciates the inclusion of CLIA relief in the Republican Medicare proposal. The ACR has been concerned by the large number of physicians' practices that have sharply limited or discontinued essential patient testing because of burdensome CLIA requirements. As a result, patients are referred to outside laboratories for routine patient testing which could be done during the office visit for far less cost and would enable the physician to treat the patient immediately. ACR believes it is critical that the regulatory burdens imposed on physicians and other health care providers by CLIA be eased so they can return to providing routine laboratory tests they are trained to perform as a part of their clinical examination. These tests are the basic tools used by the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has unintentionally caused many physicians and other health care providers to stop offering the routine laboratory tests they need to provide patients with high quality care in an efficient and cost-effective manner.

CLIA has a direct effect on a rheumatologist's practice. During the course of a patient examination on a labile specimen, Rheumatologists conduct a synovial fluid analysis. Direct examination of synovial fluid is a simple one-step test similar to qualitative semen analysis in complexity. For the direct examination of synovial fluid, a sample of joint fluid is drawn and placed on a slide. It is than viewed under a microscope. The presence of bacteria indicates a bacterial infection that should be treated with antibiotics. The presence of crystals indicates gout. This simple exam, typically performed during the physical exam, allows for immediate treatment of patients who can be in a great deal of pain. The difference between bacteria and crystals is readily apparent. The identification of the crystals themselves, which requires a higher level of skill, is not necessary to make the distinction between bacteria and crystals and to begin appropriate treatment.

However, because synovial fluid analysis is classified as a highly complex test, it comes under the CLIA regulations. This results in significantly higher costs for the rheumatologist yet providing no improvement in patient care at all. The government concluded that CLIA will add approximately $1.3 billion annually to the cost of health care.

The provision included in the Republican proposal will provide much needed relief for rheumatologists and other physicians who want to offer their patients routine laboratory testing in a timely and cost-conscious manner.

Medical Liability

The ACR is very pleased to see the inclusion of health care liability reform in the Republican proposal. As the Committee is well aware, our tort system is ladled with excessive attorney costs, potentially huge punitive damage costs, and increased filing of non-meritorious claims against physicians. Further, the current tort system inadequately compensates deserving plaintiffs and

imposes unnecessarily high litigation costs on all parties. The cost of these judgments are then passed onto the consumer in the form of increased prices and decreased productivity of the work force. Fear of suits has lead many physicians to practice "defensive medicine" adding between $20 to $25 billion dollars per year to the health care system. Physicians pay an estimated $10 billion in malpractice premiums per year. By reforming the medical malpractice laws, with limits on how much juries can award for non-economic damages and providing guarantees that most of the monetary awards will go to patients rather than their trial attorneys, the Republican proposal offers real liability relief to the medical community. Such relief will result in more efficient and less costly care.

Conclusion

The ACR commends the leadership for drafting their proposal on transforming Medicare. The document contains many provisions which ACR has long supported and we applaud your goal of preserving and strengthening Medicare for present and future beneficiaries. We are aware that this year's budget process is just underway, however, we look forward to working with Congress on this crucial issue as the debate over Medicare continues.

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STATEMENT OF AMERICAN LUNG ASSOCIATION AND THE AMERICAN THORACIC SOCIETY

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 12,500 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

The ALA/ATS would like to take this opportunity to bring to the attention of the Committee its concerns regarding access to specialty care for the chronic lung disease patient. Under the proposed Medicare reform plan, which focusses principally on enrolling Medicare recipients into managed care plans, the access to specialty care question is paramount for our constituents who suffer from lung disease. In addition to including access to specialty care in Medicare reform, we would also like to see included a provision to end restrictive insurance industry policies that limit Medicare patients' access to the latest pharmaceutical products and medical devices. Furthermore, lifetime monetary caps on prescription drugs and medical devices should be eliminated.

LUNG DISEASE AMONG THE MEDICARE POPULATION

The prevalence of chronic lung disease varies with age, but for most categories chronic lung disease hits hardest in individuals 65 years of age and older. For instance, the prevalence of chronic bronchitis is the highest in those over 65, where 61.7 persons per 1,000 are affected. The prevalence of emphysema increases steeply with age, affecting 15.6 people per 1,000 in the 45-to 64-year-old group and nearly doubling to 29.8 per 1,000 after age 65. In addition, those over age 65 experience the second highest prevalence of asthma -- 48.2 per 1,000.

With these statistics in mind, it is only natural that the ALA/ATS be concerned with how Medicare recipients with chronic lung disease are treated under Medicare reform. If current proposals prevail, there will be an increasing number of Medicare recipients enrolled in managed care. The ALA/ATS wants to make sure that those with chronic lung disease will receive the same quality care and access to specialty care they receive under the present Medicare system.

THE NEED FOR ACCESS TO SPECIALTY CARE

In order to maintain optimal functioning in the face of a disabling condition such as chronic lung disease, patients require a wide range of health-related services. Medical treatment is, of course, primary. In terms of physician care, the patient's family physician usually makes a tentative diagnosis of chronic lung disease. In most instances, a consultation with a pulmonary specialist is suggested. In some cases, because of the extent of the patient's disease, referral to a pulmonary specialist is necessary.

Specialists serve a dual role in clinical practice: as a primary physician for a person with chronic disease and as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission or referral for every visit to a specialist would be a large detractor to access for people with chronic lung problems. Appropriate management of moderate to severe asthma by a specialist, for example, is more likely to result in fewer costly hospitalizations than care of those same cases by a general internist or family practioner who does not have the extensive training to work with asthma. Further, pulmonary physicians are generally able to assume full care for the patient whose primary problem is lung related and more often do so at the patient's request.

Just as there is a need to include specialty care access in Medicare reform, there also remains the need to train specialists to perform those services. The ALA/ATS is concerned that every effort be made to continue funding of Graduate Medical Education (GME) through a Medicare set-aside. Although the trend of the medical profession is to produce more primary care physicians, the fact remains that with a growing elderly population, the need for specialized services, such as critical care/pulmonology, will continue to grow well into the next century.

The American Lung Association and the American Thoracic Society are dedicated to ensuring that

lung disease patients on Medicare have access to the appropriate specialty care. Unless there is specific language in the Medicare reform bill mandating an out-of-service option for managed health care plans, access to providers who are specialists for individuals with chronic diseases (e.g. a specialist acting in the primary care provider role) may be denied, or severely restricted in the interest of cost savings. Financial disincentives for specialty referral also must be eliminated. Referrals always must be based on the best interest of the patient, not the financial interests of the health plan.

MEDICARE RECIPIENT ACCESS TO LATEST PRESCRIPTION DRUGS AND DEVICES

A variety of oral, parenteral and aerosolized medications are required to treat chronic pulmonary disease. In addition, some patients require oxygen and durable medical equipment, such as nebulizers, humidifiers, suctioning equipment and mechanical ventilators. New drugs and devices that can better control and add improve the quality of life for lung disease patients are being made available daily. Unfortunately, Medicare recipients cannot receive the latest/experimental drugs or devices because of restrictive Medicare payment policies. As a result, these patients, who are often in most need of advanced drugs and devices, are being denied access to a series of new products and therapies.

Compounding this already stifling situation are lifetime caps on prescription drugs and medical devices. The cost of treating chronic diseases is very expensive. Lifetime monetary caps on these therapies cruelly postpone the inevitable for those with chronic conditions. For patients who have exceeded their lifetime cap, finding other cost-effective health insurance to help pay for their ongoing medical costs is a nightmare, if not impossible.

Studies have been conducted indicating that the eradication of lifetime caps would result in minimal increases in insurance premiums. Insurance companies can effectively spread their risk of having patients with catastrophic illnesses through reinsurance. From an actuarial view, there is a trivial increase in premium costs from raising the lifetime cap from half a million or a million dollars to six million dollars or eliminating it altogether -- the difference for the patient who has a chronic and costly disease, however, is tremendous.

CONCLUSION

With the ever increasing number of Medicare recipients enrolling in managed care plans and considering proposed legislative plans to encourage this trend, Congress should make sure that the issues of access to specialty care, the ending of restrictive Medicare drug and medical device policies, and the elimination of lifetime caps on prescription drugs and medical devices are thoroughly reviewed.

Continued access to specialty care, prescription drugs, medical devices and the elimination of lifetime monetary caps are of extreme importance to those with chronic diseases, especially chronic lung disease. It is the hope of the American Lung Association and the American Thoracic Society that the committee will seriously and carefully consider these options when formalizing its final plan for Medicare reform.

American Nurses Association
Statement on
The Medicare Preservation Act of 1995
Presented to the House Ways and Means Committee

September 26, 1995

The American Nurses Association (ANA) is the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse educators, nurse managers and certified registered nurse anesthetists, through its 53 state and territorial nurse associations. We appreciate this opportunity to present our views and recommendations on the Medicare Preservation Act of 1995.

Since this legislation has not yet been finalized, our comments are based on the descriptive material released by the Committee on September 20, 1995. As more detailed specifications and legislative language becomes available we would expect to have additional comments and recommendations.

Overview

ANA recognizes that very significant changes in the health care delivery system are underway across the country. These changes -- driven in part by purchaser demands for more efficient and affordable health care services and in part by reduced payments by publicly financed health coverage programs -- are responsible for consolidation and re-structuring in the health care sector. ANA recognizes that the concerns of private purchasers of health benefits and taxpayers must be addressed in order to sustain the U.S. health care system, but we strongly insist that the quality and accessibility of care are not ignored.

In the public sector, the rate of growth of expenditures for Medicare must be reduced to ensure the solvency of Medicare's Part A Trust Fund. We strongly support the continuation of assurances that Medicare beneficiaries retain their entitlement to the traditional Medicare fee-for-service program in addition to other approved options. We agree with the need to offer Medicare beneficiaries access to a broader array of alternative delivery models that meet appropriate quality standards and provide for consumer protections. We know that some beneficiaries are currently enrolled in managed care organizations that render high quality services and result in high levels of patient satisfaction. Making such arrangements available to a larger number of Medicare beneficiaries is certainly an appropriate policy goal.

However, we are strongly opposed to both the magnitude and pace of the reforms proposed in the "Medicare Preservation Act of 1995." Reducing the growth in Medicare expenditures by $270 billion over the next seven years is not only unnecessary but dangerous. The Committee's own document states that This bill is designed to address the need to modernize the Medicare program and to assure the short-term solvency of the Program." We believe that the program savings are significantly in excess of what is required to stabilize the Part A Trust Fund over the next ten years while the long-term financing challenges of the "baby boom" generation are addressed separately.

The proposal presents a clear danger to the current 37 million, projected to be 41.5 million by the year 2002, aged and disabled beneficiaries who depend on the Medicare program for access to care, economic security and their very lives. According to the Congressional Budget Office (CBO), Medicare spending over the next seven years -- assuming savings of $270 billion -- would rise at an annual average rate of 4.9 percent. In contrast, CBO estimates the annual average rise in private health benefit expenditures at 7.1 percent. When one considers the health care needs of the elderly and disabled compared to those covered under private plans, this disparity in growth rates is even more alarming. In short, it simply is not possible to constrain the growth in Medicare outlays to rates significantly lower than the growth rate for private benefits without

diminishing both the quality and accessibility of care for those who depend on Medicare.

In addition, more modest savings in Medicare expenditures -- somewhere in the range of $90 to $110 billion over seven years -- would be sufficient to prevent insolvency in the Part A Trust Fund for at least 10 years. These amounts -- while not insignificant by any measure -- would provide the "breathing room" needed to undertake a more thorough study of how to prepare Medicare for the challenge of covering the large number of "baby boomer" retirees starting in 2010. While such an approach would require Congress to revise its Budget Resolution, we think such a step is warranted to avert what in our judgment would be real harm to beneficiaries and to many of the health care facilities on which they depend.

ANA Specific Concerns

ANA approaches an analysis of the "Medicare Preservation Act of 1995" by attempting to assess its impact on four critical aspects of the program:

- the quality, accessibility and appropriateness of covered benefits;
- the affordability of coverage to beneficiaries and taxpayers;
- the utilization of an appropriate workforce; and
- the promotion of primary and preventive care and community-based care.

As noted earlier, the ANA supports the intent of this legislation to expand the health plan choices available to Medicare beneficiaries. Many of our members work in managed care plans and receive their health benefits from such plans. However, it is essential that any expansion in the eligibility of health plans to enroll Medicare beneficiaries must be accompanied by measurable and reportable standards and by the capacity to monitor and enforce those standards.

Quality and Accessibility of Covered Benefits

While more widespread utilization of managed care systems shows some promise in predicting and controlling health care costs for the Medicare population, merely expanding managed care to include more enrollees has not in and of itself shown a strong relationship to improved health status or outcomes. Past efforts to rapidly expand the infrastructure for managed care by waiving plan standards or greatly relaxing them suggest a predictable result: poor performing plans, financial failures, and egregious fraud. In addition, managed care does not assure increased health status or increased health outcomes. ANA strongly recommends that health plan standards take steps to assure the accountability of any entity that assumes financial risk for the care of Medicare beneficiaries. As the standard bearer for expectations of nursing care at the national level, the ANA has expanded this effort to the managed care arena. ANA's Task Force on the Regulations and Accreditation of Managed Care is currently working to identify nursing's recommendations for the essential elements of managed care regulations.

We are especially concerned about the potential for managed care plans to engage in inappropriate limitations on access to specialty care, selective marketing strategies, and targeted efforts to encourage the disenrollment of beneficiaries with expensive or chronic conditions. Standards are, of course, only as good as the capacity to enforce them. The resources currently available to the Medicare program to qualify and monitor plans are stretched to the limit. A substantial increase in the number of plans applying for participation in Medicare and greatly expanded oversight responsibilities will require significant additions to Health Care Financing Administration (HCFA) resources.

All of these concerns have obvious implications for the quality and accessibility of services to Medicare patients. In addition, when the impact of provider payment cuts and potential of deeper cuts from the "fail safe adjustment" included in the

Committee's proposal, are taken into consideration, we believe that even the traditional Medicare program is at risk for declines in the quality and accessibility of care. When hospitals and other providers do not have sufficient resources to maintain adequate staffing and other resources, care is delayed, quality is compromised, and costs are increased.

Managed care plans claim to be able to save money without sacrificing quality by keeping their enrollees healthy. Certainly, there are credible managed care plans that have emphasized primary and preventive care and health education classes for enrollees. Many of these plans have recognized the value of professional nursing in delivering these services.

However, many managed care plans have also tried to minimize their costs by limiting expensive services for people with serious illnesses. They have done this both by shortening the time patients spend in the hospital, for example, and also by discouraging people who are likely to use expensive care from enrolling in their plans. As for-profit health plans begin to dominate the field, for many providers, paying dividends to stockholders is prioritized over the responsibility to patient care. Nurses and patients themselves report many instances of patients being underserved. Staff nurses and advanced practice nurses find they are being capriciously replaced by unlicensed personnel in the health care facilities.

In some areas nursing leaders and others have led the way in establishing high quality service delivery systems within managed care plans. Nurses can help to motivate industry leaders to concentrate on quality. The Minnesota Nurses Association reports that hospitals affiliated with managed care organizations have responded to internal pressure by staff nurses, combined with publicity campaigns, by reversing staffing cuts.

One area of measuring quality health care services to which ANA has devoted substantial resources is the development of health care quality assessment reports (report cards). Report cards are intended for use by consumers and payers of health care to facilitate their selection and evaluation of care provided in a health care plan by specific providers and facilities. Report cards also are intended to help practitioners identify patterns of care that promote or inhibit the delivery of quality health care.

ANA commissioned Lewin-VHI, Inc. to begin the development of the **Nursing Report Card For Acute Care Settings** in order to explore the nature and strength of the linkages between nursing care and patient outcomes by identifying nursing quality indicators. The report provides a framework for educating nurses, consumers and policymakers about nursing's contribution to inpatient hospital care. Seven quality indicators were identified as "measurements of quality" of nursing care in acute care settings. These indicators are:

- **Patient satisfaction**
- **Pain management**
- **Skin integrity**
- **Total nursing care hours/patient (case and acuity adjusted)**
- **Nosocomial infections, specifically UTI and pneumonia rates**
- **Patient injury rate**
- **Assessment and implementation of patient care requirements**

Although this nursing report card is aimed at all acute care settings, it essential in assessing the utilization of acute care by beneficiaries in managed care plans.

In recent months, we have seen the first public outcry against decreased services and poor quality of care by managed care organizations. In state legislatures, as well as the U.S. Congress, legislation has been introduced to mandate minimum hospital stays for vaginal and cesarian births. Although ANA does not believe it is the role of policy makers to legislate minimum standards of care for every specific health condition, we do believe that this legislative trend is indicative of the public demand and expectation that

the government will assure minimum levels of quality patient care.

We acknowledge that fee-for-service medical care has had drawbacks for nurses and other professionals and for consumers. It emphasizes providing the most expensive care, such as institutional hospital care; and unfortunately, that is where the highest fees are found for physicians, hospitals, and insurance companies alike. While there is no one standard for medically necessary care, many observers agree that under fee-for-service, more tests and procedures are performed than necessary, at times to the detriment of the quality of patient care. Without any significant external oversight of their services or their charges, physicians have been able to dominate the health care system in their own interests and block many legislative reforms including the oversight of quality and appropriateness, and to keep out competing professions such as advanced practice nurses.

However, fee-for-service offers health professionals a great deal of autonomy in deciding what care is appropriate and offers consumers wide choices about which health professional to visit and a degree of control over which service to accept or reject. Yet, within the traditional Medicare fee-for-service program, we are disappointed that the "Medicare Preservation Act of 1995" does not include expanded recognition of non-physician practitioners as alternative providers of health care. The ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs. Current laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. These laws are so confusing and complex for carriers, providers and consumers that they have become a barrier to access to these services in and of themselves.

We must guarantee that barriers the services of advanced practice nurses for the nation's elderly are removed. ANA was pleased to have the opportunity to work closely with Members of this Committee, as well as Members of the House Commerce and Senate Finance Committees, to achieve enactment of the "Rural Nursing Incentive Act". That provision, which was included in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), allows nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare.

Every American must have access to and coverage for high-quality preventive, primary and community-care services. As cost-effective sources of quality care, advanced practice nurses can enhance patients' access to vital care. Nurse practitioners and clinical nurses specialists have demonstrated their value in the provision of care to Medicare beneficiaries in rural areas, and that provision of the Medicare law now needs to be expanded to cover the services of all nurse practitioners and clinical nurse specialists, regardless of geographic location and practice setting. If nurse practitioners and clinical nurse specialists are qualified to provide services in rural areas, they are equally qualified to provide these services in all other settings. Advanced practice nurses make health care **affordable, available, acceptable** and **accountable**. This expansion of coverage does not provide for reimbursement of new services, but rather provides for reimbursement for existing services by these advanced practice nurses. This action would enable nurse practitioners and clinical nurse specialists to provide essential services to help to meet the health care needs of older Americans. We strongly recommend that the legislation currently under consideration include provisions making available the services of nurse practitioners and clinical nurse specialists in all settings.

Affordability of Care

ANA understands that increases in the Medicare program must be brought more in line with growth in the overall Federal budget and that the Part A Trust Fund must be protected from bankruptcy. This can be accomplished with a reduced level of savings from Medicare and with modest increases in beneficiary participation in qualified managed care plans.

With respect to increases in the financial responsibility of Medicare beneficiaries, we want to caution against imposing new burdens on those with modest and low incomes. Low-income beneficiaries, including those with current eligibility for Medicaid and those who are qualified Medicare beneficiaries, should continue to enjoy special protections under the program. We are concerned that changes in the Medicaid program being considered elsewhere in Congress will expose these beneficiaries to the premium and cost-sharing increases that are called for in the Committee's bill. This would be a tragic reversal of a set of protections designed to recognize the special needs of those beneficiaries who may be largely or wholly dependent on very modest Social Security benefits. The ANA strongly recommends that any increases in premiums and cost-sharing for currently protected low income beneficiaries remain the responsibility of Medicaid or be waived for these individuals.

Two other issues related to beneficiary financial liability that are not explicitly addressed in the Committee's proposal must be raised. First, it is not clear to us whether the payment by Medicare to qualified private plans is anticipated to cover all of the costs of these plans or will be a fixed amount determined in a manner similar to the current methodology for calculation of the average adjusted per capita cost (AAPCC) with the beneficiary responsible for any difference between the cost of a private plan and the Medicare contribution. Assuming that beneficiaries pay the difference between the premium for a private plan and the Medicare contribution, we would hope that Medicare would seek to negotiate the most favorable rates for beneficiaries in a manner similar to the role played by many large employers on behalf of their workers and families.

In the absence of effective negotiations on premiums by HCFA, individual beneficiaries would be at a substantial disadvantage in obtaining favorable rates. Moreover, if most private plans require significant additional premium payments by beneficiaries it could serve as a means to assure the enrollment of only wealthy beneficiaries who in turn would likely be the most healthy. The resulting fragmentation of the Medicare risk pool would likely mean those with lower incomes and poor health status remaining in the traditional program driving up the costs in the fee-for-service sector more rapidly. This division of the Medicare population along income and health status lines would over time undermine the stability of the program.

Second, we are equally concerned about the prospect of a relaxation of the current balance billing rules in Medicare -- either in the traditional program or inside a qualified private plan. In the latter case, we are referring to the possibility of allowing physicians in HMOs and other private plans to charge beneficiaries amounts in excess of plan rates and above the maximum 120 percent limit in current Medicare. Loss of this important patient protection would, in our view, be a major retreat from a longstanding commitment to vulnerable beneficiaries -- most of whom live on annual incomes of less than $25,000. ANA urges the Committee to extend the balance billing protections in current law to private plans that desire to participate in the program.

Maintaining the Workforce

ANA believes that one of the most critical components of the delivery system consists of the health professionals responsible for the delivery of care. Without the proper number and mix of the professional skills, the quality of care for all Americans will be in jeopardy. There is considerable evidence that some segments of the restructuring and consolidation of the delivery system seen today is resulting in inappropriate staffing

reductions and an alarming decline in the skill mix in health facilities. To save money, many hospitals are replacing registered nurses with less trained and unlicensed assistive personnel, nurses aides or patient care assistants. In addition, some of these actions have been taken without adequate notice or efforts to assist dislocated staff, risking the health and safety of patients and the security of practitioners and their families.

The hospital industry is in a state of massive restructuring wherein hospitals are changing the way they operate, the way care is delivered, and the way their employees are utilized because many managed care systems are forcing them to focus exclusively on the "bottom line." To maximize profits, hospitals are reducing nurse staffing by increasing nurses' workloads and replacing them with unskilled workers. The utilization of these unskilled workers to do nursing jeopardizes the safety and quality of patient care in hospitals. ANA has proposed legislative language that would provide information to the health care consumer on the "quality" of nursing care in all health care institutions. Specifically, ANA would propose that any Medicare restructuring proposal include a requirement that:

- all hospitals be required to report their RN staffing and patient outcomes data to the general public and that those institutions and agencies create quality report cards for hospitals and other health care systems for consumers to include data on RN staffing, mortality rates, infection rates, lengths of stay, readmissions, malpractice, and other safety and quality issues.

In addition, the nursing staffs of hospitals are bearing a large share of the professional and financial pain of adjustments in inpatient capacity. Nurses who remain in the inpatient setting are expected to assume larger patient loads and additional duties. Those who are dismissed often receive no assistance or counseling in continuing their professional careers. ANA believes that all payers -- including Medicare -- should share in the costs of providing for changes in the workforce. Such assistance should include costs associated with clinical training in ambulatory sites for advanced nurse practitioners and in re-training of nursing professionals to meet other workforce needs.

While we note the inclusion of additional workforce funds for graduate medical education, ANA strongly recommends that clinical programs for the education of advanced practice nurses be eligible for such support. This will ensure that we can establish and maintain clinical education programs in settings where primary and preventive care is delivered. In addition, there is a need for funds to support re-training health professionals for careers where there are documented workforce shortages.

Promoting Primary Care, Preventive Care, and Community-Based Care

ANA has long been committed to the value of primary and preventive care. We believe there is now clear and convincing evidence of the cost-effectiveness of such care. Certainly, increasing the role of managed care in the Medicare program has the potential for expanding access to these services. However, we assume that very large numbers of beneficiaries are likely to remain in the traditional Medicare program. Current Medicare benefits related to primary and preventive care are limited to a few limited services -- for example, mammograms; pap smears; and pneumonia and influenza vaccinations.

One of our primary concerns with all of the Medicare restructuring proposals currently being discussed is that they all perpetuate what is wrong with the medical model. Although Medicare has contributed to a dramatic decline in poverty and an improvement in health status among the nation's elderly, further steps could be taken to reduce costs in the Medicare program by re-orienting from the illness model of Medicare to a wellness model of health care. Health care should be focused on a broad scope of quality health services, not just the treatment of disease. Community-based clinics, health education, home-based care, and public health initiatives are important steps

toward addressing the growing need for better and more accessible health care services over the long-term. By including services that are geared toward preventing and minimizing disease, and coordinating the appropriate level of care indicated and existing services within our nation's communities, health care plans can save immense amounts of money as well as ensure a healthier population. One of the clearest examples of preventive care saving long term costs in the health care system is the early intervention and identification of decubitus ulcers (bedsores). Numerous studies have shown that a perceptive nursing assessment and early identification of individuals at risk to develop serious bedsores can prevent grave and even life-threatening consequences. Similar studies can demonstrate cost savings of preventive care for other conditions common in the elderly population.

We would like to draw your attention to a Medicare demonstration project currently funded by the Health Care Financing Administration. The Community Nursing Organization (CNO) is a three-year national demonstration, enacted as part of the Omnibus Budget Reconciliation Act of 1987 and first funded in the 1992-1993 Federal budget. Four sites were selected and are functioning today: Carle Clinic in Urbana, Illinois; Carondelet Health Care in Tucson, Arizona; the Visiting Nurse Service in Long Island City, New York; and the Block Nurse Program in St. Paul, Minnesota. The demonstration, a capitated model of nurse-managed health care, provides community-based health services to the elderly at a predictable, and controlled rate by utilizing registered nurses as health educators and care coordinators.

Patients and families enrolled in CNOs fall into two categories:

(1) well-elderly persons who wish to maintain health and reduce risk; and
(2) persons likely to be frequent users of hospital and ambulatory services or who are at risk of poor quality outcomes.

By combining the financing and delivery of health care services to the elderly in one package, the CNOs provide mechanisms for addressing patients needs in an environment of shrinking resources. To date, the CNOs have demonstrated that they provide:

- extremely high enrollee satisfaction
- overall lower costs than initially projected
- decreased traditional Medicare home care costs
- more cost-effective mix of services
- shorter duration of traditional Medicare home care
- utilization of less expensive equipment

The CNOs are one example of how a wellness model and nursing management of care can be incorporated into the Medicare health care delivery system to save money, to provide quality care, and to prevent illness among our nation's elderly.

ANA urges the Committee to consider expanding the current benefit package to include coverage for other preventive benefits with documented cost-effectiveness. While there would be some initial costs associated with these services, the long-term benefits to individuals and the program would offset these and provide a real return on the investment in terms of better patient outcomes and lower health care costs.

Conclusion

Mr. Chairman, the American Nurses Association recognizes the enormous challenges you and your Committee face in assuring the future of Medicare and protecting the interests of the 37 million beneficiaries who rely on it for access to care and their economic security. We believe a more modest package of program reforms is called for to meet the short-term threats to the solvency of the Part A Trust Fund and to bring Medicare spending more in line with growth in the Federal budget. We are anxious to work with the Committee to achieve these goals in a manner that assures the quality and

During its June 1995 meeting, ANA's House of Delegates adopted a resolution to guide the maintenance of a working Medicare system for the health of the entire nation. That resolution provides that:

- **ANA will continue to advocate for a more cost-efficient Medicare program that stresses prevention and early intervention and Medicare must provide access to a full range of quality health care providers, including RNs, and services must be available in community settings. Redirection of Medicare funds must include funding for graduate nursing education;**

- **ANA will continue to advocate that Medicare include and incent advanced practice nurses as autonomous independent providers;**

- **Any savings realized from restructuring Medicare must be reinvested in expansion of coverage and benefits package for uninsured populations;**

- **ANA's legislative language for public disclosure of staffing and quality data must be utilized as a method of insuring that quality care is delivered when federal dollars are used and when appropriate included in any conditions of participation;**

- **Medicare must remain an affordable, accessible social program. ANA opposes the use of vouchers or Medical Savings Accounts as alternatives to providing increased access or a standard benefits program under Medicare; and**

- **Medicare must maintain at least the basic set of benefits now available and ANA will oppose any large scale cuts in Medicare, particularly in the absence of adequate quality enforcement mechanisms.**

Thank you for this opportunity to present our concerns and recommendations on the "Medicare Preservation Act of 1995". The American Nurses Association looks forward to having the opportunity to work with the Committee as this proposal continues to be developed.

STATEMENT OF AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine, representing this nation's largest medical specialty, appreciates this opportunity to share with the committee its views on the Medicare Preservation Act (MPA). Doctors of internal medicine care for the largest proportion of Medicare beneficiaries and, thus, our members are deeply concerned about any changes to this program that may affect our patients' access to high quality health care.

Expanding Choices and Competition

The fundamental approach outlined in the summary document distributed last week, which is to offer Medicare beneficiaries a wider range of competing health plans, is consistent with ASIM's own proposals for keeping Medicare affordable. In particular, ASIM commends the leadership for including provisions that would make it easier for physician-sponsored health plans to contract directly with the Medicare program without an insurance intermediary and that provide for standards recognizing the important differences between provider-directed plans and insurance companies. ASIM also supports the proposed changes in the antitrust law, including replacement of the "per se" rule on price discussions with a "rule of reason" standard.

In its own proposal for Medicare restructuring, ASIM made a number of recommendations for improvements that can be made immediately in Medicare's risk contracting program. Those changes in the Medicare Preservation Act with which ASIM agrees include the adoption of an open enrollment period for health plans, improvements in the risk contract plan payment methodology, preservation of the current Medicare benefits package and maintenance of standards governing guaranteed acceptance, appeal rights and other consumer protections. ASIM also applauds the expansion of these standards to require HHS to provide information to beneficiaries that will enable them to make informed choices in selecting a health plan and that provide a certain level of due process for physicians terminated from a health plan. ASIM believes that changes such as these will foster competition based not on risk selection but on quality of care delivered and will make Medicare more accurately reflect the health delivery system environment in which most Americans participate today.

Fee Schedule Improvements

ASIM particularly wants to commend the committee for including in its plan a budget neutral single conversion factor for the Medicare fee schedule and replacement of the current volume performance standard with growth targets based on gross domestic product plus two percent. We urge that this budget neutral conversion factor be retained during the markup. As the committee knows, the MVPS and separate conversion factors for surgery, primary care and non-surgery have served to distort the original intention of physician payment reform and have actually worked to the detriment of primary care, the very services payment reform was meant to assist in order to preserve patients' access to these vital services. Indeed, each year, the updates resulting from the separate conversion factors and MVPS have only amplified the inequity in payments between primary care and other services. The summary of the Medicare Preservation Act which ASIM has reviewed does not specify an implementation date for this change and makes reference only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to reduce volatility." ASIM urges the committee to clarify in the legislative language that the implementation date for the single conversion factor will be January 1, 1996, and to specify a lower limit on annual updates to the conversion factor to assure that the updates remain reasonable.

ASIM also wishes to express its support for the MPA's replacement of the volume performance standard with updates based on gross domestic product (GDP) plus two percentage points. This move has been endorsed by the Physician Payment Review Commission and ASIM believes it is a sound one.

Improvements in Physicians' Practice Environment

ASIM is pleased that the Medicare Preservation Act includes several provisions that will make important modifications to the environment in which most physicians practice medicine. For example, the medical liability changes will provide much needed reforms in the tort system without depriving victims of malpractice their just compensation. Among the most important of these liability reforms is the cap on noneconomic damages, which has proven to be successful in reducing health care system costs in states adopting such limits.

In addition, ASIM congratulates the committee for including significant regulatory relief in the form of changes to the Clinical Laboratory Improvement Act and self-referral laws. We agree with the committee's assessment that CLIA has become "overly regulatory, burdensome, and costly" and that the burden on physician office clinical labs should be lifted. Obviously, the manner in which that burden is lifted is extremely important to physicians and we urge the committee to clarify this further in the legislative language to encompass a complete exemption of physician office laboratories from

CLIA requirements.

Elimination of the Stark II group compensation requirements, streamlining of the designated health services list, as defined in Stark II, and placement of a moratorium on enforcement of Stark II until HHS issues its final regulations take giant strides toward removing some of Medicare's most frustrating rules for physicians. ASIM especially wishes to commend the committee for its modification of the in-office ancillary services exception as defined by HCFA in the Stark I final rule by repealing the "directly supervised" terminology. This means physicians will not have to be present in their labs while all testing done for Medicare patients is being performed. By repealing the site of service requirement, this will allow physicians to provide services at satellite locations convenient to their patients. Finally, ASIM is grateful for the committee's inclusion of a shared facility exemption to the self-referral statute. This necessary exemption has been recognized by Congress on both sides of the aisle for many years and it is unfortunate that its passage has heretofore been delayed due to circumstances unrelated to the merits of these provisions.

"Fail Safe" Provisions

While ASIM finds much to commend in the Medicare Preservation Act, there are a number of aspects to this plan about which we would like to raise some cautionary flags. Predicting increases in health spending has never been an exact science. Numerous factors over the years -- from advancements in valuable new technologies, to increases in utilization of services for medically necessary reasons, to sudden outbreaks of serious illnesses -- have confounded accurate projections of health care spending in this nation.

ASIM is concerned that creation of predetermined budget targets that will drive automatic reductions in a particular "sector" of Medicare provider payments may have adverse consequences for patient care. As ASIM understands it, the Medicare Preservation Act contains formulae for establishing budget allotments for the fee-for-service side of Medicare and divides those allotments among sectors equal to various types of provider services. If spending in the fee-for-service sector exceeds the total amount budgeted for a year, proportionate reductions will be made the following year in each sector whose spending contributed to the cost overrun. Alternatively, if a particular sector's spending falls below its baseline allotment, its unspent balance will be reallocated among the other sectors.

Making growth rates category-specific under the fee-for-service side of Medicare, as would be done under the Medicare Preservation Act, should help avoid circumstances in which a sector in which costs are being controlled is placed at risk for overspending in another sector over which it has no or little control. At the same time, ASIM questions the equity in dividing up among the other sectors the unspent balance in a sector that comes in under its budget projection. This provides almost a perverse incentive for a sector to spend as close as possible to its target. Alternatively, allowing some (or all) of the surplus to be returned to that sector for improvements in payments would be a better way to reward those providers at risk for cost efficient delivery of care.

It is not clear from the conceptual document how the "fail safe" target for the physician sector interacts with the separate recommendation to replace the current VPS formula with a "sustainable rate of growth" based on per capita GDP plus two percentage points, as recommended by the Physician Payment Review Commission (PPRC). This change by itself is projected to hold annual growth in Medicare spending for physicians' services to between 6 and 7 percent per year, according to the PPRC. It is not clear why expenditures on physician services would also need to be subjected to a fail-safe provision. ASIM agrees with the PPRC's concern that "this [fail safe] provision may conflict with the mechanism for constraining growth in physician spending. As the policy is further developed, it is important to consider the interaction between the fail safe and the mechanism for constraining growth in spending on physicians' services."

Although there were few specifics provided in the summary, constraints on spending under Medicare Plus would appear to be in the form of the government contributions, or premium payments to plans, being tied to the growth rates set out for Medicare through 2002. The government contributions, though, are tied in turn to spending under the fee-for-service side of Medicare in that total allotments provided for fee-for-service Medicare in a given year will equal the overall Medicare budget less payments the Secretary estimates will be made under Medicare Plus. These calculations depend to a great extent not only on the accuracy of estimating how many beneficiaries will join Medicare Plus plans and how many will choose to remain in the fee-for-service side of Medicare but the kinds of beneficiaries who opt for one type of Medicare over another. Recent statistics compiled by HCFA indicate that, although the average per beneficiary expenditure under Medicare is approximately $4000, for ten percent of beneficiaries the average expenditure is somewhat over $28,000. If most of the latter group of beneficiaries choose to remain in Medicare fee-for-service while healthier beneficiaries join Medicare Plus plans, this could have a significant impact on the actual spending experience of the two sides of Medicare. As the chair of the Physician Payment Review Commission,

Gail Wilensky, noted in her testimony to this committee last week, adverse risk selection between the fee-for-service side of Medicare and Medicare Plus could activate the fail safe mechanism leading to cuts in provider payments and possible reductions in beneficiaries' access to services.

ASIM recognizes the need for controlling costs in the growth of Medicare. As the foregoing examples demonstrate, however, setting budget targets so that spending in two vastly different types of Medicare programs meets predetermined limits may have unintended consequences for the system. If spending continually exceeds targets set, despite efforts to root out fraud, waste and abuse and to improve the efficiency of the system, it may be useful not only to identify additional areas where cost savings can be found but also to examine whether the targets were in fact realistic. Rather than giving the federal bureaucracy considerable authority to effect automatic reductions in provider payments, as the Medicare Preservation Act does, ASIM recommends that a commission, independent of the executive branch, evaluate a variety of options for bringing spending in line. If it is the intent of Congress to include some type of "lookback" mechanism that triggers automatic spending cuts in Medicare, ASIM intends to analyze the specific legislative language and offer additional recommendations in the future to make sure that the reductions anticipated are not so great that they make it impossible for physicians to care for Medicare patients and still cover their overhead.

Conclusion

Again, we appreciate this opportunity to comment on the Medicare Preservation Act. ASIM will be reviewing all Medicare reform proposals offered by the Congressional leadership to evaluate their consistency with our policy. Our policy promotes widening health plan choices for beneficiaries--including point-of-service plans and physician-sponsored networks (PSNs); reforming antitrust laws to facilitate creation of PSNs; enhancing competition through uniform standards and rules by which plans must abide; removing excessive lab regulations from the practice environment; and providing for a single conversion factor and update formula based on GDP plus two percent.

ASIM applauds the committee for devising a plan that seeks to involve all stakeholder's in Medicare in resolving the program's financial and operational weaknesses. We offer our commitment to work with Congress to enact reforms in Medicare that will not compromise access to care and will ensure that the program, and the peace of mind it has given the elderly for thirty years, will continue successfully well into the twenty-first century.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

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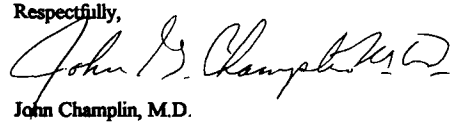
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



John Champlin, M.D.
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Berkeley, CA 94704

RONALD D. COLEMAN
16TH DISTRICT, TEXAS

COMMITTEE ON APPROPRIATIONS
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SUBCOMMITTEE ON TRANSPORTATION

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
THE RANKING MEMBER,
SUBCOMMITTEE ON HUMAN INTELLIGENCE,
ANALYSIS, AND COUNTERINTELLIGENCE

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Congress of the United States
House of Representatives
Washington, DC 20515

STATEMENT OF U.S. REPRESENTATIVE RONALD D. COLEMAN (TX-16)
COMMITTEE ON WAYS AND MEANS
September 22, 1995

I appreciate the opportunity to testify before this Committee on the proposed plan to reform Medicare. I am privileged to represent El Paso, Texas, a community of approximately 600,000 people. Of this amount, almost 60,000 people receive Medicare. In other words, 10% of El Paso's population is on Medicare. That is a significant number. These are significant cuts.

I regret that the Majority has not scheduled more time for hearings nor the ability to review the plan. The Democratic leadership has scheduled additional days of hearings on the only space provided to us, the lawn of the Capitol, so that the American people can have a chance to participate in the process that will affect 37 million of them.

I have had over 500 constituents writing or calling to urge me to oppose these cuts. One constituent writes:

> "My wish is that the Democratic Party would hammer on the fact that President Clinton wanted health care reform 2 years ago. ... The Republican Party bombarded the air waves stating that if it was not broken, don't fix it. It's ironic that the moment the Republicans came into office, health [care] had deteriorated so quickly, that now, the Republicans are the only solution to Medicare."

I could not agree more. Not only has the Republican party opposed the original drafting of this legislation, but they have continued to be antagonistic towards its existence for years. Now after providing only an outline, we are supposed to realistically debate the Republican effort "save" Medicare in one day? I have the same trouble believing this as my constituent does.

However, I will limit my comments to the minor details I am aware of regarding this plan.

Part B Premiums
First and foremost is my problem with the increase in Part B premiums. The plan calls for a continuation of the 31% premium instead of dropping the level to 25% as current law now dictates. This allows for an increase of almost $700 a year by 2002.

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Not one penny of this increase will go towards the Part A trust fund. This increase will only go towards the general fund and can be used to balance the budget while giving a $245 billion tax cut to the wealthy.

Choice
The outline states that it offers a choice to seniors in the type of health care organization they would like to become a part of without limiting their ability to stay in the traditional Medicare program.

However, the different choices available to seniors have not been subjected to a test to determine if they will save any money. And plans such as Medical Savings Accounts and HMO's are only viable options for wealthy and relatively healthy senior citizens. Therefore, these "options" are only available to the few seniors who fit that description.

Waste, Fraud, and Abuse
Waste, fraud and abuse is the single biggest concern of my constituency regarding Medicare. I have spoken to many El Pasoans and, by far, the largest complaint regarding Medicare I have heard is "Stop the waste and fraud and you will find the money to support Medicare."

The Republican plan offers only 3 minor initiatives, a "hotline", making nursing facilities provide cost estimates, and stiffer penalties for those found guilty of fraud.

Again, there is no estimate on how much these programs will actually save and these measures are not comprehensive enough to deal with the entrenched problem of fraud and abuse throughout the system.

Effect on Hospitáls and Providers
The plan also contains significant changes in assistance to health care providers. I had previously sent a letter to El Paso hospitals outlining the possible changes that might occur under this plan and asked them to illustrate how these changes might effect the day to day functioning of their hospitals. I would like to illustrate the destructive change this plan would have by reading one of those letters:

> **"Expected Effects to ... as a Result of Medicare and Medicaid Reductions:**
> Staffing:
> If funding is not available, ... would face the very real possibility of staff reduction by as much as 992 positions during the 7 year period. We would lose $31,982,080 over the next 7-year period for the El Paso economy.
> Clinics:
> Our clinics currently operate five days a week. The reductions would force a 50% cutback in operations to 2.5

days a week.
Reduction in Services:
The hospital district's mandate is to care for indigent patients and we do not believe that we could eliminate basic services. A reduction in both Medicare and Medicaid dollars wold lead to a rationing of resources that would be manifested in a number of ways:

1. Eliminate Level One Trauma Services;
2. Reduction of Pharmacy, Physical Therapy and all other outpatient services;
3. Frequent delays in all inpatient services throughout every area of care.
4. Elimination of elective cases in the operating room and reserving the operating room for emergencies only. This would lead to less funding support to the rest of the hospital and create a greater need for tax payor [sic] support.
5. Our current funding for Physician Service totaling $5,000,000 could be reduced by as much as 50% causing us to care for mainly indigent care patients.
6. Residency Programs: Our current funding of 148 residents would be reduced by as much as 60% or to only 59 residents. This sets the pattern for future physician shortages.

The above possibilities could eliminate all funded patients, putting greater risk on the tax base. All planned admissions could be delayed and the hospital could become one giant emergency room and triage hospital."

This is just one example of the type of destructive impact this plan would have on our community. I have received similar letters from all the other hospitals in El Paso.

Means Testing
The plan also proposes to charge seniors with incomes over $75,000 for individuals and $150,000 for couples higher premiums. Again, these premiums will not put one penny in the Part A trust fund. However, this revenue will go directly into the general fund. Means testing in this form is unnecessary.

Fail Safe Provision
The entire Republican budget plan rests on their ability to provide $270 billion in savings from the Medicare program. However, the plan falls short of these savings by $90 billion. Yesterday, Newt Gingrich said he was afraid that his own CBO would "substantially underscore" the savings he believed could be accomplished by using HMO's and other provider plans.

If the CBO cannot come up with the magic numbers Speaker Gingrich wants, where do you think they will come from? From the 37 million beneficiaries that Medicare now serves!

Aware that this plan may not total the $270 billion, it includes a "fail safe" provision that will allow future bureaucrats to

make additional cuts.

This hidden provision subjects beneficiaries to unknown future liability. If future decisions expose health care providers to additional cuts, they may pass the cost directly to the beneficiary or drop out of the program altogether. This would mean that even after paying more money for less services this year, seniors would be asked to do the sacrifice again, sometime in the next seven years, to achieve the same savings the original plan proposed and have a choice of much fewer providers.

This plan is the wrong way to achieve the savings that Medicare needs. This plan allows the Republicans to attempt to balances the budget while giving a huge tax break to the most wealthy Americans on the backs of senior citizens and the disabled. It is wrong.

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

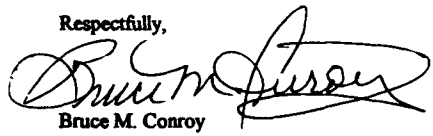
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Bruce M. Conroy
565 Bernice Ln.
Martinez, CA 94553.

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Respectfully,

Cesar B. Court, MFCC
4309 Foothill Way
Pittsburg, CA 94565

TESTIMONY
THE HONORABLE ROSA L. DELAURO
BEFORE THE COMMITTEE ON WAYS AND MEANS
SEPTEMBER 22, 1995

THANK YOU CHAIRMAN ARCHER AND RANKING MEMBER GIBBONS FOR PROVIDING ME WITH THIS OPPORTUNITY TO TESTIFY TODAY. I AM GRATEFUL TO THE COMMITTEE FOR REVERSING ITS EARLIER DECISION REJECTING MY REQUEST TO TESTIFY. I WAS DELIGHTED TO GET YOUR INVITATION LAST NIGHT.

1. INADEQUATE AMOUNT OF HEARINGS
AT THE OUTSET, I NEED TO RESPECTFULLY EXPRESS MY DISAGREEMENT WITH THE COMMITTEE'S PROCESS.

MEDICARE IS A LIFELINE FOR OUR NATION'S SENIORS. THE CHANGES BEING PROPOSED ARE -- WITHOUT QUESTION -- THE MOST SIGNIFICANT IN THE 30 YEAR HISTORY OF THE PROGRAM.
THE AMERICAN PEOPLE DESERVE A FULL DISCUSSION OF THE VAST AND DEVASTATING CUTS PROPOSED IN THIS BILL BECAUSE THEY WOULD MAKE SUCH A TREMENDOUS IMPACT ON THE LIVES OF OUR NATION'S SENIOR CITIZENS.

YET THE COMMITTEE IS CHOOSING TO HOLD ONLY ONE DAY OF HEARINGS ON THIS PLAN WHICH WILL DRAMATICALLY CHANGE THE LIVES OF AMERICA'S ELDERLY.

IT IS INSTRUCTIVE TO NOTE, BY COMPARISON, THAT BACK IN 1965 THERE WERE FOUR WEEKS OF HEARINGS ON THE BILL ESTABLISHING THE MEDICARE PROGRAM.

IN THIS CONGRESS, THERE HAVE BEEN 28 DAYS OF HEARINGS ON WHITEWATER. TEN DAYS OF HEARINGS ON WACO. AND TWO WEEKS OF HEARINGS ON RUBY RIDGE -- WITH MORE TO COME. DOES THE COMMITTEE BELIEVE THAT THESE MATTERS ARE MORE CONSEQUENTIAL TO THE AMERICAN PEOPLE THAN SLASHING $270 BILLION FROM MEDICARE?

ALONG WITH 201 OTHER MEMBERS OF THE HOUSE, I AM A COSPONSOR OF THE RESOLUTION OFFERED BY DEMOCRATIC LEADER RICHARD GEPHARDT AND CHAIRMAN JOHN DINGELL CALLING FOR FOUR WEEKS OF PUBLIC HEARINGS ON THE REPUBLICAN MEDICARE PLAN.

SO ALTHOUGH I AM GRATEFUL FOR THE OPPORTUNITY TO TESTIFY HERE TODAY, I DO NOT WANT MY PRESENCE HERE SEEN IN ANY WAY AS CONDONING THE RAILROADING OF MEDICARE CUTS THROUGH THE CONGRESS.

2. LEGISLATION STILL HAS NOT BEEN PRODUCED
EVEN IF A SINGLE DAY OF HEARINGS ON THIS MATTER WAS ADEQUATE FOR A FULL PUBLIC DEBATE, I WOULD STILL BE CONCERNED THAT RAMMING THESE DRAMATIC MEDICARE CUTS THROUGH THE PROCESS IN THE DEAD OF NIGHT IS A DISSERVICE TO THE AMERICAN PEOPLE.

BECAUSE EVEN TODAY, WE DO NOT HAVE LEGISLATION. THE OUTLINE RELEASED IS ONLY THAT: A VAGUE OUTLINE WITH MOST OF THE IMPORTANT DETAILS UNDEFINED.

> WE HAVE NO TABLE OR PRELIMINARY ESTIMATE FROM THE CONGRESSIONAL BUDGET OFFICE.
>
> THE PART B PREMIUM IS NOT SPECIFIED.
>
> THE ALLOCATION OF THE "FAIL SAFE" SPENDING LIMIT IS NOT DEFINED, THUS MAKING IT IMPOSSIBLE TO ANALYZE THE IMPACT ON DIFFERENT TYPES OF PROVIDERS.

3. $270 BILLION IN CUTS UNNECESSARY TO FIX MEDICARE
NOT ONLY IS THE PLAN BEFORE US INCOMPLETE, ITS UNDERLYING PREMISE IS WRONG.

ALTHOUGH MY REPUBLICAN COLLEAGUES CLAIM MEDICARE FACES SOME SUDDEN AND UNPRECEDENTED CRISIS, THE CUTS THEY PROPOSE ARE FAR IN

EXCESS OF WHAT IS NECESSARY TO ENSURE THE MEDICARE TRUST FUND'S SOLVENCY.

ALLOW ME TO QUOTE FROM A LETTER DATED YESTERDAY, SEPTEMBER 21, FROM TREASURY SECRETARY ROBERT RUBIN WHO ALSO SERVES AS MANAGING TRUSTEE OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND. MR. RUBIN SAYS,

> "NO MEMBER OF CONGRESS SHOULD VOTE FOR $270 BILLION IN MEDICARE CUTS BELIEVING THAT REDUCTIONS OF THIS SIZE HAVE BEEN RECOMMENDED BY THE MEDICARE TRUSTEES OR THAT SUCH REDUCTIONS ARE NEEDED NOW TO PREVENT AN IMMINENT FUNDING CRISIS. THAT WOULD BE FACTUALLY INCORRECT."

ADDITIONALLY, NOT ONE DIME OF THE PROPOSED INCREASE IN MONTHLY MEDICARE PREMIUMS WILL GO INTO EXTENDING THE LIFE OF THE TRUST FUND. AS YOU KNOW, IT IS ONLY THE MEDICARE PART A TRUST FUND THAT FACES INSOLVENCY. INCREASING PART B PREMIUMS DO NOT CONTRIBUTE TO THE SOLVENCY OF THE PART A TRUST FUND. THEREFORE, I MUST ASSUME THAT BILLIONS IN MEDICARE CUTS ARE BEING USED FOR SOME OTHER PURPOSE WHICH TAKES ME TO MY FINAL POINT.

4. <u>MEDICARE CUTS SHOULD NOT PAY FOR TAX CUTS</u>
IN THE JULY 28TH WALL STREET JOURNAL, THE SENATE FINANCE COMMITTEE CHAIRMAN SAID THAT FAILURE TO AGREE ON MEDICARE CUTS ENDANGERED THE TAX CUTS PROPOSED BY REPUBLICANS IN CONGRESS.

THE FINANCE COMMITTEE CHAIRMAN CANDIDLY LINKED THE MEDICARE CUTS TO THEIR TRUE PURPOSE: PAYING FOR A HUGE TAX BREAK FOR PEOPLE WHO NEED THEM THE LEAST.
WITHOUT THESE DRASTIC CUTS IN MEDICARE, REPUBLICANS SIMPLY WOULD NOT HAVE THE MONEY TO PAY FOR $245 BILLION PACKAGE OF TAX GIVE-AWAYS TO THE WEALTHIEST PEOPLE IN THIS COUNTRY.

IT IS WRONG TO DEMAND THAT MEDICARE BENEFICIARIES PICK UP THE TAB FOR TAX BREAKS TO THE MOST PRIVILEGED PEOPLE IN OUR SOCIETY.

IN CLOSING MR. CHAIRMAN I URGE THAT THE COMMITTEE HOLD ADDITIONAL HEARINGS ON THE LEGISLATION AFTER IT HAS BEEN WRITTEN. FAILING THAT I URGE THE REJECTION OF THIS BILL WHICH RAIDS THE MEDICARE TRUST FUND -- NOT TO FIX IT -- BUT TO PROVIDE A TAX BREAK FOR THE PRIVILEGED FEW.

THANK YOU.

STATEMENT OF STANLEY B. BENJAMIN, M.D.
PRESIDENT, DIGESTIVE DISEASE NATIONAL COALITION

Mr. Chairman and members of the committee, thank you for the opportunity to present the views of the Digestive Disease National Coalition (DDNC) regarding Medicare reform, specifically, Medicare coverage of colorectal cancer screening.

The DDNC is comprised of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases. The Coalition has as its goal a desire to improve the health care of millions of Americans who suffer from one of the many conditions, both acute and chronic, which effect the digestive tract.

One of the most common, and fatal, digestive disorders is colorectal cancer. Colorectal cancer is the second leading cause of cancer death in the United States with 155,000 new cases reported each year. The death rate from a diagnosis of colorectal cancer approaches 60%. Colorectal cancer accounts for over half (1/2) of the 80,000 ostomy operations (a surgical procedure leaving the a patient with an appliance to collect body wastes) performed each year, resulting in an annual expenditure of $1 billion. Anyone can get colorectal cancer, it is more common than either breast or prostate and cancer, and strikes men and women in almost equal numbers.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients, even though advanced detection and prevention strategies have rendered colorectal cancers almost entirely preventable. Mr. Chairman, we know that early detection saves lives and saves health care resources. Diagnosis of colorectal cancer in an early localized stage translates into a 5 year survival rate of 93% for colon cancer and 87% percent for rectal cancer. Early detection not only improves the quality of life for patients but is much more cost effective than providing complex, expensive medical care to individuals in the later stages of the disease.

Every major Federal employee health plan recognizes the importance of colorectal screening procedures and provides coverage for these treatments. However, although the average age at the time of diagnosis is 71, Medicare still does not cover colorectal screening and prevention services.

Mr. Chairman, the DDNC supports HR 922, " The Colon Cancer Screening and Prevention Act", introduced on a bipartisan basis by Congressman Cardin. This important legislation addresses the problem of Medicare reimbursement for colorectal preventive services by extending Medicare coverage to include two colorectal screening tests at annual intervals.

Specifically, HR 922 would enable early detection of colorectal cancers by providing for an annual fecal occult blood test (FOBT). This is a non-invasive procedure, with an average cost of only $5, that helps reduce the risk of death from colorectal cancer by between 33 and 43%. Second, Congressman Cardin's bill includes benefit coverage of a flexible sigmoidoscopy examination, which enables a doctor to inspect the lower part of the colon where 50 to 60% of polyps and cancers occur. Finally, this legislation permits individuals at high risk to receive a screening colonoscopy exam no more than once every two years. This procedure allows examination of the entire colon and, if necessary, biopsy and removal of suspicious polyps, which are the precursors to almost all colon cancers.

The DDNC, in collaboration with the American Cancer Society, the American Nurses Association, the American Medical Association, and several other health care advocacy organizations enthusiastically support Congressman Cardin's bill. I strongly encourage all members of this distinguished committee to incorporate the Medicare screening provisions of HR 922 in your comprehensive Medicare reform legislation. In addition, because the methods utilized for periodic screening and diagnosis vary, depending upon determination of the patient's risk category and current medical knowledge, the DDNC recommends that federal policy be flexible enough to allow the discretion of the health care professional, in consultation with the patient, to make the final decision on the screening technique to be employed. Coverage should reflect that discretion, and should allow for the most appropriate screening method.

Mr. Chairman, I believe it is apparent that providing Medicare coverage for colorectal cancer screening is consistent with this committee's goal of slowing the growth of Medicare spending. By extending Medicare coverage to include testing procedures, the federal government will give America's seniors (the most at-risk segment of the population) a financial incentive to be tested, and in the long run, save Medicare dollars.

Once again, Mr. Chairman, thank you for the opportunity to present the Digestive Disease National Coalition's views on Medicare coverage for colorectal cancer screening. It is our sincere hope that this committee recognizes the medical and economic advantages of colorectal cancer screening and extends Medicare coverage to include these vital procedures. To do less would deprive those who run the greatest risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

September 19, 1995

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It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,

Jayne Elliott

Jayne Elliott
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully, Janet Frankhouser

Janet Frankhouser, RN
118 Silvey Acres Dr.
Vacaville, CA 95688

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

Liz Garcia
2228 Colonial Ct.
Walnut Creek, CA 94598

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

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Respectfully,

Martin Garro, RN
2500 Alhambra Ave.
Martinez, CA 94553

529 Walden Circle # 104
Boulder, CO 80303
Sept. 22, 1995

Mr. Phillip Mosley
Chief of Staff
Committee Ways & Means
1102 Longworth Bldg.
Washington, D.C. 20515

Dear Mr. Mosley,

Formulating a program to control costs and growth of Medicare costs is a very difficult undertaking. As a U.S. citizen who is on Medicare, I would like to express my opinion with the following suggestions:

1) Medicare should be means tested - charge according to ability to pay, with Medicaid reserved for people of very low or no income.

2) Supplemental Medi-Gap insurance should also be paid for on a sliding scale.

3) No thousands of dollars spent in the last weeks of a terminally ill patient's life- have Hospice provide comfort and pain control.

4) Naturopaths and Homeopths should be included in the Medicare system, since many patients prfer to go to these types of practitioners with good results and emphasis on preventive care.

5) More home care instead of nusing home care when appropriate.

6) Studies made to determine whether current treatments and medications actually do what they claim.

7) Control fraud, simplify paperwork.

8) More choice for people- managed care is the opposite of free choice.

Thank you for your attention. I hope Congress will come up with Medicare reform that will not hurt the elderly.

Yours truly,
Mrs. Dorothy Goldfarb
Mrs. Dorothy Goldfarb

Medicare Hearing
Testimony of Mr. Bob Hug, Milford CT
September 22, 1995

Thank you Congressmen and Congresswomen.

I am here today to protest the cuts to Medicare. This is a very important issue affecting senior citizens all over our country. I have spoken to many senior citizens in my town and surrounding areas. They are all very concerned.

Some are living just above the poverty level.

They have high prescription drug costs, that are not covered by Medicare.

Their Cost of Living Adjustment (COLA) increase last year was 2.6% which was offset by increased Medicare premiums.

This 2.6% COLA increase is figured on the Consumer Price Index, and now Congress wants to refigure that, which means COLAs for seniors will be less.

Is this the way we should be treating our senior citizens? Who paid their taxes all their lives, and who fought wars for this country? So you and I can live in freedom?

I don't think so.

It is not fair to balance the budget on the backs of our senior citizens. I am sure there are other ways to balance the budget.

I want to give you a general overall view of my yearly income and expenses, so you will know what I am talking about.

I am a retired tax accountant. My wife and I receive social security. To supplement my income, I do some tax work for four months out of the year. My total annual income for my wife and I to live on is $27,500. After we pay for our "essential expenses" like food, shelter, health care and prescription drug costs, amounting to nearly $20,000 per year, we have less than $7,000 left. We need the $7,000 to pay for vital costs like clothing, car repairs and other incidental costs.

If the Republican Medicare plan passes and we are forced to pay twice as much for Medicare premiums, I don't know how we are going to afford it.

I sincerely think if you have to increase Medicare premiums, without adding any additional benefits then there should be a cut off. It should be increased on those who can afford it.

There should be an exemption for seniors, like myself, who are on a fixed income and cannot afford a doubling of our premiums.

In other words, I think, it should be increased on a single person earning over $25,000 per year or a couple earning $32,000 per year. Just like our tax laws are set up regarding taxes on social security.

Members of Congress, I hope you give this a lot of consideration when you cast your vote. The Medicare program serves 41 million Americans. Let me leave you with one thought. What happened to the government that was by the people and for the people?

I want to thank you very much for allowing me to come here today and voice my views to you.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

James Kimshalo, MFCC
109 Morningside Dr.
Vallejo, CA 94590

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

Linda Kirkhorn, L.C.S.W.
2335 Corona Ct.
Berkeley, CA 94708

Lake Geneva Financial Services Corp.
910 N. Elm Grove Road, Suite 26 • 414-796-0101
P. O. Box 671, Elm Grove, WI 53122-0671 • 800-236-1101

September 21, 1995

Mr. Philip Mosley
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth Building
Washington, DC 20515

Re: Medicare

Congressmen:

As a result of my extensive experience in the Medicare Supplement Insurance business, both with our clients and the clients of the agencies we service, I am convinced that one of the single major problems with Medicare is the administrative cost plus the cost it imposes upon the insurance carriers who supplement Medicare.

All Medicare claims must be processed twice, both by Medicare and the insurance carrier.

When we consider that the cost to the carrier to issue a check is in the $25 to $50 range, and the government's cost is probably in the same range; the cost to process many claims is many times the actual claim cost.

One way to avoid this administrative duplication, would be to turn the entire system over to the private carriers.

I know that sometimes the large carriers suffer the same bureaucratic problems as those plaguing the government. However, they would be forced to "keep their house in order" by the competition factor.

If someone does not like their supplement carrier, there are 6 to 12 others available. If the individual has a problem with Medicare, there is no place else to go.

Enclosed are several samples of these very small claims processed by both Medicare and the carrier.

Sincerely,

LAKE GENEVA FINANCIAL SERVICES CORP.

Chuck Roloff

C. A. Roloff
President

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME PIERCE, ELIZABETH I PATIENT NAME ELIZABETH
POLICY NUMBER 350-2411549 CLAIM NUMBER 427718

BENEFIT DRAFT WAS MAILED DIRECTLY TO: MILW RADIO LTD SC
FOR $1.91 DRAFT#8182650

MR CHARLES A ROLOFF
PO BOX 671
ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 100 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
MILW RADIO LT 6/24/95 -	22.75	9.54	7.63	0.00	1.91A	13.21B	0.00
TOTAL.....	22.75	9.54	7.63	0.00	1.91	13.21	0.00
PAYABLE AT.....				100 %	100 %		
AMOUNT PAYABLE.....				0.00	1.91		
TOTAL PAYMENT.....					1.91		

* COMMENTS *

(*) STOP THE PAPERWORK! YOUR PART B CLAIMS ARE RECEIVED ELECTRONICALLY FROM MEDICARE. YOU NO LONGER NEED TO SUBMIT PART B PAPER CLAIMS.
(A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
(B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 200519
1 AUDITED BY: EDI/NRX 8/11/95

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME PIERCE, ELIZABETH I PATIENT NAME ELIZABETH
POLICY NUMBER 350-2411549 CLAIM NUMBER 427718

BENEFIT DRAFT WAS MAILED DIRECTLY TO: FAMILY MEDICINE ASSOC
FOR $10.79 DRAFT#8182654

MR CHARLES A ROLOFF
PO BOX 671
ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 100 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
FAMILY MEDICI 7/14/95 -	71.00	53.97	43.18	0.00	10.79A	17.03B	0.00
TOTAL.....	71.00	53.97	43.18	0.00	10.79	17.03	0.00
PAYABLE AT.....				100 %	100 %		
AMOUNT PAYABLE.....				0.00	10.79		
TOTAL PAYMENT.....					10.79		

* COMMENTS *

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(A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
(B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 87112
5 AUDITED BY: EDI/NRX 8/11/95

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME PIERCE, ELIZABETH I PATIENT NAME ELIZABETH
POLICY NUMBER 350-2411549 CLAIM NUMBER 427718

BENEFIT DRAFT WAS MAILED DIRECTLY TO: CARDIAC GRAPHIC LTD
FOR $2.26 DRAFT#8174509

MR CHARLES A ROLOFF
PO BOX 671
ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 100 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
CARDIAC GRAPH 6/25/95 -	30.00	11.32	9.06	0.00	2.26A	18.68B	0.00
TOTAL.....	30.00	11.32	9.06	0.00	2.26	18.68	0.00
PAYABLE AT.....				100 %	100 %		
AMOUNT PAYABLE.....				0.00	2.26		
TOTAL PAYMENT.....					2.26		

* COMMENTS *

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(A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
(B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 00842529 0242
3 AUDITED BY: EDI/LRX 8/07/95

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME MADL, J RICHARD PATIENT NAME J RICHARD
POLICY NUMBER 350-2223948 CLAIM NUMBER 427640

BENEFIT DRAFT WAS MAILED DIRECTLY TO: CRESTVIEW MEDICAL CLINIC PA
FOR $6.62 DRAFT#8177455

MR CHARLES A ROLOFF
PO BOX 671
ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 0 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
CRESTVIEW MED 7/14/95 -	50.00	33.08	26.46	0.00	6.62A	16.92B	0.00
TOTAL.....	50.00	33.08	26.46	0.00	6.62	16.92	0.00
PAYABLE AT.....				0 %	100 %		
AMOUNT PAYABLE.....				0.00	6.62		
TOTAL PAYMENT.....					6.62		

* COMMENTS *

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(A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
(B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 01624561 J M
1 AUDITED BY: EDI/AAX 8/08/95

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

Deborah Ledesma
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

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Respectfully,

Gerald Lutovich, M.D.
579 Sausalito Blvd.
Sausalito, CA 94965

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Respectfully,

Patricia Marlow, L.C.S.W.
415 Bay St.
Crockett, CA 94525

Orwellian Doublespeak: A Citizen's Guide to the Current Medicare Debate

Jerry L. Mashaw & Theodore R. Marmor

Most of the public discussion of Medicare 'reform', dominated by the peculiar political craziness of deficit reduction and presidential politics, has been about as thoughtful as a food fight. The Republicans, who introduced their plan this week as "The Medicare Preservation Act of 1995, " claim they want to "preserve, protect and strengthen Medicare" by radically changing the program. The language is truly Owellian: saving by transforming, preserving by transforming beyond recognition. The Democratic response has been partisan fury. They charge that Republican "preservation" of Medicare means nothing less than the lingering death of the program "as we know it." Surely, most citizens are perplexed; the elderly and disabled are understandably frightened. To try to put this overblown partisan rhetoric into some perspective, consider the following views [thoughts] on Medicare's real needs for reform and the directions that such reforms should take.

First, Medicare does need adjustment. A ten percent annual growth rate in the costs of care, which is what the Congressional Budget Office has projected, is simply not sustainable in the long run. Moreover, changes in longevity, medical technology, cultural conceptions of adequate medical care, national fiscal capacity and a host of other factors demand that any long-term program of medical insurance accept periodic adjustments. Rigid defense of the status quo is silly, but so is the demand for complete overhaul even when labelled 'preservation.'. Medicare has brought considerable security to the aged and disabled.

Reformers should attend to the many small things that can be changed a little. They should not search for some (unknown) one big thing that will "fix" the system for all time.

Second, the projected "bankruptcy" of the "trust fund" is a particularly misleading way to think about Medicare's cost problems. The trust fund is an accounting convention signaling that Medicare's hospital insurance (Part A) is financed by earmarked taxes. If time is needed to make necessary gradual adjustments in Medicare, the "fund" for Part A can be increased by new taxes or by temporary transfers from the surpluses in the Social Security retirement accounts. In any event, no one is going to wake up some Saturday morning to find that their hospital coverage has suddenly ceased because Medicare is "broke". Reformers must ask and answer hard questions about the likely success of particular cost control measures, what the savings will be, and how to manage the system in the face of the inevitability that these projections will not be entirely accurate. Discussion of changes in the size, sources of revenue and responsibilities of the "trust fund" is a sensible, necessary part of this process. Talk of 'bankruptcy' is not.

Third, costs are not the only problem. Medicare coverage is seriously underinclusive. It excludes payment, for example, for most pharmaceutical therapies and for long term care, both major elements in the treatment of chronic disease. These gaps not only ensure that Medicare fails to meet important needs of the elderly and the disabled, but also promote costly gaming of the system. To get Medicare payments for nursing home care, patients must be cycled through hospital stays, whether needed or not. Personal assistance must be provided by highly-paid nurses, even if the "medical" content of the care is minimal. Meanwhile mountains of paper are shuffled to try to prevent these "abuses." Reform should concentrate

on helping Medicare meet genuine needs and avoid artificial boundaries that cannot, in any event, be policed effectively. Broadened coverage need not necessarily be the enemy of cost control and, in some instances, will be its ally.

Fourth, lest this proposal for expanded coverage suggest we have lost touch with fiscal reality, we must emphasize that the costs of care may be cut in many ways. Less expensive forms of care can substitute for more heroic interventions. Unnecessary and marginally necessary care can be reduced. The amounts paid for particular interventions can be restrained. All of these approaches, and more, will surely be necessary. But reformers should remember that Medicare administrators have been quite successful at constraining costs when given the tools and political support to do so. They can be even more effective in the current context where private insurers are doing similar things. Providers now have nowhere to hide from system-wide demands for cost control. Prices and unnecessary utilization can be reduced while expanding coverage without providers abandoning Medicare patients or effectively shifting costs to private insurers.

Fifth, taxes can be raised. So can charges. Anyone who thinks that an earmarked tax for a popular program cannot be increased marginally in the current political climate simply has not been paying attention to what we have been doing over the past decade -- or to what opinion polls say Americans will support. Moreover, there is no reason that a program originally designed to prevent financial catastrophe for the elderly and disabled should use general revenues to subsidize eighty percent of all their expenditures for physician services (Part B). Part of these costs can and should be distributed differently. In other words, reform should (and almost surely will) require some adjustments in current payment arrangements --

who pays, how much and through what types of levies, charges or deductibles. But the modifications likely to be needed, given sensible cost controls, are really quite modest. Only politicians' refusal to utter the "T" word makes the situation look as if some massive fiscal reordering is in the offing, or that everything can be done without anyone paying any more for anything

Finally, those who are old or disabled -- and also sick -- deserve a more consumer-friendly system of health insurance. Offering them a smorgasbord of private insurance alternatives by converting Medicare's entitlement into an insurance "voucher," for example, may appeal to the Health Insurance Association of America and to those for whom "privatization" is the presumptive answer to all questions of public policy. The political and economic realities, however, are very different. This type of "freedom of choice" would drive most of the old and the sick to distraction and enormously increase the administrative costs and complexity of Medicare. How it would save federal dollars remains a mystery. Moreover, responsible "voucherization" would entail the politically unpalatable necessity of massive federal regulation of the insurance industry to try to prevent "cherry picking" of the better risks and cost-shifting between Medicare and non-Medicare patients by insurers covering both.

At the other end of the choice spectrum, a program of mandatory HMOs for all has already met stiff political resistance -- and for good reason. Most HMOs have catered to a quite different and much healthier slice of the population. Whether HMOs can serve the elderly and disabled well, and at reduced costs, is unknown. Reform in the organization of either insurance markets or medical service delivery must be understood to be experimental. Only careful trial will separate panaceas from placebos. Celebrating health maintenance

organizations, the current Republican position, is both premature and an enormous flip-flop from the party's criticism of President Clinton reliance on 'managed care.'

The loud partisanship of the current political rhetoric signals a recognition that reforming Medicare will be neither simple nor painless. But solutions will not get any easier with doublespeak or namecalling, political processes that distort the real issues and the real alternatives. There are both more problems to be solved, and more ways to solve them, than the current Medicare debate has begun to suggest.

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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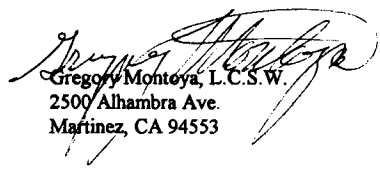
Respectfully,



Gregory Montoya, L.C.S.W.
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

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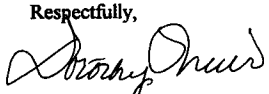

Dorothy Muir
2229 Belle Ct.
Antioch, CA 94509

National
Association of Health
Underwriters

NAHU is an association of health and disability insurance professionals serving the needs of over 119 million Americans.

Statement
on
The Medicare Preservation Act

Submitted to
The House Committee on Ways and Means
September 22, 1995

By
Donna Carnall
President
National Association of Health Underwriters

I appreciate having this opportunity to present the ideas and recommendations of the National Association of Health Underwriters on Medicare reform and their relation to The Medicare Preservation Act.

NAHU believes that America's senior citizens have a right to good quality health care under a system that is both financially sound and provides them with a range of health insurance choices.

The present Medicare program is becoming more and more financially unsound and is projected to run short of funds by the year 2002. Medicare also represents a government-run single-payor system that limits senior choices to the plan prescribed by the government and denies seniors the opportunity to participate in the range of insurance options available to other Americans.

Medicare reform is thus essential if seniors are to enjoy the security of assured health care in the years ahead. Such reforms can either be undertaken in a strictly negative manner that cuts benefits and increases costs, or in a manner that revitalizes the system and allows seniors greater choices, more flexibility, and the opportunity to obtain a wider range of benefits to better meet their own personal needs. NAHU believes the latter route is the only way to go, and our recommendations for reform reflect that belief.

Our Real Choice Medicare Reform proposal contains 15 specific recommendations for reform. I am including the list of these reforms at the end of my written statement.

The general direction of The Medicare Preservation Act tracks quite closely with what we are proposing. In particular, we agree with the idea that Medicare should be opened up to allow seniors the choice of private sector options, thus having available to them the same range of benefit plans available to other Americans.

In undertaking such an innovative approach, it is important that Congress take advantage of the knowledge and expertise which professional health insurance agents can provide. No one knows more about the contents of an insurance policy and its applicability to the personal needs of a beneficiary than does an insurance agent. An agent's career success depends on such knowledge and understanding. An agent must have this knowledge base in order to successfully go through the state licensing process.

Senior citizens are going to need help in understanding the maze of different and competing private sector plans which will be made available under a Medicare private sector program. They are certainly not going to get that help from a government bureaucrat. Nor are they going to receive unbiased advice from company employees (this includes the AARP, which is in the business of marketing its own insurance policies). Only the professional insurance agent is going to be able to meet with seniors in the privacy of their own homes and help them pick and choose from among a range of options the plan which would best meet their needs.

If seniors are forced to rely only on printed materials received from the government or a company, they are likely to feel overwhelmed and thus inclined to stick with the familiar, i.e. the current Medicare program. Seniors often have a familiar insurance agent they have used and relied on over the years, and thus have more confidence in advice from such an individual than from a stranger such as a government bureaucrat or company employee. Personal assistance from their own agent will make them more comfortable in trying something new.

Health insurance agents will also, as part of their service, act as intermediaries between the beneficiary and the plan, assisting seniors with problems involving claim denial, billing questions, etc. This service will be particularly beneficial to senior citizens, who may not have anyone else to turn to for help in receiving proper payment for their medical needs.

Finally, it should be kept in mind that a new Medicare program is much more likely to succeed if professional insurance agents are out in the marketplace talking about the positives of private sector plans than if the promotional effort is left to the bureaucracy.

With the ability of agents to provide these services, it would seem to be almost a foregone conclusion that their participation in the new program would be encouraged. It appears, however, that the Medicare Preservation Act, as it currently stands, would actually discourage and prevent agent participation through establishment of a government-run enrollment process. Hopefully this is unintentional, but by providing enrollment solely through a system where the beneficiariy checks off a box on an enrollment brouchure and sends it back to the government, as the legislation apparently does, will effectively exclude agent participation. An agent is not able to receive a commission except by being able to enroll a citizen in a plan, and that would apparently be precluded.

It is important, therefore, that the legislation include language which provides specifically for the participation of licensed health insurance agents in the program.

If this cannot be accomplished by limiting enrollment strictly to the private sector, then there should at least be a provision allowing agents to be one of the sources for enrollment.

Senator Judd Gregg, in S. 1238, has included language which we feel would accomplish this goal, and we urge that it be incorporated into The Medical Preservation Act. It reads:

> "USE OF AGENTS.--The Secretary, in consultation with the Trustees, shall implement the enrollment process in a manner that ensures that eligible individuals may utilize the services of, and enroll in the selected choice care plan through, independent insurance agents. Any plan salesperson or agent, whether independent or employed by a plan, that meets personally and directly with one or more eligible individuals to assist in their choice and enrollment in a plan, shall be required to be accredited and licensed in the State in which they operate."

This language is needed not only to allow a role for agents, but also to prevent the bureaucracy from actively precluding a role. At present in the Medicare HMO program, the Health Care Financing Administration has issued instructions which "strongly discourage" the use of independent agents to market HMO policies. HCFA took advantage of the absence of any legislative language to the contrary to issue this directive. This must not be allowed to happen in the new Medicare-plus program.

It is also important that all those who are involved in the marketing and sale of the private sector Medicare policies be licensed, in the state in which they do business. Presently, independent agents must go through a licensing process at the state level, but many states do not provide for licensing for employees of insurance companies or managed care plans. The result is an unlevel playing field in which employees with little insurance knowledge may give misleading or faulty information. It is important for the sake of our seniors as well as the success of the program that this not be allowed to happen. The Gregg language provides the proper requirement in this regard.

As I indicated at the outset, NAHU supports the general direction and conceptual framework of the Medicare Preservation Act. We would like to be able to support the legislation, but to do so, our 12,000-plus members, those who are best able to make the program work out in the field, must be assured that they will be included in, not excluded from, the program and its implementation.

Thank you for your consideration.

National
Medical
Association

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Washington, D.C. 20001-1492
(202) 347-1895 FAX (202) 842-3293

WRITTEN STATEMENT OF

Yvonnecris Smith Veal, M.D., President, National Medical Association

on

SAVING MEDICARE

Committee on Ways and Means

September 21, 1995

The National Medical Association, the oldest national group of African American physicians, is currently celebrating its centennial year. The NMA represents over 20,000 African American physicians and we have a rich history of advocacy for the poor and medically under served patients in America. We were the only national medical group to support the original Medicare and Medicaid legislation of 1965. Our primary concern is patient care. Medicare has been essential in the U.S. success in its citizens enjoying greater longevity and a more productive life.

Medicare not only serves as the safety net for the disabled, retired and elderly poor but Medicare is the country's fulfillment of its promise to its citizens. Another important benefit is that Medicare has provided a needed support system to help young and growing families maintain their economic stability while providing care, love and nurturing for their elderly

parents and relatives.

The Health Care Finance Administration reports that 3.36 million African Americans are Medicare beneficiaries. The concerns of the NMA in terms of Medicare financing are significant because the impact of changes in the Medicare entitlement programs may potentially create more barriers to health care access for our community where 23 percent of African Americans are already uninsured.

The current majority congressional proposal reduces Medicare costs by 270 billion dollars over seven years. A reduction of 124 billion dollars in Medicare spending over this same period is proposed by the Clinton administration. The important question is whether these proposed cost cutting measures will maintain access to affordable quality care for our most vulnerable patients. Any reduction in the current Medicare program must guarantee the preservation of funding of medically necessary services.

Proposals directed toward an unrealistic increase in out-of-pocket expenses for the burgeoning number of Medicare beneficiaries, as the baby boomers age, may result in a decrease in health care access. The impact of an increase in co-payments by Medicare beneficiaries requires further studies. It is unclear under the House majority proposals how quality care will be ensured. Future options for Medicare beneficiaries must clearly show maintenance of oversight for quality care.

The concept of Medical Savings Accounts needs further study to determine the impact it may have on the traditional Medicare program. If beneficiaries are allowed to move back and forth from M.S.A.'s to traditional Medicare, less money will be available in their M.S.A. for the treatment of any catastrophic illness.

We strongly purpose that changes in Medicare should not be made without more rational study and an opportunity for the majority of Americans affected to have a voice through public hearings.

WRITTEN STATEMENT OF PAUL HOUGHLAND, JR., CAE, EXECUTIVE DIRECTOR, OPTICIANS ASSOCIATION OF AMERICA, ON THE HOUSE REPUBLICAN MEDICARE REFORM PROPOSAL

SUBMITTED TO THE COMMITTEE ON WAYS AND MEANS, SEPTEMBER 26, 1995

The Opticians Association of America is pleased to have an opportunity to present its views on the House Leadership's Medicare Reform Proposal released on September 21, 1995 to the members of the House Ways and Means Committee.

The OAA represents approximately 40,000 dispensing opticians throughout the United States. Our membership consists of both individual and firm members. Individual members may work for another optician, an ophthalmologist, an optometrist or one of the large optical chain stores which dispenses eyewear. Firm members are small businessmen or businesswomen who own their own independent optical firms and compete with medical doctors (ophthalmologists), optometrists, and the chain stores in dispensing eyewear, both spectacles and contact lenses. The major issues examined in this statement reflect the concerns of the small, independent firm owner, the heart and soul of our association.

Opticians' interest in the current Medicare program is focused primarily on the Part B provision which provides reimbursement to providers who dispense eyeglasses following cataract surgery. The Health Care Financing Administration does recognize opticians as providers for the purposes of Medicare reimbursement.

As you know, under current law eyeglasses are not a reimbursable item under Medicare Part B except for those who have had cataract surgery. The issue of Medicare reimbursement has been a hotly debated topic within our association. In June, 1993 the OAA passed a resolution recommending "that Medicare discontinue the discriminatory practice of reimbursing for post-cataract surgery eyeglasses."

The Medicare Select program, which was extended and expanded earlier this year in Public Law 104-18, has allowed managed care entities in specified areas to provide additional benefits including eyeglasses to Medicare beneficiaries as an inducement to get them to enroll in their program. Under this program 23 percent of managed care companies offer eyeglasses as an added benefit.

As you might expect, in those areas where the Health Care Financing Administration has authorized managed care alternatives to provide eyewear for Medicare beneficiaries, at reduced cost or without cost, independent opticians and optometrists have lost business. Small businesses have lost customers to managed care entities supported by government tax dollars. Protests to HCFA have been routinely answered by letters explaining current law.

Now, in the name of Medicare reform, the House Leadership suggests creating private sector options in a Medicare Plus plan. One alternative would be a "Coordinated Care" choice in which a beneficiary might agree to a limited selection of physicians or other providers under a managed care option. Added benefits might be offered under this plan including EYEGLASSES. In fact, Speaker Gingrich in his press conference of September 21, 1995, referred to the great success of Medicare managed care options in Arizona which did in fact offer eyeglasses as an added inducement to get Medicare beneficiaries to join their plan.

Opticians expected better treatment from a Congress we thought supported independent businesses. Approval of the additional benefit of eyeglasses could transfer up to $3.1 billion per year from the independent optical sector to the managed care area. This would amount to the destruction of autonomous businesses, not only among opticians, but also among optometrists and ophthalmologists who also dispense eyewear. You have the potential of destroying

thousands of jobs in the small self-reliant business sector. Surely this is not the intent of Congress. We urge you to reject the added benefit of eyeglasses in the coordinated care option. This proposal amounts to nothing short of government aid to the large, well-financed HMO and managed care industry and their allies in the insurance profession.

While it is impossible to predict how many Medicare beneficiaries will elect managed care options under Medicare Plus, independent eyewear providers could lose up to 22 percent of their business to managed care. A conservative estimate of the present eyewear market shows that independent opticians stand to lose up to $530 million dollars a years in sales to the managed care industry under this House leadership option.

Even if one out of four persons selects this Medicare Plus managed care option, all independent eyewear providers (ophthalmologists, optometrists, and opticians) would lose 5.5 percent of their business. What small business can afford to take this kind of a loss without disastrous consequences? This plan could put every independent optician in the United States out of business within a few years.

The OAA strongly supports the Medisave option which would combine a high-deductible insurance policy with a designated Medicare medical savings account (MSA). The OAA agrees that Medisave will allow Medicare beneficiaries to "gain direct, personal control over how part of their Medicare benefit is provided, and what it can be used for." Funds deposited in the MSAs could be used to purchase eyewear from an independent provider of choice. It would allow consumers maximum freedom of choice.

Provider-sponsored networks (PSNs) could be a useful reform in the OAA's judgment. However, there is no mention of nonphysician providers in the discussion of this alternative in the September 21 document. Is this an oversight or is it a deliberate omission? The OAA strongly believes that PSNs should include nonphysician providers and will support amendments which will achieve that purpose.

One portion of the PSN provision --- alteration of antitrust rules -- is deeply troubling, however. The arguments presented in the September 21 document are not compelling and do not establish sound reasons why the Department of Justice and the Federal Trade Commission should be required to promulgate guidelines within 180 days for those who form PSNs. The antitrust preferences suggested in this document would limit competition, choice, and innovation in the health care market. OAA will oppose any alteration of antitrust laws with respect to PSNs.

Because opticians do business in a highly-competitive marketplace the OAA strongly supports any and all measures that will insure a level playing field. It is for this reason that opticians have strongly supported the amendments to the Omnibus Budget Reconciliation Act of 1993 usually referred to as Stark II. The September 21 proposal suggests dismantling Stark II in ways that would hurt opticians, but more importantly, would damage the interests of consumers. Strong anti-referral language is the best way to assure the preservation of competition which will lead to the lowest cost for eyewear for consumers. The OAA strongly opposes the physician self-referral amendments suggested on pages 23 to 30. If you are serious about controlling fraud and abuse, retain the provisions of OBRA 1993.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,

Angelique Parker

Angelique Parker
2500 Alhambra Ave.
Martinez, CA 94553

GERALD S. PARKER
11 SHORE ACRE DRIVE
OLD GREENWICH, CT 068780

September 21, 1995

Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Attention: Mr. Phillip D. Moseley, Chief of Staff

Subject: Saving Medicare

The person submitting this statement is an individual (named above) speaking for himself. He retired thirty years after organizing, and, all but three or four, running the individual health insurance operations of The Guardian life Insurance Company of America. He designed the first Medicare supplement policy offered to the public. It went on sale on July 1, 1966, the day Medicare took effect.

The plan being reported in the media has great promise. However, it will create problems of its own which should be addressed. Some complain that the savings will not go to the trust fund. But the trust fund is really a fiction. It's invested in government bonds, and when the time comes to draw it down, we'll have to borrow again to make the payments.

The most serious problem is the reported degree to which cost savings are expected to be achieved by cutting the rate of increase in reimbursement to providers. The providers have already been squeezed considerably.

Physicians in this area are already required to accept fees anywhere from 20% to 50% below their normal charges to younger patients. Only a minority are willing to be "participating providers" who accept assignment. A few already refuse to accept new Medicare patients.

Every hospital sees an increasing proportion of its patients on Medicare, and it loses money on every one of them. Just this night as I write, a TV program on NBC reported "enormous bills being paid by Medicare for hospital supplies." Items such as bandages that wholesale for nineteen cents were being billed by hospitals and paid by Medicare for twice to eight or nine times their cost to the hospitals.

I strongly suspect that hospitals, forced to accept Medicare patients at grossly inadequate inpatient daily rates, try to cope as best they can by loading up the charges for medications, dressings, and other hospital supplies and services.

To further squeeze the providers is not going to be a solution that will last. What is needed is to accept the necessity for all of us to pay more of our share of the cost, both we beneficiaries and the younger workers.

Raising the deductible to $140 is not enough It ought to go to $200 now and be indexed henceforth. We should raise the hospital deductible more and increase the Medicare tax on workers. Ask us who are retired to contribute Too. There has been talk of some means testing, and clearly this should be done. Low and moderate income people should be subsidized, and the affluent should carry more of their load.

Incentives for people to elect HMOs is probably a sound idea. I thin the idea of multiple choices for individual beneficiaries is a no-brainer. There is no way insurance companies can offer equivalent coverage on an individual basis for less than the Medicare premiums. Groups, yes, because they'll do it with HMOs or other managed care plans.

GERALD S. PARKER

PATIENT ACCESS TO SPECIALTY CARE COALITION

317 Massachusetts Avenue, N.E. 1st Floor Washington, D.C. 20002
(202) 546-4732 FAX (202) 546-5051

Statement of the
PATIENT ACCESS TO SPECIALTY CARE COALITION

Committee on Ways and Means
September 22, 1995

Mr. Chairman, the Patient Access to Specialty Care Coalition appreciates the opportunity to express its views on the House Medicare plan unveiled yesterday. The Coalition is comprised of one hundred patient, senior and health professional groups united in their common belief that patients and the quality of their medical care are the most important components of the health care delivery system. Of primary concern to the Coalition is that all health plans allow patients the ability to seek medically necessary out-of-network treatment and services, and retain choice of health provider.

First and foremost, the Coalition applauds the House Republican leadership for recognizing that patient protection is essential to making the new Medicare system work for beneficiaries. Not only has the leadership included existing protective measures, it has gone beyond current law to incorporate additional provisions to help ensure that patients' best interests rise above all others.

The Coalition was particularly encouraged by the plan's inclusion of the following protective measures:

- Limits placed on physician incentive plans in HMOs
- Timely decisions on authorization of non-emergency care
- Expedited appeals process in life-threatening situations
- Access to all medically necessary services
- Disclosure of important information beneficiaries need in order to make educated decisions when selecting health plans

Along with these provisions, the Coalition wholeheartedly supports a beneficiary's ability to disenroll from a managed care plan if dissatisfied with the quality of care provided. However, we feel disenrollment should not be a patient's only choice when facing a problem with a health plan. Patients should have the freedom to see health providers outside the managed care network when they feel it necessary without having to completely disenroll from one plan and join another.

For example, in many situations patients do not have the luxury of waiting to disenroll from a plan. Consider a patient who suffers a heart attack and requires immediate treatment. However, his HMO won't approve the particular cardiologist with whom the patient has formed a long-standing relationship. Is this patient made to wait 30 or even 90 days in order to have the necessary medical care?

The leadership was accurate in articulating the need for a safety valve in the system. However, the Coalition believes a simpler approach to the same concern exists -- a point-of-service option

(POS). A POS option would enable patients to see physicians and specialists inside and outside the managed care network when they felt it necessary. In this way, beneficiaries would not be required to disenroll in order to receive the kind of care to which they are entitled. The concerns of beneficiaries, recognized by the leadership, can be simply and promptly addressed by a POS option in all health plans.

Quality of care requires this kind of freedom of choice. If seniors are satisfied with the care they receive inside their Medicare managed care network, they won't choose to access doctors and specialists outside the group. But without this freedom, seniors are locked into a rigid system, which may or may not give them the kind of care they need and deserve.

Most importantly, we *can* afford to give beneficiaries choice of doctors. The Congressional Budget Office is on record stating that with a reasonable co-payment, preserving the patient's right-to-choose need not negatively impact the federal Medicare budget.

Seniors should have the option of entering into managed care. However, in a recent survey conducted by ICR Research on behalf of the Coalition, 76 percent of Americans over 50 said they would be unwilling to join a Medicare managed care plan if it denied them the freedom to choose their own physicians, whether it be a specialist or a family doctor.

While the Coalition is encouraged by the emphasis the leadership clearly has placed on patients, we must, as patient advocates, urge the House to go a step further in adopting a point of service option into its Medicare plan. We ask the leadership to do this by incorporating Rep. Tom Coburn's bill, the "Medicare Patient Choice and Access Act" (HR 2350). This bill preserves a freedom that every American senior citizen enjoys today -- the freedom to see their own doctor and to have access to a specialist when they need one.

Meaningful Medicare reform must provide beneficiaries both with choice of plans *and* with choice of doctors. This kind of freedom of choice is the ultimate patient safety net and guard against inadequate care. It also assures that the nation's commitment to the health care needs of its seniors will be met fairly and economically.

(2/23/95)

Organizations Supporting

PATIENT ACCESS TO SPECIALIZED MEDICAL SERVICES UNDER HEALTH CARE REFORM

Allergy and Asthma Network•Mothers of Asthmatics, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for the Study of Headache
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American College of Cardiology
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Lung Association
American Orthopaedic Society for Sports Medicine
American Pain Society
American Podiatric Medical Association
American Psychiatric Association
American Sleep Disorders Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Dermatology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplant Physicians
American Thoracic Society
American Urological Association
Amputee Coalition of America
Arthritis Foundation
Arthroscopy Association of North America
Association of Subspecialty Professors
Asthma & Allergy Foundation of America
California Access to Specialty Care Coalition
California Congress of Dermatological Societies
Congress of Neurological Surgeons
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Eye Bank Association of America
Federated Ambulatory Surgery Association
Joint Council of Allergy and Immunology
Lupus Foundation of America, Inc.
National Association for the Advancement of Orthotics and Prosthetics
National Association of Epilepsy Centers
National Association of Medical Directors of Respiratory Care
National Foundation for Ectodermal Dysplasias
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Psoriasis Foundation
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
Renal Physicians Association
Scoliosis Research Society
Society for Vascular Surgery
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Alexander Graham Bell Association for the Deaf, Inc.
The American Society of Dermatopathology
The Endocrine Society
The Paget Foundation For Paget's Disease of Bone and Related Disorders
The TMJ Association, Ltd.

National Committee to Preserve Social Security and Medicare

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

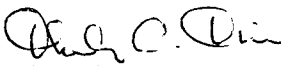
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Philip S. Piro, Clinical Psychologist
883 Redwood Dr.
Danville, CA 94526

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

Karen Pratt, MFCC
535 Talbart
Martinez, CA 94553

STATEMENT OF PRIVATE CARE ASSOCIATION, INC.

The Private Care Association, Inc. (the "PCA") is a national association representing hundreds of independently owned, private referral services that specialize in home care services for children, the elderly, and the long-term infirmed. PCA members are dedicated to providing low cost, high quality medical care and, therefore, support modifications to Medicare that would provide greater access and superior medical treatment for all Americans.

I. The Sad Predicament of Medicare Home Health Care

It is no secret that the costs of Medicare are spiraling upwards. Home health care, as a component of Medicare, represents the fastest growing expense of the program. The Prospective Payment Commission recently reported that during the period 1991 through 1993, while overall Medicare costs grew 11.8 percent, the cost of providing home care grew by a whopping 38.1 percent. In real terms, the Department of Health and Human Services predicts that Medicare home health expenditures, which were $3.3 billion in 1990, will increase to $14.4 billion (estimate) in 1995.

Although the skyrocketing escalation of Medicare home care costs could be tolerated if the program operated efficiently and fraud free, that is not the case. As Sarah F. Jaggar, Director of Health Financing and Public Health Issues for the General Accounting Office, concluded in her July 1995 report to the Senate Finance Committee:

- Medicare pays more than the market price for medical services and supplies;
- Medicare has scant ability to screen claims for overcharging or over utilization; and
- Medicare does little to scrutinize the legitimacy of providers billing the program.

In short, the existing Medicare system of home health care is *not* a low cost, high quality provider, but an excessively expensive, over utilized program that is dangerously vulnerable to exploitation and graft. Why has home health care, as provided by Medicare, come to this predicament? The answer is clear:

- Home health agencies have a monopoly on the Medicare market for home care services;
- Home health agencies operate under a financial conflict of interest. A home health agency both (1) determines the amount of home care a beneficiary needs, and (2) performs the care that it determined is needed. The resulting incentive is for the home health agency to "over utilize" Medicare services, maximizing the amount of care that can be justified under the Medicare guidelines and realizing the increased revenue that over utilization produces; and
- Home health agencies have an incentive to consistently increase their costs each year and thereby increase their Medicare "reimbursement rate."

II. The Solution for Medicare Home Health Care

PCA offers a proposal that would reduce the escalating costs of home health care while maintaining — if not improving — the quality and quantity of care. Equally important, the PCA proposal would expand individual choice.

The PCA proposal involves only three slight structural modifications of the Medicare system:

- Convert existing home health agencies into "Case Management Agencies" ("CMA"), whose *sole* function in the area of home health care would be managing cases, not providing care;
- Replace the cost reimbursement system with a system under which contracts to perform home care services are awarded on a competitive bid, fixed fee or hourly fee basis; and

- Open the Medicare market for home care to all private sector providers that satisfy applicable state licensing requirements.

A. Case Management Agencies Instead of Home Health Agencies

Medicare is cost-*in*efficient because the entity that significantly influences the determination of the amount of home care provided, the home health agency, also provides the care. Although the rules require that any program of home care services be approved by a physician, customary practices have evolved to where the physician's approval is given perfunctorily. As a consequence, home health agencies are able to significantly influence the formulation of a plan of care.

Home health agencies also are responsible for documenting the care provided and the patients' response to such care. Since that information is highly relevant for determining the type and quantity of *additional* care that will be required, a home health agency remains involved in each incremental determination of the care needed.

The conflicting roles performed by a home health agency — of determining the need for care and performing the services necessary to satisfy the "need" — create for the home health agency an incentive to determine a "need" for as much care as Medicare guidelines permit, inasmuch as the greater the need for care, the more services its employees will perform. The over utilization of services that currently plagues the Medicare home care program is attributable in large part to the over utilization of services that occurs as a consequence of the conflicting roles performed by a home health agency.

PCA proposes to alleviate this conflict of interest, and thereby eliminate the resulting over utilization of services, by separating the care provider and care decider functions. Under the PCA proposal, a CMA would be barred from providing care, and prohibited from owning an economic interest in or receiving gifts from a care providing entity. The CMA would serve as an objective actor, determining the plan of care that is truly appropriate for a patient, and awarding contracts to perform the needed care based on quality and price.

The shift to a CMA would not represent a radical departure from present practice. While the existing Medicare program requires a home health agency to provide at least one line of service with its own employees (typically nursing and companion care), the program allows home health agencies to contract-out other services, such as physical therapy, occupational therapy and speech therapy. Under the PCA proposal, the CMA would simply contract-out *all* home care services. This way, the CMA maintains impartiality.

B. Repeal the Medicare Cost Reimbursement System and Allow Competitive Bidding

Medicare's current cost reimbursement system provides yet another incentive for home health agencies to drive up costs. Home health agencies are compensated based on a reimbursement system under which the amount of costs incurred during one year will determine a "reimbursement rate" for the services performed in a subsequent year. The incentive created under this system is for a home health agency to continuously increase the amount of costs it incurs each year so as to ensure annual escalation in the Medicare reimbursement rate for the services it provides. Thus, unlike competitive bidding, which drives costs down, the reimbursement system pushes costs skyward.

Opponents of the PCA proposal argue that "the rise of home health care should be seen as an encouraging sign because it provides better quality of care and quality of life." It is submitted, however, that taxpayers may celebrate the rise in demand for home health care without the precipitous increase in home care costs that has occurred under the current system.

A strict cost comparison of similar services provided by the private sector and under the current Medicare program make the case for competitive bidding. For example, in Dade and Broward counties, Florida, the average reimbursement for a skilled Medicare visit as opposed to a private sector visit were as follows:

DADE (per visit)

	MEDICARE	**PRIVATE SECTOR**
Skilled Nursing -	$95.95	$55.00 - $70.00
Physical Therapy -	$99.08	$60.00 - $70.00
Speech Therapy -	$100.44	$60.00 - $70.00
Occupational Therapy -	$98.60	$60.00 - $70.00
Home Health Aide -	$48.20	$17.00 - $38.00

BROWARD (per visit)

	MEDICARE	**PRIVATE SECTOR**
Skilled Nursing -	$97.26	$55.00 - $70.00
Physical Therapy -	$143.00	$60.00 - $70.00
Speech Therapy -	$101.81	$60.00 - $70.00
Occupational Therapy -	$99.94	$60.00 - $70.00
Home Health Aide -	$48.86	$17.00 - $38.00

Dade County is currently producing a significant savings for Florida taxpayers by using nurse registries under a Florida Medicaid waiver that applies to a narrow slice of the state's Medicaid program. (Except for the segment of the Medicaid market for home care that is affected by the Medicaid waiver, home care referral agencies are barred from that market also.) Catalano's Nurses Registry, Inc. has been servicing clients in District 11 (Dade County) under the Medicaid waiver since April 1995. During that time, while providing a total of only 5,242 hours of personal care services, the registry has produced a savings to the state of $14,576. Based on Department of Health and Human Services estimates of the projected Medicare costs for 1995, Medicare would have saved over $3.3 billion in 1995 had the Florida waiver concept been applied on a national basis to Medicare.

Looking at cost per hour, registry services are being provided at an average cost of $8.80. Case managers in District 11 validate that the *best* hourly rate from a home health agency prior to using the registry was $12. Further, there have been no complaints of poor quality or red tape. Data from the Medicaid waiver clearly show that private sector competition works. It drives down costs while producing equal or better quality than now realized.

Opponents of **PCA**'s competitive bidding proposal charge that competitive bidding will lead to a decline in quality of service. This reasoning is obviously specious. All private contractors eligible to bid under the **PCA** proposal would be required to comply with all applicable state licensing requirements for home services. Further, as the practice of bidding for private sector nurses in Dade County Florida has shown, if anything, home care clients are well satisfied with the quality of care they receive from private sector providers.

C. Create a Competitive Market for Home Care of Providers Who Satisfy Applicable State Licensing Requirements

A related problem that has stifled competition within the home care market is the certificate of need ("CON") requirement that some states impose as a condition for eligibility to participate in the state's health care market. In some states, a CON is available only to home health agencies, thereby locking out home care referral agencies. Although the National Health Care Planing and Development Act of 1974 required states to establish CON programs, the federal mandate was repealed in 1987. Many states have repealed their CON laws, but in other states the CONs remain.

CONs are inimical to competition. They artificially freeze the "supply" side of a market, thereby artificially inflating the cost of services. In several states, such as Georgia, the number of home care providers that have been granted a CON has dwindled to two or three dominant agencies. Concentrating such market power into two or three competitors will lead to significant increases in the cost of home care. PCA supports fair competition, which the private sector provides. Consequently, PCA supports a federal prohibition against a state's use of the coercive CON system to lock out market competitors.

III. CONCLUSION — CUT COSTS AND INCREASE QUALITY

The home care industry is set to flourish in this country. Releasing the shackles of the existing home health agency system for a leaner, higher quality market-driven system will not only save taxpayers' money, but will allow a greater number of the more than 12 million Americans who need assistance with everyday activities to experience a higher quality of life.

The equation for cutting costs while maintaining or increasing quality in Medicare home care is clear: create competitiveness among providers by opening the market to the private sector. Competitive bidding through an objective, disinterested CMA will not only realize a decrease in basic costs of home care, but will unburden the system of opportunistic home health agencies that have spawned an egregious over utilization of the services made available under Medicare.

PCA is dedicated to this proposal and solicits your support in achieving enactment. We look forward to working with you to improve Medicare by providing less expensive, higher quality home care for all Americans.

Respectfully submitted,

Marc Catalano, RN, BSN
President
Private Care Association, Inc.
321 St. Charles Ave., Ste. 610
New Orleans, LA 70130
(504) 529-8800

To: Philip Moseley, Chief of Staff
House Ways and Means Committee
Frpm: F.M.Rand, "senior citizen"
Re: Medicare

There she was on TV, hobbling with a cane. "I've had 3 hip replacements already and soon I'll have to have a fourth. Who's going to pay for it?" My retort to her is, "I've helped pay for 3; why should I be required to pay for any more!"

I went to my doctor for a pap smear, but he tried to force me to take a lung pressure test to pad his bill. I refused outright. On the bill paid by Medicare was a charge of about $50 for that test, which I deem 1. useless and 2. expensive. I phoned Medicare but was told that it was "too small" to pursue a refund. That's my money they gave away! When Medicare was set up, don't tell me pros didn't anticipate frauds, large and small; why was no crew put in place to review, investigate, prevent, and pursue frauds, small as well as large?

A man on vacation came down with a medical problem but, since he was outside his HMO area, he couldn't get Florida Medicare to pay the $50 or so to cover him; he entered a hospital and Medicare paid the $450 he incurred. I, too, know that if I want my medical care covered 100%, I must enter a hospital; otherwise, I'm lucky to get 30%.

I urge Congress to enable me to set up a Medical Savings Account. If the deductible is $10,000., it would be hard but could be managed. I am worried about long-time care insurance above all. I tried a "fine" HMO for a year and want no part of that clinical medicine; I had enough of that from the Navy in WW II. Not only am I weary of helping pay for hypochondriacs or lonely elders who love visiting their doctors, but I am outraged to pay for self-abusers: alcoholics, druggies, AIDS "victims" (victims, my foot!), and felons. At the least they should be required to pay some fee for help. And I fume at families given cash if kids act up to get psycho-certification.

Finally, I firmly urge the committee to put no means cap on benefits. Although I understand my income is too small to affect my benefits, I insist that, if a man pays into Medicare, he must be given the same treatment on the same basis as any other payor. Don't retain the Democrat's "affirmative action", "progressive" discrimination on income-level basis. Whether he earns $500 or $5million, he must stand equal before the law: Equal justice for all, not class envy, rich vs. poor, means tests-- Democrat traps.

rpa
Renal Physicians Association

Testimony before the Ways and Means Committee

on the Republican 1995 Budget Reconciliation proposal

by the Renal Physicians Association

September 22, 1995

INTRODUCTION

The Renal Physicians Association (RPA) is a professional organization of nephrologists whose goals are: to insure the optimal care under the highest standards of medical practice of patients with renal disease and related disorders; to act as a national representative for physicians engaged in the study and management of patients with renal disease and related disorders; and to serve as a major resource for the development of the national health policy concerning renal disease.

As Congress and the public make increased demands for deficit reduction and a concomitant reduction in expenditures on federal entitlements, the proposal submitted to the Committee for consideration today provides an excellent guideline for discussion with other congressional leaders and health policy makers on how best to reform Medicare. The proposal includes several provisions long supported by the RPA. RPA strongly supports the plans clarification of the self-referral law which is necessary to allow nephrologists to contract with hospitals for outpatient services. RPA supports the CLIA provisions found in the plan. RPA also advocated for the use of a single conversion factor within the Medicare Fee Schedule. Further, RPA thanks the leadership for their work on CLIA reform as well as providing increased opportunities for physicians to initiate Physicians Sponsored Networks (PSN). RPA supports other provisions included in the plan. There are, of course, some provisions in the Republican proposal which give us cause for concern, especially over how the "Look Back" mechanism could arbitrarily reduce physicians fees. We will elaborate on these issues below.

The RPA would like to thank the Ways and Means Committee for this opportunity to provide written testimony. We offer the following comments on the Republican proposal and hope that you will keep our views in mind as the budget reconciliation process goes through the inevitable refinement process.

PHYSICIAN OWNERSHIP/SELF-REFERRAL

RPA is very pleased that the Republican proposal eliminates "inpatient and outpatient hospital services" as a designated health service in the Stark II law. Elimination of this language will allow nephrologists to contract with hospitals to provide inpatient dialysis services. As brief background, the Omnibus Reconciliation Act of 1993 (OBRA 93) contained language expanding the original self-referral prohibition to certain other designated health services. Among these designated health services was the listing "inpatient and outpatient hospital services". This language would prohibit situations where a nephrologist contracts with a hospital to provide its inpatient or outpatient dialysis services if the nephrologist (or group of nephrologists) had a financial interest in the dialysis service. This prohibition effectively hampers the continuum of care that nephrologists provide to their dialysis patients and it may have an adverse affect on a patient's access to inpatient dialysis. We ask that you work to fix this problem to ensure that dialysis care is not impeded.

The principal concerns underlying the self-referral prohibition language of OBRA 93, inflated charges and unnecessary utilization of services, do not apply to inpatient dialysis services. Most inpatient dialysis services are furnished to End Stage Renal Disease (ESRD) patients who are Medicare beneficiaries and are therefore covered by Medicare through the Prospective Payment System (PPS). Under this system, the hospital receives a fixed amount of reimbursement to cover all services furnished to an inpatient. Thus, opportunities for increased costs to governmental payors as a result of inpatient dialysis contracts involving nephrologists are virtually non-existent.

Similarly, over-utilization is not an issue. Again, most patients requiring inpatient dialysis have ESRD. Dialysis is a treatment that is prescribed for those with irreversible kidney failure who must receive regular dialysis to live. Dialysis is not an elective procedure for ESRD patients and its medical necessity cannot be questioned. Once diagnosed, most ESRD patients require dialysis

several times a week, for two to four hours per session, for the remainder of their lives. Dialysis is always therapeutic and never diagnostic.

In addition, unlike situations where, for example, a referring physician has an ownership interest in an MRI facility, nephrologists are directly involved in the supervision and care to their patients receiving inpatient dialysis. Indeed, this provision of dialysis services is simply an extension of the nephrologist's practice.

Prohibiting large numbers of inpatient dialysis contracts involving nephrologists will have untoward, adverse patient care consequences: Given the fact that inpatient dialysis contracts are very common in the industry, the question will become: who will assume the responsibility of providing these services? Many hospitals do not provide inpatient dialysis and often lack the expertise and desire to do so. Non-nephrologist entities could assume a greater responsibility for providing this service. However, it is questionable whether these entities could assimilate all, or even a significant part of, the potential new arrangements. More importantly, it is undesirable from a patient perspective to bifurcate the responsibility of professional inpatient nephrological care and the technical components of inpatient dialysis, placing the latter in the hands of non-physician controlled entities.

Finally, it should be recognized that the training and support for the conduct of home dialysis is often integrated with inpatient services. Therefore, prohibitions on inpatient dialysis contracts are likely to have a broader negative impact extending to patients' access to dialysis in the home.

Congress agreed with RPA's views on this issue and drafted legislative language exempting nephrologists when they refer patients for any dialysis related services. This language was included in all the major health care reform bills originating in the House, including the Ways and Means bill, the Gephardt bill, and the Rowland-Bilirakis Bi-partisan bill.

RPA is strongly supports the elimination of the inpatient/outpatient hospitals services" language which would have caused a massive disruption in delivering dialysis care.

FEE SCHEDULE IMPROVEMENTS

RPA is very pleased that the proposal includes a budget neutral single conversion factor for the Medicare Fee Schedule and replacement of the current volume performance standard with growth targets based on the gross domestic products plus two percent. As the Committee knows, the MVPS and separate conversion factors for surgery, primary care and non-surgery have served to distort the original intention of resource-based relative value system. We note however, that the proposal does not specify an implementation date for this change and makes reference only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to reduce volatility." RPA urges the Committee to clarify that the implementation date for the single conversion factor will be January 1, 1996 and also to specify a lower limit on annual updates to the conversion factor to assure that the updates remain reasonable.

RPA also expresses its support for the replacement of the VPS with updates based on GDP plus two percentage points. This move has been endorsed by the Physician Payment Review Commission.

MEDICARE SECONDARY PAYOR PROVISION FOR ESRD

The Republican proposal contains language which would extend the Medicare Secondary Payor provision for ESRD services to twenty-four months. Currently, Medicare is the secondary payor for ESRD services for eighteen months. Although the RPA believes that the 18 month MSP period is adequate, we realize the need to produce savings within the ESRD program and RPA supports this provision. However, RPA believes that extensions beyond the already envisioned 24 months would have a detrimental effect on dialysis patients.

An extension beyond 24 months could lead to higher insurance costs to ESRD patients as insurance companies try to offset the price affects of the extension. Large price increases could lead to patients dropping their coverage altogether. Some health plans could drop their ESRD coverage completely. RPA is also concerned that such an extension would cause health plans to continue to lower the ESRD reimbursement rates. In addition, an extension beyond twenty-four months could provide employers with a disincentive for hiring ESRD patients or even those predisposed to ESRD, such as individuals with hypertension or diabetes. Insurance reform which guarantees issue of coverage, provides for portability of coverage and prohibits pre-existing

condition clauses would also go along way to protecting patients with chronic conditions like ESRD.

ERYTHROPOIETIN

RPA was pleased to see that the Republican proposal did not include language which would bundle reimbursement for Erythropoietin (EPO) should into the Medicare ESRD composite rate. It is RPA's belief that there is no clinical or quality-assurance reason to bundle EPO payments into the composite rate.

EPO is a hormone produced by the kidney which is necessary for the body's production of red blood cells. Patients with kidney failure produce an inadequate level of EPO which results in anemia. Epotin, a bioengineered form of EPO, is administered to these patients in order to maintain the proper level of red blood cells. The EPO drug is currently reimbursed by Medicare at a rate of $10 per 1,000 units. This reimbursement policy is the most rational method available and the safest for the patient because it allows the nephrologist to prescribe EPO solely on the basis of the patient's need.

We believe that a primary motivation behind the proposal to bundle EPO into the composite rate is financial. Large volume providers of the drug can purchase EPO from the manufacturer at a discount. If EPO is bundled into the composite rate, large volume providers will be able to increase their financial return because of their buying power, thereby creating a disparity in financial returns between large and small distributors.

It is also our understanding that there is an interest in bundling EPO reimbursement into the composite rate in order to provide an economic disincentive against over-prescribing the drug. The perception that EPO is being over-prescribed is based on HCFA data which demonstrates that EPO dosing has continuously increased per patient while the average hemocrit (a marker of the degree of anemia) has remained flat. If this is the case, then the question of why patients are becoming resistant to the effects of EPO should be addressed by quality assessment and quality improvement methodologies, not economic disincentives.

Similarly, RPA is aware that anecdotal evidence exists regarding overdosing of EPO. However, a policy decision on bundling EPO into the composite rate should not be based on such assertions, rather, should be made after data has been collected and a scientifically accurate solution developed. The RPA is currently exploring different statistical models and other data driven studies regarding bundling and capitation of dialysis services, including EPO dosing, in order for the renal community and policy makers to come to such a solution. Additionally, the Health Services Quality Bureau and the renal Networks are planning a study on the quality and cost effectiveness of EPO. Therefore, RPA believes that a decision to bundle EPO into the composite rate would be pre-mature at best until proper data has been collated and analyzed. Once this has occurred, a scientifically accurate policy decision can be made.

RPA is pleased that the Republican proposal did not include a provision to bundle EPO into the Composite Rate.

PHYSICIAN SPONSORED NETWORKS

RPA believes that the Provider-Sponsored Networks (PSN) provision could provide the Medicare program with a new way of delivering medical care. We support the concepts behind the encouragement of these PSNs, namely, the increased competition PSNs will offer traditional health plans as well as the recognition that the physician-patient relationship is the overriding theme to physician sponsored care. RPA is currently working on adopting policy on this issue. We note that PSN's dovetail nicely with the Disease Maintenance Organization (DMO) concept that many physician groups that treat chronic condition patients are now considering. Further, Congressional attention to this concept comes at an opportune time as the Health Care Financing Administration (HCFA) is expected to begin their ESRD capitation project in the next several months. This study will hopefully allow nephrologists to more accurately calculate a capitated payment for total ESRD care. By examining the experience nephrologists have in a global capitated world, renal physicians may be able to drastically alter the way ESRD care is delivered and reimbursed.

MEDICAL LIABILITY

The RPA is very pleased to see the inclusion of health care liability reform in the Republican proposal. As the Committee is well aware, our tort system is laded with excessive attorney costs, potentially huge punitive damage costs, and increased filing of non-meritorious claims against physicians. Further, the current tort system inadequately compensates deserving plaintiffs and imposes unnecessarily high litigation costs on all parties. The cost of these judgements are then passed onto the consumer in the form of increased prices and decreased productivity of the work force. Fear of suits has lead many physicians to practice "defensive medicine" adding between $20 to $25 billion dollars per year to the health care system. Physicians pay an estimated $10 billion in malpractice premiums per year. By reforming the medical malpractice laws, with limits on how much juries can award for non-economic damages and providing guarantees that most of the monetary awards will go to patients rather than their trial attorneys, the Republican proposal offers real liability relief to the medical community. Such relief will result in more efficient and less costly care.

CIINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988 RELIEF

RPA applauds the inclusion of CLIA relief in the Republican Medicare proposal. The RPA has been concerned by the large number of physicians' practices that have sharply limited or discontinued essential patient testing because of burdensome CLIA requirements. As a result, patients are referred to outside laboratories for routine patient testing which could be done during the office visit for far less cost and would enable the physician to treat the patient immediately. RPA believes it is critical that the regulatory burdens imposed on physicians and other health care providers by CLIA be eased so they can return to providing routine laboratory tests they are trained to perform as a part of their clinical examination. These tests are the basic tools used by the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has unintentionally caused many physicians and other health care providers to stop offering the routine laboratory tests they need to provide patients with high quality care in an efficient and cost-effective manner.

CLIA has resulted in significantly higher costs for those physicians operating physician office laboratories. The government concluded that CLIA will add approximately $1.3 billion annually to the cost of health care. Despite this cost of complying with CLIA, there is little, if any, documentation that CLIA has resulted in improved patient care. The provision included in the Republican proposal will provide much needed relief for physicians who want to offer their patients routine laboratory testing in a timely and cost-conscious manner.

THE "LOOK BACK" MECHANISM

RPA urges you not to arbitrarily subject the Medicare program to a "look back sequester" if spending under the program exceed estimated budget targets. Budget targets may be exceeded for various reasons such as the availability of new expensive technologies, increased use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the program. Indiscriminately cutting reimbursement rates to providers are likely to result in access problems for beneficiaries as physicians find it financially impossible to participate in health plans accepting Medicare vouchers. RPA recommends that if spending is higher than projected because of new useful technologies or increased patient utilization of services deemed medically necessary, Congress should provide the funds necessary to reimburse for these services.

CONCLUSION

The RPA commends the leadership for drafting their proposal on transforming Medicare. The document contains many provisions which RPA has long supported and we applaud your goal of preserving and strengthening Medicare for present and future beneficiaries. We are aware that this year's budget process is just underway and refinements of this proposal are inevitable. The RPA looks forward to working with Congress on this crucial issue as the debate over Medicare continues.

Repub822.ce

832 N.E. Laurelhurst Place
Portland, OR 97232
September 20, 1995

U.S. House Ways and Means Committee
1102 Longworth
Washington, D.C. 20515

Attn: Executive Director

Re: Medicare Hearings

Health care reform should occur before any structural changes in Medicare (Medicade, too). Until this takes place, changes can't be made prudently.

There are factors causing health care costs generally to take too much of U.S. GDP. Several examples are cited. They are not necessisarily listed in order of significance, nor do they exclude other factors that need to be addressed.

-- Excess hospital capacity.

-- Luxury features in hospital construction that do not affect the delivery of services.

-- Fraud.

-- Billing systems that are wasteful and that allow overcharges to go undetected.

-- Unjustified malpractice awards.

-- The need for more full-time emergency clinics to take care of people with minor illnesses and injuries who now are treated in more expensive hospital emergency rooms.

-- The protection given to incompetent and impared health care providers by review boards.

Sincerely,

Charles L. Sauvie

Charles L. Sauvie

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,

Philip Sokolay, MFCC
2500 Alhambra Ave.
Martinez, CA 94553

STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR
ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
GRENADA, WEST INDIES

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of St. George's University School of Medicine on budget reconciliation and Medicare issues.

Since its founding in 1976, over 2000 students have graduated from St. George's with degrees in medicine. Many of these students are U.S. citizens who come from tax-paying families. Because of the quality of education received by students at St. George's, fully one-third of our students complete their second year, and transfer to a U.S. medical school.

Graduates of St. George's University School of Medicine enter primary care specialties at a rate of 76% -- a percentage for any U.S. Medical School to admire. The default rate on student loans for U.S. graduates of St. George's is less than 1%, also an enviable number.

At St. George's, we are very proud of our achievements and academic record. The states of California, New York, and New Jersey have recognized this track record, and have approved St. George's students for clinical clerkships in their respective states. The approval process utilized by New York is based on LCME accreditation guidelines and is identical in many ways.

Mr. Chairman, I bring this information to your attention because it is important that this committee not paint every graduate of a non-U.S. medical school with the same broad brush and because it is important for this committee to recognize that not every non- U.S. medical school is the same.

Council on Graduate Medical Education Recommendations

The prepublication recommendations of the seventh report of the Council on Graduate Medical Education that were transmitted recently to Congress by COGME are arbitrary in nature as they relate to International Medical Graduates, and are also directly contradictory to recommendations made in its first report related to International Medical Graduates.

Seventh Annual Report

COGME's Seventh Annual Report identifies the following commendable goals:

1) Decrease the number of specialists trained.
2) Increase the number of generalist physicians and improve primary care teaching.
3) Increase minority representation in medicine.
4) Improve physician geographic distribution.
5) Train more physicians in ambulatory and managed care settings.

COGME's Seventh Annual Report also makes the following recommendations related to IMGs:

1) Continued medicare GME funding for U.S. Medical School graduate residents at current level but reduce payments for International Medical Graduate residents.
2) Transition programs to assist IMG resident-dependent institutions.

Mr. Chairman, neither of these two recommendations will help to achieve the 5

stated goals. In fact, one could make a persuasive argument that implementation of these recommendations would make it more difficult to achieve the 5 stated national goals. Graduates of St. George's University School of Medicine, and International Medical Graduates in general are:

1) More likely to enter primary care specialties.
2) Certainly much more likely to be an ethnic minority.
3) Much more likely to enter a residency program in a setting that treats disadvantaged populations and perform these services in an ambulatory setting.

Furthermore, Mr. Chairman, the Seventh Report of COGME directly contradicts COGME's landmark first report which had the mandate to carefully review issues related to International Medical Graduates, which states that:

1) Selection into GME programs should be based on the relative qualifications of the individual applicant, not on group or institutional associations; and

2) For the purpose of limiting access to GME, the federal government should not establish policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location.

Mr. Chairman, and members of the subcommittee, St. George's recognizes that this committee has been given reconciliation instructions to achieve savings in the medicare program. We propose that if savings must be achieved in Graduate Medical Education, that they be done across the board and not be arbitrarily targeted at U.S. students who receive their medical education abroad.

I would also question the value of the Council on Graduate Medical Education and the motives of its members when recommendations such as theirs are made that do nothing to achieve the stated goals, but go a long way to protect the status quo for the U.S. medical establishment.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,

Stella Stark

Stella Stark
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

Janiece J. Sydow

Janiece J. Sydow
2500 Alhambra Ave.
Martinez, CA 94553

STATEMENT
on
MEDICARE REFORM
before the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
R. Bruce Josten
September 22, 1995

Mr. Chairman and members of the Committee, my name is Bruce Josten and I am the Senior Vice President for Membership Policy for the U.S. Chamber of Commerce. We appreciate the opportunity to submit this statement for the hearing record.

Medicare is indisputably in a state of crisis. Over the past five years, the program has grown at a staggering average annual rate of 10½%. Immediately ahead of us is a seismic demographic shift: the ratio of taxpayers to Medicare beneficiaries is declining rapidly -- from about four to one today, to only two to one in the next fifty years. The program as currently structured simply cannot survive.

These considerations led the Medicare Trustees[1] to call for "prompt, effective and decisive action" in their 1995 Annual Report. The plan put forward by the majority meets this objective for the foreseeable future, assuring quality health care for Medicare beneficiaries and removing a substantial threat to our nation's future financial health. The Chamber supports your efforts.

We believe the long-term solution to slowing the increase in Medicare spending is to increase competition. Encouraging seniors to evaluate and choose between competing health plans (including existing Medicare fee-for-service benefits) will lead to competition on the basis of quality and innovation. This competition will help bring prices down and will likely lead to expanded benefit options for seniors. We commend your focus on market forces rather than on government bureaucracies and mandates in your reform plan.

Clearly, the crisis facing the Medicare program requires fundamental change, rather than patchwork reforms. Past approaches to Medicare reform have failed to slow Medicare's growth. Worse, these approaches have increased the burden on businesses and their employees through higher payroll taxes and more expensive health insurance.

Although no one as yet has explicitly called for a hike in Medicare tax rates as a solution, it remains the hidden alternative, and is the implicit policy of those who decry the proposed slowdown in Medicare spending growth. As we can see from the 1990 and 1993 Medicare tax increases, the so-called tax solution is no solution at all. Instead, the boost in tax rates have increased the tax burden on individuals and businesses while curtailing economic performance.

The Chamber recently released a study of the effects on individuals, business and the economy of raising taxes to save Medicare. Our conclusion -- based on an optimistic evaluation, not a worst-case scenario -- is that increasing taxes rather than reforming the Medicare system will bring the economy to the brink of recession. A copy of our study appears at the conclusion of these remarks.

The Chamber's study reflects the recent report by the bipartisan Medicare Board of Trustees, which warned that Medicare trust fund reserves will be exhausted in seven years. The Trustees calculated that to balance the Medicare trust fund for the next 75 years -- the usual period for long-term fiscal solvency -- the Medicare payroll tax must

---

[1] The Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two members appointed by the President and confirmed by the Senate to represent the public. The Board is required by law to report to Congress each year on the operation of the trust fund during the preceding years and the projected financial status for future years.

immediately be increased from the current level of 2.90% to 6.42%. Delays in levying the new rate or phasing in the increase over time would result in an even higher ultimate Medicare payroll tax rate.

While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the average small business, and billions of dollars for the economy. When aggregated across the entire economy, the effect would be to lower real GDP by $179.4 billion within two years and hold GDP about $95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run, and with economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession. Over the long term, employment levels would be cut by 1.5%.

For a typical worker earning $30,000 a year, this increase would raise annual Medicare payroll taxes to $1,926 from the current $870, and a small business employing 25 such workers would be liable for an additional $13,200 tax payment per year. Because the Medicare payroll tax is levied on employment levels, not income, the tax due remains the same through both good and bad economic times, accentuating the pain of a downturn on employers who need to pay the tax regardless of profitability.

Our conclusion from this analysis is clear: higher taxes will rob working individuals of their hard-earned dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession. The tax "solution" to Medicare is tantamount to causing a recession. It is no solution at all.

The Chamber is convinced that the market approach to Medicare reform is the best and only appropriate means of solving the Medicare crisis. As reflected in the outline released yesterday, the Medicare Preservation Act is a long overdue solution that will provide solid and effective market-based reform that will secure Medicare's future over the long term. Important elements include:

- **Increased choices for Medicare beneficiaries through the MedicarePlus program.** The private sector has demonstrated that competition can bring both innovation and cost reductions. Medicare beneficiaries will benefit from these increased choices between coverage options, which would include the option of remaining in the existing Medicare program.

- **Restrained growth in Medicare spending.** Increases in Medicare spending are inevitable, even desirable. However, controlling the rate at which Medicare spending increases is as important to our nation's future financial health as Medicare itself is to seniors' health care.

- **Beneficiary incentives to report fraud and abuse.** Medicare beneficiaries should be natural allies in eliminating waste or fraud in the Medicare program, but have been underutilized in the past. Under the Medicare Preservation Act, beneficiaries will be given incentives to identify waste or fraud, or suggest means of increasing program efficiencies.

These and other elements of the Medicare Preservation Act will be explored in depth in the coming days. We look forward to working with you as this important proposal develops.

Thank you.

The Medicare Crisis: The "Tax Solution" Is No Solution

Martin A. Regalia • Vice President and Chief Economist

Robert D. Barr • Deputy Chief Economist

U.S. Chamber of Commerce • Washington, D.C.

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

> For a worker making $30,000 a year, total Medicare payroll taxes paid would jump to $1,926 from the current $870.
>
> A small business employing 25 such workers would be liable for an additional $13,200 tax payment per year.
>
> When aggregated across the entire economy, the effect would be to lower real GDP by $179.4 billion within two years and hold GDP about $95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

Overview of Medicare: Why Reform Is Necessary

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible ($716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible ($100). About a quarter of the funding comes from monthly premiums ($46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held $132.8 billion.

Conclusions of the Trustees

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees -- four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater) -- reported the following conclusions:

> ***Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years. . .*** **(HI Annual Report, pg. 2)**

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

. . .the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they write:

Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. . . Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years. (SMI Annual Report, pg. 3)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

Where Medicare Stands Today

Medicare is a huge federal program. In 1994:

Medicare expenditures reached $160 billion, just over half the size of Social Security
Expenditures grew 11.4% from 1993
Eleven cents of every dollar spent by the federal government went to Medicare
Medicare represented one-fifth of total entitlement spending

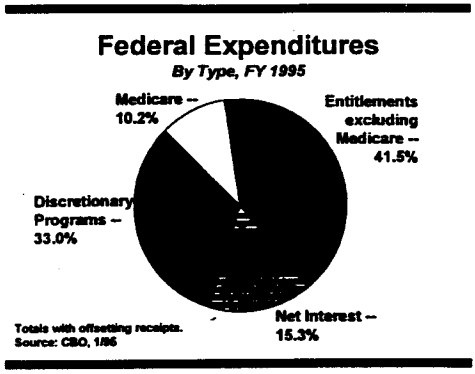
Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

Medicare and the Federal Budget

Medicare spending must be addressed as part of the solution to balancing the federal budget. That's because spending on federal entitlements -- such as Medicare, Medicaid and Social Security -- soared 8.4% annually on average between 1990 and 1994. Spending on

discretionary, annually appropriated programs -- such as defense, education and infrastructure -- increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Chart 1



Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. *If we are going to balance the federal budget -- and keep it in balance over the long term -- entitlement reform must be part of the solution.*

Where Medicare Is Headed If We Do Nothing

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach $344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust Fund, which at year-end 1994 held $132.8 billion, will have to be tapped to cover the projected $867 million difference.

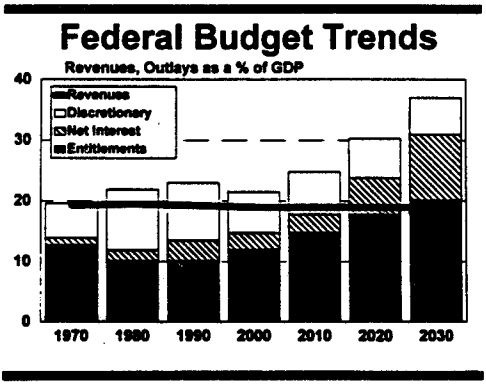
However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it

will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends, 1996 will be the first year of a hemorrhage that will deplete the entire trust fund by 2002 -- just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. *In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent -- unless we take action.*

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

Chart 2



Medicare's Impact on the Pay Stub

In addition to detailing the projected dissipation of the Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

Current Law

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning $30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or $435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another $435, resulting in $870 of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that $36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

Table 1

Medicare Hospital Insurance Payroll Taxes

	Current Law	To Balance the HI Trust Fund Over the Next:					
		25 Years		50 Years		75 Years	
	Employee + Employer	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax
Tax Rates	2.90%	1.33%	4.23%	2.68%	5.58%	3.52%	6.42%
Percent increase over current law			45.9%		92.4%		121.4%
Payroll Earnings							
$10,000	$290	$133	$423	$268	$558	$352	$642
20,000	580	266	846	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,926
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,760	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,852
70,000	2,030	931	2,961	1,876	3,906	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source(for all tables): 1995 Annual Report of the Board of Trustees, Medicare Hospital Insurance Trust Fund, Table I.D3, page 22
Calculations and macroeconomic simulations by the U.S. Chamber of Commerce

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019):
According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our $30,000/year worker for whom $870 is currently provided to Medicare HI, this increase means an additional tax of $399, bringing total annual hospital insurance payroll taxes to **$1,269**. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044):
Balancing the trust fund over the next fifty years -- a span long enough to see most of the Baby Boomers through their lifetimes -- would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning $30,000 a year, the total HI payroll tax rises from $870 to **$1,674**, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069):
Balancing the trust fund over the next seventy-five years -- roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency -- would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning $30,000 a year would rise from $870 to **$1,926**.

Medicare's Impact on Business

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns $20,000 per year is currently liable for a $7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25

Table 2

Medicare Hospital Insurance Payroll Tax

Annual Employer Tax Liability

	Average Salary: $20,000						
	Number of Employees						
	5	10	25	50	100	500	1,000
Current Law	$1,450	$2,900	$7,250	$14,500	$29,000	$145,000	$290,000
To Balance Medicare HI Over the Next:							
25 Years	2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 Years	2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 Years	3,210	6,420	16,050	32,100	64,200	321,000	642,000

	Average Salary: $30,000						
	Number of Employees						
	5	10	25	50	100	500	1,000
Current Law	$2,175	$4,350	$10,875	$21,750	$43,500	$217,500	$435,000
To Balance Medicare HI Over the Next:							
25 Years	3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 Years	4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 Years	4,815	9,630	24,075	48,150	96,300	481,500	963,000

years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from $7,250 to $10,575 per year.

Medicare's Impact on the Economy

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of the short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

Table 3

Impact on Gross Domestic Product

Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Billions of 1987 Dollars			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-$68.4	-$30.1	-$36.1	-1.2%	-0.5%	-0.5%
50 Years	5.58%	-137.1	-60.5	-72.7	-2.4	-1.0	-1.1
75 Years	6.42%	-179.4	-79.4	-95.6	-3.1	-1.3	-1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase -- enough to keep the Medicare trust fund in balance for the next 25 years -- production in the economy would be 1.2%, or almost $70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline, amounting to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump from 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

Table 4

Impact on Employment

Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Millions of Jobs			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-1.2	-0.6	-0.8	-0.9%	-0.4%	-0.6%
50 Years	5.58%	-2.4	-1.2	-1.6	-1.9	-0.9	-1.2
75 Years	6.42%	-3.2	-1.5	-2.2	-2.5	-1.2	-1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first $61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a *minimum* measure of the economic impact of raising Medicare payroll taxes. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

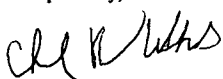
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Charles Windham, M.D.
2500 Alhambra Ave.
Martinez, CA 94553

THRIFT BAD DEBT RECAPTURE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

OCTOBER 26, 1995

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THRIFT BAD DEBT RECAPTURE

THURSDAY, OCTOBER 26, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 9:09 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisory announcing the hearing, and the text of H.R. 2494, the Thrift Charter Conversion Tax Act of 1995, follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
October 19, 1995
No. FC-10

CONTACT: (202) 225-1721

Archer Announces Hearing on Thrift Bad Debt Recapture

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on H.R. 2494, the "Thrift Charter Conversion Tax Act of 1995." H.R. 2494 was introduced on October 18, 1995 by Chairman Archer and Congressman Jim Leach (R-IA), Chairman of the Committee on Banking and Financial Services. **The hearing will take place on Thursday, October 26, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

BACKGROUND:

The Committee on Banking and Financial Services included in their budget reconciliation recommendations the adoption of several reforms to the banking system. Included among these reforms is the merger of the Banking Insurance Fund and the Savings Association Insurance Fund, and a requirement that thrift institutions convert their charters to bank charters.

In announcing the hearing Chairman Archer stated, "The thrift charter conversion proposal raises several banking, tax, housing, and accounting issues. It is not always easy to reconcile these sometimes competing policies. Nonetheless, it is clear that the thrift charter conversion proposal must contain transitional tax relief cushioning the blow to thrifts required to convert to banks. H.R. 2494 is intended to modify the tax laws to permit the conversion of thrifts to banks, consistent with the policies behind the thrift charter conversion proposal, and in a manner that is fair to the thrifts and consistent with our deficit reduction goals."

Chairman Archer further stated, "I believe that the conceptual proposal set forth in H.R. 2494 is a good resolution of these sometimes conflicting banking, tax, housing, and accounting policies. This is a complex area, however, and so I particularly welcome technical comments on the bill. I look forward to working with Chairman Leach in expeditiously including these provisions in the appropriate legislation."

Included in H.R. 2494 are two provisions which relate to the thrift charter conversion proposal. The first provision would generally repeal Internal Revenue Code section 593. Section 593 generally permits domestic building and loan associations, mutual savings banks, and certain cooperative banks to use a more favorable bad debt reserve method in determining their taxable income. Under the bill, entities currently eligible to use the reserve method under section 593 would be required to recapture the portion of their reserve attributable to reserve deductions taken after 1987. The portion of the reserve, attributable to taxable years before 1988, would not be recaptured. This recapture of post-1987 reserves would be treated as a change in accounting method under Code section 481, with the previously taken deductions included in income ratably over 6 years. An exception to this recapture rule would apply to a thrift that originates more than a certain level of mortgage loans. In such a case, the recapture would be deferred during any period in which the institution originates mortgage loans in excess of its moving 6-year average (generally based upon the average level of mortgage loans originated in preceding 6 years).

The second provision would clarify the deductibility of the "special assessment" required to be paid by thrifts. The thrift charter conversion proposal recommended by the Committee on Banking and Financial Services would require a thrift to pay a special assessment to capitalize the Savings Association Insurance Fund. H.R. 2494 would provide that the special assessment is treated as a deductible expense rather than as a capital expenditure.

DETAILS FOR SUBMISSIONS OF REQUESTS TO BE HEARD:

Requests to be heard at the hearing must be made by telephone to Traci Altman or Bradley Schreiber at (202) 225-1721 no later than the close of business, Monday, October 23, 1995. The telephone request should be followed by a formal written request to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff of the Committee will notify by telephone those scheduled to appear as soon as possible after the filing deadline.

In view of the limited time available to hear witnesses, the Committee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. **THE FIVE-MINUTE RULE WILL BE STRICTLY ENFORCED. The full written statement of each witness will be included in the printed record.**

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear before the Committee are required to submit 300 copies of their prepared statements for review by Members prior to the hearing. **Testimony should arrive at the Committee office, room 1102 Longworth House Office Building, no later than 12:00 noon on Tuesday, October 24, 1995.** Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business on October 30, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, at least two hours before the hearing begins.

FORMATTING REQUIREMENTS:

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

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

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

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

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

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

Note: All Committee advisories and news releases are now available over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

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I

104TH CONGRESS
1ST SESSION

H. R. 2494

To amend the Internal Revenue Code of 1986 to provide for the treatment of bad debt reserves of savings associations which are required to convert into banks, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 18, 1995

Mr. ARCHER (for himself, Mr. LEACH, and Mrs. ROUKEMA) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1986 to provide for the treatment of bad debt reserves of savings associations which are required to convert into banks, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Thrift Charter Conversion Tax Act of 1995".

SEC. 2. TREATMENT OF RESERVES FOR BAD DEBTS OF SAVINGS ASSOCIATIONS WHICH ARE REQUIRED TO CONVERT INTO BANKS.

(a) IN GENERAL.—Section 593 of the Internal Revenue Code of 1986 (relating to reserves for losses on loans) is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 52 of such Code is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(2) Subsection (a) of section 57 of such Code is amended by striking paragraph (4).

(3) Section 246 of such Code is amended by striking subsection (f).

(4) Clause (i) of section 291(e)(1)(B) of such Code is amended by striking "or to which section 593 applies".

(5) Subparagraph (A) of section 585(a)(2) of such Code is amended by striking "other than an organization to which section 593 applies".

(6) Section 596 of such Code is hereby repealed.

(7) Subsection (a) of section 860E of such Code is amended—

(A) by striking "Except as provided in paragraph (2), the" in paragraph (1) and inserting "The",

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows "subsection" and inserting a period.

(8) Paragraph (3) of section 992(d) of such Code is amended by striking "or 593".

(9) Section 1038 of such Code is amended by striking subsection (f).

(10) Clause (ii) of section 1042(c)(4)(B) of such Code is amended by striking "or 593".

(11) Subsection (c) of section 1277 of such Code is amended by striking "or to which section 593 applies".

(12) Subparagraph (B) of section 1361(b)(2) of such Code is amended by striking "or to which section 593 applies".

(13) The table of sections for part II of subchapter H of chapter 1 of such Code is amended by striking the items relating to sections 593 and 596.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(d) 6-YEAR SPREAD OF ADJUSTMENTS.—

(1) IN GENERAL.—In the case of any taxpayer who is required by reason of the amendments made by this section to change its method of computing reserves for bad debts—

(A) such change shall be treated as a change in a method of accounting,

(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a) of the Internal Revenue Code of 1986 (as modified by paragraph (2)) shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

(2) NO INCLUSION OF PORTION OF RESERVE.—In the case of a taxpayer to which paragraph (1) applies and which is a large bank (as defined in section 585(c)(2) of such Code) for its first taxable year beginning after December 31, 1995—

(A) no amount shall be includible in gross income by reason of the reduction of its reserve for bad debts to the extent that the amount of such reserve as of the close of its last taxable year beginning before January 1, 1996, does not exceed the amount applicable to such taxpayer under section 585(b)(2)(B) of such Code for such last taxable year, and

(B) the net amount of adjustments taken into account under paragraph (1)(C) shall be reduced by the amount not includible in gross income by reason of subparagraph (A) of this paragraph.

(3) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

(A) IN GENERAL.—In the case of a taxpayer which meets the residential loan requirement of subparagraph (B) for any taxable year—

(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

(ii) such taxable year shall be disregarded in determining—

(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

(II) the amount of such adjustment.

(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the average of the principal amounts of such loans made by the taxpayer during the 6 most recent testing years ending before such taxable year.

(C) TESTING YEARS.—For purposes of subparagraph (B), the term "testing year" means—

(i) each taxable year ending on or after December 31, 1990, and before January 1, 1996, and

(ii) each taxable year ending after December 31, 1995, for which the taxpayer meets the residential loan requirement of subparagraph (B).

(D) RESIDENTIAL LOAN.—For purposes of this paragraph, the term "residential loan" means any loan described in section 7701(a)(19)(C)(v) of such Code.

(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1) of such Code, subparagraph (B) shall be applied with respect to such group.

(F) COORDINATION WITH ESTIMATED TAX PAYMENTS.—For purposes of applying section 6655(e)(2)(A)(i) of such Code with respect to any installment, the determination under subparagraph (A) of whether an adjustment is required to be taken into account under paragraph (1) shall be made as of the last day prescribed for payment of such installment.

(4) CONTINUED APPLICATION OF PARAGRAPH (2) UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2) of such Code) for its first taxable year beginning after December 31, 1995—

(A) IN GENERAL.—Rules similar to the rules of paragraph (2) shall apply for purposes

of applying section 585(c)(3) of such Code with respect to the amount of such taxpayer's reserve for bad debts as of the close of the last taxable year before the disqualification year.

(B) TREATMENT UNDER ELECTIVE CUTOFF METHOD.—No amount shall be includible in gross income under section 585(c)(4) of such Code by reason of the reduction of such taxpayer's reserve for bad debts below the amount applicable to such taxpayer under section 585(b)(2)(B) of such Code for the last taxable year before the disqualification year.

(5) CONTINUED APPLICATION OF SECTION 593(e).—Notwithstanding the amendments made by this section, in the case of a taxpayer to which paragraph (1) of this subsection applies, section 593(e) of such Code (as in effect on the day before the date of the enactment of this Act) shall continue to apply to such taxpayer as if such taxpayer were a domestic building and loan association but the amount of the reserve taken into account under such section 593(e) shall be only the amount of such taxpayer's reserve for bad debts which is not includible in gross income by reason of paragraph (2) or (4) of this subsection.

(6) REGULATIONS.—The Secretary of the Treasury or his delegate shall prescribe such regulations as may be necessary to carry out this subsection, including regulations providing for the application of paragraph (3) in the case of mergers, spinoffs, and other reorganizations.

SEC. 3. DEDUCTION FOR SPECIAL ASSESSMENTS.

For purposes of subtitle A of the Internal Revenue Code of 1986, the amount allowed as a deduction under section 162 of such Code for the taxable year shall include the amount paid during 1996 as a special assessment under section 7(b)(6)(B) of the Federal Deposit Insurance Act, as amended by the Thrift Charter Conversion Act of 1995, as proposed by H.R. 2491, as introduced in the 104th Congress.

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Chairman ARCHER. The Committee will come to order.

We meet today to hold a hearing on H.R. 2494, the Thrift Charter Conversion Tax Act of 1995. This is a bill that I introduced with Jim Leach, Chairman of the Banking and Financial Services Committee, and also with Marge Roukema, Chairwoman of the Financial Institutions and Consumer Credit Subcommittee.

When the banking reform movement began to reach fruition in the Banking Committee, it became clear that there were certain tax aspects that needed to be considered. The recapture of reserves posed a problem, and the question of the deductibility of premiums to the insurance fund began to pose a problem. So we are here today to discuss the tax aspects of the changing developments relative to thrifts and banks in the bank reform efforts.

H.R. 2494 contains tax provisions designed to facilitate the conversion of thrifts. It is intended to be consistent with the policies behind the thrift charter conversion proposal, fair to the converting thrifts, and consistent with our deficit reduction goals.

It would repeal the special bad debt reserve rules applicable to thrifts; the recapture of those bad debt deductions, however, would be greatly ameliorated, especially for those financial institutions that continue to make residential mortgages.

We believe that it is a good approach. It may not be a perfect one, and we welcome our witnesses today so that we can get more information.

[The prepared statement follows:]

STATEMENT OF
THE HONORABLE BILL ARCHER
HEARING ON THRIFT BAD DEBT RECAPTURE
THURSDAY, OCTOBER 26, 1995

Today, the Committee on Ways and Means will hold a hearing on H.R. 2494, "the Thrift Charter Conversion Tax Act of 1995," a bill that I introduced with Jim Leach, Chairman of the Committee on Banking and Financial Services, and Marge Roukema, Chairwoman of the Financial Institutions and Consumer Credit Subcommittee.

This bill is intended to address the tax issues raised by the Thrift Charter Conversion Act, which is included in the "Seven-Year Balanced Budget Reconciliation Act." The Thrift Charter Conversion Act would generally require Federal Savings and loans to convert their charters to Federal bank charters.

Requiring thrifts to convert to banks raises several banking, tax, housing, and accounting policy issues. It is not easy to reconcile these sometimes competing policies. Nonetheless, it is clear that the thrift charter conversion proposal must contain transitional tax relief cushioning the blow to thrifts required to convert to banks.

H.R. 2494 contains tax provisions designed to facilitate that conversion. It is intended to be consistent with the policies behind the thrift charter conversion proposal, fair to the converting thrifts, and consistent with our deficit reduction goals.

The bill would repeal the special bad debt reserve rules applicable to thrifts. The recapture of those bad debt deductions, however, would be greatly ameliorated, especially for those financial institutions that continue to make residential mortgages.

This bill's approach is a good resolution of the various relevant policies. However, this is a complex area, and so I particularly welcome technical comments and improvements to the bill.

I look forward to the testimony of the Treasury Department and our panel of witnesses.

Chairman ARCHER. We also welcome Cynthia Beerbower, who is with us at the witness table today.

Ms. Beerbower is the Deputy Assistant Secretary for Tax Policy with the Treasury and is our first witness. We would be pleased to hear from you.

STATEMENT OF CYNTHIA G. BEERBOWER, DEPUTY ASSISTANT SECRETARY FOR TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

Ms. BEERBOWER. Thank you very much, Mr. Chairman and Members of the Committee.

I am pleased this morning to present the views of the Treasury Department on H.R. 2494, the Thrift Charter Conversion Tax Act. The bill, as the Chairman has already stated, repeals section 593 of the Internal Revenue Code, and generally ends the bad debt reserve method of accounting for thrift institutions. However, small thrifts, similar to small banks, would be permitted to compute bad debt reserves using the experience method under section 585. In addition, the bill ensures the deductibility of the 1996 special assessment that would be levied on thrifts in order to insure the deposits of SAIF, the Savings Association Insurance Fund.

We want to express our support for the bill. We very much appreciate the efforts of the drafters to try to reconcile what are often competing considerations of tax, banking, housing, and accounting policies that are involved in the decision of how to go forward on the tax side.

As a purely tax policy matter, we also support the bill as representing another very important step toward the financial modernization of the tax law. That is a goal that is very important to this Treasury, and we applaud the step of making the thrifts and banks subject to a common tax regime by eliminating the bad debt reserve method of section 593.

This morning our comments are really in response to the Chairman's letter and of a technical nature.

Our support for the basic repeal of the bad debt reserve method is consistent with very longstanding Treasury policy, regardless of political affiliation. We believe that this method of accounting distorts the timing of taxable income. In addition, the uniformity of the treatment of financial intermediaries, wherever possible, is an important goal of this administration.

We believe on a prospective basis that banks and thrifts should be taxed similarly and that we should minimize, as a banking and as a tax matter, the incentives for thrifts to maintain a narrow focus with respect to their investment activities.

The bill repeals the percentage-of-taxable-income method for all thrifts. However, small thrifts are permitted to continue to compute bad debt reserves using the experience method. We support these rules.

We think the percentage-of-taxable-income method might have been appropriate at one time as an incentive to encourage mortgage lending, but that it should not be retained at a time when our objectives are to remove the barriers to diversification within the thrift industry and move toward uniform taxation of financial institutions.

Concerning the recapture of the bad debt reserve with respect to prior years, the bill would require a thrift to recapture only its increase in reserves since 1987, and it would forgive the recapture of amounts prior to that. In addition, in the case of a thrift that is treated as a small bank, the bill would limit the amount of recapture to the post-1987 increase that could not have been claimed under the experience method.

As the Chairman mentioned, the bill suspends this recapture for any taxable year in which the taxpayer meets a residential lending requirement, and the requirement is satisfied if the principal amount of residential loans made by the taxpayer during that year is not less than one-sixth of the principal amount of residential loans made by the taxpayer during the 6 most recent testing years. I think this will essentially force thrifts to exceed the average of the 6 previous years in order to be certain they satisfy the residential loan requirement.

The Treasury supports the elimination of recapture for the pre-1988 reserve amounts, but this is a very difficult decision. We appreciate the difficulty that the Chairman and other drafters must have faced in resolving this issue. As a purely tax policy matter, we would require the recapture of reserves to the extent that they reflect the experience method of accounting. This would prevent the double counting of losses that are essentially the same losses.

However, it is our understanding that deferred tax liabilities have not been recorded on the thrifts' books with respect to the pre-1988 additions to the bad debt reserves. To recapture these pre-1988 reserves at this point would require thrifts to record an immediate $3 billion increase in their liabilities for financial accounting purposes.

As a banking policy matter, we are concerned that adding this additional liability to their financial accounts at this point perhaps could have a significant effect on the capital of some institutions. At a minimum, under the pending banking legislation that the Chairman referred to, the thrifts will be required to pay an approximately $6 billion special 1996 assessment. In general, this assessment must be paid in full in 1996, so a further $3 billion addition to their liabilities could constrain the resources of the thrifts.

For these reasons, we support the exemption from recapture for the pre-1988 reserves. The spirit of wanting thrifts to be encouraged to become banks and to level the playingfield in this particular case is persuasive to us.

The suspension of the recapture with respect to the residential lending troubles us more, and Treasury questions the suspension in the event that a thrift continues to specialize in residential lending. As a matter of both banking and tax policies, Treasury believes that artificial incentives that encourage financial institutions to specialize in certain areas rather than allowing them to respond to the market incentives should generally be avoided. Rewarding thrifts for continuing to increase their residential lending does just this.

Treasury has technical concerns about the residential loan requirement; specifically the suspension of the recapture, the way the provision is currently drafted is perpetual. It would continue theoretically for hundreds of years. We think if for no other reason than

just reducing recordkeeping burdens, that the suspension period should be limited and sunset.

Second, we also question the types of loans that are included in the definition of residential lending. The Committee needs to consider what it wants to achieve with respect to the suspension. Currently, the definition includes refinancing, and a thrift could refinance its existing portfolio and count the principal from these refinancings toward satisfaction of the residential loan requirement.

Similarly, for reasons that are not clear, the draft does not include mortgage modifications. So, for example, if you have a home mortgage and there is a modification to it, a thrift would be encouraged to redo all the paperwork in order to convert the modification to a refinancing that would count toward satisfaction of the requirement. As most of you know, when you do new paperwork on a mortgage in certain circumstances, you incur recording fees and other types of costs.

The definition of residential lending also includes home equity loans which can be used for general consumer spending. The Committee needs to consider whether its objectives are to encourage this type of activity. Alternatively, the Committee could concentrate on a different sort of test, such as residential lending for new homes, that would not have the complexities associated with refinancing and the other aspects I mentioned.

Third, I think Treasury questions the methodology by which thrifts will determine whether they satisfy the residential lending requirement. The bill requires that you average a 6-year period, and then in order to qualify for one particular year, you must equal or exceed that average. If, as is likely, you exceed the average, over a period of time you will be increasing the standard. As a result, thrifts will be encouraged to increase their residential lending activity rather than have it decline. This will mean that thrifts will concentrate their activities more on residential lending.

The particular years that have been chosen as base years for the test are somewhat questionable from our standpoint because they include years in which there were a large number of refinancings and a large amount of real estate activity. The resulting standard may be set artificially high, and as I suggested, will tend to increase over time.

In addition, residential lending is extremely cyclical, as well as varying regionally, and we question whether these testing years are appropriate as a base.

We recommend that if a suspension is to be allowed, it be based on a common standard for all thrifts rather than one that is determined by reference to a particular thrift's prior experience. A common standard would not penalize thrifts that have concentrated more heavily than others in mortgage lending.

Fourth, we question the use of loan origination as the basis for the test. It is not clear as a legal matter what loan origination is. It can mean simply initiating the paperwork. However, with brokers involved in the introduction of customers, it certainly is not clear to me that increased paperwork is really intended to be the standard for satisfying the residential lending requirement.

I think the Committee needs to know, or certainly be aware, that in our current financial environment, securitization of mortgage loans is a relatively easy process. We would expect that thrifts that are required only to originate loans would originate them and immediately sell them off as part of a securitization. What this amounts to is really a debt-financed origination incentive. And, again, we question whether origination is what the drafters intended to encourage.

Instead, we recommend a more portfolio-based standard similar to the 60-percent asset test in current law, but preferably with a reduced percentage. Compliance with a portfolio-based standard would tend to even out the cyclical fluctuations in the mortgage market and might better take care of the region-specific fluctuations.

Treasury does support the recapture of the pre-1988 reserves if thrifts make distributions in excess of their post-1951 earnings and profits to shareholders. We think this bill should not eliminate recapture of windfalls to shareholders by reason of excess distributions. There is a delegation authority in the legislation for Treasury to come up with regulations that address situations such as mergers and other reorganizations, and we will consider what types of adjustments would need to be made for those situations.

Regarding the deductibility of the special assessment, we have no objection to the bill establishing that the 1996 special assessment imposed by the Thrift Charter Conversion Act of 1995 is deductible, provided it is an ordinary and necessary business expense. This act would address the underfunding of the SAIF by imposing a one-time special assessment on the thrifts. The fee will be sufficient to increase the SAIF reserves to a level of $1.25 per $100 of insured deposits. This special assessment, as we understand the legislation, is due in January 1996 and would be based on March 31, 1995 deposit levels.

We understand that the purpose of this special assessment is to increase the capitalization of the SAIF so that insurance coverage is available for 1996. As a separate matter, to address the long-term weaknesses of SAIF, the Thrift Act would cause SAIF to be merged with the Bank Insurance Fund and eliminate Federal charters for thrift institutions. But these objectives are separable. We understand that the special assessment is due regardless of whether the funds merge. In fact, any excess in SAIF would be placed in a special reserve of the merged fund and would not be available for any assessment credit, refund, or any other payment.

We understand that the 1996 special assessment is entirely related to 1996 and is not a prepayment of any future liability with respect to the insurance within the fund. We understand that the assessed institutions have no ownership interest in SAIF and they won't receive a separate or distinct asset as a result of the assessment. We understand the special premium is not rebatable or otherwise recoverable.

Now, if those understandings are correct, under current law we believe the 1996 special assessment would be deductible. On the other hand, we have no problem with the bill including a provision to say that. It simply codifies the current law treatment.

That concludes my prepared technical remarks, and I am happy to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT OF
CYNTHIA G. BEERBOWER
DEPUTY ASSISTANT SECRETARY (TAX POLICY)
DEPARTMENT OF THE TREASURY
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS

Mr. Chairman and Members of the Committee:

I am pleased to present the views of the Treasury Department on H.R. 2494, the "Thrift Charter Conversion Tax Act of 1995" (the "Bill"). The Bill repeals section 593 of the Internal Revenue Code and the bad debt reserve method of accounting for thrift institutions (other than small institutions permitted to use the experience method under section 585 of the Code), as well as ensuring the deductibility of the 1996 special assessment on deposits insured by the Savings Association Insurance Fund (SAIF). We support the Bill, and we appreciate the efforts of its drafters to reconcile the competing considerations of banking, tax, housing, and accounting policies. As a purely tax policy matter, the Bill represents another step toward financial modernization of the tax law--a goal that is very important to the Treasury. Our comments today are of a technical nature.

I. REPEAL OF BAD DEBT RESERVE METHOD

Our support of the repeal of the bad debt reserve method is consistent with long-standing Treasury policy. The tax policy position of the Treasury Department has not changed. We continue to believe that the bad debt reserve method distorts the timing of taxable income, and we continue to support the repeal of the bad debt reserve method. In addition, an important tax policy objective to this Treasury Department is that we move toward uniform tax rules for financial institutions wherever possible. The repeal of the bad debt reserve method for thrifts ensures that banks and thrifts will account for bad debts in a similar manner.

Historically, Congress has accepted Treasury's recommendation only in part. The Tax Reform Act of 1986 repealed the bad debt reserve method for most taxpayers, including large banks. Small banks were allowed to continue using the reserve method because of concerns that they might be adversely affected by repeal. Thrift institutions were also permitted to continue using the bad debt reserve method, but the special benefit they previously received from using the percentage-of-taxable-income method of computing additions to the reserve was substantially reduced.[1] Congress stated at that time that thrift institutions needed some tax incentive to provide residential mortgage loans, but they should not be given a significant competitive advantage over other financial institutions. H.R. Rep. No. 426, 99th Cong., 1st Sess., 582 (1985).

We believe that on a prospective basis, banks and thrifts should be taxed similarly. This will level the playing field for banks and thrifts, and minimize incentives for thrifts to

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[1] Under section 593, a qualifying thrift institution generally may compute its bad debt reserve under either the "percentage-of-taxable-income" method or the "experience" method. The percentage-of-taxable-income method allows a thrift to deduct 8 percent of its taxable income (determined without regard to the deduction and with certain other adjustments) as an addition to its bad debt reserve. The experience method, which is also available to small banks, allows a thrift to deduct the greater of (1) the percentage of its loans outstanding equal to its average bad debt experience (i.e., bad debt losses as a percentage of loans outstanding) in the current and five preceding years, or (2) the amount necessary to restore its reserve to its balance at the close of the last taxable year beginning before 1988 (adjusted downward to reflect any post-1987 decline in loans outstanding).

maintain a narrow focus in their lending activity. Finally, as a banking policy matter, Treasury supports the repeal of the bad debt reserve method of accounting.

II. EXEMPTION OF SMALL INSTITUTIONS

The Bill repeals the percentage-of-taxable-income method for all thrifts, but allows small thrifts (those with no more than $500 million of adjusted basis in their assets) to continue to use the experience method, conforming their tax treatment to that of small banks.

We support the repeal of the percentage-of-taxable-income method for small thrifts. This method may have been appropriate at one time as an incentive to encourage thrift institutions to specialize in mortgage lending. It should not be retained at a time when our objectives are to remove artificial barriers to diversifying thrift portfolios and move toward uniform tax rules for all financial institutions.

III. RECAPTURE OF THE BAD DEBT RESERVE

Under current law, if a thrift institution ceases to be eligible for section 593, it is required to recapture (i.e., include in its gross income) its reserve. In general, the amount would be included in gross income ratably over a 6-year period. The Bill would require a thrift to recapture only the increase in its section 593 reserve since 1987. The Bill would not require the recapture of the amount of the section 593 reserve that was added in tax years prior to 1988 unless distributions to shareholders exceed post-1951 earnings and profits.[2] In the case of a thrift that qualifies as a small bank, the Bill limits the amount of recapture to the post-1987 increase that could not have been claimed under the experience method.[3]

In general, the amount recaptured with respect to post-1987 reserves would be included in income ratably over the 6-year period beginning with the first taxable year beginning after 1995. However, the Bill suspends recapture for any taxable year in which the taxpayer meets a "residential loan requirement." This requirement is satisfied for a taxable year if the principal amount of residential loans made by the taxpayer during the year is not less than one-sixth of the principal amount of residential loans made by the taxpayer during the six most recent testing years.[4] Testing years would include 1990 through 1995 and any subsequent year in which the taxpayer met the residential loan requirement. Special rules are provided for controlled groups and estimated tax payments.

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[2] Section 593(e) of current law, which requires recapture in these circumstances, would continue to apply to the pre-1988 reserve balance.

[3] We question whether the legislation achieves its purpose of forgiving recapture of pre-1988 bad debt reserves in the case of small thrifts. The technical explanation states that "a thrift institution that would qualify as a small bank generally only would be required to recapture its post-1987 additions to its bad debt reserve that were attributable to the use of the percentage of taxable income method . . . ." The legislative language, however, does not specifically provide such an exclusion, apparently under the assumption that the portion of the reserve attributable to use of the percentage of taxable income method is excluded under section 585(b)(2) of current law. Section 585(b)(2) provides that a small bank's bad debt reserve under the experience method is generally not less than the balance of its reserve at the end of its last taxable year ending before 1988 plus experience method additions since 1987. Proposed regulations under section 593 provide, however, that in applying this rule to a thrift that becomes a small bank, its bad debt reserve at the end of its last taxable year ending before 1988 must be recomputed on the experience method. Thus, pre-1988 reserve additions attributable to use of the percentage of taxable income method would not be exempt from recapture under section 585(b)(2). We will be happy to work with the Committee to fix this problem.

[4] For this purpose, residential loans would include loans secured by residential real property, real property used by churches, and mobile homes.

Treasury supports the Bill's elimination of recapture for pre-1988 reserve amounts. We appreciate that this decision is a difficult one. As a purely tax policy matter, we would require recapture of the pre-1988 reserve to the extent it reflects the experience method of accounting. This would prevent a double deduction for the same losses and is consistent with the Treasury's recommendation during the 1986 tax reform. However, it is our understanding that deferred tax liabilities have not been recorded with respect to pre-1988 additions to thrift bad debt reserves, and further that to require recapture with respect to these amounts, even on a deferred basis, would result in an immediate $3 billion increase in thrift liabilities for financial and regulatory accounting purposes.

We also note that under the pending banking legislation, thrifts will be required to pay a 1996 special assessment of approximately $6 billion to the SAIF fund. This assessment must be paid in full this year, further constraining the resources of the thrifts. Forcing recapture now would have a significant effect on the capital of some institutions. Thus, we support the exemption from recapture for pre-1988 reserves.

By contrast, we understand that deferred tax liabilities have been recorded with respect to post-1987 reserve additions. Thus, recapture will not result in any net increase in thrift liabilities for financial and regulatory accounting purposes.[5]

IV. SUSPENSION OF RESERVE RECAPTURE IF INCREASED RESIDENTIAL LENDING OCCURS

Treasury questions technical aspects of the Bill's suspension of post-1987 reserve recapture if a thrift institution continues to specialize in residential loans to the same extent as in the past.

Our first concern is the Bill's perpetual suspension of recapture. As we understand the Bill,[6] a thrift's post-1987 reserves are not fully recaptured until it fails to meet the residential loan requirement in at least six years. The time frame in which this could occur is unlimited. Even if some incentive for residential lending is currently appropriate, we question whether that incentive should continue indefinitely. If for no reason other than reducing record keeping burdens, we recommend that the suspension period be limited and sunset.

Treasury questions the types of loans included in the definition of residential lending. By including refinancings, thrifts can avoid financing new homes, for example, by offering rate reductions for refinancing. The same is true for home equity loans for current homes. The Committee should consider whether it would prefer a rule that encourages only new lending. Also, modifications to existing mortgages do not count for the test. Why force all of the paperwork to be redone? This will often result in recording fees and other burdens to homeowners.

Treasury questions the methodology by which the standard of qualified investment is determined. We do not believe suspension of recapture should depend on whether an individual thrift institution continues to specialize in residential loans to the same extent as in the past. The Bill requires that a thrift average its residential lending over a 6-year period and equal or exceed this average amount in a given year in order to qualify. By taking into account only years in which the lending equals or exceeds the average, the average amount

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[5] We also note, however, that there are precedents for providing recapture relief. For example, the Deficit Reduction of 1984 that changed the method by which life insurance companies compute their reserves allowed a "fresh start" under which excess reserve deductions for prior taxable years were not recaptured. A similar "fresh start" was allowed when the Tax Reform Act of 1986 changed the reserve rules for property and casualty insurance companies.

[6] We find the draft confusing as written and would be willing to work with the Committee to improve it.

will tend to increase over time. This will mean that thrifts will attempt to concentrate their activities even more toward residential lending. In addition, residential lending is extremely cyclical and the particular base period for testing was a historically high period of refinancing. Treasury questions whether these are appropriate test years.

Treasury recommends basing any rule that suspends recapture on a standard that is the same for all thrifts, rather than one determined by reference to the thrift's own past experience. A common standard would not penalize thrifts that have concentrated more heavily than other thrifts in mortgage lending.

Treasury questions loan origination as the basis of the test. It is not clear to us what is technically meant by loan origination other than the paperwork. In our current financial environment, the securitization of residential loans is relatively easy, and we would expect that thrifts will initiate the paperwork for a loan expecting to immediately sell it off. Using loan origination as the basis of the test amounts to nothing more than encouragement for debt-financed origination. Also, loan origination activity has little relationship to bad debt reserves and it is hard to justify on tax policy grounds. Residential loan holdings, on which a thrift has credit risk as well, may be a better measure.

Treasury would encourage the Committee to consider a portfolio-based standard similar to the 60 percent qualified asset test of current law, but preferably with a reduced percentage, instead of a loan origination test. Compliance with a portfolio-based test for this purpose would not be as dependent on cyclical fluctuations--national or regional--in the mortgage market.

Treasury notes that, if the residential loan requirement is retained, it is appropriate for regulations to provide rules for applying the requirement in the case of mergers, spinoffs, and other reorganizations.

Treasury supports the Bill's recapture of pre-1988 reserve balances if a thrift makes distributions in excess of its post-1951 earnings and profits to shareholders.

V. DEDUCTIBILITY OF SPECIAL ASSESSMENT

Treasury has no objection to the Bill establishing that the special 1996 assessment amount imposed by the Thrift Charter Conversion Act of 1995 (the Thrift Act, which comprises subtitle II.B of H.R. 2491) is deductible as an ordinary and necessary business expense. The Thrift Act would address the current underfunding of SAIF by imposing a one-time special assessment on insured depositary institutions. The assessment rate would be sufficient to increase SAIF reserves to a level of $1.25 per $100 of insured deposits. This special assessment would be due in January of 1996 and would be based on March 31, 1995 deposit levels.

The purpose of the special assessment is to increase the capitalization of the SAIF so that it has adequate reserves for 1996. To address long-term weaknesses of SAIF, including excessive concentrations of risk because SAIF insures a specialized industry concentrated on the West Coast, the Thrift Act would separately cause SAIF to be merged with the Bank Insurance Fund (BIF) in 1998, and thereafter eliminate a separate system of Federal thrift regulation. Federal thrifts would be permitted to continue in business only if they convert to a Federal bank charter or a State depositary institution charter.

We understand that the special 1996 assessment will be due independent of whether the insurance funds merge. If immediately prior to any merger the SAIF reserve ratio exceeds the required level of $1.25 per $100 of insured deposits, the excess will be placed in a special reserve of the merged fund and will not be available for any assessment credit, refund, or other payment (except as additional insurance if the insurance fund is severely weakened).

We also understand that the special 1996 assessment has been designed to provide SAIF coverage for 1996, and that it is not a prepayment of future liabilities, but relates solely to the adequacy of SAIF funding and reserve levels in 1996. The intended beneficiaries are only the depositors whose deposits are insured by SAIF. We further understand that the assessed institutions have no ownership interest in SAIF and will not be receiving a separate and distinct asset as a result of the assessment, and that the special premium will not be rebatable, refundable, or otherwise recoverable by assessed institutions.

The Bill provides that the special 1996 assessment on SAIF-insured deposits will be deductible when paid, and Treasury has no objection to this provision. Treasury believes that the special 1996 assessment would be deductible under current law, so that this provision of the Bill would simply codify that current-law treatment. Our conclusions regarding deductibility under current law are limited to the basic special 1996 assessment and should not be construed as applying to other fees that may be imposed by the Thrift Act by other provisions or for other purposes.

This concludes my prepared remarks. We look forward to working with the Committee to resolve our concerns and enact this important and necessary legislation. I would be happy to answer any questions that you may have.

Chairman ARCHER. Thank you, Ms. Beerbower. Thank you also for a detailed explanation of the bill to make the Members here more aware of the details of it and for your position, policywise, on the various elements of the bill.

Let me say in the offing that we look forward to working with the Treasury and perhaps improving this bill as to its details. But let me also say that it is the Chair's position that if there is no recapture over 60 years of existing reserves accumulated after 1986, there should be some standard for continuation of residential mortgage lending.

I know that generally you expressed some concern about that and that there ought to be a level playingfield and that we should perhaps have no such provisions in the bill. But I think the position of the Chair is shared by a majority of the Members of Congress from a public policy standpoint, and the question really is: How are we going to design the basis by which we waive recapture for tax purposes and what will the standards be? And we will be delighted to work with you on that.

Are there any other Members who wish to question? Congressman Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend you for introducing this very, very important legislation. I just have one question for the Deputy Assistant Secretary.

Ms. Beerbower, you stated in your testimony that under the Archer bill it is clear that the special assessment paid by the thrifts will be deductible as a business expense. In your opinion, will the entrance fee paid by the Oakar banks, that is, banks which acquire thrift deposits, be similarly deductible?

Ms. BEERBOWER. When we were examining the Thrift Charter Conversion Act, we did not see that fee as part of the Banking Committee's legislation, so I am not absolutely sure of the facts associated with this fee.

When you refer to it as a fee the way that you just did, that would suggest that it is not deductible. Fees that are deductible are payments that are made in a current year with respect to business expenses in that current year. Things that are not deductible would be entrance or exit fees or fees that relate to conduct that would occur over a period of time.

Mr. RAMSTAD. So unlike the former, you don't see it as being in the ordinary course of business and, therefore, not deductible?

Ms. BEERBOWER. Well, I prefaced the remarks by saying I haven't seen what is contemplated. It is not in the act that is referenced in H.R. 2494. We would be happy to look at it, but, in general, the standard for deductibility is whether a payment relates to the current year. If it does, it is normally deductible. If it relates to a future period of time, it is normally not deductible.

Mr. RAMSTAD. I appreciate the response.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Kleczka.

Mr. KLECZKA. Mr. Chairman, in your remarks you did address the mortgage origination test, and Ms. Beerbower also talked about it. The criticism that I have heard on this portion of the bill is that it would be too tough for some S&Ls to comply with, even though,

you know, they think that that is a worthwhile goal, and it seems to me that we should have a test that can be complied with.

What is your reaction to those comments?

Ms. BEERBOWER. Well, as I mentioned in the oral statement, we do question the loan origination standard as well. It is a vague standard. It is a standard that could be nothing more than simply paperwork. Increased paperwork and securitization of loans may not be the objectives that the Committee wants to achieve.

The difficulty in meeting a loan origination test may very well be triggered not so much by the loan origination test, but by the particular years that are used in computing the average amount that a thrift must equal or exceed. If those years, historically speaking, were years filled with lots of real estate lending activity and lots of refinancing, which is what we believe they were, that will set an artificially high standard for thrifts to meet in the future. And as I said, they must equal or exceed the standard so that, as a mathematical matter, the standard, which may already be too high, will tend to increase in the future.

Mr. KLECZKA. Thank you.

Mr. Chairman, could I inquire of the Chairman what the future holds for this legislation as far as the Ways and Means Committee goes? Specifically, are we going to enter into a markup at some future time so that some of the problems that we are talking about today can be addressed before it is moved up?

Chairman ARCHER. Yes, I will be happy to reply to the gentleman. We believe this is very important conjunctively with banking reform in the Banking Committee and that we must proceed with it, and we hope at the earliest possible time to have a markup. And preceding that, we want to have further interface with the Treasury and, of course, take into account the testimony of the other witnesses today as to what the Chairman's mark might actually be at the time that we mark it up. And the gentleman's input will also be welcome.

Mr. KLECZKA. So there will be an opportunity to possibly make adjustments if, in fact, they are in order?

Chairman ARCHER. Yes.

Mr. KLECZKA. A further inquiry, Mr. Chairman. Once the markup has been completed, I am assuming that it is essential that we put this in the reconciliation bill so that the banking change can be whole at that point. Is that your intention after some type of a markup on the Committee?

Chairman ARCHER. It might possibly be dealt with in the conference on reconciliation.

Mr. KLECZKA. Thank you very much.

Chairman ARCHER. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Chairman, I have some questions that have been submitted to me by some of the thrifts back home, and I would like to have unanimous consent to just put those in writing to Ms. Beerbower and to you, too, Mr. Chairman, for answers.

Chairman ARCHER. Without objection, so ordered.

Mr. COLLINS. Thank you, sir.

My concern and the concern of my constituency is that in many rural towns where we do have savings banks, they are considered

the same as a community bank, which has a far different track record in history than major banks in larger cities.

In your opinion, Ms. Beerbower, will this in any way jeopardize the savings as they appear to be, that is, community banking?

Ms. BEERBOWER. It should not have any effect on this. If a bank serves a particular community, it is going to serve them before and after this legislation. It should not have any effect on serving the community.

Mr. COLLINS. Well, many of the savings, though, do finance heavily in first-time home buying or home mortgage.

Ms. BEERBOWER. We looked at some of the statistics in preparation for the hearing. One of the things that was interesting to me is that the thrifts account for a smaller and smaller percentage of family home mortgage lending. Currently, thrifts account for about 19.5 percent of family home mortgages, with the balance of home mortgages being provided by commercial banks and nonthrift institutions. That part of the industry has been increasing its home mortgage lending.

I do not know why that has occurred, but it may be in your community that home mortgage lending is less dependent on these banks than on commercial banks.

Mr. COLLINS. Well, it is kind of the opposite. A lot of the home mortgages are dependent upon the savings banks rather than the commercial banks. That is one of the reasons they are considered more or less a community-type bank, and we don't want in any way to jeopardize that standing.

Thank you, and thank you, Mr. Chairman.

Mr. PAYNE. Mr. Chairman.

Chairman ARCHER. Yes, Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you very much for writing this bill and conducting this hearing this morning.

I would ask unanimous consent to put an opening statement in the record.

Chairman ARCHER. Without objection, so ordered. That will be granted to every Member of the Committee to insert any comments or questions in the record, without objection.

Mr. PAYNE. Thank you, Mr. Chairman.

[The opening statements follow:]

STATEMENT OF REP. L. F. PAYNE
OCTOBER 26, 1995

Mr. Chairman, thank you for holding this hearing today on H.R. 2494, the Thrift Charter Conversion Tax Act. H.R. 2494 is a very important part of the solution to the problems facing our savings and loan institutions.

As you know, the reconciliation bill contains provisions that will merge the Savings Association Insurance Fund with the Bank Insurance Fund and abolish the thrift charter. These steps, along with a special assessment on all SAIF deposits and a redistribution of the burden of payments for FICO bonds, will help us close the books on the savings and loan crisis of the 1980s. And Mr. Chairman, it will do so without costing taxpayers another penny.

However, these provisions will trigger an unintended consequence: the forced recapture and subsequent taxation of the bad debt reserves accumulated by thrifts. This is because thrifts currently enjoy a tax deduction for certain contributions to their bad debt reserves. The deduction is intended to encourage home lending on the part of the thrifts and was subject to several qualifications, one of which is that institutions maintain a thrift charter. The taxation of the bad debt reserves would not only be an enormous and unfair tax, it could also force many of them into insolvency.

And so, Mr. Chairman, I commend you for introducing H.R. 2494 which generally provides a safe harbor from the forced recapture and taxation of thrift bad debt reserves.

I understand that our witnesses here today will propose several technical changes to the bill that I hope you can support. The first would modify the residential loan requirement to prevent the refinancing wave of the early 1990s from forcing the recapture of post-1987 reserves at thrifts that are making substantial numbers of home loans. The second would simply ensure that the sale of a thrift after the 1998 abolition of the thrift charter does not trigger recapture and taxation of bad debt reserves. Lastly, Mr. Chairman, the industry is seeking assurances that it is your intention that the safe harbor provided in H.R. 2494 apply to all institutions with SAIF deposits, regardless of the method ultimately used to bring all financial institutions under one charter and one insurance fund.

Again, Mr. Chairman, thank you for holding this hearing and I look forward to the testimony of our witnesses.

STATEMENT OF U.S. REP. JIM RAMSTAD
BEFORE THE HOUSE WAYS AND MEANS COMMITTEE
October 26, 1995

I want to commend Chairman Archer for introducing the Thrift Charter Conversion Tax Act of 1995 along with members of the Banking Committee.

The historic Reconciliation legislation the House will be considering today calls for the merger of thrift and bank deposit insurance funds, and ultimately the merger of thrift and bank charters. The conversion of thrifts to banks will have major tax consequences.

I am looking forward to the testimony that will be presented today regarding the two major issues raised by the Banking Committee's charter conversion proposal -- the tax treatment of bad debt reserve as thrifts convert their charters, and the deductibility of the special assessment thrifts will pay to recapitalize their deposit insurance fund before it is merged with the bank insurance fund.

I look forward to passing legislation that is fair and equitable and will contribute to the long-term solvency of our financial institutions.

Mr. PAYNE. I would simply like to follow up Mr. Ramstad's comments concerning the Oakar banks, those banks who had purchased deposits from SAIF-insured institutions. It is my understanding that the Financial Institutions Subcommittee has already passed a bill dealing with the special assessment and moving these funds from SAIF to the BIF Fund. And it would seem to me that one of the considerations that we need to look at on this Committee would be what is the appropriate tax treatment of the special assessment that would have to be paid by these institutions.

So I would like, as we move forward on this, to continue, both with the Treasury and on this Committee, to look at that because I think that is an issue that needs attention.

One other issue that we need to address is that with the residential loan requirement provision and the 6-year average that we have discussed, apparently in this 6 years there was an unusual period of time when there was a significant amount of refinancing. I think it is also very important as we move forward that we either exclude that kind of activity from an average or we have some sort of a factor that is applied that would have the effect of excluding that sort of activity.

So I would simply mention these things, Ms. Beerbower. Thank you very much for your testimony. I thank the Chairman, and I yield back the balance of my time.

Chairman ARCHER. Mr. Portman, do you wish to be recognized?

Mr. PORTMAN. Mr. Chairman, I just want to commend you for bringing up this issue. I also have met with many of our thrifts back home which have raised some questions. If it is appropriate, I would like the option to submit those in writing to Treasury and to the Chairman.

Chairman ARCHER. The Committee Members are given general leave to do that.

Mr. PORTMAN. Thank you, Mr. Chairman.

I also would say I support the entrance-fee clarification and, again, would commend the Chairman for acting swiftly and promptly on this issue.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Ms. Beerbower, would you clarify your position on the definition of origination as to the point of refinancing of home mortgages, taking advantage of lower interest rates, how you would treat that? Also, would you comment on including the prevalence of relationship as loan brokers in your definition of origination?

Ms. BEERBOWER. Well, our testimony suggests that it is unclear what it means to originate a loan. This type of definitional problem comes up in many different areas of the Tax Code.

For example, if I bring you a customer who wants a home mortgage, have I originated it by reason of finding the customer for you and bringing him to the bank? Or when you take the mortgage application and put the fellow's name on it, have you originated it? These are not clear legal matters.

Mr. LAUGHLIN. I was asking you to comment also on the refinancing of an existing home mortgage.

Ms. BEERBOWER. On refinancing and home equity loans, refinancing is a term of art which generally suggests that the legal documentation underlying the mortgage is canceled and new documentation is provided.

Another way of adjusting a mortgage is simply to make a modification on the existing legal documentation. It is my understanding that modifications would not count toward the amount of residential loans that a particular institution has made, but that refinancings would count. As a result, there is an incentive for thrifts that are dealing with customers who are modifying mortgage documentation to refinance the loan.

The other question I had for the Committee is whether you want to encourage new-home residential lending or whether you want to encourage refinancing of existing residential lending or existing home equity loans that are secured by residential properties. I think that the Committee needs to decide what it wants to encourage, because whatever is included in the definition of a qualified loan will be what is encouraged by the legislation.

Mr. LAUGHLIN. Are you treating a new home any differently whether it is a newly constructed structure or one that has existed and there is——

Ms. BEERBOWER. No, I did not mean to make that distinction. New home means that it is a new sale as opposed to a refinancing.

Mr. LAUGHLIN. And in your definition of origination, would you in any way define the relationship among brokers?

Ms. BEERBOWER. Well, I find origination is a bad test, and I think we would recommend the Committee move away from that as a test and use something much more like what is in current law. It is very difficult to determine whether a broker originates the loan when he brings it to the bank and the bank fills out the paperwork, or whether the bank originates it when the borrower is brought in and the paperwork is transferred.

Mr. LAUGHLIN. Thank you very much. Thank you, Mr. Chairman. I yield back.

Chairman ARCHER. Are there further questions for Ms. Beerbower?

[No response.]

Chairman ARCHER. Ms. Beerbower, thank you very much. You are excused.

[Follow up answers for the record from Ms. Beerbower to Congressman Neal were subsequently received:]

RESPONSES TO MR. NEAL'S QUESTIONS

Question: Will this proposal require thrifts such as state chartered BIF insured saving banks to convert to "Banks"?

Response: No. The proposal addresses only the repeal of the special bad debt reserve rules applicable to thrift institutions and the deductibility of the special assessment for SAIF.

Question: Also, will the changes in the legislation relating to the amount of adjustment to be taken into account as a result of the required change in an institution's method of accounting for bad debts apply to institutions likely requiring taxable recapture of significant amounts of bad debt reserves, if the legislation is not amended?

Response: Yes. Unless the tax rules are changed, a Federally chartered thrift institution that becomes a commercial bank under the Thrift Charter Conversion Act would be required to recapture its entire bad debt reserve (or, in the case of a small thrift, the part of the reserve that could not have been claimed under the experience method). Under the tax rules proposed in the bill, these institutions would not be required to recapture pre-1988 reserve amounts and could suspend recapture of post-1987 reserve amounts for any taxable year in which a residential loan requirement is met.

Question: The legislation requires the inclusion of excluded debts for bad debts into gross income in certain limited circumstances. Do you think the legislation should forgive the excluded amounts for all purposes? Without this exclusion institutions will never be free from the taint of the excluded amounts.

Response: We support the provision requiring recapture of pre-1988 bad debt reserves when thrifts make distributions to shareholders in excess of post-1951 earnings and profits. We think the bill should not eliminate recapture of windfalls to shareholders by reason of excess distributions.

Question: Robert Sheridan, President Savings Bank Life Insurance Company of Massachusetts has submitted testimony for the record about the tax treatment

of consolidations of life insurance department of mutual savings banks. I believe we need to legislatively clarify that the payment of the additional annual dividend based on the combined surplus should be deductible, reflective of earnings, mortality and expenses like any other dividend. Could you comment on this?

Response: This issue was addressed in one of the miscellaneous tax proposals on which the Ways and Means Committee held public hearings in July. In the written statement we submitted in connection with the hearings, we said that the Administration would not oppose that proposal as long as it is limited to consolidation of life insurance departments of mutual savings banks under section 594 under requirement of State law, and applies only if (1) policyholders have no rights to surplus and no voting rights prior to the consolidation, and (2) their approval is not required in order for the consolidation to occur.

Chairman ARCHER. Our next panel is James Montgomery, Thomas M. O'Brien, and Stephen Kinnier.

Welcome, gentlemen. Mr. Montgomery, would you lead off and would you identify yourself for the record?

STATEMENT OF JAMES F. MONTGOMERY, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, GREAT WESTERN FINANCIAL CORP., CHATSWORTH, CALIFORNIA, ON BEHALF OF AMERICA'S COMMUNITY BANKERS

Mr. MONTGOMERY. Thank you, Mr. Chairman. I am James F. Montgomery. I am chairman of Great Western Financial Corp. and Great Western Bank, headquartered in California. At $42 billion in assets, we are the second largest thrift in America. We are the third or fourth banking-type organization in California, depending on this or that merger, but we have always been the leading lender in the inner cities of California and to minorities with respect to residential lending, and we are very proud of that.

I am here today representing our national trade association, America's Community Bankers, of which I am vice chairman. I really wish to commend the Chairman for working with Chairman Leach of the Banking Committee to fashion this legislation, H.R. 2494. This is a very important component in the BIF/SAIF deposit insurance resolution which will fully recapitalize the SAIF Insurance Fund, insure it, and assure everyone that there will never again be a thrift crisis in America.

There are two principal elements of your bill: First, we appreciate that this assures the deductibility of the $6 billion special assessment which thrifts will pay to recapitalize SAIF; second, the bill addresses in an important way the recapture of the so-called thrift bad debt reserve.

My own views on the bad debt reserve issue closely parallel the views expressed by Federal Reserve Board Chairman Alan Greenspan in testimony delivered to the Financial Institutions Subcommittee of the House Banking Committee in September of this year. To quote Chairman Greenspan,

> The special bad debt reserve treatment that provides tax benefits—and, hence, a subsidy—to mortgage lending by thrifts no longer serves a perceivable public policy function and, hence, should be removed going forward.

The proposed legislation eliminates this subsidy prospectively by treating thrifts the same as commercial banks. We think that is appropriate for the future, and this also enhances revenues to the treasury.

Chairman Greenspan continues,

> Moreover, the tax recovery of the reserve buildup from this past tax subsidy should be eliminated. In reality, this reserve was always a subsidy and never really a true bad debt reserve.

I certainly agree with that. I have felt for many years that calling this subsidy a bad debt reserve was not an appropriate thing, and I am glad we are dealing with this at this time.

Chairman Greenspan continues,

> The possibility of any significant recapture of lost tax revenue to the U.S. Treasury has been hypothetical at best because of the tax-induced high marginal cost to thrifts of reducing their mortgage portfolios and, as a result, triggering the so-called bad debt recapture.

Certainly I agree with that. That is true for Great Western. We would never do anything voluntarily to trigger this reserve recapture. Obviously, if we are going to be required to convert to a commercial bank charter, we don't think it is appropriate to have that trigger recapture as well.

The legislation does permanently remove bad debt reserves accumulated before 1988 from threat of recapture and conditionally suspends bad debt recapture on post-1987 additions, provided that we meet a new mortgage origination test. We certainly have no objection to this basic approach. We at Great Western and most thrifts that I have talked with intend to continue what we have done for a living for many years, and that is make mortgage loans. However, we do believe that the details of the mortgage test should be clarified and adjusted in ways that we have suggested in our written testimony.

We have also recommended revisions to the legislation with respect to small thrifts under recapture, the duration of the testing period, and the advisability of the continuation of 593(e). But we consider these details. We think the legislation itself is very appropriate, very timely, and we thank the Chairman for being proactive on this important subject.

I will be happy to answer any questions at the conclusion of the testimony. Thank you.

[The prepared statement and attachments follow:]

Statement
of
James F. Montgomery
Chairman & Chief Executive Officer
of
Great Western Financial Corporation
Chatsworth, California

on behalf of
America's Community Bankers

before the
Committee on Ways and Means
of the
United States House of Representatives

October 26, 1995

Introduction

Good morning, I am James F. Montgomery, Chairman and Chief Executive Officer of Great Western Financial Corporation. With assets of $42 billion, Great Western is America's second largest thrift institution. We are the third largest banking institution in California, and we have historically been the leading lender to minorities in California by a wide margin. I am appearing here today in my capacity as First Vice Chairman of America's Community Bankers, a national trade organization representing an industry with 2,200 institutions holding $1 trillion of assets. Our members provide real estate finance and community financial services, and are insured by both the Bank Insurance Fund (BIF) and the Savings Association Insurance Fund (SAIF). ACB is the only broad-based banking trade group representing Bank Insurance Fund (BIF), as well as SAIF insured institutions.

Proposed Banking Legislation

Mr. Chairman, ACB deeply appreciates your introduction of HR. 2494, the Thrift Charter Conversion Tax Act of 1995. Its provisions attempt to resolve two tax issues that stand as impediments to the efforts of the House Banking Committee to safeguard the depository insurance system. ACB members have been fully supportive of this effort. We are very grateful to you, Mr. Chairman, for your willingness to assist in moving the process forward. ACB is also very grateful to the staffs of the Ways and Means Committee and the Joint Committee on Taxation for their responsiveness, their unfailing courtesy, and their generous commitment of time to the efforts of the Banking Committee despite the extraordinary demands on their time during the budget reconciliation process.

As part of this process of banking reform, the savings and loan industry has voluntarily agreed to immediately bring the SAIF up to its statutorily-required reserve level via a one-time assessment of approximately $6.2 billion on all SAIF-insured deposits. The Banking Committee has also recognized the necessity of spreading, proportionally, the responsibility for paying the interest on Financing Corporation (FICO) bonds originally issued to provide capital to the FSLIC insurance fund. The fixed interest cost of the FICO bonds has been consuming a larger portion of each premium dollar as the SAIF deposit base against which the premiums are assessed has declined. Currently, 45 cents of each SAIF premium dollar is diverted to pay the interest on the FICO bonds. This diversion was the reason that the SAIF had not reached and could not reach its required reserve level of 1.25 percent to insured deposits in tandem with the BIF. The debt service on FICO bonds was a burden imposed on the surviving savings and loans to resolve a problem for which they bore no more responsibility than commercial banks.

With the recapitalization of the SAIF to its target level and the spreading of the FICO debt service across all deposits insured by the Federal Deposit Insurance Corporation, the destabilizing disparity in premiums for identical deposit insurance coverage will be avoided. The way will then be cleared for a merger of the separate BIF and SAIF funds into a larger, more diversified, and therefore sounder structure.

As the legislative solution to the SAIF/FICO problem has evolved, it has become apparent that two significant tax issues are involved, and that a significant dimension of the solution would actually fall within the jurisdiction of the tax-writing committees in the Congress. With the major elements of that plan now adopted by the banking committees in each chamber, these tax issues now come before this distinguished committee.

Deductibility of Special Premium Payment

The first tax issue arises with the very large payment that will be assessed on SAIF-insured deposits.

The need for full deductibility of this payment, just as for the regular risk-based premiums charged by both BIF and SAIF, has been of vital importance to ACB as a fundamental component of the legislative package. ACB has been gratified by the assurances given by the Treasury domestic finance and tax policy staffs that structuring the solution to ensure this result was of equal priority to the Administration and that the structures under consideration in both House and Senate banking committees passed muster in that regard.

ACB therefore also appreciates the clarification within Section 3 of the bill before this committee to make explicit the result that the Administration had indicated would be provided by the regulatory process. In matters of this significance, the more assurance the better.

Before moving to the more complex issues that arise from the interplay of tax and banking law provisions as regards the treatment of bad debt reserves, it may be useful to note that even a provision as straightforward and well-intentioned as the one-paragraph Section 3 does have its nuances. These are discussed more fully in Appendix B. The issues relate to the treatment of payments by so-called Oakar banks under some versions of the legislation being considered by the banking committees, the exact point at which a deduction can or must be recognized for book versus tax purposes, and the limitations on deferred tax assets (tax deductibility benefits to be obtained in future proceeds) within capital adequacy calculations prescribed under banking law and regulation.

Of course, the driving force bringing these concerns before this committee is the desire for a truly comprehensive resolution of the structural issues within deposit insurance and depository institution charter authorities. ACB has been supportive of the efforts to address these issues provided that they do not delay the legislative response to the threatened FDIC premium disparity and provided that the second tax issue ACB identified at the outset can be addressed.

This is the treatment of the tax bad debt reserves accumulated by thrifts under their special provision, Section 593 of the Internal Revenue Code. The House Banking Committee as part of its reform legislation has passed legislation that will require federally chartered savings and loans to change to either a national bank charter or to a state thrift charter. This mandatory charter change will require federally chartered savings and loans to give up important powers, including broader affiliation and branching authority than is permitted under a national bank charter. There is, however, a far more serious and immediate tax problem created by the forced changed to a national bank charter.

Current Law on Bad Debt Reserve Recapture

Under current law, where a thrift changes to commercial bank charter, it could be required to recapture the full amount of its loan loss reserves. The recapture would be huge because under the percentage-of-taxable-income method thrifts were permitted to take generous deductible additions to their loan loss reserves. This method was permitted as a subsidy to thrifts in their former role as the main source of residential mortgage lending. (See the detailed explanation of the thrift reserve method in Appendix A of my testimony.) Under the tax law, when the thrift charter disappears, an institution faces the recapture of these previously accumulated reserves. The exact procedures and the exact amount of recapture under current law are not completely clear. The actual payment of the tax can, presumably, be spread under section 585(c)(3) and (4) of the Code, though proposed regulations from the Internal Revenue Service challenge this interpretation. It is also conceivable that the amount of currently payable tax will be diminished by net operating losses enhanced by the payment of the special SAIF assessment.

An even more immediate problem is presented, however, by the accounting treatment of recapture of the loan loss reserves. Under GAAP accounting, a distinction was made between the taxable years beginning before and after 1988 owing to the expiration of the "base year rule" of section 585(b)(2)(B). The base year rule, which was an alternative computation available under the experience method, would prevent a recapture of the bad debt reserve where the reserve was larger than permitted under the experience method. For taxable years beginning after 1987, any charges against the reserve henceforth could not automatically be followed by deductions to restore the reserve to its previous level. An automatic deduction would be allowed only to restore the tax reserve to its base year level. A decline in the reserve, to the extent of the difference between the base year, reserve and the reserve at the beginning of a later year, could therefore occur in the event of charge-offs. The reserve could have increased from the base year level of 1987 by deductions claimed under the percentage-of-taxable-income method but if a subsequent significant charge-off occurred in, say, 1991, that dug down well into the reserve the reserve could be automatically restored only to its 1987 dollar value, not the higher level that it had reached prior to the charge-off.

For this reason GAAP accounting has made a distinction as regards the need to provide deferred tax liability on reserves built up before the 1988 tax year and those built up subsequently. The deferral of liability for tax on the post-1987 reserves has been treated as merely a temporary difference and its effect has been included in the financial statements as a deferred tax liability. This has therefore already indirectly reduced capital for each year's accrual of the tax liability since capital is computed as assets less liabilities. The liability for recapture tax on the pre-1988 reserve, however, is treated as a permanently deferrable difference between book and tax income for which no tax provision has been made in the financial statements. Under current GAAP, no tax provision within the financial statements has been required on the base-year amount since that level could be indefinitely retained by automatic "base-year fill-up" tax deductions.

As a result of the GAAP characterization of the pre-1988 recapture tax liability, if a savings and loan is required to change to a commercial bank charter, its capital will be reduced by the full amount of the recapture tax on the pre-1988 reserve. Although the actual payment of the tax will be spread, the full effect on capital will be immediate in the year that the requirement of a mandatory charter change is enacted. It also will not make any difference whether the actual charter change is deferred for some time after enactment. The GAAP standard is that the liability must be booked at the point where "it becomes apparent that those temporary differences will reverse in the foreseeable future."

By itself, the effect of reserve recapture on capital would be devastating for many institutions, but, following the payment of the special SAIF assessment, a truly dangerous situation across the industry will be created. The special assessment will reduce the capital of savings and loan on average by a year's earnings. The loss of capital from booking the

pre-1988 recapture tax liability will be on average twice as bad, and, for many institutions, the loss of capital would be significantly greater.

Provisions of H.R. 2494

The bill repeals the percentage-of-taxable-income reserve method for taxable years beginning after 1995. All institutions subject to the legislation, whether or not they actually change to commercial bank charters, will, after the effective date, treat loan losses under the rules applicable to commercial banks. "Large" ($500 million or more in total assets) former thrifts will be ineligible for the reserve method and be permitted to deduct loan losses only as they are actually charged off against income. "Small" former thrifts will be permitted to continue on the reserve method, but using only the moving-average experience computation of section 585(b)(2) of the Code.

The maximum amount of the reserve adjustment recaptured into income under section 481(a) upon the change from the section 593 method to the commercial bank methods will be limited to the reserves accumulated after the 1987 tax year. Any recapture will occur over six years on a straight line basis, commencing with the first taxable year after 1995.

ACB has completed a survey of its members (savings and loans, BIF-insured savings banks, and cooperative banks) to determine their tax liability upon recapture of their bad debt reserves. A separate analysis was also conducted using publicly-available Form 10-Ks filed by stock thrifts with at least a billion dollars in assets. The consistency of the two data sets, in all areas where they can be benchmarked, produces some confidence that the results from the more detailed survey response can be reliably extrapolated to the entire industry. Based on these survey results, it appears that the recapture tax liability of the industry on its post-1987 reserve accumulation is approximately 20 percent of the total estimated liability. Based on the survey responses, the recapture tax would have been approximately 25 percent of the total liability had institutions been limited to the bank moving average experience method. Approximately 70 percent of the responding institutions reported using the percentage-of-taxable-income method for their most recent taxable year and approximately 74 percent stated that they expected to be able to use that method in the current or the coming tax year. Thus, the repeal of the thrift reserve method on a go-forward basis will represent a significant revenue pick-up for the Treasury.

In the case of a large former thrift, all reserves accumulated after 1987 will be recaptured unless the institution satisfies the loan origination test outlined below. In the case of a small former thrift, the recapture is also, according to the explanation of the statutory language, to be limited to the post-1987 accumulations under the percentage-of-taxable-income method. When a small former thrift subsequently crosses the $500 million threshold, it will be required to recapture under the bank recapture timing rules of section 585(c)(3) and (4) only any amount of its experience, "bank-type" reserve in excess of the pre-1988 thrift, base-year reserve.

For both large and small thrifts, the recapture of the post-1987 portion of the reserve may be suspended, even once begun, if the former thrift meets the mortgage origination test. In order to qualify, the former thrift must continue to originate mortgages annually at the average annual level of the most recent six years. To avoid ultimate recapture under this rule, the former thrift will apparently be required to meet 100% of this annual mortgage origination target in perpetuity.

Finally, the former thrift will remain subject to the rule of section 593(e) to the extent of the amount of the pre-1988 reserve. It is as if the pre-1988 base year reserve remains in existence (and subject to current law) solely for purposes of this rule. Section 593(e) was enacted in 1962 when thrifts were beginning to undergo conversions to stock form. Section 593(e) provides that, where a thrift makes a distribution of capital, repurchases stock, or liquidates, the Treasury will recapture prior reserve deductions. Tax-free reorganizations,

however, are currently excepted from this recapture rule. (See the description of the origin of this rule in Appendix A.)

Requested Modifications

ACB appreciates the care with which the proposed language addresses the industry's concerns over adverse financial statement impact. We have identified a number of issues that we would like the Committee to consider in its speedy processing of this legislation. The issues arise in five areas:

i) the details of the mortgage origination test;
ii) the treatment of small thrifts under recapture;
iii) the period over which any recapture would occur;
iv) the continued application of Section 593(e);
v) the availability of the special carryback rule of Section 172(f).

I address these issues below.

Mortgage Origination Test

The provision that has generated the most concern is the mortgage origination test. The test is intended to encourage a continued commitment to the residential mortgage market that our members have traditionally served. As discussed below, most institutions affected by this legislation will continue to focus on mortgage lending. But even those institutions that fully intend to do so indicate that they will have difficulty complying with the test because of its inflexibility.

If the test is to be effective, it must permit a prudent focus on mortgage activities that is adaptable enough to conform to evolving market conditions. The proposed origination test may actually be unwise as a matter of policy because it creates a significant financial inducement to attempt to meet a high and rigid concentration in mortgage originations. In fact, thrift executives feel that they could be penalized by the test if they do not maintain a level of mortgage lending that their business judgment tells them may well be risky in some years and may well open them to criticism from their regulator.

Mortgage cohorts, the groups of loans originated in specific time periods, can show very different default and foreclosure rates. Recently published data from the private research organization, the Mortgage Information Corporation, show that the immediate post-closing delinquency rate for 1995 loans is six times that for 1993 loans. Forcing institutions to lend at a constant rate, regardless of likely borrower repayment capacity is clearly unwise.

The goal of the test should be to achieve the optimum level of participation in the mortgage market for an appropriate transition period by taking into account the risks of over-concentration and recognizing the variety of roles that thrifts currently play in an efficient market.

ACB deeply appreciates the cooperation between this committee and the House Banking Committee. ACB feels, however, that the structure of the origination test could be more consistent with the basic thrust of the banking legislation that these tax law amendments would perfect. The basic idea is to allow institutions to select their lines of business by choice rather than charter. Most thrift institutions will continue to focus on mortgage lending because they do it very well and very safely. Some, however, will seek to diversify into broader-based consumer banks and some will move towards greater involvement in small business and corporate lending.

Because of the changes in the mortgage market stemming from the greater role of mortgage banking entities, themselves often owned by banks or thrifts, and the ongoing rapid growth in the market share of Fannie Mae and Freddie Mac as government-sponsored loan packagers and investors, in many real estate markets specialization and economies of scale have sharply changed operating margins. Thrift institutions have been adapting to these changes and have focused more on market segments at the opposite ends of the socioeconomic spectrum not well-served by standardized secondary-market-driven loan terms. There is clearly no shortage of mortgage money for the conforming market below the $203,150 loan limit.

These market realities are irreversible. What is needed is a transition mechanism to protect borrowers from any sudden shift from the new charter changes being designed by the Congress. But the extent of the potential market shock should not be overestimated. Most thrift institutions will maintain mortgage lending as their prime or at least one of their major lines of business. The Congress cannot turn back the clock nor can the industry turn on a dime in response to those forces. The structure of the origination test should reflect those realities.

The most obvious problem with the proposed test is that, for its first three years of operation, the test will include 1993. This will skew the test upward because of the artificially high number of originations due to the refinancing boom of that period. At a minimum, ACB requests that the highest year of any testing period should be excludable, consistent with precedent under the tax code. Averaging alone will not solve the problem of the refinancing surge. From 1993 to 1994, total origination volume dropped almost 40%. The five other years in the testing period will not smooth that out. It would make equal or more sense, however, to simply exclude refinancings from the test, though this would cause some administrative burdens.

Another obvious problem with the test is that it does not take into account changes in the size of the institution from year to year. An important technique adopted by many institutions over the last five years to achieve capital compliance was increasing the capital ratio by simply shrinking the institution. Branches were sold and loans no longer originated in previously served market areas. Because the test makes no allowance for increases and decreases in size, it punishes the institution that shrinks and rewards, at least temporarily, one that grows. This aspect of the test is not only unfair, but potentially dangerous to the extent that it discourages prudent behavior.

The term "origination" should be defined flexibly to recognize the evolving role of thrifts in the mortgage process. Many thrifts have found that they can participate most efficiently in the market by working with brokers in formal or casual relationships. Lenders have formed a wide variety of relationships with loan brokers. To survive by providing the best deal to borrowers, brokers typically do not have exclusive relationships with a single lender. Thus, it is not always the case that the broker will arrange to close the loan in the lender's name with the lender's funds on the lender's forms. Even so, under "table funding" arrangements the "wholesale" lender is often immediately substituted for the "retail" lender/broker so that the wholesale lender, economically, <u>is</u> the originator as a matter of substance, if not form.

The prevalence of the lender/broker relationships that have quietly revolutionized the origination process over the last five years must be recognized within the origination test. The drafter of that test, the IRS under the bill, must confront some difficult decisions on how quickly the loan must be transferred to the ultimate servicer/investor in order to qualify as an origination under the test. One way to accommodate the more complex origination process today would be to allow a "wholesale" origination credit for any loan acquired on the first sale from a loan conduit or broker. Obviously, no double counting should be allowed for any given loan.

One of the most important roles that thrifts play in the current mortgage market is the holding of nonconforming loans that for a variety of reasons, e.g., borrower profile, loan

amount, or characteristics of the property, are unacceptable to the government-sponsored enterprises and difficult to match with other secondary market investors. ACB believes that there should be an alternative asset test that recognizes the important role thrifts play as portfolio lenders.

In fact, the tax code already contains such a test under Section 7701(a)(19)(C). Since as outlined above, there is no shortage of mortgage funds for conforming Fannie/Freddie secondary market quality loans, the area where public policy might seek to support housing credit in order to smooth a transition period is in the non-conforming product that must appear on the lender's balance sheet anyway since it cannot be sold. ACB appreciates concerns about "slippage" between actual mortgage lending and the 60% asset composition standard under the existing code, but it may be a simpler technical task to make fine-tuning adjustments to a long familiar test than to erect a whole new system.

This is all the more significant in that ACB would suggest that the basic logic of the test with which an institution must comply to suspend the Section 481(a) recapture argues for application for a limited period. The total amount of tax liability involved is approximately $1 billion, which can be suspended by meeting the test.

Some readers of the text of the bill initially formed the apparently erroneous impression that the test would be in force only for the six year period from 1996 onwards. Such a limited time period actually makes great sense. Institutions should not be permanently in thrall to a test structured to a fixed dollar amount. Eventually, organic growth will dilute the importance of the test to irrelevance.

In the meantime, however, market fluctuations may make the test impossible to meet, especially for smaller institutions with limited geographic scope. It is certainly conceivable, indeed inevitable, that, for some local market, supply and demand conditions will simply prevent any lender operating only within that market from maintaining the average origination volume of recent years. An entire local market's mortgage business can collapse from loss of a major employer or some other exogenous force.

The above mentioned balance sheet approach can accommodate such a phenomenon. If the basic origination approach is maintained, some alternative is necessary. One way to handle this contingency would be to allow institutions to be deemed to satisfy the loan origination test if, say, 50% of its loan volume were of the required type and if its Community Reinvestment Act rating is at least "Satisfactory". This would handle cases where the failure to meet the origination standard is the simple absence of any demand that the institution could prudently meet at other than give-away rates. The institution is making all the loans that the market needs, as demonstrated by its CRA passing performance.

If the originations test is to be maintained indefinitely, the institution, in addition to the above alternative, should also have the option of meeting the **lesser** of the **initial** testing period dollar target and the most **recent**. The institution earned the fixed amount of post-1987 bad debt accumulation via its performance over the 1987 to 1995 period. It should not have to do any more than that to hold on to those amounts in the future. If satisfying the test is obviously impossible over the long run, institutions will simply consider the best time to fail and desired effort on credit availability will not persist anyway.

Small Thrift Recapture

The percentage-of-taxable-income method provided a subsidy to thrifts in recognition of the vital role that the industry performed as, until recently, the sole providers of residential mortgage finance. This subsidy provided a means to build up capital in implicit recognition of the risks created by the industry's high degree of specialization. Nevertheless, a true reserve component (deductions taken for anticipated losses) can be imputed to the thrift

reserves on the basis that had the thrifts not had their subsidy method available they would have used another method that more accurately anticipates losses in the current portfolio.

The ACB survey data indicates that the aggregate dollar value of the hypothetical experience reserve and the aggregate dollar value of the post-1987 accumulation of reserves are roughly equal. The distribution across institutions, however, is quite different.

Recapture of one amount or the other would produce comparable revenue to the Government. A substitution of the post-1987 accumulation for the hypothetical experience reserve as the amount subject to recapture, however, has a very practical attraction. Recapture of the post-1987 reserve will have no impact on the industry's capital because, as mentioned, GAAP requires that the addition of each layer of post-1987 reserves reflect the effect on retained earnings of the future reversal of the current tax deduction. The tax bill from recapture of the post-1987 reserve would be borne, for the most part, by the most profitable institutions. Recapture of the hypothetical experience reserve would require the highest payments from the institutions with the most losses and it is very likely that none of their reserves would have been "tax effected" because none of them have been built up since 1987.

ACB believes that, based on this analysis, the recapture being imposed on thrifts is comparable to what was imposed on the banks in 1986. A portion of the industry's reserves that, as a percentage of total reserves, approximates the portion of the total reserves that could have been held under the experience method would be recaptured if thrifts adopt the diversified asset allocation strategies typical of commercial banks. There is an argument that, even under existing law, a converting small institution is not subject to any recapture and can simply grow into its thrift reserve, as long as the institution stays below the $500 million dividing line. This analysis is contrary to the views of the Internal Revenue Service, though the issue would be moot on enactment of this proposal.

ACB requests that, as with the treatment afforded commercial banks, no recapture be imposed on small thrifts under the legislation. If and when a small former thrift becomes "large," its experience reserve, plus its post-1987 reserve built up under the subsidy method can be recaptured -- with a credit for the pre-1988 reserve. Such treatment would be a fairer way to treat small thrifts and would be consistent with the policy underlying the legislation.

The mechanics of the recapture rules that apply to small former thrifts that are required to recapture their post-1987 reserves under the legislation and, subsequently become subject to the large bank rules are not entirely clear in the statutory language. Based on the language in the Description it appears that so much of the total thrift reserve as qualifies as a hypothetical experience reserve, even if it were accumulated after 1987, will be treated as if it were the opening small bank reserve. Thus, the post-1987 experience reserve will not be subject to recapture. Where the small bank then becomes a large bank, to avoid the loss of the benefit of the proposed treatment of recapture of the pre-1988 reserve, recapture of the experience reserve will be limited to the excess over the pre-1988 reserve. Nevertheless, although it seems apparent that the small thrift recapture rules operate this way, more detail is needed.

Recapture Timing Rules: Section 585(c)(3) - (4)

ACB requests that, consistent with the analogy to the recapture of the bank reserves, the recapture timing rules of section 585(c)(3) and (4) of the Code should be applicable to the recapture of the thrift reserves under the bill. The Committee has the power, of course, to decide the appropriate spread period for the new set of recapture rules created by the legislation. Specifically, Revenue Procedure 92-20, 1992-1 C.B. 685, provides that in certain situations the Commissioner may permit a section 481(a) adjustment to be taken into income using a cut-off method. ACB believes that the use of a cut-off method would be particularly appropriate because it was made available under section 585(c)(4) to large banks

required to change from reserve method. ACB is concerned that the use of the six-year spread typically provided in the case of voluntary changes from a "class B" method, as that term is used in Rev. Proc. 92-20, may have been influenced by the proposed reserve recapture regulations issued by the IRS in 1991.

These regulations, insofar as they applied to non-acquisitive charter changes, were criticized by every comment letter received by the IRS at the time of their publication. The theory of the proposed regulations is that a thrift that loses eligibility for the section 593 method is required to change to the section 585 method. Congress was unaware in 1985, when the section 585 recapture timing rules were created, of the IRS position that the thrift and bank methods are separate methods of accounting. This lack of awareness is apparent because the imposition of the proposed regulations creates an absurd result with respect to large thrifts.

The IRS position is that large thrifts losing eligibility for the section 593 reserve method undergo **two** accounting method changes. The first change is from the section 593 method to the section 585 method. This change has not been provided for under the Code so the IRS is free to use its administrative procedures to impose a six-year spread period for taking the section 481(a) adjustment into income. The amount of the section 481(a) adjustment is the difference between the large former thrift's actual reserves and the reserves it would have computed under the experience method. The problem with this first change is that the former large thrift has changed to an impermissible method -- large banks are not permitted to use the reserve method. It is as if the large former thrift has changed to a method to which it was not permitted to change, and then, upon discovering its mistake, changes to the permissible specific charge-off method.

Given the theoretical problems with the IRS proposed regulations, ACB hopes that the Committee would not be reluctant to take a fresh look at how best to time the recapture of the thrift reserves under the legislation. The cut-off method was created as an alternative for institutions with a portfolio of long-term loans. It is ACB's view that, in fact, it was intended to be available for the full amount of thrift reserve recapture under current law. To be consistent with the bank recapture analogy, ACB requests consideration of making the cut-off method available as a recapture timing alternative under the legislation.

Section 593(e)

ACB requests that the Committee consider at some point the continued application of Section 593(e). Appendix A to this testimony provides the historical context for this provision, but, currently, it functions as little more than a trap for the unwary. Capital distributions to shareholders, whether in the form of stock buy-backs or capital dividends, from the thrift and its holding company are strictly controlled by the regulators. When they are permitted to occur, section 593(e) is usually avoided by the interposition of a holding company.

When recapture occurs upon the acquisition of a thrift by a commercial bank, it is the result, in the typical case, of conforming the thrift's methods of accounting to the acquiring bank's methods. Section 593(e) does not trigger recapture. When the thrift and bank methods are conformed, section 593(e) by its terms should only trigger recapture in a taxable asset acquisition. Under current law when a thrift is acquired by a commercial bank in a stock swap or a stock purchase by the acquirer and the thrift becomes a member of the bank holding company, section 593(e) is not an issue. Section 593(e) clearly provides that it does not apply in carryover basis asset acquisitions and certain liquidations.

ACB believes that, with respect to the issue of whether or not section 593(e) should remain in place to trigger recapture, the testimony of Chairman Alan Greenspan of the Federal Reserve before the Financial Institutions Subcommittee of the House Banking Committee on September 21, 1995 is relevant:

The special bad debt reserve treatment that provides tax benefits -- and, hence, subsidy -- to mortgage lending by thrifts no longer serves a perceivable public policy function and, hence, should be removed going forward. Moreover, the tax recovery of the reserve buildup from this past tax subsidy should be eliminated. In reality, this reserve was always a subsidy and never really a true bad debt reserve. The possibility of any significant recapture of lost tax revenue to the U.S. Treasury has been hypothetical at best because of the tax-induced high marginal cost to thrifts of reducing their mortgage portfolios and, as a result, triggering the so-called bad debt recapture. Indeed, without a fresh start, the current bad debt recapture provisions would be a significant barrier for entities that wish to diversify. A penalty should not be charged institutions striving to respond rationally to market realities, and to legislation designed to induce portfolio diversification.

ACB believes that the continued existence of section 593(e) as a matter of policy is fundamentally inconsistent with the views expressed by Chairman Greenspan, apart from its practical irrelevance with sufficient attention to balance sheet and acquisition details. If subsection 593(e) is not repealed with the rest of the section, however, ACB strongly urges that the legislative history provide as much guidance as possible on its application. It is far preferable to ACB, based on our experiences with the IRS in the interpretation of the reserve recapture provisions, that guidance on the meaning of a tax provision be provided by the Congress.

Carryback of Special Assessment Deduction

As a final matter, ACB requests your help, Mr. Chairman, with an issue, which, while is it is not included in H.R. 2494, is consistent with the intent of the legislation. Moreover, this issue arises from your willingness to assist us in clarifying that the special assessment is currently deductible.

It is ACB's view that the special assessment qualifies for the special 10-year net operating loss carryback provisions under section 172(f), to the extent an institution suffers an overall loss for the tax year. In general, section 172(f) allows a 10-year carryback rather than a 3-year carryback for the portion of a net operating loss that is attributable to certain liabilities that arise under a federal or state law. We believe that section 172(f) clearly covers this special assessment because the purpose of this federal legislation is to provide a final resolution to the thrift crisis which arose during the 1980s. Consistent with the help provided on current deductibility, we request that the bill also clarify the application of section 172(f), to recognize this fact.

While it is our opinion that section 172(f) clearly applies, there is a heightened regulatory need for clarification on this point. The special assessment will cause a significant reduction in regulatory capital and the need to soften this effect by providing a federal tax benefit is imperative. A failure to have section 172(f) apply to an institution with losses, could restrict or even eliminate the institution's ability to book federal tax benefit currently for financial or regulatory accounting purposes. (See Appendix B). This situation could further aggravate the impact of the special assessment on the thrift's regulatory capital. In addition, given changes in federal tax rates between the carryback and carryforward years, it could be advantageous to the Treasury to allow the carryback, even allowing for the interest cost of providing the benefit more quickly.

Conclusion

ACB deeply appreciates the opportunity to raise such a wide array of complex issues before a committee that has been processing such a major share of the entire budget reconciliation work load. We are grateful as well for the case with which the proposed language was drafted under these difficult circumstances. We stand ready to address any issues that arise from this submission of our views and await your questions.

APPENDIX A

History of the Thrift Bad-Debt Reserve Method

Revenue Act of 1951

Mutual savings banks, savings and loan associations, and cooperative banks were first made taxable in 1952. They were permitted, however, to take a deduction for additions to reserves for whatever amount they deemed appropriate, so long as the addition did not exceed the lesser of taxable income or the addition needed to increase reserves and surplus to 12 percent of deposits. The addition to reserves, based on the legislative history, was intended to maintain the safety and soundness of the institutions. At the time, thrift institutions were typically mutual in form, not stock corporations. While commercial banks, which were stockholder-owned institutions, could sell new shares to obtain additional capital, thrifts could accumulate needed protective reserves only through the retention of earnings.

The limitation to 12 percent of deposits seems to have been based on the level of reserves and surplus that the institutions maintained before they were made taxable. Mutual savings banks in 1951, on average, maintained reserves and surplus equal to about 11 percent of deposits. Savings and loan associations, often because of their shorter existence, maintained surplus and reserves on average equal to about 7.5 percent of deposits (See Revenue Act of 1951, Senate Report to accompany H.R. 4473, Report No. 781, pp. 1992 and 1995). In addition, estimated overall losses of savings banks during the period 1931-1944 amounted to 12.2 percent of deposits as of the end of 1930. (See statement of Edward P. Clark, Chairman of Taxation Committee, National Association of Mutual Savings Banks, on the Taxation of Mutual Savings Banks, Hearings before the Committee on Ways and Means, House of Representatives, 87th Congress, 1st Session, August 9, 1961, pp. 149-50.)

Assuring the safety and soundness of thrifts was viewed as important because of their traditional specialized functions. Mutual savings banks were established to encourage thrift and to provide safe and convenient facilities to care for savings. Mutual savings banks were originally organized for the purpose of serving factory workers and other wage earners of moderate means who, at the time these banks were started, had no other place where they could deposit their savings. At the end of 1950, U.S. Government obligations represented nearly 51 percent, and loans (primarily mortgages) represented 38 percent of the total investments of these institutions. The primary function of savings and loan associations was to provide facilities for savings and a means for financing the purchase of homes. Mortgage loans represented 80 percent of all assets held at the end of 1950. (See Revenue Act of 1951, Senate Report to accompany H.R. 4473, Report No. 781, pp. 1991 and 1995). State and federally chartered savings and loan associations were defined as institutions substantially all of whose business was confined to making loans to members.

Revenue Act of 1962

The 1962 Act made significant changes in the tax treatment of mutual savings banks, savings and loan associations, and cooperative banks. The definition of state and federally chartered savings and loan associations eligible to use the liberal thrift reserve method was tightened: (1) they were required to be supervised and examined by the authority having supervision over such institutions, or to be insured by FSLIC; (2) substantially all of their business had to consist of receiving deposits and making loans; and (3) the qualifying asset test was introduced to the Code for the first time. Under the qualifying asset test enacted in 1962, 90 percent of the savings and loan association's assets had to be cash, government securities, obligations of state corporations that insure deposits, real estate loans, foreclosure property, loans secured by deposits, and assets used in the business. At least 60 percent of this 90 percent had to be cash, government obligations, loans to purchase or improve one- to four-family residential properties or church property, and such property acquired through foreclosure. The

changes in the definition of a savings and loan association were intended to bring it into conformity with actual practice and to restrict the availability of the special deductions for additions to reserves to those institutions making residential real estate loans, with emphasis on one- to four-family units.

The 1962 Act changes, in general, indicate a congressional intent that the liberal thrift reserve method was to be available to the extent that a thrift was engaged in home mortgage lending. The reserves maintained by thrift institutions were divided into three separate reserves. First was a reserve for qualifying real property loans. Second was a reserve for nonqualifying loans. Third was a reserve, the supplemental reserve, representing the pre-1963 reserves. Qualifying real property loans were those loans secured by an interest in improved real estate or real estate to be improved out of the loan proceeds, but excluding certain loans that were considered to be virtually risk-free. The nonqualifying loan reserve was maintained for all other loans. The qualifying and nonqualifying loan reserves were established out of the thrift's post-1951 reserve, the remainder of which became the supplemental reserve. The nonqualifying reserve was established first in whatever amount was reasonable based on experience. The qualifying reserve was then established in the amount of 3 percent of qualifying loans. The pre-1952 reserve could be added to the qualifying reserve if the post-1952 reserve was insufficient to bring it up to 3 percent, but the pre-1952 amount would be considered a reserve only for purposes of making the 3 percent level and would not be a reserve for any other purpose under the Code. The remainder of the post-1951 reserve was the supplemental reserve. The opening balance of the qualifying reserve was limited to 3 percent of qualifying loans because otherwise, if the entire remaining post-1951 reserve at that date had been allocated to the qualifying reserve, thrifts with large reserves would have been denied deductions under the 3 percent method until significant growth in their qualifying loans had occurred.

Deductions for additions to the reserve for nonqualifying loans were to be based on actual bad-debt experience. Additions to the qualifying reserve were limited to the largest of: 60 percent of taxable income computed before the bad-debt deduction (reduced by the addition to the nonqualifying reserve); an amount sufficient to bring the balance of the qualifying reserve to 3 percent of the qualifying real property loans outstanding at the close of the taxable year; or an amount based on actual experience. Under the percentage-of-taxable-income method, the addition to the qualifying loan reserve could not exceed 6 percent of qualifying loans. Under the 3 percent method, new thrifts were permitted an additional 2 percent deduction on the first $4 million of qualifying loans. The overall limit on the additions to total reserves at 12 percent of deposits was carried over from prior law. (The 3 percent method was analogous to the percentage-of-eligible-loans method that was then available to commercial banks under the administrative practice of the Internal Revenue Service.)

In adopting the 3 percent and 60 percent reserve provisions for thrifts, the Committee on Ways and Means stated that: "The bill provides reserves consistent with the proper protection of the institution and its [depositors] in the light of the peculiar risks of long-term lending on residential real estate which is the principal function of these institutions." (Revenue Act of 1962, Report of the Committee on Ways and Means, House of Representatives, to accompany H.R. 10650, House Report No. 1447, p. 33). Implicit in this statement and explicit in the adoption of the 3 percent method, which provided, in effect, a deduction equal to 3 percent of mortgage growth, is recognition of the desirability of encouraging thrifts to expand their mortgage lending activities. The 3 percent method afforded savings banks that had a relatively small proportion of their assets in home mortgages a reason to expand their holdings of these riskier investments faster than would otherwise be prudent. The intent of Congress has been widely recognized as being directed toward increasing mortgage lending by thrifts. For example, the Joint Committee on Taxation has stated: "The present percentage of taxable income method for savings and loan associations, cooperative banks, and mutual savings banks was designed to serve a non-tax purpose — encouraging these institutions to specialize in residential mortgage lending and certain other specified types of lending." (Joint Committee Print JCS-5-83, Taxation of Banks and Thrift Institutions, p. 32, prepared for the use of the Committee on Finance, March 9, 1983).

As mentioned, the generous reserve additions under the 1951 Act were permitted, in part, because thrifts at the time were typically not stock institutions and, unlike commercial banks, could not raise capital through stock sales to increase their reserves. During the 1950's, savings and loan associations began converting to stock ownership and by 1961 there were approximately 500 stockholder-owned savings and loan associations. (See Treasury Department Report on the Taxation of Mutual Savings Banks and Savings and Loan Associations, submitted to the Committee on Ways and Means, August 8, 1961.) The special thrift reserve methods continued to be available, however, regardless of whether the thrift was mutually or stockholder-owned. This fact helps to make clear that the special thrift reserve methods were intended as a subsidy to encourage home mortgage lending. Nevertheless, Congress recognized that stockholders can realize income from a thrift's undistributed reserves. Income retained by a stockholder-owned thrift will enhance the value of its stock, and this appreciation could be realized by its stockholders at capital gains rates. For this reason, Section 593(e) of current law was enacted in 1962.

Section 593(e), in the version finally enacted in 1962, provides that any distribution with respect to stock in excess of earnings and profits for any distribution in exchange for stock, that is, redemptions and liquidations, will be treated as made out of the portion of the qualifying loan reserve in excess of the amount allowed under the experience method (i.e., the thrift "subsidy" reserve component but not out of the pre-1952 addition, if any) and then out of the supplemental reserve. The amount of the qualifying reserve in excess of the experience portion (subsidy portion) and the amount of the supplemental reserve to be recaptured is the amount that, when reduced by the tax on such reserve amounts, equals the amount of the distribution. In other words, the amount of the reserves to be recaptured is equal to the amount of the distribution divided by the reciprocal of the current tax rate. For example, if an S&L were to repurchase a share of stock this year for $100, the amount of the recapture can be determined by dividing $100 by one minus 34 percent or 66 percent. Thus, rounding for the sake of convenience, the amount of the subsidy portion of the qualifying reserve and the amount of the supplemental reserve to be recaptured is $150, and the tax owed is $50. This treatment under Section 593(e) ignores any stacking order in the creation of those capital amounts. For example, a redemption of stock issued in an offering after the last year making use of the thrift method is still deemed to come from the thrift reserve accumulation.

Tax Reform Act of 1969

The 1969 Act made changes to the reserve methods of both banks and thrifts. For both banks and thrifts, additions to reserves were no longer to be made under the experience method of Section 166, but under two new methods. The first new statutory method created by the 1969 Act was the percentage-of-eligible-loans method of Section 585(b)(4). Banks had actually been using this method for several years under rulings issued by the Internal Revenue Service (See Rev. Rul. 65-92, 1965-1 C.B. 112, as supplemented by Rev. Rul. 68-630, 1968-2 C.B. 84.) Under this method, the deduction for the addition to reserves for a bank was the amount needed to increase the reserve to the allowable percentage of eligible loans at the close of the tax year, plus the amount determined under the experience method for other loans. Eligible loans were those made in the course of normal customer loan activities on which there was more than an insubstantial risk of loss. Under the 1968 Act, the maximum percentage of eligible loans was reduced from 2.4 percent to 1.8 percent through 1975, 1.2 percent through 1981, and 0.6 percent through 1987 and eliminated thereafter.

The 1969 Act also codified an experience method computation in Section 585(b)(3). The deduction for the addition to reserves under the experience method of Section 585(b)(3) is the amount needed to increase the reserve at the close of the tax year to the amount which bears the same ratio to outstanding loans at the close of the year, as the bad debts during the current and past five years bear to the outstanding loans during those six years, or as an alternative, if a larger deduction results, the amount of the addition needed to increase the reserve to the reserve balance at the close of the base year. The base year is the last taxable year before the most recent adoption of the experience method, except that the most recent base year permitted to be used is a tax year that began in 1987. The base year rule was intended to prevent institutions that changed from a more generous reserve method to the experience method from having to

draw down their reserves until they were at the level permitted by the experience method computation. Although the base-year rule is still available to thrifts changing from the percentage-of-taxable-income method, it is no longer fully effective because it references the percentage-of-eligible-loans method, which was last available for tax years that began before 1988.

When using the experience method, an institution may be permitted by the Commissioner to use a shorter period than six years where losses increase due to a change in the loan portfolio, as for example, where a bank issues a substantial number of credit cards for the first time. Permission to use a shorter period, however, must be granted by the Commissioner.

Under the 1969 Act, the qualifying assets test, within the definition of a savings and loan association, was changed to the current 60 percent qualifying asset test. The legislative history indicates that this change was intended as a liberalization of the composition of the qualifying assets test. Under the qualifying assets test, at least 60 percent of total assets at the close of the taxable year must consist of: cash; obligations of the United States or non-tax-exempt state obligations; certificates of deposits in or obligations of a state deposit insurance corporation; loans secured by deposits; loans used to purchase or improve residential real property or property used for church purposes; certain institutional loans; foreclosure property acquired from qualifying loans; and property used by the institution in the conduct of its business. (The Tax Reform Act of 1986 added certain interests in a Remic.) The 60 percent of assets tests is computed as of the close of the taxable year or, at the option of the institution, on the basis of average assets outstanding during the taxable year.

The 1969 Act eliminated the reserve method under which a deduction was permitted of 3 percent of the growth in qualifying loans. The reason given in a legislative history for the elimination of this method was that savings banks had used it to pay almost no taxes during the period from 1962 to 1969. This statement in the legislative history is, however, potentially misleading. The 3 percent method had, in one way, achieved its purpose in that savings banks during this period had substantially moved out of government obligations and other security investments into mortgage loans in order to take full advantage of the method. In the period from 1962 to 1969, savings banks utilizing the 3 percent method had expanded their total mortgage holdings by $21 billion, compared with $13 billion in the preceding six-year period, and they had increased their overall ratio of mortgage loans to total assets from 69.5 to 74.9 percent. Savings and loan associations, by contrast, started off 1962 with mortgage holdings near their practical limits. Their overall mortgage-asset ratio had remained stable from 1962 in the 84-85 percent range: thus, they did not find the 3 percent method useful. (See statement of Edward P. Clark, Chairman of Taxation Committee, National Association of Mutual Savings Banks, on the Taxation of Mutual Savings Banks, Hearings before the Committee on Ways and Means, House of Representatives, 91st Congress, 1st Session, March 24, 1969, p. 3488.)

After the 1969 Act, additions to the qualifying loan reserve could be made under whichever of the experience method, percentage-of-eligible-loans method, or percentage-of-taxable-income method, gave the largest deduction. Under the percentage-of-taxable-income method, the 1969 Act phased the allowable percentage deduction down from 60 percent in 1969 to 40 percent for taxable years beginning in 1979 and thereafter. The full percentage deduction under the percentage-of-taxable-income method was available to savings and loans (and stock savings banks after 1981) only if 82 percent of their assets were qualifying assets. The deduction was phased down by 3/4 of 1 percent for each 1 percent decrease in qualifying assets from 82 percent to 60 percent. The full percentage-deduction was available for mutual savings

qualifying loan reserve under the percentage-of-taxable-income method were limited to 6 percent of the qualifying loans outstanding, and the total limit on additions to both the qualifying and nonqualifying reserves was 12 percent of deposits. In computing taxable income for purposes of the percentage-of-taxable-income deduction, only income earned from assets that give rise to the special deduction can be used to compute taxable income. The following items of income are excluded: reserve recapture under Section 593(e); gains from the sale of corporate stock or tax-exempt securities; the benefit from the rate differential, if any, for net long-term capital gains; and dividend income qualifying for the dividends-received deduction.

The Tax Equity and Fiscal Responsibility Act of 1982 later provided a 15 percent "cutback" in many corporate preferences including the reserve addition tax deduction for thrifts. The cutback reduced the deduction for the addition to thrift reserves by 15 percent of the excess over the deduction that would have been permitted under the experience method. The Deficit Reduction Act of 1984 increased the tax preference cutback to 20 percent of the reserve deduction for the taxable year in excess of the amount permitted under the experience method. The 20 percent cutback reduced the 40 percent deduction under the percentage-of-taxable-income method by 8 percent (20 percent of 40 percent). The 32 percent deduction under the percentage-of-taxable-income method after the cut back resulted in a 31.28 percent effective tax rate for thrifts (the 68 percent of income that was taxable times the 46 percent tax rate).

Tax Reform Act of 1986

The 1986 Act changed the percentage-of-taxable-income method to a flat 8 percent deduction so long as the thrift satisfied the 60 percent qualifying asset test. The percentage of taxable income was changed to 8 percent because it also resulted in a 31.28 percent effective tax rate after repeal of the tax preference cutback (92 percent, the percentage of income that was taxable, multiplied by the 34 percent tax rate of the 1986 Act). The 1986 Act also confirmed the repeal of the percentage-of-eligible-loans method for tax years beginning after 1987. Additions to the reserve for qualifying loans can now only be made under the percentage-of-taxable-income method or the experience method. Under the experience method, however, additions may be made under either the six-year rolling average or the "fill-up" permitted by the base-year rule.

Reducing to 8% the percentage of taxable income method deduction was the final step in a progression that had decreased the attractiveness of the thrift subsidy since 1962. (Obviously if the statutory tax rate was reduced from 46% to 34%, the relative benefit of a 31.28% effective rate was diminished.) In addition, thrifts were now facing stiffer competition from a host of mortgage originators that immediately sold off their mortgage loans to packagers such as Ginnie Mae, Fannie Mae, and Freddie Mac. Originating and servicing mortgages are still profitable activities, and thrifts, based on their experience and market knowledge, are particularly well-suited to perform them. Many thrifts, however, can simply no longer afford to continue holding the mortgages they originate in portfolio simply to satisfy the qualifying assets test. Another change of far greater impact to thrifts, however, was made by the 1986 Tax Reform Act. Without warning, the reserve subsidy, which in the case of savings banks had caused a dramatic shift into mortgage lending, became a sword hanging over all thrifts. This occurred because of the interaction of the amendments made by the 1986 Tax Reform Act to Sections 585 and 593 of the Code.

Section 593 was amended to provide that satisfaction of the 60 percent test was a condition of the availability of Section 593. Under prior law, if a savings bank or cooperative bank had less than 60 percent qualifying assets, it would not be permitted to use the percentage-of-taxable-income method, but it would still be under Section 593. For a savings and loan association, however, because the 60 percent test was definitional, if it flunked the 60 percent test, it was no longer a savings and loan association. If a substantial part of its business was taking deposits and making loans, however, it would still be a bank under Section 581. It was generally believed that before 1986, flunking the 60 percent asset test would not be a disadvantage for a savings and loan association other than the loss of the percentage-of-taxable-income method. It would simply compute its reserves as a commercial bank under Section 585. (There was, in fact, a small benefit in that it could then use the percentage-of-eligible-loans

method for its nonqualifying loans.) If it requalified in a subsequent year as a savings and loan association by satisfying the 60 percent asset test, it would simply go back to using Section 593 and the percentage-of-taxable-income method. It could switch back and forth between Section 593 and Section 585 and was not considered to have made a change in accounting method.

In 1985, however, the Internal Revenue Service issued Revenue Ruling 85-171, which involved the merger of a savings and loan association into a larger bank. The Service held that under Section 381(c)(4), the method of accounting used by the larger commercial bank must be used for the items acquired from the savings and loan association. That is, the reserves acquired from the savings and loan association had now to be accounted for under Section 585 instead of Section 593. The IRS held that this involved a change in accounting method because the reserve methods under Section 585 and Section 593 were separate methods of accounting. There was, thus, a change in accounting method requiring a Section 481(a) adjustment to prevent the omission or duplication of income. It was not clear under the revenue ruling what the Section 481 adjustment would be. It was left open whether the difference between the experience method and the total amount of the reserve should be taken into income as an adjustment under Section 481.

Under the 1986 Tax Reform Act, Section 585 was amended to provide that banks with over $500 million in total assets could no longer use the reserve method, but must account for their bad debts by charging them off only as they become partially or totally uncollectible. Because deductions had already been taken in anticipation of non-collectibility by additions to reserves, it was necessary to prevent a duplication of these deductions under the charge-off method. This was accomplished by requiring that the previously taken reserve deductions be recaptured into income. Two recapture methods were provided: The bank could choose to recapture its reserves under the direct-inclusion method of Section 585(c)(3), which provided for recapture of the reserves over four years. The bank was required, in the disqualification year, to recapture a minimum of 10 percent of the total reserve. If it recaptured only the minimum 10 percent, it must recapture 20 percent, 30 percent, and 40 percent in the subsequent three years. A bank could choose to recapture more than 10 percent in the disqualification year, and, if it did so, it would be required to recapture 2/9, 1/3, and 4/9 of any remaining reserve over the succeeding three years.

In the alternative, the bank could elect to recapture its reserves under the cutoff method of Section 585(c)(4) in the year it became disqualified to use the reserve method. Under the cutoff method, losses on all loans made after the first day of the disqualification year are accounted for on the specific-charge-off method. The loans outstanding as of the first day of the disqualification year are accounted for separately. The existing reserve as of the first day of the disqualification year is maintained for pre-disqualification year loans, but no further additions to the reserve are permitted. No deductions are permitted for pre-disqualification year loans until the reserve balance is reduced to zero, then subsequent loan losses on the pre-disqualification year loans give rise to deductions under the specific-charge-off method. If, on the other hand, the reserve balance exceeds, for any year, the amount of the pre-disqualification year loans, dollar-for-dollar recapture is required of the excess of the reserve balance over the balance of the outstanding loans.

A thrift that changes its charter to a commercial bank charter would, of course, then come under Section 585. In addition, because of the amendment to Section 593, a savings bank or cooperative bank that fails to maintain 60 percent of its assets as qualifying assets would also come under Section 585, assuming that it otherwise satisfies the definition of a bank under Section 581 of the Code. Thus, if a thrift that changes its charter or fails the 60 percent asset test has over $500 million in total assets, it will be subject to recapture of the entire amount of its reserves under either the direct-inclusion method or the cutoff method.

This would subject many thrifts to an enormous tax liability and is manifestly unjust. The subsidy portion of a thrift's reserve deductions could never be duplicated under the specific charge-off method and thus no double benefit arises. A thrift that is required to recapture its reserves might be consider not to suffer a significant tax disadvantage because of the nature of its loan portfolio if it elects the cutoff method. Because of the long-term nature of the typical

thrift loan portfolio, it would not be required to recapture its reserves under the cutoff method for possibly as long as 15 to 20 years, absent a significant restructuring of its loan portfolio.

Under the rules of financial accounting, however, a thrift that is required to recapture its reserves would be dramatically disadvantaged on its financial statements. Because a thrift controls the events that require recapture generally accepted accounting principles (GAAP) as expressed in FAS #109, FAS #96 and APB #23, have not required the thrift to set up a reserve for the full amount of the taxes owed on recapture. When a thrift is required to recapture its reserve, or it becomes probable that it will be required to do so, it is required to set up immediately a liability for the taxes owed on recapture and charge its earnings and profits, despite the fact that under the cutoff method the actual payment of tax may be deferred for a significant period of time. It is likely that a profitable thrift that is required to recapture its reserves would show such an enormous loss on its financial statements that its ability to raise new capital would be diminished, and it might no longer satisfy regulatory capital requirements.

If a thrift whose total assets are $500 million or less changes its charter or fails the 60 percent test, there should be no recapture. This is not entirely clear under the statute, but the General Explanation of the Tax Reform Act of 1986 (Blue Book), prepared by the Joint Committee on Taxation, supports this result: the thrift would simply no longer be able to use the percentage-of-taxable-income method. (See the Blue Book, at page 556.) Based on the rationale of Rev. Rul. 85-17, 1985-2 C.B. 148, however, it became possible that the IRS could say that the entire excess of the reserves over the experience portion should be taken into income as a Section 481(a) adjustment intended to prevent an omission or duplication of taxable income as a result of the change from the Section 593 method of accounting to the Section 585 method of accounting for reserves. Such an adjustment would significantly disadvantage small thrifts as compared to the small banks, which suffered no recapture as a result of the 1986 Act change. In addition, the rules of financial accounting would then likely be interpreted to require that the taxes that would be owed on recapture be recognized immediately in the financial statements on the basis that the institution is no longer a thrift and permitted to treat the difference between book and tax reserves as a permanent accounting difference.

Proposed IRS Reserve Recapture Regulations for Thrifts

The worst fears of the thrift industry were confirmed when, on January 13, 1992, proposed regulations were published by the IRS applying to thrifts that fail the 60 percent asset test or change to commercial bank charters. A failure of the 60 percent test or a charter change is treated as a change in accounting method creating a positive adjustment under section 481(a) in the amount of the excess of the total thrift reserve over a hypothetical bank experience reserve. This adjustment is required to be taken into income over six years on a straight line basis. Large "former thrifts" will be permitted to recapture only the remainder of their bad debt reserves using the large bank recapture timing rules under sections 585(c) or (4). A large former thrift may elect to recapture the entire reserve as a section 481(a) outside the large thrift recapture timing rules.

Small thrifts that fail the 60 percent test or change charter are permitted to remain on the reserve method, but they must recapture the "excess" or thrift portion of their reserves as a section 481(a) adjustment over six years, like the large "former thrifts." The small former thrift that is now treated under the tax code as a small bank is permitted to continue on the reserve method using the bank experience method. Its opening reserve balance is the hypothetical bank reserve computed to determine the excess thrift reserve subject to recapture amount to be recaptured.

A "foot fault" rule is provided that permits former thrifts, both large and small, to re-qualify as thrifts -- where they have lost thrift status for only a year, presumably through inadvertence. If a former thrift regains its thrift status, it must still receive IRS permission to use the thrift reserve method again. The reinstated thrift is not permitted to set up the entire thrift reserve that it had before recapture. Its thrift reserve is limited to a new amount that is 8 percent of taxable income for the requalification year.

Appendix B

Special Assessment Deductibility and Related Issues

Section 3 of the proposed legislation puts beyond doubt the full deductibility of the special premium payment of SAIF. The exact timing of that full deductibility is a matter of some concern despite the valuable reinforcement of previous Treasury assurance.

ACB requests, however, that the language of Section 3 be amended to delete the words "during 1996." Section 7(b)(6)(B) of the Federal Deposit Insurance Act, as proposed to be amended by H.R. 2491, provides for the premium to be spread in some cases via retention of a higher premium schedule and removal of the reference to 1996 payments will avoid any possible controversy. In addition, although the issue is not certain, it is possible that under, section 446 of the Code, the year in which the special assessment may be deemed paid or incurred could be earlier or later than 1996.

Most institutions are on a calendar fiscal year. It is ACB's understanding that, under GAAP, institutions will recognize their liability for the special SAIF payment as soon as the legislation is enacted and they are notified by the FDIC as to the amount of the required payment. It is probable that this will occur in December 1995 and the liability will be posted and expense booked for the fourth quarter. Under Section 446 of the Code, accrual for book purposes would normally be followed by recognition for tax purposes. Thrifts were moved to an accrual basis by the 1986 Tax Reform Act and should therefore be allowed the deduction in 1995.

If the deduction is deferred to 1996, the deferred tax asset of that subsequent year's deduction recognized under GAAP (according to FAS #109) could be subject to the special, more stringent standard imposed by bank regulators for regulatory capital purposes. Only the amount that can be recouped by a carryback or no more than one year's carryforward will be allowed in regulatory capital despite the availability of a 15 year carryforward under the Code. Leaving open the possibility of a 1995 deduction would eliminate or reduce this concern.

A related issue here is the treatment of the special payment to be made to SAIF on "Oakar" deposits. Though the language in the bill referenced by the proposed tax law amendments would most likely not be interpreted as an entry fee to the BIF, other variants might be so classified. Any relief to Oakar deposits should be weighed carefully against the transfer of burdens to other institutions, both BIF and SAIF insured. Again this is an area where the language of the banking and tax law amendments must be coordinated to achieve whatever treatment the Congress deems is appropriate for this subset of the payment to the SAIF.

Chairman ARCHER. Thank you, Mr. Montgomery.

Mr. O'Brien, you may proceed.

STATEMENT OF THOMAS M. O'BRIEN, CHAIRMAN, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, NORTH SIDE SAVINGS BANK, FLORAL PARK, NEW YORK

Mr. O'BRIEN. Thank you, Mr. Chairman.

My name is Thomas M. O'Brien. I am chairman, president, and chief executive of North Side Savings Bank in Floral Park, New York. North Side Savings Bank is a New York State-chartered stock savings bank with total assets in excess of $1.5 billion. My institution is a full-service community lender. We make residential mortgage loans, home equity loans, commercial real estate loans, and small business and personal loans to meet the demands of our customers. In addition, I serve as chairman of the legislative committee for the Community Bankers Association of New York State.

North Side is a savings bank, as I mentioned. We are insured by BIF, the Bank Insurance Fund. North Side is not only insured like a commercial bank; it is regulated by the same agency that regulates many commercial banks, the FDIC.

The traditional savings bank grew up primarily in the Northeastern and Northwestern United States. Savings and loans were created to make residential mortgage loans, but savings banks generally had a more diversified function. Despite these historical differences, savings and loans and savings banks have been given similar tax treatment under the law.

I would like to thank you, Mr. Chairman, and the Committee and its staff, together with the staff of the Joint Tax Committee, for taking up this bad debt reserve issue at a time when we know you are so busy with all the provisions within the budget reconciliation that fall within this Committee's jurisdiction.

Institutions such as my own appreciate your willingness to hear about these often unnoticed details of our charter type as you consider how to coordinate with the House Banking Committee.

Savings banks early on agreed to the sharing of the debt service on FICO bonds via an increase in premiums charged by BIF to ensure that the weakness in the financing structure did not produce a default. Against this public policy background, relief from adverse impact of related tax law changes is justifiable.

As noted, my institution is somewhat more diversified in its asset allocation than the typical savings and loans.

I appreciate the substantial relief that the proposed legislation offers from the removal of the base-year reserve amounts from recapture. Furthermore, there is some opportunity to suspend the potential recapture of the post-1988 reserve accumulations from recapture, and that is most welcome, though I would like to echo what has been said previously about the mechanical complexity of the proposed formula. I do see some attraction to the origination rather than the asset approach that is proposed. However, the details of the test make long-term compliance very difficult.

As proposed, I would seriously consider letting my institution fail the test and get on with the transformation to a broader-based community and consumer lender. That will generate some recapture tax, but it will not promote mortgage originations.

I believe that thrifts fully earn the benefits of the bad debt reserve by past focus on the mandated types of lending and asset holdings. We are currently surrendering a very valuable deduction. Section 593(e) should be repealed along with the rest of that section of the Code.

I understand that there is precedent for that in the financial services sector in the case of insurance company policyholder reserves. If, however, 593(e) is not repealed, we would appreciate some changes in its mechanics.

First, it would be helpful and logical to change the stacking order that currently requires that recapture under this section occurs on any stock repurchase by an institution. This can be avoided in the case of a holding company, but the formation of a holding company should be driven exclusively by business rather than tax considerations.

Second, the application of 593(e) in merger situations should be clarified in statutory language or in legislative history. It really does not make good tax policy, as I see it, to generate revenue from inadvertent failure to comply with an arcane tax law.

The long-term maintenance of these suspense tax accounts maintains a level of complexity and differential recordkeeping that is at odds with the goal of tax simplicity and uniform bank taxation. However, it is excellent tax policy to show the openness and care that this Committee has shown in crafting this language to address the very pressing tax problems that are arising from actions elsewhere in Congress.

We deeply appreciate your responsiveness to our concerns, and I would be pleased to take your questions.

[The prepared statement follows:]

Statement
of
Thomas M. O'Brien
Chairman, President, & Chief Executive Officer
of
North Side Savings Bank
Floral Park, New York

before the
Committee on Ways and Means
of the
United States House of Representatives

On

H.R. 2494

Thrift Charter Conversion Tax Act of 1995

October 26, 1995

Mr. Chairman, thank you very much for giving me the opportunity to appear before your committee today. My name is Thomas M. O'Brien. I am Chairman, President, & Chief Executive Officer of North Side Savings Bank, Floral Park, New York. North Side Savings Bank is a stock savings bank with total assets in excess of $1.5 billion. My institution is a full-service community lender. We make residential mortgage loans, home equity loans, commercial real estate loans, small business, and personal loans to meet the demands of our customers in the intensely competitive banking environment of New York City and its Long Island suburbs.

North Side is insured by the Bank Insurance Fund (BIF). This is the same insurance fund that insures commercial banks and it is to be distinguished from the Savings Association Insurance Fund (SAIF), which insures mostly savings and loans, though these lines are blurring with hybrid entities like so-called "Oakar" and "Sasser" institutions. North Side is not only insured like a commercial bank, it is regulated by the same agency that regulates many commercial banks. the Federal Deposit Insurance Corporation. Savings and Loan Associations are regulated by the Office of Thrift Supervision (OTS).

The traditional savings bank was a form of bank that grew up primarily in the Northeastern and Northwestern United States. Savings Banks, or "mutual savings banks," as they are called in the Internal Revenue Code, were created as depositories for the savings of working men and women. Their historical function and purpose was always somewhat different than that of savings and loans, or building and loans, as they were often called. Jimmy Stewart's institution in the movie It's a Wonderful Life, you may recall, was a building and loan. Savings and loans were created to make residential mortgage loans, but savings banks always had a more diversified function. Although they always allocated a significant part of their deposits to investments in U.S. Treasury securities, they historically functioned as fairly broad-based community lenders, as opposed to savings and loans, which historically had a narrower function. The names of many savings banks indicate their historical link with the small saver and the notion of thrift, for example, Five Cent Savings Bank, Dime Savings Bank, Peoples Savings Bank. Over their long history of community service, many of our institutions have grown into large full service banks. Washington

Mutual Savings Bank of Seattle, Washington, for example, has almost $20 billion of assets and an active business in securities and mutual fund brokerage.

Despite these historical differences, savings and loans and savings banks have been given similar treatment under the tax law, although there are still some distinctions. Savings and loans must satisfy a definition in the tax code, while there is no definition of mutual savings bank. More important, although the basic principles of their taxation were always the same, the details of their tax treatment differed. Different percentages were at one time provided for savings and loans and savings banks under the percentage-of-eligible-loans method, the subsidy reserve method provided for thrift institutions. Most of these historical differences have now been eliminated. Both savings and loans and savings banks are equally eligible to use the "subsidy", percentage-of-income method of reserving for bad debts under section 593 of the Code.

I would like to thank you, Mr. Chairman, and the committee and its staff, together with the staff of the Joint Tax Committee, for taking up this bad debt reserve issue at a time when you are so busy with all the provisions within budget reconciliation that fall under this committee's jurisdiction. Institutions such as my own appreciate your willingness to hear about the details of these often unnoticed details of charter type as you consider how to coordinate with the changes that the House Banking Committee is proposing in banking law.

Clearly the impetus for taking on these issues is the urgency of the need to address the problems of the SAIF insurance fund and the potential for default on the FICO bonds. That is an event no one wishes to risk.

For that reason, savings banks early on agreed to the sharing of the debt service on the FICO bonds via an increase in the premiums charged by BIF to ensure that the weaknesses in the financing structure do not produce this result. Obviously, this is not something that any BIF- insured entity is eager to do, and some commercial banks have not fully reconciled themselves to this approach, but it was the right thing to do if no better way could be found. Again, though FICO debt service is an item for the Banking Committee, the impact of FICO problems on the credit status of overall U. S. government and agency debt is a matter at the heart of the jurisdiction of this distinguished committee.

Thus it is appropriate, against this public policy background, for this committee to consider the best way to handle the treatment of institutions that fall under the same tax code provisions as SAIF-insured institutions but otherwise would not have been affected by the banking law changes, other than their willingness to help resolve a difficult and urgent policy issue. Relief from adverse impact from the related tax law changes is certainly justifiable.

As noted, my institution is somewhat more diversified in its asset allocation than the typical savings and loan. Though North Side Savings Bank still easily meets the thrift definition in the Internal Revenue Code, changes in market conditions have caused us to rethink how our institution can best evolve to serve our customers and our stockholders.

I appreciate the substantial relief that the proposed legislation offers from the removal of the base-year reserve amounts from recapture. Furthermore, there is some opportunity to suspend the potential recapture of even the post-1989 reserve accumulations from recapture, which is also most welcome, though I would like to indicate some problems with how that mechanism works. Also, the treatment for small institutions could be adjusted to forestall recapture and allow them to grow into their reserve, provided that they do not cross the $500 million threshold. This is obviously not an issue for my institution, given our asset size, but it would be helpful to the smaller, less sophisticated entity that could have real problems with the origination test. I would like to discuss that test briefly.

Reliance on mortgage lending and portfolio holding as the major source of income for my institution is increasingly precarious. The changes in the mortgage market caused by the growth of the secondary market government-sponsored enterprises, especially Fannie Mae

and Freddie Mac, have narrowed margins substantially. Making and holding the fixed rate loans that consumers often prefer is difficult to do on any reasonable risk-reward basis.

Consequently, I do see some attraction to the origination, rather than an asset approach, that is proposed. Institutions would theoretically have the opportunity to originate loans for the secondary market, rather than hold them in portfolio. But the defects in the details of the test make long term compliance very difficult.

The six-year moving-average approach simply will not accommodate a sharp decline in market demand. If the market volume ever drops off by more than the variation within the previous six-year testing period, the institution cannot be protected sufficiently by the smoothing process.

Nor do institutions have the option of going out and capturing additional origination market share to compensate for that market decline. Some institutions already have such a large share in their market that they cannot offset that decline. Expansion merely triggers diminishing returns and safety and soundness concerns. Remember that the test puts them on a treadmill whose speed is always ratcheted upward.

Also, the origination market is highly competitive with low barriers to entry and enormous excess capacity. Origination margins are paper thin. In fact, it is very difficult to sell origination (as opposed to servicing) systems. Much of this excess capacity was developed in the extraordinary refinancing boom of 1993. This type of loan business adds a great deal of "noise" and excess volatility to market volumes, driven as it is by interest rate gyrations. Excluding refinances, at least as an option to the institution, is vital.

Unless that test is revised to allow some lower percentage of the moving-average period (say 75%) or contains some other safeguard to allow for market fall-offs, I would seriously consider letting my institution fail the test quickly and get on with my transformation into a broad-based consumer and community bank. That may generate a modest amount of recapture tax but it will certainly not promote mortgage originations.

Balancing the goals of revenue generation and credit availability is a delicate matter. The need for revenue should not be paramount as I see it since the pick-up from the loss of future availability of the percentage-of-taxable income method should be significant.

I believe that my institution fully earned the benefits of its bad debt reserve by its past focus on the mandated types of lending and asset holdings. So I would like to address the retention of Section 593(e) as applied to the base-year amounts that can be set aside from recapture. Since my institution is being forced off the method we have long used, by public policy changes that are not of our doing, ideally Section 593(e) would be repealed along with the rest of that code section. I understand that there is precedent for that in the financial services sector in the case of insurance company policy-holder reserves. If, however, Section 593(e) is not repealed either as part of this welcome legislative initiative or in the foreseeable future, we would appreciate some changes in its mechanics.

First, it would be both helpful and logical to change the "stacking order" that currently requires that recapture under this section occurs on any stock repurchase by an institution. This can be avoided in the case of a holding company but the formation of a holding company should be driven exclusively by business considerations rather than its tax dimension.

Secondly, the application of Section 593(e) in merger situations should be clarified in the statutory language or in its legislative history. It is one thing to carry over the apparatus of recapture and whether distributions come out of earnings and profits or tax bad debt reserves (but only to the extent that they exceed the experience reserve) to acquirers of thrift institutions that themselves come from within the traditional thrift sector. It is quite another to apply these complexities to acquirers that do not have the familiarity or database that can

produce compliance with these rules. It really does not make good tax policy, as I see it, to generate revenue from inadvertent failure to comply with arcane tax law provisions.

It is, however, excellent tax policy to show the openness and care that this committee has shown in crafting this language to address the very pressing tax problems that are arising from actions elsewhere in Congress. We deeply appreciate your responsiveness to our concerns and would be pleased to respond to any questions that my testimony may produce.

Chairman ARCHER. Thank you, Mr. O'Brien.
Finally, Mr. Kinnier.

STATEMENT OF STEPHEN R. KINNIER, SENIOR VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, VIRGINIA FIRST SAVINGS BANK, F.S.B., PETERSBURG, VIRGINIA

Mr. KINNIER. Thank you, Mr. Chairman and Members of the Committee. My name is Stephen R. Kinnier, and I am the senior vice president and chief financial officer of Virginia First Savings Bank. We are based in Petersburg, Virginia, and we have assets of approximately $700 million. We are a full-service community bank. We have 23 retail branches in Virginia, and we provide mortgage loan financing in the States of Virginia and Maryland.

I am here to voice my support for H.R. 2494. In our view, it is absolutely critical that in order to accommodate banking and thrift policy as we go forward, it is important that this year the treatment of the accumulated thrift bad debt reserves be addressed.

Mr. Chairman, I am very grateful that you have taken a step forward on this because there was some concern earlier in the year that the banking legislation was going to go forward without addressing this, and I do thank you for holding this hearing today.

The bill addresses rules regarding the treatment of the accumulated reserves on thrift bad debts if the thrift institutions either convert on their own or are required to convert to banks. Under the bill, the maximum amount of reserve recapture would generally be limited to the reserves accumulated after the 1987 base year.

I must state that not having to recapture the pre-1988 reserves is really important to us. If we had to take it into income, there would be a substantial reduction in our capital. As you know, nowadays for thrift institutions as well as banks, capital is very, very important. They say capital is king these days, and the last thing we need is to have a substantial hit to our capital by having to take into income, into taxable income, the pre-1988 reserves. This is especially more important now that the proposed legislation to satisfy the BIF/SAIF legislation would hit our industry with approximately $6.2 billion of the special assessment.

The amount that is being proposed for the one-time special assessment is huge for our industry. In the case of my institution, it will represent approximately 40 percent of this year's pretax earnings. So this is going to hit us hard, but we are willing to make that contribution as part of our industry's contribution to clean up this mess, which is why not having to recapture the pre-1988 reserves is so important to us.

We are also very sympathetic to the Chairman's desire that thrifts and former thrifts, once they become former thrifts, remain active players in the mortgage loan origination business. That is our business. More than 80 percent of the assets in my institution are loans. We are a mortgage lender.

I do think there are some modifications that can be made to the proposed mortgage loan requirement that would make it a little bit easier for thrifts like mine to meet. One that was mentioned earlier was to find a way to exclude refinancings from the test. Volumes of refinancing of mortgage loans can create enormous swings in the total volume of mortgage originations from year to year.

By including refinancings in the test, it could make it almost impossible for some thrifts to meet the test. In the case of our institution, we had massive refinancing activity in 1993 and 1994. I have already run the numbers for my institution using your test, and I would fail it in the first year of the test, even though that is our primary business, Mr. Chairman. But this could be fixed, we think, by somehow eliminating refinancings or somehow taking them out.

Also, in recognizing the changes in the business practices, we would like the term origination to include activities with mortgage loan brokers, because an institution such as ours, we will deal with local brokers to help provide financing in our areas.

Finally, I would like to make a point that I think Congress should consider sunsetting the section 593(e) rules. I personally believe that it serves no useful purpose other than to be a trap for the unwary.

Again, I would like to thank the Committee for the opportunity to testify and thank the Chairman for taking the lead on this issue.

[The prepared statement follows:]

Statement of
Stephen R. Kinnier
Chief Financial Officer
of
Virginia First Savings Bank, F.S.B.
Petersburg, Virginia

Before the
Committee on Ways and Means
of the
U.S. House of Representatives

October 26, 1995

My name is Stephen R. Kinnier and I am Senior Vice President and Chief Financial Officer of Virginia First Savings Bank, F.S.B. Virginia First is based in Petersburg, Va., and has assets of $700 million. We have 23 retail branches in Virginia and originate residential mortgage and construction loans in Virginia and Maryland.

I am testifying today to express my general support for H.R. 2494, legislation introduced last week by Chairman Archer, and to address certain technical aspects of the bill. In the view of Virginia First, it is absolutely critical, in order to accommodate banking and thrift policy for the future, that Congress, this year, address the treatment of accumulated bad debt reserves as they pertain to thrift institutions.

Most importantly, the Chairman's bill addresses these issues in a manner that would eliminate many of the hurdles standing in the way of the continued financial safety and modernization of depository institutions.

I would like to make some general comments about thrift bad debt reserves and their treatment under the bill. In addition, I would like to discuss several technical issues that I hope can be addressed as the Committee considers this important legislation.

The conversion of thrift institutions into bank-chartered institutions is viewed by many policy makers as inevitable in light of the ongoing transformation of the banking and financial services industries. The thrift industry is supportive of provisions included in the current budget reconciliation legislation that would bring the Savings Association Insurance Fund, or SAIF, up to its statutorily required reserve level through a one-time assessment of approximately $6.2 billion on all SAIF-insured deposits. In addition, the thrift industry generally agrees with banking policy makers that the SAIF and the Bank Insurance Fund, or BIF, should be combined. The conversion of thrift institutions into bank-chartered institutions is viewed by many as inevitable as this restructuring progresses.

I am particularly pleased that Chairman Archer has introduced H.R. 2494 because it indicates there is an understanding of the important role tax policy must play as banking policy is formulated.

Under current law, banks and thrift institutions generally are treated under the same tax rules that apply to other corporations. The primary difference between the taxation of thrifts and other corporations, including banks, involves the treatment of bad debts. Thrifts meeting certain requirements are allowed to maintain reserves for bad debts in lieu of claiming bad debt losses when specific debts become wholly or partially worthless. Generally, banks (and banks in controlled groups) with total assets greater than $500 million are not permitted bad debt reserves.

Historically, Congress has provided more generous bad debt treatment to thrifts as an incentive for them to hold residential mortgage loans. Thrifts lose this special incentive when they fail to meet certain qualifying tests. Under proposed IRS regulations, failure to meet the qualifying

tests or conversion to a bank charter will result in the recapture -- or the taking into taxable income -- of the excess of a thrift's tax reserves over its allowable bank tax reserve.

Under generally accepted accounting principles (GAAP), thrifts are not required to record for financial statement purposes a liability against the tax bad debt reserves accumulated in years prior to and including 1987 -- the so-called base year. After 1987, deferred taxes must be provided for any increases above the base-year reserves.

H.R. 2494 would repeal the special bad debt deduction for thrifts for taxable years beginning after 1995. Thus, institutions that had been allowed to take advantage of the special deduction would, on a going forward basis, be subject to the rules that currently apply to commercial banks for purposes of treating loan losses.

Most importantly, the bill includes rules relating to the treatment of accumulated reserves that are critical if thrift institutions convert on their own, or are forced to convert to banks. Under the bill, the maximum amount of reserve recapture generally would be limited to the reserves accumulated after the 1987 base year.

This so-called fresh start for pre-1988 reserves is vitally important.

If a thrift is required to take the pre-1988 bad debt reserves into income, the associated income tax will have an immediate and adverse effect on capital. This would be the case even if the reserves were taken into taxable income over several years. This reduction in an institution's capital as a result of having to record for GAAP and regulatory purposes the liability for deferred taxes may cause many institutions to fall below acceptable capital levels.

The potential damage to the capital position of these institutions is particularly significant given the capital requirements established by the banking legislation of the late 1980s. Moreover, the BIF/SAIF legislation now before the Congress would address the severe shortfall in the SAIF, and the competitive imbalance of the two insurance funds resulting from sharply differing premiums. The current proposal would require thrifts to pay a $6.2 billion special assessment to ensure the full funding of the combined insurance fund. Requiring thrifts to pay tax on accumulated reserves in addition to making a large contribution to the insurance fund would clearly jeopardize the capital position of many institutions.

The fresh start also is appropriate in that it properly recognizes that the preferential bad debt deduction methods allowed thrift institutions effectively acted as a permanent incentive for thrift institutions to actively participate in the residential mortgage business.

A second important feature of the bill generally would require thrift institutions to take into income the post-1987 accumulated reserves over a 6-taxable year period, beginning with the first taxable year beginning after 1985. However, institutions meeting a special test, called a residential loan requirement, for any year would have this recapture treatment suspended for that year. This test runs in perpetuity and requires that the principal amount of residential loans made by the taxpayer during the year not be less than the average of the principal amount of such loans made during the six most recent years.

We are sympathetic to the Chairman's desire to encourage thrifts and former thrifts to remain active players in the mortgage loan business in return for deferring the recapture of post-1987 reserves. However, we believe the test as currently drafted will pose problems for institutions of all sizes and may not accomplish what I perceive to be the intended goal of encouraging institutions to make credit available to home buyers.

I suggest two modifications to this test:

The first modification relates to the inclusion of refinancings in the test. The volume of refinancings of mortgage loans can create enormous swings in the total volume of mortgage originations from year to year. Including refinancings as part of the test will make it virtually

impossible for thrifts to meet the mortgage origination test for any extended period of time. Thus, any incentive element of the proposal would be lost.

To illustrate, in the fiscal year that ended June 30, 1995, my institution originated more loans to finance home purchases than ever before. However, if the residential loan test as drafted applied in the current year, we would likely fail to meet the target because mortgage loan refinancings in the 1993 and 1994 time period greatly distort the average originations over the testing period.

In my view, this problem could be fixed by eliminating refinancings from the test to moderate the skewing effects caused by refinancings. There may be other workable alternatives.

The second modification relates to the term "loan made." In recognition of changing business practices, the term should be clarified to include mortgage loans originated by mortgage loan brokers and either closed in the name of the lender or funded by the lender within a short period of time after the loan is made.

Finally, I urge the committee to be mindful of how the rules will operate as the banking industry continues to undergo significant changes. Institutions are consolidating at an ever increasing pace both through mergers with other institutions, but also from realignments of their existing corporate structures. As a result, there can be no ambiguity in the legislation regarding the effect tax-free reorganizations will have on thrifts that are involved in these transactions. Additionally, taxpayers will not have the luxury of waiting on the Treasury Department to issue regulations instructing them how the test will operate following an acquisition.

Therefore, I encourage the tax-writing committees to provide as much guidance as possible on the effect tax-free mergers and consolidations will have on thrift bad debt reserves that are either forgiven or have been suspended under this bill. I believe the legislative history should state specifically that tax-free mergers, acquisitions, or consolidations do not result in either the pre-1988 or post-1987 reserves being included in income even if the acquiring or resulting institution is not a thrift. Additionally, specific rules should be provided to guide an acquiring institution, if it was not a thrift, on how to meet the residential loan requirement following an acquisition or merger.

Again, I would like to thank the Committee for the opportunity to testify and express my appreciation to the Chairman for taking the lead on an issue of such importance to my institution and the thrift industry. I would be happy to take any questions you may have.

Chairman ARCHER. Thank you, Mr. Kinnier.

Gentlemen, let me see if you are together on a couple of items here. Do all three of you agree that refinancing should be taken out of the formula?

Mr. MONTGOMERY. Yes, I do.

Mr. O'BRIEN. Yes, I do, too.

Mr. KINNIER. Yes, sir.

Chairman ARCHER. As between the origination test and an asset test, which do you prefer? Which do you think is the most appropriate?

Mr. O'BRIEN. I like the origination test.

Mr. MONTGOMERY. I think without the refinance element, the origination test works fine.

Mr. KINNIER. I agree, sir.

Chairman ARCHER. And can you briefly tell us what your definition of origination would be?

Mr. O'BRIEN. If I can start, the origination would be the inhouse origination purchased from a broker at the closing or other acquisition of the loan in its first year.

Mr. MONTGOMERY. I do think it is important to have the origination test include loans purchased from brokers, because that is an increasing trend in mortgage finance around the country, and it needs to be recognized, yes.

Mr. KINNIER. And you may consider including the home equity line type of financing, and I would also ignore the fact that once the loan is originated, however defined, the loan might be sold on the secondary market to be able to provide us with more funds to make more loans. So I don't think the fact that loans might be sold should be a consideration.

Chairman ARCHER. You would not have any holding period requirement test?

Mr. KINNIER. No, sir. We are the frontline loan originator. We are the people who deal with the community. The fact that we may turn around and sell the loan almost immediately to get more money to make more loans, I don't think there should be any holding period at all.

Mr. O'BRIEN. We tend to be a portfolio lender, Mr. Chairman, but that kind of recordkeeping is awfully complex and, again, would certainly deter from the value of the formula.

Chairman ARCHER. Thank you very much.

Any Members of the Committee wish to inquire?

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Montgomery, I would like to hear your views on section 593(e) specifically as it relates to the possibility of it being a recordkeeping problem for your institutions.

Mr. MONTGOMERY. I think 593(e) to me no longer serves a useful purpose if we are dealing with the recapture problem of the pre-1988 reserves. It does represent a bookkeeping problem. A lot of things could happen in the future with respect to mergers and this sort of thing. I think it was described here it could end up to be a trap for the unwary, and in order to avoid that, there is an awful lot of recordkeeping that will be needed.

I don't believe that there has ever been significant revenue generated under 593(e) to the Treasury, and I would think that would be the case in the future, except through inadvertent noncompliance. And it just doesn't seem to me to be worth keeping under those circumstances.

Mr. COYNE. So, in your view, it is not a revenue generator?

Mr. MONTGOMERY. Oh, I don't believe so, no.

Mr. COYNE. Thank you.

Chairman ARCHER. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

I think the common thread here is problems in the origination test. Clearly, in 593(e), if I heard the panel correctly, they think that the origination test can be fixed by excluding the refinancing from the test. As far as 593, I am told by Joint Tax that they have no objection to excluding stock purchase from earnings and profits.

I know Mr. O'Brien indicated that we should repeal the entire section, but, Mr. Montgomery, would 593(e) be workable if we would exclude the stock purchase from earnings and profits? At that point, would the balance be workable?

Mr. MONTGOMERY. I think my colleague on my right is more of an expert on 593(e), so——

Mr. KLECZKA. I was going to call on him, but I can't pronounce his name. [Laughter.]

Mr. KINNIER. My personal belief is that 593 in its entirety is not a revenue raiser at all; that it is truly the trap for the unwary; that if a party has informed tax advice, they will find a way to get around it.

As you may know, many institutions these days have put in place holding companies, and by using the holding company device and with informed tax advice, you can get around 593 anyway. In my opinion, it would be better just to let it go, especially if it is not scored as a revenue loser.

Mr. KLECZKA. OK. I won't ask this panel about the Oakar banks, because I don't know if you would have a comment on that, but I think the Committee is aware of that problem.

The last question I have is regarding the small thrifts. It has been raised that the small commercial banks were exempted in, I think, 1986 and there is a feeling here that we should do the same to small thrifts today. Do you folks have any opinion on that?

Mr. MONTGOMERY. As a very large thrift, I would support exempting small thrifts. I think it does make sense.

Mr. KLECZKA. Just to be nice to your small brethren, or what?

Mr. MONTGOMERY. Well, I just think that there are certain situations where the small thrifts should be relieved from the burdens that some of us have to bear.

Mr. KLECZKA. You are talking about equity here, the same as was provided 10 years ago for the small commercials?

Mr. MONTGOMERY. I think that is correct, yes.

Mr. KLECZKA. Any other comments, gentlemen?

Mr. O'BRIEN. I would agree. Comparable treatment I think is appropriate for the small thrifts.

Mr. KINNIER. I would agree.

Mr. KLECZKA. Fine. Thank you, Mr. Chairman.

Mr. LAUGHLIN. Mr. Chairman.

Chairman ARCHER. Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Mr. Kinnier, as a representative of a large rural area, I have only small institutions, so I picked up on your comment about 593(e). As I take from your comment, the large institutions and the institutions that are part of the sophisticated holding companies are not going to have a problem with this. It is the small savings and loans, and savings banks in my district that are going to have the problem.

Mr. KINNIER. Yes, sir. That is my belief, because in many cases they may not have either the resources or the availability of the tax advice. They may not have holding companies in place.

What I would be afraid of, sir, would be if, say, an institution like you have described might be about to be acquired or merged with some other institution, and I would hate to think that a potential buyer would say, you know, we would sure like to pay market value for your stock but you have this 593(e) problem here, so we are going to discount your stock.

Now, that may not occur under the rules, but I would hate to think that some local owners of a stock institution would get hurt because this is there. And like I said, and as you said, the only people who are really going to be hurt by this are the smaller institutions, perhaps less sophisticated on this kind of matter.

Mr. LAUGHLIN. Mr. Montgomery, some people told me that the mortgage origination test in this bill may be too tough for many savings and loans to comply with. I would like your opinion on that. It seems to me that we ought to—if that is the case, I would like for you to tell us what a test should be, because it seems to me that it makes sense in terms of the Chairman's goal to provide an incentive for at least some savings and loans to remain dedicated to residential mortgage lending.

Mr. MONTGOMERY. Yes, we agree with the thrust and the intent of the test. We do disagree with the makeup, and I think as we have said earlier, removing refinance would help in a number of ways. It helps do what you are trying to do, which is to continue to have us originate loans. But we had such a surge of refinancing activity all over the country in 1993 and 1994 that that distorts the numbers and would make the test very difficult for most all of us to comply with. So taking that out will help a great deal.

Mr. KINNIER. I would like to add to that.

Mr. LAUGHLIN. Yes.

Mr. KINNIER. As you know, institutions such as ours are already gathering a lot of this data for a number of the reporting requirements that we have outside the grounds of this Committee. And so if the data is already there, it should not be that much of an incremental burden to meet this test. It is not like we would be gathering data that we are not already gathering.

Mr. LAUGHLIN. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman ARCHER. Mr. Neal.

Mr NEAL. Thank you, Mr. Chairman. I think Mr. Laughlin raised a proper question, and I thought the panelists addressed it accurately.

Mr. Kleczka and I were on the Banking Committee at the same time in the middle of the S&L issue. There is one model that sticks in my mind; and that was the rush at the time to correct the situation and to point fingers at everybody who might have even been remotely involved. But I remember one particular amendment during that period of time, and it was to raise capital standards. At the time that is what everybody said, we had better raise those capital standards, and the end result of that was to drive some good S&Ls over the deep end. So I think the question that Mr. Laughlin raised is an entirely accurate one. I appreciated the candid responses.

Mr. KLECZKA. Would the gentleman yield?

Mr. NEAL. Yes.

Mr. KLECZKA. Mr. Neal and I and I think other Members of the Committee left the Banking Committee because for years and years we were steeped in the S&L crisis, and so we escaped to come over here. And, lo and behold, in 1995 you folks are back. So I don't know if you are following us or what, but it is good to see you all.

Mr. MONTGOMERY. We don't intend to be back again. [Laughter.]

Chairman ARCHER. Does the gentleman yield back his time?

Mr. NEAL. Yes.

Chairman ARCHER. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I just would like for you to comment generally on the recapture provisions. Are you generally satisfied with what is in this bill? Can you live with it? Can your industry live with it like it is written, or is there something that is critical that you need changed?

Mr. O'BRIEN. It would be very helpful, sir, to clarify the 593(e) section or just eliminate it. As I said, it is complex and it does go against the whole concept of a unified bank tax structure. It is another set of records, and as has been said, it is a potential trap or a problem for years going forward, and I think elimination at this point would just solve a lot of problems.

Mr. MONTGOMERY. Just to clarify, I think what we have proposed right here and in our written testimony represents what I would consider fine tuning of what really is an excellent bill. We think that a very good job has been done here in addressing an important issue. We can make some changes on the margin to make it better such as we have discussed, but on the whole I think it does quite a good job.

Mr. MCCRERY. Thank you.

Chairman ARCHER. Any other member wish to inquire?

[No response.]

Chairman ARCHER. Gentlemen, thank you very much. You have been very helpful to us, and we appreciate having the opportunity to hear from you.

Mr. MONTGOMERY. Thank you.

Mr. O'BRIEN. Thank you.

Mr. KINNIER. Thank you, Mr. Chairman.

Chairman ARCHER. We will also include in the record the statement of Robert Sheridan, president, Savings Bank Life Insurance Co. of Massachusetts, and the statement from the staff of the Joint Committee on Taxation.

The Committee will be adjourned.

[Whereupon, at 10:11 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN
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EXECUTIVE DIRECTOR
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Edward L. Yingling
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October 25, 1995

The Honorable Bill Archer
Chairman, House Ways & Means Committee
1236 Longworth House Office Building
Washington, DC 20515

Dear Chairman Archer:

The American Bankers Association (ABA) is pleased to submit written comments for the record regarding the topic of your October 26, 1995 hearing on the "Thrift Charter Conversion Act of 1995" (H.R. 2494). The ABA is the only national trade and professional association serving the entire banking community, from small community banks to large bank holding companies. ABA members represent approximately 90% of the commercial banking industry's total assets, and about 94% of ABA members are community banks with assets less than $500 million.

We want to commend you for introducing this important bill, which we believe is a very positive step on an issue that needs to be addressed by Congress. While we may have a few suggestions for improvements, we support your bill and will be pleased to work for its enactment.

The ABA appreciates your acknowledgement, and that of your co-sponsors, Chairman Leach and Representative Roukema, that a comprehensive solution for the thrift industry SAIF issue must include a charter conversion requirement along with a certain level of forgiveness of the bad debt reserve recapture. We recognize that such forgiveness should be part of a requirement that thrifts convert to banks in order to make the comprehensive solution workable from a capital standpoint. Furthermore, we agree with the basic concept that the bad debt reserve was essentially a subsidy for mortgage loans, and therefore, not really subject to the usual arguments for recapture. We agree with your statement that the bad debt recapture issue should accompany the charter conversion requirement.

It is important that the bad debt forgiveness issue related to the base year amount be coordinated with any plan to merge the Bank Insurance Fund (BIF) and Savings Association Insurance Fund (SAIF). The simultaneous imposition of the special assessment and the recapture of the base year amount would clearly result in significantly reduced capital levels for a number of thrifts. If those thrifts then become part of the BIF, they would enter the bank insurance fund at much lower levels of capital than is acceptable from a regulatory standpoint.

We may have some further suggestions with respect to the provisions on post-1987 reserves. Our general concern is that we believe the concept of requiring that a specified percentage of originations be housing related is outdated in today's marketplace. Federal Reserve Board Chairman Alan Greenspan clearly laid out the problems with such a concept in testimony before the House Banking Committee, and we agree completely with his analysis.

The intent of the co-sponsors with respect to transition, acquisition, and other issues are important components of this legislation and future regulations. We believe that it is

extremely important that these issues be resolved in a fair and equitable manner as they pertain to banks. For example, the beneficial effects of this legislation should also apply to banks that have already begun recapturing bad debt reserves for thrifts they have recently purchased. Further, the legislative history and provisions of H.R. 2494 should confirm that the 1987 base year is not required to be recaptured upon merger of a thrift with a bank; that is, the provisions should apply to any thrift or its successor(s).

Another extremely important issue that is addressed in your bill is the deductibility of the special assessment. We agree with your provision, and we encourage you to specifically include in the language of Section 3 a provision specifying that the deduction be allowed for "the amount paid or incurred as a special assessment", replacing the existing language, "the amount paid during 1996 as a special assessment".

The ABA stands ready to work with Congress on this issue. Please feel free to contact us if we can be helpful.

Sincerely,

Edward L. Yingling

Edward L. Yingling
Executive Director, Government Relations
American Bankers Association

cc: The Honorable Sam M. Gibbons

TAX TREATMENT OF THRIFT INSTITUTIONS UNDER H.R. 2494, THE "THRIFT CHARTER CONVERSION TAX ACT OF 1995"

Scheduled for a Hearing

Before the

HOUSE COMMITTEE ON WAYS AND MEANS

On October 26, 1995

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

October 25, 1995

JCX-46-95

INTRODUCTION

The House Committee on Ways and Means has scheduled a public hearing on October 26, 1995, on H.R. 2494 (the "Thrift Charter Conversion Tax Act of 1995"), which was introduced by Chairman Archer, Mr. Leach, and Mrs. Roukema on October 11, 1995. H.R. 2494 addresses certain Federal income tax issues relating to the treatment of thrift institutions raised by proposed banking legislation (H.R. 2363, the "Thrift Charter Conversion Act of 1995," the principal provisions of which are contained in Title II of H.R. 2491, the 1995 budget reconciliation bill as reported by the House Committee on the Budget.[1]) This document,[2] prepared by the staff of the Joint Committee on Taxation, describes present law and background with respect to the treatment of thrift institutions and the provisions contained in H.R. 2494.

Part I of the document provides an overview. Part II provides a description of the treatment of bad debt reserves of thrift institutions under present law, prior law, and the bill, and a discussion of the issues raised by H.R. 2491 and H.R. 2494. Part III provides a description of the tax treatment under present law and under H.R. 2494 of certain special assessments proposed to be levied upon thrift institutions by H.R. 2491.

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[1] See Title II of H.R. 2491 ("Seven-Year Balanced Budget Reconciliation Act of 1995"), as reported (H. Rept. 104-280, October 17, 1995.)

[2] This document may be cited as follows: Joint Committee on Taxation, Tax Treatment of Thrift Institutions Under H.R. 2494, the "Thrift Charter Conversion Tax Act of 1995" (JCX-46-95), October 25, 1995.

I. OVERVIEW

Thrift institutions (i.e., building and loan associations, mutual savings banks, or cooperative banks) historically have been allowed Federal income tax deductions for bad debts under reserve methods that were more favorable than those granted to other taxpayers (and more favorable than the rules applicable to other financial institutions, including banks). The thrift bad debt method of present law, contained in section 593 of the Internal Revenue Code, allows a qualified thrift institution to deduct as an addition to its reserve for bad debts an amount equal to the larger of: (1) 8 percent of its taxable income, or (2) the amount determined under the experience method generally applicable to small banks. Under proposed Treasury regulations, the conversion of a thrift institution to a bank requires the institution to recapture all or a portion of its bad debt reserve.

H.R. 2363 (the "Thrift Charter Conversion Act of 1995," the principal provisions of which are contained in Title II of H.R. 2491, the 1995 budget reconciliation bill), contains a provision that would require a Federally-chartered savings and loan institution to become a Federally-chartered bank or State-chartered savings and loan institution. It is understood that the recapture for Federal income tax purposes of a portion of the bad debt reserve of a thrift institution upon the conversion to a Federally-chartered bank would require the institution to record a tax liability for financial accounting purposes that would reduce the regulatory capital of the institution.

H.R. 2494, the "Thrift Charter Conversion Tax Act of 1995," would (1) repeal the special bad debt reserve method of section 593 for all thrift institutions, (2) not require the recapture of a certain portion of the institutions' bad debt reserves, and (3) suspend recapture of the remaining portion of the reserve for each taxable year an institution met a residential loan requirement. The residential loan requirement would be met for a taxable year if the institution made a principal amount of loans secured by certain residential real or church property equal to the average amount of such loans made by that institution during a preceding 6-year period.

In addition, H.R. 2491 would require thrift institutions to pay a special assessment to the Saving Association Insurance Fund ("SAIF"), the insurance fund for deposits in thrift institutions. Effective January 1, 1998, the SAIF would be merged with the Bank Insurance Fund ("BIF") (the insurance fund for deposits in banks). Thrift institutions and banks currently are required to pay annual premiums to the SAIF and BIF, respectively, based on the amount of their insured deposits, but the premium rate for the SAIF deposits is substantially higher than the premium rate for BIF deposits. After the merger of the SAIF and BIF in 1998, thrift institutions and banks would be subject to the same lower deposit insurance rates generally applicable to banks.

It may be unclear under present law whether the payment of the special assessment under H.R. 2491 would be deductible for the Federal income tax purposes. H.R. 2494 would provide that the special assessment would be deductible when paid.

II. ACCOUNTING FOR BAD DEBTS BY THRIFT INSTITUTIONS

A. Present Law

Tax treatment of bad debt deductions of savings institutions

Reserve methods of accounting for bad debts of thrift institutions

A taxpayer engaged in a trade or business may deduct the amount of any debt that becomes wholly or partially worthless during the year (the "specific charge-off" method). Certain thrift institutions (building and loan associations, mutual savings banks, or cooperative banks) are allowed deductions for bad debts under rules more favorable than those granted to other taxpayers (and more favorable than the rules applicable to other financial institutions). Qualified thrift institutions are eligible to compute deductions for bad debts using either the specific charge-off method or the reserve method of section 593 of the Internal Revenue Code. To qualify for this reserve method, a thrift institution must meet an asset test, requiring that 60 percent of its assets consist of "qualifying assets" (generally cash, government obligations, and loans secured by residential real property). This percentage must be computed at the close of the taxable year, or at the option of the taxpayer, as the annual average of monthly, quarterly, or semiannual computations of similar percentages.

If a thrift institution uses the reserve method of accounting for bad debts, it must establish and maintain a reserve for bad debts and charge actual losses against the reserve, and is allowed a deduction for annual additions to restore the reserve to its proper balance. Under section 593, a thrift institution annually may elect to calculate its addition to its bad debt reserve under either (1) the "percentage of taxable income" method applicable only to thrift institutions, or (2) the "experience" method that is also available to small banks.

Under the "percentage of taxable income" method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to 8 percent of its taxable income (determined without regard to this deduction and with additional adjustments). Under the experience method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to the greater of: (1) an amount based on its actual average experience for losses in the current and five preceding taxable years, or (2) an amount necessary to restore the reserve to its balance as of the close of the base year. For taxable years beginning before 1988, the "base year" was the last taxable year before the most recent adoption of the experience method (i.e., generally, the last year the taxpayer was on the percentage of taxable income method). Pursuant to a provision contained in the Tax Reform Act of 1986, for taxable years beginning after 1987, the base year is the last taxable year beginning before 1988. The base year amount is reduced to the extent that the taxpayer's loan portfolio decreases. Prior to 1988, computing bad debts under a "base year" concept allowed a thrift institution to claim a deduction for bad debts for an amount at least equal to the institution's actual losses that were incurred during the taxable year.

Bad debt methods of commercial banks

A small commercial bank (i.e., one with an adjusted basis of assets of $500 million or less) only may use the experience method or the specific charge-off method for purposes of computing its deduction for bad debts. A large commercial bank must use the specific charge-off method. If a small bank becomes a large bank, it must recapture its existing bad debt reserve (i.e., include the amount of the reserve in income) through one of two elective methods. Under the 4-year recapture method, the bank generally includes 10 percent of the reserve in income in the first taxable year, 20 percent in the second year, 30 percent in the third year, and 40 percent in the fourth year. Under the cut-off method, the bank generally neither restores its bad debt reserve to income nor may it deduct actual losses relating to loans held by the bank as of the date of the required change in the method of accounting. Rather, the amount of such losses are charged against and reduce the existing bad debt reserve; any losses in excess of the reserve are deductible. Any reserve amount in excess of actual losses is includible in income.

Recapture of bad debt reserves by thrift institutions

If a thrift institution becomes a commercial bank, or if the institution fails to satisfy the 60-percent qualified asset test, it is required to change its method of accounting for bad debts and, under proposed Treasury regulations,[3] is required to recapture its bad debt reserve.[4] The percentage of taxable income portion of the reserve generally is included in income ratably over a 6-taxable year period. The experience method portion of the reserve is not restored to income if the former thrift institution qualifies as a small bank. If the former thrift institution is treated as a large bank, the experience method portion of the reserve is restored to income either ratably over a 6-taxable year period, or under the 4-year recapture method described above.

In addition, a thrift institution may be subject to a form of reserve recapture even if the institution continues to qualify for the percentage of taxable income method. Specifically, if a thrift institution distributes to its shareholders an amount in excess of its post-1951 earnings and profits, such excess will be deemed to be distributed from the institution's bad debt reserve and must be restored to income (sec. 593(e)).

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[3] Prop. Treas. reg. sec. 1.593-13.

[4] The requirement of the proposed regulations that a thrift institution recapture its bad debt reserves upon a change in the method of its accounting for bad debts is based on Nash v. U.S., 398 U.S. 1 (1970), where the U.S. Supreme Court held that a taxpayer essentially was required to recapture its bad debt reserve when the related accounts receivable were transferred by the taxpayer .

B. Prior Law

Savings and loan associations, cooperative banks and mutual savings banks were tax exempt until the Revenue Act of 1951. While thrift institutions were made taxable as part of that Act, they also were given generous bad debt deductions that effectively kept thrift institutions exempt from income tax. In the Revenue Act of 1962, Congress attempted to end this virtual tax exemption by modifying the bad debt reserve deductions.

The system set up in 1962 allowed thrift institutions to choose among two alternative formulas: (1) an annual addition to reserves of 60 percent of taxable income (limited to a loss reserve of 6 percent of qualifying real property loans), or (2) a loss reserve of 3 percent of qualifying real property loans plus a percentage of other loans based on experience. Savings and loan associations and cooperative banks were allowed to use these methods only if 82 percent of their assets were invested in residential real estate, liquid assets and certain other assets, but no similar restrictions were applied to mutual savings banks.

The Tax Reform Act of 1969 eliminated the 3-percent method, phased down the percent of taxable income from 60 to 40 percent over 10 years, applied limits on the use of the percentage of taxable income method to mutual savings banks similar to those applicable to savings and loan associations (but with a 72-percent qualifying asset requirement in place of 82 percent), provided that the taxable income percentage was to be phased down gradually if an institution's proportion of qualifying assets fell short of 82 or 72 percent (instead of causing that institution to lose all benefit from the percentage of taxable income method), and made a series of other modifications to the bad debt provisions.

The Economic Recovery Tax Act of 1981 expanded the organizations eligible for these special rules to include stock savings banks. The rules applicable to stock savings banks are the same as those applicable to savings and loan associations.

The Tax Equity and Fiscal Responsibility Act of 1982 enacted Code section 291 which required that deductions for bad debts by a thrift institution must be reduced by 15 percent of the amount that the institution's bad debt deduction exceeded the amount that would have been allowed under the experience method. The section 291 cut-back percentage was increased to 20 percent by the Deficit Reduction Act of 1984.

The Tax Reform Act of 1986 ("1986 Act") created the present system for accounting for bad debts by limiting the percentage of taxable income method to 8 percent of taxable income for those thrift institutions that met the 60-percent qualifying asset test of present law and repealing the section 291 cutback provision.[5] The 1986 Act also repealed the percentage-of-

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[5] The 1986 Act changes did not change the effective tax rate applicable to thrift institutions. Before the 1986 Act, the effective tax rate was 31.28 percent, computed as:

(1) 46-percent corporate tax rate times,

(2) 68 percent (100 percent minus 32-percent deduction allowed under 40-percent

eligible loans method for taxable years beginning after 1987. The 1986 Act significantly changed the treatment of accounting for bad debts for other taxpayers by requiring the use of the specific charge-off method for all taxpayers, except thrift institutions and "small banks" (i.e., those with assets of $500 million or less). Small banks were allowed to continue to use the experience method of section 585. The experience method was amended to establish 1987 as a permanent base year for all taxpayers eligible to use the experience method, including thrift institutions.

C. Proposed Banking Legislation (H.R. 2491)

Treatment of thrift institutions under H.R. 2491

H.R. 2363 (the "Thrift Charter Conversion Act of 1995," introduced by Mrs. Roukema, and Messrs. Leach, McCollum, Roth, Baker of Louisiana, Bachus, Vento, Flake, Royce, Lucas, Weller, Metcalf, and Watts of Oklahoma on September 10, 1995, the major provisions of which are contained in H.R. 2491, the 1995 budget reconciliation bill) would require savings and loan institutions to forego their Federal thrift charters and become either State-chartered savings and loan institutions or Federally-chartered banks. Under proposed Treasury regulations, if a thrift institution becomes a bank, the institution would be subject to recapture of all or a portion of its bad debt reserve . As described in detail below, it is understood that such recapture would require the institution to immediately record, for financial accounting purposes, a current or deferred tax liability for the amount of recapture taxes for which liabilities previously had not been recorded (generally, with respect to the pre-1988 reserves) regardless of when such recapture taxes are actually paid to the Treasury. It is further understood that the recording of this liability generally would decrease the regulatory capital of the new bank.

Financial accounting treatment of tax reserves of bad debts of thrift institutions

In general, for financial accounting purposes, a corporation must record a deferred tax liability with respect to items that are deductible for tax purposes in a period earlier than they are expensed for book purposes. The deferred tax liability signifies that, although a corporation may be reducing its current tax expense because of the accelerated tax deduction, the corporation will become liable for tax in a future period when the timing item "reverses" (i.e., when the item is expensed for book purposes but for which the tax deduction had already been allowed). Under the applicable accounting standard (Accounting Principles Board Opinion 23), deferred tax liabilities generally were not required for pre-1988 tax deductions attributable to the bad debt reserve method of thrift institutions because the potential reversal of the bad debt reserve was

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of taxable income method, adjusted for the 20-percent cutback of sec. 291).

After the 1986 Act, the effective tax rate also was 31.28 percent, computed as:
(1) 34-percent corporate tax rate times,
(2) 92 percent (100 percent minus 8-percent deduction allowed under percentage of taxable income method).

indefinite (i.e., generally, a reversal would only occur by operation of sec. 593(e), a condition within the control of a thrift institution). However, the establishment of 1987 as a base year by the 1986 Act increased the likelihood of bad debt reserve reversals with respect to post-1987 additions to the reserve and it is understood that thrift institutions generally have recorded deferred tax liabilities for these additions.

D. Description of H.R. 2494

H.R. 2494 (the "Thrift Charter Conversion Tax Act of 1995," introduced by Chairman Archer, Mr. Leach, and Ms. Roukema on October 11, 1995), would repeal the section 593 reserve method of accounting for bad debts by thrift institutions, effective for taxable years beginning after 1995. Under the bill, thrift institutions that qualify as small banks would be allowed to utilize the experience method applicable to such institutions, while thrift institutions that are treated as large banks would be required to use the specific charge-off method. Thus, the percentage of taxable income method of accounting for bad debts would no longer be available for any institution.

A thrift institution required to change its method of computing reserves for bad debts would treat such change as a change in a method of accounting, initiated by the taxpayer, and having been made with the consent of the Secretary of the Treasury. Any section 481(a) adjustment required to be taken into account with respect to such change generally would be taken into account ratably over a 6-taxable year period, beginning with the first taxable year beginning after 1995. For purposes of determining the section 481(a) adjustment of a taxpayer, the balance of the reserve for bad debts with respect to the taxpayer's base year (generally, the balance of the reserve as of the close of the last taxable year beginning before January 1, 1988, adjusted for decreases in the taxpayer's loan portfolio) would not be taken into account. However, the balance of these pre-1988 reserves would continue to be subject to the provisions of present-law section 593(e) (requiring recapture in the case of certain excess distributions to shareholders).

Thus, under the bill, subject to the special rule described below, a thrift institution that would be treated as a large bank generally would be required to recapture its post-1987 additions to its bad debt reserve, whether such additions are made pursuant to the percentage of taxable income method or the experience method. In addition, subject to the special rule described below, a thrift institution that would qualify as a small bank generally only would be required to recapture its post-1987 additions to its bad debt reserve that were attributable to the use of the percentage of taxable income method during such period. If such small bank would later become a large bank, any amount required to be recaptured under present law would be reduced by the amount of the pre-1988 reserve.

Under a special rule, if the taxpayer meets the "residential loan requirement" for any taxable year, the amount of the section 481(a) adjustment otherwise required to be restored to income would be suspended. A taxpayer would meet the residential loan requirement if for any taxable year, the principal amount of residential loans made by the taxpayer during the year is not less than the average of the principal amount of such loans made during the six most recent

testing years. A "testing year" means (1) each taxable year ending on or after December 31, 1990, and before January 1, 1996, and (2) each taxable year ending after December 31, 1995, for which the taxpayer met the residential loan requirement. For this purpose, a residential loan would be a loan described in section 7701(a)(19)(C)(v) (generally, loans secured by residential real and church property and mobile homes). The special rule would continue to apply until the taxpayer recaptured its entire section 481(a) adjustment. The determination of whether a member of a controlled group of corporations meets the residential loan requirement would be made on a controlled group basis. A special rule would provide that a taxpayer that calculates its estimated tax installments on an annualized basis would determine whether it meets the residential loan requirement with respect to each such installment. Treasury regulations are expected to provide rules for the application of the residential loan requirement rules in the case of mergers, acquisitions, and other reorganizations of thrift and other institutions.

Effective date.--The bill would be effective for taxable years beginning after December 31, 1995.

E. Issues Raised by H.R. 2491 and H.R. 2494

Title II of H.R. 2491 (the proposed banking legislation) and H.R. 2494 (the proposed tax legislation) raise and address certain accounting, banking, and tax policy issues. First, H.R. 2491 would require a Federally-chartered savings and loan institution to become either a Federally-chartered bank or a State-chartered savings and loan. If an institution became a bank, absent any accompanying tax legislation, the converting institution would be denied the future benefit of the bad debt reserve method of section 593 and, pursuant to proposed Treasury regulations, would recapture all or a portion (depending on whether the institution would be treated as a small or a large bank) of its bad debt reserve. Thus, H.R. 2491, without any legislative tax relief, would impose a financial burden upon those institutions selecting Federal bank charters rather than State thrift charters. Further, as described in Part C. above, requiring the recapture of all or a portion of an institution's bad debt reserve may require the institution to record a deferred tax liability for such amounts, thereby reducing the regulatory capital of the institution. Taken together, the financial and capital requirements burdens imposed by bad debt reserve recapture may provide an incentive for thrift institutions to become State-chartered savings and loans rather than Federally-chartered banks, thus potentially frustrating Federal banking policy.

H.R. 2494 resolves this issue by forgiving, subject to certain restrictions, recapture with respect to that the portion of the bad debt reserve for which it is understood that deferred tax liabilities have not been recorded for financial accounting purposes. Such forgiveness raises certain tax policy concerns. In general, whenever a taxpayer changes from one method of accounting to another, such change is implemented by way of a section 481(a) adjustment that reflects the cumulative difference between the old and new accounting methods. This adjustment generally is restored to income over a specified period of time so that a taxpayer does not receive a "double deduction" with respect to an item of expense--once under the old method and again under the new method. Restoring the section 481(a) adjustment to income with respect to a repeal of a reserve method of accounting for bad debts ensures that the taxpayer does

not receive a double deduction with respect to the same expense--once when the reserve is established and again when the bad debt is actually realized. The opposite of implementing an accounting method change under section 481 of the Internal Revenue Code is the "fresh start" approach, wherein the taxpayer is allowed deductions under both its old and new methods of accounting with no adjustment to reconcile the two methods.

H.R. 2494 effectively allows "fresh start" with respect to the pre-1988 reserves of a thrift institution (subject to the sec. 593(e) limitation) and requires a section 481(a) adjustment with respect to the post-1987 additions to the reserves of the institution (subject to the residential loan requirement). Some would argue that allowing "fresh start" is appropriate with respect to bad debts computed under the percentage of taxable income method of section 593 because such method effectively acted as a permanent incentive for thrift institutions in the residential mortgage business. Conversely, others would argue that fresh start is not appropriate because the benefits of the percentage of taxable income method were never intended to be permanent benefits--pointing to the recapture potential under section 593(e) (relating to certain excess distributions to shareholders). Finally, a third argument could be made that it is appropriate to allow "fresh start" with respect to the pre-1988 portion of the reserve and require recapture for the post-1987 additions to the reserve because the change made by the 1986 Act establishing 1987 as a permanent base year changed the nature of the bad debt deductions of thrift institutions from one of permanency to one of timing.[6] Indeed, the 1986 Act change appears to be the

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[6] As discussed in Parts A. and B. above, the 1986 Act changed the base year balance to the reserve balance at the close of 1987 taxable year. Prior to the 1986 Act, the base year balance of a thrift institution was the reserve balance whenever the institution changed from one bad debt method to another (e.g., from the percentage of taxable income method to the experience method). How the establishment of 1987 as a permanent base year changed the nature of bad debt deductions between pre-1988 years to post-1987 years can be illustrated by the following example:

Assume that a thrift institution ("T") always used the percentage of taxable income ("PTI") method to deduct bad debts through 1986 when its reserve balance was $10,000. Further assume that in 1987, T: (1) has insufficient taxable income to use the PTI method, (2) has actual bad debt losses of $1,000, and (3) under the six-year average formula of the experience method, would be allowed a deduction of $900. Under pre-1986 Act law, T would be allowed a bad debt deduction of $1,000 (rather than $900) in 1987 because $1,000 is the amount necessary to restore the reserve to its base year (PTI) level. Specifically, in 1987, T would charge the year-end 1986 reserve of $10,000 for the $1,000 actual loss and then add (and deduct) $1,000 to the reserve so that the balance of the reserve at year end 1987 is once again $10,000. Thus, T's former PTI deductions, which gave rise to the $10,000 reserve balance, generally would not be restored to income under pre-1986 Act law (subject to sec. 593(e)).

Further assume that in 1988, T has sufficient taxable income to be allowed a PTI deduction of $1,500, increasing the balance of the reserve to $11,500 at year-end 1988. Further assume that in 1989, T: (1) again has insufficient taxable income to use the PTI method, (2) has

principal reason that accountants changed the treatment of accounting for income taxes with respect to bad debt deductions of thrift institutions for financial accounting purposes.

H.R. 2494 suspends the recapture of post-1987 additions to the bad debt reserve of a thrift institution so long as the institution continues to originate a certain level of loans secured by residential property. The residential loan requirement test is determined with respect to any loans secured by an interest in residential real or church property (including mobile homes not used on a transient basis). Such loans could include conforming and nonconforming[7] home purchase mortgages, home improvement loans, second trusts, mortgage refinancings and home equity loans. This provision raises and addresses certain tax and banking policy issues. The first issue is whether banking policy should be implemented through the Internal Revenue Code. The second issue is whether the residential loan requirement of the bill is appropriately tailored to meet the perceived banking policy goal of ensuring a source of mortgage financing. Specifically, (1) should this benefit be provided permanently or during a limited transition period; and (2) does the provision encompass the appropriate types of loans for the appropriate types of property?

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actual bad debts of $2,500, and (3) under the six-year average formula of the experience method would be allowed a deduction of $900. Pursuant to the change made by the 1986 Act, T would be allowed a deduction of $1,000 (i.e., the amount necessary to restore the reserve to its base year (year-end 1987) level.) Specifically, T would charge the year-end 1988 reserve balance of $11,500 for the $2,500 actual loss and then add (and deduct) $1,000 to the reserve to restore the balance to the $10,000 base year amount. Thus, T's post-1987 PTI deduction of $1,500 is restored to income under post-1986 Act law (i.e., T had actually losses of $2,500 in 1989, but only was allowed to deduct $1,000).

[7] A loan generally is "conforming" if it readily acceptable on a secondary market. A loan may be "nonconforming" if it exceeds a certain principal amount, provides for certain variable interest rates, is secured by both a personal residence and other (e.g., farm) property, or is made to an individual who fails to meet certain creditworthiness standards.

III. TAX TREATMENT OF SPECIAL ASSESSMENTS

A. Present Law and Background

Title II of H.R. 2491 would require thrift institutions to pay a special assessment to the Saving Association Insurance Fund ("SAIF"). The SAIF generally is the insurance fund for deposits in thrift institutions. The amount of the assessment would be the amount necessary to ensure that the SAIF has reserves of $1.25 for each $100 of insured deposits and the due date of the payment would be the first business day of January 1996. Effective January 1, 1998, the SAIF would be merged with the Bank Insurance Fund ("BIF") (the insurance fund for deposits in banks). Thrift institutions and banks also are required to pay annual premiums to the SAIF and BIF, respectively, based on the amount of their insured deposits. Currently, the premium rate for the SAIF deposits is substantially higher than the premium rate for BIF deposits. After the merger of the SAIF and BIF in 1998, under H.R. 2491, thrift institutions and banks would be subject to the same lower deposit insurance rates generally applicable to banks.

In general, a taxpayer is allowed to deduct ordinary and necessary expenses paid or incurred in carrying on a trade or business during the taxable year (sec. 162). However, amounts that give rise to a permanent improvement or betterment must be capitalized rather than deducted currently (sec. 263). Whether an expenditure is deductible under section 162 or must be capitalized under section 263 is often a matter of dispute between the IRS and taxpayers, and has been the subject of significant litigation. Most recently, in INDOPCO v. Commissioner, 503 U.S. 79 (1992), the U.S. Supreme Court noted that the capitalization of expenditures is the norm and that a current "income tax deduction is a matter of legislative grace and that the burden of clearly showing the right to the claimed deduction is on the taxpayer."[8] In INDOPCO, the Court distinguished its prior decision in Lincoln Savings v. Commissioner, 403 U.S. 345 (1971), (relating to additional premiums paid by a thrift institution to the Federal Savings and Loan Insurance Corporation) to hold that it is not necessary for an expenditure to give rise to the creation of a separate and distinct asset before such expenditure is capitalized. Rather, the Court held that "although the presence of an incidental future benefit may not warrant capitalization, a taxpayer's realization of benefits beyond the year in which the expenditure is incurred is important in determining whether the appropriate tax treatment is immediate deduction or capitalization." In INDOPCO, the Supreme Court found that the record supported the lower courts' findings that the investment banking fees in question produced significant benefits extending beyond the tax year in which they were incurred so as to warrant capitalization.

The scope of the INDOPCO decision and its application to the payments of the special assessments provided in H.R. 2491 is uncertain. On the one hand, if the special assessments are

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[8] INDOPCO, citing Interstate Transit Lines v. Comm., 319 U.S. 590, 593 (1943); Deputy v. DuPont, 308 U.S. 488, 493 (1940); and New Colonial Ice Co. v. Helvering, 292 U.S. 435, 440 (1934).

viewed as payments necessary to raise SAIF funding to a level appropriate for current needs,[9] a current deduction arguably would be allowable. If, on the other hand, the special assessments are viewed as current payments that will facilitate the future BIF/SAIF merger (such merger providing the assessed institutions with significant future benefits such as reduced deposit insurance rates), capitalization arguably would be required.[10]

B. Description of H.R. 2494

The bill would provide that the special assessment paid to the SAIF as required by H.R. 2491 would be deductible when paid.

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[9] See, e.g., the testimony of the Hon. John D. Hawke, Jr., Undersecretary of the Treasury for Domestic Finance on the SAIF, before the Subcommittee on Financial Institutions and Consumer Credit of the House Committee on Banking and Financial Services, August 2, 1995, calling for a special assessment at least partially to correct current SAIF weaknesses. The testimony did not discuss the proper Federal income tax accounting treatment for the assessment.

[10] See, e.g., Private Letter Rulings 9348003 (August 30, 1993) and 9402006 (September 24, 1994), where the IRS required capitalization of certain "exit and entry" fees paid by institutions on the transfer of insured deposits from the SAIF to the BIF. However, these rulings are not dispositive of the proper treatment of the special assessments required under H.R. 2491 because private letter rulings are only applicable to the taxpayers to whom issued and the facts underlying the rulings differ from the facts underlying the special assessments.

TESTIMONY OF
ROBERT K. SHERIDAN, PRESIDENT
SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS

BEFORE THE COMMITTEE ON WAYS AND MEANS
U. S. HOUSE OF REPRESENTATIVES
OCTOBER 26, 1995

ON

H.R. 2494
"THRIFT CHARTER CONVERSION ACT OF 1995"

Chairman Archer and Members of the Committee on Ways and Means, my name is Robert K. Sheridan and I am President of the Savings Bank Life Insurance Company of Massachusetts.

I am grateful for the opportunity to explain the relationship between the demutualization of savings bank life insurance (one product line of the very same institutions addressed by H.R.2494) mandated by Massachusetts law in 1990, and what you are here today to consider -- establishing certainty with regard to the Federal tax rules when demutualizing entire thrift institutions should Federal banking law mandate the conversion of mutual thrift institutions into commercial banks.

I am hopeful that the Committee will resolve favorably in this legislation, the question of how the Internal Revenue Code of 1986 should treat the additional policyholder dividends required to be paid by SBLI to individuals over twelve years due to the similar SBLI demutualization legislation enacted in 1990 by Massachusetts. The payment of the additional annual dividend based on the combined surplus should be legislatively clarified as deductible, reflective of earnings, mortality and expenses like any other dividend.

Due to the previous diligent work of Members of the Massachusetts delegation, I am able to provide the Committee with current revenue estimates from the Joint Committee on Taxation based on appropriate policy considerations and proposed legislative language known to the Committee and Administration.

ADDITIONAL BACKGROUND

The Savings Bank Life Insurance Company of Massachusetts (SBLI) provides low-cost life insurance consistent with absolute safety to the citizens of Massachusetts. Legislative language is being sought which would clarify the tax consequences of the consolidation of the SBLI into a stock life insurance company pursuant to state legislation. The issue comes down to whether or not an additional policyholder dividend that is to be paid over a twelve year period is treated the same as any other policyholder dividend as was the intention of the state legislation.

The sole reason there is any question is because of the unique nature of SBLI. In truth, it is unlike any other company in the country. Massachusetts SBLI was created by an act of the Massachusetts Legislature in 1907 as the brainchild of Justice Louis D. Brandeis. The enabling legislation represented one of the earliest efforts at progressive, consumer reform. Justice Brandeis felt that there was much waste in the prevailing system of selling life insurance, in response, he devised a plan whereby life insurance could be purchased at a cost much lower than that generally available. The vision for SBLI was a system of over the counter sales with reduced costs by eliminating sales commissions and other ancillary expenses. Justice Brandeis' selection of mutual savings banks can be traced to history as at that time savings banks were the banking institutions of low income and immigrant consumers. Experience has shown that the Brandeis experiment has even exceeded the

greatest of expectations. Consumer's Report made a study of insurance company costs in the United Sates and concluded that before any Massachusetts citizen purchases life insurance, they consider SBLI, noting that "Massachusetts Savings Bank Life Insurance in particular is a model for what all life insurance ought to be". Consumer's Report, in a three-part series on life insurance, consistently rated SBLI in the top tier of low cost, high quality life insurance companies, including number one in whole life coverage, and other categories. Many other consumer-oriented publications have similarly endorsed SBLI.

Presently, SBLI has over 500,000 policies and $12 billion in in-force insurance. While we have the full range of life insurance products our yearly renewal term insurance has grown in popularity and does represent about 80% of current issues. An example of our rates for a 30 year old non-smoker should show why the product is so popular -- $99 for $100,000; $180 for $250,000; and $315 for $500,000. This policy, as virtually all of our policies is participating, meaning that dividends can be expected at some point in time.

The deregulation of the banking industry posed a significant challenge to the prior SBLI system. During the 1980's, many savings banks converted to stock ownership which produced a natural conflict between a stock bank and a non-stock life insurance department. Moreover, as a stock entity, such banks were subject to acquisition and if a non-savings bank were involved, SBLI outlets would have diminished. Desirous of preserving and protecting SBLI for future generations of Massachusetts consumers and wanting to make available low-cost life insurance through a banking network, legislative and consumer leaders overhauled the SBLI governing statute in 1990.

The plan consolidated the fifty separate life insurance departments into a closely held stock company. All conceivable so-called home office functions, including the underwriting and servicing of policies and the investment of premiums, were transferred to the consolidated entity. Almost immediately, the efficiencies of consolidation manifested themselves as after the first year of operation in 1992, the restructured SBLI realized a 34.1% reduction in general insurance expenses. Further aspects of the plan included the repeal of artificially capped policy size limits and the creation of a public watchdog group whose mandate was to see that SBLI remained faithful to safe, low-cost life insurance.

In effecting consolidation, the SBLI banks received stock in the new company roughly in proportion to the size of the surplus in the life insurance department. The size of the stock distribution sought to equitably recognize the degree of subsidy and support that was provided by any host savings bank. To buttress the provision of low-cost insurance, an additional dividend was prescribed to be paid out to policyholders over a twelve-year period. This dividend roughly equated to the present value of 60% of the total combined surplus and constituted mounts made excess by operating one consolidated entity as opposed to fifty small life insurance departments.

The issue was raised as to whether such dividend is the same as the payout of surplus to policyholders for their ownership interest in a conventional demutualization. In a typical demutualization, policyholders receive a payment for their legal ownership interest as it is considered a redemption.

Unfortunately given the sui generis nature of SBLI, conversion models cannot be followed. If ownership is the controlling factor, then the normal attributes of ownership were not held by a SBLI policyholder: 1) there was no right to vote; 2) the right to participate to earning was qualified; and 3) there was no right to participate in the distribution of assets.

The prior regulatory body, the State Division of Savings Bank Life Insurance, and the Massachusetts Legislature carefully analyzed the status of policyholders and concluded that SBLI policyholders did not have an equity interest in the surplus of their life insurance department.

For the reasons cited above, the payment of the additional annual dividend based on the combined surplus should not be construed as payment for the redemption of any ownership interest, but rather represents a dividend payment as it would be reflective of earnings, mortality and expenses like any other dividend. Moreover, the legislation made clear that a policyholder must keep his policy in force so in the case of a lapse or surrender such individual would cease to be eligible for the dividend.

While it is crystal clear in our opinion that the additional dividend is the same as any other dividend pursuant to SBLI operations, our unique fact pattern did not permit Internal Revenue Service guidance through a private letter ruling. Among developments considered was the pending regular demutualization of the Equitable Life Assurance Society in New York so the IRS was disinclined to create any exceptions to standard practice, however meritorious the facts or arguments.

Legislative clarification was decided upon as the best route to give meaning to the intent of Massachusetts law.

The Joint Tax Committee has estimated a revenue loss of $25 million over five years if the additional dividend was legally found to be a non-deductible redemption of a propriety interest as opposed to a deductible repayment of a creditor interest. This estimate must be placed in perspective. In 1992, the federal government realized more than $5 million more in federal income taxes from SBLI since the small business deduction ended due to corporate reorganization. Ongoing, SBLI will pay more in federal income taxes as one large taxpayer in contrast to multiple smaller ones. This permanent revenue windfall to the federal government should more than mitigate the impact of clarifying the additional dividend. We understand that the Joint Tax Committee's methodology prevents taking into account any revenue enhancements. For purposes of revenue estimates, we do, however, understand that a revenue offset has been identified.

In summation, I believe that the amendment merely clarifies the state of the law and effectuates the intended meaning of the Massachusetts legislation. In so doing, the legitimate interests of SBLI policyholders and stockholders are acknowledged. It is crucial that this matter be resolved soon so we can continue to provide consumers with the most cost-efficient life insurance coverage. If the tax clarification is not made, SBLI will be subject to a tax inequity which would regrettably be passed on to the consumer. Accordingly, we urge approval of this important amendment.

I appreciate your consideration and attention.

FINANCIAL CONDITION OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

FEBRUARY 29, 1996

Serial 104–63

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FINANCIAL CONDITION OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

THURSDAY, FEBRUARY 29, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:12 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 21, 1996
No. FC-11

CONTACT: (202) 225-1721

Archer Announces Hearing on Financial Condition of Federal Hospital Insurance Trust Fund

-Report Shows Trust Fund Spending Exceeds Revenues-

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing to review the current financial condition of the Federal Hospital Insurance Trust Fund. **The hearing will take place on Thursday, February 29, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

The Committee will receive testimony from Federal Hospital Insurance Trust Fund Trustees and other Administration witnesses.

BACKGROUND:

The payroll taxes paid by working Americans and employers into the Federal Hospital Insurance Trust Fund (HI Trust Fund) pay for about 60 percent of the medical care for Medicare beneficiaries. The Hospital Insurance program (Medicare Part A) is obligated to cover the costs of inpatient hospital care and other related services for those Americans who are entitled to insurance coverage under Medicare Part A.

A recent story in the *New York Times* indicates that the HI Trust Fund is in financial imbalance. Beginning late in 1995, the HI Trust Fund has spent more in outlays than it received in income.

Currently, payroll taxes from about four workers cover the Medicare Part A costs on average for each beneficiary. This ratio worsens over time, and drops precipitously when the baby boomers become eligible for Medicare after the year 2010. It is noteworthy, however, that the current financial imbalance in the HI Trust Fund occurs prior to the eligibility of baby boomers and is occurring months earlier than had even been projected in the 1995 report of the Trustees of the HI Trust Fund.

"This new information on the HI Trust Fund is an early warning signal that cries out for immediate Congressional attention. I am very concerned about the manner in which this information was conveyed to the public and its implications for the future solvency of the Medicare program," Archer said.

FOCUS:

This hearing will focus on the manner in which the information concerning the Medicare shortfall was made available to the public and will review the financial status of the HI Trust Fund.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, March 14, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 300 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, at least one hour before the hearing begins.

(MORE)

WAYS AND MEANS COMMITTEE
PAGE TWO

FORMATTING REQUIREMENTS:

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

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

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

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

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

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

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman ARCHER. The Committee will come to order.

I am informed that the Secretaries do have a limited timeframe, which is understandable with all their duties, so unfortunately, the vote on the floor of the House has delayed some of our Members from returning, but it is my intention to proceed, and they will be able to participate as they arrive.

I am pleased to welcome two of the major members of the President's Cabinet before the Committee today, and Madam Secretary, Mr. Secretary, thank you both for taking the time to join us today.

We want to discuss the latest information concerning the financial condition of the Medicare Trust Fund. As you know, last April, Congress was informed by the Medicare Board of Trustees that the Trust Fund would be insolvent and unable to pay its bills in the year 2002. That, of course, was a best judgment projection based on the data available at that time. The Trustees also told us that Medicare would run surpluses through fiscal year 1997, at which time the Fund would then begin to spend more than it took in annually. But on February 5 of this year, the story appeared in the press stating that the condition of the Trust Fund was worse than expected. That story, which quoted Medicare's chief actuary, reported that the Trust Fund actually started losing money in fiscal year 1995, 2 years earlier than was projected at roughly this same time last year.

Considering the fact that a surplus was expected in 1995, I personally consider this unexpected shortfall to be an important milestone in the history of Medicare. Some might argue that it does not matter. Medicare, they say, was going broke anyway, so what difference do a couple of years make? But I personally believe that it makes a great difference.

Too often, the Congress and the White House are unable to reach agreements on important issues until the very last minute. For Medicare, if the last minute moves up in an unexpected way, we will lose the luxury of shoring up the program with relatively modest solutions. Every day the Trust Fund loses money, our options become more and more difficult. That has been confirmed by other witnesses before this Committee in the last year.

In fact, this week, we have learned that Medicare's financial condition is deteriorating faster than even this new information suggests. Chairman Thomas has received new data concerning the Trust Fund's balance for the first 4 months of this fiscal year, and it shows that Medicare appears to be in far worse shape than even last year.

Secretary Shalala, you are a Medicare Trustee, and Secretary Rubin, you are a Trustee, and you are Medicare's managing Trustee. As such, you enjoy a heightened responsibility to this Committee and to the public on all issues, but especially for this Committee's oversight responsibilities of the Trust Fund, your opinions and evaluations are extremely important to us.

The purpose of this hearing is to assess what this latest news means for the solvency of the Trust Fund. We are also here to discuss the manner in which the news of the shortfall was made available to the public. I am concerned that the news of the shortfall was buried at a time when key budget negotiations were under way. It was revealed in a sliver of a 45-page statement issued by

Secretary Rubin and the Office of Management and Budget Director Alice Rivlin on October 27.

This statement listing the entire receipts and outlays in great detail of every function of the Federal Government was mailed to congressional offices and to numerous government agencies. It was not, however, made public or made available to the press.

I personally believe this was an inadequate and inappropriate way to highlight a major milestone in Medicare. While I have no doubt that you can cite some technicians who were able to find this needle in a haystack, I do not think this manner of disclosure was sufficient to bring it to the attention of the public, to policymakers, or even to some of Medicare's own Trustees; and I suspect Secretary Rubin might possibly agree with that statement.

It should also be noted that the administrator of the Health Care Financing Administration did not become aware of this information until early December, more than 1 month after the release of the 45-page statistical printout. And my understanding is that Secretary Shalala did not become aware of it until mid-December.

When all is said and done, what does this new information mean? I conclude that we should continue our efforts to pass a bill that saves Medicare and do it this year. Chairman Thomas is working with a group of Democrats to develop a bipartisan bill that preserves, protects and strengthens Medicare. I hope he will be successful and that the Clinton administration will work with us to pass such a bill.

Separate and apart from this legislation, however, our Committee does have significant important oversight functions. These include reviewing the changing status of the Trust Fund and whether the Trustees adequately fulfilled their responsibilities and obligations as the leaders in whose hands the public puts that trust.

I am now happy to yield to the Ranking Minority Member, Mr. Gibbons, for a statement.

Mr. GIBBONS. Thank you, Mr. Chairman. I listened very closely to what you had to say, and this is not a time for us to bicker about the fact that we all missed the announcement that the Trust Fund was running out of money sooner than proposed. From what I know about the situation, our staffs were too busy, for good reason, to read all the detail of the reports that came to us and that come to us all the time. In fact, the press was too busy, everybody was too busy and just overlooked the situation. That is regrettable.

But that is water over the dam, and it is time for us to go forward. I think we as Democrats are willing to tell you and the other Members of this Committee and the public that we want to sit down with this Committee at the earliest possible date to try to work out the differences we have over Medicare. We want to save the program, and we do not want to pass any additional costs on to the beneficiaries. We believe there are ways in which the Part A Trust Fund can be saved, without any radical changes in it.

The President of the United States has put forward a program that would extend the program to the same extent, I believe, as far as your program would. There are many things in all of this that we can agree to and agree to rather readily, but I think all of us are going to have to be willing to do some working together to get

that done. We do not want to be faced with having to beat back radical changes.

You must remember, and I am sure you do, that last year, when all of this debate began, you proposed to take $270 billion out of the Medicare Program. We just do not believe that is desirable. We would be willing to take out $124 billion and do it very readily and very quickly and save the Trust Fund.

So I am not going to throw any stones. I want to work with you. We Democrats want to work with you, and as soon as you call a meeting, we will put our program on the table, and we will respectfully reexamine yours.

I think that is about all that needs to be said.

Mr. MATSUI. Will the Ranking Member, Mr. Gibbons——

Mr. RANGEL. Mr. Chairman.

Mr. GIBBONS. Yes, but just very briefly. Go ahead.

Mr. RANGEL. All I would like to say, Mr. Gibbons——

Chairman ARCHER. Mr. Gibbons, let me say, in deference to the Secretaries' time, if we start opening statements by every Member of the Committee, there will be no time for him to make his presentation and no time for questions.

Mr. RANGEL. I am terribly sorry. I do not want to say anything, Mr. Gibbons.

Mr. Chairman.

Chairman ARCHER. Without objection, each Member will have the right to enter his written statement into the record.

If the gentleman from Florida wishes to yield briefly to another Member on his side for less than 1 minute, then certainly, that will be accommodated.

Mr. GIBBONS. Well, Mr. Rangel is our Ranking Member.

Mr. RANGEL. Well, I do not want too much democracy to spread over this Committee with Members making statements here. As a matter of fact, I have changed my mind. I think we ought to get a special prosecutor to look into this matter. I think it is a coverup. This whole damned idea of a "sliver" means that there is more information, and I think we ought to proceed. I yield back. [Laughter.]

Mr. GIBBONS. Maybe we could get Mr. D'Amato to look at it. [Laughter.]

OK. Thank you, Bill. We appreciate it.

Chairman ARCHER. Secretary Rubin, welcome to the Committee, and we will be pleased to receive your testimony. If you can summarize it, that will be helpful. Your entire statement will, without objection, be printed in the record, but certainly you are free to spend as much time as you like.

You may proceed.

Secretary RUBIN. Mr. Chairman, thank you very much. It is traditional for the Secretaries to testify in order of precedence, but in light of the fact that this is a Medicare issue, and the leading member of the Cabinet with respect to Medicare is Secretary Shalala, our view was that Secretary Shalala would testify first, and I would testify second, if that is acceptable to you.

Chairman ARCHER. Of course.

You may proceed, Secretary Shalala. Welcome to the Committee. We are happy to receive your testimony.

STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary Shalala. Mr. Chairman, Congressman Gibbons, thank you for the invitation to join you today. I welcome the opportunity to discuss with you the status and the future of the Medicare Hospital Insurance Trust Fund.

Since the day he took office in 1993, the President has devoted himself to improving the availability and affordability of medical care in this country, especially for those who rely on Medicare—our senior citizens and those who are living with disabilities.

In his first year in office, the President's economic recovery program breathed new life into the Medicare Trust Fund, extending the fiscal solvency of the Part A Trust Fund by 3 full years for that critical program. And I would note that that legislation passed without a single Republican vote in either House of Congress.

Last year, and now this year, the President is again proposing measures to extend the fiscal solvency of the Part A Trust Fund. As part of his comprehensive plan to balance the Federal budget in 7 years, the President has proposed $124 billion in Medicare reforms that would extend the life of the Part A Trust Fund for more than a decade from now.

Throughout this process, the administration's policies on Medicare have been based on three basic principles: First, that Medicare should be a more prudent purchaser of health care services for the 37 million beneficiaries who depend on it. Second, senior citizens need greater choice of high-quality health plans that also preserve the important consumer and financial protections Medicare promises. And third, we must increase our effort to root out waste, fraud and abuse of the Medicare Program.

These are the elements that must form the basis of any agreement we reach to balance the Federal budget, and the good news is that those elements are on the table in both the President's plan and some of the proposals made by the majority party in Congress.

Our job is to come to an agreement on those elements while discarding proposals that would weaken the Trust Fund and endanger the physical and financial health of beneficiaries. For example, it is our firm belief that we should not dramatically increase out-of-pocket expenses for senior citizens when they are already spending 20 percent of their own limited income on medical expenses not covered by Medicare.

We also should not eliminate important limitations on balance billing that protect seniors against overcharging by providers.

We should not open the Medicare Program to untried and untested health care approaches, like medical savings accounts, which have been estimated to cost Medicare more than $4 billion rather than save Medicare money. And we should not weaken our efforts against fraud and abuse at a time when we have finally begun to win the battle against those who would abuse the system for their own financial gain.

As the President has said, the elements of a bipartisan agreement to balance the budget in 7 years are on the table. The question is whether we can come together and approve those elements this year. In light of the Trust Fund's short-term financing prob-

lems, we would urge that this be accomplished sooner rather than later.

We would also urge that we will be more likely to accomplish this if Republicans set aside their proposals that harm the Medicare Trust Fund and harm beneficiaries.

Now I would like to turn to the question of the current financial health of the Part A Trust Fund. Mr. Chairman, I am deeply concerned about recent allegations from Members of the majority party in this Congress of a breach of trust by this administration in its oversight of the Part A Trust Fund. Nothing could be further from the truth.

Far from a breach of trust, the administration has worked hard to protect Medicare and the Trust Fund as I have just outlined.

I want to take this opportunity to walk you through the process through which the administration and the Medicare Trustees' Report to Congress on the Trust Fund. I would like to submit for the record a copy of my February 12 letter to the Committee on this subject. By law, the Medicare Trustees submit their annual report on the status of the HI Trust Fund to Congress each spring. The law specifically requires the Trustees to report on the performance of the Trust Fund in the prior fiscal year.

In their report, the Trustees also make projections about future performance and solvency. The report is widely distributed to the Congress and to the public.

In addition to the statutory requirement to issue an annual report, other specific statutory requirements ensure that Congress will be notified if the outlook for the Part A Trust Fund is particularly critical.

For example, the law requires the Trustees to notify Congress if the Trust Fund's assets are expected to fall below 20 percent of 1 year's expenditures in the short term, which the Trustees have used to mean 10 years. The Trustees have sent this special notification, known as a "section 709 letter" along with their annual reports during each of the last 3 years.

The section 709 letter sent to congressional leaders in April 1995 indicated that the Trustees projected that the HI Trust Fund would be depleted in 2002.

In addition to the annual report, the administration prepares semiannual estimates of the financial operations of the HI Program as part of the President's budget process. Each year, the administration releases Medicare baseline projections as part of the President's budget proposal for the upcoming fiscal year. These estimates for fiscal year 1997 will be released next month as part of the President's fiscal year 1997 budget submission to Congress.

The Treasury Department, which serves as the official bookkeeper of government outlays and revenues, reports retrospectively on outlays from and revenues to the Part A Trust Fund. These reports show actual cash flows to and from the HI Trust Fund, in contrast to the projections in the Medicare Trustees' Report and the projections in the President's budget.

In October 1995, the Treasury Department reported on the Trust Fund income and outlays, together with the Fund's assets at the end of fiscal year 1995.

The Treasury reports are widely distributed to each Member of Congress, to the Congressional Budget Office, this Committee, the House and Senate Budget Committees, the Senate Finance Committee, and others on request.

The data provided in the Treasury reports are analyzed by a variety of public and private agencies and organizations. For example, in November of last year, the Congressional Budget Office reported on the Treasury data for fiscal year 1995 in a report entitled, "Analysis of the September Treasury Statement."

In addition, CBO used this data to update their Medicare baseline in December 1995, which reflects the higher growth on part A spending and the lower growth on part B spending.

Furthermore, the American Academy of Actuaries noted in its December 1995 report, "Comments and Recommendations on Medicare Reform," that the total expenditures exceeded income for the Hospital Insurance Trust Fund in 1995.

On February 12, 1996, in a bulletin released by the Senate Budget Committee, Chairman Domenici acknowledged having received the Treasury data in October and noted, "The recent changes in projections do not significantly affect the longrun Medicare situation."

I would now like to talk specifically about how one should interpret the information that is provided in the Trustees' Report.

The primary purpose of the Trustees' Report is to provide estimates of the future financial status of the Trust Fund for use by the Congress in making decisions about the Medicare Program. Because of the uncertainty inherent in projections, the future status of the Trust Fund is examined under three alternative sets of assumptions: "intermediate," "low cost" and "high cost." The intermediate set of assumptions represents the Trustees' best estimate of expected future economic and demographic trends—in employment, in wage increases, in health care prices, and utilization and other factors that will affect the financial status of the Trust Fund.

Each year, the Trustees' projections are updated, using the most recent available information on several factors, including inflation, wages, and utilization. One of those factors is actual experience in the past year.

For example, the Treasury report released in October provided actual cash revenues and outlays from the Part A Trust Fund for fiscal year 1995. This information on actual experience will be incorporated into future projections.

In summary, projections in the Trustees' Report are routinely updated to reflect actual experience and new economic data, but the projections themselves remain estimates of the future of the Medicare HI Trust Fund. Any given projection of Trust Fund status, by its very nature, cannot be expected to exactly mirror actual experience.

The Trustees construct our projections with the best and most recent information available and continually benchmark projections against actual results to obtain feedback on improving our methodology. Consequently, the Trustees' projections provided the most useful guides available to decisionmakers in addressing the issues of an uncertain future.

The 1995 Trustees' Report projected that under the intermediate assumptions, the HI Trust Fund would be depleted in 2002. This depletion date was 1 year later than was projected in the 1994 Report. The estimates under the "low cost" and "high cost" alternatives ranged from 2001 to 2006, and both of those numbers were included in our 1995 Trustees' Report. The Trustees estimated that HI Trust Fund income would exceed expenditures by $4.7 billion in fiscal year 1995; income would approximately equal expenditures in fiscal year 1996, and income would fall short of expenditures by approximately $5 billion in fiscal year 1997. However, as you know, actual expenditures exceeded revenues for fiscal year 1995 by $36 million.

The 1995 Trustees' projections were within a reasonable range of variation, as they have been over the past several years. Let me repeat that. The 1995 Trustees' projections were within a reasonable range of variation, as they have been over the past several years.

In each of the past 10 years, actual HI income has been within approximately 1.5 percent of projections in either direction. Actual HI expenditures exceeded projections in 6 of the last 10 years by amounts ranging from 0.4 percent in 1993 to 5.6 percent in 1992. Projections were higher than actual experience in 4 of the last 10 years, by amounts ranging up to 2 percent. This past year, in fiscal year 1995, total HI income was 1.2 percent less than projected, and expenditures were 3.1 percent greater than projected. Thus, the 1995 variation was within a normal range of variation.

Considering the complexity of the projections at stake, the Office of the Actuary has a very good track record with its estimates. By way of comparison, the Congressional Budget Office March 1995 baseline projections for HI were very comparable to the Trustees' Report projections and estimated a surplus in fiscal year 1995.

Moreover, a comparison of Trustees' Report and Congressional Budget Office projections of total Medicare spending, when the projections were made during the actual year in question, shows similar ranges of differences between projections and actual spending. Over the period 1987–95, the Trustees' Report overestimated same year spending four times and underestimated same year spending two times, and came within $1 billion twice; CBO overestimated spending three times, underestimated spending three times, and came within $1 billion on two occasions.

We fully recognize that you are very interested in having the most up-to-date projections of the HI Trust Fund depletion, and the Trustees will provide them to you as soon as they become available. Without the detailed analysis that these projections involve, it is too soon to draw firm conclusions about the extent to which the performance of the Trust Fund in fiscal year 1995, or any other factors, will affect the Trust Fund's estimated depletion date.

Despite the fact that these projections are not yet available, the HCFA actuaries have made an interim calculation based on incomplete information, suggesting that the projected Trust Fund depletion date would move back from 2002 to 2001.

However, this interim projection is preliminary and incomplete since it does not take into account any other changes in the data or assumptions that are currently being reviewed.

Finally, this projection is subject to change and the Trust Fund depletion date substantially delayed, if the Congress acts soon to adopt the constructive Medicare reforms that this administration has recommended.

In closing, let me again thank you for allowing me to appear before you today to set the record straight regarding the status of the HI Trust Fund. Although the status of the HI Trust Fund may be slightly worse than projected last year, the long-term outlook for Medicare has not changed and requires action. Without intervention, the Trust Fund will be exhausted within the next 5 years or so.

To meet this challenge, the President has submitted a 7-year balanced budget plan that ensures that the Trust Fund will remain solvent for more than a decade from now and provides us with an opportunity to tackle the longer term issues in a measured fashion.

We should move forward in a responsible bipartisan manner to enact these changes, as the Medicare Program requires and as the citizens we serve expect.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF DONNA E. SHALALA
SECRETARY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you for the opportunity to address the Committee on the performance of the Medicare Hospital Insurance Trust Fund in 1995. Since coming into office, the Clinton Administration has worked continually to address the problems affecting the Trust Fund, and we are hopeful that we can find common ground with this Committee and with the Congress this year on reforms to the Medicare program that will strengthen the Fund.

It should be remembered that it was the Clinton Administration and Congressional Democrats who argued successfully for the President's 1993 five-year deficit reduction package (OBRA '93) which extended the life of the Trust Fund by an additional three years by achieving realistic Medicare savings and by stimulating economic growth in the general economy.

The Administration has continued our commitment to controlling Medicare costs in the future. As part of his comprehensive plan to balance the Federal budget, the President has proposed $124 billion in specific policy changes designed to strengthen Medicare. The President's proposal extends the life of the HI Trust Fund for more than a decade from now.

To achieve these savings, the Administration's plan modifies Medicare payments in a number of ways. Our plan achieves substantial savings through provider payment changes that promote greater efficiency and make Medicare a more prudent purchaser and through increased efforts to combat waste, fraud and abuse. Importantly, it does so while maintaining and strengthening key protections for the beneficiaries Medicare serves.

The Administration plan represents a balanced approach -- one that protects traditional Medicare while expanding choice and preventive benefits. First, our proposal does not impose additional costs on beneficiaries; the plan maintains Part B premiums at 25% of program costs. Second, the plan maintains important protections for low-income Medicare beneficiaries. Third, the package expands the range of private plans available under Medicare without harming the traditional fee for service program, inviting dangerous risk selection, or shifting costs to beneficiaries. Finally, the Administration maintains critical prohibitions against "balance billing", which protects the programs 37 million beneficiaries from excessive charges from providers. I am hopeful that in the weeks ahead we can all focus our efforts on positive steps to enact such proposals.

I am concerned about recent allegations of a "breach of trust" by the Administration in its oversight of the HI Trust Fund. Far from a "breach of trust", the Administration has spent the past year focusing on the need to improve the Medicare program and uphold our commitment to current beneficiaries and future generations.

I would like to take this opportunity to clarify the process through which the Administration and the Trustees report to Congress on the Trust Fund, as I did in my letter to the Committee dated February 12, 1996, which is attached to this statement. The Administration has consistently made information about historical and projected performance of the HI Trust Fund available to Congress and the public. Section 1817 (b) of the Social Security Act requires the Medicare Trustees to submit their annual report on the status of the HI Trust Fund to Congress in the Spring. The law specifically requires the Trustees to report on the performance of the Trust Fund in the prior fiscal year. In their report, the Trustees also make projections about future performance and solvency. The report is widely distributed. Copies are provided to each Congressional office and to many others.

In addition to the statutory requirement to issue an annual report, other specific statutory requirements ensure that Congress will be notified if the outlook for the HI Trust Fund is particularly critical. For example, under section 709 of the Social Security Act, the Trustees are required to notify Congress if the Trust Fund assets are expected to fall below 20 percent of one year's expenditures in the short term, which the Trustees have used to mean 10 years. The Trustees have sent this special notification, known as a "section 709" letter, along with their annual reports during each of the last three years. The section 709 letter sent to Congressional leaders in April 1995 indicated that the Trustees projected the HI Trust Fund would be depleted in 2002.

In addition to the annual report, the Administration prepares estimates of the financial operations of the HI program semi-annually as part of the President's Budget process. Each year, the Administration releases Medicare baseline projections as part of the President's budget proposal for the upcoming fiscal year. These estimates for fiscal year 1997 will be released next month by the Office of Management and Budget as part of the President's fiscal year 1997 Budget Submission to the Congress.

The Treasury Department, which serves as the official "bookkeeper" of government outlays and revenues, reports retrospectively on outlays and revenues to the HI Trust Fund. These reports show actual cash flows to and from the HI Trust Fund, in contrast to the projections in the Medicare Trustees Report and the projections in the President's Budget. In October 1995, the Treasury Department reported on the HI Trust Fund income and outlays together with the Fund's assets at the end of fiscal year 1995. The Treasury reports are widely distributed to the Congressional Budget Office, House and Senate Budget Committees, this Committee, the Senate Finance Committee, each member of Congress, and others upon request.

The data provided in the Treasury reports are analyzed by a variety of public and private agencies and organizations. For example, in November of last year, the Congressional Budget Office reported on the Treasury data for fiscal year 1995 in a report entitled, "Analysis of the September Treasury Statement." In addition, CBO used the data to update their Medicare baseline in December 1995 which reflects the higher growth in Part A and lowers growth in Part B. Furthermore, the American Academy of Actuaries noted in its December 1995 report, "Comments and Recommendations on Medicare Reform" that the cost of benefits exceeded income for the Hospital Insurance Trust Fund in 1995. On February 12, 1996 in a bulletin released by the Senate Budget Committee, Chairman Domenici acknowledged having received the Treasury data in October, and noted that, "The recent changes in projections do not significantly affect the long-run Medicare situation."

I would now like to talk specifically about how one should interpret the information that is provided in the Trustees Report.

The primary purpose of the Trustees Report is to provide estimates of the future financial status of the Trust Fund for use by Congress in making decisions about the Medicare program. Because of the uncertainty inherent in projections, the future status of the Trust Fund is examined under three alternative sets of assumptions: "intermediate," "low cost" and "high cost." The intermediate set of assumptions represents the Trustees' best estimate of the expected future economic and demographic trends that will affect the financial status of the Trust Fund.

Health care expenditures tend to exhibit much more volatile rates of change than expenditures for many other private and social insurance programs. As the Trustees Report notes, projections are intended to illustrate how the HI program would operate under specified, reasonable assumptions concerning trends in employment, wage increases, health care prices, utilization, and other factors. Actual future Trust Fund operations will almost always differ somewhat from specific projections.

Each year the Trustees Report projections are updated using the most recent available information on several factors, including inflation, wages, and utilization. One of the factors is actual experience in the past year. For example, the Treasury report released in October provided actual cash revenues and outlays from the HI Trust Fund for fiscal year 1995; this information on actual experience will be incorporated in to future projections.

In summary, projections in the Trustees Report are routinely updated to reflect actual experience and new economic data, but the projections themselves remain estimates of the future of the Medicare HI Trust Fund. Any given projection of Trust Fund status, by its very nature, cannot be expected to exactly mirror actual experience. The Trustees construct our projections with the best and most recent information available, and continually benchmark projections against actual results to obtain feedback for improving our

methodology. Consequently, the Trustees' projections provide the most useful guides available to decisionmakers in addressing the issues of an uncertain future.

The 1995 Trustees Report projected that the HI Trust Fund would be depleted in 2002 under the intermediate assumptions. This depletion date was one year later than was projected in the 1994 Report. The estimates under the "low cost" and "high cost" alternative ranged from 2001 to 2006. The Trustees estimated that HI Trust Fund income would exceed expenditures by $4.7 billion in fiscal year 1995; income would approximately equal expenditures in fiscal year 1996; and income would fall short of expenditures by approximately $5 billion in fiscal year 1997. However, as you know, actual expenditures exceeded revenues for fiscal year 1995 by $36 million.

The 1995 Trustees projections were within a reasonable range of variation, as they have been over the past several years. In each of the past ten years, actual HI income has been within approximately 1.5 percent of projections in either direction. Actual HI expenditures exceeded projections in six of the last ten years, by amounts ranging from 0.4 percent in 1993 to 5.6 percent in 1992. Projections were higher than actual experience in four of the last ten years, by amounts ranging up to 2 percent. This past year, in fiscal year 1995, total HI income was 1.2 percent less than projected and expenditures were 3.1 percent greater than projected. Thus, the 1995 variation was within a normal range of variation.

Considering the complexity of the projections at stake, the Office of the Actuary has a pretty good track record with its estimates. By way of comparison, the Congressional Budget Office's March 1995 baseline projections for HI were very comparable to the Trustees Report projections, and estimated a surplus in fiscal year 1995. Moreover, a comparison of Trustee Report and Congressional Budget Office projections of total Medicare spending, when the projections were made during the actual year in question, shows similar ranges of differences between projections and actual spending. Over the period 1987 to 1994, the Trustee Report overestimated same year spending four times, underestimated same year spending two times, and came within a billion dollars twice; CBO overestimated spending three times, underestimated spending three times and came within a billion on two occasions.

I know that you are very interested in having the most up-to-date projections of HI Trust Fund depletion, and the Trustees will provide them as soon as they become available. As I described earlier, the performance of the Trust Fund in fiscal year 1995 is just one of the factors upon which the HCFA actuaries base their projection of the Fund's performance over the longer term. The HCFA actuaries are in the process of completing the analyses they need to make these projections. Their projections will be included in the 1996 Trustees Report.

Without the detailed analysis that these projections involve, it is too soon to draw firm conclusions about the extent to which the performance of the Trust Fund in fiscal year 1995, or how the many other factors that affect the Fund, will affect the Trust Fund's estimated depletion date. Despite the fact that these projections are not yet available, the HCFA actuaries have provided the following interim calculation; using the (no longer current) assumptions from the 1995 intermediate Trustees Report estimate, but reflecting actual Fund operations in fiscal year 1995. Based on this incomplete information, the projected depletion date would move back from 2002, as projected in 1995, to 2001, as we projected in our 1994 Trustees Report. However, this projection is preliminary and incomplete since it does not take into account any other changes in the data or assumptions that are currently being reviewed. Finally, this projection is subject to change -- at a substantially lengthened time frame -- if the Congress acts soon to adopt the constructive Medicare reforms that this Administration has recommended.

In closing, I appreciate the opportunity to appear before you today to set the record straight regarding the status of the HI Trust Fund. Although the status of the HI Trust Fund may be slightly worse than projected last year, the long term outlook for Medicare has not changed. Without intervention, the Trust Fund will be exhausted within the next five years or so. To meet this challenge, the President has submitted a balanced budget proposal that insures the Trust Fund will remain solvent for more than a decade from now, and provides us with an opportunity to tackle the longer term issues in a measured fashion. We must move forward in a responsible, bipartisan manner to enact the President's Balanced Budget proposal as the Medicare program requires and as the citizens we serve expect.

APPENDIX A

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 12 1996

The Honorable Bill Archer
Chairman
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515-6348

Dear Mr. Chairman:

Thank you for your letter of February 5, 1996, regarding the status of the Hospital Insurance (HI) Trust Fund. As you know, the Clinton Administration has always been and remains committed to the fiscal integrity of the Medicare trust funds and to the health security of all our elderly. For this reason, I welcome the opportunity to set the record straight.

Your letter states that the HI Trust Fund "went broke" in 1995. This is simply not true. Far from being "broke", the Trust Fund's balance at the end of fiscal year 1995 was over $129,000,000,000 – sufficient under current law to carry the Fund past the end of the decade. During fiscal year 1995, expenditures from the Fund ($114.*883* billion) slightly exceeded total income ($114.*847* billion). The resulting $36 million deficit reduced the Fund's net assets from $129.*555* billion at the beginning of fiscal year 1995 to $129.*520* billion at the end of the year.

Almost a year ago in the 1995 HI Trustees Report, I and the other HI Trust Fund trustees pointed out that, without further action, the HI Fund would be depleted early in the next decade. Based upon the intermediate projections prepared by the HCFA actuary at that time, depletion was estimated to occur in the year 2002 (a slight change from the previous year's estimate of 2001). The Administration responded last summer by proposing a series of measures to extend the Fund. We have proposed additional steps in the President's budget for fiscal year 1997. Taken together, these proposals should extend the HI Fund for more than a decade from now.

As you know, each year the HCFA actuary and the Trustees develop projections of the future status of the Trust Fund. These projections cover a period of 75 years into the future. To reflect the uncertainty inherent in projection, the future of the Trust Fund is examined under three alternative sets of assumptions: "intermediate," "low cost," and "high cost". The intermediate set of assumptions represents the Trustees' best estimate of the expected future economic and demographic trends that will affect the financial status of the program. Estimates of future health care expenditures are inherently less certain than estimates for many other Federal programs because so many factors affect expenditures: changes in the number of beneficiaries, changes in the age and health status of beneficiaries, trends in health care inflation, increasing use of new technologies, and changes in the use of health services, among other factors.

Based on the intermediate set of assumptions, the 1995 Trustees Report published last April estimated a fund exhaustion date of 2002. The individual estimates for the next several years were as follows: (1) HI Trust Fund income would exceed expenditures by $4.7 billion in fiscal year 1995; (2) income would approximately equal expenditures in fiscal year 1996; and (3) income would fall short of expenditures by approximately $5 billion in fiscal year 1997.

The Congressional Budget Office also estimates the future operations of the Trust Fund. The Congressional Budget Office estimates were very similar to the intermediate Trustees Report estimates, and also projected a fiscal year 1995 surplus. For comparison purposes, the Congressional Budget Office estimates for fiscal year 1995 are shown below together with the intermediate estimates from the 1995 Trustees Report (amounts in billions).

	1995 Trustees Report	CBO March 1995 baseline	Actual
Income	$116.2	$116.6	$114.8
Expenditures	111.5	113.6	114.9
Net change in assets	4.7	3.0	-0.036
Assets at end of year	134.3	131.7	129.5

Actual expenditures in the Trust Fund were 3.1 percent higher and income was 1.2 percent lower than estimated by the HCFA actuaries. Such differences are within the range of normal variation.

In your letter, you asked when the Administration became aware of the performance of the Trust Fund in fiscal year 1995, and why the Adminstration did not make this information public until February 5th. The Adminstration became aware of the Fund's performance, and reported these results, more than three months ago.

Each month, the Treasury Department issues public reports that track cash income and outlays and the balance of the Trust Fund. Information on the HI Trust Fund income and outlays together with the Fund's invested assets at the end of fiscal year 1995 was reported in the "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government". This information was released publicly by the Treasury Department on October 27, 1995.

The Treasury Department and the Office of Management and Budget distributed nearly four thousand copies of the October report to the public, including individual copies for every Member of Congress, with extra copies to the House and Senate Budget, Appropriations and Banking Committees, the Senate Finance Committee, the Congressional Budget Office, and to your Committee.

Furthermore, we know that interested parties read these reports. The American Academy of Actuaries noted the HI Fund's 1995 results in its "Comments and Recommendations on Medicare Reform" on December 21, 1995. Medicare outlays were also reported on by the Congressional Budget Office ("Analysis of the September Treasury Statement," November 7, 1995.)

In late November, the HCFA actuaries received more detailed information on the components of the income, outlays and Fund balance from the Treasury Department based on this report. The actuaries informed HCFA Administrator Bruce Vladeck of the Trust Fund's status on December 2, 1995. The Administrator subsequently briefed me on these findings in a meeting on December 9, 1995. The Administrator, as Secretary to the Board of Trustees, provided an interim report on the Trust Fund's performance for fiscal year 1995 at the Trustees' regular meeting on December 13, 1995.

Your letter also asked for the latest projections for the Trust Fund. The projections you described in your letter are made annually by the HCFA actuaries and included in the annual Trustees Report. It is important to note that the performance of the Trust Fund in fiscal year 1995 is just one of many factors upon which the HCFA actuaries base their projection of the Fund's performance over the longer term, and its projected depletion date. In making these projections, the HCFA actuaries not only analyze data concerning the actual experience in 1995, but also the additional experience in the current fiscal year, new analyses of the factors affecting HI benefit growth during fiscal years 1990-1995, updated projections of HI payroll tax income and revenue from the taxation of OASDI benefits and current interest rate expectations.

They are currently engaged in this very activity, and their projections will be included in the 1996 Trustees Report, as they are each year. Although the report is typically issued in April, the HCFA actuaries have informed me that this year's report may be delayed by about six weeks because of the government furlough and snow storms. We will of course make it available to your Committee, all Members of Congress, and the public as soon as it is completed.

Without the detailed analysis that these projections involve, it is too soon to draw firm conclusions about the extent to which the performance of the Trust Fund in fiscal year 1995, or the many other factors that affect the Fund, will affect the Trust Fund's estimated depletion date. Despite the fact that these projections are not yet available, the HCFA actuaries provided the following calculation: using the (no longer current) assumptions from the 1995 intermediate Trustees Report estimate, and reflecting only the actual Fund operations in fiscal year 1995, they calculate that under those outdated assumptions the projected depletion date would move back from 2002, as estimated in 1995, to 2001, as estimated in 1994. This estimate does not take into account changes in any of the many other data and assumptions that are being reviewed, including such obviously important factors as economic performance, current interest rate expectations, health care costs, HI payroll tax income and revenue from the taxation of OASDI benefits.

In closing, let me emphasize that the most important issue is for the Congress, working with the Administration, to take the steps necessary to strengthen the Medicare trust funds. One year's results will not change the need to strengthen the HI Trust Fund. As you know, the President's 1993 Economic Plan added three years to the life of the Fund. The President, in his seven-year balanced budget plan, has proposed additional measures. The Congress, too, has made proposals in this area. I am hopeful that, working together, we can agree upon necessary changes to the Medicare program, which is so essential to the security of all Americans.

A similar letter is being sent to the co-signers of your letter.

Sincerely,

Donna E. Shalala

cc: The Honorable Sam M. Gibbons

APPENDIX B

Budget Bulletin

Pete V. Domenici - Chairman
G. William Hoagland - Staff Director
611 Senate Dirksen Building • 202/224-4615

A Weekly Bulletin produced when the Senate is in session by the Senate Budget Committee - Majority Staff

104th Congress, 2nd Session: No. 5 — February 12, 1996

INFORMED BUDGETEER

AGRICULTURE'S CONTRIBUTION TO BALANCE?

- The Senate passed the Farm Bill (S.1541) on February 7, 1996, by a vote of 64 to 32. The SBC majority *staff estimates* that the bill, as amended, will cost $0.1 billion over 7 years from the December 1995 baseline. The Balanced Budget Act of 1995 reduced farm spending by $4.6 billion over 7 years.

BUDGETARY IMPACT OF AGRICULTURE LEGISLATION ($ in Billions)	
Balanced Budget Act of 1995	-4.6
Farm Bill (S. 1541)*	0.1
Amount of Lost Savings	4.7

*Preliminary SBC majority staff estimates

THE BUDGET DIDN'T STAY BALANCED FOR LONG

- President Clinton's January 6th budget achieved a surplus of $1 billion in 2002 according to CBO. The budget outline that President Clinton issued on February 5th is different from the January budget proposed. While the President's February outline claims to achieve a surplus of $3.7 billion in 2002, if scored by CBO it will show a deficit of $9 billion instead.

- Table 1 (page 15) of the President's budget outline is the most important piece of evidence *underlying* the President's claim of a surplus. The table—entitled "The President's Budget Proposals Under CBO Assumptions"— says it uses CBO December economic and technical assumptions. Except when it doesn't. The President uses box text and footnotes to muddy the waters and depart from CBO's numbers— once again.

- The first line of the table purports to show CBO's December estimate of the baseline deficit. The line, however, has a footnote that "OMB has adjusted CBO's December baseline to... reflect the pending Supreme Court review of a lower court decision on accounting for 'goodwill'." In effect, the President pretends to use the CBO baseline and estimates, as the Congress has insisted and as he seemingly agreed to, but now changes the baseline or ignores the estimate when it suits his purposes.

- Let's look at this change to the CBO baseline, as well as a change to CBO's estimate of a proposal on spectrum, which make the President's job of eliminating the deficit $18.5 billion easier in 2002 and $26 billion easier over seven years.

"Goodwill" Turns into Ill Will

- The September 11, 1995, *Bulletin* related how a federal appeals court decided (vote of 9-2) that a 1989 federal law broke a contract between a savings and loan institution and a federal regulator/deposit insurance agency, which could wind up costing the federal government from $10 billion to $20 billion. (The federal agency had encouraged the S&L to buy other failed S&Ls with the promise that the buyer could employ favorable accounting treatment of "supervisory goodwill"; the subsequent 1989 law reversed that agreement, costing the S&L millions.)

- The Supreme Court just recently agreed to review this case, with arguments expected in April, and a decision by the end of the term in June. Given the lopsided nature of the appeals court's decision, CBO, in developing its December baseline, had to consider the possibility that the Supreme Court would uphold the decision and some payments would be made from the Treasury.

- If CBO estimated that zero payments would be made (which is OMB's position, as it assumes the federal government will win its appeal at the Supreme Court), it would be, in effect, predicting the outcome of the case: the Supreme Court overturns. On the other hand, if CBO estimated that $20 billion would be paid out of the Treasury, it would be predicting that the federal government would lose and would have to pay the maximum amounts that have been claimed as damages. In its December baseline, CBO did not predict the outcome of the case, but rather selected an approximately middle estimate of $9 billion in payments spread evenly over 1997-2002 to minimize the magnitude of error, whatever the outcome at the Supreme Court and any subsequent awards or settlements for damages.

- The Administration, after finally agreeing to using CBO assumptions in determining if a budget plan gets to balance in 2002, promptly reneged on that understanding by taking the $9 billion out of the CBO baseline shown in their budget.

OMB to CBO: Forget I Even Asked About Spectrum

- Even as the President attempts to cloak his budget with the mantle of CBO scoring, his picking and choosing among individual CBO estimates makes the fit more like the emperor's new clothes. Again on page 15 of the budget the President claims to use "(1) CBO estimates of proposals where available and (2) OMB estimates based on CBO's December baseline where specific CBO estimates are not available." The most clever but obvious example of this is the "Other mandatory" line of table 1 where savings of $8.1 billion in 2001 magically escalate to $26 billion in 2002. What accounts for this?

- In 2002, the President assumes he will auction spectrum that will be returned by television broadcasters (in 2005), and that if the auction does not generate $17 billion, then broadcasters will be charged a fee on their remaining spectrum to make up the difference between the auction proceeds and the target of $17 billion. CBO estimates an auction of returned spectrum would yield $6 billion. OMB could not get CBO to estimate its scheme would ever realistically produce $17 billion in 2002, but did not want to use the CBO estimate of $6 billion. So OMB disregarded the CBO estimate, claiming it was unavailable and using its own estimate instead.

- Combining this convenient omission of the CBO estimate (worth $11 billion in 2002) with the beneficial scorekeeping adjustments above produces a $13.6 billion difference from CBO. That means that if all CBO numbers were used for these items alone, the President's budget, rather than being in surplus, would have a $9 billion deficit in 2002.

TRUST FUNDS 101: C, CONSPIRACY 101: F

- A recent New York Times article indicated that Medicare Hospital Insurance (HI) expenditures for fiscal year 1995 were $3.4 billion higher than the Trustees projected in their report last April. HI trust fund revenues were $1.3 billion less than projected. These two errors resulted in a $36 million trust fund deficit last year, rather than a projected $4.7 billion surplus.

- Budget analysts often examine expenditures on a cash-flow basis. The HI trust fund first ran a cash flow deficit in FY 1992. The trust fund "surpluses" over the past two fiscal years have been cash flow deficits, offset by general revenue payments labeled as interest on HI trust fund assets.

HOSPITAL INSURANCE TRUST FUND, FY 1995 PROJECTIONS VS. REALITY ($ in Billions)			
	Projected	Actual	Difference
Including Interest			
Trust Fund income	116.184	114.847	-1.337
Outlays	111.481	114.883	3.402
Surplus	4.703	-0.036	-4.739
Excluding Interest			
Trust Fund cash income	104.979	103.619	-1.360
Outlays	111.481	114.883	3.402
Cash flow Surplus	-6.503	-11.264	-4.762

- There are three definitions of a trust fund "going broke": running a trust fund deficit; running a cash flow deficit; and depletion of the trust fund's assets.

- The New York Times article points out that the first occurred last year, which the Trustees projected would first happen in FY 1997. The second happened in FY 1993. The third will happen in FY 2001 or 2002. Recent political attention has focused on this last definition.

- A recent letter to Secretary Shalala said that the authors were "very concerned that officials of the Administration involved in the negotiations over the legislation to save Medicare may have known about the early deficit spending during those negotiations and chose to withhold that information from the public."

- But the information in the New York Times first became available last October, in the Monthly Treasury Statement (MTS) summarizing outlays for FY 1995. This new data was incorporated by CBO into their revised December baseline. It was partially offset by Medicare part B expenditures which came in lower than projected.

- Readers should note the following for the next Medicare quiz:

1. The recent changes in projections do not significantly affect the long-run Medicare situation.

2. The net effect of this data is (slightly) good for Medicare. CBO accounted for this new data in its revised December baseline. The downward revisions in projected part B (Supplemental Medical Insurance) spending more than offset the higher part A (Hospital Insurance) spending. CBO's projections for total Medicare spending came *down* in December.

3. The growth rate of total Medicare spending is a more important measure of Medicare's fiscal health than the solvency of a "trust fund" for only part of Medicare. Insolvency is an indicator of an underlying problem; it is not the problem itself.

4. None of the plans proposed over the past thirteen months have slowed Medicare spending enough to produce a program that is sustainable in the long run. The latest Republican and Presidential offers are *worse* for the long-run sustainability of Medicare than the Balanced Budget Act of 1995, since they slow the growth rate less than does the BBA. They are, of course, more politically palatable in the short run.

IMPROVED CHILD SUPPORT COLLECTIONS?

- The Bulletin continues its look at the state run, federally sponsored Child Support Enforcement system.

- The Administration released its annual report to Congress on Child Support Enforcement for Fiscal Year 1994. The report proclaims that "since the Clinton Administration took office, our partnership with states has brought about unprecedented increases in support for children." The study highlights an increase in the number of cases with a collection and an increase in the total amount of collections.

- What is this "unprecedented" improvement? The data behind the introductory paragraphs shows an increase in collection rate from 18.2% of the total caseload to 18.3% of the caseload, or stated differently, now only 81.7% of children do not receive any payment at all.

- More disturbing is that while the caseload increased by 8.7%, the building blocks for future child support collections, have not kept pace with the caseload increase.

- Paternity establishment, which is needed before establishing an order, increased only 6.5%. Support order establishment, which is necessary before receiving a payment, *decreased* 0.2%. In cases where a state has already established an order, the payment rate decreased 0.3%.

- To establish paternity and support orders in the first place, states must locate absent parents. The number of parents located dropped 9.8% in 1994.

- Despite these dubious achievements, states continue to return more to their state treasuries than they pay out for child support enforcement. State "profits" increased in FY 1994 by over $20 million. Incentive payments for good performance increased over $10 million. At the same time the federal share of expenditures increased $235 million. Enforcing child support orders now costs taxpayers overall close to $1 billion.

- Pointing out the costs of child support should not be construed to suggest that costs are bad. Beyond offsetting AFDC payments, there is the intangible amount of "cost avoidance" from mothers never going on welfare because of child support payments. There are societal returns from absent parents being involved in the lives of their children. In fact increased costs are expected as states move beyond simply enforcing the easy cases.

- The welfare reform bill, vetoed by the President, contained major consensus reforms giving states needed tools to improve collections. Included in this legislation is an overhaul of the current financing system that enables states to maximize returns to the state treasury or "profits" at the expense of improving collection rates.

- The new financing system, for the first time, focuses incentive payments on states with good performance. For example, states that make collections on 7% of their cases will no longer qualify for incentive payments.

- Of course, good performance is still relative. Even the "best" performing states, like Wisconsin and Washington, have collection to caseload rates of well under 40%. Wisconsin which has the highest collection rate of any state in 1994, made a collection on less than 37% of its caseload. This means that 63% of children -- and their custodial parents who are often struggling to get off or stay off welfare -- did not receive support from the absent parent. (Note -- A collection does not necessarily mean regular payment, only that some time during the year a payment was made. Statistics on child support show that roughly half of the payments were made in full and on time.)

- Finally, given the dismal state performance, one might expect that the Administration's audits would find most states out of compliance. However, about half the states passed the audit and only two states were penalized for continued deficiencies.

CALENDAR

February 14, 1996: *Economic Report of the President*, released.

February 22, 1995: Senate Finance Committee hearing on recent Governor's welfare and Medicaid proposals (tentative).

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Washington, D.C. 20510-6100
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U.S.S

Chairman ARCHER. Thank you, Madam Secretary.

Secretary Rubin, we would be pleased to receive your testimony now.

STATEMENT OF HON. ROBERT E. RUBIN, SECRETARY, U.S. DEPARTMENT OF THE TREASURY

Secretary RUBIN. Thank you, Mr. Chairman.

Thank you for having us here today to discuss a subject that is of enormous importance to the country—Medicare, and particularly the Medicare Part A Trust Fund. My testimony is brief, but let me summarize if I may the most important points.

First, the Trustees regularly report the financial status of the Medicare Funds in conformity with law and precedent. The Trustees during this administration have never deviated from the practices of previous administrations in making these disclosures—not once, not for any reason.

Second, following our established procedures, the Board annually reports the current and projected financial status of the Funds to the Congress as we did last April. In addition, the Treasury Department reports monthly on receipts and outlays in the Fund and issued its fiscal 1995 yearend report last October 27. That report, Mr. Chairman, which I hold in my hand, was a public document—in fact, this is a press release that says "Embargoed for Release at 2 p.m. EDT," so it was publicly available—and it has highlighted in it on the initial summary certain of the information with respect to Medicare.

These reports are provided to every Member of this Committee and to the public, and every member of the negotiating team on both sides, with respect to both parties, had received copies of this report. Indeed, as Secretary Shalala mentioned, the Congressional Budget Office and the American Academy of Actuaries analyzed the yearend report and in turn made their findings public within 2 months of issuance.

Third, each year, the actual results differ slightly from the forecasts. As Senator Domenici and the Senate Budget Committee staff have pointed out, neither the administration nor the Congress looked at these fluctuations as significant in the Medicare debate. Whether they improve or regress does not affect in any way whatsoever the need to extend the life of the Medicare Trust Fund. And while we disagree on policy, Mr. Chairman, as Secretary Shalala said, our shared concern must be how we can extend the life of the Fund to maintain the viability and vigor of the Medicare Program.

These are the facts. In our April 1995 Trustees' Report, we concluded that, using intermediate assumptions, the HI Trust Fund would be depleted in 2002—a 1-year change from the 2001 estimated in the 1994 report.

We asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then to make long-term changes in the system to accommodate the influx of the baby boomer generation. The first baby boomers will reach age 65 in the year 2010. We felt that this would provide adequate time for responsible, bipartisan, long-term solutions to the financing problem.

Last June, the administration put forth a proposal that the Health Care Financing Administration Chief Actuary certified

would extend the life of the HI Trust Fund through 2006. This initiative was consistent with actions by prior Congresses in affording us more than sufficient time to propose a bipartisan solution to the long-term problems of Medicare. Such a bipartisan solution will be needed for the long-term health of Medicare regardless of which plan is finally adopted.

Additionally, during the budget negotiations last December, the President, as Secretary Shalala said, laid down a proposal that would have extended the Trust Fund for at least another decade from now.

Last October 27, the final fiscal year 1995 numbers were published, which showed that Trust Fund income was 1.2 percent less than projected, and expenditures were 3.1 percent greater than projected. This is consistent with normal fluctuations and variances from prior forecasts.

The key is that last year's information does not change whatsoever the fundamental need, as we expressed in the report to Congress last April, to reform Medicare, to ensure the near- and long-term solvency of the HI Trust Fund. And it is exactly that observation that Senator Domenici's report also made, the report issued, I believe, on February 12. The report said that the results of 1995 in no way whatsoever alter the fundamental situation, which is that the Medicare Trust Fund needs to be reformed to provide for both near-term and long-term solvency.

Mr. Chairman, let me conclude by saying that one of the great accomplishments of government over the last 30 years is that we have in very large measure conquered poverty among senior citizens, although there is certainly still additional work to do. We did that by having strong and effective programs in Social Security, Medicare, and Medicaid. Medicare has effectively provided a reliable source of medical care coverage for aged and disabled Americans.

There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly. That is why the administration and the Congress must strive to work together to energetically address the solvency problem of this great program so that it can continue providing the services on which 37 million of our elderly and disabled depend.

I hope, Mr. Chairman, that this hearing will contribute to addressing those issues and to providing for the near- and long-term health of Medicare.

Thank you very much.

Chairman ARCHER. Thank you, Mr. Secretary. We do have a major responsibility, to the senior citizens of this country and to generations to come who will become senior citizens, for this very vital program, and we all agree on that.

The Board of Trustees is set up under the law with a very special responsibility, a front line responsibility, a responsibility of significant trust; that is why it is called "Trustees." And as a result of that law which creates this board, the members of that board are of course charged with this significant additional responsibility in advising Congress and advising us as quickly as possible so that we will be aware of what is going on.

And Secretary Shalala, you are one of those Medicare Trustees, and I am curious as to when you first learned about Medicare's early financial shortfall.

Secretary SHALALA. As I reported to you in my letter, it was in early December, in preparation for the midyear Trustee meeting.

Chairman ARCHER. So the first you knew about it was when you were given a memo from Sandra Bart, your policy coordinator, on December 11?

Secretary SHALALA. Yes.

Chairman ARCHER. OK.

Secretary SHALALA. And a meeting followed that memo. That was a memo in preparation for a briefing meeting with me by my senior staff.

Chairman ARCHER. So you personally did not learn of it from this October 27 release that you have raised.

Secretary SHALALA. I did not.

Chairman ARCHER. And you are a Trustee.

Secretary SHALALA. I am a Trustee, and I did not learn it from the October Treasury Department report but instead learned about it at the December midterm meeting when we would normally receive an analysis on the condition of the HI Trust Fund from our senior officials.

Chairman ARCHER. I do not want to bore in on this, but I am very curious because you and Secretary Rubin both have held up an October 27 release and said everybody should know about it because of that, but as a Trustee, you did not know about it until December 11.

Secretary SHALALA. That is correct.

Chairman ARCHER. Did you at that time inform Alice Rivlin about the shortfall?

Secretary SHALALA. I did not.

Chairman ARCHER. Did you inform Leon Panetta?

Secretary SHALALA. I did not.

Chairman ARCHER. Did you or anyone else to your knowledge inform the President about it?

Secretary SHALALA. I did not inform the President about it.

Chairman ARCHER. And to your knowledge, nobody else did?

Secretary SHALALA. Not to my knowledge.

Chairman ARCHER. OK. Why not?

Secretary SHALALA. For several reasons—because when I was informed the numbers were within the normal range of variations for these projections, because the Congressional Budget Office and all the appropriate fiscal offices that take these numbers and adjust baselines were informed and had discussion on these numbers, and because they were preliminary projections. The Trust Fund was solvent at the end of 1995 because there was $129 billion in that Trust Fund. And all of us read these numbers the same way that Senator Domenici did, and that is that there was still urgency, that we still needed to move ahead with the Medicare changes that all of us were working on.

Chairman ARCHER. Of course, but what we are talking about here is actual changes in spending, not projections. And in the memo that you have given us from Sandra Bart, it says here that

the date of default or the date of exhaustion of the HI Trust Fund would now have to be moved up to the year 2001 instead of 2002.

It seems to me that that is a very important and significant item that would be very much a part of the budget negotiations and determining what would occur. After all, the only time that the HI Trust Fund has gone negative in all of its history was once, in 1972.

This truly was a historic moment and I would think of some serious import.

Secretary SHALALA. Excuse me, Mr. Chairman. The HI Trust Fund was not going negative. There was $129 billion in the HI Trust Fund.

Chairman ARCHER. Well, the whole——

Secretary SHALALA. The HI Trust Fund had balances.

Chairman ARCHER. Well, yes, but——

Secretary SHALALA. What we are talking about is a crossover—obviously, between revenues.

Chairman ARCHER. But what we are discussing, Madam Secretary, today is the fact that it took in less money in 1995——

Secretary SHALALA. That is correct, but that does not mean——

Chairman ARCHER [continuing]. Than it paid out in spending. And that had only happened one time before, and that was in 1972.

Secretary SHALALA. Let me make two points here. First, that did not mean that the Trust Fund went broke at that moment, because there was $129 billion in assets in the Trust Fund, and it was not beyond the normal variations in terms of projections of what was going to happen to the Trust Fund, and second, it did not change our conclusion as Trustees. I will remind you what we said to the Congress in 1995. We reminded you that the Trust Fund would be exhausted in less than 11 years and urged the Congress to take additional actions designed to control HI Program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of a broad-based health care reform. We believe that prompt, effective and decisive action is necessary.

And that crossover simply reinforced that view that prompt, effective and decisive action was necessary.

Chairman ARCHER. So you did not consider this significant.

Secretary SHALALA. I did not.

Chairman ARCHER. Thank you.

Secretary SHALALA. I consider the condition of the Trust Fund significant. I consider the fact that the Trust Fund is running out of money significant, and the fact that our projections now make it even more urgent simply reinforces the very strong language that we used in 1994 and 1995, and makes it even more urgent that all of us deal with the issue of Medicare.

Chairman ARCHER. But the fact that it was deteriorating more rapidly by between 1 and 2 years, you did not count as being important.

Secretary SHALALA. As I reported, with both the CBO projections as well as in the Trust Fund projections, these are projections and estimates, and they always vary a certain percentage. This was not outside the range. And as Senator Domenici reported, this was in the range, and therefore was not significant in his judgment to

change our conclusion that we must deal with the Medicare Trust Fund.

Chairman ARCHER. All right. Did you attend the December 13 Trustee meeting?

Secretary SHALALA. I did.

Chairman ARCHER. Was the shortfall discussed at that meeting?

Secretary SHALALA. It was. It was reported, and I specifically asked a question on what accounted for it. Administrator Vladeck had some information, and I specifically asked that we get a lot more information about what was happening to the Trust Fund.

Chairman ARCHER. So it was specifically discussed at the December 13——

Secretary SHALALA. It was discussed.

Chairman ARCHER. Was Secretary Rubin at that meeting?

Secretary SHALALA. He was.

Chairman ARCHER. OK. Thank you very much.

Secretary Rubin, you also are a Medicare Trustee.

Secretary RUBIN. That is correct.

Chairman ARCHER. With the very special extra responsibilities that I know you take very seriously. And you are actually the managing Trustee of the Board of Trustees, is that not correct?

Secretary RUBIN. That is correct, Mr. Chairman.

Chairman ARCHER. And Secretary Shalala said you were at the December 13 meeting; I assume that is true?

Secretary RUBIN. That is also correct.

Chairman ARCHER. Can you tell us whether you recall it being discussed at the December 13 meeting?

Secretary RUBIN. Mr. Chairman, I do not know whether the—I do not recollect the discussion that Secretary Shalala just reported, although if she reported it, it undoubtedly occurred. But I really do not think that is the point. I think the point is the point that Secretary Shalala made. In our April report, what we said was that with the exhaustion date approaching, the near- and long-term solvency of the Medicare Trust Fund had to be addressed. That was our consistent position, it is what we worked for through this entire period.

I might observe, as Secretary Shalala observed, that Senator Domenici's report on February 12, specifically referring to the numbers, to the performance in 1995 in the HI Trust Fund, said: "The recent changes in projections do not significantly affect the longrun Medicare situation."

Chairman ARCHER. Mr. Secretary, you and Secretary Shalala have now repeated that three times. I think it is in the record, and it is not necessary to repeat that.

Secretary RUBIN. Well——

Chairman ARCHER. I am curious as to what capacity you attended that December 13 meeting.

Secretary RUBIN. I attended as a Trustee.

Chairman ARCHER. Were you also chairman of that meeting?

Secretary RUBIN. Yes. I am the managing Trustee of the Medicare Trust Fund.

Chairman ARCHER. But you don't recall what Secretary Shalala says was specifically discussed at that meeting?

Secretary RUBIN. Mr. Chairman, I do not recollect what was specifically discussed at that meeting. What I do recollect is what we said in our April report; I recollect what we worked on through this whole time; I recollect what I think is absolutely imperative that we have done and that we have said throughout this process, which is that we restore the solvency, near-term and long-term, of the Medicare Trust Fund.

Chairman ARCHER. I understand. But you remember Secretary Domenici's release precisely, but you do not remember what was discussed at a meeting that you chaired on December 13?

Secretary RUBIN. Well, Mr. Chairman, I remember Senator Domenici's release because when I was notified of this hearing we got hold of it, we got a copy of this release, and we thought we would share it with you because we thought you would find it useful in evaluating the importance of those numbers.

Chairman ARCHER. Is there a record kept of the discussion at your Trustee meetings?

Secretary RUBIN. There are minutes; they are minutes like all other meetings. They tend to be summary in form.

Chairman ARCHER. Have you taken occasion to go back and refresh your memory by looking at those?

Secretary RUBIN. No, I have not. Secretary Shalala may have.

Secretary SHALALA. No.

Secretary RUBIN. But let me just add if I may, Mr. Chairman, that the reason I have not is that this—and Secretary Shalala said it very well—there is no change in our view with respect to the importance of—our differences with the congressional majority never lay over the question of the importance of addressing the solvency of the Medicare Trust Fund. We always said that that was critically important. The differences lay in policy. We did not think premiums should be raised. The congressional majority did think premiums should be raised. We felt that the reductions——

Chairman ARCHER. I understand, Mr. Secretary, but——

Secretary RUBIN [continuing]. Wait 1 minute—the cuts should be of a level that were consistent with having an effective program. We felt the congressional majority's cuts were too large, and so forth. That is where the differences lay, not in whether we needed to address this shortfall.

Chairman ARCHER. But let me tell you what troubles me, and this will be my last comment. What troubles me is that you have come to this Committee, and you have said that we should know. Because there was a needle in a haystack buried in a very big document, we should have known about this shortfall, and that has been the inference from both of your testimonies. But you, as chairman of a Board of Trustees, in a meeting that only lasted I believe 18 minutes, do not recollect this, and Secretary Shalala specifically remembers it being discussed. That just—I find that hard to believe because I attach a great deal of importance to this significant change in the trust account for the Medicare beneficiaries of this country.

So I am going to yield to Mr. Gibbons for inquiry.

Secretary RUBIN. Could I respond to that, though, Mr. Chairman?

Chairman ARCHER. Well, actually, it really wasn't a question, but you certainly are free to respond.

Secretary RUBIN. Well, it has the nature of a comment—it is a question, I guess. My comment is not that you should have known of the material in this document. My comment was that it was broadly distributed, including to each Member of Congress.

I will stick with what Senator Domenici said, and I will not quote him again because as you observed, he has now been quoted a number of times. But I would also observe that the CBO revised their baseline, and when they came to the December 12, I believe it was, negotiating session, and they had already revised their baseline to reflect these numbers, they too did not mention these numbers. And I think the reason they did not mention these numbers, Mr. Chairman—and this is the point that I was trying to focus on—is that all of us, based on all of the information with regard to the HI Trust Fund, were committed to the proposition that we need to deal with both near- and long-term solvency, and these numbers did not change whatsoever the need to address that problem.

Chairman ARCHER. Well, it still is very interesting to this Committee that you as the managing member of the Board did not know about this until you read a press account about it in February of this year. And I believe you that you are being totally forthright in saying that you just do not remember it, but it does strike me as being rather strange.

Mr. Gibbons.

Mr. GIBBONS. Mr. Chairman and witnesses, I think we would serve the country better if we spent more time discussing how you fix the problem rather than trying to assess blame around here.

Madam Secretary, I would like for you to tell me as briefly as you can what changes you think this Congress should make in the Medicare Part A Trust Fund.

And Secretary Rubin, I would like for you to tell this Committee what is going to happen to Medicare and the whole rest of the government if we do not get our work done in passing a clean debt ceiling by the middle of this month.

Secretary Shalala, would you go first?

Secretary SHALALA. Thank you, Congressman Gibbons.

The President has laid out in his balanced budget proposal a series of changes in the Medicare Program that will improve the managed care options of new plans including PPOs and PSOs, improve the program's payment methods, improve the quality protections and provide better beneficiary information.

In addition to that, the President has recommended that we expand some of our prevention benefits, including mammogram coverage. The President also included considerably stronger waste, fraud and abuse protections, in his proposal.

To achieve $124 billion in savings, we propose to slow down the growth of Medicare with a series of very specific recommendations on hospital updates, on other special hospital payments, on an SNF prospective payment system, on a home health prospective payment system, on HMO payment revisions, and on physician updates. We have given the Congress a very specific set of cuts that will slow down the growth of the Medicare Program as well as a

set of options that will increase the availability of Medicare and the choices available to every American.

All of this will extend the Trust Fund into the second decade of the 21st century and give all of us enough time to deal with the long-range problems of financing the Medicare Program.

Mr. GIBBONS. Secretary Rubin, what is going to happen if we do not get a clean debt ceiling.

Secretary RUBIN. Mr. Gibbons, this Committee, as you well know, is the Committee of jurisdiction with respect to the debt limit, and your Chairman has played, I think, a very constructive role in providing the $29 billion that got us through March 1. That was a very important contribution.

I think, Mr. Gibbons, we have come a long way. When this process started, many, many months ago, there were those who were saying that default was acceptable as the price for getting their way on the budget negotiations, and it was our view that nothing, but nothing, should be allowed to in any way create a question with respect to the creditworthiness of the United States of America. And I think that this period, although it has been a difficult period, has accomplished a great deal in the sense there seems to be an almost universal view now, given that people have had time to reflect on the importance of the creditworthiness of the Nation, that default is unthinkable, and I believe it is unthinkable, and it will not happen.

On March 15, Mr. Gibbons, that will be the date when, under Chairman Archer's legislation, there will in effect be a "snapback," so that the debt that has been issued will be treated as debt above the debt limit. For that reason, we will not be able, as a matter of law—not choice on our part—as a matter of law, we will not be able to reinvest the incoming proceeds, the incoming cash, to the Social Security, Medicare and other trust funds in interest-bearing government securities. So instead, they will go on the books of the Federal Government as credits backed by the full faith and credit, but without interest. Congress could, of course, restore interest legislatively.

We will still, however, have a cash balance. As the days go on, additional Trust Fund investments will come in; as a matter of law, we will not be able to invest them, but we will continue to have a cash balance.

On March 21, according to our projections, we are a slight bit either way, depending on the day, of being able to meet the obligations of the U.S. Government, so that default is possible on the 21st—based on the most recent projections we have, default would occur by a slight bit, but those projections put us slightly over or slightly under, depending on the particular day of the projections, and we are making projections 1 month out, on a $1.5 trillion budget.

But I think it is imperative that we put in place a debt ceiling increase, that we do it promptly, and that we do it in a manner consistent with the letter that the leadership, I think very constructively, gave to the Congress—which means taking out the use of the debt ceiling to pressure with respect to other legislative agendas.

Mr. GIBBONS. As a de facto situation, the Medicare Trust Fund would be in just as bad a position on March 22 as it would be in 2001. You would not be able to spend any bills in this year.

Secretary RUBIN. Well, this country will not default, I am confident, Mr. Gibbons. But if ever we did, it would create a lot of problems with respect to the Trust Funds. But that will not happen, I am confident.

Mr. GIBBONS. Can you tell me about when we are going to get any legislation on that?

Secretary RUBIN. Well, all I can tell you, Mr. Gibbons, is that in my view and in the spirit of the letter that the leadership gave us and in the spirit of the legislation that the Chairman here provided, which I think was very useful and constructive, I think it is important that we move promptly and that we not let this issue linger because of its enormous importance to the country.

Mr. GIBBONS. Thank you.

Chairman ARCHER. Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman.

Secretary Rubin, in whose name was that October 27, 1995, report issued?

Secretary RUBIN. Well, this is the regular—it is called "Treasury News," but it was actually put out as a joint statement from myself and Alice Rivlin, Director of the OMB.

Mr. CRANE. Now, my recollection is you indicated that you and Alice Rivlin first learned about that shortfall in the New York Times article you read in February of this year?

Secretary RUBIN. Mr. Crane, when we were doing a press conference on this year's budget, and we were asked that question, I said that I did not at that time know whether I knew it from then or not. It certainly was not in my mind at the time of the February 5 press conference that you are talking about, and I believe Director Rivlin said the same thing.

Mr. CRANE. So you are saying that you did not know what was in your release of October 27, and that Alice Rivlin did not know it either.

Secretary RUBIN. Well, let me just try to be a little bit more precise if I may, Mr. Crane. What I was saying was that I just did not know on February 5 whether this had been in my mind October 27 or not, and as I said a moment ago to the Chairman, that really is not the point. The point is the point that was in our April report, which is that the Medicare solvency issue has to be dealt with, and it has to be dealt with effectively and promptly.

Mr. CRANE. Right, but I mean, it obviously was not that significant to you until you read the New York Times. It was inconsequential, basically, I gather, because at the meeting you chaired on December 13, you have no recollection of it being discussed, notwithstanding what Secretary Shalala said.

Secretary RUBIN. I agree with Senator Domenici's bulletin—and I will not read it again because the Chairman has said it is in the record, which is true—but he refers to the projections as not being significant. And I think——

Mr. CRANE. Well, wait——

Secretary RUBIN. Could I just——

Mr. CRANE [continuing]. You are confirming that from your perspective it is not significant.

Secretary RUBIN. Mr. Chairman, there was about a $36 million shortfall in about a $130 billion fund.

Mr. CRANE. Instead of the $4.7 billion surplus that had been anticipated.

Secretary RUBIN. That is correct, and if you look back——

Mr. CRANE. Well——

Secretary RUBIN. If I could, Mr. Crane.

Mr. CRANE. I am just curious as to how much significance you attach to figures like that. You do not have to pursue it, but I have a question for Secretary Shalala.

I have half a dozen news releases that you have issued since 1994, November 1994, and they deal with a variety of things, including the hearings, public hearings soliciting input from the public, their ideas, and highlighting studies of Medicare payments and medical equipment and supplies. In these news releases, though, you never once made any reference to the information that you knew on December 13 and was in that October 27 report. Is that because you two do not think that is all that significant?

Secretary SHALALA. The information that we were given was a preliminary report, and the variation that was described was within the normal range of variation.

Mr. CRANE. So, roughly $5 billion here or there is not that significant?

Secretary SHALALA. Well, as you could see from what we had done before on projections compared to what CBO has done on their projections, it was within the normal range of variation. Adjustments were made in the baselines from this information. CBO was informed, they were briefed extensively, they made adjustments in the baseline.

My staff has to keep me informed when there is something beyond the normal range of variation. I was briefed for that meeting; I asked questions about what was the explanation within the numbers. We expected to have a full report in 1996. The information I was given did not change any conclusion that we had made as Trustees or any information we had given to the Congress about the urgency of dealing with the Medicare Trust Fund.

Mr. CRANE. At that December 13 meeting of the Trustees, who raised the question of the difference in the figures?

Secretary SHALALA. We were briefed by the HCFA Administrator on the preliminary actuarial figures. I asked a question about what was inside of those numbers, and we knew that we would get a firmer report in April, but the figures we were given were within the normal range of variation. They did not change our very firm conclusion that this Congress must deal with the Medicare Trust Fund problem.

Mr. CRANE. Thank you very much.

Chairman ARCHER. Mr. Thomas.

Mr. THOMAS. Thank you very much, Mr. Chairman.

First of all, I thank both of you for coming, and especially, Secretary Shalala, for the information that you provided that is helpful to try to put timelines together.

Secretary Rubin, you have indicated that on that October material, which was the monthly update, and it just happened to be the last month of the fiscal year, that not only was this information included in the monthly statement, but it was highlighted in the "Treasury News" that was embargoed for release, which was a public document. And I went through that, and apparently you are referring to the page 4 reference about the actual outlays for the Medicare Program; is that the statement you were talking about which highlighted the deficit?

Secretary RUBIN. Yes. It is about the middle of page 4, that is right.

Mr. THOMAS. Yes, I see that, and nowhere do I see it stating that there was a deficit in the Trust Fund. So how is it highlighted?

Secretary RUBIN. Well, the Trust Fund, as you know, did not have a deficit. The Trust Fund had——

Mr. THOMAS. No—the yearly report, on the monthly report——

Secretary RUBIN. Yes.

Mr. THOMAS. Where is the deficit shown for the year in this highlighted paragraph?

Secretary RUBIN. Mr. Thomas, what this highlight was intended to do was to do exactly that, highlight the most important parts of the report, and then people who are interested can——

Mr. THOMAS. So it was not important that the deficit——

Secretary RUBIN. No—Mr. Thomas, I think if you will let me finish, maybe you will find——

Mr. THOMAS. No. I would like to ask the question. Was there anywhere in the document a statement or a number that showed that it actually was a minus number?

Secretary RUBIN. Yes. Now let me respond, if I may. What you will find in the middle of page 4 is a highlight with respect to the Medicare Trust Fund, pointing out that the outlays exceeded estimates by the amount that is indicated.

Mr. THOMAS. Yes.

Secretary RUBIN. For anyone who is interested in Medicare and in pursuing that, you can then go back into the material. The point of the highlights is to point out the most important pieces of what is then a longer document.

Mr. THOMAS. And somewhere in the middle of the document, there is a number that shows that for the year, you missed the estimate.

Secretary RUBIN. Well, each of these items——

Mr. THOMAS. No. Is there somewhere in the document——

Secretary RUBIN. Yes. The answer to the question is yes.

Mr. THOMAS. Where is that?

Secretary RUBIN. That is about page 28.

Mr. THOMAS. So on page 28——

Secretary RUBIN. I think—yes, it is on page 28.

Mr. THOMAS [continuing]. There is a single number that says minus 36.

Secretary RUBIN. Let me say, if I may, Mr. Thomas——

Mr. THOMAS. No. What that means—take a look at the chart over here. That is what the Trustees estimated. And you will notice between 1994 and 1995, you estimated a reversal of the trend that had been carried out over several years. The next chart shows ex-

actly what happened—in fact, a continuation of the trend over the last several years. So when you compare the two, what you really have is a difference—and there on the chart is a dotted line showing the original estimate, and the line below that, which was the actual one, and the zero for the year which you folks do not seem to place much significance on produces a yearly deficit for the first time since 1972. And the last time there was a deficit, the Democratic-controlled Congress responded by raising taxes.

So no one thought that because there was a deficit it made any difference, or it was not important, or it was not significant at all?

Secretary RUBIN. Mr. Thomas, let me—would you like me to respond to that?

Mr. THOMAS. Yes.

Secretary RUBIN. Let me respond in two respects, and in one of them, I will just repeat something I have said several times before.

There has never been a disagreement about whether or not the solvency——

Mr. THOMAS. No. I understand that.

Secretary RUBIN. Wait 1 minute——

Mr. THOMAS. No. I have heard your statements, and I understand that, and my time is almost out. So you did not think it was significant to really focus on the minus. That is OK.

Secretary RUBIN. I think that——

Mr. THOMAS. I understand that. I would like to ask——

Secretary RUBIN. I think that what is significant is to focus on the solvency, which we have been trying to do all along. I agree with Senator Domenici's report——

Mr. THOMAS. We know that. You have relied on him significantly.

Secretary RUBIN. Well, he is very thoughtful about these things.

Mr. THOMAS. OK.

Secretary RUBIN. I do not think that this particular number affected the imperative to deal with that problem.

Mr. THOMAS. Secretary Shalala, you did not think the minus 36 was significant——

Secretary SHALALA. The information we had——

Mr. THOMAS. No. Question: You did not think it was significant, either?

Secretary SHALALA. The variation was within a normal range for these projections. I think the——

Mr. THOMAS. Why, then, on the memo that is dated December 8, did your aides say that this number may be controversial?

Secretary SHALALA. Because it was a change in what our projections indicated, but it was within the normal range of variation as the actuaries concluded. The numbers were also preliminary, and I made sure that we found out what was underlying those numbers.

Mr. THOMAS. No, no, no. The statement was: "It may not be perceived as trivial." Was it because it was a deficit for the first time since 1972?

Secretary SHALALA. Congressman Thomas, I do not consider any variation in the Trust Fund trivial. I do not consider any information I get about the Trust Fund trivial. We act on that information——

Mr. THOMAS. I did not use the word "trivial." That was in a memo to you.

Secretary SHALALA. And all of the information in the memo to me, as well as what I heard at that meeting, was consistent with what we had urged Congress to do.

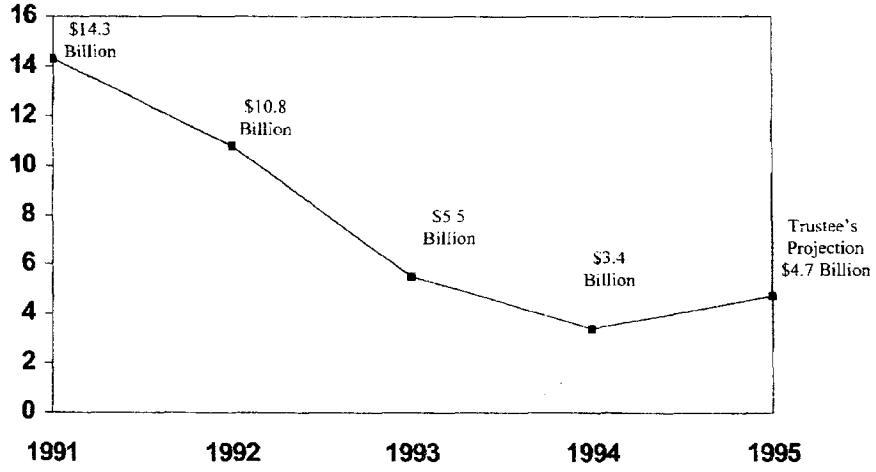
Mr. THOMAS. Madam Secretary, here is the real problem, and this is looking forward as Mr. Gibbons urged us. On the left was the fiscal year 1995. Encapsulated in blue are the first 4 months, which showed a $3+ billion amount. But for the entire year there was that deficit of $36 million.

My real concern is that on the right side of that chart is fiscal year 1996, and in fiscal year 1996, we do not have the frontload in the first 4 months of that more than $3 billion.

Now, what happened with the actual numbers was that we were in the worst case scenario, according to the profiles as outlined by the Medicare Trustee actuaries. Where are we if, in the first 4 months, we have only that much of a frontload? What is going to be the yearend in fiscal year 1996, and are we going to be outside the worst case scenario as profiled by your actuaries?

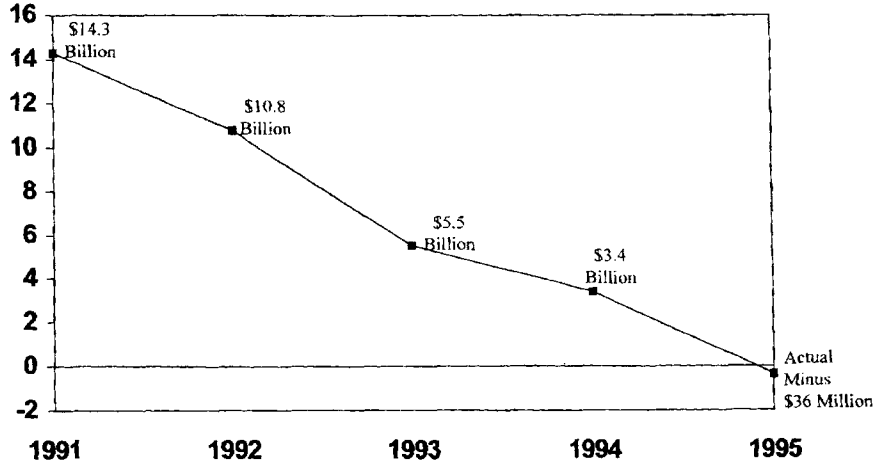
[The following was subsequently received:]

Medicare's Cash Position is Declining Faster Than Expected



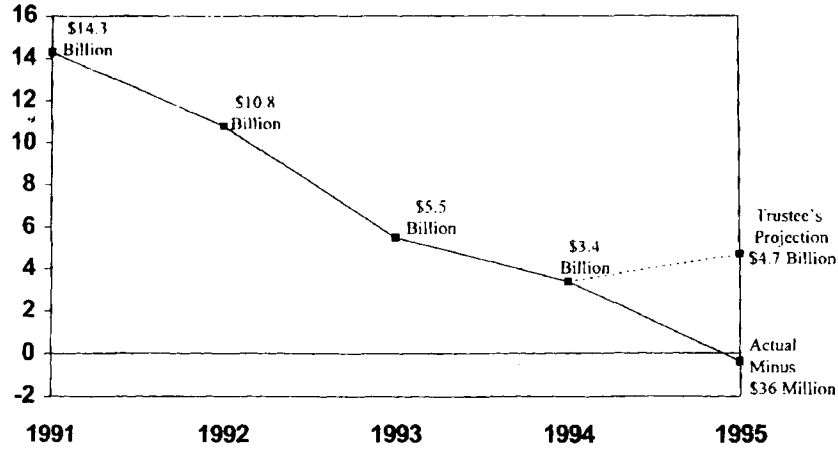
Source: Monthly Treasury Reports and 1995 Hospital Insurance Trustees Report

Medicare's Cash Position is Declining Faster Than Expected



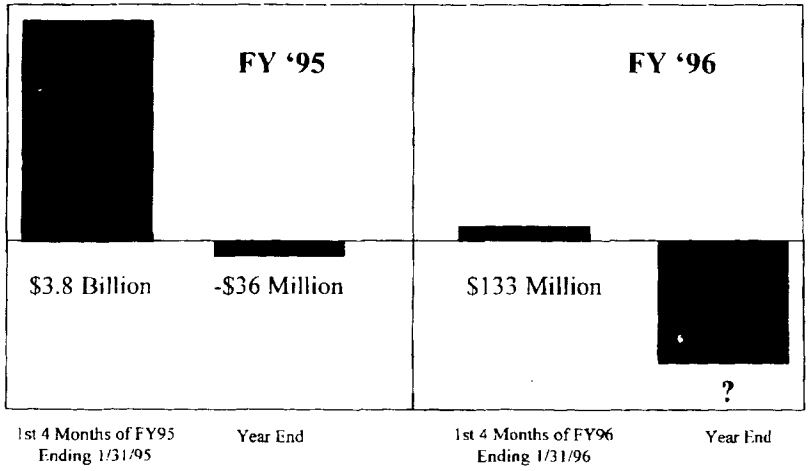
Source: Monthly Treasury Reports and 1995 Hospital Insurance Trustees Report

Medicare's Cash Position is Declining Faster Than Expected



Source: Monthly Treasury Reports and 1995 Hospital Insurance Trustees Report

Medicare's Condition is Worse than Expected



Source: Monthly Treasury Reports

Secretary SHALALA. Congressman Thomas, as far as we are concerned, it is urgent and imperative that this Congress deal with the Trust Fund situation. We reported that in 1994 and 1995. These projections simply confirm that conclusion——

Mr. THOMAS. I agree with you completely. As Congressman Gibbons said, we started out at $270 billion of slowing the growth; we went to $225 billion in December. We are currently negotiating with reasonable Democrats a $168 billion—we have come down more than $100 billion of slowing the growth of Medicare.

He repeated, you repeat, a $124 billion number. Why don't you come up $50 billion? We have come down $100 billion. And we would have that agreement which you folks seem to want to reach. Only come halfway. We have already come more than $100 billion. All you have to do is come to $50 billion. Reasonable Democrats are there. When are you folks going to be there?

Chairman ARCHER. The gentleman's time has expired.

Mr. Rangel.

Mr. RANGEL. Mr. Chairman, the way this works out is that I would get a chance to vote and question——

Chairman ARCHER. You can use as much time, and use the rest of your time when you get back.

Mr. RANGEL. Well, Mr. Chairman, as usual, you are very generous.

Let me say this to the witnesses. It is abundantly clear that—no, no, that is all right——

[Mrs. Johnson assumes the chair.]

Mr. RANGEL. Thank you so much, Madam Chairperson.

It is abundantly clear that no one here——

Mrs. JOHNSON [presiding]. The Committee will recess for a few minutes until the Members return from the vote.

[Pause.]

Mrs. JOHNSON. Will the witnesses please return to the witness table.

Mr. Matsui.

Mr. MATSUI. It was only a difference of 18 months in terms of the default and the shortage in the Trust Fund. So nobody paid a lot of attention to this because we were looking at the bigger issue. We were not dealing with the kind of minutiae. We wanted to solve the bigger problem.

I really do not understand what this hearing is about. Last October, we asked the Republican leadership to hold a series of hearings on Medicare once your bill was introduced, and you only gave us one hearing. Now you want to hold a hearing on this.

They did a very poor job, Mr. Rubin and Secretary Shalala, if in fact they wanted a coverup, because they sent this out to your office—all 435 Members of Congress got this on October 28, 1995. Every one of us got this. I happened to read it. Apparently, nobody on the Republican side of the aisle read this report. If they did read it, they could not have thought it was too important.

So I really do not understand what the problem happens to be with respect to all this, and I just have to say that I am just somewhat surprised at all this.

Mr. Barbour, Haley Barbour, just issued a press release yesterday, accusing the administration of a coverup. Is this a political

issue, or are we trying to really solve the problem of the Medicare Trust Fund?

I would hope that we would all act in a responsible, adult fashion to try to solve the problem of the Medicare Trust Fund instead of playing politics. You know, many senior citizens rely only on their Medicare payments in terms of their health care coverage. We do not need politics as usual, but apparently, you guys have no issues to play with, so you are playing politics with this issue.

I just have to say that I do not know the relevance of this hearing. It is really somewhat astonishing and surprising to me, and it would be my hope that we act in a more responsible fashion in the future.

I really do not have any questions. I am just astonished that we are wasting our time when we have a debt limit that we have to deal with in the next 2 weeks. I just find it absolutely astonishing, and I do not even understand, frankly, why your leadership insisted upon this.

Mrs. JOHNSON. The gentleman from Florida.

Mr. SHAW. Thank you, Madam Chairman.

I would like to review a few things here, because I think some things have been said that are of a little bit of concern.

Secretary Rubin, before coming here, you were an investment banker on Wall Street; is that correct?

Secretary RUBIN. That is correct, Mr. Shaw.

Mr. SHAW. And as far as analyzing a corporation, if the corporation goes into the red for the first time since the seventies, it would certainly be brought to your attention if that were in your investment portfolio; is that right, Mr. Rubin?

Secretary RUBIN. You know, Mr. Shaw——

Mr. SHAW. Yes or no, please, sir. I am not going to be filibustered. Is that right, or is that wrong?

Secretary RUBIN. Mr. Shaw, the results of any particular period would have to be taken in context and considered, as I said, in the context. I actually am very accustomed to analyzing financial statements and results, and I——

Mr. SHAW. Well, I have analyzed them, too, as a certified public accountant and a lawyer, and I can tell you, Secretary Rubin, that I would think that was very significant, and I think you would, too. Now——

Secretary RUBIN. Well, Senator Domenici and I don't.

Mr. SHAW [continuing]. Let me go on. I have some further things that I want to say.

Now, it has come out—Secretary Shalala has said that she learned of this on December 11, and it was discussed at a meeting that you chaired, I believe, on December 13.

Secretary RUBIN. Correct.

Mr. SHAW. How long did that meeting go, Mr. Secretary?

Secretary RUBIN. I have been told since; it was roughly 18 minutes.

Mr. SHAW. Eighteen minutes. I would assume that your attention span certainly would last 18 minutes, but in any event, you say you just cannot remember anybody saying anything about the Trust Fund going into the red; is that correct?

Secretary RUBIN. Mr. Shaw, I don't know if I was aware of these numbers being discussed at that time or whether it registered on me or not, but I will say once again—and we have now said it many times——

Mr. SHAW. Could we——

Secretary RUBIN [continuing]. We are exactly where Mr. Domenici is, Senator Domenici.

Mr. SHAW. Could we——

Secretary RUBIN. These are very important issues. Nobody has ever disagreed about the importance of dealing with solvency. The question is what path do we take to addressing the solvency, and that is what has separated the parties.

Mr. SHAW. I think this is very important because the previous questioner talked like this was just politics as usual, and it is not.

Could we play a tape over here, please?

Secretary RUBIN. Mr. Shaw, while we are waiting, could I just—I may have misheard you. If you said the Trust Fund was in the red, that was not correct.

[Videotape of press conference shown.]

TRANSCRIPT OF PRESS BRIEFING BY SECRETARY RUBIN AND MRS. RIVLIN

Q. Mr. Secretary, how long has the administration known that the Medicare Trust Fund was going to suffer a deficit and not a surplus this year?

Secretary Rubin. I just heard about this—Alice, do you know the answer? This was not something I had known about before.

Ms. Rivlin. Today is what? I heard.

Secretary Rubin. Yeah, my first knowledge of it was today.

Jim Lehrer. You first found out about it in the New York Times? Is that what I'm led to believe hare?

Secretary Rubin. It's actually a very good paper. You should read it. I mean, there are a lot of other good papers, too. I didn't mean—that was not a relative comment.

Q. If I could ask, then, why is it that the administration did not know this, especially since there was sensitive budget negotiations going on for a couple of months?

Secretary Rubin. Well, Jim, there may well have been people who in analyzing this were familiar with it. I learned about it today. But I don't think it matters.

Mr. SHAW. OK, Mr. Secretary, proceeding along those lines, I would assume that if I asked you if you had brought this up at any of the negotiating sessions with the Members of Congress—I understand you were at all of them—that you did not bring it up because you say you did not remember it.

Let me ask you a question. If you did remember it, and particularly since that is going to affect the "drop dead" date on Social Security, would you have thought it was important to bring up—please, yes or no?

Secretary RUBIN. Mr. Shaw, it does not affect the "drop dead" date on Social Security, so I do not know what you are referring to.

Mr. SHAW. I am sorry. Medicaid. Medicare.

Secretary RUBIN. And if it has any effect at all——

Mr. SHAW. Secretary Shalala said that Medicare is no longer solvent until 2002. It is now solvent until 2001. Do you think that was a significant thing to bring to the attention of the negotiators who were trying to negotiate with the President?

Secretary RUBIN. I agree with Senator Domenici and his comment. I agree with——

Mr. SHAW. I did not——

Secretary RUBIN [continuing]. Wait 1 minute—let me just finish—I agree with what implicitly must have been June O'Neill's view, that of CBO, because they had changed their baseline to reflect these numbers and did not bring it up in the negotiating session.

Mr. SHAW. Am I correct——

Secretary RUBIN. I think it was critically important that we address the issue of the solvency of Medicare, and I do not think that that importance was significantly impacted by the operating deficit in 1995.

Mr. SHAW. I would take your answer to be, then, that you do not take much significance in the fact that the Trust Fund took in less money than it paid out in 1995. I find that unbelievable, and I am very concerned.

I think the real message we have here is what didn't you know, and when did you forget it.

Secretary RUBIN. Well, Mr. Shaw——

Chairman ARCHER. The gentleman's time has expired.

Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Do either of you two have counsel here?

Secretary RUBIN. We will serve as counsel to each other, thank you, Mr. Rangel.

Mr. RANGEL. Well, I don't think anyone on this Committee, except the last speaker, is challenging the validity of your remarks. They believe what you are saying, but as Clay Shaw said, the questions are what did you know and when did you know it? And we want you two to understand that we do not have much legislation to work on for the rest of this year, so it is very important to us that we try to get as much information about these types of things as we can, especially when we are enjoying the television cameras here with us today.

So we do hope that if you have any notes or any evidence at all around in your bedrooms, office files, or memorandums that you could use to refresh your recollections as to who was at these meetings that you attended and when you found out the shortfalls you will let us know. Notwithstanding that these variations were not too far from norm, this is the only issue we have, so we have to stick with this.

Now, at any of these meetings at the White House did you know or should you have known that there was a Dr. O'Neill in attendance. Does that name mean anything at all to either of you?

Secretary RUBIN. Well, Mr. Rangel, Dr. O'Neill was at the December 12 meeting—and it was actually held up on the Hill—at which all of the budget negotiators from the congressional majority, congressional minority, and the White House were present.

Mr. RANGEL. I know, and I appreciate your testimony on these questions.

Now, is Dr. O'Neill the Republican-appointed head of the Congressional Budget Office?

Secretary RUBIN. Yes, she is, Mr. Rangel.

Mr. RANGEL. Now, did you have reason to believe that she would report to the Republicans as to exactly what took place at this meeting that was held in December?

Secretary RUBIN. Well, she was not at the December meeting, but she was fully cognizant of the numbers that were reported—oh, in the December 12 meeting?

Mr. RANGEL. Yes.

Secretary RUBIN. That she would report everything that she felt was relevant?

Mr. RANGEL. Yes.

Secretary RUBIN. I cannot speak for Dr. O'Neill, but she is very highly respected; I presume that she would.

Mr. RANGEL. So if there was an attempt to cover up—of which, of course, there is a strong implication here—this information, Dr. O'Neill would have been a part of that coverup, now, wouldn't she? [Laughter.]

Now, you don't have to answer this.

Secretary RUBIN. Well, not necessarily, Mr. Rangel. She may have forgotten, or——

Mr. RANGEL. Well, we think that you ought to consider getting counsel in this matter, because we don't have time to take up the flat tax, and we don't expect that we will be getting any meaningful legislation out of this Committee still we are going to be on this until we get to the bottom of it. [Laughter.]

And so I agree with my friend Clay Shaw—he is gone—that as long as we can get away with this, we are going to try.

I want to thank you, Mr. Chairman.

Chairman ARCHER. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I think it does matter when you knew things, and it does matter what got forgotten, because this is one of the two most important programs for the seniors of America, and on Medicare's solvency not only rests the health and well-being of the seniors, but the peace of mind and well-being of their families.

So I take this hearing seriously, and if I am the only one here who does, so be it. But we are talking about in 1 year, a $4.7 billion surplus, almost a $5 billion surplus, becoming a $36 million deficit.

You say in your testimony, Secretary Shalala, that that means that the Medicare Trust Fund will be exhausted in 5 years or so. I mean, 5 years, for a Nation our size, for a program this size, is a short period of time.

And the reason why a lot of us want to know how come a little release was put out on October 27, and you guys did not pay any attention to it until recently; you did not even discuss it in a meeting until December, and then you did not tell the President or anyone else in charge about such an important event.

The reason I am interested in that is because we have to save this program. Now, the Chairman mentioned that there was only one other time that Medicare actually paid out more than it took in—1972. There is only one other time that Medicare had three bad Trustee reports, that is, where the fund was going to go broke in 7 or fewer years—that is my definition of "bad"; that is worse than your definition; I am more liberal than your definition—but there was only one other time, and when that happened, Secretary Heckler got out there, and she raised you-know-what. And she came up with the DRG system because she said 7 years is too little.

Now, what is wrong with this is that the Republicans have been saying 7 years is too little, 6 years is too little. Now we are down to 5 years. So this does matter, and we need to have a better answer than estimates and within the accepted range of blah, blah, blah, because these are facts. These are not estimates. These are dollars and values.

And of course, if you see a loss in a company, you do not immediately make a judgment about whether that company is in trouble, but it is a big red flag, and you look at it differently than if it had been $36 million-plus. A $36 million-minus in the Medicare Fund is a flag that we all ought to care about.

Now, the reason this matters to me is that you guys let some of the physicians have a 12-percent increase in reimbursement rates last January. Why? Because you were not paying attention. If you were paying attention, you would have come to this Committee and said, "Change the law; we cannot let that go into effect."

It is the same thing that almost happened to Medicare Select except that, frankly, I was there, and I said this is going to expire.

We have got to mind the shop. Otherwise, we are not going to have a program.

Now, Madam Secretary—and I am sorry I am taking my time to tell you what I think, but this has not been the kind of quality dialog that I had expected from this hearing—but you keep going to the President's proposal. It is imperative to get on the record that the President's proposal to save the Medicare Trust Fund "saves part A by robbing part B."

And you know and I know that part of the way it "makes $125 billion in savings" is by moving the responsibility to pay for home health care from part A to part B.

Now, CBO, the Congressional Budget Office, states that is not Nancy Johnson. And that is one of the reasons why we are having trouble getting together. I have not met a senior out there in America who does not think that the Republican proposal says that upper-income seniors should pay more of their part B premiums is not fair and just. But you won't even consider it.

We have a 5-year problem now, and that 5-year problem is under your intermediate estimates. I would assume, looking at your other estimates, that under your most serious estimates, your worst case scenario, we are talking 4 years because your estimate backed up 1 year. You back up the lowest, your most serious estimate, 1 year, and you are down to 4 years now instead of 5.

So the business of the Nation and of the seniors and of all of us demands that we buckle down and do this. And $124 billion of which $35 billion is sleight of hand—or $50 billion; I have forgotten just which one—is sleight of hand and smoke and mirrors is not good enough. But that is for another time.

I have been part of the bipartisan group that has tried to negotiate. We just do not get clear input from you guys. One of the reasons why we are concerned is that your people put out a press release in October. They did not bother to tell you, you did not bother to tell the President, and we are 5 years from bankruptcy. We are into broke. When you are paying out more than you are taking in, you are broke. We are not bankrupt because we have assets in this program, but we are broke already, and we are going to be bank-

rupt in 5 years, and I challenge this administration to do something better than just oppose the Republican proposal.

Thank you.

Chairman ARCHER. The gentlelady's time has expired.

Secretary SHALALA. If I might respond, Mr. Chairman.

Chairman ARCHER. I don't think there was a question.

Secretary SHALALA. But the Congresswoman made some accusations. If I might respond.

Chairman ARCHER. Madam Secretary, you certainly shall have time to respond.

Secretary SHALALA. Congressman Johnson, you have made our case. We have been arguing about the urgency as Trustees from the beginning. But since you don't want me to talk about the President's Medicare proposal, suppose I make some points about your Medicare proposal.

Mrs. JOHNSON. Madam Secretary, I would be happy to talk about both of those proposals in a setting in which we could come to agreement. This hearing is about why this administration did not pay attention to warning signs that are so serious that they have not occurred since 1972, and when a similar situation, but not as bad, occurred in the early eighties, we took strong action.

Chairman ARCHER. The gentlelady's time——

Secretary SHALALA. Congressman Johnson, we have been warning the Congress since we arrived in this administration, in 1993, in 1994, in 1995, in reports of the Trustees——

Mrs. JOHNSON. Madam Secretary, it was all talk and no action.

Secretary SHALALA [continuing]. With language that could not be more urgent. And when the Republicans put a proposal on the table that does not weaken the Medicare Program, like the MSAs do, I would be happy to have——

Mrs. JOHNSON. Madam Secretary, our proposal does not weaken Medicare.

Chairman ARCHER. The gentlelady's time has expired.

Mr. Bunning.

Mr. BUNNING. Thank you, Mr. Chairman.

First of all, I would like to welcome the Secretaries to the "David Letterman Show" chaired by Charlie Rangel. They want to make light of the fact that there is a serious problem with our Medicare system, and we are serious about addressing it.

We are serious about the manner in which the deficit was released in an overall omnibus release out of the Treasury. Rather than coming to us and saying, Oh, by the way, we miscalculated, or our projections are not right, and saying while you are in budget negotiations that, by the way, those projections for Medicare, instead of a $4+ billion surplus, we are going to have a shortfall of $36 million.

Now, $36 million is not a lot in an overall program, but it does red flag the program as turning negative before the Trustees anticipated it turning negative, and that is a big problem.

I heard from both of the Secretaries—both of you in your statements today said that there were going to be cuts in Medicare, in the President's proposal—cuts in Medicare.

Secretary Rubin, you just said it. Secretary Shalala, you just said it—cuts in Medicare. Is that accurate—both of you?

Secretary RUBIN. I will speak for myself, and the answer is absolutely yes. In every company I ever worked on, Mr. Bunning, and I worked on a lot of them in the private sector, what you would do is you would take the programs that you had, you would project out, you would see what they would cost, and then, if you were going to try to reduce your expenses, you would say you were cutting your programs, and that is precisely the same approach that we took here. But what we did was we proposed cuts in the program that would maintain the effectiveness of the Medicare Program, and the concern we had——

Mr. BUNNING. Then, in other words, the President's——

Secretary RUBIN [continuing]. Was the cuts in excess of that—wait 1 minute——

Mr. BUNNING. The President's proposal actually cuts Medicare.

Secretary RUBIN. The cuts in excess of that would affect access and choice and were imprudent. What?

Mr. BUNNING. The President's proposal actually cuts Medicare.

Secretary RUBIN. It cuts Medicare below what it otherwise would have been, which is precisely the approach that I took in 26 years on Wall Street in dealing with private companies.

Mr. BUNNING. When Mrs. Clinton testified before this Committee—and I can get you the tape—Mrs. Clinton said that they wanted to cut Medicare, or the rate of growth, back to 6 percent.

The Republican proposal only reduces the growth to 7 percent, 1 percentage point higher than the Clinton proposal.

Secretary RUBIN. Well, but as you remember, Mr. Bunning, that was in the context of overall health care reform, which——

Mr. BUNNING. No. We are talking specifics. We are talking about Medicare.

Secretary RUBIN. No. We are talking about apples and oranges because one——

Mr. BUNNING. No. We are talking about Medicare. She was specifically talking——

Secretary RUBIN. Yes, but——

Mr. BUNNING [continuing]. And the question to her was a specific question on Medicare.

Secretary RUBIN. I understand that, Mr. Bunning, but I believe that you will find—I assume this was during the health care debate—yes, this was in the context of health care reform, and as you remember, the health care reform would have had effects on the expenses of the Medicare Program, and I think it was a very sensible approach to dealing with Medicare; unfortunately, not one in which we could engage enough Members of Congress to ultimately produce a health care reform program.

Mr. BUNNING. Well, we think it is a very serious problem, the problem that instead of 6, 7 years, that Medicare is going to in fact lose the surplus in 5 years, according to Ms. Shalala's testimony.

Secretary RUBIN. Mr. Bunning, we agree with you there is a red flag. There was a red flag in the 1995 April report, as Secretary Shalala said, there was a red flag in the 1994 report. There is no disagreement between the administration and the congressional majority about the need to address Medicare solvency.

Mr. BUNNING. Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

In the event that some of my constituents might be listening to this hearing and trying to figure out what the purpose of the hearing is and what the current status is of Medicare, we are talking about the Medicare Part A Trust Fund dealing with hospitals. And our Republican friends want us to treat the Trust Fund very seriously, as a trust fund, as moneys that are there.

First, let me ask, has there been any change that would concern the hospitals in my district or my seniors in my district about getting their hospital bills paid in 1996?

Secretary SHALALA. No.

Mr. CARDIN. In fact, is there any danger from what you have projected that those bills will be paid in 1997 and 1998?

Secretary SHALALA. No.

Mr. CARDIN. So we are talking here about a change in a projection in the Trust Fund that does not immediately affect the hospitals in my district or my beneficiaries as far as being paid or reimbursed for hospital care?

Secretary SHALALA. Yes, Mr. Cardin.

Mr. CARDIN. You have stated a couple of times, both of you, and it has not been challenged, that the difference in the income coming into the Part A Trust Fund and the expenditures going out of the Part A Trust Fund, the actual 1995 figures were within the statistical range of historical data. Is that fairly accurate to say?

Secretary SHALALA. Yes. And we have also discussed the accuracy of the previous Trustees' Reports, and the ranges are consistent with the CBO's own projections and with their accuracy.

Mr. CARDIN. So both CBO and the Trustees have been somewhat consistent in these numbers. In fact, I think you said the Part B Fund expenditures were actually less than what had been projected.

Secretary SHALALA. Yes.

Mr. CARDIN. So, in one case, we spent more for hospital care and less for physician care than we anticipated—of course, they are separate trust funds, and we are here talking about the Part A Trust Fund, not the Part B Trust Fund.

Let me go back to fiscal year 1992. The figure that I have here is that the income was adjusted that year by 1.4 percent——

Secretary SHALALA. That is correct.

Mr. CARDIN [continuing]. Which is a higher variation than we are dealing with here, of a −1.2 percent—and the expenditures were misjudged by 5.6 percent in that year.

Secretary SHALALA. That is correct. The worst year of projections was in fact the last year of the Bush administration.

Mr. CARDIN. I guess that is the point I want to make. Does anyone here recall whether we had an emergency hearing of the Ways and Means Committee in order to deal with those changes in projections in calendar year 1992? I know you were not Secretary at the time, but I am just curious as to whether we had a hearing of our Committee to deal with those changes. And I must admit, I don't read every report that comes into the office. I did not read that report that came into the office. I am going to confess that I did not know about it until I read it in the paper. And I might have missed a hearing notice of this Committee.

But has there been a hearing scheduled on the debt extension in our Committee that either one of you have been advised of?

Secretary RUBIN. Not to the best of my knowledge, Mr. Cardin.

Mr. CARDIN. And if we don't pass legislation on the debt extension, is there a danger in 1996 that my hospitals may not get payment under Medicare, or that my beneficiaries might lose some coverage? Is that a real risk if no legislation moves through this Committee?

Secretary RUBIN. Well, let me give you a two part answer. One, there is no question in my mind, as Chairman Archer said, that this Nation is not going to default, but if that were to happen—which won't happen—then that would create very serious problems with respect to all the trust funds.

Mr. CARDIN. And you are talking about in the month of March, this coming month, we run the risk of having our hospitals in our districts not receiving Medicare payments because of the debt extension not being enacted upon in Congress? Yet, we have no hearings set on that issue? Yet we have a hearing set on a matter that does not affect the payment of my hospitals this year?

Secretary RUBIN. The debt extension is clearly an immediate issue that must be resolved promptly. The Medicare issue, as we have all agreed, is an extremely important issue, but it has a longer timeframe to it.

Mr. CARDIN. And as has been pointed out, the Clinton administration has come up with a proposal that they support that will extend the solvency for another 6 years or so beyond the current projections. We have, as the President said, agreement on some $120 billion of Medicare reductions. Yet we cannot get action in this Congress on what has been agreed upon by both Democrats and Republicans that could extend the solvency of the Trust Fund. We are having a hearing today to deal with an issue that does not affect the immediate problem. When we have an immediate problem, we don't have a hearing set on it with the debt extension.

It is baffling to my constituents and to me.

Chairman ARCHER. Mr. Houghton.

Mr. HOUGHTON. Thank you very much, Mr. Chairman.

I am not going to take long because I would like to yield some of my time to Mr. English, but Mr. Secretary and Madam Secretary, it is good to have you here.

I am not going to get into who did what when, and who forgot what when, because I do not think that is an argument that anybody is going to win. I have just a couple of points.

The numbers jumped around a bit, and I have some historical data, and the estimate in 1993 for 1994 was off on a plus side by about $3 billion. And if we had estimated in 1993 for 1995, it was pretty much what it was, what it came out. So it is very hard to sort of "G" in the forecast with what actually happened.

I guess the major thrust is this, and I am sure you recognize this. Is something different happening? Is there something we ought to be aware of now, both in terms of the Treasury and Secretary Shalala's department and Congress, so that we will do something different? We know we are on a slippery slope. We have already chopped off 1 year. This is a concern to an awful lot of people.

What should we be doing to make sure that this thing is looked at in terms of its trends, the actual numbers, and is there something we should be doing differently? I ask those questions.

Secretary SHALALA. Congressman Houghton, thank you for the question. Even though under the interim projections, the estimates that we were given were within the normal range of variation, we asked that the actuaries and our analysts look within those numbers to see if something different is happening. At that meeting, Bruce Vladeck said something about hospital admissions going up somewhat more than projected, from 3.2 to 3.5, but I specifically asked them to get inside the numbers.

For example, most recently, there may be some evidence that the hospitals are putting in their bills earlier than they have in the past. We need to find that out, and in our April report, we will report that to Congress in more detail. But since we don't have the final numbers yet, and the analysis goes on during the course of the year, and then we report in April, you can be assured that if something different is going on, we will report it in detail with as much accuracy as we can to Congress.

Mr. HOUGHTON. Yes, I think that is helpful, because—although this will not happen because the numbers dramatically changed in terms of their magnitude—if we slip a year, and next year we slip another year, that is something we have got to be very, very sure of.

Secretary SHALALA. Thank you very much, Congressman. And I want to make the point that even when the variations are within the range, it does not mean that we are not anxious to find out what is going on. It is very important in terms of the kinds of reforms that both Republicans and Democrats are talking about that we know what is going on in terms of Medicare expenditures, and that is exactly what we are trying to assure.

Mr. HOUGHTON. Sure. Secretary Rubin, do you have any comment?

Secretary RUBIN. No. I would exactly identify with Secretary Shalala's comments.

Mr. HOUGHTON. Fine. I yield to Mr. English, if that is all right, Mr. Chairman.

Chairman ARCHER. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman, and I would like to thank the gentleman from New York, my distinguished neighbor, for allowing me to speak.

I have a comment and then a question for both Secretaries. I have listened with a great deal of interest to your testimony this morning, and I am intrigued by it.

Secretary Rubin, I do not have your financial expertise. However, I did serve as Trustee of a municipal pension system in the third largest city in Pennsylvania, and when we were facing a terrible financial problem, I felt obliged to go public with it because it was obvious that it would have a direct impact on the deliberations before city council occurring at that time.

Now, the gentleman from Maryland has suggested that since the bankruptcy of Medicare is a few years away, that perhaps this was not an immediate problem, but I think when Medicare goes bankrupt and how quickly it is going bankrupt, and the fact that it was

already running a deficit would have had a direct bearing on the deliberations going on in Congress because of some of the kind of "feel good" statements coming from people who were part of that debate.

Having a fiduciary responsibility as Trustees for the system, don't you feel that you had a little more responsibility than simply making sure that a report was delivered on time that had in the body of its arcana a reference to the fact that part A was running a deficit for the first time since 1972?

Secretary RUBIN. Mr. English, there is nothing you have said that I would not agree with fully. We in our April report in 1995, and as Secretary Shalala said, also in 1994, said very specifically that the exhaustion date was much too close for comfort, and that it was imperative that we deal with the issue.

So I think there is no question that we have been focused on the imperativeness of resolving these issues—and I do not think the gentleman from Maryland was at all suggesting it was not important; he was just talking about the difference, I believe, between the immediacy of the debt limit issue and the fact that there is some time on this——

Mr. ENGLISH. My time has expired. I just wanted to suggest that I think when Trustees realize that an important milestone like this has been passed that they have an affirmative responsibility to call its attention to the public and not simply allow it to be buried in the details of a financial document. And I appreciate your coming here to testify today.

I thank the gentleman from New York.

Chairman ARCHER. Secretary Rubin, we have reached 12 o'clock. Can you stay any longer with us?

Secretary RUBIN. Mr. Chairman, I do have a little more time. I need to be back, if possible, for a meeting at 12:30.

Chairman ARCHER. Well, you certainly will be excused at whatever time you need to leave.

Secretary RUBIN. Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Mr. Secretary, Madam Secretary. Secretary Shalala, I appreciate your point that the CBO reported information about Medicare in its November 7, 1995, analysis of the September Treasury statement. I think it would be important for the purposes of this hearing to examine the document itself. I believe you referred to it earlier. Do you have a copy of that document?

Secretary SHALALA. The CBO document.

Mr. RAMSTAD. Yes. The CBO document entitled, "Analysis of the September Treasury Statement."

Secretary SHALALA. I have it somewhere here.

[The following was subsequently received:]

NOTICE
Internal Memorandum
Not for Public Release

November 7, 1995

ANALYSIS OF THE SEPTEMBER TREASURY STATEMENT

The September surplus of $7.3 billion was $3.0 billion higher than a year ago but $1.7 billion lower than our estimate for the month. The fiscal year ended with a deficit of $163.8 billion, $39.3 billion below last year's deficit of $203.1 billion (see Table 1).

TABLE 1. BUDGET RECEIPTS, OUTLAYS, AND THE DEFICIT FOR SEPTEMBER 1995 (In billions of dollars)

Budget Aggregates[a]	September 1995	September 1994	Fiscal Year Totals 1995	1994	Percent Change
Receipts	143.2	135.9	1,350.6	1,257.5	7.4
Outlays	135.9	131.6	1,514.4	1,460.6	3.7
Deficit/Surplus (-)	-7.3	-4.3	163.8	203.1	-19.3

a. Includes Social Security and Postal Service, which are off-budget.

The 1995 deficit was $10.8 billion lower than the CBO March baseline estimate but $2.4 billion higher than our August baseline estimate (see Table 2). CBO's deficit estimates were closer to the mark than OMB's. The President's February budget overestimated the 1995 deficit by $28.7 billion, and the OMB July mid-session review underestimated the deficit by $3.8 billion.

TABLE 2. BUDGET RECEIPTS, OUTLAYS, AND THE DEFICIT FOR FY 1995 (In billions of dollars)[a]

Budget Aggregates[a]	CBO March Baseline	CBO August Baseline	Actual	Actual Less CBO March	Actual Less CBO August
Receipts	1,355.2	1,356.7	1,350.6	-4.6	-6.2
Outlays	1,529.9	1,518.2	1,514.4	-15.5	-3.8
Deficit	174 6	161.4	163.8	-10.8	2.4

a. Includes Social Security and Postal Service, which are off-budget.

Receipts

Receipts in September were $143.2 billion, up $7.3 billion from a year ago but slightly ($0.8 billion) lower than we estimated for the month. September receipts and fiscal year totals are shown by major source in Table 3.

TABLE 3. SEPTEMBER RECEIPTS (In billions of dollars)

Major Source	September 1995	Fiscal Year Totals 1995	1994	Percent Change
Individual income taxes	60.9	590.2	543.1	8.7
Corporate income taxes	33.0	157.1	140.4	11.9
Social insurance taxes	39.9	484.5	461.5	5.0
Excise taxes	5.7	57.5	55.2	4.1
Estate and gift taxes	1.3	14.8	15.2	-3.0
Customs duties	1.6	19.3	20.1	-4.0
Miscellaneous receipts	0.8	27.3	22.0	24.2
Total Receipts	143.2	1,350.6	1,257.5	7.4

Note: Details may not add to totals because of rounding.

Receipts for the year totaled $1,350.6 billion, up 7.4 percent from 1994. This was $4.6 billion lower than our March baseline estimate and $6.2 billion lower than our August baseline update. The Administration's misestimates were comparable in magnitude although somewhat different in direction. Actual receipts were $4.2 billion higher than the February budget estimate but $7.3 billion lower than the mid-session review estimate. Table 4 provides a comparison of actual receipts by major source with the CBO March and August estimates.

Three quarters of the $6 billion receipt shortfall from our August baseline update was in individual income tax receipts, mostly in taxes withheld from paychecks. Withheld taxes come in at a rate of roughly $35 to $45 billion per month, making a divergence from projected levels of this size a persistent event. Divergences in other tax sources were small, with shortfalls in customs duty and Federal Reserve receipts edging out an overage in corporate income tax receipts.

TABLE 4. FISCAL YEAR 1995 RECEIPTS (In billions of dollars)

Major Source	CBO March Baseline	CBO August Baseline	Actual	Actual Less CBO March	Actual Less CBO August
Individual income taxes	593.7	594.9	590.2	-3.6	-4.7
Corporate income taxes	149.0	156.0	157.1	8.1	1.1
Social insurance taxes	493.8	483.8	484.5	-9.4	0.7
Excise taxes	55.9	58.1	57.5	1.6	-0.6
Estate and gift taxes	16.0	14.5	14.8	-1.2	0.3
Customs duties	21.3	20.3	19.3	-2.0	-1.0
Miscellaneous receipts	25.5	29.2	27.3	1.8	-1.9
Total Receipts	1,355.2	1,356.7	1,350.6	-4.6	-6.2

Note: Details may not add to totals because of rounding.

Outlays

September outlays of $135.9 billion were only $4.3 billion higher than a year ago and $0.9 billion higher than we estimated for the month. The higher-than-expected outlays in September can be attributed largely to the early payment of October's cost for rental assistance and public housing operating subsidies. Table 5 summarizes the September results and the fiscal year totals by major spending categories.

TABLE 5. SEPTEMBER OUTLAYS (In billions of dollars)

Major Source	September 1995	Fiscal Year Totals 1995	1994	Percent Change
Defense-Military	25.0	259.6	268.6	-3.4
Social Security and Medicare	44.1	509.0	475.6	7.0
Other Major Benefits	30.4	331.0	319.1	3.7
Net interest on the public debt	19.9	239.2	210.6	13.6
Other federal programs	16.5	175.6	186.6	-5.9
Total Outlays	135.9	1,514.4	1,460.6	3.7

Note: Details may not add to totals because of rounding.

Outlays for the fiscal year totaled $1,514.4 billion, an increase of 3.7 percent from the 1994 level, the same percentage increase in outlays as for the previous year. Defense-Military outlays continued their downward trend, falling $9 billion (3.4 percent) below the 1994 level. Social Security benefits and Medicare outlays increased by $33 billion (7.0 percent) over 1994, about the same rate of growth as during the previous year.

Other major benefits grew by $12 billion (3.7 percent) in 1995, down slightly from the rate of growth in 1994 for this category of programs. Medicaid grants were up 8.6 percent, marginally above the 8.3 percent growth in 1994. Unemployment benefit outlays continued to decline in 1995, dropping $5 billion from the 1994 level. Food and nutrition outlays rose by only 2 percent in 1995 and supplemental security income benefits grew by less than 1 percent (1994 was boosted by an extra monthly payment because of the calendar). On the other hand, EITC outlays were up 30 percent over 1994.

Debt service costs rose sharply in 1995. Net interest on the public debt rose by $29 billion (13.6 percent) over the 1994 level. Other federal program outlays, however, fell by $11 billion (5.9 percent), but this was the result of spectrum auction receipts of $7.6 billion and a $10 billion increase in net negative outlays for deposit insurance programs. If these two items were excluded, other federal program outlays rose by $7 billion (3.6 percent) over the 1994 level.

TABLE 6. FISCAL YEAR 1995 OUTLAYS (In billions of dollars)

Major Source	CBO March Baseline	CBO August Baseline	Actual	Actual Less CBO March	Actual Less CBO August
Defense-Military	258.3	255.3	259.6	1.2	4.2
Social Security and Medicare	510.8	509.8	509.0	-1.9	-0.9
Other Major Benefits	333.3	331.5	331.0	-2.3	-0.5
Net interest on the public debt	243.5	240.4	239.2	-4.3	-1.1
Other federal programs	183.9	181.2	175.6	-8.3	-5.6
Total Outlays	1,529.9	1,518.2	1,514.4	-15.5	-3.8

Note: Details may not add to totals because of rounding.
a. Less than $50 million.

Total outlays in 1995 were $15.5 billion lower than we projected in our March baseline and $3.8 billion below our August update estimate. The comparable OMB misestimates were $24.5 billion for the February budget and $3.5 billion for the July mid-session review. As shown in Table 6, the bulk of the lower-than-expected spending from the CBO estimates were in the "other federal programs" category and involved a variety of programs including deposit insurance, CCC farm price supports, Public Health Service, Justice Department, NASA, and the Postal Service.

Defense-Military outlays were higher than both our March and August estimates, but these overruns were more than offset by shortfalls in other spending areas. Medicare outlays in total were $1.0 billion lower than projected in March and August, although hospital insurance (Part A) exceeded our projection by $1.4 billion while supplementary medical insurance (Part B) outlays fell short by $2.4 billion. Medicaid outlays, on the other hand, were quite close to our baseline estimates. The major shortfall from our March estimate for "other major benefits" was for the earned income tax credit, which was reflected in our August update.

October Projections

October receipts are estimated to be $97 billion and outlays $125 billion, giving a deficit of $28 billion for the month. Last year, October receipts were $89.0 billion, outlays were $120.4 billion, and the deficit was $31.3 billion.

Jim Blum
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Mr. RAMSTAD. If I could refer you, Madam Secretary, to table 3 on page 2 of that document. From the information listed, Madam Secretary, on the table, again just so we are on the same page, so to speak, could you tell me what the receipts are for Medicare payroll taxes on that page?

Secretary SHALALA [perusing document]. I think they have got Social Security and Medicare in the same numbers. If we are looking at the same document, they have combined the two.

Mr. RAMSTAD. They are gross figures for Social Security and Medicare, in other words?

Secretary SHALALA. Right.

Mr. RAMSTAD. Now let us look at the next page, at table 5 of the document.

Secretary SHALALA. Yes.

Mr. RAMSTAD. From the information listed on the table there, could you tell us where the outlays are for the Medicare HI Trust Fund on that page?

Secretary SHALALA. In both cases, it looks like they are combining both Social Security and the Medicare Trust Fund numbers.

Mr. RAMSTAD. Together?

Secretary SHALALA. Yes.

Mr. RAMSTAD. Lumped together. I think if we had time to go through the rest of the document, you would not find any reference, Madam Secretary, to the $36 million deficit in the Trust Fund spending over receipts in fiscal year 1995.

And frankly, Madam Secretary, with all respect, this document does not tell us anything about the financial activity, much less the financial condition, of the HI Trust Fund. It seems to me that your use of this document as one of your examples of—I think you used the words—how readily available this information about the Trust Fund is to Congress and the public, illustrates the very point we are trying to make today, that is, the administration was more interested in keeping this issue in the shadows rather than shedding light on the very pressing problem of the deficit in Medicare.

Secretary SHALALA. Congressman Ramstad, I should have been more comprehensive. Subsequent to the document, the November 7 document, the CBO staff on November 28, led by Paul Van de Water, who is the Assistant Director of their Budget Analysis Division, and his health staff spent an entire morning meeting with the HCFA actuaries to discuss the possible revisions to the CBO Medicare baseline in December. CBO was briefed extensively on the particular issues that we are discussing today. They had already acknowledged the Trust Fund shortfall in previous conversations with the HCFA actuaries. So CBO was not only informed; they went through their own briefings and spent considerable time with the HCFA actuaries. How they decided to use that information was public. It was used, obviously, to adjust the baseline. Whether they thought it was more dramatic than we did is obviously not evident, but let me simply make the case that CBO spent considerable time reviewing this issue with the HCFA actuaries and was very well-informed—as reflected in their own baseline adjustments and as reflected in Senator Domenici's own points in his own memo.

Mr. RAMSTAD. Well, Madam Secretary, I am not sure the fact that CBO was briefed extensively means that the information

about the Trust Fund was, as you stated before, readily available to Congress and the public. As you have cited, the numbers in the document are gross figures.

Secretary SHALALA. Yes, I understand that, Congressman, but there is a series of documents in which this material was available. But remember, these are interim estimates.

We do present a public report. The Board of Trustees in April presents a public report. The information that we had in December would not have changed the conclusion that we came to in 1995, and that is that we advised the Congress that prompt, effective and decisive action is necessary. A change from 2002 to 2001 would not lessen the urgency of this Congress dealing this year with the issue of the Medicare Trust Fund. And I fully expect us to use the same kind of language in our 1996 report if these numbers hold up in the final analysis and recommendations that the actuaries give us.

Mr. RAMSTAD. Well, again, Madam Secretary—and my time is up, so I will conclude—but with all respect, it just seems to me that this was enough of a milestone that the administration should have been more forthcoming instead of letting things be rather obscured.

Secretary SHALALA. Yes.

Mr. RAMSTAD. Thank you, Madam Secretary.

Secretary SHALALA. I also would refer you to the last page of the document, which makes a specific point about the Medicare outlays. It says "Medicare outlays in total were"—and it goes through the Medicare outlays, so it is much more specific than the tables. That is on page 5 of the same report. But it does not change our final conclusions, and that is, I cannot repeat enough what I repeated in the other hearing that I had with this Committee, and that is that we must deal with the Medicare Trust Fund.

Chairman ARCHER. The gentleman's time has expired.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Madam Secretary, Mr. Secretary, I am not so sure today whether we are holding a witch hunt, or an inquisition, or so-called hearing, but I am always happy to see you.

Let me just say that I am sorry we are here wasting your valuable time and wasting our valuable time. I do not think we need another so-called hearing that is used to attack you and criticize the administration and the President.

If you think back, Madam Secretary, we only had 1 day of hearings on the Republican Medicare bill. I think it is a shame and a disgrace that we have time for this hearing, but we do not have hearings for bills.

In fact, today, right now, we should be marking up a bill to extend the debt ceiling.

Mr. Secretary, are we facing a serious problem if we do not address the debt ceiling issue soon? What may happen if no action is taken by March 15, will we lose interest on the Trust Fund? It seems to me that if we are so concerned about the Medicare Trust Fund, we would act on the debt ceiling. If we do not, it could cost the Trust Fund money. Is that correct, Mr. Secretary?

Secretary RUBIN. Yes, Mr. Lewis. On March 15, there is about $2.2 billion, I believe, of cash proceeds that as a matter of law we will not be able to invest—cash proceeds going into the Medicare

and Social Security Trust Funds, a total, I think, of a little over $9 billion for all the trust funds put together. And there is no restoration of interest provisions for those trust funds, so what you say is correct. Congress would have to legislate to provide the restoration of interest.

Mr. LEWIS. Do you have any legislation coming before you? Has anyone on the other side, the majority side, offered a proposal to you and to the administration?

Secretary RUBIN. No, they have not, Mr. Lewis. I think your basic point is exactly right. It is absolutely essential that this debt limit ceiling be increased on a long-term basis and that that be done very promptly.

Mr. LEWIS. Madam Secretary, it is my understanding that you, other members of the administration and the President are going all out to protect Medicare. This is how we should be spending our time—trying to address the big issue, the global picture of protecting Medicare.

Wouldn't you agree, and would you like to elaborate?

Secretary SHALALA. Congressman, we have laid out a plan that will extend the life of the Medicare Trust Fund, and that plan includes reductions in the growth for hospital updates and other special kinds of what we have both described as cuts of $124 billion.

In addition, we have made recommendations to this Congress that will allow for more choice for Medicare recipients but also allow us to get more efficiency in the system through PPOs, through PSOs, through improved payment methods, through stronger quality protections.

Our great concern is that the proposals that we have seen thus far from your Republican counterparts in fact have some suggestions that would weaken the Trust Fund. The medical savings accounts, the Congressional Budget Office has already said, are a coster—$4 billion wasted, that will come from the Medicare Trust Fund, that will weaken the Trust Fund, as well as other recommendations that will allow for cherrypicking or allow for things that we have banned before, like self-referrals by doctors, which the CBO has also said would weaken the Trust Fund.

It is time that we got on with this, and I repeat what I repeated at the single hearing that I attended on Medicare, and that is we must deal with the Trust Fund issue.

Mr. LEWIS. Madam Secretary and Mr. Secretary, thank you.

Mrs. JOHNSON [presiding]. Mr. Hancock.

Mr. HANCOCK. Madam Secretary, a real quick one. You said that allowing people to save their own money to pay their own medical bills is wasted money for the government?

Secretary SHALALA. I—excuse me?

Mr. HANCOCK. Yes, you did. You said that the MediSave plan was wasted money.

Secretary SHALALA. No. I——

Mr. HANCOCK. How can you logically say that to allow people to save their own money to pay for their own medical bills is wasted money from the government? I'm sorry, I——

Secretary SHALALA. Medical savings accounts—I did not say it. What I said was that the Congressional Budget Office said that we were spending money that we would not otherwise spend in the

Medicare system in medical savings accounts. I was simply quoting——

Mr. HANCOCK. Madam Secretary, Madam Secretary——

Secretary SHALALA [continuing]. The Congressional Budget Office.

Mr. HANCOCK [continuing]. You said that to allow people to save their own money to pay for their own medical bills was wasted money on the part of government. I beg your pardon——

Secretary SHALALA. The Congressional Budget Office has said that the——

Mrs. JOHNSON. I would like to recognize——

Secretary SHALALA [continuing]. Medical savings accounts will cost Medicare over $4 billion that we would not otherwise spend on the individuals who will participate in the program.

Mrs. JOHNSON. I would like to recognize Mr. English.

It is true that the Congressional Budget Office has estimated that provision of the Republican proposal to cost $4 billion. There is also a great deal of disagreement as to whether that is going to happen or not.

It is also true that Republicans believe very strongly that that will reduce the rate of growth in spending for those people. And so this is a difficult issue. It is a new approach to health insurance, and that is why there are legitimate differences about it.

Mr. English.

Mr. ENGLISH. Madam Chairman, I will yield my time.

Mrs. JOHNSON. Mr. Portman.

Mr. PORTMAN. I thank the Chairwoman, and I appreciate, Mr. Secretary, your staying for this final round of questioning, and Madam Secretary, thanks for being here.

I listened very carefully today Madam Secretary, to your testimony, and let me briefly summarize where we are and why this conversation today continues to concern me.

It is very important that we talk about this data which was not properly released because I think the perception of the problem is extremely important to solving the problem, and I think that that is something both the White House and the Congress have realized over the past year.

As I see it, in 1993, 1994 and 1995, you did indeed send us warnings, and you talked about that, Ms. Shalala, several times in your testimony, and how it was so important that we deal with this issue on an urgent basis. At the same time, there was no action. And when you testified before the Ways and Means Committee the last time, my whole point was to tell you that we were desperate; we begged for you to send us a proposal. Eventually, after we went ahead and came up with our proposal, which was criticized by the White House, there was a proposal forthcoming from the administration. Ours was about a $270 billion reduction in the rate of growth of Medicare. Your proposal was about a $124 billion reduction in the rate of growth.

Again, the issue became how much of a problem do we have, and that was the great challenge we had with the American people, was trying to explain on a factual basis where we actually were. And this is why this information which was not properly released is so important.

We then went through the process of the television ads, which were played in my district repeatedly, that demagogued the issue and misinformed the public as to what the problem was and what we were doing. We in turn moved from about a $270 billion reduction in the rate of growth to a $168 billion reduction in the rate of growth, so over $100 billion, in the process. I just ask you this question, because these are ongoing negotiations to try to save the program, has the administration moved from $124 billion? We have gone from roughly $270 to $168 billion.

Secretary SHALALA. Let me first, before we get into the negotiations, indicate that the material was properly released. We never publicly released information from the December meeting of the Medicare Trustees, but the official release of detail and data that was released was released in the proper channels. And the GAO report, which reviewed the release of this information, did not indicate that there was anything improper in the information we released, and that we annually released the details officially as part of our April report.

Mr. PORTMAN. I think we have gone over that in some detail today, and I purposely was not going to focus on that. If you would like to, I am happy to, because I think there was on the part of the fiduciaries of the Fund a responsibility to report the information properly, and it was not done so. But I am talking about what you said you wanted to talk about, which is the future and how we get there.

You have gone from $124 billion to where over the last year?

Secretary SHALALA. Let me say that we have been at $124 billion. Those are very deep cuts in the program, but at the same time, we have made recommendations that would make the program more competitive. We have objected to Republican proposals that would cost money, weaken the Trust Fund, and shift costs to beneficiaries. But we are not willing to do——

Mr. PORTMAN. Well, let me just focus on that, because——

Secretary SHALALA [continuing]. What you are obviously willing to do—we are not prepared to shift costs to beneficiaries.

Mr. PORTMAN. Well, I am willing to make significant changes to an entitlement program that needs changes, and you have not moved from $124 billion, which I guess is your answer. Let us talk about the beneficiaries. In your statement, you say that "Our proposal does not impose additional costs on beneficiaries." You also say in your statement to us this morning, "Beneficiaries' out-of-pocket expenses should not be substantially increased," implying, of course, that the Republican proposal does that.

Let us talk about that since you just brought it up again, because this is where we are getting into how do we bridge this gap. You say it is so important that we save the program, we say it is important, and yet there is no movement on your side, and there has been substantial movement on our side.

What is the difference in cost to the beneficiary over the next 7 years? It is my understanding that the difference between the administration's plan and ours is between $5 and $10 per beneficiary per month—$5 to $10 a month—is that what you would call a major difference, a substantial increase? Is that the reason why you are not willing to come together with us to solve the problem?

Secretary SHALALA. Congressman Portman, there is a significant hit on beneficiaries that goes beyond the amount of money that they would pay every month—balance billing; there are plans that the Republicans are putting forward that would allow doctors to charge anything on top. In addition to that, these proposals would hit low-income beneficiaries—the average Medicare recipient in this country has an income of $13,000 a year and already has 20 percent of that in out-of-pocket costs. They cannot get back into their Medigap plans if they go out into a managed care plan. That would impose a huge cost on a beneficiary, particularly those with preexisting conditions.

Throughout the Republican plan are hidden costs for beneficiaries that would make it very difficult for relatively low-income people. As people get older, they get poorer. Our concern is that they will not be able to use those Medicare plans at the end of the day because it will cost them too much to use those plans.

So it is not simply what they are going to pay for the basic insurance plan; it is all the other costs that they will have to pick up, particularly if they decide to go outside of traditional Medicare.

Our argument is let us protect the beneficiaries but slow down the growth; let us increase the efficiency of the system; let us make sure we have eliminated waste, fraud and abuse, aggressively; let us not mandate and take off some of the restraints that we have put in that will lead to more fraud in the system.

Mr. PORTMAN. I thank you for your statement. I don't think anybody on this panel, I hope, on our side or the other side would disagree with any of those principles that you outlined, and my question is, over the last year, we have changed our proposal substantially to address specific concerns raised by the administration, and why hasn't the administration been willing to bridge the gap. I think the answer is that there frankly is not the will to do so, so long as this can be a political issue, bandied about and demagogued.

Thank you, Mr. Chairman.

Secretary Shalala. I respectfully disagree, Mr. Portman.

Mr. LAUGHLIN [presiding]. The gentleman's time has expired.

Next, the Chair will recognize the gentleman from Washington, Mr. McDermott.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Rather than asking if I can show a videotape of the speaker saying that he wants Medicare to wither on the vine, I would like to ask you a serious question.

As you analyze these changes in the Trust Fund, we all know that the Republican Medicare proposal wants to put more senior citizens into managed care, but we know from a recent Mathematica study that Medicare managed care plans are being overpaid by almost 6 percent per enrollee. So it seems to me that the deficit which we are allegedly here discussing is caused in part by proposals which the Republicans are pushing and trying to expand.

In addition, my understanding is that the MSA proposal which they are proposing for Medicare would cost Medicare $4.6 billion over 7 years.

It seems to me that the proposals they are offering as solutions to the Medicare problem make its financial condition worse, and I would like your comments about what it is that they have proposed and what the President has proposed and what the differences are, and why the President's proposal is better, because I personally think the President has made a good proposal.

Secretary SHALALA. Two points about the Republican plans. One is that they do indeed have costers; that their proposals will weaken the Medicare Trust Fund directly, as you pointed out, with the medical savings accounts. But in addition, the medical savings accounts will also weaken the pool, because it will allow cherry-picking of those who are wealthier and healthier, which will incur costs on the Medicare Program.

The Republican plan has significant savings because they shift costs onto the beneficiaries, and as I pointed out, the average elderly person in the Medicare Program has an income of $13,000 a year. They already pay 20 percent of that in out-of-pocket health care expenses. They are being asked to go out into managed care companies or other kinds of alternatives that may be able to charge them more on top, and even if they went out into managed care, the Republican proposal does not allow them to come back into the traditional Medicare fee-for-service because they cannot get their Medigap plans back.

For a senior citizen, it is the worst of every world, choice that is not choice at all, increasing costs, weakening of the Medicare pool by putting in costers, and weakening of our ability to fight waste, fraud and abuse because of cuts in both HCFA Administration budgets as well as eliminating some of the referral restraints that we have put on in the past.

What the President does is protect beneficiaries, increase choice for the beneficiaries so that more beneficiaries can choose not only managed care, but PPOs and other kinds of new delivery systems. It protects them to come back into traditional Medicare if that is what they want to do, and at the same time, firmly squeezes down on the growth of the Medicare system, mostly on the provider side, which we think is very important.

Mr. MCDERMOTT. Do I understand what you are saying is that if someone chooses a managed care plan—some senior citizen—once they go into that, if they get dissatisfied with it, and they would like to go back into the fee-for-service system, they will not be able to get Medigap insurance? Is that what you are saying?

Secretary SHALALA. That is what I am saying. If you will remember, the Medigap period for enrollment is the first 6 months, and there is no provision in the Republican plan that if you go out to a managed care plan that you can go backward and go back in. So it is not real choice.

Real choice is where you could go back and forth and change your mind. Many seniors may not like managed care. They may well want to go back into traditional Medicare, into the fee-for-service. Most of them will have preexisting conditions, so they won't be able to get their Medigap plans back. We will not be able to protect them under the Republican plan to go back into Medigap.

Mr. MCDERMOTT. My understanding is that there are 9 million widows in this country living on less than $8,000 a year. Is that correct?

Secretary SHALALA. That is correct.

Mr. MCDERMOTT. And that is the group that would be incurring additional costs under the Republican plan; the Republicans would be shifting that cost onto those beneficiaries, the 9 million or so widows making less than $8,000 a year.

Secretary SHALALA. That is exactly right.

Chairman ARCHER. The gentleman's time has expired.

Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Secretary Shalala, thank you for being here, and I know Secretary Rubin had another meeting to go to, and I am sorry that he could not be here, but I would ask you to pass on why I think this hearing is so important.

Unlike Secretary Rubin, I never worked on Wall Street, and unlike Secretary Rubin, I never knew a Rhodes scholar until I met President Clinton at the White House. I talk to an awful lot of people in my State and my district who are greatly concerned about Medicare and its impact on their lives, and I think I have more in common with those people, who have never met a Rhodes scholar or worked on Wall Street.

The dollars that we are talking about here are out of the imagination of people like me and most of the people out here, dependent upon Medicare. When I hear that there is a projected surplus of about $4.7 billion, and then, in October, someone—not you and not Secretary Rubin and not the President, but someone reportable to you—makes a determination that we are going to have a shortfall of about $36 million, and while the math is not accurate, it is about a $5 billion shift, that is real money to the people whom I talk to. I think that you and Secretary Rubin particularly, who are Trustees, have an obligation to those people out there that this amount of money amounts to real money. While it may be insignificant to people who have Wall Street backgrounds, these are significant shifts of money for which they feel—and I have heard this said many times in the last several weeks—someone should have been talking about.

So I think that is the real reason, and the important reason, for this hearing. I hear a lot of them talking about the rhetoric that comes out of Washington, DC, by some, that strikes fear in the hearts of citizens that Medicare is going to go away. And then we have the problem of what many would consider significant dollars in the forecast, either disappearing or not meeting the expectations.

And with this great debate going on in the National Capital, don't you feel that the people out there in the countryside are entitled to know when this significant amount of money does not remain on the books or remain to be used in this debate whether we have medical savings accounts or whether we leave the system as it has been for the last 30 years and just raise taxes?

Secretary SHALALA. Congressman Laughlin, not only do I believe that everyone should know that the Medicare Trust Fund is in trouble and must be dealt with, but we said it in 1993, we said it

in 1994, we said it in 1995; we said it was urgent, that it had to be dealt with directly and quickly, and I am repeating it in 1996. There is no question in my mind.

It does not have anything to do with just the estimates that we were given in December. Without those estimates, I would have the same note of urgency in my voice that I had in 1993, in 1994, in 1995, and now in 1996.

Mr. LAUGHLIN. Well, while I have heard repeated references to Senator Domenici—and I am sure that his report gives some comfort to whomever failed to bring to your and Secretary Rubin's attention this problem—he is not a Trustee, is he, with an obligation to the Congress and the American people? He is not a Trustee of this Trust Fund, is he?

Secretary SHALALA. He is not.

Mr. LAUGHLIN. And the last thing I want to ask is this. There has been great reliance upon the "Treasury Notes" dated October 27, and now I have forgotten, because time has passed, whether it was you or Secretary Rubin—and it is now important—who was here. One of you testified that in this report, it was highlighted about the shortfall. And the way I understand the word "highlighted" in a report, it tells me that it either marks a lot in some unusual color, or "Please Note" in capital letters, or "Important to Observe," or just some kind of warning in the document. And with all due respect to both you and Secretary Rubin, I have looked through this, and I do not find any highlighting of the information you all are here testifying about, that somebody on the congressional staff should have found.

Secretary SHALALA. Congressman Laughlin, in 1993 in April, a few minutes after we had come to office——

Mr. LAUGHLIN. Secretary Shalala, I want to interrupt——

Secretary SHALALA [continuing]. We warned about the condition of the Trust Fund; in 1994, we warned about the condition of the Trust Fund. The urgency has been with us——

Mr. LAUGHLIN. My question was not about 1994, and the red light is on, but do you find anything highlighted in the "Treasury Notes" that we have been referenced, and either you or Secretary Rubin said it was highlighted?

Secretary SHALALA. Congressman Laughlin, there is nothing in that report that would change the conclusion that I have given this Congress as a Trustee of the system since we arrived in 1993. We must deal with the Medicare Trust Fund now.

Chairman ARCHER. The gentleman's——

Mr. LAUGHLIN. I understand your answer. It does not answer my question.

Mr. Chairman, would you instruct the witness to answer my question, Where is it highlighted in this document?

Chairman ARCHER. I think she has responded that it is not. But the gentleman's time has expired.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Levin.

Mr. LEVIN. Welcome. When did you first hear about this letter of February 5, signed by four Members of the House? Do you remember?

Secretary SHALALA. I am sorry?

Mr. LEVIN. This letter that was sent to you on February 5, do you remember—did any of the four call you about this subject matter?

Secretary SHALALA. No.

Mr. LEVIN. So they sent you a letter.

Secretary SHALALA. Actually, I heard about it in a press statement from a reporter.

Mr. LEVIN. I think so. In other words, this is a matter of major importance, a letter is sent to you, and no one calls you?

Secretary SHALALA. No.

Mr. LEVIN. Did Chairman Archer call you?

Secretary SHALALA. No.

Mr. LEVIN. Did Mr. Bliley call you?

Secretary SHALALA. No.

Mr. LEVIN. Did Mr. Thomas call you?

Secretary SHALALA. No.

Mr. LEVIN. Did Mr. Bilirakis call you?

Secretary SHALALA. No.

Mr. LEVIN. And you first heard about this from a reporter?

Secretary SHALALA. Yes.

Mr. LEVIN. Was there a press conference—apparently, there was a press conference about this letter before you received it?

Secretary SHALALA. I do not remember that, but I do remember that I first heard it in a press——

Mr. LEVIN. This is the letter to you dated February 5, regarding this matter, and saying they were shocked to read press reports. That is the letter you are referring to?

Secretary SHALALA. Yes.

Mr. LEVIN. Do these four gentleman know the telephone number of HHS?

Secretary SHALALA. I am sure they do.

Mr. LEVIN. Now let me ask you about CBO——

Chairman ARCHER. Will the gentleman yield?

Mr. LEVIN. I will.

Chairman ARCHER. The gentleman has referred to a letter that I signed. The letter was in the Secretary's office before the press ever knew anything about it, number one. I cannot vouch for how quickly information gets to the Secretary; some of this hearing today is devoted to that very issue. But the letter was certainly there——

Mr. LEVIN. Mr. Chairman——

Chairman ARCHER [continuing]. And if the gentleman would yield for just one small additional comment, had we received a letter on October 27, we would have been much better advised as to the condition of the Trust Fund.

Mr. LEVIN. If I could say a word——

Chairman ARCHER. I thank the gentleman for yielding.

Mr. LEVIN. What disappoints me most about the way you all have proceeded in holding this hearing is that I thought this year might be different from last year. I still have hope that we can proceed in some type of bipartisan manner on other important issues.

This hearing has the exact opposite purpose or surely tone to it. No one called the Secretary about this matter. A letter was sent, and then a press conference was held. A press conference was held

I think the next day. CBO had full knowledge of this, and I cannot ask you questions, but I wonder whether CBO notified any of you. They put this into their assumptions. They worked for you. Instead of having Donna Shalala, you ought to have CBO here and your own staff. Your staff received a copy of this material.

I am not faulting your staff or faulting June O'Neill; she handled it the same way that HHS did, and Mr. Domenici—it is his words, Mr. Laughlin; it is their words. The word "significant" comes from them, not from Donna Shalala. It says, "The recent change in projections do not significantly affect the longrun Medicare situation." And the Senate Budget Committee gives your conspiracy theory an "F."

And the disturbing thing is that it is being pursued here when we should be working on a bipartisan basis to resolve the Medicare issue. There is a shortfall, and that is the most disturbing part of this. She hears about this through a press report instead of someone picking up the telephone and trying to discuss this on a sensible, rational basis.

Chairman ARCHER. Mr. English.

Mr. ENGLISH. Secretary Shalala, this hearing has run a long time, and I will try to be brief. I have already made one comment previously.

I want to thank you for being here. I think clearly the point of what we are discussing today is the timely presentation of this information to the American public, and the fact that part A was going south a lot quicker than a lot of us had originally thought.

You have pointed out correctly that last year, you were one of the Trustees who called our attention to this problem, and I have applauded your report in town meetings in my district.

However, the fact that it was not called vividly to the attention of the American public at a time when we were debating Medicare, and a lot of people have had questions about why this issue had even come up, or whether there was really a crisis in Medicare. You have made it clear that you think there is a crisis in Medicare. There are some among my colleagues who have made statements that were more doubtful. I have to say this information coming available when it did might have had a substantial difference in the debate, might have shaped public perceptions of the nature of the problem, might even have changed the outcome of some of the debates in the House, simply because I think that if more of my colleagues had had access to this information, they might have taken this problem more seriously, and we would have seen more bipartisanship in the Medicare reform issue as it had been debated.

I think the point of this hearing has been to explore whether we could have gotten the information sooner, whether the American public could have had access to it, whether it could have been introduced into the public debate; and, contrary to some of my colleagues on this panel, I do not think that is a trivial issue.

I want to give you credit for the positive efforts that you have made. As I think I have made clear, and I do not want to belabor the point, I am disappointed that it was not made public several months earlier than it was. I have your word on the fact that this was nothing deliberate on your part, and certainly, I think we have buried the notion that today's hearing was in any way a witch

hunt. This was on a very substantive issue which I think was within the Committee's jurisdiction and is of immediate concern to the American public.

Mr. Chairman, I would be happy to yield back the balance of my time.

Chairman ARCHER. I thank the gentleman for yielding.

Madam Secretary, I understand that you also, as all of us do, have schedule constraints, and that you need to leave at 12:45, so we will have one last questioner, Ms. Kennelly.

Ms. KENNELLY. Thank you, Chairman Archer.

I think it has come out clearly in this hearing that when you get all through what has been said, the facts that we are looking at today are very important facts because they relate to the solvency of the Medicare Fund. We all wish that we had all read every last word in that monthly Treasury report, but a lot of people did not. And I just want to salute you for the work you have done this year. I have met with you, and every member of this panel has met with you on the solvency of Medicare, and I think the one thing that should come out of this hearing is that we all agree that we are very, very committed to the solvency of Medicare, and I thank you for that.

Secretary Shalala, I wonder if you would comment to me about medical savings accounts. What I find when I go home is that medical savings accounts are not totally understood and also that there is a difference between medical savings accounts for someone who is 25 years old and someone who is 65 years old.

So I wonder if, before you leave us today, having really withstood a good deal of questioning, and you have handled yourself as you always do, could you comment on the medical savings account—but before you do that, I just thought of something. The next summary of Medicare solvency comes out, I believe, in April?

Secretary SHALALA. Yes.

Ms. KENNELLY. I have the feeling that everybody will read every word of the next report of the Trustees. Is there any possibility that report might be late, Madam Secretary, because of the closing down of the government?

Secretary SHALALA. Well, it may be late because of the closing down. We are trying to make sure that we get it as much on time as possible, and I would be happy to come up and brief the Members of this Committee early, as soon as it is ready to go into printing or something, if the Committee would like that. But at the moment, I think——

Chairman ARCHER. I think that would be very helpful. Thank you.

Secretary SHALALA. At the moment, I think we are working very hard, but I did get some information that the dates may slip because of the furlough. And, in fact, that Trustee meeting that we were talking about happened during the furlough, too, so we have been working with less staff than we normally do.

Ms. KENNELLY. I am asking you this about the medical savings accounts because we don't know what will exactly happen as we move forward. I think we all hope that there is a budget that we can agree to. But I come from Hartford, Connecticut, which has an interest in insurance, and I know the difficulty of doing a risk ad-

juster, so I wish you would comment on how you think medical savings accounts would affect Medicare if in fact they were enacted.

Secretary SHALALA. All of the analysts who have looked at medical savings accounts, including the Congressional Budget Office, believe that basically, they would segment the market and allow those sponsors of the medical savings accounts to take out of the pool those elderly people who are healthier and wealthier. These are people who currently probably do not use very much Medicare money, and then give them money that we would not otherwise be spending on them.

An example of these kinds of people would be my mother, who is 84 and plays tennis every day and is very healthy, who barely dips into her Medicare insurance. We would be allowing her to get money from the government that she would not otherwise get, and that would weaken the Medicare Trust Fund because it would take a healthier population out of it—but it is precisely why the Congressional Budget Office said it would cost $4 billion as opposed to saving money.

We believe that senior citizens ought to have alternatives, but that those alternatives ought not to weaken any of the markets and cost the Medicare Trust Fund more money than it would be currently spending.

Right now, I think about 11 percent of Medicare recipients never dip into the Medicare Fund, and we have to be very careful that we do not do something with them, spend money on them that we are not now spending on them, because that is the way in which we can spend money on those who are less healthy.

Ms. KENNELLY. So it is wise of me to keep looking at that.

Secretary SHALALA. Absolutely.

Ms. KENNELLY. Thank you very much, Madam Secretary.

Chairman ARCHER. Madam Secretary, thank you for taking the time today. It has been over 2 hours, and we are very grateful for that time. We know you have other duties, so you certainly are excused to go attend to those duties.

Thank you very much.

Secretary SHALALA. Thank you very much, Mr. Chairman.

Chairman ARCHER. Our next, Sarah Jaggar, Director of Health Financing and Public Health Issues of the GAO.

Ms. Jaggar, thank you very much for coming to help us through this process today. We would appreciate your statement, and you may proceed.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. JAGGAR. It is a pleasure to be here, Mr. Chairman.

Mr. Chairman and Members of the Committee, you asked us to be here today to testify on our ongoing review of the status of Medicare's Federal Hospital Insurance Part A Trust Fund. Specifically, the Committee asked us to determine, first, when the administration became aware that the Trust Fund had an operating deficit of $36 million for fiscal year 1995 and how the information was

disseminated, and second, the status of current projections regarding the Trust Fund.

With your permission, I will summarize my statement and request that the full statement be submitted for the record.

Chairman ARCHER. Without objection, so ordered.

Ms. JAGGAR. First, when did the operating deficit become known? The fact that the Part A Trust Fund had run an operating deficit during fiscal year 1995 was first published in a Department of the Treasury monthly report dated October 27, 1995. Table 8 in the Treasury report showed that the Trust Fund had cash receipts of $114.85 billion and cash outlays of $114.88 billion, resulting in an operating deficit of $36 million during 1995.

[The report is being held in the Committee's files.]

Ms. JAGGAR. HCFA's Chief Actuary told us he became aware of the operating deficit in late November 1995, after HCFA received from the Department of Treasury more detailed monthly tables on the Part A Trust Fund.

On December 2, in response to the HCFA Administrator's request several days earlier for an update on Medicare and Medicaid spending, the Chief Actuary sent the Administrator an electronic mail message explaining the operating deficit. In a December 6 electronic mail message, the Chief Actuary told the Administrator that if the assumptions used for the April 1995 Trustees' Report were applied without change to the new data, the Trust Fund depletion date would advance from the end of calendar year 2002 to roughly the middle of calendar year 2001. He pointed out that changes to the assumptions could advance or postpone the depletion date somewhat, but he would not know for sure until the estimates for the 1996 Trustees' Report are completed.

The Secretary of HHS was informed by memo dated December 8, 1995, that she would be briefed by the HCFA Administrator on the Social Security and Medicare Trust Funds in preparation for the biannual Trustees meeting and that one important item to be discussed was the part A operating deficit. This briefing occurred on December 11. The other Federal Trustees were also briefed individually before the Board of Trustees meeting.

The Board of Trustees biannual meeting was held on December 13, 1995. All of the Trustees, which include the Secretaries of Labor, HHS and the Treasury, the Commissioner of Social Security and two public Trustees, participated in the meeting, which was chaired by the Secretary of the Treasury.

Also on December 13, the Congressional Budget Office released its updated budget baseline, which reflected the fiscal year 1995 data on the Part A Trust Fund. The overall spending estimates for Medicare for fiscal years 1996 through 2002 decreased slightly.

OMB staff became aware of the part A operating deficit for fiscal year 1995 in December 1995. An OMB official advised the Special Assistant to the President for Health Policy Development of the operating deficit sometime after the December 13 Board of Trustees meeting.

In our discussions with the Chief Actuary and a public Trustee who attended the December 13 Board of Trustees meeting, they said that the news of the operating deficit for fiscal year 1995 did not seem to cause alarm. They stated that the need for corrective

action was clear in prior Trustees' Reports, and that the Trust Fund's 1995 performance did not change this need.

The Chief Actuary and the public Trustee also remembered a question being asked about the Part A Trust Fund deficit, related to whether this information would be fully discussed in the 1996 Trustees' Report. The question was answered in the affirmative.

Now, second, I would briefly like to mention the status of current projections regarding the Trust Fund. The Part A Trust Fund had an operating deficit in October and November 1995, but the monthly Treasury statement for December 1995 showed that the Part A Trust Fund generated a surplus of $747 million for the first quarter of fiscal year 1996. The surplus for the first quarter of fiscal year 1995, in contrast, was $3.3 billion.

The Office of the Actuary has been trying to identify reasons for the estimating error in the 1995 Trustees' Report. Preliminary data indicate that hospitals had speeded up the submission of claims, causing some claims to be paid in September rather than October. Because the Trust Fund numbers are presented on a cash basis, this resulted in higher than expected outlays in fiscal year 1995. In addition, preliminary data indicate that admissions to hospitals and the case mix index of admissions also increased at faster rates than had been estimated, which would tend to increase outlays. Finally, Trust Fund receipts were somewhat below projected amounts.

The Office of the Actuary expects to complete its analysis for the 1996 Trustees' Report by late March or April.

This completes my prepared statement. I will be glad to answer any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT OF SARAH F. JAGGAR
DIRECTOR
HEALTH FINANCING AND PUBLIC HEALTH ISSUES
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee:

You asked us to testify today on our ongoing review of the status of Medicare's Federal Hospital Insurance (part A) Trust Fund. Specifically, the Committee asked us to determine (1) when the administration became aware that the trust fund had an operating deficit--that is, cash outlays exceeded cash receipts--of $36 million for fiscal year 1995 and how the information was disseminated and (2) the status of current projections regarding the trust fund.

To address your questions, we spoke with officials of the Departments of Health and Human Services (HHS), Labor, and the Treasury; the Health Care Financing Administration (HCFA), including its Chief Actuary; the Congressional Budget Office (CBO); the Office of Management and Budget (OMB); the Social Security Administration; and one of the public members of the Board of Trustees. We also obtained relevant documents from these officials and reviewed the monthly cash-basis part A trust fund reports for fiscal years 1991 through 1995 and the first quarter of fiscal year 1996.

The Board of Trustees'[1] annual report issued in April 1995 estimated that the part A trust fund would have an operating surplus in fiscal year 1995, just about break even in fiscal year 1996, and move to an operating deficit in fiscal year 1997.[2] The Trustees projected that the fund would be depleted in calendar year 2002. The fund actually had an operating deficit for fiscal year 1995.

WHEN DID THE OPERATING DEFICIT BECOME KNOWN?

The fact that the part A trust fund had run an operating deficit during fiscal year 1995 was first published in a Department of the Treasury monthly report[3] dated October 27,

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[1]The Federal Hospital Insurance Board of Trustees consists of the Secretaries of Health and Human Services, Labor, and the Treasury; the Commissioner of Social Security; and two members who represent the public.

[2]The Trustees' report presents three sets of estimates based on high cost, low cost, and intermediate sets of assumptions. In this testimony, we use the estimates based on the intermediate assumptions, which are those the Trustees considered the most likely to occur.

[3]Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 1995 Through September 30, 1995, and Other Periods (Washington, D.C.: Department of the

1995.[4] This report includes a number of tables summarizing the financial activities of the federal government.[5] HCFA's Chief Actuary told us he became aware of the operating deficit in late November 1995 after HCFA received from the Department of Treasury more detailed monthly tables on the part A trust fund.[6]

On December 2, in response to the HCFA Administrator's request several days earlier for an update on Medicare and Medicaid spending, the Chief Actuary sent the Administrator an electronic mail message explaining the operating deficit. The message stated that cash outlays were $3.3 billion higher than estimated in the Trustees' 1995 report and that cash payroll tax receipts were $1.6 billion lower, accounting for most of the estimating error.

In a December 6 electronic mail message, the Chief Actuary told the Administrator that, if the assumptions used for the April 1995 Trustees' report were applied without change to the new data, the trust fund depletion date would advance from the end of 2002 to roughly the middle of 2001. He pointed out that changes to the assumptions could advance or postpone the depletion date somewhat, but he would not know for sure until the estimates for the 1996 Trustees' report are completed.

The Secretary of HHS was informed by memo, dated December 8, 1995, that she would be briefed on the Social Security and Medicare trust funds in preparation for the biannual Trustees meeting and that one important item to be discussed was the part A operating deficit. The Administrator briefed the Secretary of HHS on December 11 on the trust fund operating deficit and other matters related to the upcoming Trustees meeting, and the other federal Trustees were also briefed individually before the Board of Trustees meeting on December 13, 1995. The Administrator's briefing document basically covers the items included in the two electronic mail messages from the Chief Actuary to the Administrator.

Treasury, Oct. 27, 1995).

[4]This report is routinely distributed to about 2,400 addressees.

[5]Table 8 in the Treasury report showed that the trust fund had cash receipts of $114.85 billion and cash outlays of $114.88 billion, resulting in an operating deficit of $36 million. (See appendix I for a copy of table 8.)

[6]About 3 weeks after HCFA receives the Treasury's monthly receipts and outlays report, Treasury also sends a more detailed monthly set of tables on the part A trust fund.

The Board of Trustees biannual meeting was held on December 13, 1995. All of the trustees participated in the meeting, which was chaired by the Secretary of the Treasury.

Also on December 13, CBO released its updated budget baseline,[7] which reflected the fiscal year 1995 data on the part A trust fund. The overall spending estimates for Medicare for fiscal years 1996 through 2002 decreased slightly.[8] While CBO's March 1995 baseline had underestimated part A expenditures by about $1 billion, it said that lower inflation would largely offset the rise in spending. CBO did not make an estimate of trust fund receipts and has not updated its estimate for the date the trust fund will be depleted.

OMB staff became aware of the part A operating deficit for fiscal year 1995 in December 1995. An OMB official advised the Special Assistant to the President for Health Policy Development of the operating deficit sometime after the December 13 Board of Trustees meeting.

In our discussions with the Chief Actuary and a public trustee who attended the December 13 Board of Trustees meeting, they said that the news of the operating deficit for fiscal year 1995 did not seem to cause alarm. They stated that the need for corrective action was clear in prior Trustees' reports and that the trust fund's 1995 performance did not change this bottom line. Outlays have been growing faster than receipts in recent years, leading to the operating deficit.

The Chief Actuary and the public trustee also remembered a question being asked about the part A trust fund deficit related to whether this information would be fully discussed in the 1996 Trustees' report. The question was answered in the affirmative.

STATUS OF CURRENT PROJECTIONS REGARDING THE TRUST FUND

The part A trust fund had an operating deficit in October and November of 1995, but the monthly Treasury statement for December 1995 showed that the part A trust fund had generated a surplus of $747 million for the first quarter of fiscal year 1996. The surplus for the first quarter of fiscal year 1995 was

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[7]The Economic and Budget Outlook: December 1995 Update (Washington, D.C.: CBO, Dec. 1995).

[8]Spending on part A and part B (Supplemental Medical Insurance) was estimated to be $45 billion lower than in the March 1995 baseline, mainly because part B spending was about $2 billion lower relative to CBO's March 1995 baseline for fiscal year 1995.

$3.3 billion, as shown in appendix II.

The Office of the Actuary has been trying to identify reasons for the estimating error in the 1995 Trustees' report. We were told that a number of possible reasons are being explored. Preliminary data indicate that hospitals had speeded up the submission of claims, causing some claims that normally would have been paid in October to be paid in September. Because the trust fund numbers are presented on a cash basis, this would result in higher than expected outlays in fiscal year 1995. In addition, preliminary data indicate that admissions to hospitals and the case mix index of admissions also increased at faster rates than had been estimated. Both of these factors would tend to increase outlays. Finally, trust fund receipts were below projected amounts.

The Office of the Actuary expects to complete its analysis for the 1996 Trustees' report by late March or April.

- - - -

This completes my prepared statement. I will be glad to answer any questions you may have.

For more information on this testimony, please call Tom Dowdal, Assistant Director, at (202) 512-6588. Other major contributors were Roger Hultgren and Pete Oswald.

TREASURY'S FISCAL YEAR 1995
TRUST FUND SUMMARY

Table 8. Trust Fund Impact on Budget Results and Investment Holdings as of September 30, 1995

[$ millions]

Classification	This Month			Fiscal Year to Date			Securities held as investments Current Fiscal Year		
							Beginning of		Close of This Month
	Receipts	Outlays	Excess	Receipts	Outlays	Excess	This Year	This Month	
Trust receipts, outlays, and investments held:									
Airport	333	777	−445	6,125	7,242	−1,117	12,206	11,547	11,145
Black lung disability	416	462	−46	987	987	(*)	.....	.....	.....
Federal disability insurance	4,749	3,606	1,143	70,215	41,380	28,835	6,100	34,146	35,225
Federal employees life and health	.....	−145	145	.....	−1,240	1,240	22,503	23,601	23,729
Federal employees retirement	24,375	3,268	21,108	66,821	38,899	27,923	346,317	353,081	374,219
Federal hospital insurance	9,150	10,271	−1,121	114,847	114,883	−36	128,716	130,931	129,864
Federal old-age and survivors insurance	26,560	24,569	1,991	326,064	294,474	31,611	413,425	445,944	447,947
Federal supplementary medical insurance	1,746	5,903	−4,157	58,169	65,213	−7,044	21,489	17,673	13,513
Highways	2,115	2,340	−226	23,613	22,688	925	17,694	18,846	18,531
Military advances	967	1,314	−347	12,469	13,417	−948	.....	.....	.....
Railroad retirement	451	675	−224	9,093	7,924	1,169	12,203	14,063	14,440
Military retirement	918	2,386	−1,468	34,624	27,797	6,827	105,367	114,320	112,963
Unemployment	336	1,801	−1,465	32,820	25,282	7,539	39,788	48,660	47,141
Veterans life insurance	23	110	−86	1,356	1,231	126	13,477	13,690	13,606
All other trust	525	555	−30	6,056	4,346	1,710	12,317	14,180	14,060
Total trust fund receipts and outlays and investments held from Table 8-D	**72,865**	**57,893**	**14,772**	**763,281**	**664,521**	**98,760**	**1,151,801**	**1,240,682**	**1,256,385**
Less: Interfund transactions	27,150	27,150	.....	212,849	212,849	.....			
Trust fund receipts and outlays on the basis of Tables 4 & 5	45,515	30,742	14,772	550,432	451,671	98,760			
Total Federal fund receipts and outlays	**100,994**	**108,480**	**−7,486**	**838,221**	**1,097,794**	**−262,573**			
Less: Interfund transactions	443	443	.....	975	975	.....			
Federal fund receipts and outlays on the basis of Table 4 & 5	100,551	108,037	−7,486	834,245	1,096,819	−262,573			
Less: Offsetting proprietary receipts	2,846	2,846	.....	34,101	34,101	.....			
Net budget receipts & outlays	**143,219**	**135,933**	**7,286**	**1,350,578**	**1,514,369**	**−163,813**			

... No transactions.

Note: Interfund receipts and outlays are transactions between Federal funds and trust funds such as Federal payments and contributions, and interest and profits on investments in Federal securities. They have no net effect on overall budget receipts and outlays since the receipts side of such transactions is offset against budget outlays. In this table, interfund receipts are shown as an adjustment to arrive at total receipts and outlays of trust funds respectively.

Note: Details may not add to totals due to rounding.

Source: Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 1995 Through September 30, 1995, and Other Periods (Washington, D.C.: Department of the Treasury, Oct. 27, 1995).

RECEIPTS, OUTLAYS, AND BALANCE OF FEDERAL HOSPITAL INSURANCE TRUST FUND FOR FISCAL YEARS 1991-95 AND FIRST QUARTER OF FISCAL YEAR 1996

Dollars in millions

	Quarterly			
Quarters	Receipts	Outlays	Change in trust fund balance	Balance in trust fund (at end of quarter)
Fiscal year 1991				
Oct-Dec	$19,300	$15,998	$3,302	$98,933
Jan-Mar	20,433	17,270	3,163	102,096
Apr-June	25,313	18,399	6,913	109,009
July-Sept	18,892	17,971	921	109,930
Total	**$83,938**	**$69,638**	**$14,299**	
Fiscal year 1992				
Oct-Dec	$24,201	$19,074	$5,127	$115,057
Jan-Mar	20,134	20,167	(33)	115,024
Apr-June	28,927	21,328	7,598	112,623
July-Sept	19,415	21,405	(1,990)	120,633
Total	**$92,677**	**$81,974**	**$10,703**	
Fiscal year 1993				
Oct-Dec	$25,360	$21,971	$3,389	$124,022
Jan-Mar	20,833	22,134	(1,301)	122,722
Apr-June	29,581	23,982	5,599	128,320
July-Sept	21,327	23,517	(2,190)	126,131
Total	**$97,101**	**$91,604**	**$5,497**	
Fiscal year 1994				
Oct-Dec	$26,446	$24,758	$1,688	$127,818
Jan-Mar	22,047	25,458	(3,411)	124,408
Apr-June	33,155	25,937	7,219	131,626
July-Sept	24,547	26,618	(2,071)	129,555
Total	**$106,195**	**$102,770**	**$3,425**	
Fiscal year 1995				
Oct-Dec	$29,821	$26,533	$3,288	$132,844
Jan-Mar	25,215	28,638	(3,423)	129,420
Apr-June	35,570	30,513	5,057	134,477
July-Sept	24,241	29,199	(4,958)	129,520
Total	**$114,847**	**$114,883**	**($36)**	
Fiscal year 1996				
Oct-Dec	$30,001	$29,253	$747	$130,267

Note: Totals may not add because of rounding.

Sources: Fiscal year 1991-95 data were compiled from monthly reports prepared by HCFA's Office of the Actuary. Fiscal year 1996 data are from the monthly Treasury statement, Dec. 31, 1995.

Chairman ARCHER. Thank you, Ms. Jaggar.

Did you examine the minutes of the December 13 meeting?

Ms. JAGGAR. Mr. Chairman, the minutes of the meeting have not been completed at this time. We have examined the rough notes that were taken by the Chief Actuary, who was tasked with that activity.

Chairman ARCHER. So do those rough notes confirm what Secretary Shalala testified to, that this operating deficit was discussed at that meeting?

Ms. JAGGAR. Yes, sir.

Chairman ARCHER. Thank you very much.

Do any other Members have questions?

Mr. Rangel.

Mr. RANGEL. Yes, thank you.

Thank you, Director Jaggar. We are trying to find out whether or not there was a conspiracy, and if not, whether there was a deliberate coverup of the fact that there was an operating deficit in 1995. And after preparing and reviewing your testimony, do you find any scintilla of coverup by anybody?

Ms. JAGGAR. Mr. Rangel, we found that the Treasury Department in accordance with its routine procedures published the information about the deficit in its October 27 report and that other routinely produced reports were generated and distributed as they normally would be.

In looking at the discussion at the Trustees meeting and in talking to individuals who were in attendance at that meeting, there was no notice or intimation of any attempt not to discuss fully that information; rather, the focus was on assuring that there was clear understanding of the many different factors that might influence the overall health of the Trust Fund and make that public in the Trustees' Report which is due out this spring.

Mr. RANGEL. Historically, the General Accounting Office has never gotten involved in any political issues or any partisan issues but has been a very objective arm of the U.S. Government. I have no reason to believe that that has changed. Do you still maintain that reputation of the GAO that you do not get involved in political or partisan issues?

Ms. JAGGAR. It is certainly our main goal to be objective and to serve the needs of both sides of the Congress with factual information that can be used for the debate, but without political opinions about those facts.

Mr. RANGEL. Thank you so much for your testimony.

Ms. JAGGAR. My pleasure.

Chairman ARCHER. Are there any other questions?

Mr. Shaw.

Mr. SHAW. Mr. Chairman, I would like to just briefly respond to what Mr. Rangel just said, and then I do have a couple of questions.

I do not think anybody here has indicated that there is a conspiracy or a coverup. I think it is a question of whether a duty was performed to report to this Committee. As I am sure every Member on this Committee agrees, we have a very significant duty to the Trust Fund and that the Trustees, the Managing Trustee specifi-

cally, the U.S. Treasurer, has a fiduciary relationship to that Trust and a responsibility to report specifically to Congress.

Now, I would like to go back to the question of the meeting and the minutes of the meeting—was it December 13——

Ms. JAGGAR. Yes, sir.

Mr. SHAW [continuing]. That Secretary Shalala indicated and you confirmed in a response to a question by Chairman Archer, that the question of the Trust Fund going into the red, being that more was going out than coming in, was discussed at that meeting.

Ms. JAGGAR. Yes, sir.

Mr. SHAW. Do the notes indicate who discussed it?

Ms. JAGGAR. Briefing documents that were handed out in advance of the meeting so that people would know essentially what the agenda was, indicate that Mr. Vladeck, who is the Administrator of the Health Care Financing Administration, would present the information about the status of the HI Trust Fund. The meeting notes indicate that that is indeed what happened.

Mr. SHAW. Do the notes reflect that the deficit in the Trust Fund was discussed at the meeting?

Ms. JAGGAR. Yes, sir.

Mr. SHAW. Does it indicate who discussed it?

Ms. JAGGAR. Other than Mr. Vladeck presenting the information about the status, the notes that we have seen do not say who asked what questions about it.

Mr. SHAW. What questions were asked?

Ms. JAGGAR. I am aware that a question was asked as to whether or not the causes and factors affecting the more rapid expenditure and higher outlays would be thoroughly explored and presented in the Trustees' Report. And the answer was that, yes, they would be so discussed.

In addition, I should mention that the Trustees routinely have a meeting, their second meeting of every year, before that report is made public, to review the report and discuss the issues that are going into it.

Mr. SHAW. What other matters were discussed at that meeting? Were there other matters discussed at the meeting, other than the status of the Trust Fund?

Ms. JAGGAR. The status of the other Trust Funds, because this is a meeting also for the Social Security Trust Fund, and its status was also discussed.

Mr. SHAW. What other——

Ms. JAGGAR. And in addition—I have the agenda, if you will wait one moment—but in addition, there were new public Trustees who were present at this meeting, and they were introduced and welcomed.

Mr. SHAW. Mr. Chairman, I wonder if we could see the agenda that the witness has referred to.

Chairman ARCHER. Without objection——

Mr. SHAW. Could we look at that, please? Could somebody bring that up and let the Committee see what the witness has in her hand?

Chairman ARCHER. Without objection, it will be inserted in the record.

[The documents follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

DEC 8 1995

To: The Secretary
Through: DS _____
COS _____
ES _____

From: Acting Assistant Secretary for Planning and Evaluation (Peter Edelman)

Subject: December 13 Meeting of the OASDI, HI, and SMI Boards of Trustees -- BRIEFING

PURPOSE:

To provide information about the board meeting and topics that may be discussed at the meeting of the Federal Old-Age, Survivors, and Disability Insurance (OASDI), Federal Hospital Insurance (HI), and Federal Supplementary Medical Insurance (SMI) Boards of Trustees. To recommend responses to specific issues that may be raised during the meeting.

BACKGROUND

The Boards are comprised of six Trustees: The Secretaries of the Treasury, Labor, and Health and Human Services, the Commissioner of Social Security, plus two Public Trustees. The Secretary of the Treasury is the managing Trustee and presides at the meetings which are held every Spring and Fall. The Principal Deputy Commissioner of Social Security is Secretary to the Board for the OASDI Trust Funds. Since the Principal Deputy Commissioner will be out of town on the date of the meeting, another Deputy will be acting in his place at this meeting. The Administrator of the Health Care Financing Administration (HCFA) is Secretary to the HI and SMI Boards. The primary responsibilities of the Boards relate to management of the trust funds as opposed to direction of general program policies. The main purpose of the Spring meeting is to adopt and to sign the annual reports of each of the trust funds. Members of the Boards are updated on the financial status of the trust funds and on other relevant activities at the Fall Meeting.

The boards will approve the minutes of the April 3, 1995 meeting (Tabs C and D)

Secretary Rubin will introduce the two new Public Trustees to the board during the meeting. Tab B has short biographies of the Trustees.

Page 2 - The Secretary

PRINCIPAL PARTICIPANTS

The Honorable Robert E. Rubin, Secretary of the Treasury (Presiding)
The Honorable Robert B. Reich, Secretary of Labor
Shirley S. Chater, Commissioner of Social Security,
Carolyn Colvin, Deputy Commissioner of Social Security
Bruce C. Vladeck, Administrator, Health Care Financing Administration
Marilyn Moon, Trustee
Stephen G. Kellison, Trustee

In addition to the principal participants, Peter B. Edelman, Acting Assistant Secretary for Planning and Evaluation, Jack Ebeler, Deputy Assistant Secretary for Planning and Evaluation for Health Policy and other DHHS support staff will attend the meeting. Kathleen Buto, the Associate Administrator for Policy, and Richard S. Foster, the Chief Actuary, will accompany Mr. Vladeck. Each ex officio Trustee and the two Secretaries of the Boards will be accompanied by a small number of support staff.

Update of the Financial Status of the Social Security and Medicare Trust funds

Secretary Rubin will call on Ms. Colvin or on Mr. Ballantyne, the Chief Actuary of Social Security, to report on the financial status of the OASDI Trust Funds. SSA's talking points are

- At the end of fiscal year 1995, the combined Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds held total assets of $483.2 billion, representing about 137 percent of estimated outgo in fiscal year 1996.

- During fiscal year 1995, the combined OASI and DI Trust Funds grew by $60.4 billion, which was about $2.5 billion less than was predicted in the 1995 Report of the Board of Trustees.

- Most of the difference from the estimated growth was due to an overestimate of tax income. Although the overestimate was relatively small, less than 0.6 percent, it amounted to $2.1 billion. Income after 1995 will probably continue at a somewhat lower level as well.

- Although tax income to the DI Trust Fund was overestimated by the same percentage as for the combined funds, it was offset by an overestimate in DI benefit payments of the same magnitude, about $0.4 billion. Benefit payments from the DI Trust Fund after 1995 will also probably continue at a somewhat lower level for some time.

- Benefit payments from the OASI Trust Fund in fiscal year 1995 exceeded the estimated amount by only $0.1 billion.

Page 3 - The Secretary

Secretary Rubin will call on Mr. Vladeck to report on the financial status of the HI and SMI Trust Funds. HCFA will report that:

- The HI Trust Fund Balance essentially was unchanged from FY1994 to FY1995 at 129.5-$129.6 billion. There was in fact, however, a $36 million (.03%) decrease instead of an anticipated $5 billion increase. Revenues were a little lower and outlays somewhat higher than was anticipated in the 1995 Report.

- This change is probably sufficient to move the exhaustion date from CY2002 or FY2003 to 2001. Because the projection assumptions have not been finalized, we cannot tell whether the fund will necessarily be exhausted in CY2001.

- The SMI Trust Fund balance is slightly better off than was projected in the 1995 Annual Report. Expenditures have been running about 1.8% lower than projected.

It seems unlikely that any other important issues will arise at the meeting. All the trust funds are in about the same condition as last year. The funding of the SMI Trust Fund has been set through 1996.

Update on Status of 1996 Report Preparation

Preparation of the 1996 Reports is proceeding approximately on schedule.

Update on Activities of the Public Trustees

The public Trustees are developing their own talking points for the meeting. It is not clear what they will be, but they will probably not be controversial.

It was earlier suggested that the Public Trustees might discuss a possible research project focusing on possible physiological causes for the slowdown since 1982 in the improvement in life expectancy for older women. It was thought that the Public Trustees might wish to quantify how much of the gap between life expectancies for men and women has narrowed and to get suggestions from academics about changes in the assumptions for the trust fund projections.

Further, it was thought that they might state their goal of continuing the tradition of the Public Trustees' role in sponsoring and otherwise encouraging research on issues affecting the Social Security and Medicare Trust Funds.

It seems likely still that their statements will be along those lines, but no one knows at this point.

OTHER ITEMS OF BUSINESS

We expect no other business.

Page 4 - The Secretary

TALKING POINTS

Tab A is an annotated agenda. It includes a talking point on the problem of the HI (Part A) Trust Fund and a suggested response to a possible suggestion by the Public Trustees.

Peter B. Edelman

Attachment:

Tab A - Annotated Agenda
Tab B - Bios for the Public Trustees
Tab C - Minutes of the April 3, 1995 Meeting of the OASDI Board of Trustees
Tab D - Minutes of the April 3, 1995 Meeting of the HI-SMI Board of Trustees

Tab A

ANNOTATED TENTATIVE AGENDA FOR THE SECRETARY
BOARDS OF TRUSTEES MEETING
OASDI, HI, AND SMI TRUST FUNDS
ROOM 3327, MAIN TREASURY BUILDING
WEDNESDAY, DECEMBER 13, 1995, 11:00 A. M.

Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund

Board of Trustees of the Federal Hospital Insurance Trust Fund

Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund

1. Approval of the Minutes of April 3, 1995 Meeting

   The minutes for the December Meeting have been reviewed by staff and are acceptable as submitted.

2. Adoption of the Agenda

   The Agenda is acceptable.

3. Update on the Financial Status of the Social Security and Medicare Trust Funds

   a. Presentation on the Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds.

      Ms. Colvin or Mr. Ballantyne will make the report.

   b: Presentation on the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds

      Mr. Vladeck will make the report.

      If it seems appropriate for you to comment on the HI (Part A) balance, you might say

[redacted] **administration is trying to get on top of the problem. The President has outlined a proposal for $124 billion in Medicare savings. This proposal should put the HI Trust Fund in balance through 2011. If Congress accepts the proposal, the Fund should be in good shape for the foreseeable future.**

4. Status of 1996 Report Preparation.

Preparation of the 1996 reports is proceeding according to schedule.

5. Update on Public Trustees Activities

Secretary Rubin will introduce the new Trustees to the rest of the board and will indicate something about their backgrounds.

As you know, Marilyn Moon is a distinguished scholar with a multitude of publications on Medicare and health economics. She has worked at the AARP and at the Congressional Budget Office and currently is a Senior Fellow at the Urban Institute.

Stephen G. Kellison is also a distinguished scholar. He is currently Vice President and Chief Actuary of the Variable Annuity Life Insurance Company in Houston. Mr. Kellison was chairman of the Panel of Technical Experts appointed by the 1991 Advisory Council on Social Security. He has been on the faculty of the University of Nebraska-Lincoln and Georgia State University.

Short biographies are attached in Tab B.

The Public Trustees are developing their own talking points for the meeting. We are not sure of their content, but they will probably not be controversial.

If it seems necessary to provide a response on a possible research project, you might say

Money is tight, but we would be happy for our staffs to take a look at the issue. You might call Mr. Vladeck to set up an appointment for him or for someone on his staff to meet with you and your staff to discuss how we might best work together to get such a project started.

6. Other Items of Business.

There will probably not be any other items of business.

Mr. SHAW. Do the notes indicate that this was a principal matter of discussion at that meeting or an incidental matter of discussion?

Ms. JAGGAR. The entire meeting lasted about 18 minutes, as you have heard today, and according to the notes that we have, it was one matter; it was not the primary matter, and it was not brushed over. It was talked about I would say briefly, given the time constraints—not the principal topic of discussion.

Mr. SHAW. How many matters were referred to in that meeting?

Ms. JAGGAR. Sir, I have that information, and I would like to give it to you later. I have it——

Mr. SHAW. Perhaps you could supply it for the record.

Ms. JAGGAR. Yes, sir, I would be delighted to. What we could do is we could provide the agenda for the meeting, which would provide that information for you, and then a copy of the rough notes that were taken, which would show you that those topics were discussed. They are handwritten notes, and a bit cryptic, as handwritten notes tend to be, but that would show you what was discussed.

Chairman ARCHER. Without objection, that will also be inserted in the record.

Ms. JAGGAR. Thank you.

[The following was subsequently received:]

BOARD OF TRUSTEES MEETING
DECEMBER 13, 1995
LIST OF ATTENDEES

Robert Rubin , Secretary, Dept. of Treasury/Managing Trustee
Dan Sichel, Treasury
Robert Reich , Secretary, Dept. of Labor/Trustee
Marilyn Moon , Urban Institute/Public Trustee
Ms. Meridith Miller, Labor
Robert Gillingham, Treasury
John Hambot, Treasury
Peter Bieger, General Counsel, Treasury
Kathy Buto, Assoc. Administrator for Policy, HCFA
Rick Foster, Chief Actuary, HCFA
Bruce Vladeck, Administrator, HCFA
Carolyn Colvin, Deputy Commissioner for Programs, Policy Evaluations, Communications, SSA
Katherine King, (B. Vladeck's assistant) HCFA
Harry Ballantyne, Chief Actuary, SSA
Brian Coyne, SSA
Mike Andrew, Staff Assistant to Public Trustee, SSA
Judy Hunt, Staff Assistant to Public Trustee, HCFA
Gene Moyer, (advisor to D. Shalala) HHS
Joe Hight, (staffer to R. Reich) Labor
Steve Kellison, Public Trustee
Shirley Chater, Acting Commissioner, SSA
Donna Shalala, Secretary, HHS/Trustee
Steve Goss, Office of the Actuary, SSA
Jack Ebeler, Acting Deputy Assistant Secretary for Planning Evaluation/Health Policy, HHS
Gus Faucher, Treasury

Source: John Hambot, Dept. of Treasury (622-2350)

12/13/95 TR meeting — SSA Chief Actuary's Notes

11:35 A.M.
- Welcomed PT's / Mention Ross + Walker
Minutes approved
Agenda adopted
Status report - OASDI - Carolyn Colvin
" " - Medicare - Bruce Vladek
HI Taxes $1.6 billion lower
benefits 3.3 " higher
4.9
1996 TR schedule - on track
questions - Reich - "Reasons for drop in tax income,
2. Trend in real growth GDP - Goss answer.
Public Trustees -- activities - Marilyn M.
Steve K.
Demog
Mortality improvement
Economic
CPI
Indexing
real wage
real interest
Investments
AC
Reaction from PTs
Round table
Spring/early summer.

New bus?
No
Move to adj. 11:50

Source: Harry Ballentine, Chief Actuary, SSA

✓ Rubin ✓ Miller ✓ [illegible] ✓ [illegible] ✓ Hight
✓ Sickel ✓ Gillingham ✓ Foster ✓ Coyne ✓ Kellum
✓ Reich ✓ Hembor ✓ Ulanek ✓ Andrew ✓ Chaten
✓ Moon ✓ Bagg ✓ Colvin ✓ Hurt ✓ Shalak
✓ King

HCFA Chief Actuary's Notes
Board of Trustees Meeting
12/13/96

11:33
Minutes approved
Agenda adopted
OASDI update (CC)
Medicare update (BCV)
- Rubin: Basis for change?
- Shalak: True basis for ΔHI?
- Reich: Overestimate of taxes? NIPA adjust

Status of preparation (HCB)
- Reich: Proj's for GDP, working pop

Pub 7 activities
MM: Public understanding & confidence
Summary
Roundtable discussions on assump's
SK: Mortality roundtable; male/female shifts -- seek understanding
Economic -- no specific plans yet; CPI discussion of interest
TF investment; possible AIC rec's

Other business:
SSC adjourns 11:50

Source: Rick Foster, Chief Actuary, HCFA/HHS

TRANSCRIPTION OF
Chief ACTUARIES NOTES
AT Medicare Board of TRUSTEES MEETING
12/13/95

11:33
Minutes approved
Agenda adopted
OASDI update (CC)
Medicare update (BCV)
- Rubin: Basis for change (in expenditures) Vladeck [illegible]
- Shalala: True basis for Δ HI (jobinity) Vladeck said same
- Reich: Overstrictor of taxes? NIPA adjust

States of preparation (HCB) Bulletin
- Reich projection for GDP, working population

Public trustee Activities
MM: public understanding and confidence
Summary (trustees')
Roundtable discussions on assump's
SK: Mortality roundtable, male/female shift -- seek understanding
Kellner Economic -- no specific plans yet; CPI discussion of interest
TF investments; possible advisory council rec's

Other business (none)
SSC adjourn 11:50

Chairman ARCHER. Are there any——

Mr. STARK. Mr. Chairman.

Chairman ARCHER. Mr. Shaw, are you finished with your inquiry?

Mr. SHAW. Yes, Mr. Chairman.

Chairman ARCHER. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I just wanted to thank Ms. Jaggar for her testimony. In your investigation of this matter, did you find that the administration or any of the Trustees did anything wrong?

Ms. JAGGAR. We found that the Trustees acted in accordance with the requirements of the legislation regarding reporting information about the status of the Trust Fund.

Mr. STARK. So you didn't find that anybody did anything wrong, did you?

Ms. JAGGAR. Nothing that would be called, I think, legally in question.

Mr. STARK. Yes, OK—illegal—immoral. Do you know if the Trustees' loyalty oaths are all current?

Ms. JAGGAR. I am sorry, I could not hear you.

Mr. STARK. Do you know if the Trustees' loyalty oaths are all current?

Ms. JAGGAR. No, sir, I don't know that.

Mr. STARK. That might be important to know.

Well, Mr. Chairman, I think that the only comment I can make is that—to call this hearing "immature," and "irrelevant" is giving it more kind treatment than it deserves. Fortunately, this is February 29, and if memory serves me right, this kind of silliness can only come up once every 4 years, and I hope that that augurs well that we will not hear any more about it.

If in fact there is any blame, it is the Republican staff. If this was important enough to know, and they were not smart enough to read this report and tell you about it, if it were me, I would get rid of the staff. If the Republicans feel that this is such an almighty important issue——

Chairman ARCHER. Is the gentleman directing a question to the witness?

Mr. STARK. No; I am just finishing my comment on my time, Mr. Chairman——

Chairman ARCHER. Just ruminating.

Mr. STARK [continuing]. And letting you know that I think if anybody is screwed up, it was the Republican staff. Your staff tells me he was here, that he only took 2 days off, so if he did not think it was important and you guys did not act—Mr. Chairman, you have said to the press that you are going to get some of this insurance reform out of here by March, but I have not heard a peep out of the leadership of this Committee about doing anything to save the Trust Fund. And if in fact these things are important, in the 8 years or 10 years that I am aware that the now minority ran the Health Subcommittee, this issue never came up. We met our responsibilities in a timely and bipartisan fashion. We had our hearings, we had markups.

And I would just say that it is a sad day when we can posture like this about saving the Trust Fund, and yet the leadership of

this Committee has done nothing to try to save the Trust Fund or protect the senior citizens except a lot of blather in the press and a McCarthy-like hearing.

So I think that a fitting end to this nonsense would be that we do not see it again for 4 years and that sooner or later, the Republicans get around to dealing with the administration's bill, which would extend the Trust Fund for 10 years and do the responsible thing. This is McCarthyism of its worst kind, and I am ashamed to say that it probably lies with the staff—the Republican staff—packed with former insurance company lobbyists, and that is probably why we are going to do insurance company reform in March and not get around to saving the Trust Fund.

I thank Ms. Jaggar for a reasoned explanation, and I think it is just a sad day for the Ways and Means Committee and a sad tribute to what used to be a well-managed Committee.

Chairman ARCHER. Mr. Portman.

Mr. PORTMAN. I thank you, Mr. Chairman.

I did not think it was a sad day. I think it was an interesting day. I learned a lot, and I think it was a helpful exchange between the Committee and the two witnesses.

I was not going to talk about this, but Mr. Rangel talks about us alleging a coverup; now Mr. Stark talks about a McCarthy-like hearing and that we are alleging some illegality. I did not hear any of that, and I was here for 95 percent of the hearing today. So it is interesting hearing allegations about what we are alleging, but that is not why I was here, and that is not what I heard today.

Ms. Jaggar, just briefly, I enjoyed your testimony, and you talked a little about the projections, you talked a little about why, perhaps, the projections were off. I think you summarized well what we heard earlier today about the possibility of some payments being requested sooner and so on.

I wonder if you could respond to an additional question as to the projections. You indicated that in the first quarter of this fiscal year, there might have been a surplus, although we had the deficit in the last year. You may have not been here when Mr. Thomas had a chart which showed the trend lines. The trend lines are very disturbing because they indicate, as would conventional wisdom, that we are going to continue to go into a deficit position and that perhaps the Trust Fund will be bankrupt by the year 2000, rather than 2002 or 2001.

Have you looked into that from a GAO perspective as to what this short-term projection means for the long term, and whether you think these trends will continue?

Ms. JAGGAR. Mr. Portman, we have not tried to do a thorough analysis, I believe that would duplicate the efforts of the HCFA Actuary, who has access to much of the information that is needed and also, in doing the final analyses, uses information and data from Department of Labor and other economic indicators.

However, appendix II of my statement—perhaps you have it there—is a chart which shows what the change in the Trust Fund balance has been over the past several years. Indeed, in the next-to-the-right column, if I might impose upon you to look at that, what you can see is that at the end of the first quarter of fiscal year 1996—the October through December quarter—there is a

$747 million balance in the Trust Fund. And if you look at comparable first quarters in the previous 5 years, balances were always in the billions, not the millions.

Mr. PORTMAN. Right.

Ms. JAGGAR. So it is clear that everyone agrees the Trust Fund is running out of money, and this is something that is of grave concern.

Mr. PORTMAN. So what you can tell from both the historical data and the $747 million figure as compared to the $3 billion, $1 billion, $1.6 billion and so on in previous first quarters, it looks as though the deficit trend will continue and at a rate which could perhaps lead to the long-term projection being pushed back to the year 2000 or some other earlier date?

Ms. JAGGAR. There are many other factors to consider to determine where those estimates finally will come out when the Trustees' Report is issued this spring, but surely there is nothing at this point, from looking at this data, that indicates it is going to be a rosier scenario——

Mr. PORTMAN. Than projected.

Ms. JAGGAR [continuing]. Than projected.

Mr. PORTMAN. I thank you, Director Jaggar.

Chairman ARCHER. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Ms. Jaggar, can you tell me how much this investigation costs, how much you have spent on this?

Ms. JAGGAR. Mr. McDermott, to date we have spent about 35 staff-days doing this, which is probably around $20,000 of time as GAO calculates it.

Mr. MCDERMOTT. I read in your report that 2,400 of these Treasury reports went out all over Washington, DC. I assume that is the basic mailing list for those reports. Is that correct?

Ms. JAGGAR. Yes, sir. The mailing list that the Department of Treasury uses, to be precise, sends out 2,439 reports to various addressees around Washington and also to other countries.

Mr. MCDERMOTT. And are Members of Congress on that list?

Ms. JAGGAR. Yes, sir.

Mr. MCDERMOTT. And are Committee staff on that list?

Ms. JAGGAR. Yes, sir.

Mr. MCDERMOTT. So this was something that was widely distributed here on the Hill. From looking at the report and from your background in health finance examinations, can you offer us an opinion as to why no one seemed to take this seriously when they received the information in the mail, why it did not rise to the level of the furor that we are seeing here today?

Ms. JAGGAR. I think that several groups of people did take it seriously: That the Congressional Budget Office worked with those numbers in revising their budget estimates for subsequent years in their December update, as has been discussed here.

Several attendees at the Medicare Trustees' meeting indicated to us that while they did take the numbers seriously, they felt that a thorough analysis of all the factors that needed to be considered before the revised projections were put out would be forthcoming, and would be timely.

Mr. MCDERMOTT. Do you think that that was a prudent judgment on their part that, given your background in analyzing health care issues, they took it seriously but felt that it was not something that they had to shoot up red flares in the sky about?

Ms. JAGGAR. With respect, I would decline to say whether it was prudent judgment on their part. Several of them are political appointees and involved in many complicated issues in relations with Congress. But we detected nothing that would indicate that they were, for political reasons, trying to hide information.

Mr. MCDERMOTT. Did you do any examination in your inquiry about why the relevant Subcommittees, for example, of the Ways and Means Committee, like the Oversight Committee, did not call a hearing once they had received the report and read it? Did you look into that at all?

Ms. JAGGAR. No, sir, we did not.

Mr. MCDERMOTT. You were not tasked to do that, or were you told not to do that?

Ms. JAGGAR. We were not tasked to do that. It did not come up as an issue.

Mr. MCDERMOTT. And so you made the assumption that they all read it, is that correct, that it was read by the people who would have the responsibility on this Committee?

Ms. JAGGAR. Sir, I have no information about whether anyone on this Committee, the Budget Committee, or any of the other Committees that received it, read the material or noticed it.

Mr. MCDERMOTT. Well, you did find out—or at least we know now in this hearing—that Senator Domenici read it, or his staff read it, and commented that it was not a serious problem.

Ms. JAGGAR. Yes.

Mr. MCDERMOTT. So you would assume that it was done in the House, wouldn't you?

Ms. JAGGAR. I am not sure of the timing of Senator Domenici's piece. It may well have been after the news release that brought it to people's attention.

Mr. MCDERMOTT. I see. So he may not have read it, either, until then; is that what you are saying?

Ms. JAGGAR. I really don't have any information about whether it was read by others. We do know that the American Association of Actuaries read it and incorporated it into their report, as did the Congressional Budget Office.

Mr. MCDERMOTT. So that, really, you do not know what happened up here on the Hill; you just know that the report was sent out.

Ms. JAGGAR. Yes, sir.

Mr. MCDERMOTT. And the closing down of the government, do you think that played any part—we were closed down approximately from November 16 to 19, when the Republicans thought the government made no difference—that the shutdown did not interfere in the processing of this information?

Ms. JAGGAR. To the best of our knowledge, it did not interfere in the processing of the information. The possible impact of the furloughs may be felt this spring as the Department of Labor and other departments provide input to the HCFA Actuary for reassess-

ing the status of the Medicare Trust Fund as part of the Medicare Trustees' Report.

Mr. MCDERMOTT. Thank you very much for your report.

Mr. LAUGHLIN [presiding]. The time of the gentleman has expired.

Mr. English may inquire.

Mr. ENGLISH. Thank you, Ms. Jaggar. I appreciate your testimony, and if we could, I would like to walk through a couple of elements of it.

My understanding from your testimony is that you have examined the relevant documents as you were tasked to do and that you have discovered that indeed, in late October, it became apparent that the Part A Trust Fund was running not a surplus for the last year as expected, but actually was running a deficit; is that correct?

Ms. JAGGAR. That is correct.

Mr. ENGLISH. And that shortly thereafter, that information became available to the individual Trustees and that that included the two Cabinet members who testified today?

Ms. JAGGAR. Yes, sir—if "shortly thereafter" is December when they became aware of it.

Mr. ENGLISH. December.

Ms. JAGGAR. Right.

Mr. ENGLISH. And then, at a meeting which both of the Cabinet members as Trustees attended and which Mr. Rubin presided over, this matter was discussed.

Ms. JAGGAR. Yes, sir.

Mr. ENGLISH. And that there was a report mailed out, which I believe we have copies of here, which included, buried in a mountain of data, a reference to the fact that part A was currently running a deficit. Have you examined that report?

Ms. JAGGAR. Yes, sir.

Mr. ENGLISH. Did you see anything that in any way highlighted that figure or called attention to it?

Ms. JAGGAR. I think that it is important to recognize that that report is normally the focus of people who, if you will allow me to call them technical individuals, actuaries and the like, who read numbers frequently——

Mr. ENGLISH. Right.

Ms. JAGGAR [continuing]. And there is a reference in the material to the variation in outlays. I don't know whether a technical person would consider that highlighting it or not.

Mr. ENGLISH. I used to be the executive director of our State Senate Finance Committee for the minority, so I used to receive reports like this on a regular basis from various departments of State government, and we were virtually awash in them, and I imagine you have to be familiar with how many reports come into legislative offices, that certainly, this was one of many, many reports that came in.

Ms. JAGGAR. Right. There was not a special notice that was made——

Mr. ENGLISH. There was no special notice, and it was simply a technical report that included that detail buried in it.

Ms. JAGGAR. That is how I would characterize it.

Mr. ENGLISH. Is that a fair characterization?

Ms. JAGGAR. That is how I would characterize it.

Mr. ENGLISH. And you have received nothing—you have become aware of nothing in your limited investigation that suggests there was any effort made by either of the Cabinet Secretaries to subsequently call public attention to this, a fact which obviously was coming to the fore at a time when Medicare reform was being vigorously debated, at a time when it had become a very partisan issue, and at a time at which obviously this information was extremely inconvenient to one side—you have not seen any evidence of an effort by any of the Trustees to bring this issue to the attention of the public, have you?

Ms. JAGGAR. Mr. English, we found nothing that would suggest that anyone tried to hide it, and we have found nothing that suggests that anyone tried to highlight it.

Mr. ENGLISH. I appreciate your bringing that up.

Do you have any recommendations for changing the statute that spells out the responsibilities of the Trustees to maybe clarify a responsibility, a fiduciary responsibility, to call attention to these sorts of public issues? Have you explored any ways of strengthening the statute that governs the role of the Trustees?

Ms. JAGGAR. We have noted that the statute requires the Trustees at this point to identify and notify Congress when the Trust Fund is "unduly small"; and there also is, in a separate but related section——

Mr. ENGLISH. But it does not specify "unduly small," does it?

Ms. JAGGAR. A separate, related section requires notification when the balance ratio is below 20 percent. And the Trustees have done that when they completed their annual projections. This was an interim projection, and it is being considered in making the overall projections for the Trustees' Report.

Mr. ENGLISH. I understand. I think what you have done here is testify to the fact that the legal forms strictly understood were followed, although I will say there are other statutes governing other Trustees that are much stronger and would require a Trustee to bring this very much to the attention of the public and to everyone who is a stakeholder.

I want to thank you for the professionalism of your testimony today.

Mr. LAUGHLIN. The time of the gentleman has expired.

The gentleman from Georgia is recognized.

Mr. LEWIS. Thank you, Mr. Chairman, and I will be very brief.

Ms. Jaggar, I know you have been here for a long time, but let me just ask you—you have limited resources as Director of this section of GAO.

Ms. JAGGAR. Yes, sir.

Mr. LEWIS. And do you think it is fitting and appropriate to use your limited resources to engage in this type of inquisition?

Ms. JAGGAR. Mr. Lewis, we respond to the requests of Members, of Committee Chairmen and Subcommittee Chairmen, both minority and majority parties, and when it is possible, we respond to the needs that they have to the best of our capability. In this case, we were requested, and we were able, to provide assistance.

Mr. LEWIS. Ms. Jaggar, were you asked to examine the personal calendars for the month of December of the Secretary for Health and Human Services and the Secretary of the Treasury?

Ms. JAGGAR. We were asked to identify whether those individuals had—I should say verify—whether those individuals had participated in meetings to discuss budget negotiations subsequent to having been informed about the status of the Trust Fund, and we did do that.

Mr. LEWIS. So did anyone on your staff examine all of the calendars for the month of December of the two Secretaries?

Ms. JAGGAR. We contacted the "handlers," if you will——

Mr. LEWIS. The schedulers?

Ms. JAGGAR. The schedulers—the schedulers of each of the three Secretaries because Secretary Reich is also a Trustee member and was in attendance at the meeting. We obtained the calendars—in some cases, not the full calendar, but the relevant portions of the calendar that would show whether the Secretaries also had participated in the budget negotiations subsequent to the Trustees meeting.

Mr. LEWIS. Ms. Jaggar, I know you are carrying out your job and your duty, your responsibility, but it just seems so strange to me, that it would be a better use of the limited resources of GAO to try to find a way to strengthen and protect Medicare, maybe to look at some of the abuses, fraud and waste. But I appreciate your testimony.

Ms. JAGGAR. Thank you, sir.

Mr. LAUGHLIN. OK. That concludes the hearing. I thank the witness for being with us, and we stand adjourned.

[Whereupon, at 1:20 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN ACADEMY of ACTUARIES

February 29, 1996

The Honorable Bill Archer
United States House of Representatives
Washington, DC 20515

Dear Chairman Archer:

The American Academy of Actuaries Social Insurance Committee requests that this letter be submitted for the record on today's full committee hearing regarding the financial condition of the Medicare Hospital Insurance (HI) Trust Fund.

As you know, data reported by the Health Care Financing Administration (HCFA) indicate that the HI Trust Fund experienced a deficit in fiscal year 1995. **The Academy believes the data further underscore the need for Congress to act now to bring the HI program into long-range actuarial balance.** The HCFA data state that in 1995, actual expenditures from the HI Trust Fund exceeded income to the Trust Fund by $.036 billion. In contrast, Medicare trustees in their April 1995 report projected that the Trust Fund would run a $4.7 billion surplus in 1995. HCFA reported that actual Trust Fund income was $1.4 billion (1.2%) less than projected, while actual expenditures were $3.4 billion (3.1%) greater than projected in 1995.

This shortfall raises questions as to whether the Trust Fund will be depleted before 2002, the year trustees projected in the 1995 report. Although we cannot yet determine whether the 1995 shortfall will have a substantial effect on the HI program's long-term actuarial balance, we believe that the fact that the HI Trust Fund contains almost $5 billion less in assets than projected, and ran a deficit in 1995 (a year earlier than anticipated), should serve as a warning that the HI program's financial problems need to be addressed sooner rather than later. Delay will limit the options for change and require such changes to be more extreme. The Academy has evaluated potential solutions to the Medicare program's financial problems in a recently released monograph, "Solutions to Social Security's and Medicare's Financial Problems."

The Academy is a national organization that represents actuaries of all specialties and serves as the profession's public policy voice. It is a primary source of actuarial analysis for policy makers. We look forward to the opportunity to provide the committee with such analysis on this important issue. Please contact Christine Cassidy, Assistant Director of Public Policy, if we can be of assistance.

Sincerely,

Jerry Bogart

Jerry Bogart, FSA, MAAA
Chairperson
Social Insurance Committee

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Statement
of the
American Hospital Association
before the
Committee on Ways and Means
of the
U.S. House of Representatives
on
The Financial Condition of the Federal Hospital Insurance Trust Fund

February 29, 1996

The American Hospital Association, representing 5,000 hospitals, health care systems, networks and other providers of care, is pleased to submit a statement for the record on the issue of improving the long-term future of Medicare and the Hospital Insurance Trust Fund (HI Trust Fund, or Medicare Part A).

America's hospitals and health systems are at the forefront of change in the way health care is being delivered. In communities across the country, hospitals and health systems are creating new and better ways to provide high-quality health care. They are forming partnerships and creating integrated systems of care that are designed not just to treat illness and injury, but also to make the communities they serve healthier.

This is happening partly in response to market changes, but also because hospitals and health systems share a vision of a society of healthy communities, where all individuals reach their highest potential for health. This vision cannot be achieved without a strong Medicare program. As more and more Americans reach retirement age, and as the population in general ages, it is becoming clear that this nation simply cannot afford to let the Medicare program become financially weakened.

Unfortunately, Medicare's Hospital Insurance Trust Fund is becoming more and more fragile. The number of Medicare enrollees is increasing exponentially. When Medicare became law in 1965, 19.1 million people were covered; today the figure is closer to 38 million, a number that is expected to swell to more than 40 million by the year 2000. It is estimated that the average one-earner couple turning 65 last year will use an estimated $126,700 more in Medicare benefits than they paid during their working years in payroll taxes and premiums. In just 15 years, the nation's baby boomers will begin turning 65. And not too long after that, there will be only two workers supporting each enrollee, instead of the four workers supporting each enrollee today.

All of these facts are contributing to the HI trust fund's weakening condition. Last April, the trust fund's board of trustees reported that the fund will be insolvent by 2002 -- just six years from now. The board also reported that program costs are expected to far exceed revenues over a 75-year long-range period under any set of circumstances.

But Medicare is a contract with America's seniors, and the trust fund is the financial backing that keeps the Medicare contract from becoming an unfulfilled promise. Something must be done to fulfill that contract for generations to come -- not just for a short-term political fix.

An Independent Commission on Medicare

Clearly, we must be thinking now about the long-term future of Medicare. While Congress must be held ultimately accountable, an independent commission on Medicare could provide Congress an important level of public trust and debate. The American people have a right to know that what the nation spends on Medicare is buying the best benefits and the most efficient care. They should be confident that federal budget pressures will not entirely dictate how health services are provided for older Americans now, five years from now, or 30 years from now.

An independent commission can do this job, and put the "trust" back in the trust fund. The commission would annually assess how much money is needed to maintain the commitments it establishes. Then, Congress would set a target -- through its regular budget resolution -- for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional budget target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations -- which would then be voted up or down as a package.

We believe a bipartisan commission on Medicare should be permanent, with a life expectancy beyond the current crisis. Otherwise, older Americans will continue to be caught in the political crossfire obscuring the real issue: how to provide quality, cost-effective health care to a growing number of people. Creating an independent commission does not mean that we will not constrain growth; it means we will do it rationally and publicly.

We also believe that the independent commission should govern a single Medicare Trust Fund, in which the HI Trust Fund (Medicare Part A) -- which covers inpatient hospital services -- and Medicare Part B -- which, with premiums and general revenues, funds physician, ambulatory and other services -- are combined.

Capitated payments and approaches that "bundle" Part A and Part B services are erasing the distinctions between Medicare Parts A and B. Today, the HI Trust Fund finances a variety of services that occur outside the hospital, such as skilled nursing, home health and hospice care. In fact, these services are the fastest growing portion of Medicare spending. At the same time, hospitals are reimbursed for a variety of services provided under Part B, such as outpatient, clinical laboratory and physician care.

Medicare is composed of both Parts A and B, and we believe it is time for them both to be considered as one program under the aegis of an independent commission.

Legislative proposals for an independent commission on Medicare

We appreciate the willingness of many in Congress to consider the creation of an independent commission. Most notably, we support the Commission to Save Medicare Act of 1995 (HR 2152), which was proposed last year by Rep. Phil English (R-PA). His bill was an important tangible step toward the much-needed long-term restructuring of the Medicare program. It would create a mechanism to balance Medicare benefits with available federal financing, and remove Medicare spending decisions from the federal budget process, where sound health care policy often takes a back seat to political expediency.

Rep. English's proposal would create a commission of seven members, chosen in a bi-partisan manner, appointed by the President, and subject to Senate confirmation. These members would serve full-time, and be nationally recognized experts in health care. The commission would report annually to Congress and the President on the per capita value of services delivered through the Medicare benefits package, and the projected growth in program expenditures. Each April, Congress would set a target for Medicare spending for the upcoming year, taking into account the amount of revenue collected through payroll taxes, enrollee premiums and transfers from general revenue. In July, the commission would recommend specific changes in the program to bring spending within the budget target set by Congress the previous April.

A similar concept for an independent commission has also been proposed by the conservative House Democrats who make up the Coalition -- also known as the Blue Dogs. In its balanced budget proposal, the Coalition calls for an independent commission to help Congress make the tough choices on Medicare for the next 30 years. The commission outlined in the Coalition plan is also a full-time, bipartisan working group that could make Medicare less of a political football.

The Coalition would create a permanent Medicare Reform Commission to examine how Medicare has met budgetary and program goals. The commission would report periodically to Congress on the status of traditional Medicare, and on any new Medicare payment options that may be adopted, such as Medicare Choice. If budgetary or program goals are not met, the President could make specific legislative recommendations that would be approved by Congress through a fast-track process.

Both H.R. 2152 and the Coalition bill are sound proposals that can help bring more logical and reasoned decision making to the Medicare funding process. We commend those involved for recognizing that Medicare funding decisions must be made outside of the political arena. And we are gratified that, during the debate over how to balance the federal budget, the idea of a bipartisan Medicare commission has attracted more and more attention.

It is also important to note that Rep. Cliff Stearns (R-FL) has proposed a commission with a shorter-term focus. And Senate Majority Leader Robert Dole was quoted during the budget debate as saying "the best solution is a bipartisan" approach. We look forward to working with these members and others to create a bipartisan, independent commission that will address the long-term problems of Medicare funding.

Conclusion

The issues we are addressing here are not just political issues -- they are people issues. The decisions that Congress makes about Medicare will affect almost every American: the 38 million people who rely on Medicare benefits for their health care; the families of those beneficiaries; the millions of baby-boomers who are edging closer to retirement; the young workers who are paying into the system and rightfully expect Medicare to be there for them when they grow older and retire; and all our citizens who receive care from hospitals and health systems that could be adversely affected if change is achieved simply by the traditional and irrational method of ratcheting down provider payments.

America's hospitals and health systems are proud of the high-quality health care they have provided Medicare beneficiaries over the first 30 years of the program. We look forward to providing high-quality care in an even better delivery system for the next 30 years and beyond. We believe strongly that, by creating an independent commission on Medicare, we can achieve that goal.

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REPLACING THE FEDERAL INCOME TAX

HEARINGS

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

VOLUME II

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REPLACING THE FEDERAL INCOME TAX

WEDNESDAY, MARCH 20, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:17 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisory announcing the hearings follows:]

ADVISORY
FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
March 6, 1996
No. FC-12

CONTACT: (202) 225-1721

Archer Announces Hearing Series on Replacing the Federal Income Tax

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing series on replacing the Federal income tax. **The initial hearing days will take place on Wednesday, March 20, and Wednesday, March 27, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. each day.**

In view of the limited time available to hear witnesses, oral testimony on these hearing days will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. Chairman Archer intends to announce additional hearing days in the near future at which the Committee will receive testimony from the public.

BACKGROUND:

Last year, the Committee held three days of preliminary hearings on proposals to replace the current Federal tax system. In 1996, Chairman Archer intends to continue the Committee's examination of fundamental tax reform and to explore in-depth the various issues arising out of such a change.

In announcing the hearing, Chairman Archer stated, "Last weekend, Committee members attended a very productive three-day issues seminar focusing on issues related to replacing our current tax system. As I listened to the members of the Committee, it was clear to me that Members are eager to explore these questions more fully in the months ahead."

Archer added, "For those with a bent for history, the original bill that President Wilson signed to give us the income tax will be on display at the first hearing. It is appropriate that we view the original law as we begin consideration of its potential replacement."

FOCUS OF THE HEARING:

The hearing day on March 20 will review problems inherent in the current tax system giving rise to calls for reform, and the hearing day on March 27 will review the potential economic considerations of replacing our tax system with various alternatives.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Wednesday, May 1, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 300 additional copies for this purpose to the Full Committee office, room 1102 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

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

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

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

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

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

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman ARCHER. The Committee will come to order.

Today's hearing, the first of this year on the abolition of the current tax system, marks what I hope will be the beginning of the end for America's complicated, intrusive, loophole-ridden, unfair Tax Code, a code that more often works against the best interest of Americans rather than for their betterment.

We have in this room today the very document that created the income tax that was signed into law by President Woodrow Wilson on October 3, 1913, and it is encased in tamper-proof plastic.

I suspect that perhaps the National Archives that has graciously loaned it to us today has carefully protected it knowing that I am pledged to tear the income tax out by its roots, and this original document represents the basic roots of the income tax that we live under today.

It was very different then, very short, basically a flat tax, taxing only those people in 1913 who earned over $20,000 a year, which inflated in today's marketplace, would probably be somewhere close to $100,000 a year. It was originally a tax just on the rich.

Those roots over the years sunk deeper and deeper into the income ladder to where people today earning very small amounts of money are subject to the income tax.

I am grateful to the National Archives for allowing us to view this document this morning, and I have promised the Archives that I do not intend literally to work on the roots of the first income tax.

In 1909 when the House debated and passed the constitutional amendment that allowed for an income tax, Congressman Serenov Payne of New York said the following:

> As to the general policy of an income tax, I am utterly opposed to it. I believe with Gladstone that it tends to make a nation of liars. I believe it is the most easily concealed of any tax that can be laid, the most difficult of enforcement, and the hardest to collect; that it is, in a word, a tax upon the income of the honest men and an exemption—

"men" was generic in those days, for all the ladies in the audience, but this is a quote—

> a tax upon the income of the honest men and an exemption to a greater or less extent of the income of the rascals.

Congressman Payne, I couldn't agree with you more.

One other historical note, those who wrote the 1913 income tax recognized that an income tax was tantamount to lowering the compensation of the American people, and because the Constitution prohibits Congress from changing the President's compensation, what did Congress do? They exempted President Woodrow Wilson from personally paying the first tax. It might also have been an encouragement to him to get him to sign the law.

I suppose you could say that that exemption was the first step on the path to Gucci Gulch, but we have come a long way since then, most of it in this room.

Here was the 1913 return, four pages of return and instructions.

Here is what it has grown to. This is for 1995. It is probably a little bigger for 1996. Five volumes of taxpayer information publications and two volumes of forms and instructions. If you have a complicated tax return, there are even more publications that are not included in these volumes that are available to help you.

But my point is not to criticize IRS, the Internal Revenue Service. They merely interpret and enforce the laws written by this body, the Congress of the United States. The problem with the Tax Code begins with Congress, and Congress should fix it. As the first Chairman in recent history who continues to do his own tax returns, and I see April 15 looming ahead for me very shortly, my intention is to fix this Code. If I can't fix it, I will continue to suffer through it personally, so that I know what it does to individual taxpayers and, unfortunately, to tax preparers, because more and more individuals cannot cope with it and have to turn to preparers.

Today, we are going to hear from several witnesses about some of the Tax Code's greatest complexities and problems. As we move forward to change the Code, the issues we discuss today should be kept in mind as we consider fairer, simpler, less intrusive proposals for tax reform.

Next week we will hear from several leading economists about how changing our tax system can lead to a stronger economy, benefiting all Americans, and, for the remainder of the year, we will continue to hold hearings to explore the impact of various tax proposals on individuals from a fairness point of view and on various sectors of the economy as well.

I intend these hearings to be bipartisan and indepth. The subject of tax reform is not limited to party. It is vital to the future of our country, and I, for one, and I am sure the other Members of this Committee, look forward to a learning process this year from the witnesses who appear before the Committee.

Mr. Gibbons.

Mr. GIBBONS. Thank you, Mr. Chairman.

I think this is an important hearing, and I am glad to be able to participate in this series of hearings on this very serious subject.

First of all, I would like to make it clear that I was not here when the Tax Code was adopted. I do have some recollection, though, of what the tax situation was in the United States at that time.

Historically, our government was largely funded by tariffs, really very high tariffs in some areas, and it was funded by a series of excise taxes, some pretty high. Then, that not being sufficient revenue, the income tax was invented and imposed. It was a tax that had been used during the Civil War to finance the war. It had been declared unconstitutional by the Supreme Court, and the 16th amendment had to be adopted in order to legalize the tax and allow it to be reenacted in the form that it was in at that time.

At that time, it was probably a good modern tax system for its day, but its day has long expired. When we look at other nations on Earth, and there are a lot of them, about 150-some of them altogether, we find that most of them have converted their revenue system from an income tax system, although many of them still have vestiges of income tax systems on their books, to a consumption tax system.

In fact, in raw numbers, everybody but the United States and Australia have gone, essentially, to a consumption tax base for their revenue system.

Now, that causes us financial problems in the world, and I won't try to cover all of those in my opening statement here, but it is a

problem, and I think it is the reason why America continues to export jobs and job opportunities from our society. I think that is one reason there has been middle-income stagnation, and it is a part of the reason for the dissatisfaction with our government, but I think there is, perhaps, an even more serious problem.

The current income tax law is so complicated and, in many ways, so convoluted that it is impossible for the taxpayer to understand, it is impossible for the ordinary American to understand, and I get the impression that the ordinary American comes away from their experience with the tax system very disillusioned.

That disillusionment means that they don't think that Congress has got enough sense or enough fairness to enact a fair revenue system; that they are paying too much in taxes, at least as compared to their friends and neighbors, and their friends and neighbors are all getting some kind of break that they are not getting; and that the rich are getting this kind of break and the poor are getting shafted in some way or the other. So I think it has caused a great deal of dissatisfaction in our society.

It is at a point now where this dissatisfaction has risen to a serious point and has really impacted our ability to govern in a sensible, sane manner. So I think it is time for a change.

Change will not be easy. We should profit by the examples that other nations have had in such a change, and we should not make the same errors that they have made in their change.

Mr. Chairman, I have come to the conclusion that the income tax, both corporate and personal, should be abolished, that the payroll tax should also be abolished—and that is 95 percent of all the revenue that we now collect—and that we should substitute in lieu thereof a consumption tax.

Now, a consumption tax should be broad based. It should tax all goods and all services at the same rate, with no exception, no matter who produces that good or service. It should be adjustable at the international border, so that we can be in step with the rest of the world as far as the economy of this country is concerned.

As I say, we are now exporting jobs because of the way our tax system works on our individuals and on our society.

We do not need to go through a very complicated transition. I know that will come as a shock to many people, but it is possible to do this without a very complicated transition.

A consumption tax should only be adopted if it is a substitute for the repeal of other taxes. It should not be an add-on tax.

Our current revenue system has one characteristic that I think condemns it. It is a very, very expensive system to administer.

Estimates that I have seen, and I think are sound, put the total cost of administering our revenue system at between $300 billion per year and $600 billion per year, and if you contrast that to the $1.4 trillion that we currently collect each year, we are spending an excessive amount of our revenue on just the collection and administration process.

We can't afford it. It makes our economy poorer, it makes our standard of living lower, and we need to change it.

It can be done. It should only be done after a thorough discussion and after the American people understand it, and we do need the help of whoever is in the White House to get it done.

One of the things that I haven't touched upon, Mr. Chairman, is this matter of burden. A consumption tax would be levied at one single rate, and a pure consumption tax standing alone would tend to shift the distribution of tax burden from what it has been in the last 25 or 30 years.

We have some pretty fair figures on what the burden is today. It has, surprisingly, despite all the massive changes that we have gone through in this room, not changed remarkably between income categories in this society, with the exception that we have substantially removed the tax burden from low-income individuals. We are probably not back to where the 1916 law was, but it has certainly been reduced as to low-income individuals.

I think we have to have a burden adjustment system in connection with our consumption tax. It can be simple. It does not have to be a complicated income tax, and at the appropriate time, I will unveil some of the thinking that I have done on this area for your examination, suggestions, and criticism.

I regret—and one of the considerations that I took in account when I decided not to seek reelection—was that I wanted to be here when we got into the nitty-gritty of making the change in the tax system, but I will probably come back after my quarantine has expired and be working with you and Members of this Committee and with the public on trying to think our way through this problem.

It is, perhaps, the most serious problem that this country faces, although I must admit it is not a very dramatic problem.

As we learned at our retreat in Warrenton—2 weeks ago, was it, or maybe 3—the experts told us in that retreat that we could not expect to maintain the current system and meet the needs of the future.

I was surprised when I thought that was a unanimous opinion of all of the experts that had attended there.

So, Mr. Chairman, I have made a long statement, but you have started us in the right direction. We must learn, we must listen, we must discuss, and we must develop a consensus about what needs to be done. We owe nothing less than that to our country.

Thank you.

[The opening statement follows:]

THE HONORABLE SAM M. GIBBONS
Ranking Democrat, Committee on Ways and Means

Statement
Hearing on Tax Reform
Committee on Ways and Means
March 20, 1996

In my 27 years on this esteemed Committee I have given a great deal of thought to the way this country raises the revenue it needs and about the impact of the various alternatives on taxpayers, on our national economy, on our competitive position worldwide, and on our future.

For ten years now I have been a strong advocate of replacing our current income tax system. As most of you know, I have developed and refined over the years my version of a singe-rate subtraction-method value-added tax as a replacement for our current personal and corporate income taxes as well as most of our payroll taxes. I look forward to discussing my proposal with you next week in this Committee.

As we consider tax reform, it is imperative that we are clear about the problems our current system poses and the peripheral discussions which belong outside of this debate.

First, let me be clear: Our current tax system should be fundamentally restructured. It has become a maze of complexity. It is widely perceived as unfair. It has not kept pace with the economic realities of the modern global marketplace. It creates economic distortions, thus interfering with economic efficiency and growth. It has become burdensome to many taxpayers, particularly small businesses who must struggle through piles of federal tax forms every quarter.

Second, in the process of considering replacement tax proposals we should all remember that two debates should remain outside of this discussion: the amount of revenue the government raises and spends, and the progressive distribution of the tax burden. The former has been discussed to death in this Congress, and perhaps rightly so, but on any count it is a debate that should take place outside of tax reform. The latter, distribution, should remain as it is -- a progressive American system that helps the least of us and ensures that those who have benefitted the most from our democratic government and open economy pay their fair share.

As we consider alternatives to our current system, we must assess any proposal against certain fundamental criteria. No proposal that violates these principles should be entertained.

Revenue Neutrality. This is not a debate about how large our government should be, about what the proper role of government in society is, or about what the priorities of government spending should be. All those issues can be and should be discussed, but not in the context of tax restructuring.

Fairness. Equitable distribution of the tax burden is of paramount importance. We govern a society that worries about all of its citizens, not just the successful ones, and to that end, we should maintain the current progressivity that provides some relief for the least well-off among us.

Simplicity. Both individuals and businesses resent and complain about the level of complexity of the current tax system. Taxpayers worry that they are being unfairly taxed and that others have found ways to avoid the tax. Extensive and lucrative industries of lawyers, accountants, and tax preparers spend countless hours and unbounded energy helping taxpayers through the maze of complexity to minimize

their tax liabilities. A simpler tax system would free up these resources to engage in more productive economic enterprises. A simpler system would be better understood by the average citizen and, thus, would avoid the ill will and skepticism generated by the current system. A simpler system would improve compliance and streamline administration.

Many alternative tax systems purport to be simple, but a close examination of the details belies that claim. One of the reasons I believe my proposal is preferable to others is that it has almost no special exemptions or deductions and it has only one rate. This is very important to achieving the simplicity for which we all strive.

Economic Efficiency. A good revenue system should minimize interference in economic markets. It should result in the least amount of distortion and bias, should encourage economic growth, and should promote the vigor and competitiveness of American companies. Complying with a good revenue system should be straightforward and not too costly. A simpler, less burdensome, more neutral tax system would provide opportunities for more efficient use of our Nation's resources. That would be to the benefit of all Americans and would improve the future standards of living of our children and grandchildren. In our examination of alternative tax systems, we must keep this goal in the forefront and make sure that every decision we make along the way furthers this goal.

International Competitiveness. The current income tax is an impediment to maximum competitiveness of American companies in international markets. Our income tax simply has not kept up with the many changes that have occurred in the global marketplace. Income taxes cannot be removed from the price of goods when they cross the border to be exported. The current system penalizes exports because under the rules of the World Trade Organization (WTO), formerly the General Agreement on Tariffs and Trade (GATT), only indirect taxes, such as a VAT, can be adjusted at the border. A border-adjustable tax system would promote the competitiveness of American companies and invigorate American exports.

As we look to reforming our current system, the implications of replacement must be fully understood and dealt with. We need to educate ourselves and public about the advantages and disadvantages of our current system and of the many alternatives. I applaud Chairman Archer for taking the first step toward that end.

We need to hear expert opinions and openly and objectively debate the issues. The public must understand the choices and knowingly signal its readiness to embrace a new system. As with all successful legislation, a new revenue system must evolve from an deliberate, ongoing exercise in education and serious thought. It cannot be a flash-in-the-pan solution, but rather, must be well thought out for its practical and long-term advantages both domestically and in the world market.

I look forward to a substantive and informative dialogue here in the Committee and with the American public.

# # #

Chairman ARCHER. Mr. Gibbons, you have made an outstanding opening witness for this Committee's deliberations.

Mr. RANGEL. Mr. Chairman.

Chairman ARCHER. I would offer to any Member that would like to make an opening statement the opportunity to do so at this time. Hopefully, they will be kept reasonably short, so that we will not keep our witnesses waiting.

Mr. Thomas.

Mr. THOMAS. Just two points. One, I do think we need to fundamentally reexamine our tax system to get us ready for the 21st century, but as Sam indicated, we need to try to pull off the switch in a way that no other country in the world so far has been able to do it.

I am reminded of a B movie where at night the two cars pull up on either side of the bridge, and in trench coats, they escort the hostages to the center of the bridge, and they, in the glare of the headlights, exchange the hostages very carefully.

If we are going to move to some kind of a tax on goods and services, I also am in agreement with the gentleman from Florida, we have to do away with the income tax, both personal and corporate, but we are going to have to be very, very careful that that exchange is made and that we do not wind up with a system which not only has a tax on goods and services, but also on income as well.

It is going to be an exciting time on this Committee, Mr. Chairman. I think no Committee could do a greater service to this country than to rethink the way we finance our country because no country in the world does it poorer than we do, putting us at jeopardy, not only domestically in terms of accumulating savings, but at an economic disadvantage in trading around the world.

It is a very worthwhile endeavor, and I compliment the Chairman on the beginning of the process.

Chairman ARCHER. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Let me join with those in congratulating you for bringing into focus a problem that most all Americans have. That is, how we can have a system that is more equitable and, at the same time, more simple.

I intended to make a parliamentary inquiry because your written statement is not available, but it was my understanding you said that this Committee was going to spend the rest of our legislative year reviewing a reformation of the tax system, and I gather from previous statements made that you don't intend to reach any legislative conclusions.

Having noticed that this subject matter was of great interest to the Republican's candidate for mayor, I was wondering why we would be pursuing this issue now if we don't intend to do anything about it while we are in session.

Chairman ARCHER. I think Mr. Gibbons spoke to that when he said we must learn, we must build a consensus. This is a major undertaking. It is not something to be done in a short period of time without thoughtful consideration, without input from an awful lot of people in this country.

It is going to take us the better part of this year, I think, to do that job.

Mr. RANGEL. Thank you.

Chairman ARCHER. Mr. Houghton.

[No response.]

Chairman ARCHER. Mr. Herger.

[No response.]

Chairman ARCHER. Mr. McCrery.

[No response.]

Chairman ARCHER. Mr. Payne.

[No response.]

Chairman ARCHER. Mr. Camp.

[No response.]

Chairman ARCHER. Mr. Ramstad.

Mr. RAMSTAD. Mr. Chairman, just very briefly, I, too, want to applaud you for your leadership in this area and for calling the hearings. I know that the level of discourse in this room will be a lot higher concerning tax reform than it has been on the campaign trail.

There have been a lot of misstatements out there, and I am glad we have some true experts here today to clarify some of the misrepresentations that have been very unfortunate, but that are not totally foreign to political campaigns.

I think we all agree, Mr. Chairman, that the present system is not efficient, it is not simple, it is not flexible, it is not responsible, and it is not fair, and with the current system flunking each of these fundamental characteristics or fundamental tests for any tax system, it is imperative, as you suggest, Mr. Chairman, that we do make major changes.

I am very, very concerned about the current system's perverse incentives, to save and invest. We should not have a tax system that discourages savings and investments. This certainly means lost opportunities and lost jobs.

I think we can all agree that the current system isn't working and deserves a major overall, and I look forward to hearing from the witnesses and to reaching some conclusions at the proper time as a Member of this Committee.

Thank you again, Mr. Chairman.

[The opening statement follows:]

STATEMENT OF REP. JIM RAMSTAD
WAYS AND MEANS COMMITTEE
HEARING ON REPLACING THE FEDERAL INCOME TAX
March 20, 1996

Mr. Chairman, thank you for convening these hearings on the need to replace our deeply flawed tax system.

Economists list five traits which should characterize any tax system: economic efficiency, administrative simplicity, flexibility, political responsibility and fairness. I am certain we will hear today about how the current system flunks each of these tests.

We have all heard horror stories about the complexity of the present income tax system. The document on display today which created this current system is an innocuous 16 pages long -- 11,400 words. But it has spawned a tax code of 10,000 pages with over 555 million words.

As we will hear today, even the most expert tax preparers arrive at widely varying bottom lines when faced with the identical set of facts. How can we expect untrained taxpayers to negotiate their way through the tax maze when the experts routinely make mistakes that could expose families to a painful IRS audit?

Today's system is also costly and far from efficient. Revenue lost to the Treasury because of tax evasion exceeds $100 billion. And total compliance costs for taxpayers are staggering -- estimated at $225 billion to comply with 1996 federal taxes.

And this is not to mention the perverse incentives in the current system -- disincentives to save and invest. This means lost opportunities and lost jobs.

While we may come to different conclusions about how the tax code should be reformed, I think we can all agree that the current system isn't working and deserves a major overhaul.

Again, Mr. Chairman, thank you for calling this series of hearings. I look forward to hearing the testimony today and look forward to progress on improving the system for all taxpayers.

Chairman ARCHER. Mr. Zimmer.

[No response.]

Chairman ARCHER. Mr. Nussle.

Mr. NUSSLE. Mr. Chairman, I would just ask unanimous consent that Members be allowed to put a statement in the record.

Chairman ARCHER. Absolutely. Without objection, each Member can insert a statement in the record. I will give further opportunity for brief oral comments.

[The opening statement of Mr. Nussle follows:]

STATEMENT BY
THE HONORABLE JIM NUSSLE
BEFORE THE COMMITTEE ON WAYS AND MEANS
REGARDING ABOLISHING THE INCOME TAX
MARCH 20, 1996

Thank you Mr. Chairman for calling this landmark hearing in what will be a series of hearings on replacing the current federal income tax system. I also want to thank the distinguished witnesses for their expert testimony.

Today's hearing launches the first phase of a three phase effort to conduct an in-depth study of alternatives to the current federal tax system. We will begin our work by examining the problems with the current system.

To help put today's tax labyrinth into perspective, the National Archives brought to today's hearing the original copy of the 16-page income tax bill signed into law by President Wilson in 1913. This document is in stark contrast to the 2823 pages that comprise the current tax laws.

The second phase of our effort will focus on the economic benefits of changing the tax code. The final and third phase will allow us to examine how proposed changes will affect families, individuals, farmers, businesses and other sectors of our society such as charitable organizations.

Last month I travelled throughout my congressional district in Iowa holding town meetings in 21 counties to listen and learn from my constituents. During those meetings, I heard a lot of concern, criticism and anxiety about the current federal tax system. Iowans want a tax system based on fairness, simplicity and uniformity.

Iowans, like most Americans, are civic minded and want to meet their obligations of citizenry, including paying their taxes. Sadly enough, our current tax system makes it a challenge just to prepare tax returns with the confidence that you are in full compliance with all of the nuances of the complex tax laws.

Our current tax system also places an undue burden on working families, farmers and small businesses. For example, estate and capital gains taxes make it exceedingly difficult for farmers to pass the family farm on to the next generation.

While I have my share of criticisms of the current tax system, I enter today's hearing with an open mind for alternatives.

I do believe, however, that our next tax system should be more fair and simple for Iowa's and America's families and businesses; encourage savings, investment and capital formation; allow our businesses to effectively compete in a global economy; and be based on sound economic principles and not contrived for political gain.

Chairman ARCHER. Mr. Portman.

[No response.]

Chairman ARCHER. Mr. Laughlin.

[No response.]

Chairman ARCHER. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman, and I will be brief.

I want to congratulate you for having this hearing. I think it comes at a very important time in this debate. I believe it is very important that this Committee is serving as a catalyst for a debate which is going to have a profound effect on America's economy and on the prospects of working families for many, many years to come.

If we can make the case here in this Committee against the current tax system, I believe that we will lay the groundwork for considering an alternative tax system which will greatly simplify the experience of working families as they deal with their tax returns, greatly simplify the tax system for small business, and at the same time create massive incentives for economic growth.

Our savings rate in this country is far too low, and it is fairly clear that our tax system is a significant burden to international trade, as Mr. Gibbons has most eloquently stated.

I believe that the case for tax reform is powerful and compelling, and I want to congratulate you again, Mr. Chairman, for taking the bull by the horns and helping to set this debate and helping to bring Congress into the thick of it at a time when we desperately need to look to the tax system that we need to have to build the economy of the future.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. McNulty.

Mr. MCNULTY. This is going to be a massive undertaking, Mr. Chairman, and I just want to thank you for your leadership in getting us off to an early start.

Thank you.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Mr. Chairman, I would like to compliment you and Mr. Gibbons on your opening statements and particularly to comment you, Mr. Chairman, for bringing this hearing about. It is certainly bold. It is not for the fainthearted. We are going to find a lot of fishhooks as we go through this and a lot of vested interests that are represented in the present Tax Code.

As the only former CPA that is sitting on this Committee, I can say that the present Tax Code is nonsensical, it doesn't make sense, it defies logic, it is burdensome, it makes people make investments and financial decisions that aren't necessarily in their best interest but for the tax law, and I think it penalizes our business people on a global basis. As I say, this is going to be tough.

Mr. Gibbons was right. A lot of this is going to depend on who is the next occupant of the White House because we certainly will have to have the cooperation of the President of the United States after the next election to make this happen. This is something that is going to have to be a partnership.

I don't expect either of the Presidential candidates to take a firm position with regard to this, nor has this Committee taken a firm position, except that we are interested in following this up; we do

think there is a better way, and there is a better taxation method for the American people.

I think it is going to be a most interesting process that we are going to be going through, and I commend you for bringing this out. I know it is something that you have been thinking about for a long time, Mr. Chairman. I compliment you and look forward to working with you, the other Members of the Committee, and the White House.

Chairman ARCHER. Mr. Christensen.

[No response.]

Chairman ARCHER. All right. Thank you for your patience to our witnesses who have come forward to help us in this process in the beginning.

Mr. Frank Lalli, managing editor, Money magazine, would you lead off and proceed. If you have a longer written statement, without objection, it will be inserted in its entirety in the record, and if you could capsulize your testimony within 5 minutes verbally, we would appreciate it.

Thank you.

STATEMENT OF FRANK LALLI, MANAGING EDITOR, MONEY MAGAZINE, NEW YORK, NEW YORK

Mr. LALLI. Thank you, Mr. Chairman.

Mr. Chairman and esteemed Members, I am Frank Lalli. I have been managing editor of Money magazine for the past 6 years, and it is my honor to represent Money magazine, which is the largest financial publication in this country and its 10 million readers. Thank you for inviting me to testify.

When it comes to the U.S. Tax Code, simplification can get awfully complex. Let me explain.

As you well know, Congress passed one of the most sweeping tax reforms in history in 1986. Still, Money magazine's editors suspected that the Tax Code remains so complex that even informed accountants were having trouble filling accurate returns.

We decided to give an open-book exam to 50 volunteer tax preparers from all walks of the industry, from small-town storefront preparers to enrolled agents to CPAs at what were then called the Big Eight firms.

In January 1988, we mailed the volunteers the financial profile of a hypothetical family, and we asked them to prepare tax returns based on our information.

This was no trick quiz. The experts who helped write our test said it was neither overly optimistic nor too simplistic. It was just right, but the results were startlingly wrong. The 50 pros computed 50 different amounts of tax owed for the same family, and those tax bills varied by nearly 50 percent, from around $7,200 to about $12,000. What is more, the fees the tax preparers would have charged our family ranged from around $200 to $2,500.

Now, the conclusion was obvious. Though one-half of the Nation's taxpayers seek professional help, the typical taxpayer has no way of knowing how much tax they actually owe—nor what they need to pay to get competent advice.

Despite these depressing results the first year, we figured that diligent professionals would become more familiar with the sweep-

ing changes in the Code and fare better in the future, but we were wrong.

When we tried the test the next year, 50 new tax preparers, once again, came up with 50 different tax estimates.

Now, this time, the taxes ranged from $12,500 to almost $36,000. What is more, 11 of them missed our expert's tax target by more than $5,000, and 4 out of 5 made major mistakes, the kinds that could expose a family to an IRS audit.

When that story made national headlines, we decided at Money to turn our test into an annual event. We had two goals. We wanted to warn the public about the complicated Tax Code. We also hoped to spur the accounting profession to educate its 400,000 members about the various tax complexities.

Unfortunately, we got, essentially, the same results year after year, 50 preparers, 50 different tax bills, 50 different fees for service, all because our convoluted Tax Code is apparently baffling even veteran tax pros.

If I might draw your attention to the easel right here on my right, it illustrates the discrepancies we found in one of our recent tests in 1993. If you could read that table, it shows you that there is little correlation between the tax preparer's fees and the accuracy of their work.

For example, among the seven who came within $1,000 of hitting our tax target that year, two charged around $1,000 for their service, but the other five charged double to triple that amount, up to $3,200.

Better yet, in one year the pro who filed the most accurate return in our test worked for H&R Block. He charged $187.

Furthermore, throughout the years, our test has shown time and again that neither the ability to pay extra nor the privilege of position guarantees that you will file an accurate tax return.

Let me add this point. I am not here to advocate solutions. I am a journalist. Nor has Money magazine taken any stand on the various reform ideas being debated, but this much is clear. Something has to change.

Each April, Americans should not be faced with the question, How much do I owe Uncle Sam. Is it $1,000, is it $5,000, is it some other amount that an IRS auditor will end up dictating?

As our tax test has shown, the taxpayer's guess may be as good as their accountants. That is not the way the Tax Code should work.

Thank you very much for your time and attention.

[The prepared statement follows:]

STATEMENT OF FRANK LALLI, MANAGING EDITOR
MONEY MAGAZINE

Herewith the testimony of Frank Lalli, managing editor of MONEY magazine, before the U.S. House of Representatives Committee on Ways and Means; Wednesday, March 20, 1996:

Mr. Chairman.

When it comes to the U.S. tax code, simplification can get awfully complex. Let me explain:

As you well know, Congress passed one of the most sweeping tax reforms in history in 1986. Still, MONEY magazine's editors suspected that the tax code remained so complex that even informed accountants were having trouble filing accurate returns.

We decided to give an open-book exam to 50 volunteer tax preparers from all walks of the industry; from small-town storefront preparers to enrolled agents to C.P.A.s at what were then called the Big Eight firms. In January 1988, we mailed the volunteers the financial profile of a hypothetical family, and we asked them to prepare tax returns based on our information.

This was no trick quiz. The experts who helped write our test said it was neither overly optimistic nor too simplistic. It was just right. But the results were startlingly wrong. The 50 pros computed 50 different amounts of tax that the same family owed, and those tax bills varied by nearly 50%--from $7,200 to about $12,000. What's more, the fees the tax preparers would have charged our family ranged from around $200 to $2,500.

The conclusion was obvious: Though half the nation's taxpayers seek professional help, the typical taxpayer has no way of knowing how much they actually owe--nor what they need to pay to get competent tax advice.

Despite those depressing results the first year, we figured that diligent professionals would become familiar with the sweeping changes in the code and fare better in the future. We were wrong. When we tried the test the next year, 50 new tax preparers once again came up with 50 different tax estimates. This time the taxes ranged from $12,500 to almost $36,000. What's more, 11 of them missed our experts' tax target by more than $5,000. And four out of five made major mistakes--the kinds that could expose a family to an I.R.S. audit.

When that story made national headlines, we decided to turn our test into an annual event. We had two goals: We wanted to warn the public about the complicated tax code; and we also hoped to spur the accounting profession to educate its 400,000 members about the various tax complexities. Unfortunately, we got the same results year after year: 50 preparers; 50 different tax bills; 50 different fees for service--all because our convoluted tax code is apparently baffling even veteran tax pros.

If I may draw your attention to the table on my [direction]. It illustrates the discrepancies we found in one of our recent tests, in 1993. Reading that table, you will see little correlation between the preparers' fees and the accuracy of their work. For example, among the seven who came within about $1,000 of hitting our tax target, two charged around $1,000. But the other five charged double to triple that amount--up to $3,200. Better yet, in one year the pro who filed the most accurate return worked for H&R Block. He charged $187.

Furthermore, throughout the years our test has shown time and again that neither the ability to pay extra nor the privilege of position guarantees that you'll file an accurate return.

But let me add this point: I'm not here to advocate solutions. Nor has MONEY magazine taken any stand on the various reform ideas being debated. But I would like to share with you the results of a January poll of taxpayers across the country that MONEY conducted.

The vast majority (84%) agreed that the U.S. tax system needs a major overhaul, and 59% said the number-one goal should be fairness. In addition, despite the push for a flat tax, 64% of the taxpayers said the rich should pay more tax than others. But Americans remain divided on how reform should be achieved: 33% favored a flat tax; 16% liked a national sales tax; and 19% wanted a plan to tax income minus savings. And let me add this note: Most taxpayers (59%) said tax reform will not influence their votes in November.

Obviously, Americans haven't yet embraced a remedy for our complex tax code. We trust that your hearings will help educate the public about viable solutions.

But this much is clear: Something has to change. Each April, Americans should not be faced with the question: How much do I owe Uncle Sam? Is it $1,000? Or $5,000? Or some other amount an I.R.S. auditor will end up dictating? As our tests have shown, the taxpayers' guesses may be as good as their accountants'. That's not the way our tax code should work.

Thank you for your time and attention.

Chairman ARCHER. Thank you, Mr. Lalli.

Dr. Hall, senior economist with the Tax Foundation. Under the basic format, you can insert your full testimony for the written record.

I will say this for all of the witnesses. Without objection, your entire written record statement will go into the record, and if you will summarize verbally, you may proceed, Dr. Hall.

STATEMENT OF ARTHUR P. HALL II, SENIOR ECONOMIST, TAX FOUNDATION

Mr. HALL. Thank you, Chairman Archer, Members of the Committee. It is an honor for me to represent the Tax Foundation at this important hearing.

Many sound arguments will be made about how replacing the income tax will promote saving, investment, and economic growth, but there is another argument that in and of itself recommends replacing the income tax. That reason is the massive cost of the paperwork burden generated by the income tax laws.

The Tax Foundation estimates that complying with the entire Federal tax system will cost Americans about $225 billion in 1996. The rules and regulations for the Federal income tax alone account for approximately $157 billion of this cost. About two-thirds of the cost is borne by the business sector.

I have estimated that 90 percent of U.S. corporations bear a compliance cost burden about 700 percent greater than their collective income tax liability.

The cost of compliance, which adds nothing to national output, is tantamount to a tax surcharge on all taxpayers. One way to comprehend the magnitude and economic waste of this $157 billion income tax surcharge is to imagine wantonly destroying every vehicle produced by the Ford Motor Co. last year.

If Congress were to replace the income tax with any one of the three predominant alternatives currently being discussed, whether that be the flat tax sponsored by Representative Dick Armey and Senator Shelby, the USA Tax System sponsored last year by Senators Domenici and Nunn, or the National Retail Sales Tax Act recently presented by Representatives Schaefer and Tauzin, it could dramatically reduce America's tax-related burden without necessarily sacrificing a dime of Federal tax revenue.

The Tax Foundation has estimated how much each plan could reduce the current system's massive tax surcharge, assuming a reasonable transition period had ensued.

The Armey-Shelby flat tax could reduce the surcharge by 94 percent to $9.4 billion. The USA Tax System could reduce the surcharge by 77 percent to $36 billion. The Schaefer-Tauzin tax could reduce the surcharge by about 95 percent to $8.2 billion, but the entire burden of that sum would fall on retail and service businesses. However, as currently written, the Schaefer-Tauzin plan would compensate businesses for about one-half of this cost.

When considering these estimates, please be mindful that they are based on pure versions of the alternative systems. It is reasonable to assume that the effect of molding any of the alternative plans into a functioning Tax Code could increase their complexity and, therefore, their associated compliance costs.

The cost of complying with the tax system is directly related to the complexity of the system. In terms of complexity, it is fair to say that an income tax, the core of the U.S. Government's tax system, ranks among the worst of the tax systems currently in operation around the world.

The give-and-take of politics by continually expanding and revising the definition of taxable income accounts for a substantial measure of the complexity of the current Code. However, in the context of these hearings, it is important to emphasize that an income tax is inherently complex.

Ironically, the term "income" itself accounts for the inherent complexity. Income, particularly business and investment income, is tricky to define and has, therefore, always added excess complexity to our tax system.

I have discovered complaints about the complexity of the tax system that date back to 1914, the year immediately following the adoption of the 16th amendment to the Constitution which authorized the income tax.

Indeed, the 1927 report of the Joint Committee on Internal Revenue Taxation states that, "It must be recognized that while a degree of simplification is possible, a simple income tax for complex business is not."

The complexity of systems that tax people and businesses directly, like the current income tax, the flat tax, or the USA tax, is almost wholly related to tax-based questions; that is, questions or uncertainty about the timing or definition of taxable transactions.

Multiple statutory tax rates alone don't generate much complexity. On the other hand, multiple tax rates do generate complexity in systems that tax people indirectly. Administrative complexity in systems like value-added taxes or retail sales taxes results primarily from the application of multiple tax rates to differentiated products.

The inherent complexity of income tax base, which bears most predominantly on the income taxation of commercial activity, results from the difficulty of defining income and determining when to recognize income and expense for tax purposes.

Furthermore, a properly constructed income tax, unlike the current Federal income tax, must adopt the added complications associated with adjusting for the effect inflation has on these difficult timing issues.

The flat tax and the USA tax are direct tax systems that immediately eliminate these timing-related complexities and, therefore, their compliance costs. Both plans accomplish this objective by moving to a cash flow tax base, rather than an accrued income tax base.

A cash flow tax, as it applies to business, simply calls for the totaling of business receipts and then subtracting off purchases from other business. There is no reason to synchronize the timing of income and expense in such a system.

A business cash flow-type tax also eliminates any need for the complexities associated with depreciation and depletion allowances, foreign source income rules, inventory capitalization, amortization of intangibles, and long-term contracting. This list of items accounts for the bulk of business compliance cost. In fact, adoption

of any of the three replacement alternatives would make obsolete almost every Tax Code provision commonly cited as a major source of complexity.

Although the flat tax, USA tax, or a retail sales tax are inherently far less complex than even the most unadulterated income tax, misguided political tampering can ruin the integrity of any system.

Nevertheless, any one of these plans could be a sound replacement for the current Federal income tax. They can satisfy the current political demand for tax revenue. They stop punishing savings and investment, and by offering the potential for huge reductions in the cost of compliance, they can eliminate hundreds of billions of dollars of economic waste.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony of Arthur P. Hall, II
Senior Economist, Tax Foundation
Washington, D.C.

Before the Committee on Ways and Means,
U.S. House of Representatives
on the Subject of
Replacing the Federal Income Tax
March 20, 1996

The Tax Foundation estimates that complying with the entire federal tax system will cost Americans almost $225 billion in 1996. The rules and regulations for the federal income tax alone account for approximately $157 billion of this cost.

The cost of compliance, which adds nothing to national output, is tantamount to a tax surcharge on all taxpayers. One way to comprehend the magnitude — and economic waste — of the $157 billion federal income tax surcharge is to imagine wantonly destroying every vehicle produced by the Ford Motor Company and more than one-third of the vehicles produced by the Chrysler Corporation.

If Congress were to replace the current federal income tax with any one of the three predominant alternatives currently being discussed — the Flat Tax sponsored by Rep. Armey (R-TX) and Sen. Shelby (R-AL), the USA Tax System sponsored in 1995 by Senators Domenici (R-NM) and Nunn (D-GA), or the National Retail Sales Tax Act recently presented by Reps. Schaefer (R-CO) and Tauzin (R-LA) — it could dramatically reduce America's tax-related burden without necessarily sacrificing a dime of federal tax revenue. The Tax Foundation has estimated how much each plan could reduce the current system's $157 billion tax surcharge, assuming a reasonable transition period had ensued.

The Armey-Shelby Flat Tax could reduce the surcharge by 94 percent to $9.4 billion. The USA Tax System could reduce the surcharge by 77 percent to $36 billion. The Schaefer-Tauzin sales tax could reduce the surcharge by about 95 percent to $8.2, but the entire burden of this sum would fall on retail and service businesses. However, as currently written, the Schaefer-Tauzin plan would compensate businesses for about one-half of this cost.

These estimates are based on pure versions of the alternative tax systems. It is reasonable to assume that the effect of molding any of the alternative plans into a functioning tax code could increase the complexity, and therefore their associated compliance costs.

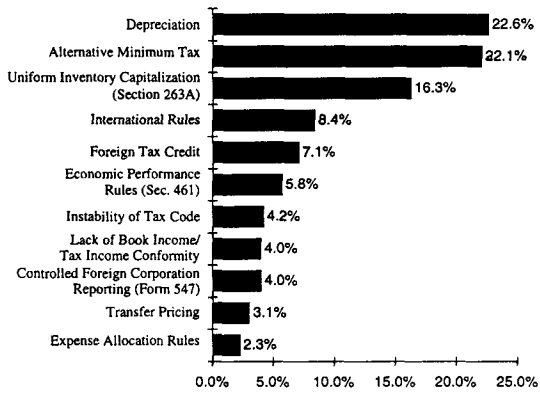
Fundamental Sources of Tax Complexity

The cost of complying with a tax system is directly related to the complexity of the system. In terms of complexity, it is fair to say that an income tax — the core of the U.S. government's tax system — ranks among the top of the tax systems currently in operation around the world. Ironically, the term "income" itself accounts for the inherent complexity. Income, particularly business and investment income, is tricky to define, and has, therefore, always added excess complexity to our tax system.

I have discovered complaints about the complexity of the federal income tax system that date back to 1914, the year immediately following the adoption the 16th Amendment to the Constitution which authorized the income tax. Indeed, the 1927 Report of the Joint Committee on Internal Revenue Taxation (Vol. 1, p. 5) states that: "It must be recognized that while a degree of simplification is possible, a simple income tax for complex business is not."

The complexity of systems that directly tax people and businesses — like the current income tax, the Flat Tax, and the USA Tax System — is almost wholly related to tax base questions, that is, questions or uncertainty about the timing or definition of taxable transactions.

Figure 1
Where the Tax Code is Most Complex (percent of total survey mentions)



Note: 315 of 365 survey respondents answered this question. Many respondents listed more than one aspect. Only the responses receiving at least 10 mentions were included.

Source: Tax Foundation.

Multiple statutory tax rates alone do not generate much complexity. On the other hand, the complexity of indirect taxes — like value-added taxes or retail sales taxes — results primarily from the application of multiple tax rates to differentiated products.

The inherent complexity of an income tax base, which bears most predominantly on the income taxation of businesses, results from the difficulty of defining income and determining when to recognize income and expense for tax purposes. Furthermore, a properly constructed income tax (unlike the current federal income tax) also must adopt the added complications associated with adjusting for the effect inflation has on these difficult timing issues.

The Flat Tax and the USA Tax System immediately eliminate these timing-related complexities and, therefore, their attendant compliance costs. Both plans accomplish this objective by moving to a cashflow tax base, rather than an accrued income tax base. A cashflow tax, as it applies to business, simply calls for the totaling of business receipts and then subtracting off purchases from other businesses. There is no reason to synchronize the timing of income and expenses in such a system.

A business cashflow-type tax also eliminates any need for the complexities associated with depreciation and depletion allowances, foreign-source income rules, inventory capitalization, amortization of intangibles, and long-term contracting. This list of items accounts for the bulk of business compliance costs. For example, based on research sponsored by the Tax Foundation, the current rules pertaining to foreign-source income alone account for 45.5 percent of the total federal income tax compliance cost for the firms of the Fortune 500. In fact, adoption of either the Flat Tax or the USA Tax would eliminate virtually every item on Figure 1, which illustrates the findings of a Tax Foundation-sponsored survey of senior corporate tax officers about the sources of complexity in the current federal income tax code.

Political Sources of Tax Complexity

Although the Flat Tax, USA Tax System, or a retail sales tax are inherently far less complex than even the most pure income tax system, misguided political tampering can ruin the integrity of any system. Indeed, over time, the political process of give and take has exacerbated

Table 1
Comparison of 1954 Code and 1986 Code (as of 1994)

Subchapter of Income Tax Code	Number of Sections in Subchapter 1954	1994	Percent Growth
Determination of Tax Liability	4	44	1000%
Computation of Taxable Income	9	145	1511
Corporate Distributions and Adjustments	14	35	150
Deferred Compensation	2	30	1400
Accounting Periods and Methods	6	33	450
Tax-Exempt Organizations	4	17	325
Corporations Used to Avoid Income Tax on Shareholders	4	27	575
Banking Institutions	3	20	567
Natural Resources	3	10	233
Estates, Trusts, Beneficiaries, Etc.	7	29	314
Partners and Partnerships	7	29	314
Insurance Companies	5	29	480
Regulated Investment Companies, Etc.	1	17	1600
Tax Based on Income from Within or Without the United States	9	78	767
Gain/Loss on Disposition of Property	7	42	500
Capital Gains and Losses	4	52	1200
Readjustment of Tax Between Years and Special Limitations	6	5	-17
Tax Treatment of S Corporations	0	14	NA
Other (a)	8	42	425
Total	103	698	578%

(a) Includes all subchapters not explicitly listed as well as Chapters 2-6 of Subtitle A of the Internal Revenue Code.
Source: Tax Foundation computations from Internal Revenue Code.

the inherent complexities of the federal income tax system. The definition of taxable income has not only expanded dramatically, but it has undergone chronic revision.

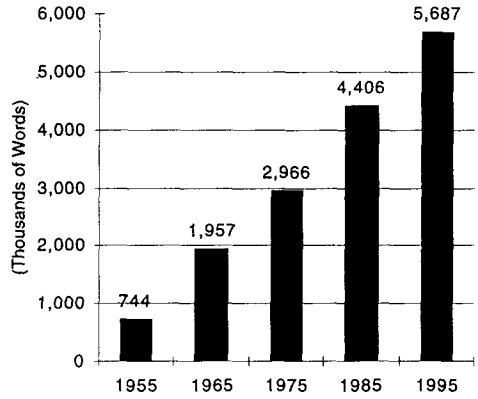
Table 1 reveals the dramatic growth in the income tax code over the past 4 decades. In 1954, the federal income tax law comprised 103 code sections. Today, that law comprises 698 code sections, a 578 percent increase. Almost all of the growth relates to tax base questions. Note that since 1954 the number of sections dealing with the "Determination of Tax Liability" has grown 1,000 percent; the number of sections dealing with "Capital Gains and Losses," most of which detail "special rules" for calculating capital gains and losses, has grown 1,200 percent; the number of sections dealing with "Deferred Compensation" (e.g., pension plans) has grown 1,400 percent; and the number of sections dealing with the "Computation of Taxable Income" has grown more than 1,500 percent.

Perhaps a more revealing measure of the growth in tax code complexity is the growth in the number of words that comprise the income tax law and its attendant regulations. Figure 2 charts the growth in the combined number of words that define the body of both the federal income tax laws and their attendant regulations. The Tax Foundation has determined that over the past 4 decades the number of words detailing the income tax laws has grown 370 percent. The words detailing income tax regulations, which provide taxpayers with the "guidance" they need to calculate their taxable income, have grown 753 percent. The combined growth is 664 percent.

The growth in the volume of the income tax laws and regulations has resulted piecemeal from the 31 major tax enactments and the more than 400 other public laws that have amended the Internal Revenue Code since the 1954 Act. Based on a sample of one-fifth of the core sections of the income tax code, these enactments have not only increased the volume of the code but have resulted, on average, in the amendment of each code section once every four years. As Figure 3 illustrates, this instability has been much more pronounced in the past 20 years than it was during the 20 years immediately following the 1954 Act.

The complexity generated by the growth and constant change of the tax code creates two general types of economic costs. One is the overhead cost associated with the economically sterile

Figure 2
Growth of the Income Tax Code (Laws and Regulations)



Source: Tax Foundation.

exercise of tax planning, compliance, and litigation. The second cost results from the economic opportunities that are foregone because of taxpayer uncertainty.

Because of complexity and instability, despite substantial cost to fund diligent and expert research, taxpayers may not be able to obtain a reasonably certain conclusion about how taxation will affect a business plan or investment. In many businesses, research and development require longer and longer lead times. If taxpayers cannot accurately predict the tax consequences of a particular economic activity, either because of vagueness, complexity, or instability in the tax code, then tax policy is handicapping the growth and dynamism of the U.S. economy.

Quantifying the Overhead Cost of Tax Compliance

In 1996, based on historical data from the Internal Revenue Service and the Office of Management and Budget, taxpayers will spend about 5.3 billion hours complying with federal tax laws. An hourly cost of $42.4 can be derived by averaging the average labor cost of both the IRS and the accounting firm of Price-Waterhouse. Applying that hourly cost figure to 5.3 billion hours results in a total compliance cost of $224.7 billion. Historically, about two-thirds of the compliance burden (or $150.6 billion) is borne by the business sector. The remaining $74.1 billion is borne by individual taxpayers.

Based on my calculations, at least 70 percent of the total cost of federal tax compliance is due to the income tax, indicating that businesses will pay an estimated $105.4 billion in 1996 to comply with the federal income tax. For businesses, that figure is up from an estimated $83.3 billion in 1992 (70 percent of $119 billion), the latest year for which complete income tax revenue data is available. The 1992 cost of $83.3 billion amounted to 41 percent of the income tax revenue received from all businesses. This ratio offers solid evidence that the income tax on business, particularly the corporate income tax, is an inefficient revenue system for the federal government.

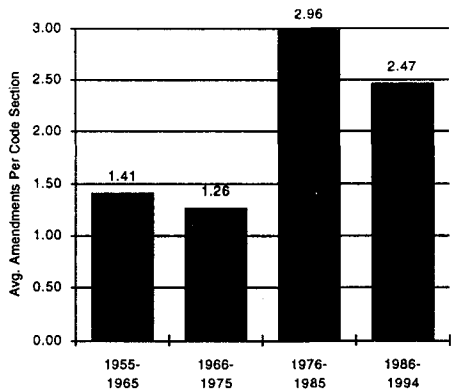
To date, the Tax Foundation has focused its detailed research on the cost to corporations of complying with the federal income tax. The total cost of compliance differs widely across companies of different size. Based on a 1992 survey of large corporations sponsored by the Tax Foundation, the 1996 cost of complying with the federal corporate income tax for the average Fortune 500 firm will amount to an estimated $1.63 million (or $815 million for the entire Fortune

Table 2
Estimated Cost of Corporate Income Tax Compliance by Amount of Company's Asset Size, 1996

Asset Size/1 ($Thousands)	Compliance Cost as % of Assets	Estimated Compliance Cost
$1,000	0.81%	$8,100
$25,000	0.66%	$165,000
$50,000	0.49%	$245,000
$100,000	0.31%	$310,000
$250,000	0.14%	$350,000
$500,000	0.10%	$500,000
$1,000,000	0.09%	$900,000
$2,000,000	0.08%	$1,600,000
$3,000,000	0.08%	$2,400,000
$4,000,000	0.04%	$1,600,000
$5,000,000	0.04%	$2,000,000
$7,500,000	0.05%	$3,750,000
$10,000,000	0.03%	$3,000,000

1. Excludes financial and life insurance firms.
Source: Tax Foundation.

Figure 3
Instability in the Federal Income Tax Code Based on Selected Code Items



Source: Tax Foundation compilation from U.S. Code Annotated (Title 26).

500). For the average small corporation, those with $1 million or less in assets, the minimum cost amounted to an estimated $8,160. But simple averages are quite misleading.

A common research finding clearly demonstrated in Table 2 is that economies of scale exist in tax compliance. That is, relative to asset size, small corporations bear a compliance cost burden at least 27.2 times greater (and, on average, perhaps as much as 184 times greater) than the largest U.S. corporations, those with $10 billion or more in assets. What makes this huge differential more amazing from a public policy standpoint is that only 0.16 percent of all U.S. corporations (6,290 returns) paid three-quarters of all corporate income taxes in 1992.

More than 90 percent of all U.S. corporations have assets of $1 million or less and, therefore, bear tremendous relative compliance burdens. In 1992, as a group, these small

Table 3
Compliance Costs to Businesses of the Value-Added Tax in Great Britain, 1986 and 1987

Size of Business (Annual taxable sales per business in $U.S.)	Compliance Costs as a Percentage of Taxable Sales
0 to 30,000	1.940
30,000 to 75,000	0.780
75,000 to 150,000	0.520
150,000 to 750,000	0.420
750,000 to 1.5 Million	0.260
1.5 Million to 15 Million	0.040
15 Million or More	0.003

Source: Congressional Budget Office, Effects of Adopting a Value-Added Tax, Feberuary 1992, p. 71. Original data from Cedric Sandford, et. al., Administrative and Compliance Costs of Taxation (Bath, England: Fiscal Publications, 1989), p. 116.

corporations had to pay at a minimum $724 in compliance costs for every $100 they paid in income tax. (For the subset of small corporations that had net income, the figure is $361 in compliance costs for every $100 of income tax paid.) They bore about $28.6 billion in compliance costs for $3.9 billion in income taxes. (That represents about 4 percent of corporate income taxes paid and about 90 percent of the minimum measure of the corporate income tax compliance cost.)

Because complying with tax laws is a fixed cost for any business, it seems likely that smaller companies will bear a greater compliance burden than larger companies under virtually any type of tax system. For example, Table 3 demonstrates that the value-added tax in Great Britain imposes a compliance burden on that country's smallest companies that is 647 times greater than the burden on the largest firms. Interestingly, however, one measure taken by tax authorities to reduce the compliance burden on small companies in countries that have a value-added tax is to allow these companies to calculate their tax liabilities in a way that is identical to the cashflow method proposed by the Armey-Shelby Flat Tax and the USA Tax System.

Comparing the Relative Compliance Burden of the Federal Income Tax and the Alternative Replacement Proposals

Tables 4 and 5 form the basis of the Tax Foundation's comparison of the cost of complying with the current federal income tax and the various replacement alternatives. Table 4 compiles a list of the core individual income tax forms along with both the estimated paperwork-burden calculations (in hours of compliance time) generated by the Internal Revenue Service. It also reports IRS projections for 1996 of the number of tax returns by type. Table 5 compiles a similar list for the business sector. These lists are far from exhaustive. The lists are also incomplete to the degree that adequate tax return information could not be obtained or estimated for the many schedules and forms that are common auxiliary components of the core forms.

Tables 4 and 5 combined report a total of 3.6 billion hours of required compliance time for the items reported. This figure is well short of the IRS-estimated 5.3 billion hours of compliance time required for the entire federal tax system. However, the magnitude of the minimal lists compiled provide ample information to make comparisons with the replacement alternatives.

To estimate the paperwork burden associated with the alternative replacement proposals (with the exception of the compliance burden on retail businesses of a national sales tax), the Tax Foundation used the same methods that underlie the IRS estimates. These methods are laid out in Development of Methodology for Estimating the Taxpayer Paperwork Burden, the 1988 report to the IRS delivered by the consulting company of Arthur D. Little, Inc. In brief, these methods estimate taxpayer paperwork burdens using the various characteristics of tax forms and the informational content of the instructions for these forms.

A. The Armey-Shelby Flat Tax

The postcard-size tax forms advertised by the Flat Tax plan makes the paperwork requirements readily discernible. The average individual taxpayer should take no longer than one hour and eight minutes each year to comply with the Armey- Shelby Flat Tax. The compliance time for the Flat Tax is compared to 11 hours and 36 minutes for the average 1040 Form and two hours and 54 minutes for the average 1040-EZ Form.

Recordkeeping would be simple under the Flat Tax. Both the wage and pension distribution data are supplied to individuals on standard forms (Form W-2 and Form 1099). The average compliance time would be somewhat lower, but, because of the current tax treatment of contributions to pension plans, for the foreseeable future many taxpayers reporting pension and individual retirement account distributions would probably have to make extra calculations to determine what part of the distribution is taxable.

The average business taxpayer should take no longer than three hours and 24 minutes each year to comply with the Flat Tax. That compares to an average 21 hours and 54 minutes for a nonfarm sole proprietor under the current income tax system. It compares to 100-plus hours for the average partnership and the 200-plus hours for the average C corporation. The reduction in compliance time comes from a major reduction in every aspect of the overall paperwork burden.

B. The USA Tax System

The USA Tax streamlines the definition of taxable income and would, therefore, substantially reduce the compliance burden associated with the current income tax. However, the USA Tax would require a somewhat greater paperwork burden than the Armey-Shelby Flat Tax. The USA Tax places a levy on both wage and nonwage income and then allows individuals to deduct an unlimited amount of current-year saving. (It also allows individuals to take a credit for payroll taxes paid.) The Flat Tax by contrast adopts a "prepayment" approach that taxes all of an individual's wages (over the exemption threshold), but never taxes income that results from saving.

As a result of this procedural difference, the USA Tax would retain a tax form similar to the current system's 1040A Form and suggests two new basic tax forms — Schedule S (Net Savings Deduction) and Schedule S-1 (Savings and Withdrawal Information). For the average taxpayer that took advantage of the savings deduction, the USA Tax should require no more than eight hours and 58 minutes of compliance time.

The business side of the USA Tax is similar to the Flat Tax in that it is a business cashflow tax. From a compliance perspective, one difference is that the USA Tax would be border adjustable. That is, U.S. businesses could deduct the receipts they generate from the sale of exported goods and services. Border adjustability, therefore, would add to an average business's recordkeeping requirements relative to a Flat Tax. This added recordkeeping accounts for the small difference in business compliance time between the Flat Tax and the USA Tax. In addition, the USA Tax allows for a payroll tax credit. However, the additional compliance costs associated with this credit should be minimal.

C. The Schaefer-Tauzin National Retail Sales Tax

In 1990, the accounting firm of Price-Waterhouse submitted to the American Retail Education Foundation their final report for the Study to Estimate the Costs of Collecting State and Local Sales and Use Tax. The study determined that the cost of sales tax compliance for the nation's retailers, on average, amounted to 3.48 percent of total sales tax liability. In dollar terms, this amounted to a 1990 cost of $4.4 billion. This figure is adjusted upward to $6.8 billion in order to reflect the dollar value of all service transactions that would be taxed under the Schaefer-Tauzin plan, but that are typically not taxed under state and local sales tax regimes.

Table 4
A Comparison of the Compliance Burden on Individuals of the Current Income Tax and Alternative Replacement Plans

Individuals Only	1996 Estimated Number of Returns	Average Time in Hours per Form for 1996 Tax Year: Record-keeping	Education Stage	Form Preperation	Packaging/ Sending	Total	Total Hours
Forms							
1040	58,301,036	3.1	2.9	4.7	0.9	11.6	675,320,329
1040A[a]	17,810,000	2.2	2.8	4.2	2.1	11.2	199,175,167
1040EZ	15,510,000	0.1	0.8	1.3	0.7	2.9	44,979,000
1040ES	38,623,500	1.3	0.3	0.8	0.2	2.6	101,064,825
1040X	1,881,500	1.2	0.4	1.2	0.6	3.4	6,334,383
4868 (Extention of Time)	4,854,000	0.4	0.2	0.3	0.3	1.3	6,067,500
1041 (Estates and Trusts)	3,102,300	41.9	17.7	34.1	4.3	97.9	303,766,875
1041A	41,571	28.7	16.9	30.8	9.9	86.3	3,589,538
1041ES	678,500	0.3	0.2	1.4	0.3	2.2	1,504,008
1040 Schedules							
Sch A	44,858,193	2.5	0.4	1.2	0.5	4.6	205,600,049
Sch B	64,083,132	0.6	0.1	0.3	0.3	1.3	83,308,072
Sch D	22,429,096	0.9	0.7	1.0	0.7	3.3	72,894,563
Sch E	27,235,331	2.9	1.1	1.3	0.6	5.8	158,872,765
Sch EIC	8,010,392	0.0	0.0	0.1	0.1	0.2	1,468,572
Sch R	480,623	0.3	0.3	0.4	0.6	1.5	736,956
Individual Totals– Current Income Tax (Forms + Schedules)	307,899,174	NA	NA	NA	NA	NA	1,864,682,603
Armey-Shelby Flat Tax	91,621,036[b]	0.04	0.4	0.3	0.4	1.14	104,447,981
USA Tax System							
Basic Form	94,723,336[c]	0.3	1.8	1.3	1.6	5.00	473,932,423
Sch S (Net Savings Deduction)	66,306,335	0.03	0.3	0.63	0.4	1.36	90,176,616
Sch S-1 (Savings & Withdrawal Info.)	66,306,335	0.14	0.8	1.26	0.4	2.6	172,396,471
Individual Totals– USA Tax (Forms + Schedules)	227,336,006	NA	NA	NA	NA	NA	736,505,509
Schaefer-Tauzin Retail Sales Tax	0	0	0	0	0	0	0

[a]Schedules 1-3 are included in the average time.
[b]Equals sum of nonbusiness 1040, 1040A, and 1040EZ Forms.
[c]Equals sum of nonbusiness 1040, 1040A, 1040EZ, and 1041 Forms.

Source: Tax Foundation, using Internal Revenue Service data and estimation methods.

The 3.48 percent-of-tax-revenues figure generated by Price-Waterhouse is best viewed as an historic relationship that does not necessarily generalize to future tax collections. Therefore, my adjustment to the 1990 cost figure ($6.8 billion) is increased by the increase in inflation-adjusted retail sales (20 percent) to yield an $8.16 billion estimated 1996 compliance cost for the Schaefer-Tauzin national retail sales tax. The total hours reported in Table 5 result from dividing the 1996 cost by the hourly labor cost of $42.4, the labor cost figure used to generate the Tax Foundation's $224.7 billion total compliance cost estimate.

To offset the regressive incidence commonly attributed to a broad-based sales tax, the Schaefer-Tauzin plan proposes to provide a rebate to all wage-earning taxpayers. The rebate will be calculated according to a formula that combines family size, official poverty level statistics, and the number of wage earners per family.

Table 5
A Comparison of the Compliance Burden on Businesses of the Current Income Tax and Alternative Replacement Plans

Businesses	1996 Estimated Number of Returns	Average Time in Hours per Form for 1996 Tax Year: Record-keeping	Education	Form Preperation	Packaging/ Sending	Total	Total Hours
Sole Proprietorships*							
Form 1040	20,735,964	3.1	2.9	4.7	0.9	11.58	240,191,587
Sch C	18,791,763	6.4	1.2	2.1	0.6	10.27	192,928,762
Sch F	1,944,202	4.4	0.4	1.3	0.3	6.43	12,507,698
Sch SE	12,112,085	0.4	0.3	0.4	0.3	1.33	16,149,446
Partnerships							
Form 1065	1,485,600	38.4	19.8	35.4	4.0	97.58	144,969,800
Partnership Schedules							
Sch D	1,485,600	5.5	1.2	1.3	0.0	8.03	11,934,320
Sch K-1	1,485,600	24.6	8.6	9.4	0.0	42.68	63,410,360
Sch L	1,485,600	15.5	0.1	0.4	0.0	16.00	23,769,600
Sch M-1	1,485,600	3.4	0.2	0.3	0.0	3.82	5,670,040
Sch M-2	1,485,600	1.6	0.2	0.3	0.0	2.07	3,070,240
Corporations							
Forms							
1120	2,115,000	71.3	41.1	72.0	8.0	192.47	407,067,000
1120A	341,900	43.3	23.3	40.8	4.6	111.88	38,252,912
1120S	2,203,100	62.7	20.7	36.6	4.0	124.02	273,221,118
1120X	23,900	12.2	1.1	3.2	0.5	17.10	408,690
1120L	2,747	75.3	23.9	37.3	3.2	139.77	383,924
1120F	21,300	102.4	36.8	64.5	7.0	210.58	4,485,425
1120PC	2,747	106.4	33.3	54.2	5.1	199.02	546,678
1120RIC	7,100	52.4	15.3	29.9	3.8	101.25	718,875
1120REIT	322	55.7	17.3	33.9	4.3	111.18	35,801
7004	2,303,600	5.5	0.8	1.8	0.3	8.35	19,235,060
4626 (AMT)	339,279	18.4	18.2	15.2	0.0	51.88	17,602,926
4562 (Depreciation)	2,456,900	33.7	4.5	5.2	0.0	43.40	106,629,460
1120 Schedules							
Sch D	2,115,000	6.9	3.5	5.7	0.5	16.63	35,179,500
Sch H	211,500	6.0	0.6	0.7	0.0	7.28	1,540,425
Sch PH	105,750	15.3	6.1	8.5	0.5	30.43	3,218,325
1120S Schedules							
Sch D	2,203,100	9.3	4.2	9.2	1.3	24.10	53,094,710
Sch K-1	2,203,100	14.8	10.3	14.7	1.1	40.95	90,216,945
Business Total (Forms + Schedules)	79,153,958	NA	NA	NA	NA	NA	1,766,439,628
Flat Tax	26,881,564	2.3	0.3	0.4	0.4	3.4	91,397,319
USA Tax System	26,881,564	2.5	0.3	0.4	0.4	3.6	96,773,632
Schaefer-Tauzin Retail Sales Tax	NA	NA	NA	NA	NA	NA	192,452,830

* No attempt is made to estimate the other schedules of the 1040 Form that a business filer may be required to complete. Such compliance burdens are left in the Individual section (Table 4).

Source: Tax Foundation, using Internal Revenue Service data and estimation methods.

The plan proposes to administer this rebate through a system of payroll tax credits. The rebate, therefore, will not add to individuals' compliance costs, but will add an addition to the compliance costs businesses must bear in association with the payroll tax. However, the additional compliance would be minimal and the Schaefer-Tauzin plan would allow businesses to keep 0.5 percent of the sales tax revenue that they collect on the federal government's behalf.

Chairman ARCHER. Thank you, Dr. Hall.

Our next witness is a tandem, as I understand it; Rachel Wildavsky, who is accompanied by Mr. Dautrich. Ms. Wildavsky is the senior staff editor of Reader's Digest.

I don't know whether you want to testify and have backup from Mr. Dautrich or whether both of you want to testify, but either way, it is OK.

You may proceed.

STATEMENT OF RACHEL WILDAVSKY, SENIOR STAFF EDITOR, READER'S DIGEST, VIENNA, VIRGINIA; ACCOMPANIED BY KENNETH J. DAUTRICH, PH.D., PROFESSOR OF POLITICAL SCIENCE, AND ASSOCIATE DIRECTOR, ROPER CENTER FOR PUBLIC OPINION RESEARCH, UNIVERSITY OF CONNECTICUT, STORRS, CONNECTICUT

Ms. WILDAVSKY. Thank you, Mr. Chairman, and thank you for inviting Reader's Digest to testify today. Mr. Dautrich will help me in the Q&A, if that is all right with you.

Chairman ARCHER. OK.

Ms. WILDAVSKY. As you requested, I will take a few minutes to brief the Committee on the findings of a survey the Digest commissioned last October. But first, here is how the survey began.

Last fall, the Digest's editors met with Everett Ladd of the Roper Center for Public Opinion Research in the hope of catching up on some polling issues. Over dinner, Ladd mentioned that each year he asks his students what they think most Americans should pay in taxes. Each year his students respond with numbers well below what most Americans actually do pay.

This story at once caught our editors' attention. Why not, we asked Ladd, conduct a major national poll asking the same question?

Over the next few weeks, we worked with Ladd to develop just such a poll. In October 1995, the Roper Center administered the poll to a cross section of over a thousand Americans. I must emphasize that our poll did not ask just about Federal taxes. Each question on our survey asked respondents to consider all the taxes they pay to every branch of government, including Social Security, State income, sales, and property taxes.

In February we published our findings, and today I will highlight our story's two most important revelations.

First, we found that the maximum tax burden Americans think a family of four should bear is 25 percent, in all the family's taxes combined. As I will demonstrate in a moment, we found a remarkable consensus on that point.

Second, we found that most Americans believe they are overtaxed. What is more, they believe their neighbors are, too—their poor neighbors and their rich neighbors alike. The Digest's editors had often heard that what bothered middle- and working-class Americans about their taxes was their belief that affluent Americans were not paying their fair share. Our poll found no support whatsoever for that claim.

What did we ask to get these results? Here is how our poll was structured.

First, we asked respondents what percentage of their total incomes they thought they paid every year when they added *all* their taxes together. We then asked them if they thought that percentage was fair. If they didn't think it was fair, we asked them what was the highest percentage they thought would be fair.

Then we asked each respondent to consider a few hypothetical families of four, one earning a high but unspecified income, one earning $200,000 a year, one earning $100,000, one earning $50,000, and one earning $25,000 a year.

For each of those hypothetical families, we asked again, What did the respondent think each of these families paid? Did the respondent think that was fair? What was the highest percentage that would be fair?

The maximum tax burden our respondents thought it fair to impose on any of our hypothetical families was the one they named for the family earning $200,000 a year. Evaluating median responses, the maximum fair tax burden our respondents named for that family was 25 percent. According to the Tax Foundation, such a family actually pays about 39 percent.

Our most stunning result was the unanimity we found on this belief, and here I will refer you to this chart to my right.

As the chart illustrates, male respondents to our poll thought 25 percent should be the top for any family. So did female respondents. So did respondents earning $75,000 or more. So did respondents earning less than $30,000. So did conservatives. So did liberals. I could go on. The median response was 25 percent not just across the board, but for every subgroup we analyzed except one, which was statistically insignificant.

If you asked whether the ocean was wet, you would probably find this kind of unanimity in response to a survey question, but to find agreement this widespread on a matter this important and potentially controversial is nearly unprecedented.

What does it mean? Common sense suggests it means people are very sure of their answers, just as sure as they would be in answering that the ocean was wet. Phone interviews I conducted after our results were in confirmed this commonsense interpretation.

I had been worried that when pressed, our respondents would back down. But the people I called affirmed their answers firmly and rationally. One respondent was on welfare herself, but wanted the rich to keep their money so they could create jobs. Another respondent, a working man, felt the rich were entitled to keep their money "to raise their families, improve their homes, and live a better life."

Our respondents didn't think the rich were the only ones who were overtaxed. Sixty-eight percent of our respondents thought their own taxes were too high, and according to the Tax Foundation, most made a fairly accurate estimate of what they paid.

On this point again, the consensus across diverse groups of Americans was strong. Conservatives, liberals, blacks, whites—they all thought they paid too much.

Today the Committee is considering tax reform. What might the Committee learn from our findings that could help us in this important work?

I believe the Committee might take away two points. The first is that there is in our Nation a widespread and deeply held belief that Americans of every income are paying too much. The point is drawn from our respondents' belief that not even the affluent should pay more than 25 percent. The second point is that Americans do not appear to be as wedded to the principle of progressive tax rates as the current Federal Tax Code is progressive.

The Reader's Digest wishes the Committee well as it ponders the policies toward which these conclusions might point.

[The prepared statement and attachment follow:]

March 20, 1996

Committee on Ways and Means
U.S. House of Representatives

Testimony of Rachel Wildavsky
Senior Staff Editor
The Reader's Digest Magazine

Thank you for inviting **The Reader's Digest** to testify today. As you requested, I'll take a few minutes to brief the Committee on the findings of a survey the **Digest** commissioned last October. But first, here's how the survey began:

Last fall, the **Digest's** editors met with Everett Ladd of the Roper Center for Public Opinion Research, in the hope of catching up on some polling issues. Over dinner, Ladd mentioned that each year, he asks his students what they think most Americans should pay in taxes. Each year, he said, his students respond with numbers well below what most Americans actually do pay.

This story at once caught our editors' attention. Why not, the **Digest** asked Ladd, conduct a major national poll asking the same question?

Over the next few weeks, we worked with Ladd to develop just such a poll. In October, '95 The Roper Center administered the poll to a cross-section of 1015 Americans. I must emphasize that our poll did not ask just about federal taxes. Each question on our survey asked respondents to consider "...all the taxes you pay to the federal, state, and local governments, including Social Security taxes, state income and sales taxes and local property taxes." In February, we published our findings in **The Reader's Digest**, in an article called "How Fair Are Our Taxes?"

What did our survey find? Today, I'll highlight only our two most important discoveries. For more, I'll refer you to a reprint attached to my testimony.

First, we found that the maximum tax burden Americans think a family of four should bear is 25 percent, in all the family's taxes combined. As I'll demonstrate in a moment, we found a remarkable concensus on that point.

Second, we found that most Americans believe they are overtaxed. What's more, they believe their neighbors are too -- their poor neighbors and their rich neighbors alike. The **Digest**'s editors had often heard that what bothered middle- and working-class Americans about their taxes was their belief that affluent Americans were not paying "their fair share." Our poll, however, found no support whatsoever for that claim.

What did we ask, to get these results? Here's how our poll was structured:

First, we asked respondents what percentage of their total incomes they thought they paid every year, when they added all their taxes together. We then asked them if they thought that percentage was fair. If they didn't think it was fair, we asked them what was the highest percentage they thought *would* be fair.

Then we asked each respondent to consider a few hypothetical families of four -- one earning a "high" but unspecified income; one earning $200,000 per year; one earning $100,000; one earning $50,000; and one earning $25,000. For each of those hypothetical families, we asked the same questions we had asked about the respondent himself. What did the respondent think each of these families paid? Did the respondent think that was fair? What was the highest percentage that *would* be fair?

The maximum tax burden our respondents thought it fair to impose on any of our hypothetical families was the one they named for the family earning $200,000. Evaluating median responses, the maximum fair tax burden our respondents named for that family was 25 percent. According to The Tax Foundation, such a family actually pays about 39 percent.

Our most stunning result was the unanimity we found on this belief. Male respondents to our poll thought 25 percent should be the top for any family. So did female respondents. So did respondents earning $75,000 per year or more. So did respondents earning less than $30,000. So did blacks, whites, conservatives, liberals -- I could go on. The median response was 25 percent not just across the board, but for every subgroup we analyzed except one. (Unmarried respondents came in at 29 percent, but this exception was statistically insignificant.)

If you asked whether the ocean was wet you'd probably find this kind of unanimity in response to a survey question. But to find agreement this widespread on a matter this important and potentially controversial is nearly unprecedented. What does it mean? Common sense suggests it means people are very sure of their answers -- just as sure as they would be in answering that the ocean was wet. And phone interviews I conducted with some of our respondents after our results were in confirmed this common-sense interpretation.

I had been anxious about those phone calls -- worried that when pressed, our respondents would back down, or be unable to defend their point of view. But the people I called affirmed their answers firmly and forthrightly, and offered rational and principled reasons for their beliefs. One respondent was on welfare, herself, but wanted the rich to keep their money so they could create jobs. "If we didn't have folks that could make more money," she said, "the poor folks wouldn't be making anything." Another respondent -- a working man -- felt the rich were *entitled* to keep their money, "to raise [their] families, improve [their] home[s], and live a better life."

But our respondents didn't think the rich were the only ones who are overtaxed. 68 percent of our respondents thought their own taxes were "too high" -- and according to the Tax Foundation, most made a fairly accurate estimate of what they paid. On this point, again, the concensus across diverse groups of Americans was strong. 68 percent of "conservatives," 67 percent of "liberals," 70 percent of blacks, and 68 percent of whites thought they paid too much. Of those with children living at home, 74 percent were dissatisfied. I should note that it does not appear always to have been thus. According to The Gallup Organization, as recently as 35 years ago, 46 percent of Americans thought their federal income taxes were "about right."

Today the Committee is considering tax reform. What might the Committee learn from our findings, that could help it in this important work? Nothing direct, I am afraid, about specific measures.

But the Committee might take away two points. The first is that there is in our nation a widespread and deeply held belief that Americans of every income are paying too much. The second point is drawn from our respondents' belief that not even the affluent should pay more than 25 percent. This second point is that Americans do not appear to be as wedded to the principle of progressive tax rates as the current federal tax code is progressive. **The Reader's Digest** wishes the Committee well as it ponders the policies toward which these conclusions might point.

How Fair Are Our Taxes?

BY RACHEL WILDAVSKY

Special Report

A Reader's Digest poll reveals what Americans feel is the most anyone should have to pay

How Fair Are Our Taxes?

BY RACHEL WILDAVSKY

FOR YEARS, we have heard that Americans—rich and poor and those in between—disagree about tax fairness. According to this conventional wisdom, the middle class and the poor think the rich should pay a heavy share. The rich supposedly think otherwise—and manage to pay very little.

True?

Last fall, Reader's Digest commissioned an exclusive poll for the purpose of learning what Americans really think. Our key findings:

- The maximum tax burden that Americans think a family of four should bear is 25 percent of its total income. That's not just federal income tax. That's 25 percent for all the major levies combined—federal, state and local—including income, Social Security, sales and property taxes. In fact, most Americans pay far more than this maximum.
- There is remarkable consensus on the issue of tax fairness. When asked to name the highest total tax that families of four should pay, respondents across economic, racial and ideological lines answered with

astounding unanimity. Again and again, the median response was the same: 25 percent. (See chart on page 59.)

"This consensus is the single most extraordinary finding in the history of domestic-policy polling in the United States," says Everett Ladd, a professor of political science and director of the Roper Center for Public Opinion Research at the University of Connecticut. Ladd, who conducted the Reader's Digest poll, has 19 years of experience in international survey research. "America is probably the only country in the world," he says, "where there are no significant differences by party or class in the 'ideal,' fair tax."

Another crucial finding of the poll is Americans' extraordinary personal unhappiness with the amount they themselves pay in taxes. More than two-thirds—68 percent—felt their own total tax payments were "too high."

This broad dissatisfaction with taxes has not always been the case. According to survey research from the Gallup Organization, as recently as 1961, Americans were equally divided between those who thought their federal income taxes were "too high" and those who thought they were "about right" (46 percent for each). Since that date, though, the percent of dissatisfied Americans has risen steadily. By 1982, 60 percent thought their taxes were too high and only 32 percent were satisfied—a 28-point gap. By 1994, the gap had widened to 36 points, with 66 percent dissatisfied and 30 percent thinking their taxes were fair.

What happened in that period? According to William Schneider of the American Enterprise Institute, people lost confidence in the government—even as inflation drove their taxes up, up, up. "People started to think in the mid-1960s that the government was not in control of events and was out of sync with society," Schneider says, basing his comments on polls taken at the time. "People were paying more, and they didn't think they were getting value for their money." He says dissatisfaction with the government remains "the basic political fact of the '90s" and still affects opinions about taxes today.

But other pundits and political leaders offer different explanations for why Americans resent their taxes. One perennial claim is that Americans are angry because they think that others aren't paying enough. House Democratic Leader Richard A. Gephardt (D., Mo.) made this assertion last September. In announcing a plan to reform taxes, Gephardt declared that, from walking door-to-door in St. Louis, he knew Americans were bothered because "a privileged few" pay too little, squeezing everyone else.

Washington analyst and commentator Kevin Phillips made a similar point in his 1993 book *Boiling Point*. Phillips blamed "the dangerous rise of middle-class frustration" on, among other things, "tax rates that hit record highs for average families and record lows for millionaires."

Contrary to these claims, The

Digest's poll found evidence that Americans at every income level think we are all overtaxed.

The Reader's Digest poll was administered by phone to a cross-section of 1015 Americans in late October 1995. For each question, we asked respondents to think about "not just federal income taxes, but all the taxes you pay to the federal, state and local governments, including Social Security taxes, state income and sales taxes and local property taxes."

We asked, "About what percentage of your total income do you think you pay every year, when you add all these taxes together?" Then we asked respondents to consider the same question for various families of four, each of which earned a different income. Evaluating their median responses—which are less susceptible to distortion than are other measurements—we found that respondents did a good job estimating their own overall taxes and the taxes paid by families earning $25,000 and $50,000. But they significantly underestimated the taxes paid by higher income families.

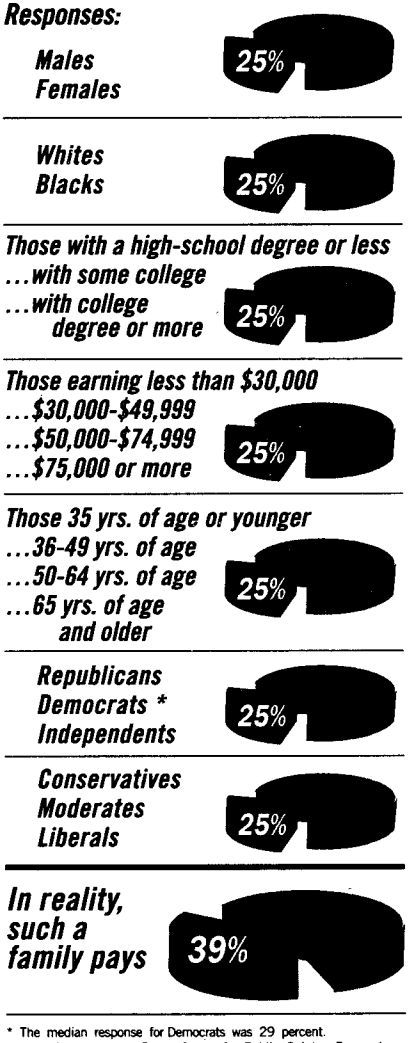
We also asked Americans about tax fairness. "What," we asked, "is the highest percentage you think would be fair for a family making $200,000 a year to pay when you add all their taxes together?"

Despite the oft-heard belief that the poor and middle-class resent "the privileged," Americans earning less than $30,000 per year agreed with

How Much Is Fair?

Question: What is the highest percentage of income that would be fair for a family of four making $200,000 to pay in all taxes combined?

Responses:



* The median response for Democrats was 29 percent.
Source: Survey by the Roper Center for Public Opinion Research for Reader's Digest, October 21-29, 1995; The Tax Foundation

the other income groups that 25 percent was the maximum tax burden that would be fair for a family of four earning $200,000 a year.

In real life, such a family pays on average 39 percent of its total income in taxes.

Clearly, our respondents felt that's too much. Self-described conservatives agreed with self-described liberals. Singles agreed with marrieds. Blacks agreed with whites. Americans in nearly every group—across racial, economic, age, ideological, religious, educational and sexual lines—had the same median response: a family of four with an income of $200,000 should pay no more than 25 percent in all its taxes combined. (The median among Democratic respondents was 29 percent. This exception is statistically insignificant.) Says Ladd, "Consensus like this means people have thought about this issue. It indicates an opinion that is rock-solid and national."

When we worded the question a little differently, we got an even lower percentage. In this question we simply asked people to consider a family of four "that makes a high income." What is the "highest percentage that you think would be fair for any family to pay in all their taxes combined, no matter how high their income?" Here the answer was 20 percent. Again, the consensus was striking; that same median amount was suggested by, among others, men, women, the elderly, the young. Even Democrats and Republicans agreed on this question.

Respondents we contacted after completing our poll were surprised that they had underestimated the taxes people pay. Emery Platt of Garnet, Kan., is now retired from a farmer's co-op where for years he ran the grain elevator, loaded fertilizer and did "about everything else." Platt is not affluent, but he doesn't think that taxes should consume 39 percent of any family's income. He says, "You ought to be able to use your money for your own purposes—to raise your family, improve your home, and live a better life."

Another respondent we contacted is from Elkhart, Ind. This woman, who is on welfare, thinks it only hurts her if the government heavily taxes high earners. They "can create jobs and hire poor people," she says.

To a remarkable degree, different groups of Americans agree they themselves pay too much in taxes. The percentage is the same for men and women (68 percent), virtually the same for blacks and whites (70 percent and 68 percent), conservatives and liberals (68 percent and 67 percent). By party, Republicans (73 percent) and Independents (71 percent) think their taxes are too high; 60 percent of Democrats think so.

Respondents with children living at home were especially dissatisfied; a whopping 74 percent of them said they pay too much, versus 64 percent of those without children at home. The elderly—who in many polls express satisfaction with their financial lives—were less unhappy; only 47 percent complained about what they pay. But, overall, how many

of our respondents said the taxes they pay are fair? Just 27 percent.

Respondent Shelia Richardson of Philadelphia says she earns "between $25,000 and $30,000" per year. Richardson—who is separated, with four children ranging from five to 20 years old—thinks she is "definitely" overtaxed. "When I do a little bit of overtime, they take so much out it's hardly worth it," she says. "But I have to do the overtime, because I need the money. I'm between a rock and a hard place."

Some politicians, sensing wide and profound dissatisfaction with the status quo, have proposed significant changes in our federal income tax. Some call for a flat tax, for example, which would replace the present complicated system of different rates and deductions with a single, low rate for everyone. Others have proposed replacing the federal income tax with something else entirely, such as a national sales tax.

The Digest did not ask respondents what they thought of any of these proposals. What we did ask, however, clearly revealed that Americans regard the tax burden as unfair. And to an extraordinary extent, diverse groups agree on what the maximum tax burden should be. As the Reader's Digest poll so powerfully reveals, there is in this country a sweeping and deeply held belief that we are all overtaxed.

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Chairman ARCHER. Thank you very much, Ms. Wildavsky.

Our last witness on this panel is Mr. Burnham, an author who has written "A Law Onto Itself: The IRS and the Abuse of Power."

Mr. Burnham.

STATEMENT OF DAVID BURNHAM, AUTHOR, "A LAW ONTO ITSELF: THE IRS AND THE ABUSE OF POWER"

Mr. BURNHAM. Thank you, Chairman Archer and Members of the Committee, and thank you for requesting my testimony.

My purpose, as I understand it, is to describe some of the systematic problems that have resulted from the administration of the income tax laws by the IRS. I speak today as an experienced investigative reporter, mostly with the New York Times, and as the author of "A Law Onto Itself: The IRS and the Abuse of Power."

My book, the product of 4 years of scholarship, argues that since the passage of the income tax law in 1913, the IRS has indirectly become the Nation's single most powerful instrument of social control.

Everyone knows that information is power. Everyone knows that when confidential information is collected and stored, it is very hard to prevent its misuse.

If limiting the abuse of tax information only required us to control the wrongdoing of individual rotten apples within the agency, it would be easy to do, but history tells us that the real problems lie not with the individual rotten apples within the barrel, but the barrel itself.

In the case of the IRS, the record is clear. Over and over again, the use of the agency and its information for improper political purposes has gone forward on the basis of direct orders from the most senior officials of the government, including several Presidents.

President Herbert Hoover, for example, angered by conservative attacks on his plan to cut back on military expenditures, ordered an investigation that eventually led to a search of IRS records for confidential information about the Navy League and its members.

Henry Morganthau, President Franklin Delano Roosevelt's Treasury Secretary, directly ordered the IRS to investigate and bring criminal tax charges against his immediate predecessor, Andrew Mellon. While the IRS reluctantly obeyed Secretary Morganthau's order, a Federal grand jury, in an unusual show of independence, refused to indict the Republican millionaire.

The Roosevelt administration also used the IRS to investigate and harass a wide range of other political opponents, including Huey Long, the Governor of Louisiana; Rev. Charles E. Coughlin, the rightwing radio commentator; Republican Representative Hamilton Fish, who I believe was a Member of this Committee for many years; and Paul Robeson, the great singer and Communist Party member.

Under John F. Kennedy, the IRS systematically stripped tax-exempt status from conservative religious groups that spoke out against the Kennedy administration.

Under Richard Nixon, the IRS formed the Special Services staff, a secret IRS unit that for a fairly short period of time audited political dissidents who had been nominated for such treatment by local police departments.

During the period Ronald Reagan was in the White House, one organization that openly opposed the President's position in Central America and another that supported the evolutionary theories of Charles Darwin were subjected to heavyhanded IRS challenges that raised the possibility of political policing.

These seven examples of how the IRS were manipulated by various Presidents and their assistants for political purposes have one thing in common. They all involved actions designed to injure a single individual or group, the Navy League, Huey Long, or the North American Congress on Latin America, but there have been instances when the men around the President have sought to use the IRS for a broader political purpose.

Both Kennedy and Nixon, the record shows, attempted to influence the political mood of the American people by secretly pressuring the IRS to alter its handling of income tax refunds.

In the case of Kennedy, the administration ordered the IRS to speed up refunds in an effort to boost the flagging economy at a politically sensitive moment.

In the case of Nixon, Peter Flanigan, a White House aide, sought to arrange widespread overwithholding by corporations so that the national mood would later be elevated when the IRS began sending out more than generous refunds than usual.

This kind of manipulation has happened throughout the IRS history. With the income tax, the collection of all that information makes it almost inevitable.

I will remind you of a little bit of history. The British Government during the Napoleonic wars wanted an income tax, and to get it, the British Parliament was very much against us, and to get it—the government promised that once the war was over, they would destroy the records. With the ultimate British victory and a great public show, all the records were taken into a public square and burned in a huge bonfire. Many years later, however, in an obscure warehouse, evidence was discovered that proved the bonfire was a sham; that a complete copy of the records had been made before the fire for use for whatever the government wanted it for.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF DAVID BURNHAM, AUTHOR "A LAW ONTO ITSELF: THE IRS AND THE ABUSE OF POWER"

IRS ABUSES: PRESENT, PAST AND FUTURE

Mr. Chairman and members of the committee. Thank you for requesting my testimony. My purpose, as I understand it, is to describe some of the systematic problems that have resulted from the administration of the income tax law by the Internal Revenue Service. I speak today as an experienced investigative reporter and author of A Law Onto Itself: The IRS and the Abuse of Power. My book, the product of four years of scholarship, argues that since the passage of the income tax law in 1913 the IRS has become the nation's single most powerful instrument of social control.

The growing reach of the IRS, however, is very much a work in progress. Just one month ago, for example, the Computer Science and Technology Board of the prestigious National Research Council released its final report on the IRS's technically troubled multi-billion Tax System Modernization program.[1]

News accounts about the NRC report emphasized the finding that IRS's management of the modernization program had not met the challenge of developing a new tax system that will be able to effectively handle the extraordinarily complicated business of collecting income taxes from hundreds of millions of American taxpayers in the 21st century.

The accounts, however, did not emphasize what the NRC indicated could develop into an even more serious shortcoming of the IRS's tax modernization system.

Without immediate, extensive and substantial changes in the security systems now being put in place, the NRC said, highly personal information about the lives of every single American taxpayer and their families will be far more subject to improper and unlawful use and distribution than it is today.

Should the IRS fail to deal with this serious management and technical challenge, the NRC report said, the gap between the agency's security mechanisms and its lawful obligation to protect

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[1]The GAO, in its 1995 report, Tax System Modernization: Management and Technical Weakness Must Be corrected If Modernization is to Succeed, GAO/AIMD-95-156, documents that as of that period the IRS had already spent $2.5 billion for TSM since 1986. The National Research Council reports that as of early this year the FY 1996 appropriations for TSM appear to be $695 million.

individual tax information from unauthorized snooping will continue to widen, "thus virtually ensuring massive security breeches in the coming years."[2]

The National Research Council prediction of what will happen to tax return information in the future, of course, is extraordinarily utopian. I say this because we all know that serious abuses related to such security breeches -- sometimes for political purposes -- have been a frequent occurrence in the long, and continuing, history of America's income tax.

Very recently, for example, we learned that more than 1,300 IRS employees had been investigated for using IRS computers to improperly snoop of American citizens.[3]

According to the news reports, about one third of 1,300 employees who were investigated were subjected to sanctions ranging from counseling to discharge from the agency, with several hundred cases still unresolved. (A later analysis by the agency's inspector general indicated that the IRS had been too lenient in its treatment of the snoopers.)

We further know that just a few months ago in Boston a member of the Knights of the Ku Klux Klan named Richard Czubinski was convicted of unlawfully using IRS computers to obtain confidential information about more than 30 people who he had concluded were his political enemies. Among these "enemies" was an assistant district attorney who was prosecuting Czubinski's father and members of a campaign committee that had supported a political candidate who defeated Czubinski in a primary election. Czubinski, of course, was an IRS employee at the time of his snooping.[4]

Czubinski was not the only Boston-area IRS employee caught with his hand in the cookie jar. Also indicted was Walter Higgins, who held a second job as a private investigator. The government

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[2]Final Report, "Continued Review of the Tax System Modernization of the Internal Revenue Service," Computer Science and Telecommunications Board, National Research Council, January 18, 1996, p. 58

[3] Robert D. Hershey, IRS Staff is Cited in Snooping, The New York Times, July 19, 1994, p. 1.

[4]Information Access Company, IRS Worker Guilty of Snooping Taxpayer Info, December 20, 1995.

said Higgins had waltzed around the theoretically stringent computer controls and extracted IRS information about a former congressional candidate, as well as someone who owed him money.

Naturally enough, the IRS response to all the unpleasant publicity about all this inhouse snooping was to focus a large chunk of its efforts in seeing to it that such unauthorized access to tax records by IRS employees was made more difficult.

This response, however understandable, was wrong headed for several obvious reasons.

First, as emphasized by the National Research Council report, the penetration of IRS computers by outsiders may well be a more serious threat than that posed by insiders.

The committee said that outsiders -- including individuals, corporations and foreign governments -- were seeking to obtain the massses of confidential and extremely valuable taxpayer information stored in the IRS computers for a variety of reasons. Some hoped to sell the information to the highest bidders. Some saw the IRS computers as a rich source of blackmail information. Others wanted to alter their own records and thus eliminate possible legal problems they might have with the IRS. Yet others viewed the information as a good way to improve their negotiating positions in civil and criminal actions of all kinds.

A second reason why the IRS's myopic focus on the wrong doing of individual "rotten apples" within the agency is flawed is that it ignores a historic fact: rogue agents probably are not the central problem. As historical record strongly suggests, the misuse of the tax information collected by the government for improper political purposes frequently has gone forward on the basis of direct orders from the most senior officials of the government, including several presidents.

The research for my book found strong evidence that the abuse IRS tax information by individuals at the highest levels of government has been a continuing problem under both parties. For example:

* President Herbert Hoover, angered by conservative attacks on his plan to cut back on military expenditures, ordered a secret investigation that eventually led to a search of IRS records for confidential information about the Navy League and its members.

* Henry Morganthau, President Franklin Delano Roosevelt's Treasury Secretary, directly ordered the IRS to investigate and bring criminal tax charges against his immediate processor, Andrew Mellon. While the IRS reluctantly obeyed Secretary Morganthaus's order, a federal grand jury, in an unusual show of independence, refused to indict the Republican millionaire.

* The Roosevelt Administration also used the IRS to investigate and harass a wide range of other political opponents, including Huey Long, the governor of Louisiana; the Reverend Charles E. Coughlin, the right-wing radio commentator, Republican Representative Hamilton Fish, and Paul Robeson, the great singer and Communist.

* At 11:50 AM, on January 13, 1944, a young, well-connected and extremely ambitious congressman named Lyndon Johnson had a private meeting with Franklin Roosevelt. Johnson and his most generous corporate supporter -- Brown & Root -- were the subject of a very serious criminal investigation that was about to erupt in series of criminal tax charges. Four hours after the meeting between FDR and the young LBJ, a senior IRS official named Elmer Irey requested the agency's investigators in Texas to send him a report on Brown & Root's political contribution to johnson's 1941 campaign, The criminal prosecution was not to be. Some months later, Brown & Root paid $375,000 in back taxes in a civil proceeding that by law was confidential.

* Under John F. Kennedy, the IRS systematically stripped tax exempt status from conservative groups that spoke out against the Kennedy administration.

* Under Richard Nixon, the IRS formed the Special Service Staff, a secret IRS unit that for a fairly short period of time audited political dissidents. I happen to be a friend of Mae and Robert Churchill, a Los Angeles couple who publicly questioned the operating procedures of the Los Angeles Sheriff's Department and as a result became the subject of four audits by the SSS.

* During the period Ronald Reagan was in the White House, one organization that openly opposed the president's position in Central America and another that supported the evolutionary theories of Charles Darwin were subjected to heavy-handed IRS challenges that raised the specter of a political police operation.

These seven examples of how the IRS powers were manipulated by various presidents and their assistants for political purposes have

one thing in common: they all involve actions designed to either help or injure a single party -- the Navy League, Huey Long, Lyndon Johnson or the North American Congress on Latin America.

But there have been instances when the men around the president have sought to use the IRS for far broader political purposes. Both Kennedy and Nixon, for example, attempted to influence the political mood of the American people by secretly pressuring the IRS to alter its handling of income tax refunds. In the case of Kennedy, the administration ordered the IRS to seep up refunds in a secret effort to boost the economy. In the case of Nixon, Peter Flanigan, a White House aide, sought to arrange widespread over withholding by corporations so that the national mood would be elevated when the IRS began to send out more generous than usual refunds.

Every one knows that information is power. Everyone knows that when confidential information is collected and stored it is very hard to keep it from being abused.

It is this reality that makes so astonishing the December 1994 disclosure by Frank Greve, an investigative reporter with Knight-Ridder's Washington bureau that the IRS was not satisfied with all the information already being provided it each year by the nation's taxpayers.[5] In an official notice in the Federal Register, Greve reported, the IRS had said that along with all the existing tax data the agency already possessed that it now planned to develop a vast new data base. This new data base would contain every scrap of public and private information that the agency could lay its hands on about every American. Among the desired scraps were the following: credit reports, news stories, tips from informants and information drawn from real estate, motor vehicle and child support records.

"Any individual who has business and/or financial activities," the IRS notice said, can expect the new computer system to make such information available to every IRS auditor upon demand. While the IRS conceded that some of the information it planned to collect would be inaccurate, the agency said that taxpayers would not be permitted to see the raw data so they could rebut any false allegations.

The publication of Frank Greve's report about the tax agency's expansive enforcement plan generated a wave of protests from

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[5]Frank Greave, "IRS Is Watching You -- Secret Files to Expand," Knight-ridder Newspapers, January 20, 1995.

citizens all over the United States and within days the IRS announced that it had all been a big mistake, that it never really planned to create the intrusive data base so clearly described in the Federal Register notice.

But as a careful reading of history tells us, we should not put too much faith in the promises of the IRS or any other bureaucracy. During a particular grievous period of the Napoleonic Wars, the British government persuaded a reluctant Parliament to agree to an early income tax on the promise that the tax records would be destroyed at the end of the war. With the ultimate British victory, with great fanfare, the records were apparently burned in a gigantic public bonfire. Many years later, however, in an obscure London warehouse, it was discovered the bon fire had been a sham, that the government had carefully made a second set of records that of course were not put in the bonfire.

Chairman ARCHER. Thank you, Mr. Burnham, and our gratitude to all of you who have come today and given us a good insight into the current system.

Thomas Jefferson wrote in his memoirs that his greatest achievement in public office was the elimination of any direct contact between an individual citizen and a Federal tax collector. He cited that as his greatest achievement. He did not cite the Declaration of Independence. He did not cite his writings on religious liberty. He cited the removal of the Federal tax collector from any direct contact with individual sin in this country.

I guess I have laid the predicate for my question that I want to ask of each of you. How much would each of you pay not to have to deal individually with a Federal tax collector per year?

Mr. Lalli.

Mr. LALLI. Well, it would save me whatever I pay my accountant, and I think that would be a start.

Mr. HALL. I would say——

Chairman ARCHER. That varies depending on which accountant you used, based on your testimony.

Dr. Hall.

Mr. HALL. I would say a couple hundred dollars a year. Happily, I have never had a direct run-in with a Federal tax collector, though.

Chairman ARCHER. But you figure that would be a good insurance premium?

Mr. HALL. Yes, sir, absolutely.

Chairman ARCHER. Ms. Wildavsky.

Ms. WILDAVSKY. I have to say I don't understand the question. You are wondering what it would be worth to pay for a guaranty that you would not have anything to do with a Federal tax collector?

Chairman ARCHER. That you would not individually have to deal with a Federal tax collector.

Ms. WILDAVSKY. I would have to consult with my husband before I could make a commitment on that figure.

Mr. BURNHAM. I would have to consult with my wife. She loves the numbers, and she has a program and she really gets into it, but I know it takes her a lot of time, and I am sure she would love not to have to do it.

Chairman ARCHER. Dr. Dautrich.

Mr. DAUTRICH. At least several hundred dollars.

Chairman ARCHER. Several hundred dollars.

Have any of you placed a value on individual freedom and privacy in that analysis, or just strictly the administrative cost?

Mr. BURNHAM. I was thinking of the administrative cost.

If you add the political manipulation and the controlling, it gets much bigger, much, much bigger.

I think privacy is an enormously important value in our society, and inevitably, with the Tax Code and the IRS, that value is undermined.

Chairman ARCHER. In the opinion of each of you, what would be the simplest form, just from the standpoint of simplicity because you always get into the argument of equity relative to simplicity,

but from simplicity, what would be the best form of taxation for the Federal Government to use to raise its money?

Mr. LALLI. We have taken no stand on that at the magazine.

I would just caution that as I tried to point out in my testimony, past attempts at simplicity have sometimes turned out to be quite complex as well. So I don't have a ready answer for you.

Mr. HALL. I think from a purely administrative standpoint, you would be hard pressed to find anything more simple than a single-rate retail sales tax that exempted nothing and gave no one special privileges.

Chairman ARCHER. Ms. Wildavsky.

Ms. WILDAVSKY. I am afraid I am not prepared to make a recommendation on that today either. I can only tell you about the results of our poll, I am afraid.

Chairman ARCHER. Dr. Dautrich.

Mr. DAUTRICH. I will pass as well. I would have to defer to my accountant.

Chairman ARCHER. You people are supposed to be pretty knowledgeable about the subject matter. It is a little disconcerting.

Mr. BURNHAM. We are all journalists, also, and we are trying to maintain an objective look at each of the possibilities and maintain that position. It is a little bit of a problem for us.

Clearly, the sales tax would appear to be—if you got it in place—it would appear to be less intrusive, though I imagine there are a number of corporations which would find it pretty intrusive, also.

As I understand the administration of the value-added tax in England, the corporations have the tax collectors knocking on their door. No system is going to be surveillance free.

Chairman ARCHER. You have got to have a point of collection. You have got to raise revenue to pay the legitimate government bills. We have to accept that.

Mr. BURNHAM. We agree to that.

Chairman ARCHER. But the question is how do we do it in the simplest way, and I appreciate your responses, although we at some point have got to make a decision. We can't simply say, Well, we are not really sure.

Mr. BURNHAM. We are not elected.

Chairman ARCHER. I understand, but we need your help and the help of every other American to give us their ideas as we develop our concepts during this process.

Let me ask one last question, and then I will turn to my Members. Mr. Lalli, I guess this is primarily directed at you, although others could chip in on it. Tax preparers are not accurate under today's system, would you clearly have established that for this Committee?

Mr. LALLI. Yes.

Chairman ARCHER. Then how can we have confidence in the accuracy of IRS decisions, because I assume that, for the most part, the IRS agents are not better educated or better qualified, individually, as they make their audits and as they pursue compliance, than the outside private tax preparers.

Mr. LALLI. Mr. Chairman, I think you have a fine point there. They are the last word in the debate, and I think there are many ambiguities built into the Tax Code. We knew this when we put

the test together, and we did that with great care to be sure that it would be as fair and accurate as it could be.

We brought experts in to devise the test for us. Then we pretested it. We had other experts take the test and then come to some conclusion about what the correct tax was, but in some cases, we had esteemed experts who came to different conclusions about different entries, and they could defend it, not necessarily by looking to the Tax Code, perhaps looking to a private letter ruling, perhaps looking to a judge's decision, and operated from some base of knowledge and also some base of credibility, but yet reach different decisions.

I think when you get before an IRS auditor, if that happens, the IRS auditor is going to be the final judge unless you take it on to a Tax Court.

Let me add just one other point on your previous question. We did do a poll in January. This is a national poll as well, and I think it points to the task that you face in trying to devise a fairer system.

At this point, the American public has no consensus that we can see on what a fairer system would be. They want reform. Something like 80 percent want reform, and certainly, the number one priority is that it is fair, but when we ask the question what kind of tax would you like, there is no consensus. So only about 30 percent at this point would favor a flat tax, 16 percent would prefer a national sales tax, and then it falls off from there.

So one of the jobs that you will have to do in coming to a conclusion about what a fairer system will be is then to sell it to the American public because at this point they are unsold.

Chairman ARCHER. Thank you.

Mr. Gibbons.

Mr. GIBBONS. Ms. Wildavsky, your chart over here, the 25 percent that the respondents thought was fair, I assume, included all taxes of all levels of government.

Ms. WILDAVSKY. Yes, it did. That is all the taxes that you pay at every level of the government combined. That was the highest response we got.

Mr. GIBBONS. I certainly don't challenge that. It is probably right, but I would point out that the average American family today pays in Federal taxes just 23.8 percent of their family income. So that doesn't leave the States and the local governments much room to get within the fairness picture or us to get within the fairness picture.

Ms. WILDAVSKY. I should say that the 25-percent figure was not what our respondents said the median family should pay, or it wasn't what our respondents said everyone should pay. That was what our respondents thought a family earning $200,000 a year should pay.

Mr. GIBBONS. Oh, $200,000.

Ms. WILDAVSKY. Right. When we asked people what do you think you should pay, what would be the maximum fair tax burden for you, all of the responses at every income level, I mean, for respondents of every income level, it fell between 15 and 20 percent.

So, no matter what the income level of the respondent, the median answer to that question, what do you think would be the max-

imum fair tax burden for you, was somewhere between 15 and 20 percent, a remarkably narrow range, I should add.

Mr. GIBBONS. I don't want to speculate about that, but that would require a revolution beyond, I think, anything that anybody has contemplated in America to ever get to that rate unless there is some magic way to increase our income substantially that no one has ever come up with.

Dr. Hall, you have said that you thought that a retail sales tax would perhaps be the easiest to collect, and let me take issue with you on that.

I happen to be an expert on the retail sales tax. I used to make a considerable amount of money out of litigating the Florida retail sales tax, and a retail sales tax is not as simple as it looks on its face.

The principal problem that you have with a retail sales tax is determining where the final sale takes place. I won't go into an in-depth discussion, but let me tell you, that is a very complex issue that all tax authorities break down on, and it is like defining income in the income tax system. It is extremely complicated when you begin to apply it.

That is the reason why I finally went to a subtraction method, value-added tax system because it does away with that complexity, and also, for the parallel reason, the States have pretty much preempted the retail sales tax as a source. I think we would run into a lot of political problems with the States if we tried to engraft our retail sales tax on their retail sales tax.

Do you have any comments on what I have just said?

Mr. HALL. No, sir. I certainly defer to your experience, and I was speaking strictly from an administrative point of view, and I acknowledge your comments.

Mr. GIBBONS. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS [presiding]. Thank you.

I think all of us are fully cognizant of the fact if there was an easy and painless alternative to the current structure, we wouldn't be here. What we are looking at is the best of options which will have some downside to it.

My big worry is that, as indicated by the Reader's Digest poll and as indicated by other people's guesses as to what they think would be an appropriate structure, my constituents are probably right smack in the middle, and that is every one of them wants to pay their fair share. Currently, they are paying more than their fair share, and that is just about the way it is with everyone. We understand the problem that we have going forward.

You are not elected, but you are more powerful than we are, in bringing the American people to an understanding of the realistic options that they have in front of them.

Take a look at the recent Presidential primaries in terms of an attempt to sell, an alternative which has some attractiveness to it, but which clearly has some negatives to it as well, the flat tax as proposed by several individuals.

It is almost always sold in a political context as a panacea, rather than a choice which gives you some upside and some downside.

In 1993, when President Clinton and the First Lady rolled out their health care proposal, one of the things I honestly believe that led to its defeat was the relatively objective approach of the media in explaining what was in it, so that the more the American people knew what was in it, the less they liked it.

The reason I say you are more powerful than we are is that I think it is going to fall upon you folks as journalists, both in the print and audio, to explain the options to the American people, so that they understand the upsides and the downsides, and especially the secondary benefits from choosing a different system.

Now, you haven't been willing to tell us which one it ought to be, and I understand. You all said you were journalists. I will ask you the question I think you should be asked. Is it your intention, your desire, your willingness, your hope that if we can carry out from our end of the bargain a relatively objective, rational examination that you folks will magnify it through your ability to focus and put it in more understandable terms that we sometimes are able to do, what those options are, what the upsides and the downsides are? Our job will be to roll out the product. Your job will be to compare it with what we do.

Is that a process that over the next year or two, do you think, that can bring the level of the American people in terms of their education and understanding, rationally their options, to a conclusion? Do you think we can create a funnel of a discussion on options that would at least narrow our options with a full understanding that our goal is to replace the income tax? Is that something that you think you could participate in, that you would want to, and that it would be worthwhile?

Mr. BURNHAM. Mr. Thomas, with all due respect to Congress and this Committee, could I point out that one of the chief responsibilities of Congress is to do oversight of the IRS, and that, historically, the GAO and Congress have spent more time worrying about getting the income in than looking for abuses in the agency, and I think all of you know that. If there was more tough-minded IRS oversight about the failings of the way the tax is administered, there would be more public support for your position.

Mr. THOMAS. I will tell the gentleman, I was on the Oversight Committee when J.J. Pickle carried on some fairly extensive oversight hearings of the IRS and some of the abuses and just the complete lack of professionalism being carried on in certain regional branches, but on this one, Mr. Burnham, I really don't think the American people need education about the onerousness of the IRS. They run into it every year.

It isn't something, I think, that is even latent. It is out there on their cuff, and what my concern is, is not generating a desire to pull the IRS out by its roots. I think everybody is in agreement, but once you pull it out by its roots, what do you do with the plot of land? Do you put stones? Do you put cement? Do you brick it in? What is the replacement for pulling the IRS out by its root?

There, I think, you need more of an objective, educational analysis of the alternatives with the pie charts, as was done with the President's health care. You can talk about what the various options are, rather than someone trying to sell something, so that they can use it as a device or a vehicle to move to another office.

That was the point I was trying to make, but it would seem to me that if you could carry out additional polls, if you could run a series of articles, if you could begin this discussion of what other countries have done, where we are at a disadvantage in terms of the underground economy, in terms of trade with other countries, that that would begin a broad, general public discussion of options and without that fertilizing of the public in terms of options.

Everyone agrees the IRS is unacceptable. Where do we go? That is my concern that it ought to be a very rational, objective discussion.

All I am asking is if you are willing to undertake that. It seems to me it may cut down on your ability to run scare articles on why they should buy your magazine, Mr. Lalli, to make sure that they do the best job they can on a very complex system. Maybe it is not a good idea because it will simplify the system and people won't buy your magazine, but it seems to me that it would be exciting where you don't make a decision in buying property or selling property or investing, where you aren't in the back of your mind thinking about the Tax Code which clearly makes it more difficult to make those kinds of financial decisions because they are never financial. They are almost always financial and Tax Code related.

Mr. LALLI. Well, I think there is no question that there is a great feeling in the public that the Code needs to be reformed in some massive way. As I pointed out, there is no meeting of the minds yet on what that solution will be.

We have written a series of articles about ideas for reform. One of the frustrations we faced—let's just take the flat tax, for example—is that the flat tax impact on business, which has been relatively underreported, is very difficult to report because the plans are very sketchy, but it looks to us in articles that we have written that there would be major loopholes there for businesses to leap through.

So we are far from a point where we have a consensus on this, but if we are about to enter a system in which a homeowner loses their deduction for the home mortgage, but a corporation can write off the corporate jet, I think you are going to have to do a lot of explaining before you get the American public behind that idea.

Mr. THOMAS. I think if you wrote an article pointing out that that would be one choice under a flat tax and that these are other choices and that these are the consequences of those choices, people would better understand the problems under the flat tax.

Mr. LALLI. There is in April 1996.

Mr. THOMAS. I am sorry. I didn't want to step on your commercial. Which issue?

Mr. LALLI. In April 1996. It is in the current issue.

Mr. THOMAS. April 1996, Money magazine. Page?

Mr. LALLI. Excuse me?

Mr. THOMAS. Page?

Mr. LALLI. Page 18.

Mr. THOMAS. I mean, if you are going to do it, you might as well go all the way.

Mr. LALLI. Page 18.

Mr. THOMAS. It is something that we are going to have to do together. You people have an ability to present options in a way that

we oftentimes cannot. Working together, perhaps, will carry out a mutual education not only of Congress, but the American people about the consequences of the decision, but none of you disagree that we do have to move forward. Is that correct? There has got to be an alternative.

Thank you very much.

Does the gentleman from Florida wish to inquire?

Mr. SHAW. Briefly, Mr. Chairman.

Mr. Lalli, I would like to follow up on the poll that you mentioned during the questioning period and also in your opening statement where you said 33 percent favored a flat tax, 16 percent liked the national sales tax, and 19 percent wanted a planned tax income minus savings.

How large was that poll?

Mr. LALLI. That was a national poll, statistically valid. I think it was somewhere—about 800 people. I think the Reader's Digest poll was 1,000. Ours was about 800.

Mr. SHAW. So that would be probably within 3 or 4 points.

Mr. LALLI. It would be 3 or 4 points.

Mr. SHAW. In that poll on the sales tax, was the question asked that this would be a replacement, a total replacement for the income tax?

Mr. LALLI. No, I believe it was not.

Mr. SHAW. So a lot of the people being questioned were thinking this is just another tax.

Mr. LALLI. It could be.

Mr. SHAW. With regard to the flat tax, that is probably one of the most abused words in the English language right now. It is like reform. Everybody is for reform, but there are so many differences, whether it is welfare reform, tax reform, or whatever. Also, the flat tax. You really get into it with Mr. Forbes, with his exemption of investment income.

Mr. LALLI. Right.

Mr. SHAW. Then you get into the question of charitable deductions and home mortgages, and then you get into local taxes and things like this.

I would suppose that there is no way that you could have gotten into the details of a flat tax on that particular poll.

Mr. LALLI. We didn't. We tried to describe it in a way that it was 17 percent. If you were a close reader of the newspapers, I think you would have identified it as the Forbes plan, just by the rate, by the 17-percent rate, as opposed to Gramm's 16 percent or someone else's higher number, but in a poll, you can't get into detail like that.

Mr. SHAW. I would guess if this was strictly a random poll, people just being taken off of a voters list or out of the phone book, however the names were chosen, that probably over one-half of the people you contacted didn't have a clue as to what flat tax really meant under any of the definitions. Wouldn't you guess that that is probably true?

Mr. LALLI. There may be something to that.

I think you look for the much bigger numbers. I think if you see 60 percent of the people saying their highest priority is fairness, if you see 64 percent as that poll showed believing that people who

have more money ought to pay more taxes than others, I think those are significant numbers.

When you get down to whether the sales tax, the national sales tax at this point is a 16-percent preference in the public. All it shows and all I was trying to say is there seems to be no consensus at this point on what a fairer replacement tax would be. A simple point.

Mr. SHAW. Do any of you on this distinguished panel wish to comment on the question of regressivity, as to whether or not this tax would be regressive in applying to all income levels at the same percent? Because that is a problem that we are eventually going to have to tackle, and we are going to have to address whether you have people at the lowest income applying for refunds, similar to EITC, the earned income tax credit or something of that nature.

Yes, ma'am.

Ms. WILDAVSKY. We didn't ask in our poll about the flat tax, and in fact, we didn't ask about Federal taxes at all. Our questions concerned all the taxes that you pay to the government, from all branches of government.

We did in our results find something, learn a little bit about how people feel about graduated tax rates, and what we found is that people think the maximum fair tax burden at different income levels should be graduated slightly for income level, but not graduated nearly as steeply as the present tax system is graduated. When I say tax system, I use that word to refer to all the Codes together in their totality because our poll wasn't about Federal tax.

So we found that for maximum fair tax burdens, our respondents identified incomes between $25,000 and as high as you like, and it ran between 10 percent for a family earning $25,000 a year, and 25 percent was the highest figure we got.

That is not flat. It is flatter, but it is not flat.

Mr. SHAW. Were the people in your poll advised as to the bottom figure you have up there on the chart, where families with an income of $200,00 are paying 39 percent? Were they advised of that?

Ms. WILDAVSKY. No, they were not.

After the poll was complete, I called some of the people who had given the median responses to tell them how the poll had come out and to tell them what the actual numbers were and to ask them if they still wanted to stick to their answers once they had that information, and they all stuck like glue to what they had said the first time, nobody should pay more than 25 percent. That was what they said.

Mr. SHAW. Thank you very much.

Chairman ARCHER [presiding]. Just one quick followup. That 25 percent, as I understand your poll, was on all taxes, the aggregate of all taxes—State, local, and Federal. Is that correct?

Ms. WILDAVSKY. Right, and I repeat once again, that isn't what they thought everybody should pay. That is the highest figure they said anybody should pay, and the only way we got that figure was by asking them about a hypothetical family of four earning $200,000 a year.

When we asked what about a hypothetical family of four earning a high income, but we didn't specify the income, just said no matter how high, they actually said 20 percent. When we asked them what

they thought was the maximum they should pay in taxes, in all of their taxes combined, respondents at every level of income answered between 15 and 20 percent. The affluent answered between 15 and 20 percent.

I could give you the breakdown on that if you want it, but none of the answers, median answers, fell outside of that range.

Mr. SHAW. Mr. Chairman, what is the average? Does anybody know?

Chairman ARCHER. Average of what?

Mr. SHAW. Of what people pay for all taxes.

Ms. WILDAVSKY. I think I can, maybe, answer that.

Chairman ARCHER. State, local, and Federal, percentage of income.

Mr. GIBBONS. She says 39 percent over here.

Ms. WILDAVSKY. No, no. That is——

Mr. SHAW. Well, that is $200,000, I think.

Ms. WILDAVSKY. The median, according to information provided for us by actually the Tax Foundation, the median family pays about 30 percent in all of its taxes combined.

Mr. GIBBONS. To answer your question, I can't give you the State tax burden. Frankly, in undertaking this task, I just didn't try to change everything in the world at one time. I was just trying to change the Federal system.

In the Federal system, the Congressional Budget Office tells us that the average tax burden on a family in the United States is 23.9 percent of all Federal taxes. That is estate taxes, excise taxes, tariffs, payroll taxes, and income taxes. That is what it is.

Ms. WILDAVSKY. We added non-Federal taxes as well.

Mr. GIBBONS. Yes. You added non-Federal taxes, and I, frankly, just don't know the answer to that.

Chairman ARCHER. I believe the total for the country, Mr. Shaw, of all taxes on average for all income categories is that government takes about 32 percent of the total income that is generated in this country, across the board.

Mr. HALL. The Tax Foundation calculates Tax Freedom Day every year, which was May 6 last year, which, in effect, takes total tax burdens, all levels of government, and divides it by net national product, which is gross domestic product less depreciation, which we believe is the correct income to use. Last year, that figure came to 35 percent.

Chairman ARCHER. Again, you get back into the question that you mentioned in your statement as to what is income. You still have to define income in order to be able to determine the percentage, and different people have different ideas of what ought to go into the definition of income. You just gave us one of them.

Mr. HALL. Yes, sir.

Chairman ARCHER. Thank you.

So, basically, and just to wrap this part of it up, if, in fact, the overwhelming majority of the American people think that no family should pay over 25 percent, then the first thing that has got to happen is we have got to cut the cost of government in this country by 10 percent, both State, local, and Federal, in order to come out at your 25 percent, and if that is the top, we have got to cut it even more, if the average is 35 percent, that is first.

Second, the income tax at the Federal level has got to have a maximum rate that is way below 25 percent, way below 25 percent in order to make the total of all tax come out to 25 percent.

Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

To follow through with what you just said, if we are going to have to reduce the cost of government by 10 percent, if we have 35 percent and we have to get down to an average of 25 percent, it would seem to me that as a part of this educational process, to make an informed decision, we would also have to share with them where we intend to reduce the size of government. This brings me around to an uncomplicated theory that Senator Long had when he chaired the Senate Finance Committee. It is a theory that most taxpayers would have, and seems to be supported by Ms. Wildavsky. That is, don't tax me, don't tax thee, tax the person behind the tree.

It basically seems what she is saying is that everyone believes someone should be taxed more, but certainly, they themselves should be taxed less, and I assume that everyone is saying that those who are more affluent should carry a heavier burden, but certainly, the affluent, like most people, would want to find out what formula would allow them to pay less taxes. I mean, that is what we are talking about.

All of this education about what happens later—now, this flat tax, Federal tax, sales tax, value-added tax, consumption tax, there is no question that this sounds simple. I have found that most simple formulas don't have the equity and the distribution of burden, but Sam Gibbons said that he is not giving up on me; that he is going to stick with me, at least as long as he can, to make me understand that these things can be done without adding the burden of complexity to the system.

I love the flat tax. I would like to have a little adjustment for the poor and an adjustment for the churches and an adjustment for the hospitals and an adjustment for mortgage deduction. It just seems to me that deductions, depreciation, and tax credits, no matter how much you pay, your accountant is going to say before reform, but this is the system where you can save tens of thousands, if not millions, of dollars.

Having said that, you can bet your life you are not elected, but this room does not normally have the attendance that it has today, and the closer we get to making a decision, they will be in the hallway and in the streets and everywhere, and everyone wants to have it fair the way they see it.

Having said that, it seems to me that even if we had a dramatic change in the system because people were demanding it, as Clay Shaw said, a flat tax or reform without knowing what the heck we are talking about, if we were able to come up with some broad-based solution, the idea of the transition as to how we treat assets that are already taxed and what happens with the tens of billions of dollars that are under the present system, in my opinion, it will take a long time to weed those things out. Since we all believe that we have to tackle this problem, my question to you is, while we are waiting for the final solution, could you state just what was it that irritated the taxpayers the most in terms of outrage of the existing

system, excluding that they are paying too much in taxes? I mean in terms of the complexity of this system.

Is there anything that we could do with the present system to make it more simple without losing a lot of revenue while we are waiting for me and others to understand how fast we can get a flat, more simple tax?

Ms. Wildavsky.

Ms. WILDAVSKY. Yes. I am afraid that the only answer that emerged from our poll in response to your question is the one you excluded, which is just lower it.

What bothered our respondents about their taxes was that they felt their taxes were too high. They didn't just feel that their tax——

Mr. RANGEL. That is never going to change. I don't care—it is not going to change. So that is not a consideration.

Ms. WILDAVSKY. That is up to you.

Mr. RANGEL. We got a range of revenue. We have got to carry government, but excluding that, what was it besides the fear of making a mistake and the fact that the IRS would terrorize them and they will be on the way to jail for a simple mistake, which we all understand. But getting the form, is there any one thing that we can do under the existing system so that we can say we are a long way from flat tax, but at least we have done something to reform the system to make it easier for you?

Mr. BURNHAM. I would think, from looking at the IRS, that a great deal could be done if the IRS was administered better.

In addition to being a writer, I am the codirector of a research organization that collects data from government agencies.

We have looked at the IRS. The audit rates, for example, in different districts are wildly different. The seizure rates are different; the rates that taxpayers are allowed to enter installment agreements. The IRS is not a well-administered agency. It is erratic. It is an ad hocracy.

If the public had the impression that an effort was being made to treat similarly situated citizens in a similar way, I think you would go a long way, but I do not think the IRS has paid enough attention to this internal administrative process.

Mr. RANGEL. Well, you are talking about an irrigation at the IRS and the bias, and what you are saying is legitimate bias against the tax collectors still wouldn't change it.

We have to do a better job in oversight.

Mr. Chairman, I just wanted to ask whether or not—it seems to me that we didn't have those lights on until it was time for me to inquire. Is there any special reason for that?

Mr. SHAW [presiding]. It was on when I inquired.

Mr. RANGEL. It was?

Mr. SHAW. Yes.

Mr. RANGEL. OK. Thank you very much.

Mr. SHAW. Mr. Houghton may inquire.

Mr. HOUGHTON. No.

Mr. SHAW. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, and I want to thank the members of the panel for coming and being patient today and testifying.

Ms. Wildavsky, first, I want to congratulate your publication, the Reader's Digest. Since Money magazine has gotten a little play here today——

Ms. WILDAVSKY. Thank you.

Mr. MCCRERY [continuing]. I will say that Reader's Digest is certainly a well-respected publication, and we are glad to have you here to share with us your findings.

One thing that you didn't give us the answer to, though, at least not that I heard, you said in your poll you asked the respondents what did they think each of their families paid, what percentage of their income did they think they paid actually in taxes. What was that response?

Ms. WILDAVSKY. Most of our respondents estimated their own income—excuse me—their own total tax burdens fairly accurately.

They also estimated reasonably accurately the tax burdens of the families toward the middle range of income that we asked about, the $25,000 families and the $50,000 families.

Stop me if I am wrong, Ken, but I think at the $75,000 level, too, they estimated taxes actually paid fairly accurately.

At the upper ranges, they underestimated what people actually pay.

Mr. MCCRERY. So, on average, they were estimating that they were paying 30 to 35 percent?

Ms. WILDAVSKY. Pretty close to what they are. People seem to know what they are paying in taxes.

Mr. DAUTRICH. Specifically, in terms of how people responded to the question, What do you pay?, the average response is for the family—if the family is making at least $75,000 a year, the average response was 35 percent. It was 35 percent for those in the $50,000 to $74,000 category, 30 percent for those in the $30,000 to $49,000 category. For those under $30,000, they estimate, on average, that they are paying 25 percent in total taxes.

Mr. MCCRERY. So you are telling me, then, that the average respondent pretty well pegged his own tax burden which was somewhere between 30 and 35 percent, but he thought his tax burden ought to be between 15 and 20 percent. Then the conclusion we can draw from those different responses, then, is that they think they are overtaxed.

Ms. WILDAVSKY. Everyone at every income level that we surveyed thought they were overtaxed. Not every individual. Excuse me. But the median response is that every income level, the majority—excuse me—thought they were overtaxed.

Mr. MCCRERY. So, if we in Congress respond to the public's conception of fairness, we have quite a job to do, don't we, and curtailing activities of government and cutting spending at all government levels?

Ms. WILDAVSKY. Not only did everyone think they themselves were overtaxed, but they thought their neighbors who had different income levels were also overtaxed. The middle class thought the affluent were overtaxed. The working class thought the middle class and the affluent were overtaxed, and the other way around.

So it wasn't just that people thought they themselves paid too much. They thought everybody else paid too much, too.

Mr. MCCRERY. Mr. Burnham.

Mr. BURNHAM. The results are very interesting. I wonder what would have happened, however, if they had also—Reader's Digest had also asked whether you want the air controllers in your district removed because that is going to cost money, or fewer cops, or we are going to close down a few schools, and whether that would have changed the answers. I suspect it might have changed them. I mean, in the abstract, I would like to pay less taxes. I think everybody says that.

As you know as a Congressman, when you start saying what are we going to cut, the answer changes.

Mr. MCCRERY. Yes.

Ms. WILDAVSKY. If I may say one more thing on behalf of our respondents, our respondents did not say they didn't think they should pay any tax at all, and they didn't say 1 percent and they didn't say 2 percent. They said between 15 and 20 percent. They stuck with, really, an incredible degree of consensus within that range.

Mr. MCCRERY. The fact is, though, right now government consumes a much greater share of total income in this country than people think is fair.

As Mr. Burnham suggests, it is a very difficult process to get from where we are now in spending down to where the public thinks we should be in terms of what we should take from them, and they are the only place we can get income to finance activities of government.

So, as we go through this process, while this kind of data is interesting and helpful in giving us some guidance, we also have to be mindful of the priorities of government and the demands of people for services of government. In thinking about going toward a system different from the income tax, we have to decide at some point whether we want to be a revenue-neutral transition or a tax reduction transition to accommodate these kinds of responses from the American public.

So this is going to be, in fact, a very long time-consuming debate, an interesting one, and certainly, your testimony today has helped to get us started on that road.

Thank you.

Mr. SHAW. Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman, and I want to thank the panel very much for the testimony today.

I think that we, among ourselves, generally have reached a consensus that the Tax Code, indeed, does need to be reformed.

You all have certainly contributed to the evidence that that is, indeed, what ought to happen. I think we generally have concluded that if this were a perfect world and we didn't have any kind of Tax Code and we were inventing one that a consumption tax, whether it is a national sales or value added or something along that line, makes a great deal of sense as we think about how to structure a Tax Code.

The difficulty we are having, though, is that we have a huge Tax Code now. We have a lot of transactions that have occurred. A lot of people have made decisions, investment decisions, home-buying decisions, have bought machinery and equipment, and so forth based on a Tax Code that we currently have.

Part of that Tax Code has a lot of incentives. In fact, just yesterday we increased those incentives in terms of the deductibility of health insurance because we want more people who are not covered to have health insurance.

We have a deductibility of home mortgage interest so people will buy homes. We have deductions for charitable giving so that people will give to their churches and give to other charitable organizations. All of this, of course, would be affected if we change from one Tax Code to another.

So what all of this means for us and what we have to deal with is that, while there are definite rewards that we can see from changing the Tax Codes, there are some huge risks involved as well as it relates to many of the elements that would be affected and to the economy in general.

It seems to me there are really two ways to mitigate this risk. One would be that we fix the existing Code and try to solve the problems that we can identify and keep this Code in place.

Another way to mitigate would be to try to have a transition from the kind of Tax Code we have now to a consumption Tax Code, which means at least for some period of time, we would have both income taxes and consumption taxes. This seems to be what many of the other nations in the world have.

I would just appreciate any advice you might have for us in terms of how we might mitigate the risks that we think will be incurred.

Specifically, Dr. Hall, any comments you might have along that line would be appreciated.

Mr. HALL. Well, I would start off my comment by saying, and it is an easy comment to make, that all roads lead back, ultimately, to the size of government. You can buy yourself a great deal of flexibility if you don't have to raise as much revenue as you are currently raising, OK? It is simple to say.

I would say, my knowledge with regard to complexity itself, and that is, what to do about the current system and, therefore, essentially, avoiding the risks you spoke of, is on the business sector, you could move to a territorial tax system. That is, eliminate all of the complicated rules dealing with foreign source income.

It is only really big corporations in America that deal with that extensively, but nevertheless, a Tax Foundation-sponsored study estimated that about 45 percent of the compliance cost for the Fortune 500 is directly related to foreign source income rules alone, and I believe the Congress raises, at most, about $5 billion a year from that. It is really not a big revenue item at all, and it is a major headache.

The other is the alternative minimum tax. There is absolutely no good tax policy or economic reason for that tax. It is pure politics. It doesn't raise very much money, and what it does do is get companies that are involved with it in a swap of building up AMT credits, which is a major transaction problem, from the current system to another system. So that is a problem.

Then, the other, for businesses, and this would include small businesses as well, would be to go to expensing, which is what, essentially, the reform plans do, either de facto or explicitly. Depre-

ciation schedules, in and of themselves, are a very complicated part of tax compliance.

For individuals, it is harder to say. It is really the people who have a lot of capital income that face—investment income that face a lot of the complexities.

I would say if you were able to move toward a great expansion of IRAs, back-ended-type IRAs—would lose less revenue—people would not have to worry about the tax consequences of shifting their portfolio around to fund things like, for example, if you took the Contract With America, the American dream savings account, that model where all of your income is taxed prior to putting it into the IRA, but there are no tax consequences of taking it out, and you are allowed to remove money from there for major expenses, medical, college, education—I am sure you know—what that does is eliminate the tax consequences of shifting investment portfolios, and that would relieve a major headache for a lot of people.

Mr. PAYNE. I see my time has expired, but thank you all very much for all the information you have imported to us, and thank you, Dr. Hall, for your answer.

Chairman ARCHER [presiding]. My compliments to each of you, also.

Unfortunately, there are aspects of our life over which we do not have adequate control, and one of them is that when those lights come on and those buzzers go on, it means we are having votes on the floor of the House.

We have about 5 minutes to go over and make this vote, which will be followed by additional votes, and I am going to suggest that if you can come back—we are going to take a break for lunch now, and perhaps some of you are hungry—if you can come back at 1 o'clock, we would be glad to have you back and take further questioning by Members of the Committee who have not questioned.

If you have to leave because of your own schedules, we will understand that.

The Committee will stand in recess until 1 o'clock, and we hope you can come back and spend some more time with us, but if you have to leave, we will understand that.

Mr. Neal.

Mr. NEAL. Mr. Chairman, just one quick observation. Hearings addressing tax reform are precisely what the Presidential election should be about. These kinds of issues give us an opportunity, I think, for all of us to remind the news media and others that a campaign in the end should be about ideas and forming opinion, and what better opportunity to provide that forum for the American people than a Presidential campaign.

The truth is, that unless the Presidential campaign focuses on these kinds of issues and unless the candidates pick up this kind of an issue, we are going to be back here 3, 4, or 5 years from now debating the same topics without a lot of results.

I hope the candidates for President will embrace at least thinking about these notions.

Chairman ARCHER. For those of you who cannot come back at 1 o'clock, thank you very, very much.

For those of you who can, we will see you at 1 o'clock.

[Whereupon, at 12 noon, the Committee recessed, to reconvene at 1:10 p.m., the same day.]

Chairman ARCHER. The Committee will come to order.

Since there are no other Members who have not questioned, who appear eager to question, and, Mr. Gibbons, unless you have a further question you would like to ask——

Mr. GIBBONS. No, I don't, but I want to thank the witnesses for coming and for staying here. We appreciate it very much.

Chairman ARCHER. I feel very bad that we held you over, and I hope it hasn't interfered with your day's schedule, but I am very grateful for your coming. I think you have made a real contribution to our consideration of this very important issue.

The only thing that I might like to just clear up specifically, to be sure we understand fully the nature of your survey, this 25 percent of all aggregate taxes, wherever collected, that the overwhelming majority of the American people believe is the top amount that anybody ought to pay—I am stating what I think your survey said. If not, I would like for you to correct it.

Ms. WILDAVSKY. Our survey said that 25 percent was the amount that a family of four earning $200,000 a year—excuse me. I have misspoken.

Respondents didn't say that was the amount that family should pay. Our respondents said that would be the most that it would be fair to make that family pay.

Chairman ARCHER. OK, exactly. Well, that is what I understood you to say. I may not have stated it exactly correctly, but I understand that.

So that would be the maximum.

Ms. WILDAVSKY. That is the highest number we got.

Chairman ARCHER. So the average that would be paid for people of lower income, coupled with those of higher income, I assume, would be less than 25 percent.

Ms. WILDAVSKY. It would. Asked what is the maximum fair tax burden any of them should pay, our respondents at every income level answered between 15 and 20 percent, and asked about hypothetical families of lower incomes, like a family earning $25,000, the median response came in that that family should pay no more than 10 percent of its income. There were different levels.

Chairman ARCHER. So the range was roughly 10 to 25 percent, then.

Ms. WILDAVSKY. Right. That was the range.

Chairman ARCHER. If 25 percent would be the highest that people thought anybody should pay in aggregate, then the amount of our income tax, percentagewise, at the Federal level would have to be way below 20 percent in order to be able to accommodate all of the other taxes to fit under the 25 percent which would be the top rate, not the average rate that would be paid.

So we have got a lot of work to do, to reduce spending on the part of the government in order to be able to get down to that regardless of what method that we use to tax.

Ms. WILDAVSKY. That is a conclusion that seems logical to draw.

Chairman ARCHER. Mr. Christensen may want to inquire.

Mr. CHRISTENSEN. Thanks, Mr. Chairman.

I just caught the tail end of what you were saying, but it might have been what I am going to say. Earlier today, I heard some of the people talking about cutting the taxes 10 percent, but, really, we have got to cut the size of Federal Government 28.5 percent because a 10-percent tax cut from its current 35 percent is only 31.5 percent. So there is a lot more that we have got to do than just to get it down to 25 percent. We have got to cut it 28.5 percent.

The thing that I wanted to ask you, Ms. Wildavsky, was what can we do? Earlier today, when this room was half full or full of special interest groups that have a certain position on this already, all of them are issuing their own position papers relative to their own point of view, whether it be the retail sales tax or the charitable deduction or the mortgage interest deduction, and a lot of them have put pressure on the grassroots movement to get their various interest group to say, Oh, that is a bad idea, we wouldn't want to do that.

Even Presidential politics were affected, and we saw one campaign trash the flat tax for purely political reasons. I think that was unfortunate.

How can the media, and how can you and the "molders" of public opinion, help move this grassroots debate along? I truly believe if we are going to get to a simpler, fair, flatter Tax Code, it has to bubble up from the grassroots. It is going to have to come from the people, and I know we can help in that public opinion debate, but I believe that there has got to be a role and some role that Reader's Digest and Money and the other news magazines can help percolate that debate up from the grassroots. What suggestions do you have?

Ms. WILDAVSKY. For my own industry, I mean, all we can do is try to report the news fairly and to apply the same standard of fairness to our feature work and to think carefully about topics that are worth covering.

Having hearings gives us material to work with. So we thank you for that.

I don't really know how to go beyond that, but I take your point.

Mr. CHRISTENSEN. Dr. Dautrich.

Mr. DAUTRICH. Speaking as a pollster, not a journalist, I think as specific proposals are put forth, it will make it easier for pollsters or those conducting public opinion polls to get specific measures and reactions to a flat tax proposal or a consumption tax proposal.

Right now, these are very nebulous things, and without a specific proposal, it is hard to poll people and find out what their reactions to differing kind of taxes are.

As this Committee and others begin to formulate very specific proposals for change, it will become easier to gauge public reaction to those proposals.

Chairman ARCHER. I want to thank your editors and the people at Reader's Digest who put out the little piece on "How Fair Are Our Taxes?" I think that was an excellent, well-written piece, and a very neutral, factfinding-type of information that I think the American people need to get their hands on and that they need to continue to understand.

For people to come out and say, though, Do you favor a flat tax or a retail sales tax or a VAT tax?, I mean, it is so early in the whole dialog that I think it is totally unfair to even ask that question at this point because people on the Committee don't even know exactly where we are going to go with that, and that is why we are going to be holding these hearings over the next year.

I really applaud your efforts in just getting the debate out there on the idea of taxes, and are we overtaxed or are we undertaxed. I think your poll clearly shows that this country is overtaxed and that the average family in 1950 only paid 5 percent of their earnings in taxes, and today, that average family pays, as your polls have showed, upward in the neighborhood of 35 to 40 percent, if you include local and State taxes as well.

I applaud your efforts, and thank you very much for being here. You have been a wonderful, wonderful witness.

Thank you.

Ms. WILDAVSKY. Thank you.

Chairman ARCHER. Thank you very much for staying around and for your contribution. We wish you well on your trip back home.

Ms. WILDAVSKY. Thank you.

Mr. DAUTRICH. Thanks.

Chairman ARCHER. Would our next panel please take a seat at the witness table; Elizabeth MacDonald, Harvey Shulman, Ann Cook, and Jean Hodges.

Ms. MacDonald, you are the financial editor of Worth?

Ms. MACDONALD. That is right.

Chairman ARCHER. You will be our first witness.

As I mentioned to the other panelists earlier, your written statement, should it be elongated, without objection, will be inserted in the record. Your verbal statement, we hope you will limit to 5 minutes, and you may proceed.

STATEMENT OF ELIZABETH MacDONALD, FINANCIAL EDITOR, WORTH MAGAZINE, NEW YORK, NEW YORK

Ms. MACDONALD. Thank you, Congressman.

I want to commend and congratulate Congressman Archer and the House Ways and Means Committee for its courage in trying to forge a new tax system that, hopefully, will include a less burdensome tax collector, and I applaud you on your efforts to spark this national debate. I am delighted and honored to be a part of Congress' efforts to reform the tax system.

As a journalist, however, I need to make one thing clear. When Americans believe what I report, they do so because they see me as an independent, objective observer. That helps the free flow of information, which I hope in the end is enormously useful to Congress. Please understand that I come here out of a sense of loyalty and civic duty to our government, to Congress, and to American taxpayers. I mean this sincerely. I come here in the spirit of serving and helping you.

Today, something is abroad in the land that is sharpening the division between the American people and the government, and I firmly believe that this division is largely rooted in the IRS' intrusive, stone-cold, and intractable behavior.

The agency routinely severs the connection between the government and the American taxpayer, and as a result, the American tax system is losing its sense of fairness and moral suasion.

Because of this division, few Americans realize that many compassionate workers at the IRS want to treat taxpayers fairly. This division also obscures the fact that there are way too many people who cheat the government. Even so, negative perceptions about the IRS continue to deeply roil the American electorate, largely because these perceptions are often based on reality.

The most illuminating example about the IRS' attitude toward taxpayers is this. In the past, I have attended numerous hearings on the IRS where I have listened to the Commissioner and the Assistant Commissioners testify about the agency's problems. However, the minute Congress calls any subsequent panel of taxpayers to testify, what do these IRS officials do? They get up and walk out without waiting to hear what these taxpayers have to say. I really feel that this behavior exemplifies the agency's lack of humility and their treatment of taxpayers.

I have been thinking really hard about how I can help you in your efforts, and I have decided to try to explain how the IRS' lack of concern is embedded in the rigid way it conducts its business of collecting taxes. I will base my testimony on confidential reports prepared by the IRS' internal auditors, which I obtained through the Freedom of Information Act.

In the final analysis, I will show you how in the shadowy corners of this bureaucracy apathy manages to nestle and thrive. Such apathy is largely due to the agency's sclerotic approach to its business of collecting taxes. As a result, now what we have is an agency that spends more time dissembling than speaking the truth.

To be sure, the IRS is charged with an awesome task. The IRS administers a circa sixties computer system that swallows an enormous amount of paper each year, and if the IRS taped together all of the pieces of paper it receives annually, the trail would wrap around the Earth roughly 36 times.

I am sure you also know that the average tenure of the IRS Commissioner has been about 37 months, and between 1992 and 1995, four individuals have walked through the turnstile at the IRS Commissioner's office. So there is a revolving door at the top, and it is largely left to the middle managers, the career bureaucrats, to run the agency.

My question to you is, Have you ever looked at how these bureaucrats, how these middle managers run its business? An IRS internal audit report that I read shows that the IRS uses a management approach that would be hooted right out of Harvard Business School. Let me explain.

As early as 1988, the Office of Management and Budget, the General Accounting Office, and the IRS acknowledged an alarming increase in the amount of uncollected IRS assessments. Those amounts are referred to as taxes, interest, and penalties. They are basically the bills that the IRS assesses against taxpayers every year, and that amount is known as the accounts receivables inventory. This inventory amount has mushroomed from $61 billion in fiscal year 1989 to $200 billion by the end of fiscal year 1995. It

is due to, according to the IRS, zoom to about $220 billion by the end of 1997.

I am all for getting a team together to finish off a project, especially if that task involves hauling in a heck of a lot of money that hopefully will prevent future tax increases. But the IRS didn't do that according to this confidential January 1993 report that I read.

Instead, here is what it did. In June 1991, it appointed an accounts receivable executive officer to handle the problem, but this really mystifies me. The IRS gave that person no authority whatsoever to bring in that revenue. According to this report, the IRS' mindset when it comes to such problems is this. Ostensibly appoint an executive to fix a problem and then forget about it. That is the way the IRS runs its business. That way, it no longer becomes the IRS' problem, but that executive's problem.

Let me explain further. To do his job, the IRS gave this official instructions which oozed with bureaucratic molasses. The IRS told this official that he had to abide by the IRS' matrix management structure, this policy that often keeps the IRS from getting much of its work done.

At this point, I would like to define this management policy. It is a real jawbreaker, but it is a key and it is a clue to a lot of the IRS' problems. The IRS refers to it as a "multidimensional system of sharing decisions, results, and rewards in an organizational culture characterized by multiple authority/responsibility/accountability relationships."

Now, again, as I pointed out earlier, I am all for getting a team together, but when you have a division of accountability amongst a whole slew of people, that is going to create problems, and it will up the odds of errors and slippage.

You can see, given the cavernous IRS building and its long hallways, that the IRS has willfully upped its chance of errors and slippage because of this matrix management structure.

Furthermore, the IRS ordered this official to answer to the IRS' chief financial officer, but that person has no authority to make any decisions whatsoever about the accounts receivable inventory. So, here is what happened.

In December 1991, the accounts receivable officer, along with IRS top management, issued numerous plans to rake in the money due and owing the government. But when internal auditors looked at 13 of these plans in the spring of 1992, they found that IRS Commissioners had postponed their deadlines 81 times in a 10-month period, from August 1991 through May 1992.

When the inspectors took a closer look at why the IRS was blowing off its deadlines, they found that IRS officials failed to approve or gave no reasons for 38 of these delays.

I think a similar story can be told about tax systems modernization which many are referring to as TSM, which now seems to be an acronym for time to stop moving.

Given this approach, the IRS is an example of the triumph of form over function. Even the current IRS Commissioner, Margaret Richardson, admitted recently that "the sheer number of distinct functions and layers of management delay decisionmaking." There is bureaucratic foot dragging all over the place, not only with tax systems modernization, but also with a pretty severe problem with

the crediting of Social Security earnings to the proper taxpayer accounts at Social Security.

Currently there is about $25 billion sitting in the Social Security suspense file, which the IRS could help whittle down by giving taxpayer identify information, such as correct names and Social Security numbers. But the agency and the Social Security Administration are at an impasse on fixing that problem. This problem has been outstanding since 1978.

So, in conclusion, the problems at the IRS remind me of an old saying by George Bernard Shaw, that if all economists were laid end to end, they would never reach a conclusion. It seems to me that the way the IRS runs its business, in large part, lies at the root of the problems that we are going to talk about today and its effect on taxpayers. This management problem lies at the root of the IRS' problems.

I thank you.

[The prepared statement follows:]

STATEMENT BY ELIZABETH MACDONALD
FINANCIAL EDITOR
WORTH MAGAZINE

I want to commend and congratulate Congressman Archer and the House Ways and Means Committee for its courage in trying to forge a new tax system that, hopefully, will include a less burdensome tax collector. I applaud you on your efforts to spark this national debate. I am delighted and honored to be a part of Congress's efforts to reform the tax system.

As a journalist, however, I need to make one thing clear: When Americans believe what I report, they do so because they see me as an independent, objective observer. That helps the free flow of information, which, I hope, in the end is enormously useful to Congress. So, please understand that I come here out of a sense of loyalty and civic duty, to our government, to Congress, and to American taxpayers. I mean this sincerely—I come here in the spirit of serving and helping you.

Today, something is abroad in the land that is sharpening the division between the American people and the government. I firmly believe that this division is largely rooted in the IRS's intrusive, stone-cold, and intractable behavior. The agency routinely severs the connection between the government and the American taxpayer. As a result, the American tax system is losing its sense of fairness and its moral suasion. When thinking about this subject, one idea stayed uppermost in my mind—it's at the intersections where real life begins. Today, the point where the American public intersects with the U.S. government—the federal tax system—is jammed with bureaucratic gridlock and justifiable anger.

Because of this division, few Americans realize that many compassionate workers at the IRS want to treat taxpayers fairly. This division also obscures the fact that there are way too many people who cheat the government. Even so, negative perceptions about the IRS continue to deeply roil the American electorate, because these perceptions are often based on reality.

The most illuminating example about the IRS's attitude toward taxpayers is this: In the past, I've attended numerous hearings on the IRS, where I have listened to the commissioner and assistant commissioners testify about the agency's problems. However, the minute Congress calls any subsequent panel of taxpayers to testify about their personal IRS problems, what do these IRS officials do? They get up and walk out, without listening to a word of what the taxpayers have to say. That behavior exemplifies the agency's lack of humility, but Congress can fix that problem. You can make it mandatory for IRS officials to wait until the conclusion of each and every hearing you convene on this issue, since the IRS's problems strike at the heart of America's discontent with the government today.

In your efforts to reform the system, one fact remains—we'll still need a tax collector. I've been thinking hard about how I can help you in our efforts, and I have decided to try to explain how the IRS's lack of concern is embedded in the rigid way it conducts its business of collecting taxes. I will base my testimony on confidential reports prepared by the IRS's internal auditors, which I obtained through the Freedom of Information Act. In the final analysis, I'll show you how, in the shadowy corners of this bureaucracy, apathy manages to nestle and thrive. Because of the agency's sclerotic approach to its business of collecting taxes, we now have an agency that spends more time dissembling than speaking the truth.

To be sure, the IRS is charged with an awesome task. It is the biggest government agency in the land, employing 109,656 people, a workforce equal in size to Eastman Kodak, Merrill Lynch and Apple Computer combined. Today, as you know, the IRS administers a circa 1960s computer system that is choking on a massive annual paper load. If the IRS taped together all the pieces of paper it receives annually, the trail would wrap around the earth roughly 36 times.

However, a good portion of the IRS's problems stems from weak leadership and low morale that would sink any organization. A revolving door at the top post guarantees that the agency's commissioners can never fairly be held accountable for the IRS's successes or its failures. Since the end of World War II, the average tenure of the IRS commissioner has been 37 months. Between 1992 and 1995, four individuals have walked through the turnstile at the IRS commissioner's office.

However, such rapid turnover at the top begs this question: how do the IRS middle managers, the career bureaucrats, go about making important decisions that affect taxpayers as well as Congress's attempt to cut the $3.6 trillion federal deficit? The answer: The IRS uses a management approach that would be hooted right out of Harvard Business School. Let me explain.

As you know, as early as 1988, the Office of Management and Budget, the General Accounting Office and the IRS acknowledged an alarming increase in the amount of uncollected IRS assessments, (taxes, interest and penalties). That amount, known as the accounts receivable inventory, mushroomed from $61 billion in fiscal year 1989 to $200 billion by the end of fiscal year 1995. The IRS expects that figure to balloon to $220 billion by the end of 1997. This figure represents outstanding tax bills owed by taxpayers. Currently, the IRS is trying to figure out, based on these numbers, how much it should bill taxpayers, how much it can realistically collect, either through installment plans, offers in compromises, liens or levies.

Now, I'm all for getting a team together to finish off a project, especially if the task involves hauling in money that will, hopefully, prevent future tax increases. But the IRS didn't do that. Instead, in June of 1991, it appointed an accounts receivable executive officer to handle the problem. Yet, and this still mystifies me, the IRS gave that person no authority whatsoever to bring in that revenue. A January 1993 IRS internal audit report reveals, in sharp relief, the IRS mindset when it comes to such problems: Ostensibly appoint an executive to fix a problem, then forget about it. That way, it becomes no longer the IRS's problem, but the executive's problem. That's the way the IRS operates. So, right from the start, the IRS bureaucracy doomed this official's efforts to bring in this money.

Let me explain. To do his job, the IRS gave this official instructions which oozed with bureaucratic molasses. The IRS told this official that he had to abide by the IRS's 'matrix management structure,' a policy that often keeps the IRS from getting much of its work done.

The IRS defines this management policy, and this one is a real jawbreaker, as a "multidimensional system of sharing decisions, results and rewards in an organizational culture characterized by multiple authority/responsibility/accountability relationships." What this means is, before the official could make any moves to whittle down this mushrooming balance, he first had to get numerous assistant commissioners and more senior persons to sign off on his decisions. So, given the cavernous IRS building and its long hallways, you can see why the IRS has willfully upped its odds of errors and slippage. I sure would like to sit around all day and wait for one of my co-workers to send me a memo telling me that I can

start to do my work. If any company in the private sector conducted its business in this manner, they'd be bankrupt within a year.

Furthermore, the IRS ordered this official to answer to the IRS's chief financial officer, a person who has no authority to make decisions about the accounts receivable inventory, (the chief compliance officer retains that power).

So, here's what happened. In December 1991, the accounts receivable officer, along with IRS top management, issued numerous plans to rake in the money due and owing the government. But when internal auditors looked at 13 of these plans in the spring of 1992, they found that IRS commissioners had postponed their deadlines 81 times in a ten-month period, from August 1991 through May 1992. When the inspectors took a closer look at why the IRS was blowing off its deadlines, they found that IRS officials failed to approve or gave no reasons for 38 of these delays. A similar story can be told about decision-making on tax systems modernization, or TSM, (which some say really stands for 'time to stop moving.')

This approach shows that the IRS is an example of the triumph of form over function. This may be why top IRS officials seem driven to distraction on the agency's problems—getting them to move on a project is the equivalent of squeezing 1,000 crickets into a jelly jar. It reminds me of an old saying by George Bernard Shaw, that if all economists were laid end to end, they would never reach a conclusion. Even the current IRS commissioner, Margaret Richardson, admitted recently that "the sheer number of distinct functions and layers of management delay decision-making." In 1994, after two years of foot dragging, the IRS finally abolished this official's job, and split the task of collecting this money between the IRS chief financial officer and chief compliance officer.

Bureaucratic foot dragging affects taxpayers in another way. Currently, an estimated $25.1 billion in Social Security earnings sit uncredited to taxpayer accounts at the Social Security Administration, based on data provided by this agency. Why? For one, taxpayers and employers are to blame. Routinely, workers' incorrectly enter their last names or Social Security numbers on their W-2 earnings statements. When that happens, the SSA cannot match their Social Security contributions to their accounts. Also, the GAO says each year thousands of defunct businesses fail to send in W-2s for their former employees.

The GAO says much of this problem could be fixed if the IRS shared its more current taxpayer information with the Social Security Administration. However, the IRS and the Social Security Administration have been locked in a feud since 1978 over which agency is responsible for cleaning up this situation, according to the GAO and confidential IRS reports. Like it or not, the government's problems are our problems—the GAO says at least 10 million workers could miss out on thousands of dollars in annual benefits, partly because the IRS and the Social Security Administration are not cooperating on this matter.

The GAO says the IRS, because it constantly updates records, should help resolve this problem. To keep its records current, the agency can wave its big stick by, say, holding on to refund checks until taxpayers correct faulty records. The IRS also penalizes businesses if they don't provide accurate tax records on their workers.

The IRS, however, "refuses to give the Social Security Administration its more up to date taxpayer name and Social Security information so we can correct our benefits records for individuals," says an SSA official. In its defense, an IRS spokesperson told me that doing so would violate the IRS's 'disclosure policy,' meaning, the agency is restricted by law in giving out this confidential information. However, it is hard to understand this rationale, particularly as the IRS willingly shares its taxpayer information with more than 200 state and local taxing authorities across the country to catch criminals, such as the Oregon Public Utility Commission and the Washington Department of Fisheries. The IRS does say it tells taxpayers to correct their name and Social Security numbers with the SSA when the IRS notifies them about a mismatch in its records. To date, for the most part, the two agencies are still at an impasse.

So, in conclusion, these anecdotes show that a step toward straightening up the gridlock at the IRS would help avert future tax increases and slice the budget deficit, among other things. Here's one recommendation: Make it a job requirement for the top IRS posts that an applicant have a management or even a military background, someone who knows what it's like to handle tens of thousands of people. Most all IRS commissioners are tax lawyers. They're probably perfectly good lawyers, but I truly do wonder about their managerial abilities.

Chairman ARCHER. Harvey Shulman, general counsel, National Association of Computer Consultant Businesses.

Mr. Shulman, we would be pleased to receive your testimony.

STATEMENT OF HARVEY J. SHULMAN, GENERAL COUNSEL, NATIONAL ASSOCIATION OF COMPUTER CONSULTANT BUSINESSES

Mr. SHULMAN. Thank you, Mr. Chairman.

My message today is simple. I am concerned that your debate over tax reform will emphasize only issues like economic growth, tax equity, and simplicity. These are important issues, but I fear that lost in the debate will be something that is not a Democratic issue or Republican issue, but, rather, something fundamentally and uniquely American, the right to privacy.

My experiences as a partner at Ginsburg, Feldman & Bress, Chtd., representing hundreds of clients throughout the country, compel me to urge that there should be no higher priority than protecting against unwarranted government intrusions.

Mr. Chairman, I represent clients where the rubber meets the road. I sit across the table from IRS examiners throughout the United States. Unfortunately—and I had to think a lot about using these words—I have seen how the Internal Revenue Code has become a "peephole on America."

We have gone far beyond mere revenue generation to create an army of auditors who delve into almost every day-to-day transaction of America's individuals and businesses.

The four instances of IRS intrusiveness I will address here are not the worst I have seen, but they do illustrate a general course of conduct in many of the IRS matters I have handled. These are exhibits to my written testimony, and they will be presented on the easel as well.

First, our current tax system allows IRS examiners to intrude into the lives of individuals who are not even under an IRS audit. These individuals are considered third parties whom the IRS thinks may possess information helpful to the IRS in its audits of a business.

For example, in one case, my client received a call from the wife of a man who had provided some services to my client as an independent contractor. As the wife related in essence,

> My husband is at work today, but there was an IRS examiner here. He says that my husband and I are not being investigated, but he was in our home, sitting on our living room sofa, using our telephone, trying to track down my husband and ask him questions about the services he provided for your company. What is going on here?

On the easel as exhibit A is a letter sent by the IRS a few days before Christmas to 30 self-employed contractors who worked for a heating and air-conditioning business that was being audited. Even though these contractors themselves were not being audited, the auditor demanded that they come to her office the week after New Year's with hundreds of documents, including their own tax returns and all of their canceled business checks, billings to clients, lists of suppliers, and on and on.

Unfortunately, Mr. Chairman, under our tax system, intrusive contacts like these happen all of the time, including by phone or

even IRS visits to the homes of such third parties not being audited.

Second, our tax system allows IRS examiners to intrude deeply into a businesses' relationships with its customers. The examiners seek information from the customers about the businesses' operations, revenues, or expenses. These intrusions can destroy a business, even if it wins the audit.

By way of example, on exhibit B are excerpts from one IRS examiner's notes which report on his field visits to track down the customers of a high-tech firm he was auditing. He literally drove around the Boston beltway and stopped at big buildings with high-tech logos to ask companies if they did business with firm X, the firm being audited.

Only two of the companies visited had done any business with firm X. Yet, through his visits, surely all seven learned of the IRS investigation of high-tech firm X.

As in similar cases of IRS contacts with customers, the damage to firm X's reputation was irreparable.

Third, our current tax system allows examiners to take private information from the tax returns of taxpayers who are not being audited and use that information against taxpayers who are being audited.

Exhibit C on the easel shows how an IRS examiner retrieved from IRS files the income tax returns of 15 independent contractor specialists who provided services to a business the examiner was auditing, and then shows how she used selective information of those returns against the business.

Because the business could not fairly defend itself without seeing the information used against it, the government had to give us copies of these specialists' private tax returns. Unfortunately, such IRS use of tax returns is not uncommon.

Finally, Mr. Chairman, our current tax system encourages and rewards snitching, and other practices that turn taxpayers against one another.

Exhibit D on the easel is what one IRS examiner called a "snitch sheet." It was used in the late eighties in California until later condemned by the IRS Commissioner, but the principle behind the snitch sheet is still alive and well today. The IRS still encourages, rewards, and sometimes even requires a taxpayer who is being audited, especially small business taxpayers, to turn in competitors.

In conclusion, Mr. Chairman, the intrusiveness of the IRS is deeply embedded, and perhaps it is even inherent, in our current income tax-based system. It is time to look toward a system which is free from government-sponsored financial voyeurism into the lives of America's individuals and businesses.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

Before the
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C.
March 20, 1996

TESTIMONY OF
HARVEY J. SHULMAN
PARTNER in GINSBURG, FELDMAN & BRESS, CHTD. (WASHINGTON, D.C.)
AND
GENERAL COUNSEL of NATIONAL ASSOCIATION OF COMPUTER CONSULTANT BUSINESSES

I. INTRODUCTION: My name is Harvey Shulman. I am a partner in the Washington, D.C. law firm of Ginsburg, Feldman & Bress, Chtd. and have been a lawyer for 24 years. I am also general counsel of the National Association of Computer Consultant Businesses ("NACCB"), which is the largest national association that exclusively represents high-tech firms that provide computer and engineering professional consultants to customers in need of temporary support for special projects. NACCB has actively participated in many Congressional hearings, including those involving the Taxpayer Bill of Rights[1], pension simplification (including the need to re-define who is a "leased employee")[2], and worker classification (including the need to repeal Section 1706 of the 1986 Tax Reform Act).[3]

I come to these hearings after years of providing counsel to mostly mid-sized and small businesses, with gross revenues of between one million and one hundred million dollars. Many of my clients are high-tech professional services firms, though others have been in health care, securities and financial services, telecommunications, biotechnology and pharmaceuticals, oil and gas, heating and air conditioning, and construction and real estate.

My message today is a simple but critical one. I am concerned that as you go through months and probably years of hearings, dominating the evolving debate over tax reform will be factors like providing adequate revenue, encouraging economic growth and the investment needed to compete in a global marketplace, assuring some sense of "fairness", and replacing complexity with simplicity. These are all valuable considerations. Yet, I am greatly concerned that lost in the debate – or at least minimized -- will be the recognition that we must protect something else that is not a Democratic issue or a Republican issue, but rather something that is uniquely American, i.e., the "right to privacy". My years of experience with the intrusive nature of our present tax system compel me to urge that in your debate on tax reform there should be no higher priority than protecting this right.

II. CLOSE THE INTERNAL REVENUE SERVICE'S "PEEPHOLE ON AMERICA": For me, meaningful tax reform is not merely an academic, political or philosophical issue. Rather, I am "where the rubber meets the road". After representing clients in countless IRS investigations, and sitting across the table from IRS tax examiners throughout the United States, the broad picture that emerges of our tax system is not a pretty one. The Internal Revenue Code, with all of its complexity particularly in the areas of income and employment taxes, has become a "peephole on America". What I mean is that, unfortunately, our tax system delves too often into almost every aspect of the day-to-day transactions of America's businesses, whether they are sole proprietors working out of home-based offices or mid-sized firms with multi-state facilities. I know that it is very difficult to fully appreciate this perspective well unless you have been intimately involved in dozens and dozens of IRS investigations, but I hope that my first-hand experience will give you an insight into the problem.

Preliminarily, let me note that the income tax started out during the Civil War as a temporary and simple 3% federal income tax that affected few Americans – because only extremely high incomes were taxed. Yet, in 100 years the income tax has been transformed into a complex morass of double-

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[1] Our position has been that Congress must do far more, even beyond last year's proposed Taxpayer Bill of Rights 2 ("T-2"), to protect the rights of all taxpayers, particularly small and mid-sized businesses.

[2] NACCB believes that Congress should include an updated version of last year's pension simplification proposals (that were in the vetoed budget reconciliation bill) in a debt ceiling bill, continuing appropriations bill, "tax extenders" bill, or other appropriate legislation as soon as possible. There is strong bi-partisan support for such simplification, including a consensus for further clarification of the "leased employee" definition as it applies to computer professionals.

[3] It is now time to repeal Section 1706. In the past two Congresses, a majority of the Senate – and much of the House, including the then- House Government Operations Committee – have called for repeal of Section 1706 of the 1986 Tax Reform Act. Fourteen national associations representing businesses and workers have also urged repeal of this law which uniquely discriminates against the use of self-employed computer and engineering consultants by America's high-tech industries. A 100-page Treasury Department study of this law found a key aspect of its coverage to be "difficult to justify on equity or other policy grounds" and noted that tax "compliance" by the technical workers targeted by Section 1706 has been "somewhat better" than other types of workers not subject to the same restrictions.

digit taxes on gross income less numerous deductions, with withholding and employment taxes thrown in, that affects virtually every working person and business in America. In the process of this transformation, we have created a systems that literally requires an army of tax examiners and collectors who have the right to probe the conduct of ordinary citizens in connection with just about every financial transaction in which we engage.

After hearing my testimony, I hope that you will have a better understanding of my deeply held concern about the need to create a tax system that gives much greater weight to protecting the privacy of all Americans, including small and mid-sized businesses. Please let me assure you that the examples I provide are not isolated instances. The general conduct I am about to describe has occurred in close to half of the IRS investigations in which I have been involved. In fact, I am not even mentioning some of the more egregious IRS conduct because of my duty to protect some of my clients who have done nothing wrong, but are frightened about attracting even more IRS examinations. Further, based upon the information I will present, it will become apparent that neither the good faith and honesty of the overwhelming number of IRS employees, nor the enactment of additional procedural protections, can solve the intrusiveness concerns that are inherent in our current tax system. Here are some of the areas where the IRS's intrusiveness has been prominent in my experience.

A. Intrusion Into Homes and Offices of Individuals Not Under IRS Examination: Under our current tax system, it is not unusual for the IRS to seek out information from "third-parties" who are not themselves being audited. Although these persons are accused of no wrongdoing, the IRS may believe that they have information about another taxpayer under audit. In these situations, the IRS has chosen to intrude into the homes and offices of these persons as part of its investigation -- not only is the privacy of the individual invaded, but the individual's relationship with the business being audited is often seriously hurt. For example:

* The IRS was examining one of our mid-sized high-tech clients in New England. The IRS showed up -- without an appointment -- at the homes or new places of employment of a number of consultants who had worked for this firm in order to ask them about their work for the firm. Our client reported receiving a phone call from the wife of one of these consultants. The conversation was along these lines (with names changed): "John, this is Mary Jones. I'm Tom's wife. Of course, Tom's at work today. But there was an IRS examiner here. He says that Tom and I are not being investigated, but he was in our home, sitting in our living room on our sofa, using our phone, trying to track down Tom and ask him questions about the work he did for your company. Maybe Tom never should have worked for you. What is going on here?".

* We saw similar scenarios in audits being conducted in Maryland, New Jersey, Minnesota and other states. By way of example, I have attached as Exhibit A to my testimony a sample letter written by an IRS examiner to an individual who was not being audited, but who had provided services as a self-employed contractor to a business that was being audited. As you can see, two days before Christmas 1991 the IRS examiner sent a certified letter to these workers stating that one week after New Years they should come to her office and bring with them, among other things, copies of their licenses, their billing statements to their other clients, their list of suppliers, the Schedule C's on their personal income tax returns, their commercial bank account statements and all cancelled business checks, advertisements they had run, invoices for the purchase of their business cards and business stationery, and other items. Now let me emphasize: the individuals who received these letters were not being audited, but were being asked to provide this information about themselves in connection with the audit of a client to whom they had provided services! The most surprising thing to me about this letter was that the IRS examiner's request was in written form; on many other occasions similar requests have been made orally by other IRS examiners to workers in similar situations. It is hard to imagine anything more intrusive than this type of communication directed to a third-party who is not being audited.

B. Intrusion Into the Relationships with a Taxpayer's Customers: Another type of IRS "third-party" interview may be done with the customers of a business which is being audited, even though those customers are accused of no misconduct. Such IRS intrusions into customer relationships can literally destroy a business before an audit is even over. For example:

* In the Midwest, an IRS examiner simply showed up -- again, without an appointment -- at the major customer of our client, which was a small high-tech firm under audit. The IRS examiner flashed her credentials and demanded, on the spot, that the customer provide her with copies of certain contracts between the high-tech firm and its customer and allow her to interview an official of the customer. She refused to leave until her demands were met. After the incident, the customer complained to our client that there were many firms it could do business with other than our client, and that these

firms were not being audited and the customer would not have to risk these types of offensive IRS intrusions if it took its business to these other firms.

* In New England, an IRS examiner auditing a high-tech consulting firm admitted how he literally drove around the Rte. 128 beltway trying to find the firm's customers. When he saw high-tech logos on large buildings, he assumed that these businesses might be customers of the consulting firm. He would then stop, enter the building, identify himself as an IRS examiner, and ask if they were doing business with "ABC Company" (the firm under audit). The IRS examiner made 7 such visits, but only 2 firms had ever heard of ABC Company. Let me quote from portions of his notes, attached as Exhibit B, which illustrate the kind of "fishing expedition" that was conducted:

> Field Visit to Rt. 128 area of MA re: third party contacts to attempt to receive information on the operation of [ABC] and the business of computer programming industries in general....
>
> [In one Dedham, MA firm], security was tight -- they would pass my c/c [calling card] on but would not disclose any further info at this time -- they do have computer programs....
>
> [At another firm] I asked if they ever did receive programs from [ABC] or if they did business with them -- She said she did not recall ... but records may be located in Garden City, N.Y.....
>
> [At still another firm] I asked if he had used the services of [ABC] ... ans. neg.
>
> Field Visit [to another firm]. Security was tight -- probably due to corp. espionage & Gov't. work. Got appt. for tomorrow ....

In a couple of days of visits, the IRS examiner's intrusive conduct probably did more harm to the business and reputation of our client than its competitors could do to it in years of tough but fair competition. Responding to my complaint that this conduct is unfair, an IRS examiner in New Jersey -- who suggested that she might similarly visit my client's customers -- said to me words like these: "Under our tax system, that's your problem. It's what we call life in the audit lane".

C. Use and Disclosure of Tax Returns of a Taxpayer NOT Under Audit: Under our current tax system for income and employment taxes, it has become common practice in certain types of income tax audits (e.g., transfer pricing cases) and employment tax audits (e.g., worker classification cases) for many IRS examiners to look at the private tax returns of taxpayers who are NOT being audited and then to use information from those returns against another taxpayer who is being audited. Part of an IRS examiner's file, attached as Exhibit C, shows how she made use of such tax returns. By this type of conduct, the IRS has created a "no win" situation. Unless it provides this private information to the taxpayer under audit and against whom the information is being used, the IRS is denying due process to the taxpayer under audit. Imagine having "secret" information being used to make an assessment that could shut down your business, and then being told that you cannot see this information even though you want to rebut it. It seems fundamental in a democracy that a citizen is entitled to access to information being used against him or her. Yet, if the IRS reveals to the taxpayer under audit the private tax information from another taxpayer, the IRS invaded the privacy of that other taxpayer.

We have handled several cases in at least eight different states in which an IRS examiner has used another taxpayer's private tax return information against our client. In cases where we pursued our requests, the IRS had to provide us with copies of that private tax return information. You can imagine how strange it felt, having in front of me, income and expense information from hundreds of tax returns of persons whom I had never met. Yet my clients could not defend themselves against proposed tax assessments that would have destroyed their businesses without seeing the information that the IRS used against them. You can imagine how I was even more amazed when I found out, after seeing this information, that much of the private tax information used against my client was taken completely out of context or even helped --rather than hurt -- my client's case.

These situations are exemplified by a conversation we had with one individual whom we told that the IRS was auditing our client and was using information against us that was supposedly contained in his tax return. When we asked him if he would voluntarily give us his tax return so we could rebut the

IRS, his response was along these lines: "I have done nothing wrong, nor has your client. All I will tell you is that the IRS is not honestly describing the information on my tax return. But there is no way that I'm going to give you a copy of my tax return. The IRS may be denying your client due process, but I don't want them taking away my privacy." Ultimately in that audit the IRS backed off and closed its examination without any assessment against our client.

Here again, the intrusiveness of our tax system is apparent. What type of tax system have we created when information on one taxpayer's return can be used against a second taxpayer -- and when the price to be paid for protecting the due process rights of the second taxpayer is to reveal information that invades the privacy rights of the first taxpayer?

D. "Snitch Sheets" and Other Government-Sponsored Informing: In April 1990 I testified before the Senate Finance Committee's Subcommittee on Private Retirement Plans and Oversight of the IRS regarding the Taxpayer Bill of Rights. I revealed that an IRS District Office in California had distributed a document that it called a "snitch sheet", attached as Exhibit D, to members of a local business association. The IRS official distributing the sheet noted that it would be used to pursue audit "leads" on the names of businesses who were "turned in". The "snitches" themselves were told not to put their own names on the sheets, lest the IRS want to visit them as well. To his credit, then-IRS Commissioner Goldberg called the District Office's conduct "reprehensible" and promised to put an end to it. Here's what then-Chairman Pryor said:

> [W]e have created a monster... A bureaucratic Frankenstein. They are tearing down walls in Eastern Europe. They are doing something with the KGB. They are doing something with Secret Police. I do not want to see us creating an underworld of IRS agents in this country, who could use their leverage to turn people against people.
>
> I was in China some years ago, and on every floor of the hotel there was someone posted to monitor the comings and goings of everyone there. To find something on someone and turn them in. We are not going to create that system here, Mr. Commissioner.

Yet, despite the unanimous condemnation of the "snitch" program considered at that hearing, our current tax system still encourages and rewards -- and sometimes even requires -- that one taxpayer "turn in" another.

For example, Section 7623 still authorizes the IRS to pay awards to informers who provide information that leads to the collection of taxes from another person. In my experience, only a tiny percentage of "snitches" ever qualify for such awards. Rather, in most cases, at least in the business community, "snitching" to the IRS has become a "competitive tool" for some companies to make baseless charges against their competitors with the goal of bringing the intrusive, expensive, and time-consuming IRS audit process into the lives of their competitors. A good illustration of this point is a situation in which I was involved where a "snitch" turned in the names of six of its competitors to the IRS, claiming that they needed to be investigated for costing the IRS millions of dollars in tax revenues. The "snitch" helped trigger audits of these six competitors in four states. The audits were conducted using many of the intrusive techniques discussed above. Yet, over four years later, when the last of these audits ended, the IRS determined that four of the companies owed no additional taxes and the other two companies -- which had several million dollars in income -- owed a tiny additional amount in taxes (about $10,000 each) due to a couple of small, technical violations. Meanwhile, compared to the $20,000 paid to the IRS, these six companies paid a total of about $500,000 to lawyers and accountants to go through these audits -- or about one additional dollar in taxes for every fifteen dollars it cost them to defend themselves. These figures do not even include the cost to the IRS of conducting these audits. Even though the "snitch" who triggered these audits collected no award, he -- like many others -- was able to use our current tax system in a way that seriously and unfairly hurt his competitors who committed no wrongs.

In another example of how "snitching" is inherent under our tax system, it is useful to look at how IRS examiners conduct income tax examinations that trace a business's multiple sources of income and recipients of business expenditures. In this process, each new "source" and "recipient" becomes a potential new lead for an examiner to make certain that there is not a "whipsaw" situation. That is a situation in which two taxpayers to a transaction treat it differently for tax purposes, each to its own advantage and to the disadvantage of the IRS. By the very nature of our income tax system, however, many business transactions involve potential "whipsaw" situations where honest differences of legal

interpretation abound. For example, one business taxpayer may treat a payment it receives for selling part of its business as a long-term capital gain subject to lower tax rates, whereas the maker of that payment may treat part of it as a payment for a covenant not to compete and the other part as depreciable assets. In such situations, the IRS examiner of the first taxpayer is encouraged to assure that the other taxpayer who is not being audited is not placing the IRS in a "whipsaw" situation. One taxpayer, in effect, must thereby become a witness against another taxpayer if it wants to protect its own tax treatment of the transaction. Unfortunately, this is but another and sanctioned variant of the "snitching" that is inherent in our current tax system.

A final example of government-induced "snitching" that is even more troublesome exists in the employment tax area. In Section 530 of the Revenue Act of 1978, Congress stated that a taxpayer may treat a worker as an independent contractor if, among other things, the taxpayer can show reasonable reliance on a long-standing practice of a significant segment of the industry in which the taxpayer is engaged. In order to support its position that the use of self-employed workers is common practice, the taxpayer will present the results of studies by trade associations which provide data as to the percentage of firms in the industry which treat their workers as independent contractors. Yet the IRS requires more information from the taxpayer under audit. According to IRM 5(10)26.4, the taxpayer must also provide "the names of the currently in business entities for the same industry with whom the taxpayer is competing which treat the same class of workers as independent contractors ...." In such cases I have explained to IRS examiners that my client does not want to become a "snitch", but that if my client provides this type of information to "save itself", we are concerned that the IRS may pursue potential audits against these competitors. The typical response I have received from IRS examiners is along these lines and is troubling: "The survey is not enough. I need the names of specific companies that also use self-employed workers. If we decide that we must audit them also, that's just the way the system operates."

*** *** *** ***

III. STOP "GOVERNMENT SPONSORED FINANCIAL VOYEURISM" OF INDIVIDUALS AND BUSINESSES: Although it may not be easy to understand all of the details in my message, I hope that one overriding message has emerged: in the debate over tax reform, the "right to privacy" must receive the highest priority. We can no longer embrace a tax system that depends upon "government sponsored financial voyeurism" into the lives of America's individuals and businesses.

Mr. Chairman, because I strongly identify with your concern about privacy, I understand your interest in replacing the current income and employment tax system with another system -- such as a consumption or VAT tax. While it may be too early to reach the ultimate conclusion on what type of system is appropriate, I urge Congress to keep an open mind on this issue. And if you determine that a broadly-based income and employment tax system inherently intrudes too deeply into our lives, I urge you to have the courage to move to an alternative system.

As an alternative to the present tax system, Americans want a system that is equitable, produces adequate revenue, and encourages the economic growth and investment needed in today's global marketplace. But the voices of many Americans that I hear are also insisting that this alternative must rekindle the flame of individual entrepreneurism that has sustained our country since its founding and must protect individual freedoms and privacy. Indeed, these Americans are willing to pay a reasonable price just to re-gain their independence from the intrusiveness of the IRS. Don't let these voices go unanswered.

Internal Revenue Service

Department of the Treasury

District Director

[redacted] District

[redacted]

Person to Contact: [redacted]

Telephone Number: [redacted]

Refer Reply To: [redacted]

Date: 23 December 1991

Certified Mail

Recd 12/25/91

[redacted]

Dear Ms. [redacted]

I would appreciate your furnishing the information indicated below, for use in a Federal tax matter. We have scheduled an appointment for you on January 8, 1992 at 10:30AM at the address listed below. It is pertinent, that we received this information for verification of the independent nature of your business enterprise during the years of 1988 and 1989.

This request is made under the authority of section 7602 of the Internal Revenue Code. Thank you for your cooperation, we may some questions regarding your performance of service to your client(s).

Sincerely,

[redacted]

Revenue Off:

IRS [redacted]

Enclosure:
Self-addressed envelope

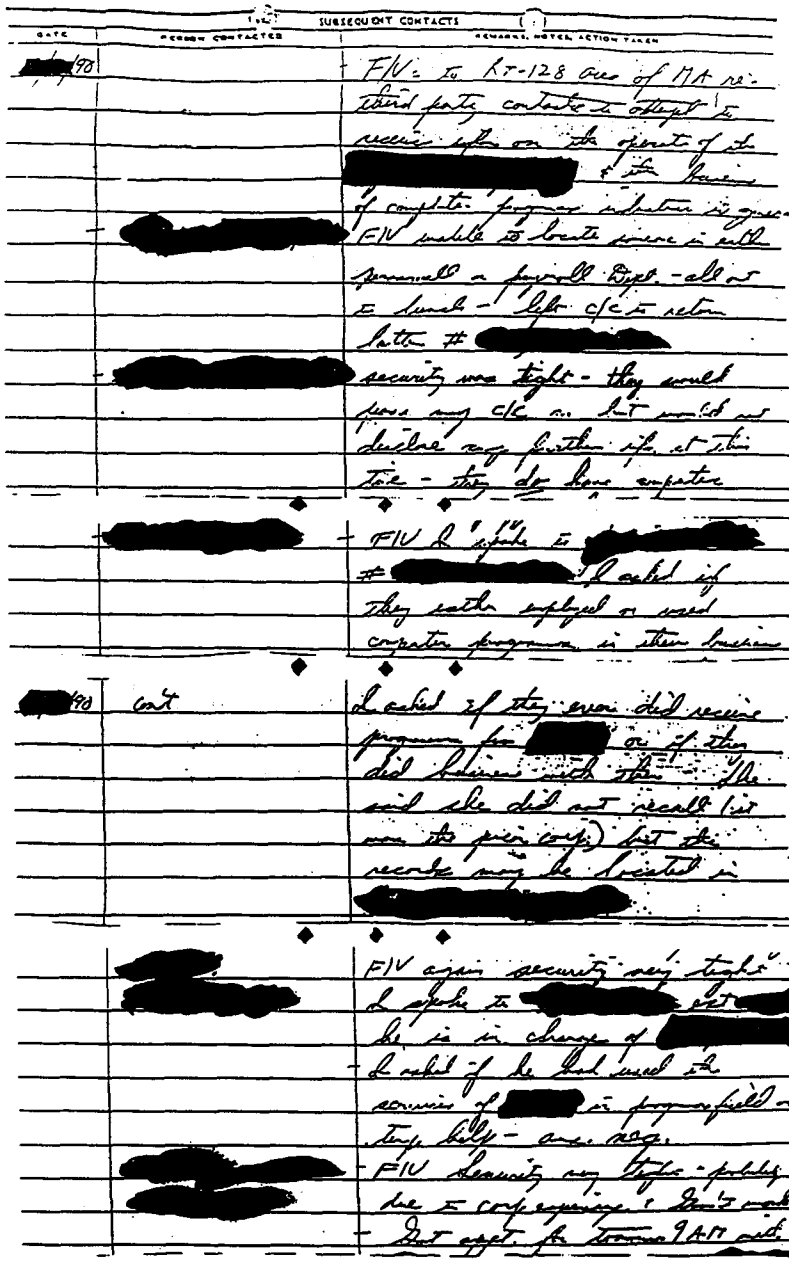
Information Requested:

Proof of advertisements in any news media
Business telephone number (bills)
Proof of Office location
Proof of Vehicle and Uniform Logo
Proof of Permits and Licenses Acquired
Federal and State Identification Numbers
Worker's Compensation Policy
Copy of contracts and billings to client(s).
List of your suppliers and clients
Form 1040, Schedule C in 1988 and 1989
Copies of your Form 1099, Earning Statements for years 1988 and 1989
Copies of your commercial bank account statements and cancelled checks
Invoices of purchase of business cards and business letterhead stationery
Copy of business liability insurance, including commercial auto insurance
Copies of earning statements to your workers
Any work-related injury claims?

Definately not a "Happy New Year greeting!

Joe

EXHIBIT A - SHULMAN TESTIMONY



SUBSEQUENT CONTACTS

DATE	PERSON CONTACTED	REMARKS, NOTES, ACTION TAKEN
[redacted]/90		FIV - to RT-128 area of MA re-
		third party contacts to attempt to
		receive info on the operation of the
		[redacted] & the business
		of computer programs industries in general
	[redacted]	FIV unable to locate someone in either
		personnel or payroll Dept. - all out
		to lunch - left c/c to return
		letter # [redacted]
	[redacted]	security was tight - they would
		pass my c/c on but would not
		disclose any further info at this
		time - they do have computers
	[redacted]	FIV I spoke to [redacted]
		# [redacted] I asked if
		they either employed or used
		computer programs in their business
[redacted]/90	cont	I asked if they ever did receive
		programs for [redacted] or if they
		did business with them - She
		said she did not recall (it
		was the prior corp.) but the
		records may be located in
		[redacted]
	[redacted]	FIV again security very tight
	[redacted]	I spoke to [redacted] ext [redacted]
		he is in charge of [redacted]
		I asked if he had used the
		services of [redacted] in programs field or
		temp help - ans. neg.
	[redacted]	FIV Security very tight - probably
	[redacted]	due to corp expansion & Gen't work.
		Got appt. for tomorrow 9AM with

EXHIBIT B - SHULMAN TESTIMONY

For use by the Appeals Officer only

Income tax returns of a sampling of [redacted] technical specialists are enclosed for Appeals review. Of significant importance is the correlation between the specialists' [redacted] from [redacted] and the "matching" gross sales shown on the Schedule C of the 1040 or the 1120\ 1120s of the "personal service" corporations.

[redacted]

Information is enclosed for the following technical specialists:

1) Ge[redacted]
2) Am[redacted]
3) Ba[redacted]
4) Jo[redacted]
5) Ro[redacted]
6) Ha[redacted]
7) Ed[redacted]
8) Ke[redacted]
9) An[redacted]
10) St[redacted]
11) RW[redacted]
12) Ro[redacted]
13) St[redacted]
14) Ri[redacted]
15) Wi[redacted]

Attached to each specialist's income tax returns and [redacted] information are the corresponding payroll records, time & expense records, invoices, and contracts. These records have been assembled to facilitate analysis of each specialist's individual situation.

"SNITCH SHEET"

(as orally described)

REFERRAL TO EMPLOYMENT TAX EXAMINATION PROGRAM

PLEASE COMPLETE THE FOLLOWING ITEMS (IF KNOWN)

NAME OF FIRM: _____

FIRM'S ADDRESS: _____

_____

TELEPHONE: _____

TAXPAYER FEDERAL
IDENTIFICATION NUMBER: _____

ISSUES INVOLVED: (CIRCLE ONE)

A. NO REPORTING OF WAGES.

B. UNDERREPORTING ON EMPLOYMENT TAX RETURNS (FORM 940, 941)

C. EMPLOYEES PAID AS INDEPENDENT CONTRACTOR.

D. OTHER:

JOB DESCRIPTION(S)
OF WORKER(S) : _____

_____

NUMBER OF WORKERS
INVOLVED : _____

PLEASE SEND THIS FORM TO:

INTERNAL REVENUE SERVICE
EMPLOYMENT TAX EXAMINATION GROUP 56
3660 WILSHIRE BLVD. SUITE 400
LOS ANGELES, CA 90010

ATTN: LEAD COORDINATOR

PLEASE INCLUDE ALL PERTINENT DOCUMENTATION, W2'S , 1099'S, 941'S , NAMES OF WORKERS WITH ADDITIONAL INFORMATION.

EXHIBIT D - SHULMAN TESTIMONY

Chairman ARCHER. Thank you, Mr. Shulman.

Our next witness is Ann Cook from South Windsor, Connecticut.

STATEMENT OF ANN COOK, SOUTH WINDSOR, CONNECTICUT

Ms. COOK. Thank you, Mr. Chairman.

Our life was turned into shambles when in 1983 we were informed that our 1981 joint return was selected for audit. During the course of this audit, we were informed that American Express card credit receipts were insufficient proof of purchase. We were told "vendor invoices" would be the only acceptable proof of deductions.

This examiner was made aware of our recent sale and purchase of a home in Seattle and should we have any problem locating invoices, we would contact the vendors for copies. After several phone calls to inform this examiner that vendors were forwarding invoices, within 3 weeks of our last phone conversation we received the revised audit findings.

Even after contacting this examiner and confirming that we had all invoices, we were told the matter was closed.

This revised audit, completely erroneous, was the beginning of multiple garnishments of wages, tax liens on property we did not own, documents being sent to incorrect mailing addresses, false tax returns with tax liabilities filed in Ogden, Utah, and without any notification from the IRS, an audit of our 1982 return by the same examiner who refused to review our documentation for 1981.

Our anger is not directed at the fact of being taxed, but rather, the process which allowed such travesties to occur.

We are angry that we lost our savings, our life insurance policies, angry that we lost the ability to support our family, personal possessions, and ultimately the loss of our home.

More importantly, we suffered the indignity of being put in a position of impoverishment, literally overnight, the indignity of being labeled as tax evaders by friends and relatives because few people realized that a Federal agency is capable of such actions without due process and without having to account for them.

Because the situation was so complex and overwhelming, it seemed we were doomed to be simply a statistic, and through the efforts of our attorney, who worked pro bono, and Elizabeth MacDonald, an editor at Worth magazine, we were able to hold onto the knowledge that we were not crazy and we were not stupid and, yes, these things happen more frequently than imagined. It is through Ms. MacDonald that I am able to be here today.

Ladies and gentlemen, over the course of 10 years of exhaustive efforts to bring this horrendous episode to a conclusion, while barely keeping our body and souls together, we found that the IRS continues to have a $25,000 lien against us.

Thank you.

Chairman ARCHER. Thank you, Ms. Cook.

Our last witness of this panel is Ms. Hodges, chief executive officer, Hodges Associates, from Fayetteville, North Carolina.

Ms. Hodges, you may proceed.

STATEMENT OF JEAN H. HODGES, CHIEF EXECUTIVE OFFICER, HODGES ASSOCIATES, INC., FAYETTEVILLE, NORTH CAROLINA

Ms. HODGES. Thank you for allowing me to share my story with you which I am sure is common among many, many small businesses.

In February 1994, Hodges' bookkeeper-in-charge came to me in a near hysterical state and told me that she had to resign right now. After more than 1 hour's time trying to calm her, I learned that she had not paid our payroll taxes for the entire year of 1993. She took complete blame for this and gave very little explanation of why this had happened, and quite naturally, we allowed her to resign.

I immediately contacted our financial consultant, who has been retained by our agency for 20 years, and asked him to come and investigate and to take steps immediately to resolve this matter with the IRS. Incidently, the IRS never came to us with this problem. We went to the IRS with the problem.

After further investigation, we discovered the third and fourth quarters for 1992 had never been mailed or filed. The checks for payment for these two quarters were written and signed, but the deposits for the fourth quarter were not made, and this discovery was made at the same time.

We also discovered that the first and second quarter 941s for 1993 were never filed, although the checks for the liability had been written. They had not been sent. The third and fourth quarters had not been filed, nor had the taxes been paid.

Because the State reports were signed by the bookkeeper and filed, we assumed the Federal reports had also been filed and paid.

The bookkeeper-in-charge had been employed by this agency for 10 years and had our complete trust and confidence. She also had the authority to sign and file these reports. More than one person at Hodges Associates has the authority to sign checks. It was not unusual for someone other than myself to sign these checks, and if the bookkeeper was questioned, she would name another person as having signed them.

We never received notice from the IRS that these reports were not filed or payment was not received. At the time, we were, and still are, a small agency. At that time, we were billing about $2 million.

Checks for $5,000 to $15,000 are not unusual, and it is not unusual to have outstanding checks in the amount of $75,000 to $100,000 each month.

During the examination process by the local collection officer, we were able to show evidence of checks written for tax liabilities, but never sent, and the bank reconciliations that indicated that funds were available to pay the liability.

We also provided a letter signed by the employee responsible for this problem stating her actions and lack of diligence in filing and paying the taxes.

We also discovered that probably one of the reasons that started this bookkeeper's actions was a penalty that had been imposed for the nonfiling of W–2 forms in 1989 for $23,000-plus, and rather than the bookkeeper coming and finding out that this was really

not an error and these W–2s had been filed, she paid this check. Even later, the IRS discovered that these W–2 forms had been filed. They had not rebated our $23,000 in penalties. They had simply been holding it because they said they didn't know where to apply it.

We also asked them to pay any interest on this expense that was their error.

After meeting with our local IRS representative on more than one occasion, we paid $60,000-plus in 941 taxes. We asked for an abatement of penalties in the amount of almost $52,500. We were waiting for some kind of direction on interest and penalties, but when this did not come in August, we paid the interest of $3,000.

Our consultant who had been sure this was going to be a very simple matter to settle, if for no other reason we had reported this to the IRS, they had not advised us of it, had not been easy to resolve. It was just becoming more problematic.

At this time, I turned it over to my attorney who is a corporate tax specialist. We received a letter in December 1994 wherein our revenue officer said that our request for an abatement of the civil penalties had been requested for the 1989 W–2 forms, which I mentioned before was their error. She advised that they could not recommend an abatement of the penalties for the late filing, depositing, and paying of the 941s and 40s.

They would apply $22,500 from 1989 to the $52,000 as a credit, and that we should pay the balance no later than January 15. That gave us 15 days to pay that balance to avoid further collection, which could include the filing of a Federal lien against our property.

This, in spite of the fact that we had already paid all back taxes and interest, our attorney filed for an appeal of these findings. Time goes by, and to make short of a lot more detail, we paid the government an additional $30,000 on April 18, all in penalties.

In all of this reporting, we have found so many errors by the IRS that we have had to go back and spend hours and hours proving where we were right. You would think that they would feel a little embarrassment.

In June of last year, my attorney filed a claim for refund amounting to almost $29,000. This claim was disallowed, and we will be taking this matter to court.

Discounting my time when I could have been making money for this small business and the time I have had to pay my own accounting department, the time taken from the secretarial staff, the over $2,000 I have paid to the attorney and the almost $4,000 to the business consultant, and the fees go on and on, I feel that the Internal Revenue Service has far too much power over the taxpayer.

It is my understanding that the rules of our country state that you are innocent until proven guilty. This is certainly not the case with the IRS. I think that they should be held accountable for the mistakes they make. Small businesses need relief from onerous and intimidating IRS regulations, as well as penalties for actual and perceived noncompliance, and I certainly feel that people should be treated with a little more dignity.

Last, I thank you for confirming that small voices can still be heard in America.

Chairman ARCHER. Ms. Hodges, thank you very much.

We want it to be the hallmark of the Committee's hearings that we talk to real people in real life at the point of application in our society, rather than simply have witnesses come and testify from ivory towers. We are very grateful to you for coming, and to you, Ms. Cook, for coming.

I am going to ask you the same question that I asked the panelists ahead of you. How much would you pay each year not to have any interface with the IRS, not to file a return, nor to keep any records, to be totally free as individuals in your individual life relative to your individual return? How much would each of you pay annually, or would you not be willing to pay anything?

Ms. MACDONALD. That is an interesting question. It presumes that we would be paying the government a fee for keeping the government out of our lives. Is that correct?

Chairman ARCHER. I am not saying who would receive it. I am just asking you hypothetically how much it would be worth to you.

Ms. MACDONALD. What I would pay my tax preparer.

Chairman ARCHER. Mr. Shulman.

Mr. SHULMAN. I would pay a lot more than that, and I really analogize it to the national defense. We pay a lot of money to have our security and freedom. It is really hard to put a figure on it.

Most of the small business people I know would pay a lot in taxes if there was a simple way to send in a check and be left alone and let the government get on and do its other work. That is what I am trying to do today: to give a sense that the right of privacy in America today is as important as a lot of other unquantifiable things, like the right to national defense.

Chairman ARCHER. Ms. Hodges.

Ms. HODGES. First of all, I really think it is a shame that we even have to equate money with having to deal with the IRS, but I would be willing to pay several, several thousands of dollars because it costs me more than that to have to deal with them.

Chairman ARCHER. Ms. Cook.

Ms. COOK. I would give up my first born.

Chairman ARCHER. Wow.

Ms. COOK. I have already given them over $75,000. So I think I am free and clear for the rest of my life.

Chairman ARCHER. I really did want to get a little bit at what Mr. Shulman said, because with the previous panel, they were thinking in terms of administrative cost, and as Ms. MacDonald said what she paid her tax preparer. To me there is a far greater value to individuals, and that is the value of privacy and freedom.

I know that it is hard to place a quantitative value in dollars and sense, but it surely is worth something to every one of us, and probably more to some than others; but too often, we lose sight of that.

I thank you, Mr. Shulman, for the testimony you have given that really concentrates on that issue in our lives.

Frankly, I wish that each of you could have been with me over the last year and a half to listen to the speeches I have made along this very line.

Let me ask you this. How many of you are familiar with what the flat tax proposal contains and how it would work?

Ms. MACDONALD. I have written about it in the October 1995 issue of Worth. We also reported about it in April 1995.

Chairman ARCHER. Mr. Shulman, I am sure you are familiar with it, generally.

Mr. SHULMAN. Yes, sir.

Chairman ARCHER. Ms. Hodges, are you?

Ms. HODGES. Yes.

Chairman ARCHER. Ms. Cook.

Ms. COOK. A sketchy background.

Chairman ARCHER. Let me ask you this question, first, to Mr. Shulman. The intrusion that you are concerned about in which I share your concern, would that continue under the flat tax?

Mr. SHULMAN. I believe, Mr. Chairman, that it would be less, but it would continue.

I think Mr. Gibbons and others this morning were right on the mark when they said that in any tax system based on income tax, one of the first things you have to do is determine what is income.

It would blow your mind to read the Internal Revenue Manual and see the techniques that examiners are taught to determine whether a taxpayer is or is not receiving income.

So, putting aside the whole issue of deductions, let's just talk about a tax on income. For 30 seconds I would like to read something that just came out a few months ago on the auditing of gasoline stations: this is an IRS training manual. The IRS is telling the examiner to visit the station prior to the start of the audit which will make the audit a lot easier:

> Compare the prices of the taxpayer's station to competitor's stations nearby. Do they offer discounts for cash? One important thing to observe is how many customers are pumping their own gas and how many are getting full service. There are potential sources of additional income that may be hidden. For example, inquire whether the service station sells beer or liquor, does it have vending machines, how many pumps does it have, does it engage in snow plowing, how far away is the nearest recreation area, does it have a walk-in cooler.

These are all questions geared to find out whether that little service station owner is getting income, and in a flat tax system, you would have those same questions, unfortunately, that would have to be asked.

Chairman ARCHER. What about the intrusion to which you testified in third parties and the possible revealing of confidential tax information in a third party situation? Would that continue under a flat tax?

Mr. SHULMAN. Absolutely, Mr. Chairman, because whether one party to a transaction considers something income may depend in part how the other party to a transaction considers it, and that requires looking into both taxpayers' tax returns, including the return of someone not being audited.

I know I sound a little bit like a broken record here and I apologize, but when you have sat through as many audits as I have with people like the two witnesses next to me, it even breaks a lawyer's heart to see some of the things that are going on in this country, and you just throw up your arms and you say, We have got to do better.

Chairman ARCHER. Would any of the rest of you like to comment on that? Then I am going to yield to Mr. Gibbons.

Ms. Cook.

Ms. COOK. Yes. Mr. Chairman, I am not so sure it is the structure of the way taxes are being collected because I don't think it would matter if we had a structure like we have now, a flat tax, or any kind of consumption tax.

If you have an agency such as we have now doing the collecting, they are going to abuse it, no matter what system comes out of it, as you just said.

I think that aspect of it should be addressed as well as the structure of the tax collection.

Chairman ARCHER. I certainly appreciate that. I agree with you that we are always going to have to have some method of collecting money to pay the government's bills; and we must forever be doing oversight and be conscious that it be done in the proper way. I personally think we could take a giant step forward, if we could eliminate the need for every individual in this country to have any interface with the IRS. We can then concentrate on potential abuses that deal with how money is collected through business as a vehicle, and we can concentrate on it better; but we can eliminate over 100 million tax returns every year if we go to a consumption tax. Certainly, your personal problem on the sale of your house would have been totally eliminated.

The other thing, Mr. Shulman, would you not still keep records for at least 7 years under the flat tax, so that if you are ever audited for what you report, you would be able to support it from those records?

Mr. SHULMAN. Yes, sir. I think it would be impossible to have any type of tax system that looks at taxing incomes of individuals and allows the government to go back without keeping those records. You make a good point, sir. Also, I think one of the witnesses, perhaps unknowingly, made a brilliant point. Under our tax system, there is no such thing as innocent until proven guilty. The taxpayer under this system has to prove that they did the right thing. The government does not have to prove that you did the wrong thing.

Chairman ARCHER. So, under the flat tax, you would still be subject to having to produce your records to prove the number that you sent in was accurate, if the IRS contested the accuracy of that number?

Mr. SHULMAN. Absolutely.

Ms. MACDONALD. I am not so sure of that because 90 percent of the revenue that the IRS collects is through withholding, and the complexities due to the deductions and the credits and the exemptions, and that is what largely the IRS is examining every year. I would argue that the IRS does a pretty decent job of matching through 1099s and W–2s the amount that they do get through withholding.

So what the IRS is really setting out to do is to go after the erroneous deductions and the underreporting. Yes, I would think that the IRS would still need to audit for that and to go after the underground economy which is where I hope the resources would be directed.

I think under a flat tax, given that it would ideally abolish all deductions, it would, I think, cut it to its intrusiveness.

The problem is, yes, there is a presumption of correctness on the part of the IRS which leads to the notion that guilty until proven innocent, but inside the IRS, there are 66,000 people who have access to taxpayer records, and these people can assess infinite amounts in fines.

We have to look at it from the inside out and understand what the IRS is about as a tax collector and how it operates internally.

Chairman ARCHER. I am just trying to explore a little bit, though, the practical application if we were to decide that the flat tax was the best way to go. Each individual would send in one aggregate amount on a postcard and pay their tax on that. You can get into the debate if you can have any deductions or not, or are you going to tax dividends or interest, and different people disagree on that and still say that they have a flat tax.

Let's push that aside for the moment. You still have to have that aggregate number, and that aggregate number is a total of all of the taxable income that you have, which may be from more than one source. In fact, it would probably be from more than one source.

I know from my own experience in doing my own tax return, in handling any problem with the IRS myself, that under the matching process, if I don't positively identify the item in the way that it is reported on the form 1099, they will come back and contest that——

Ms. MACDONALD. I agree with you on that.

Chairman ARCHER [continuing]. Even though I put the accurate number on there. They will come back and contest it. I then have to do the proving, and I think that is the point that Mr. Shulman is making.

If I aggregated all of that into one number, it would be subject to even greater dispute because they could not be sure precisely the cumulation of the numbers I had put in there. They would then be more likely to come back and dispute what I had sent in and demand that I produce the records to prove that number was accurate.

Am I wrong about that or not?

Ms. MACDONALD. No, Mr. Chairman, you are correct, and I agree with you on that. I was just speaking to the fact that inner flat tax deductions would be wiped out, but, yes, the IRS would still——

Chairman ARCHER. Not too quick about deductions all being wiped out.

Ms. MACDONALD. Under ideal, that is what a flat tax could clearly do.

Chairman ARCHER. Under someone's ideal.

Ms. MACDONALD. That is right.

Chairman ARCHER. Under other politicians' ideals, they would continue to have deductions——

Ms. MACDONALD. I am aware of that.

Chairman ARCHER [continuing]. But we don't want to get into that debate today.

Ms. MACDONALD. No, but what I am saying is that I agree with you that the IRS would still check to make sure that you reported your income correctly.

Mr. SHULMAN. Mr. Chairman, I would go a step further. I would say that not only would the IRS in many cases—perhaps not in your case, but in many cases—not only ask you to prove your income, but they will start doing a number of the things that I have tried to testify to here, particularly when they are examining the income of a small businessowner, like a retail gasoline station.

They are going to start investigating how you run your business and how you live your life because there is some doubt that if your income didn't quite match up in the first place, maybe there is actually something else there you are not reporting, like income from a candy vending machine or some of these other things on this list that they look at in small businesses. It goes beyond looking at papers. That is the problem.

Chairman ARCHER. Thank you.

Mr. Gibbons.

Mr. GIBBONS. Thank you, Mr. Chairman.

I want to express my appreciation to the panel for coming today and for informing us of the problems they have. I feel and hear you very clearly, and I think a lot of your problem is because we just outlived the ability to provide a sensible income tax system. It is functionally obsolete, and no matter what we do to it, all the tinkering we can do, I have seen 27 years of tinkering with it, and attempts to major reforms, and they just haven't worked. We have to take another crack.

So thank you for coming and helping us with this.

Chairman ARCHER. Mr. Christensen.

[No response.]

Chairman ARCHER. Mr. Laughlin.

[No response.]

Chairman ARCHER. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I just want to thank Ms. Cook for coming to Washington today. You came really at great effort, and I appreciate your sharing with us the experience that you and your husband went through over so many years.

I would like to say for the record that one of the things that I found most appalling about your case was the inaccuracy of the information that the IRS gave you and the lack of timely response. There simply is no excuse for the government not responding in a more timely and accurate fashion, and I thought, Ms. Hodges, your case was a very interesting example because if we are going to increase compliance, we have to reward people who come forward and report problems and not put them through the kind of abusive experience that you endured.

I don't know that our penalty structure is able to take into account the kinds of circumstances or the voluntary effort that you made, but we will look into that.

We are, in our Taxpayer's Bill of Rights that will be up on the floor for debate next week, I believe, shifting the burden of proof onto the IRS at least in the appeals process.

We are looking at those issues, and we will make at least some progress in addressing the balance between the taxpayer and the IRS in the near future.

Thank you.

Ms. HODGES. Could I say to you that we know that we all have the right for an appeal, and this was not granted to us. This was the reason that we felt we could take this case to court, is they denied an appeal. We can always go from Fayetteville to Greensboro, and they said no.

Mrs. JOHNSON. I am glad you are taking it to court because that shouldn't be.

Ms. COOK. Mrs. Johnson, just as a footnote to this, I was stunned to find out that when I was being garnished and being left $150 a week for my family to live on——

Mrs. JOHNSON. Three children, as I recall.

Ms. COOK. Three children, yes. It took me, with the help of your office, 9 months before I could find someone in the agency who would sit down and figure out why I was being garnished because I couldn't find anyone who would give me that information for 9 months.

Mrs. JOHNSON. That was what was so appalling to us. Even as a team, we simply couldn't get a response.

Thank you very much for coming today, Ms. Cook.

Chairman ARCHER. If I may just briefly follow up and say there are a lot of very conscientious people working with the IRS trying hard to be fair, trying hard to do a good job. There are also some abuses in the IRS, but I believe that the major problem is what the Congress assigned the IRS to do. They assigned the IRS a virtually impossible task, and they gave them all types of subjective power, but even beyond that—and Mr. Gibbons and I both were in this room when this has happened over and over again during the eighties. When the Congress was unwilling to raise taxes, they simply gave the IRS more power, more penalties, more interest, more ability to go out and pull money from taxpayers on the basis that way nobody paid any increased taxes.

You two people, Ms. Hodges and Ms. Cook, can testify that those are increased taxes. The Congress may call them penalties. The Congress may call them interest and say, Oh, we didn't raise anybody's taxes, just give the IRS more power, and they will bring more money in out of the current system.

The Congress itself—and I voted against every one of those, so I can say this without any participation on my part in those laws, and I spoke out against it over and over and over again, and you are living proof of what has happened in the past, and sadly enough, it has not been partisan. It has been bipartisan in giving that power to the IRS. We have got to turn that around and change it and stop thinking in terms of how we are going to raise money and nobody pays any extra taxes as a result of it.

I didn't mean to get into this, but you two ladies, after what you have suffered, I thought maybe you might like to hear that there are some of us up here that understand this and have understood it for many, many years.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. I apologize to the panel for missing your presentation, but I appreciate very much your coming today and sharing with us your testimony.

Ms. Hodges, what kind of business are you in?

Ms. HODGES. It is a full-service advertising agency.

Mr. MCCRERY. Advertising.

Ms. HODGES. Right.

Mr. MCCRERY. That is interesting.

Mr. Shulman, you are connected with the computer business in some way.

That brings up a point about tradeoffs in how we collect revenues to run the government's activities. We have heard a lot today about how the income tax is perhaps not the ideal way to tax citizens, but then, if you do away with the income tax, you have to collect revenue some other way. Obviously, the Chairman and Mr. Gibbons prefer some kind of consumption tax.

Most retail folks that I talked to that probably do a lot of advertising and sell a lot of computers are not real enamored with the consumption tax. So, can you talk a little bit about where we go and what the tradeoffs are?

We are going to have to collect revenues. We all agree, I think, that there is a necessity for a government in a civilized society, and the government has an obligation to provide certain services, national defense being probably the number one priority, and then it goes down from there. So we have to collect revenues.

How do we get around all of the problems you have discussed today, and then when we try to suggest VAT, a value-added tax, or a consumption tax of some sort, a national sales tax, we get met with the objection from people that pay your bills saying we don't want to be taxed in a way that would cut down on consumption?

Would anybody like to address that while you are here?

Mr. SHULMAN. I could probably take a stab at it. I think there are really two components to it. One which was discussed a bit this morning with the Committee was the transition, the whole transition issue.

It is ironic to me that we look at what has happened in Eastern Europe and we tell the countries and the people over there:

> Don't look just to next year or 2 years down the road, look 10 years down the road and realize that the price that you are paying now in terms of some dislocations in your economy and some of the other personal sacrifices that you are making, that when you eventually make that transition, hopefully, from a Communist system to a capitalistic system, you will look back 10 years earlier and see that whatever the transition was, the price was worth it.

I think it is up to the journalists, it is up to Congress, it is up to professionals like myself, and small business people and the average citizen to educate themselves and similarly to take the long-term look of things.

Now, when you go to the long term, I agree with you. There are going to be, to some degree, greater winners and greater losers in any reformulated tax system, but ultimately, I think all of us at the end of the chain are the ones paying the taxes.

It would be ideal if we could all drop our money in a box and that would be the end of it. We are going to have to come up with something that is not quite that simple.

Most of the businesses I know who have been through sales tax audits, for example, tell you that the State sales tax auditor was in for a day, they looked through some records, they wanted a few more things, and they made a slight adjustment. This is a totally different scenario from talking to someone who has gone through an IRS audit.

So, as strange and as unfair to a lot of people as the sales tax or VAT tax seems today, I think it can be enacted only after educational process and after trying to deal with some of the inequities that may happen with low-income people, and so forth. We are a very creative society, and we can come up with something that is less intrusive and meets revenue-generating requirements.

Ms. COOK. Ms. Hodges or Ms. MacDonald, since your magazine depends on advertising from retailers, I just saw an advertisement in here from Brooks Brothers. How would they look at a consumption tax?

Ms. MACDONALD. There are about 21 million self-employed people in the United States, and if, in fact, we move to a tax where there would be no deductions, for example, the 25-percent deduction for premiums for self health insurance and the taxation of fringe benefits, that, to me, is the biggest stumbling box, and I think that is the reason why you may be hearing a lot of complaints about the various forms of taxation.

In the future I would like to do more stories, and I am going to throw this idea out to any journalist who is sitting here. We should compare these different forms of taxation to real life and what is happening, for example, in Europe with Britain's pay-as-you-learn system or France's VAT.

France, I know, is paying, effectively, I think, 60 percent in taxes. They pay tax on everything, tax on their rent, tax for even renting an apartment. It can lead to absurdity, too, these different forms of taxation.

So, as long as we keep it clean, simple, pure, and honest, which is an ideal, but if we stick to those ideals, I think that we are going to be OK.

Ms. HODGES. Clearly, I am not a tax expert or I wouldn't have been in the mess that I was in in the first place. I am getting to be somewhat of one, but I think, logically, if you went to a consumption tax, your customers might not think that was a bad thing when they eliminated all of these other taxes over here.

Right now, in the State of North Carolina, we have an ongoing fight with the State over taxes, charging us sales and use tax on service. They don't charge attorneys that, but they happen to want to do us that way.

I feel that in the study of this with people who are much more aware and have more information than I, they might be able to weigh the difference between this being a consumption tax versus a flat tax.

As you said, you couldn't debate the deductions. We clearly know that we have people with low income that could not afford to pay a 17-percent flat tax. I am sure those things would have to be weighed.

Mr. MCCRERY. Thank you, Mr. Chairman.

Thank you all.

Chairman ARCHER. Mr. Christensen, did you have a followup?

Mr. CHRISTENSEN. Yes, just a quick question and also a comment to Mr. Shulman.

In the computer business, I know you have a lot of independent contractors, and some reference was made to the independent contractor issues and the onslaught that the IRS inspectors have over that area.

Interestingly enough, this year I introduced a bill that is going to simplify the 20-point test, providing an alternate 3-point test for the independent contractor issue.

Just last month, the IRS, coincidentally, said that they are going to reexamine the independent contractor issue, and it seems the closer we get to 218 cosponsors, the more they are laying off their audits of the independent contractor employee issues, and we are now at 217. So, hopefully, we will be able to clear up that issue for some of your computer operators and some of the small businessowners out there; that each year 4.5 million of our small businesses are targeted on the independent contractor issue alone.

So, until we get the current code pulled out by its roots and move to a fairer, flatter system for the American people, hopefully, this legislation, if we can get it through, will be able to give some temporary relief to those independent contractors out there that you represent.

Thank you, Mr. Chairman, and thank you for being here. This has been a very good hearing.

Thank you, Ms. MacDonald.

Chairman ARCHER. Thank you, Mr. Christensen.

That brings up another question. Mr. Shulman, under a flat tax, irrespective of the deductions or whether you tax income or dividends, but a flat tax concept, would you still have problems on the independent contractor issue, which is plaguing this country right now in creating tremendous controversy?

Mr. SHULMAN. Mr. Chairman, we have to remember that part of the reason there is a problem with the whole independent contractor issue is that we have an income tax which is tied to withholding, and that relates to the status of a worker. Everything is tied together.

Now, 50 percent of the time that I spend on tax matters involves independent contractors. I can guarantee both you and Mr. Christensen that I can tell you stories without exaggerating of things that have happened on the independent contractor front with the IRS that you wouldn't believe.

I really commend Mr. Christensen. I think it is remarkable that a bill on this issue has 217 cosponsors in the House.

Now, I realize there are a lot of questions about the bill. I like a lot of things about the bill, but we may be able, as Mr. Gibbons said this morning, to deal with the tax reform issues in a way that we can get away from the whole classification issue.

Certainly, with the flat tax, we are going to continue to have the payroll tax questions, the withholding, and a lot of the other things we are talking about.

If you move to some sort of consumption-based tax, depending on the rate and what is taxed and a number of other details, there may not be a need to decide who is an independent contractor or

who is an employee, and to have income tax withholding done and some of the other things.

I urge you when you take up your discussion of the Tax Code—and I know, Mr. Chairman, you said this in your announcement because I looked for it—that it is not only the income tax issue you are looking at, but you are also looking at how it ties into employment taxes.

Many of us have talked before about the computer industry and about the need to repeal laws, like section 1706 of the 1986 Tax Reform Act, in which Congress penalized independent contractors in the computer industry. We need to be moving in this direction, and I hope you all do that because the IRS announcements, like the other week on the training manual, fall far short of where we need to go.

Chairman ARCHER. Thank you very much, and my thanks to each of the four of you. My heart really goes out to Ms. Hodges and Ms. Cook. We have got to do everything that we can to see that the treatment of our citizens does not continue along those lines.

We are committed to do that. Congresswoman Johnson, who is the Chairman of our Oversight Subcommittee, is going to be moving ahead on the Taxpayer Bill of Rights next week, and that, hopefully, will be somewhat helpful to your two situations, although, generically, it doesn't get at some of the other problems that we talked about. I am very grateful to you for taking the time to come and give us your ideas today, and we will benefit from them.

Thank you very much.

[Whereupon, at 2:19 p.m., the hearing was adjourned, to reconvene on Wednesday, March 27, 1996, at 10 a.m.]

REPLACING THE FEDERAL INCOME TAX

WEDNESDAY, MARCH 27, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

Chairman ARCHER. The Committee will come to order.

Today's hearing continues the Committee's inquiry into the fundamental reform of our Nation's income tax system.

I have said over and over again that I believe the time has come for us to tear the income tax out by its roots and throw it away so they can never grow again, and I believe that the witnesses who testified at our hearing last week certainly made the case that the current income tax system does not serve this country well in any regard, and that it is so broken that it cannot be fixed.

Professional tax return preparers can't tell you how much tax you owe. These are people who are trained to be knowledgeable about this Tax Code, and when given the financial information of an average family of 4, 50 preparers come back with 50 different tax returns, with 50 different tax liabilities, with fees for the preparation of those returns ranging from $200 to $2,500. Clearly, something needs to be done about this system.

The IRS income tax audit machine, once started, is almost impossible to turn off, and the tax system has or soon will outstrip the ability of the IRS to administer it. Continued development of electronic capability poses greater problems for tracking and pursuing income for the purpose of gaining compliance of this Code. It is vital that fundamental tax reform improve the economy for all Americans.

In fact, I believe that our economy can become the economic juggernaut of the world if we make the right changes in our tax system. That means that if we do, American workers will once again be able to realize their dream, which is more real pay in their family paychecks and that their children will be able to do better than they have done. That is why I look forward to hearing the testimony today of the eminent economists who are with us.

I also look forward to hearing from Members of Congress who will explain the benefits of their own tax reform proposals. So many Members of Congress share the common goal of fundamental tax reform, and I am confident we can achieve that goal. Current differences of opinion in how we achieve that goal will not, in my opinion, prevent or delay the ultimate outcome.

I am today announcing a further hearing on April 24 that will focus on the impact of tax reform on small business. That hearing will be the first in a series of hearings on the effects of tax reform on various sectors of our economy.

Now I will recognize Mr. Gibbons for any opening statement he might like to make, and as usual, without objection, each Member will have the opportunity to insert a written statement in the record.

[The opening statement of Mr. Ramstad follows:]

OPENING STATEMENT OF HON. JIM RAMSTAD

Mr. Chairman, thank you for your commitment to reforming our deeply flawed tax system and for giving the American people a public forum to examine the options available to us.

We already know that the current system flunks the critical tests of efficiency, simplicity, flexibility, political responsibility, and fairness.

We also know that our current system discourages saving and investment, robbing Americans of economic opportunities and incentives to be innovators.

While our distinguished guests—many of whom also happen to be our distinguished colleagues—may have different ideas about how the Tax Code should be reformed, I know they will all help to improve the quality of this debate. I am grateful for their willingness to help this Committee and the American public grapple with the challenges of overhauling our tax system.

Again, Mr. Chairman, thank you for convening these critical hearings. I look forward to hearing the testimony today and appreciate the opportunity to further my own education.

Mr. GIBBONS. Mr. Chairman, I commend you for these hearings. I don't have a statement at this time. I am testifying a little later, and I would be glad to listen to these witnesses first.

Chairman ARCHER. Thank you, Mr. Gibbons.

We do have three eminent economists with us today. First, I would like to ask Dale Jorgenson, professor, Department of Economics, Harvard University, to give us his testimony.

I think you gentlemen know the rules here that we would appreciate it if you would keep your oral testimony within 5 minutes, and without objection, each of you will have the right to insert a full written statement of a lengthier nature in the record.

Mr. Jorgenson, you may proceed.

STATEMENT OF DALE W. JORGENSON, PROFESSOR, DEPARTMENT OF ECONOMICS, HARVARD UNIVERSITY, CAMBRIDGE, MASSACHUSETTS

Mr. JORGENSON. Thank you, Mr. Chairman.

Honorable Members of the Committee and ladies and gentlemen of the audience, I would like to begin my testimony by drawing your attention to a series of charts that I have appended to my prepared statement.

Adoption of a consumption tax would be the most dramatic change in tax policy since the adoption of the Federal income tax in 1913. It is not surprising that the economic impact would be truly staggering.

As an illustration, I have considered in my prepared statement the impact of substituting a tax on consumption for corporate and individual taxes at Federal, State, and local levels; in other words, all income taxes.

For this purpose, I have simulated U.S. economic growth with and without a change in tax policy. For simplicity, I have limited

my analysis to a tax substitution that would leave government expenditure programs fully funded.

Since State and local income taxes typically employ the same legal tax base as the Federal taxes, it does not make very much sense to assume that existing tax rules would continue to govern State and local taxes even if the Federal income tax were abolished.

Finally, I have focused on the impact of tax reform on economic growth, leaving progressivity to be determined by the adjustment of expenditures.

My conclusions about the adoption of a consumption tax with a very comprehensive, all-inclusive tax base are illustrated in the charts, and I can summarize them in the following six points.

First, substitution of a consumption tax for all of our existing income taxes, beginning January 1 of this year, would have had an immediate and powerful impact on the level of economic activity. U.S. domestic product would have increased initially by about 13 percent, and this increase would gradually have declined over the long run, indicated in the first chart, to about 9 percent.

Second, the imposition of a consumption tax would obviously produce a sharply higher tax rate on consumer goods and services. The consumption tax rate required to finance existing government programs at Federal, State, and local levels would be around 15 percent. That is Federal, State, and local.

This would gradually rise over time, ultimately reaching 21 percent. As a consequence of the total transformation of the tax system, individuals would obviously sharply curtail their consumption of goods and services, but they would also curtail their consumption of leisure. In other words, they would increase their labor supply.

There would, in fact, be a dramatic jump in savings and a very substantial rise in the supply of labor. These increases would subside only very gradually over time.

Fourth, taxation of consumption would induce a radical shift away from consumption and toward investment. Real investment would leap upward by about 80 percent, as shown in the chart. Real consumption would initially decline by about 5 percent, again, shown in the chart, but would gradually grow and overtake the level under the income tax within 2 years.

Since producers would no longer pay taxes on profits and workers would no longer pay taxes on wages, prices would fall by an average of 20 percent, while consumers would pay about the same taxes, face practically the same prices as they do now.

Industry outputs would rise by an average of about 20 percent with substantial relative gains for investment goods producers. That is also shown in the two charts.

Finally, in the long run, aftertax prices would fall by more than 25 percent, there would be a shift toward investment and away from consumption that would redistribute economic activity among industries, and while output would increase in all industries, as you can see in my final chart, the rise would be greatest for investment goods producers.

Obviously, these conclusions are preliminary, and they are subject to many qualifications which are spelled out in my prepared statement. However, they illustrate the quantitative importance of the impact of a consumption tax on U.S. economic growth, and I would like to submit that that is the central issue facing this Committee.

Thank you very much.

[The prepared statement and attachments follow:]

THE ECONOMIC IMPACT OF TAXING CONSUMPTION

by

Dale W. Jorgenson

INTRODUCTION AND SUMMARY

In this testimony I consider the economic impact of substituting a tax on consumption for corporate and individual income taxes at federal, state, and local levels. I limit my analysis to a revenue neutral substitution-one that would leave the government deficit unchanged. Finally, I focus on the impact of this fundamental tax reform on economic growth, leaving progressivity of the resulting combination of taxes and government expenditures to be determined on the expenditure side of the government ledger. I have summarized my conclusions in a series of charts.

1. The revenue neutral substitution of a consumption tax for existing income taxes at both federal and state and local levels would have an immediate and powerful impact on the level of economic activity. The first chart shows that U.S. gross domestic product (GDP) would increase initially by about fifteen percent and this increase would be sustained for a substantial time period.

2. The imposition of a consumption tax would produce a sharply higher tax rate on consumer goods and services. Elimination of the individual income tax would result in a dramatic decline in the impllicit subsidy rate on leisure time. The implied rate of subsidy on leisure is equal to the marginal tax rate on labor income and would drop to zero if the tax were abolished.

3. As a consequence of the total transformation of the tax system, individuals would sharply curtail consumption of both goods and leisure. This would produce a dramatic jump in saving and a substantial rise in labor supply. These increases would subside only very gradually.

4. Taxation of consumption would induce a radical shift away from consumption toward investment. The second chart shows that real investment would leap upward by a staggering eighty percent! The third chart shows that real consumption would initially decline by more than ten percent, but the level would grow rapidly and would overtake that under the income tax within five years.

5. The fourth chart shows that the consumption tax rate required for replacing existing revenues from individual and corporate income taxes at both federal and state and local levels would be around fifteen percent. This would gradually rise over time, ultimately reaching twenty-one percent.

6. Since producers would no longer pay taxes on profits or other forms of income from capital and workers would no longer pay taxes on wages, prices received by producers, shown in the fifth chart, would fall by an average of twenty percent. The sixth chart shows that industry outputs would rise by an average of fourteen percent with substantial relative gains for investment goods producers.

7. In the long run producers' prices, shown in the seventh chart, would fall by almost twenty-five percent, relative to prices under an income tax. The shift in the composition of economic activity toward investment and away from consumption would drastically redistribute economic activity. The eighth chart shows that production would increase in all industries, but the rise in production of investment goods would be much more dramatic.

IMPLEMENTATION OF A CONSUMPTION TAX

In *Hearings on Replacing the Federal Income Tax*, held by the Committee on Ways and Means last June, testimony focused on alternative methods for implementing a consumption tax. The consumption tax base can be defined in three alternative and equivalent ways. First, subtracting investment from value added produces consumption as a tax base, where value added is the sum of

capital and labor incomes. A second definition is the difference between business receipts and all purchases from other businesses, including purchases of investment goods. A third definition of the tax base is retail sales to consumers.

The three principal methods for implementation of a consumption tax correspond to these three definitions of the tax base:

1. The subtraction method. Business purchases from other businesses, including investment goods, would be subtracted from business receipts, including proceeds from the sale of assets. This could be implemented within the framework of the existing tax system by integrating individual and corporate income taxes, as proposed by the U.S. Treasury (1994). In this approach all businesses would be treated as partnerships or "sub-chapter S" corporations. The second step would be to allow full expensing of investment goods purchases in the year of acquisition. If no business receipts were excluded and no deductions and tax credits were permitted, the tax return could be reduced to the now familiar postcard size, as in the Flat Tax proposal of Majority Leader Dick Armey and Senator Richard Shelby (1995).[1] Enforcement problems could be reduced by drastically simplifying the tax rules, but the principal method of enforcement, auditing of taxpayer records by the Internal Revenue Service, would remain.

2. The credit method. Business purchases would produce a credit against tax liabilities for value added taxes paid on goods and services received. This method is used in Canada and all European countries that impose a value added tax. From the point of view of tax administration the credit method has the advantage that both purchases and sales generate records of all tax credits. The idea of substituting a value added tax for existing income taxes is a novel one. European and Canadian value added taxes were added to pre-existing income taxes. In Canada and many other countries the value added tax replaced an earlier and more complex system of retail and wholesale sales taxes. The credit method would require substantial modification of collection procedures, but decades of experience in Europe have ironed out many of the bugs.

3. National retail sales tax. Like existing state sales taxes, a national retail sales tax would be collected by retail establishments, including service providers and real estate developers. This would also require a new system for tax administration, possibly sub-contracting the actual collection to existing state agencies. Enforcement procedures would be similar to those used by the states and the Internal Revenue Service could be transformed into an agency that would sub-contract collections. Alternatively, a new agency could be created for this purpose and the IRS abolished.

The crucial point is that all three methods for implementing a consumption tax could be based on the same definition of the tax base. This greatly simplifies the tax economist's task, since the economic impact would be the same for all three approaches. This leaves important issues to be resolved by other tax professionals, including especially, tax lawyers who would write the legislation and the implementing regulations and tax accountants who would translate the laws and regulations into accounting practice and advise economic decision-makers about their implications.

From the economic point of view the definition of consumption is straightforward and a useful starting point is Personal Consumption Expenditures (PCE) as defined in the U.S. national income and product accounts. However, the taxation of services poses important administrative problems reviewed in the U.S. Treasury (1984) monograph on the value added tax. First, PCE includes the rental equivalent value of the services of owner-occupied housing, but does not include the services of consumers' durables. Both are substantial in magnitude, but could be taxed by the "prepayment method" described by David Bradford (1986). In this approach taxes on the consumption of the services would be prepaid by including investment rather than consumption in the definition of the tax base.

The prepayment of taxes on services of owner-occupied housing would remove an important

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[1]Economists will recognize the Flat Tax proposal as a variant of the consumption-base value added tax proposed by Robert Hall and Alvin Rabushka (1995).

political obstacle to substitution of a consumption tax for existing income taxes. At the time the substitution takes place all owner-occupiers would be treated as having prepaid all future taxes on the services of their dwellings. This is equivalent to excluding not only mortgage interest from the tax base, but also returns to equity, which might be taxed upon the sale of residence with no corresponding purchase of residential property of equal or greater value. Of course, this argument is vulnerable to the criticism that home owners should be allowed to take the mortgage interest deduction twice-once when the substitution occurs and again when consumption tax liabilities are assessed.

Under the prepayment method purchases of consumers' durables by households for their own use would be subject to tax. This would include automobiles, appliances, home furnishings, and so on. In addition, new construction of owner-occupied housing would be subject to tax, as would sales of existing renter-occupied housing to owner-occupiers. These are politically sensitive issues and it is important to be clear about the implications of prepayment as the debate proceeds. Housing and consumers' durables must be included in the tax base in order to reap the substantial economic benefits of putting household and business capital onto the same footing.[2]

Other purchases of services especially problematical under a consumption tax would include services provided by nonprofit institutions, such as schools and colleges, hospitals, and religious and eleemosynary institutions. The traditional, tax-favored status of these forms of consumption would be defended tenaciously by recipients of the services and even more tenaciously by the providers. Elegant and, in some cases, persuasive arguments could be made that schools and colleges provide services that represent investment in human capital rather than consumption. However, consumption of the resulting enhancements in human capital often takes the form of leisure time, which would remain as the principal untaxed form of consumption. Taxes could, however, be prepaid by including educational services in the tax base.

Finally, any definition of a consumption tax base will have to distinguish between consumption for personal and business purposes. On-going disputes over exclusion of home offices, business-provided automobiles, equipment, and clothing, and business-related lodging, entertainment and meals would continue to plague tax officials, the entertainment and hospitality industries, and holders of expense accounts. In short, substitution of a consumption tax for the federal income tax system would not eliminate all the practical issues that arise from the necessity of distinguishing between business and personal activities in defining consumption. However, these issues are common to the two tax systems.

CONCLUSION

Under any one of the three approaches to implementation of a value added tax, substitution of a consumption tax for existing individual and corporate income taxes would be the most drastic change in federal tax policy since the introduction of the income tax in 1913. It should not be surprising that the economic impact I have already summarized would be truly staggering in its dimensions. It is easy to foresee that as Americans become more fully apprized of the manifold ramifications of fundamental tax reform that Gucci Gulch[3] will be transformed into the political equivalent of the Grand Canyon.

The coming debate over tax reform is a both a challenge and an opportunity for economists. It is a challenge because the impact of fundamental tax reform will involve almost every aspect of economic life. Economists who have spent their lives pre-occupied by the latest debating points in

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[2]See, for example, my testimony before the Committee on Ways and Means ofJune 6, 1995.

[3]It is difficult to believe that anyone reading this testimony will be unaware of this colloquial expression for the corridor outside the hearing room of the Committee on Ways and Means. The expression appeared in the title of the definitive journalistic account of the Tax Reform Act of 1986 by Jeffrey H. Birnbaum and Alan S. Murray (1987).

professional journals read only by other economists will suddenly find themselves swept up in the journalistic maelstrom of American political life. The fine points that dominate scholarly discussions will be subjected to the refiner's fire of public exposure. While translation of professional debating points into sound bites requires considerable talent and experience, a substantial number of economists have acquired the requisite skills.

The debate will be an opportunity for economists because economic research has generated an enormous amount of valuable information about the impacts of tax policy. Provided that the economic debate can be properly focused, economists and policy makers will learn a great deal about the U.S. economy and its potential for achieving a higher level of performance. I am personally very gratified that the Joint Committee on Taxation has taken the initiative in this daunting enterprise and will shortly convene a group of leading tax economists to began serious work on shaping the professional discussion. In my remaining testimony I will outline my own recommendations at the beginning of this landmark debate.

The first issue that will surface in the tax reform debate is progressivity or the use of the federal tax system to redistribute resources. My first recommendation is that this issue be set aside at the outset. Fiscal economists of varying persuasions can agree that progressivity or the lack of it should be used to characterize all of government activity, including both taxes and expenditures. Policies to achieve progressivity could and should be limited to the expenditure side of the government budget. This initial policy stance would immeasurably simplify the debate over the economic impact of fundamental tax reform. I view this radical simplification as essential to intellectual progress, since there is no agreed upon economic methodology for trading off efficiency and equity in tax policy or anywhere else.

The second issue to be debated is fiscal federalism or the role of state and local governments. Since state and local income taxes usually employ the same tax bases as the corresponding federal taxes, it is reasonable to assume that substitution of consumption for income taxes at the federal level would be followed by similar substitutions at the state and local level. For simplicity I propose to consider the economic impact of substitution at all levels simultaneously. Since an important advantage of a fundamental tax reform is the possibility, at least at the outset, of radically simplifying tax rules, it does not make much sense to assume that these rules would continue to govern state and local income taxes, even if the federal income tax were abolished.

The third issue in the debate will be the economic impact of the federal deficit. Nearly two decades of economic dispute over this issue has failed to produce resolution. No doubt this dispute could continue well into the next century and preoccupy the next generation of fiscal economists, as it has the previous generation. An effective rhetorical device for insulating the discussion of fundamental tax reform from the budget debate is to limit consideration to deficit neutral proposals. This device was critical to the eventual enactment of the Tax Reform Act of 1986 and is, I believe, essential to progress in the debate fundamental tax reform.

APPENDIX

The simulations of U.S. economic growth summarized in the charts appended to this testimony are based on an intertemporal equilibrium model of the U.S. economy that I have constructed with Peter J. Wilcoxen. The details of the model and more than a dozen applications are summarized in our survey paper, "Energy, the Environment, and Economic Growth," published in 1993. The model has been continuously revised and updated since it was first published in 1990 and Version Nine incorporates the detailed representation of the U.S. tax strcuture published in my 1991 book with Kun-Young Yun, *Tax Reform and the Cost of Capital.*

Our model of U.S. economic growth is disaggregated to the thirty-five industries listed in the final four charts of my testimony. In addition, the model distinguishes among 1344 types of households, disaggregated by family size, age and gender of household head, region of residence, race, and urban versusrural location. The model is built around sub-models of investment and saving based on rational expectations. The price of investment goods in every period is based on

expectations of future capital services and discount rates that are fulfilled by the solution of the model.

In order to analyze the economic impact of changes in tax policy, we simulate the growth of the U.S. economy with and without changes in these policies. The first and most difficult step is to generate a simulation based on current tax policy. We call this the *base case.* We then produce an alternative simulation based on a consumption tax. This represents the *alternative case.* Finally, we compare the base case with the alternative case in order to assess the effects of the substitution of a consumption tax for the existing income tax system.

The most difficult part of tax policy evaluation is to project U.S. economic growth under the existing tax system. For this purpose I have introduced the characteristic features of U.S. tax law into the cost of capital, distinguishing among assets employed in three legal forms of organization-households and nonprofit institutions, noncorporate business, and corporations. Income from corporate business is subject to the corporate tax, while distributions to households are subject to the individual income tax. Income from unincorporated business-partnerships and sole proprietorships-are taxed only at the individual level, while income from equity in household assets is not subject to the income tax.

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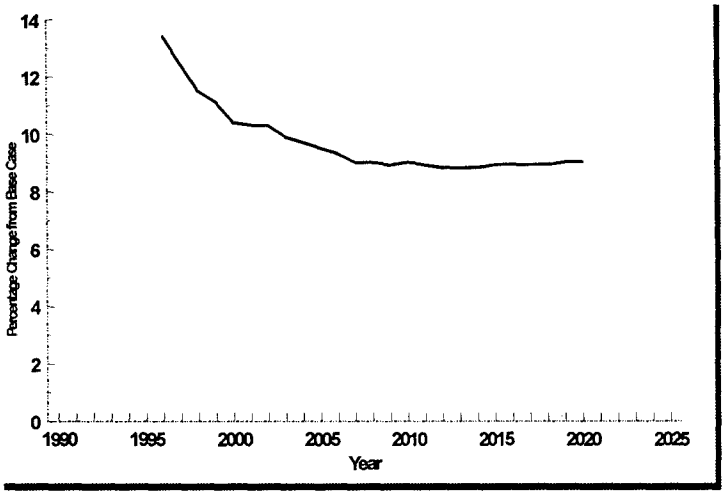
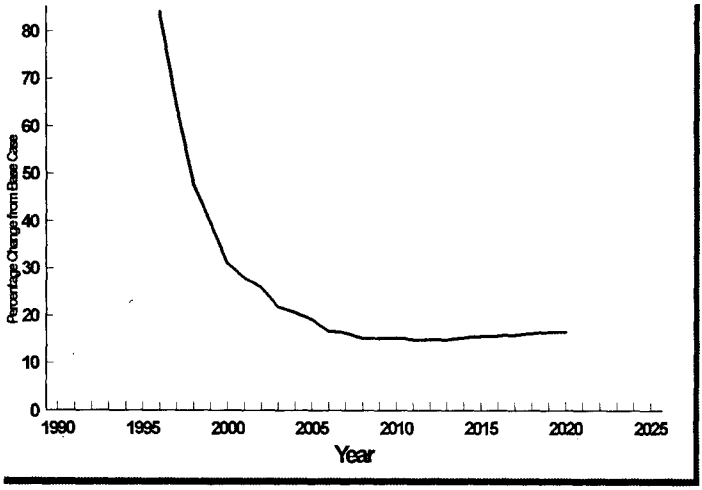
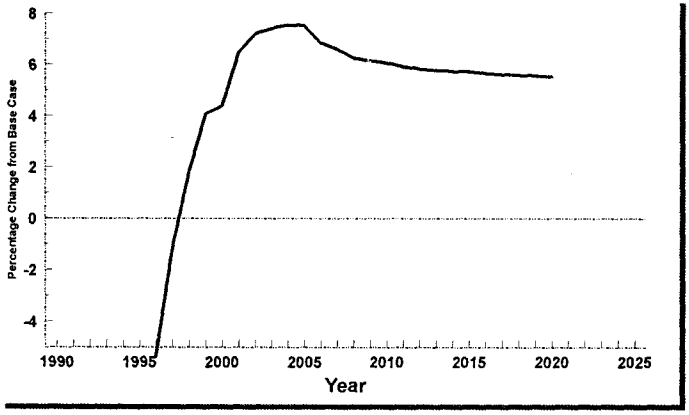
Effect of Consumption Tax on Real GDP



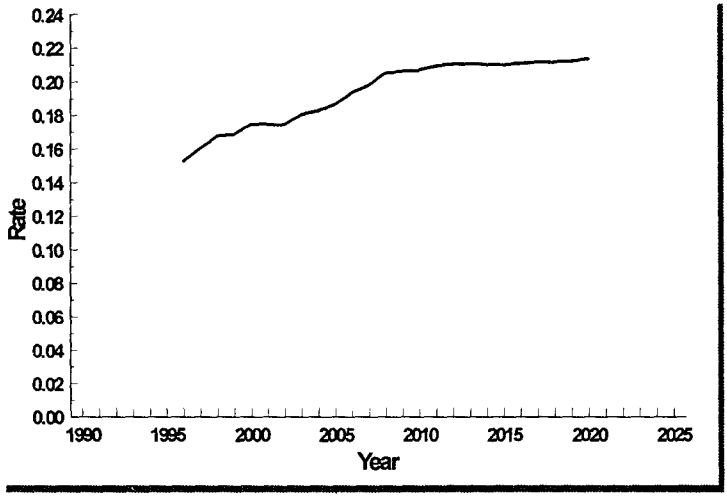
Effect of Consumption Tax on Real Investment



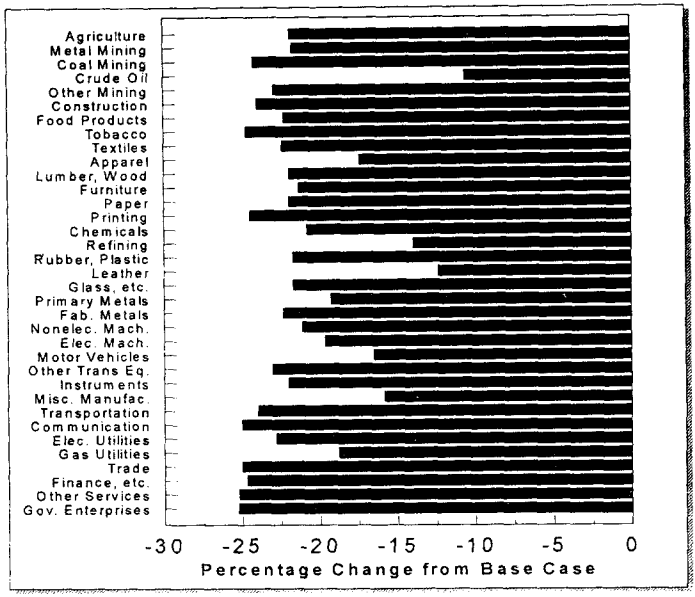
Effect of Consumption Tax on Real Consumption



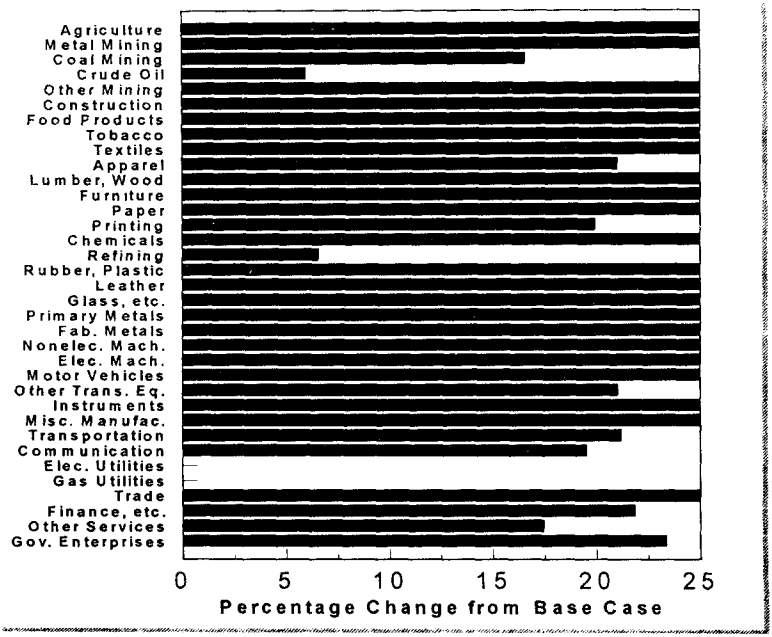
Consumption Tax Rate

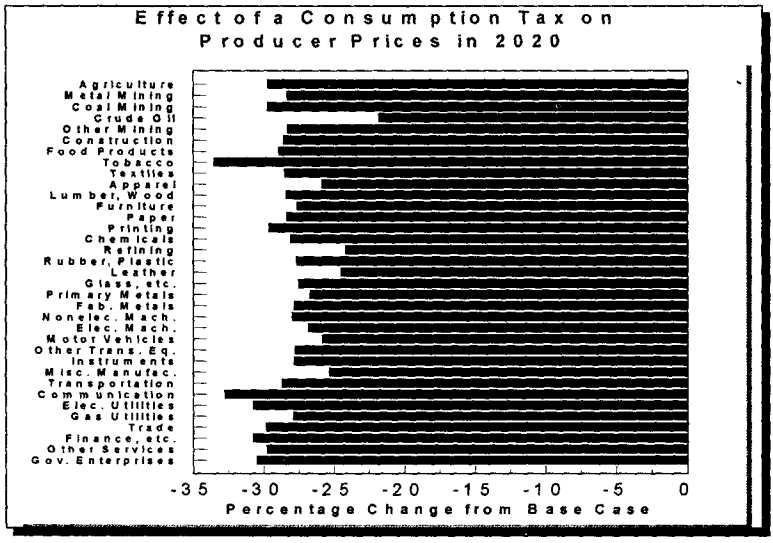


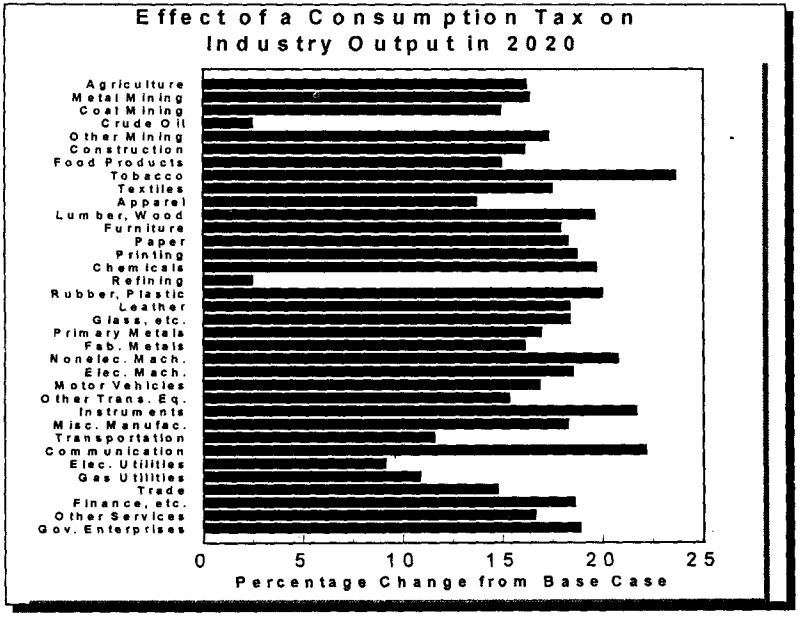
Effect of a Consumption Tax on Producer Prices in 1996



Effect of a Consumption Tax on Industry Output in 1996




Effect of a Consumption Tax on
Producer Prices in 2020
Agriculture
Metal Mining
Coal Mining
Crude Oil
Other Mining
Construction
Food Products
Tobacco
Textiles
Apparel
Lumber, Wood
Furniture
Paper
Printing
Chemicals
Refining
Rubber, Plastic
Leather
Glass, etc.
Primary Metals
Fab. Metals
Nonelec. Mach.
Elec. Mach.
Motor Vehicles
Other Trans. Eq.
Instruments
Misc. Manufac.
Transportation
Communication
Elec. Utilities
Gas Utilities
Trade
Finance, etc.
Other Services
Gov. Enterprises
-35 -30 -25 -20 -15 -10 -5 0
Percentage Change from Base Case


Effect of a Consumption Tax on
Industry Output in 2020
Agriculture
Metal Mining
Coal Mining
Crude Oil
Other Mining
Construction
Food Products
Tobacco
Textiles
Apparel
Lumber, Wood
Furniture
Paper
Printing
Chemicals
Refining
Rubber, Plastic
Leather
Glass, etc.
Primary Metals
Fab. Metals
Nonelec. Mach.
Elec. Mach.
Motor Vehicles
Other Trans. Eq.
Instruments
Misc. Manufac.
Transportation
Communication
Elec. Utilities
Gas Utilities
Trade
Finance, etc.
Other Services
Gov. Enterprises
0 5 10 15 20 25
Percentage Change from Base Case

Chairman ARCHER. Thank you, Mr. Jorgenson.

Our next witness is Glenn Hubbard, professor of economics and finance at Columbia University.

Mr. Hubbard, welcome to the Committee. You may proceed.

STATEMENT OF R. GLENN HUBBARD, RUSSELL L. CARSON PROFESSOR OF ECONOMICS AND FINANCE, COLUMBIA UNIVERSITY, NEW YORK, NEW YORK

Mr. HUBBARD. Thank you.

Mr. Chairman, Ranking Member Gibbons and distinguished Members of the Committee, I think it is clear as an opening observation that the current Federal tax system violates economists' norms of efficiency, fairness, and simplicity. There is no need for a litany of the current ills.

The big economic issues have to do with the distortions in the way our Nation allocates its capital and savings, and with the level of savings and investment. Both the allocation of capital and the level of saving are strange and distorted in sometimes very complex ways by the Tax Code.

Fundamental tax reform, whether it is broad-based income tax reform or consumption tax reform, should be judged by its ability to alleviate these distortions, while not giving ground on fairness or simplicity.

The bottom line of my remarks is that there is a very good case to be made for some broad-based consumption tax proposals. Let me also add a word of caution: Don't let the best be the enemy of the good. Many of the gains from major currently proposed consumption tax proposals could be achieved from principal income tax reform.

I join many economists in supporting the use of broad-based consumption taxes, and that support is primarily grounded in economic efficiency considerations.

As Dale Jorgenson just highlighted in his remarks, there are likely to be significant gains in capital accumulation and ultimately family incomes from a switch to a consumption tax, as well as the removal of the distortions and the way we allocate capital and the way businesses finance and organize themselves.

There is also an important fairness issue. Most economists would argue that consumption is a better measure of ability to pay than current income, and, regarding simplicity, a properly designed consumption tax can avoid a lot of the costly complexity with the current income tax. The $64,000 question, of course, is how would we get there, wherever that is, from here, wherever that is.

As we move there, we would like to know some concrete steps for tax reform, and to fix ideas, I have taken one of the major tax reform proposals, the flat tax proposal of Robert Hall and Alvin Rabushka from the Hoover Institution. In exhibit 1 of my prepared testimony, at the risk of oversimplifying, I outline nine steps that one could take to go from the current broken Federal Tax Code to the flat tax.

Without walking through all of those steps, let me mention three general themes. The first theme is "tax income once." That is achieved in the first three steps by integrating the corporate and individual tax systems—that is, eliminating the perverse double

taxation of dividends and capital gains and taking the Tax Code out of business people's decisions about organization and finance.

The second theme is "broaden the base and lower the rates." Eliminate special provisions in the business tax base and the individual tax base, and lower marginal tax rates for both individuals and businesses.

The first seven steps in the exhibit that I submitted with my testimony are consistent with broad-based income tax reform. Indeed, the Treasury Department submitted them in a comprehensive business income tax proposal during the Bush administration. Those reforms would capture a good chunk of the efficiency gains being discussed.

Steps 8 and 9 in the table, moving to expensing and moving to a territorial tax system, would be necessary to get to the flat tax and would also introduce very significant gains in economic efficiency.

Let me leave you with two thoughts. One, there are very large gains in economic efficiency to be obtained from tax reform. Two, if you break down tax reform into, for lack of a better term, bite-sized pieces, you can see that there are very large gains associated with proposals that economists, policymakers, and many Members of this Committee have advocated for years.

So, again, let me commend the Committee's interest in fundamental tax reform and urge you to consider tax reform very broadly in your deliberations.

[The prepared statement and attachments follow:]

STATEMENT ON "ISSUES IN FUNDAMENTAL TAX REFORM"
BY
R. GLENN HUBBARD
RUSSELL L. CARSON PROFESSOR OF ECONOMICS AND FINANCE
COLUMBIA UNIVERSITY
FOR
HEARINGS BEFORE THE COMMITTEE ON WAYS AND MEANS
OF THE ONE HUNDRED AND FOURTH CONGRESS
ON
MARCH 27, 1996

Mr. Chairman, Ranking Member Gibbons, and distinguished members of this committee, I am delighted to appear before you today to discuss economic considerations of replacing our tax system with various alternatives. To preview my remarks, I believe that the current federal income tax is fundamentally flawed, generating adverse consequences for economic efficiency, costly complexity, and significant violations of conventional norms of fairness. Fundamental income tax reform or a switch to a broader based consumption tax would likely lead to significant improvements in efficiency, simplicity, and fairness. Mr. Chairman, I salute this Committee's interest in economic issues surrounding fundamental tax reform.

THE NEED FOR FUNDAMENTAL TAX REFORM

Current U.S. tax law distorts the allocation of the nation's capital stock and reduces saving and investment. To begin, current law treats corporations and their investors as separate entities. Under this so-called "classical" system of corporate taxation, two levels of tax are levied on earnings from investments in corporate equity. First, income earned by corporations is taxed at the corporate level. Second, when the corporation distributes dividends to shareholders, the income is taxed at the shareholder level as ordinary income. Undistributed earnings, which increase share values, are also double taxed, since they are taxed at capital gains rates when shares are sold.

In contrast, investors who conduct business activity in noncorporate form, such as a sole proprietorship or partnership (or in corporate form through an S corporation), are taxed once on their earnings at their individual tax rate. Corporate earnings distributed as interest to suppliers of debt capital are generally taxed to U.S. taxpayers as ordinary income. However, interest paid is generally deductible by the corporation, and thus not subject to tax at the corporate level.

"Integration" of the corporate and individual income taxes refers to any plan in which corporate income is taxed only once, rather than taxed both when earned and when distributed to shareholders as dividends. Integration has many variants. In January 1992, the U.S. Treasury Department released a study of corporate tax integration, *Integration of the Individual and Corporate Tax Systems*. The American Law Institute also released a report on integration. The two reports document the economic distortions caused by the current two-tier tax system and the need to change the way in which the United States taxes corporations and their shareholders, and presents the issues involved with alternative approaches.

Despite their differences, methods of integration reflect a common goal: To the extent practicable, fundamental economic considerations, not the tax structure, should guide investment, organizational, and financial decisions. Although the Tax Reform Act of 1986 reduced the effect of taxation on many business decisions, that reform did not directly address distortions in business organizational and financing decisions under current law. Thus, integration can be viewed as the next logical step in tax reform.

The current system of business income taxation raises questions of fairness because it creates differences in the taxation of alternative sources of income from capital. A taxpayer conducting an equity-financed business in corporate form faces a different tax burden than a taxpayer conducting the same business in noncorporate form. A corporation that raises capital in the form of equity faces a different tax burden than a corporation that raises the same amount of capital from debt. A similar disparity exists in the treatment of corporations that finance investment with retained earnings and those that pay dividends and finance investment with new equity. Because of its bias towards debt, the current tax system encourages taxpayers to engage in practices that tend to disguise equity as debt. This effort represents a wasteful use of resources, and imposes significant administrative costs in attempting to distinguish debt from equity. These arguments for integrating the corporate and individual income tax systems have been put forth by economists and legal specialists for more than a generation. Three factors have maintained tax integration's place in the tax reform debate over the past decade.

First, the 1980s witnessed an explosion of corporate borrowing in the United States. Indeed, many observers believe that this activity—and the accompanying financial distress it brought in many sectors of the economy—was influenced significantly by the tax bias against equity finance. While the greatest reliance on debt had its origin in many factors, the use of debt contracts with virtually no provisions to index repayments to shifts in industry-wide or economy-wide conditions almost surely reflects the tax preference given such debt under current law. Financial decisions, which may leave firms more vulnerable to a downturn in the economy, should be based on fundamental economic considerations, not the tax code. The tax bias against equity finance needs to be addressed.

Second, these distortions have economic costs. Integration of the individual and corporate tax systems would reduce or eliminate these economic distortions. The potential economic gains could be substantial, as suggested in the Treasury Report.

Third, aside from these efficiency gains, the various integration prototypes, especially those that also focus on the taxation of interest, provide a mechanism for addressing a problem which has increasingly troubled many governments—the difficulty of taxing income from capital in a global economy. It is desirable to keep the overall tax rate on income from capital as low as possible. However, the ability of some investors to avoid or reduce taxation of capital income, while other investors cannot, is not an adequate surrogate for a uniform lower rate of taxation on all income from capital.

Finally, the thrust of integration on tax reform—taxing income once—still leaves a single level of tax on capital income. Many economists believe that the resulting intertemporal distortions of household saving decisions and business investment decisions are large, reducing growth opportunities and economic efficiency.

A CONSUMPTION TAX AS FUNDAMENTAL TAX REFORM

The term "consumption tax" actually applies to a range of tax systems. The base of a broad-based consumption tax is households' consumption, not households' net income. "Consumption taxes" can be collected from businesses, households, or both. They can be familiar sales taxes, but do not have to be. Further, consumption taxes can incorporate exemptions and graduated marginal tax rates, as under the income tax. Many economists support the use of consumption taxes to replace the current individual and corporate income taxes. This support reflects efficiency, fairness, and simplicity concerns.

The nation would enjoy three sources of efficiency gains from moving to a broad-based consumption tax. First, the removal of the current tax on returns to new saving and investment increases capital accumulation and, ultimately, household incomes.[1] Second, the consumption tax

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[1] Many economists have argued that switching from an income tax to a consumption tax significantly increases saving and capital accumulation. This is because a consumption tax exempts returns to new saving, thereby increasing households' willingness to save. In the early 1980s, Laurence Summers, currently Deputy Secretary of the Treasury Department, concluded that a move to a consumption tax would lead to major increases in capital accumulation and economic well being. See Laurence H. Summers, "Capital Taxation and Accumulation in a Life-Cycle Growth Model," *American Economic Review* 71 (September 1981): 533-544.

There are two reasons to suspect that gains in saving may be smaller than researchers originally guessed. The first is that the current "income" tax already embodies some elements of a consumption tax. For example, saving through pension plans, IRAs, Keoghs, or 401(k) arrangements already enjoy cash flow treatment. In addition, investment incentives offer a form of partial expensing. Second, recent research on saving suggests that a significant function of household saving is "precautionary saving" against uncertainty over future earnings, medical expenses, or length of life as opposed to saving for retirement *per se*. Such saving decisions are less influenced by changes in the after-tax interest rates than retirement saving decisions, implying a smaller overall response of saving to tax reform. Nonetheless, combining these two caveats, a recent Brookings Institution study concluded that saving rates would fall by between 5 and 10 percent. See Eric Engen and William Gale, "The Effects of Fundamental Tax Reform on Saving," Mimeograph, The Brookings Institutions, February, 1996.

Another reason that many economists and policymakers favor fundamental tax reform emphasizing consumption taxation over income taxation is that such reform may stimulate

removes distortions in the allocation of capital across sectors and types of capital. Third, a broad-based consumption tax avoids potentially costly distortions of firms' financial and organizational structure.[2] Taken together, efficiency gains from moving to a consumption tax are potentially dramatic. Professor Dale Jorgenson of Harvard University estimates the present value of growth opportunities created by the move from the 1985 to law to the Tax Reform Act of 1986 to be about $1 trillion (1987 dollars). Jorgenson also estimates that, had the United States moved from the 1985 income tax law to a broad-based consumption tax, gains in growth opportunities would have doubled to about $2 trillion. The additional gains are due to leveling the playing field and to expensing business investment.

With respect to fairness, many economists believe that consumption represents a better measure of "ability to pay" than does current income, because households' consumption decisions depend on wealth and expected future income as well as current income. Finally, a properly designed broad-based consumption tax promotes simplicity. Several consumption tax systems avoid much of the costly complexity associated with the present income tax.

STEPS TOWARD FUNDAMENTAL TAX REFORM

How might we move from the current tax system to a broad-based consumption tax? What aspects of reform generate significant improvements in efficiency, simplicity, and fairness? To fix ideas, I focus on the "flat tax" proposal of Robert Hall and Alvin Rabushka of the Hoover Institution.[3] While I abstract from many details of the proposal and from transition complications, I show in Exhibit 1 that it is possible to characterize this fundamental tax reform as a nine-step process. While each step represents a significant change in tax policy, virtually all of the steps are consistent with fundamental *income* tax reform. Moreover, many of the steps to reform have been advanced for many years by economists and policymakers. I consider the steps in turn below under three themes: (1) integrating the corporate and individual tax, (2) broadening the base and reducing marginal tax rates, and (3) moving to consumption taxation.

Integrating the Corporate and Individual Income Tax

The first three steps toward fundamental tax reform integrate the corporate and individual tax system. Step 1 ends the double taxation of corporate equity returns. The Treasury Department's integration report recommended a dividend exclusion prototype for dividend relief. Under this prototype, corporations would pay the corporate income tax, computing taxable income in the same way as under current law. However, dividends paid would not be taxed again at the investor level. The Treasury model also ended double taxation of retained earnings by allowing shareholders to

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business investment. Under the current income, tax businesses are permitted to depreciate capital investment over time. Under a consumption tax, investment is expensed. Under current law, the present value of one dollar of depreciation allowance is about $0.83 for equipment investment; under expensing, that present value is, of course, $1.00. In a study of effects of the cost of capital on investment, Kevin Hassett and I estimate that this change would raise the annual business equipment rate by 10 percent. See Kevin A. Hassett and R. Glenn Hubbard, "Tax Policy and Investment," Mimeograph, Columbia University, January 1996.

[2] Distortions in the allocation of capital and in financial and organizational structure can also be reduced through fundamental income tax reform. The Treasury Department's 1992 study of corporate tax integration study estimated increases in economic well-being from integration in many cases as large as gains accompanying reforms in the Tax Reform Act of 1986. The gains result from improved allocation of real resources, reductions in the likelihood of firms experiencing financial distress, and the shift toward allowing corporations to make capital structure and dividend decisions based on nontax benefits and costs. See U.S. Department of the Treasury, *Integration of the Individual and Corporate Tax Systems: Taxing Business Income Once*, Washington, D.C.: U.S. Government Printing Office, 1992.

[3] In the *Appendix* of this testimony, I offer a brief comparison of alternative forms of broad-based consumption taxes and arguments for favoring the flat tax over a value-added tax or a national retail sales tax.

increase stock basis for retained earnings, thereby avoiding a subsequent capital gains tax on retained earnings.

Step 2 ends the tax bias against equity finance in favor of debt finance. The Treasury Department's integration study proposed to accomplish this by extending the dividend exclusion prototype to interest. Treasury's model—the Comprehensive Business Income Tax (CBIT)—would apply to all businesses, noncorporate and corporate. Under CBIT, neither deductions for payments to debtholders nor to shareholders would be permitted, and a tax would be collected at the entity level (at a rate equal to the highest marginal individual tax rate). However, both interest and equity distributions would be excludable from income by investors. Step 3, which would consolidate reporting of business income for tax purposes, would be accomplished by a proposal such as CBIT.

Broadening the Tax Base and Reducing Marginal Tax Rates

The next four steps implement the maxim guiding the Tax Reform Act of 1986—"broaden the base and lower the rates." Step 4 broadens the base of the business tax by eliminating preferential tax provisions for particular industries and firms and by repealing the alternative minimum tax. Step 5 continues the theme of "taxing income once" by collecting taxes on employee fringe benefits at the business level. In practice, this could be accomplished by disallowing business deductions for expenditures on employee fringe benefits and removing tax liability for such benefits from the individual tax. Step 6 broadens the base of the individual tax—eliminating all itemized deductions, the standard deduction, and any adjustments to gross income and repealing the alternative minimum tax. Having accomplished base broadening under the income tax, one can lower marginal rates on individuals and businesses. In practice, this could be accomplished by replacing the graduated-rate individual tax system with a single-rate system and reducing the business tax rate to the same single rate as the individual tax rate. To maintain progressivity, one could retain and expand the generosity of the personal exemption. A refundable individual tax credit could also be added for low-income households.

Steps 1-7 attempt to accomplish broad-based *income* tax reform by taxing income exactly once, broadening the tax base, and reducing marginal rates. These steps have, in one form or another been advocated by many economists and policymakers for many years. Enacting tax reform that embraced the missions of these steps would stimulate saving and investment, significantly reduce tax distortions of financing and organization decisions, and improve the efficiency with which the nation's capital stock is allocated.

Moving to Consumption Taxation

It is only in Step 8 that we begin to introduce fundamental *consumption* tax reform. After the first seven steps, the tax base is (approximately) employee compensation plus business income (receipts less the sum of expenditures, compensation, materials, and depreciation of capital assets). The tax base under the consumption tax should be employee compensation plus business cash flow. Accordingly, Step 8 replaced accrual accounting for businesses with cash flow accounting. Most important, this step allows expensing for all purchases from other firms including purchases of capital assets. Relative to the business income tax, the move to expensing exempts from taxation the return on marginal investment projects—projects for which expected returns just cover the opportunity cost of funds.[4] Economic profits—based on entrepreneurial skill or good fortune—are taxed equally in the business income tax and in the business cash flow tax.[5]

The first eight steps essentially treat the United States as a closed economy. A broad-based consumption tax would not tax overseas income of U.S. enterprises. Hence Step 9 shifts the tax base from a residence-based tax system to a territorial tax system. This step would remove foreign-source

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[4] One could also implement a broad-based consumption tax by taxing compensation once at the business level by using a subtraction-method value-added tax. Relative to Step 8, this would require eliminating the individual tax and disallowing businesses' deductions of payments to labor.

[5] For a general discussion of this point, see William M. Gentry and R. Glenn Hubbard, "Distributional Implications of Moving to a Broad-Based Consumption Tax," Mimeograph, Columbia University, March 1996.

income from the U.S. tax base.[6]

As I noted earlier, enacting the set of nine steps would lead to large gains in economic efficiency, simplicity, and tax fairness. It is important to note that even if one wanted to enact all nine—and move to a broad-based consumption tax such as the flat tax—significant gains can be accomplished by focusing on themes of "taxing income once" and "broadening the base and lowering the rates."

Mr. Chairman, let me again commend this Committee's interest in fundamental tax reform and urge you to continue your investigation of economic gains from tax reform and how tax reform might be implemented.

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APPENDIX
DESIGNING A BROAD-BASED CONSUMPTION TAX

The discussion below reviews salient features of four consumption tax system: (1) a retail sales tax, (2) a value-added tax, (3) a two-tiered cash flow tax, and (4) a full-fledged personal cash flow tax. The first two systems collect revenue only from businesses, while the last two collect revenue from households and businesses. As broad-based consumption taxes, each is borne by consumption. While, under some conditions, these systems are roughly equivalent in their economic effects, they differ in their ease of administration and in their ability to achieve objectives for progressivity.

OPTIONS FOR A BROAD-BASED CONSUMPTION TAX

Taxes Collected from Businesses

Retail Sales Tax. Perhaps the most familiar "consumption tax" in the public imagination is the retail sales tax, in which tax is collected on businesses' sales of goods and services to households. Most states have retail sales taxes. As a broad-based consumption tax, a retail sales tax should exempt sales between businesses and tax all goods and services. Conventional state-level sales taxes are not broad-based consumption taxes because they generally do not apply to all forms of consumption (for example, food and health care expenditures and certain services). Only domestic consumers pay the retail sales tax, so that it taxes imports and exempts exports.

Two-Tiered Cash Flow Tax. The two-tiered cash flow tax involves two tax-collecting vehicles, a business tax and an individual compensation tax. The coordinated use of these two instruments allows one to tax consumption at different rates for different people.

Calculating the business tax base begins with value added (sales less purchases from other firms), as with value-added taxes. In a cash flow tax, payments to workers (for current, past, or future labor services) are deducted. Investment is expensed, so there are no depreciation allowances. Similarly, no interest is deductible. Firms then pay a flat rate of tax on the final amount, cash flow.

The base for the individual tax is the set of payments received by individuals for current, past, and future labor services. Capital income is not taxed. The rate of individual tax could be flat or graduated, and further progressivity can be incorporated by adding an exemption.

One popular variant, the Simple Flat Tax of Robert Hall and Alvin Rabushka, in which the business and individual tax share a common flat marginal rate, is related to a value-added tax. Under a value-added tax, payments for compensation are not deductible by businesses, but they are not taxed for individuals. Under the Simple Flat Tax, payments for compensation are deductible by businesses, but taxable for individuals. If the businesses and individual marginal rates are identical, the value-added tax and the simple flat tax are identical, if the flat tax has no individual exemption. This is not a coincidence, of course. It is a consequence of the fact that they are different ways of taxing the same base—personal consumption. Progressivity can be introduced by allowing an exemption. Other variants of the two-tiered cash flow tax can incorporate graduated marginal rates.

While "pure" two-tiered cash flow taxes do not embody deductions, it is possible to include

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[6] One can also make a principled argument for moving to a territorial tax system as part of fundamental income tax reform. See R. Glenn Hubbard, "U.S. Tax Policy and Foreign Direct Investment: Incentives, Problems, and Reform," In *Tax Policy and Economic Growth*, Washington, D.C.: American Council for Capital Formation, 1995.

certain deductions in a consistent manner. Because the objective is to design a consumption tax, allowing interest deductions would be inconsistent. However, deductions for state and local taxes or charitable contributions, if desired, are consistent with the approach. The costs of such deductions are additional complexity and the need for a higher rate of tax on the remaining tax base.

Full-Fledged Personal Cash-Flow Tax. A full-fledged cash flow tax (or "consumed income tax") would be collected solely from individuals. The tax base is a cash flow rather than the current accrued-income base. Individuals pay tax on reported cash flow less net saving. Because consumption equals the difference between income and net saving, the base of the personal cash flow tax is consumption. While saving is deductible, proceeds from borrowing, as a cash inflow, are included in the base to measure cash flow properly. A personal cash flow tax can incorporate a flat rate, an exemption and flat marginal rate, or an exemption and graduated marginal rates.

A full-fledged personal cash-flow tax allows elimination of the corporate income tax. With cash flow tax treatment, individual shareholders are permitted a deduction for the purchase of shares; dividends and the value of shares sold are included in taxable cash flow. Similar treatment is given to partnership and proprietorship organizations. Partners and proprietors pay tax on net cash flow; cash receipts are included in the base, and net contributions are deducted.

Under some circumstances, the personal consumption tax and the two-tiered cash flow tax discussed earlier are equivalent. If there were no exemptions and businesses and individual taxpayers pay tax at a uniform rate, the systems are equivalent. This equivalence assumes that all financial transactions are in the tax base.

One drawback of full-fledged personal cash flow taxes is administrative burden. For example, the government would have to monitor returns on savings deducted by taxpayers in the past. It is possible to limit this monitoring problem by requiring funds to be placed in qualified accounts (for example, accounts maintained by financial intermediaries or pension plans or closely held businesses). Dealing with fringe benefits is also more difficult in a personal consumption tax than in a two-tiered cash flow tax. On the one hand, under a personal consumption tax, a value of employee fringe benefits would have to be included in the employee's taxable cash flow. On the other hand, under a two-tiered cash flow tax, denial of a deduction at the entity level can replace the inclusion of fringe benefits in the individual tax base.

IMPLICATIONS FOR DESIGN OF A BROAD-BASED CONSUMPTION TAX

Goals

- Achieving the *efficiency* goal of moving to a consumption tax requires the selection of the broadest possible tax base: *A desirable system should not make it easy to have different rates of tax for different goods and services.*

- Achieving the *fairness* goal of moving to a consumption tax requires the ability to make the system progressive. Retail sales taxes and VATs alone are unlikely to be fair in this sense.

- Achieving the *simplicity* goal of moving to a consumption tax requires reduction in complexity (and rent-seeking activities) associated with the current income tax: *A desirable system should not extend information and monitoring requirements beyond those associated with the current in come tax (and, hopefully, would reduce them).*

Steps Toward Designing a Proposal

A two-tiered cash flow tax—such as the simple flat tax or a business transfer tax plus a wage tax—probably comes closest to achieving efficiency, fairness, and simplicity goals of the reform. Such a tax is also more likely to be politically acceptable than a uniform sales tax or value-added tax because progressivity can be maintained even under current rules for distributional analysis.

EXHIBIT 1
MOVING FROM THE CURRENT TAX SYSTEM TO A CONSUMPTION TAX

Steps 1-3: Integrate the tax system.

Step 1: End the double taxation of corporate equity returns.
Integrate the corporate and individual tax systems by excluding dividends from taxable income at the individual level (Treasury proposal) or by fully crediting taxes paid at the corporate level to recipients of dividends (American Law Institute proposal). Eliminate the capital gains tax on accumulated retained earnings.

Step 2: End the tax bias against equity finance in favor of debt finance.
Collect the tax on returns to debt at the entity level by disallowing business deductions for interest payments and removing interest receipts from taxable income at the individual level (Treasury proposal).

Step 3: Consolidate reporting of business income for tax purposes.
Report all business income on a single business tax form—including income currently reported from sole proprietorships, partnerships, rental property, and Subchapter S corporations (Treasury proposal). *Note:* Because we eliminated the corporate/noncorpor-ate business distinction in Step 1, all businesses can use the same tax form.

Steps 4-7: Broaden the base and lower the rates.

Step 4: Broaden the base of the business tax.
Eliminate any preferential tax provisions for particular industries and firms. Repeal the alternative minimum tax.

Step 5: Collect taxes on employee fringe benefits at the business level.
Disallow business deductions for expenditures on employee fringe benefits. Remove tax liability for such benefits from the individual tax.

Step 6: Broaden the base of the individual tax.
Eliminate all itemized deductions, the standard deduction, and any adjustments to gross income. Repeal the alternative minimum tax.

Step 7: Lower marginal tax rates on individuals and businesses.
Replace the graduated-rate individual tax system with a system with a single rate. Reduce the business tax rate to the same single rate as the individual tax rate. To maintain progressivity, retain and expand the generosity of the personal exemption. *Note:* A refundable individual tax credit could also be added for low-income households.

BOTTOM LINE: BROAD-BASED INCOME TAX REFORM

Steps 8-9: Move to a consumption tax.

Step 8: Replace accrual accounting for businesses with cash flow accounting.
Allow expensing for all purchases from other firms including purchases of capital assets.

Step 9: Shift from a residence-based tax system to a territorial tax system.
Remove foreign-source income from the U.S. tax base.

BOTTOM LINE: THE FLAT TAX (STYLIZED VERSION)

Chairman ARCHER. Thank you, Mr. Hubbard.

Our third witness this morning is no stranger to this Committee. You have worked with us for a period of several years. Alan Auerbach, now professor of tax policy at the University of California at Berkeley, welcome back to the Committee.

You may proceed.

STATEMENT OF ALAN J. AUERBACH, ROBERT D. BURCH PROFESSOR OF TAX POLICY AND PUBLIC FINANCE, UNIVERSITY OF CALIFORNIA, BERKELEY, CALIFORNIA

Mr. AUERBACH. Thank you very much.

Mr. Chairman and other Members of the Committee, few doubt the wisdom of seeking to reform the current income tax, both because it is rife with distortions and because of the complexities that frustrate honest taxpayers and, at the same time, facilitate avoidance by the opportunistic. But, of course, your task is to decide how to effect this reform and whether that reform should include replacement of the individual and corporate income taxes.

Contemplating replacement of the income tax is a challenge compared to which the past reform efforts, including those in the mideighties, seem simple and straightforward, but it is important to recognize that under a system such as ours that relies so heavily on voluntary compliance, a tax structure that loses favor among taxpayers cannot long be maintained.

In my written remarks, I address several questions having to do with the economics of tax reform. First, what are the most important defects of the current system? Second, what alternatives are available to the current tax system, and how would they address these defects? Third, what new problems arise under these reforms? Fourth, what transition problems would arise under a move to a new tax system, and how might we address these transition problems? Finally, what alternatives exist for reform within the current tax system?

As Glenn said, reform of the current system is something that ultimately may need to be considered, comparing the benefits of these reforms to the benefits of replacing the income tax with an alternative tax system. In my comments here, I will simply summarize the conclusions in my written testimony.

First, in order to focus one's thinking, among the myriad distortions present in the current income tax—and we could be here forever if we tried to enumerate them—the three of greatest significance are those that discourage work, discourage saving, and distort the allocation of capital from nonresidential uses to residential uses.

Currently, both the labor supply decision and the saving decision face a significant marginal tax rate which discourages those activities, while residential investment, which is about one-half of the Nation's capital stock, is taxed much more lightly.

Second, a shift to a broad-based consumption tax would reduce two of these distortions, that affecting the taxation of saving and that causing a misallocation of capital between residential and nonresidential uses. However, it would not necessarily alleviate the distortion facing the labor supply decision, even if we were not to tax labor income directly, because the tax on consumption, by re-

ducing the purchasing power of income, would have the same effect as taxing labor directly and would, therefore, discourage work. The extent to which it would discourage work would depend on the rate, about which I will say more shortly.

Third, a consumption tax can be achieved in many ways. It can be achieved by taxing sales, by taxing value added, or as an individual consumption tax. These tax systems are a lot more similar than they may first appear, although they can differ in the extent to which they can accommodate certain specific features; for example, progressivity. A sales tax or value-added tax, as practiced by the United States and in European countries, typically attempts to achieve some progressivity by exempting commodities or certain taxpayers, which tends to make the system a lot more complicated. A flat tax, by shifting the burden of labor taxes to workers, can allow personal exemptions and a standard deduction to get progressivity.

Fourth, consumption taxes improve international competitiveness primarily to the extent that they increase national saving. Border adjustment should not be seen as a major part of that process in a world of flexible exchange rates.

Fifth, while I do find that significant gains in economic efficiency and production can occur under a move to consumption tax, close evaluation of these results suggest that a large part of this gain would be diminished if we tried to provide very generous transition relief for existing assets and, at the same time, tried to maintain a degree of progressivity comparable to that under the current income tax.

Thus, taking progressivity and taking transition relief into account, it may very well turn out that what may appear in the long run to be an attractive system—a consumption tax—it may be very difficult to get to, and that under the current income tax system, there are alternatives that can help in alleviating the same three major distortions that I mentioned before.

Therefore, it is really up to you, and it is a matter of politics rather than economics, to decide whether it is easier or more feasible to move to a new system to try to attack these distortions rather than trying to work within the current system.

Thank you very much.

[The prepared statement follows:]

Replacing the Federal Income Tax: Economic Considerations

Testimony before the Committee on Ways and Means, U.S. House of Representatives

by

Alan J. Auerbach
Robert D. Burch Professor of Tax Policy and Public Finance
University of California, Berkeley

March 27, 1996

Mr. Chairman and Members of the Committee:

I am grateful for the invitation to give my views on the economic effects of replacing the federal income tax as this country's major source of revenue.

Few doubt the wisdom of seeking to reform the current income tax, as it is rife with distortions that waste resources and complexities that frustrate the honest taxpayer and facilitate avoidance by the opportunistic. It is your task to determine *how* to effect reform. If the income tax is to be repealed, what should take its place and how should the transition be structured? Alternatively, if it is better to restructure the income tax that to repeal it, what are the most important improvements to make? Yours is a challenge compared to which the arduous tax reform efforts of the past seem simple and straightforward. But under a system that relies so much on voluntary compliance, a tax structure that has lost favor among many taxpayers cannot long survive.

In my testimony, I will address several questions related to the economics of tax reform:

1. What are the most important defects of the current federal income tax?

2. What alternatives are available to the current tax system, and how would they address these defects?

3. What new problems would arise under alternative reforms?

4. What transition problems would arise if we adopted a new system, and how might these be addressed?

5. What alternatives for reform exist within the current tax system, and how would the benefits of these reforms compare to the benefits from replacing the income tax with an alternative system?

Let me begin by summarizing my conclusions:

1. Among the myriad distortions present in the current income tax, the three of greatest economic significance are those that discourage work, discourage saving, and distort the allocation of capital from nonresidential to residential uses.

2. A shift to broad-based consumption-based taxation would reduce two of these distortions, encouraging saving and improving the allocation of capital. It would not necessarily lessen distortions in the labor market.

3. A consumption tax may be achieved by taxing sales, value added, or individual consumption expenditures. These approaches are fundamentally equivalent, although they differ in the extent to which they can accommodate a progressive tax structure. For example, a flat tax is a progressive variant of a subtraction-method value-added tax.

4. Consumption taxes will improve international competitiveness to the extent that they increase national saving. Border adjustments do not play a significant role in this process and should not be viewed as an economic benefit of shifting to consumption taxation.

5. Adoption of a consumption tax will raise taxes on previously accumulated wealth and reduce the relative value of previously tax-favored assets. However, providing generous transition relief can eliminate much of the gain in economic efficiency from the reform, as the relief will require higher tax rates in the future that will worsen the distortion of labor supply permanently. A consumption tax reform that maintains a reasonable degree of progressivity and provides generous transition relief may well *reduce* economic efficiency.

6. It is possible to encourage work and saving and improve the allocation of capital within the present tax system. It is within the realm of politics, rather than economics, to determine whether such changes are more or less feasible than the adoption of an entirely new tax system.

Distortions of the Current Income Tax

The income tax distorts behavior by altering the relative economic benefits from engaging in different activities. Decisions about whether to enter the labor force, whether to save for retirement or education, or whether to invest in corporate equity or an apartment building, are all influenced by the income tax. Taxpayers are encouraged to choose less productive alternatives in order to lessen their tax burdens. The income tax reduces economic efficiency further to the extent that it requires that government or private resources be devoted to compliance, administration and enforcement rather than to productive uses. A more efficient tax system is surely feasible, but the most efficient tax system -- a "lump sum" or head tax on each individual -- is widely viewed as inequitably regressive. The challenge is to find a more realistic tax system that also reduces the existing distortions.

There are so many distortions in the current tax system that, if this committee were to devote a day's hearing to each one, few current members would still be around at the completion of the hearings (even without the enactment of term limits). But counting the number of distortions isn't particularly worthwhile; it is their overall magnitude that matters. In a recent evaluation of the combined effect of the federal taxes on individual and corporate income[1], I concluded that the most significant economic distortions are those affecting labor supply, saving, and the allocation of capital between residential and nonresidential uses. The economic significance of each distortion relates not only to the scale of the activity involved, but also to the marginal income tax rate it faces; the marginal tax rate indicates how large the gap is between what an activity produces and what a taxpayer keeps. The larger the gap, the less attractive the activity becomes. The average marginal federal tax rate on labor income is now approximately 24 percent (without taking into account the additional payroll taxes of the Social Security system). The average marginal tax rate on the return to saving in nonresidential assets is about 26 percent, and the tax rate on the income from investments in housing is close to zero. Thus, taxpayers are discouraged from working, discouraged from saving, and particularly discouraged from investing in assets other than housing.

Consumption Taxation as An Alternative

Many argue that a consumption tax would provide a less distortionary tax system than the present one. As I discuss below, a consumption tax effectively would eliminate the federal marginal tax rate on nonresidential investment, thus wiping out two of the three distortions just identified. Taxpayer choice would no longer be tilted toward residential investment, nor would the tax system discourage saving overall. But, although this might not be immediately obvious, the distortion of labor supply would remain, even with the elimination of any direct tax on labor income. This is because taxing consumption reduces the purchasing power of income in the same manner that a direct income tax would.

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[1] "Tax Reform, Capital Allocation, Efficiency and Growth," presented to the Brookings Conference on Fundamental Tax Reform, February 15-16, 1996; revised March 21, 1996.

The magnitude of the labor supply distortion would depend on the breadth of the consumption tax base; the broader the base, the lower the rate and hence the distortion. Two factors contribute to a narrowing of the base and a worsening of the labor supply distortion: progressivity (reducing the tax burden on consumption by poorer individuals) and transition relief (reducing the tax burden on consumption by owners of certain assets). This does not mean that progressivity and transition relief are bad, but simply that they come at a cost for which account must be taken.

Approaches to Consumption Taxation

There are several different approaches to taxing consumption. Whether these taxes are collected from households or businesses, whether they are imposed on consumption directly or only indirectly, however, all approaches are basically equivalent in underlying structure and economic impact. The economic effects of one consumption tax will be similar to those of another, with differences introduced only to the extent that one consumption tax base is broader than another, or has a different rate of tax.

The most commonly discussed method of taxing consumption is through a national sales tax, similar in form to the sales taxes currently imposed by states but extended to cover services as well. To ensure that such a tax falls only on consumption, it would be necessary not to collect any tax on the sales of investment goods to businesses.

Like a sales tax, a value-added tax (VAT) imposed on businesses could also be used to implement a tax on consumption. Because of the national income identity that equates income and production, taxing all value added at each stage of domestic production produces a tax on all domestic income -- an *origin-based* income tax. To convert this to a tax on consumption, it is necessary only to alleviate the tax on the income that is not consumed -- on investment goods (most easily through a deduction for those who purchase them) and on exports -- and to include in the tax base the consumption that does not arise from domestic production -- imports. The result is a *destination-based* consumption tax with the same tax base and economic effects as those of a national sales tax.

While both the sales tax and the VAT are collected from businesses, it is also possible to tax consumption by individuals, not by keeping track of their consumption directly, but by taxing them on income and providing a deduction for all income that is saved and not consumed. If assessed at a single rate, such a personal consumption tax would have the same base as the sales tax and the VAT. The flat tax, as proposed by Representative Armey, is a final approach to consumption taxation that adopts a hybrid approach of collecting part of the tax from businesses and part from individuals. It differs from the VAT by collecting the tax on wages from individuals rather than from businesses.

The flat tax differs from a VAT in two other respects. First, it has no border adjustments -- it is an origin-based tax. Second, it is progressive, in that the tax on wages is reduced by personal exemptions and a standard deduction, as under the present income tax. Indeed, this is one of the attractions of the flat tax, as providing progressivity at the personal level in this manner is simpler and less distortionary than by exempting basic commodities, the approach taken under existing VATs in Europe and under many state sales taxes. However, neither of these differences alters the conclusion that the flat tax *is* a value added tax on consumption. One may like or dislike its lack of border adjustments or its progressivity but, for better or for worse, the flat tax is no less a consumption tax than is a national sales tax or a destination-based VAT.

Consumption Taxes and Competitiveness

Because so much of the support for consumption taxes is associated with the perceived impact on international competitiveness, it is important to clarify the extent to which adopting a consumption tax would encourage U.S. exports or otherwise improve our competitive position. The point can be put quite bluntly: a consumption tax promotes competitiveness through its impact on national saving and income, not through border adjustments. Thus, the distinction between a destination-based consumption tax, such as a national sales tax or VAT, and an origin-

based consumption tax, such as a flat tax, is of little consequence: both types of consumption taxes promote competitiveness by promoting saving.

The intuition that border adjustments promote exports and discourage imports ignores the fact that the exchange rate, like other prices, is free to move in response to demand and supply. If the foreign exchange market is in equilibrium without border adjustments, then it will be driven out of equilibrium if border adjustments are imposed, with the relative cheapness of U.S. goods stimulating demand for dollars and causing the exchange rate to appreciate. Once this appreciation occurs, the economy will essentially be back where it started, with U.S. goods no cheaper to foreigners, foreign goods no more expensive to U.S. residents, and no change in the trade imbalance.

Why can't border adjustments induce a change in the trade balance? The answer is that the trade balance is basically a residual, the difference between what we, as a nation, produce and what we consume (privately and publicly) and invest. If we don't change the level of government purchases, and don't wish to reduce domestic investment, then we can improve our trade balance only by raising income or increasing saving. Income, in turn can increase only if we raise the level of productive inputs of capital, labor and technology or utilize these inputs more efficiently. Saving can contribute to increased capital formation, and a less distortionary tax system might also contribute to increased labor supply and technological innovation and the efficient use of capital, labor and technology. Thus, adopting a consumption tax might well spur competitiveness, but not through border adjustments.

Aside from having no direct influence on competitiveness, border adjustments actually would cost the United States revenue over the long run. For a country that is a net debtor, as the United States has become in recent years, an origin-based VAT will raise more revenue in the long run by denying border adjustments for the future trade surpluses needed to service our foreign debt.

Efficiency Gains, Transition Relief and Progressivity

Adopting a consumption tax can contribute significantly to increasing the level of national saving and production. For example, my own estimates are that immediate adoption of a broad-based national sales or value-added tax, with no transition relief and no progressivity, could raise output by perhaps 6 percent within ten years and 9 percent in the long run, as the result not only of increased saving but also a reduction in the effective marginal tax rate on labor supply.[2] However, leaving aside questions concerning implementation and administration, this result hinges crucially on the lack of any progressivity or transition relief under the new tax system.

Under a national sales tax or a broad-based VAT, each household's tax burden would be in fixed proportion to its consumption. Because consumption falls with income, it is customary to refer to such a tax as regressive -- its burden falls as a share of income as income rises. In recent years, many economists have come to challenge annual income as an accurate measure of one's ability to pay, because much of the observed variation in income is temporary or related to life-cycle factors. This critique implies that consumption, or at least some longer run measure of family income, is a more accurate measure of a family's taxpaying capacity. If this is true, a proportional consumption tax is not as regressive as has traditionally been thought. Still, by any measure, it is considerably less progressive than the current income tax. This has led to the formulation of consumption tax alternatives that provide at least some level of progressivity at the low end of the income distribution, such as the flat tax, or that try to replicate the current level of progressivity at all income levels, such as the Domenici-Nunn "USA" tax system, which combines a VAT and a progressive individual consumption tax. Based on my simulation results, reintroducing progressivity back into the tax system, as under current flat tax proposals, would raise the average marginal tax rate on labor supply by 4 to 8 percentage points and reduce the potential increase in output roughly in half, to between 2 and 4 percent after 10 years.

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[2] "Tax Reform, Capital Allocation, Efficiency and Growth," Op. Cit., Table 4.

The economic benefits of a shift to consumption taxation also hinge on the absence of transition relief. As many have pointed out, a consumption tax may impose a higher burden on taxpayers, particularly older individuals, who have accumulated assets in order to finance future consumption. This is because they will be taxed on all consumption financed by these assets, not just the additional income the assets generate. The losses to such taxpayers would be at least partially offset by increases in asset values that a consumption tax might generate through a boom in saving and asset demand. Still, there may be considerable pressure to provide transition relief. Under a value-added tax, for example, newly purchased investment goods qualify for immediate expensing, while existing capital receives no depreciation deductions at all. Owners of existing assets might well lobby for a continuation of depreciation allowances on these existing assets. Similarly, under an individual consumption tax, there are bound to be objections to the provision that treats existing assets as having zero basis, regardless of what their basis was under the prior income tax.

While the arguments may seem compelling, adding full transition relief for existing assets would drive output gains, and overall gains in economic efficiency, close to zero.[3] Even though national saving would still rise under the shift to consumption taxation, the higher marginal tax rates on labor supply needed to pay for transition relief and progressivity together would essentially offset these gains with the losses from a more distorted labor market.

In addition to overall effects on asset values, a shift to consumption taxation would also induce a shift in *relative* asset values, with previously tax-favored assets, such as housing and municipal bonds, suffering considerable declines in value even as other assets, notably corporate equity, fared relatively well. While the interest rate would fall, it probably would not drop by enough to offset the increased cost of home-ownership produced by the elimination of the deductions for mortgage interest and property taxes. These capital losses might well call forth further provisions such as a continuation of the mortgage interest deduction. Again, the revenue cost of such provisions would have to be offset by an increase in marginal tax rates, further reducing the economic gains from adopting a consumption tax.

In summary, while the exact magnitudes of gains and losses would depend on the degree of progressivity and the extent of transition relief included in any proposal, the message is clear: to achieve significant economic benefits from a shift to a consumption tax, we must accept either a decline in tax progressivity or a limit on the relief given to existing assets. If neither of these conditions is met, then a consumption tax, no matter how attractive in the abstract, will not improve economic efficiency or increase output when implemented.

Searching for Other Alternatives

Above, I argued that there are three major distortions in the current income tax, with respect to decisions regarding work, saving, and the allocation of capital between residential and nonresidential uses. Adopting a consumption tax would eliminate two of these distortions but, under realistic assumptions, make the remaining distortion worse and leave us with little overall gain in economic efficiency. But there are other ways to attack these distortions, without necessarily inducing adverse distributional effects. Without attempting to be comprehensive, I will offer one example of the type of reform that might be considered.

In 1993, the top marginal tax rate on high income individuals was raised, with the introduction of the 36% and 39.6% brackets. One year later, the marginal income tax rate on the labor income of roughly the same group of individuals rose by an additional 2.9 percentage points as a result of the uncapping of the Medicare payroll tax. While these changes clearly made the tax system more progressive, they did so at the cost of a considerable increase in the distortion of the labor supply of affected individuals, and an increased incentive for them to seek compensation in sheltered forms. By scaling back these tax increases, and making up the lost

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[3] Ibid. This result holds both for a flat tax that maintains depreciation deductions and the Domenici-Nunn USA tax, which provides this transition relief for depreciation deductions and preserves basis under its individual consumption tax.

revenue through cutbacks in residential tax expenditures benefitting the same general group of taxpayers (for example, by capping the deductions for mortgage interest and local property taxes at levels that would affect only the affluent), you would simultaneously lessen the labor supply distortion, the distortion in favor of residential investment and (by discouraging borrowing) the bias against saving without altering the general progressivity of the tax system.

Finally, there are other reforms that, while not as specifically directed at the three major distortions emphasized here, would work to lessen other distortions that help contribute to the overall mess that is today's tax system. Here, there are too many options to be enumerated, except for one illustrative example. Imagine a tax package that raised excise taxes on commodities that cause demonstrated social damage (such as tobacco, alcohol and gasoline), eliminated the tax benefits on certain employer-provided fringe benefits, and used the revenues so generated to reduce marginal income tax rates in a distributionally neutral manner. Such sweeping changes may begin to appear more realistic when the chief alternative is replacing the income tax with an entirely new tax system.

Conclusions

In evaluating the current income tax, it is important not to use an unrealistic alternative as a standard of comparison. Moving without transition relief to a broad-based, low-rate national consumption tax would enhance economic efficiency, but these economic gains would not necessarily accompany a more measured transition to a progressive consumption tax. In light of this, more modest improvements in the income tax itself take on more appeal, and deserve serious consideration.

Chairman ARCHER. Thank you, Mr. Auerbach, and I thank all three of you for, I think, some very constructive testimony.

I am sure that a lot of this will be developed in greater detail during the question-and-answer period.

I would like to ask you just a couple of preliminary questions to start this round. Do economists place any economic value on freedom and privacy? Would any one of you or all three of you like to respond to that?

Mr. JORGENSON. I would respond to that by saying that one of the fundamental principles under which we conduct our business professionally is the idea of consumer sovereignty. Translated into plain English, that certainly is a principle of individual freedom and privacy. So that certainly is a fundamental value.

Chairman ARCHER. Mr. Hubbard.

Mr. HUBBARD. I would agree with that, although in point of fact, most of the models that are reported to you don't really distinguish among freedom and privacy differences in these alternative forms of consumption taxes.

Chairman ARCHER. Mr. Auerbach.

Mr. AUERBACH. I would say that economists by their nature place a lot of weight on those factors as individuals, but I don't think it plays an important role in our economic analysis.

Chairman ARCHER. It is very difficult to quantify, in any event, and I would expect that the computer models and the analyses really do not place a dollar value on it, but it is very interesting that when we had witnesses before this Committee in our previous hearing, I asked them how much they would pay annually not to have any interface personally with the IRS every year. The minimum response was what it cost them to pay their preparer to prepare their return. The most fascinating response was from one woman who said she would give her first-born child.

Obviously, the weight that individual Americans attach to removing the IRS from their individual lives, completely and totally, is different from one person to another, but it is significant for everyone, and yet, it does not show up in any of these computer models.

Does it show up as an increase in economic activity and productivity when we have released some of the brightest minds in this country who are currently spending full time dealing with the tax system? Does that show up in the computer models?

Mr. JORGENSON. It certainly doesn't, Mr. Chairman, and you are on to a very important point here.

You received testimony last year in great detail on both the issue of the cost of compliance and the enforcement costs that are involved in collecting a tax.

A retail sales tax, which you have often advocated, involves 10 million retail establishments. Whereas, anything involving something like the income tax, for example, a substraction-basis VAT which would be administered by an income tax-like return, is going to involve every family in the country, plus every business. So there is no doubt that there is a very, very significant difference in terms of the people who are involved and the costs that are imposed on them associated with these different proposals, and that

is certainly something to be taken into account in the final reckoning.

Chairman ARCHER. Thank you very much.

Mr. Gibbons.

[No response.]

Chairman ARCHER. We will hold Mr. Gibbons for a moment.

Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman.

I have just one question about the consumption tax, and I would address it to all of you, and that is how we deal with the impact that it could have on the working poor.

Mr. AUERBACH. As I mentioned in my comments, a retail sales tax or a European-style value-added tax attempts to deal with it either through the transfer system, that is, not through the tax system at all, or by exempting commodities such as food or certain necessities.

I think the general consensus is that is a fairly inefficient way of achieving help for the poor because most of the expenditures made on these items aren't made by poor people. So there is a lot of leakage.

For that, a system such as a flat tax, which is a consumption tax, but which has an individual tax component, makes taking care of the poor easier because it would allow provisions such as an earned income credit or personal exemptions and a standard deduction, that are present now to be maintained, to provide the same relief as is provided under the current system.

Mr. CRANE. Would it not go beyond just food? I mean, that you would have to exempt medical expenses, would that be fair to include?

Mr. AUERBACH. If you were trying to do it under a retail sales tax or under a value-added tax, it would be up to you to decide how to do it, but, ultimately, it wouldn't be targeted assistance for the poor because for medical expenditures, food, or any item you choose, although the poor may benefit, so will the rest of the population.

Mr. CRANE. That was the question in my mind. How do you separate the extension of the benefit between, say, people who are in the wealthy category and those who are truly needy that are working and not on welfare?

Mr. AUERBACH. Ultimately, if you want to target it toward individuals, it has to be an individual-based system, not a commodity-based system, and it can be a hybrid. You can have part of the tax system based on sales and commodities as a value-added tax or a sales tax, and then you could have elements of the system which would be based on the individual taxpayer and, therefore, could be tailored toward the individual's ability to pay.

Mr. JORGENSON. I think there is a point here that you have alluded to that is worth a little bit more consideration.

Take, for example, the case of medical care, the case you cited. You are going to hear many, many arguments about exempting medical care, but think about the alternative.

Under the income tax, medical providers pay income taxes. Doctors pay income taxes. Nurses pay income taxes. All of the people who work in the health care industry pay income taxes.

Therefore, there would be a very powerful argument, it seems to me, on equity grounds for people who are receiving these services versus people who aren't of essentially substituting for the income taxes paid by the providers, some kind of sales tax or value-added tax, and I think that is a fundamental point that can be extended further.

That applies to all nonprofit institutions, the people who are employed by those institutions. The expenses that they incur in providing their services are all now covered by the income tax and, therefore, should be covered by some kind of sales or consumption tax.

It is, therefore, very, very important to have an all-inclusive consumption tax base.

Mr. HUBBARD. The simple answer to your question is that the flat tax really does offer you a chance to maintain the progressivity you have at the low-income levels. Use of exemptions, even refundable tax credits are possible.

When you try to exempt certain commodities, you run into the problems that Alan Auerbach and Dale Jorgenson alluded to of having a very loose and leaky system.

Mr. CRANE. Is it possible that you could have some kind of a refund in effect to people in that category at the end of each year?

Mr. JORGENSON. One idea that has been proposed, and you are going to hear it again, is the idea of a "demigrant." The whole idea is to avoid having an exemption or a refund that depends on people's specific behavior. You want to avoid the distortions. That was Glenn's point in his testimony. Therefore, you could have a system of demigrants that would be given uniformly across the population. That would obviously affect the poor, including the working poor, more than in proportion to their consumption and more than in proportion to their income. So that is an alternative approach that avoids building that into the tax base, which I think inevitably would cause distortions.

Mr. CRANE. Thank you. My time has expired.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. I think I will pass at this time, Mr. Chairman.

Chairman ARCHER. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

At some point, Mr. Jorgenson, I thought in response to Mr. Crane's question that you had suggested the earned income tax credit as a possible way to cushion the impact on the working poor. Other suggestions that were not in the testimony, but given as an afterthought to Mr. Crane's question, it would manipulate or put variances in there so that the working poor would be cushioned, which to me is you get out of the flat tax.

Mr. Jorgenson, if we decided just how much relief we are prepared to give to the working poor, would that not ultimately end up with a minimum wage standard?

Mr. JORGENSON. No. I think the minimum wage standard is something quite different. It really affects an hourly figure that would apply to part-time workers.

Mr. RANGEL. Strike that out. Strike that out.

At what basis would you determine the earned income tax credit should level off?

Mr. JORGENSON. My preference would be to treat this, as Alan Auerbach just said, as a transfer program.

Mr. RANGEL. But you mention an earned income tax credit in your testimony. So I just was figuring, since we want the free marketplace to work its will——

Mr. JORGENSON. Right.

Mr. RANGEL [continuing]. Then how are you going to do that? All of you agree you have to make exceptions for the poor, and somebody is going to have to determine who is poor, at what level are we talking about, and at what income group. I don't want to say "income" or any word that you economists can grab on to, but I am talking about disposable income. Do you say that is enough for those people?

Mr. JORGENSON. Mr. Rangel, we have a federally defined standard of poverty that is used in compiling our poverty figures that are routinely published by this Committee, and that would give us the standard to work from.

Mr. RANGEL. The working poor are above the poverty line. We have the earned income tax credit to take them up to the poverty line. Obviously, where we find poorer people who are not wealthy, consuming more of their disposable income than people who have a larger amount of income, you have to give relief beyond poverty.

I am only attacking what you people give with such ease. This is an economist delight, but it is a politician's nightmare. At what point do we determine as lawmakers what relief should be given to those people who cannot protect themselves against this free market.

Mr. HUBBARD. The principal point, I think, Mr. Rangel, is that whatever progressivity you deem desirable, you could accomplish under either the current system or under something like the flat tax. That doesn't diminish the significance of the measurement questions you asked.

Mr. RANGEL. How would you do it? Just tell me how you would do it.

Mr. HUBBARD. You could do it by any of the means that were suggested. You could have a refundable credit, a demigrant, or a special transfer program. All the tools that are open to you currently, you would still have. That doesn't diminish your measurement questions, but the same issues arise under either the income tax or the consumption tax.

Mr. RANGEL. Someone mentioned the fact that this would eliminate the local and State income tax system and corporate system as we know it because if they were to do it, they would piggyback on this consumption tax or whatever you want to call it.

They would determine the rates of their own consumption tax, right?

Mr. JORGENSON. That is right.

Mr. RANGEL. So, while the other system piggybacks in our income tax system, any one of our local or State governments could distort the national system, in my opinion, by how far they are prepared to decide what services they want to render and how high they want their consumption tax.

So, unless we wipe them out completely, under today's system, we can deduct whatever they pay to the city and State. Under this system, there would be no deductions. Is that correct?

Mr. JORGENSON. Let's just focus on the rates involved. We are talking about a 15-percent consumption tax rate including State and local taxes. That is a very, very low rate. That would be the average across the——

Mr. RANGEL. How do you include the State and local tax in determining what the Federal taxes are going to be?

Mr. JORGENSON. By taking all of the receipts from State and local income taxes, along with Federal income taxes at both the individual and the corporate level, and asking the question, What would it cost to maintain the existing level of government services at the Federal, the State, and local levels?

Mr. RANGEL. That doesn't work. That doesn't work.

In New York State and California, we are so way ahead of the rest of the States in what we thought it would take in local and State taxes, and indeed, we are now going backward.

Are you saying that once we decide what the Federal tax is going to be that the city and States are stuck with that?

Mr. JORGENSON. No. I am saying that the cities and States, as they do now, would have to raise the same amount of money that they do under the income tax to fund these programs, but the governments involved would have to pay a lot less.

Why? Because the providers are no longer subject to the income tax. All of the people who are working for these State and local governments, all of the agencies that they depend on would no longer be subject to the income tax, and that being the case, the prices that these governments would have to pay to maintain their services would be radically reduced. That is where you arrive at the 15 percent.

Mr. RANGEL. Isn't it true, Dr. Jorgenson, that while they may no longer have to pay the income tax that, indeed, they would not be able to enjoy the present deductions which lowers their tax?

Mr. JORGENSON. That is exactly how we get to the 15 percent, Mr. Rangel. We eliminate all of the deductions. We have a totally comprehensive tax base and a very low rate, and that is reinforced by the fact that the governments, Federal, State, and local would be paying much lower prices for the services that they provide to the public than they are now because the providers are not subject to the tax.

Mr. RANGEL. Then, that would be a reduction in salary and wages, right?

Mr. JORGENSON. Precisely, exactly.

Mr. RANGEL. Who is going to be around here to make that determination?

Mr. JORGENSON. I hope you are, Mr. Rangel. I certainly hope you will be.

Chairman ARCHER. The gentleman's time has long since expired.

Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman, and I want to thank all of you for your testimony.

I have a question regarding those who are maybe newly entering the business world as small businessowners or young family farm-

ers who may have a high level of debt because they are just getting their businesses or their farms off the ground, and obviously, the current tax system gives them deductions, existing deductions in order to borrow at high levels.

In your opinions, and any of you can answer if you choose to, what would a consumption tax do to those newly entering the business or agricultural world, compared to already existing, established businesses?

Mr. HUBBARD. You referred to the loss of the interest deduction which clearly would not be a plus for those businesses. Offsetting that are two points. First, expense, write off capital goods as they are purchased rather than depreciating them. Second, pretax interest rates should come down in response to the introduction of the consumption tax. In the short run, it would still be true that small businesses or any business that had done a lot of financing with debt would lose.

Mr. JORGENSON. I would like to respond to that because I think it is a fundamental point, and that is, you must focus on the idea that the suppliers of capital, people who lend money or who provide it in the form of equity, are no longer going to be subject to tax.

Think about a mortgage lender or, relevant to your point, think about a banker. These people are no longer going to be subject to taxes on their capital income. They are going to be able to provide financing for small businesses and small farms on the same terms that people who are providing tax-free financing to municipal governments are doing at present because the treatment will be the same.

Furthermore, most of the accumulation of capital for small businesses, including small farms, is from retained earnings in equity. That will no longer be subject to tax. That is the implication of substituting a consumption tax for an income tax. Neither debt nor equity income will be subject to tax; only consumption.

Mr. CAMP. Thank you.

I appreciate the answers. There have been some differences on how much economic growth potential might come out of changing our current tax system, and I think there are slight differences in your projections, the three of you.

Can you explain to me why those differences might be there?

Mr. JORGENSON. Let me try that and then give Alan Auerbach a chance to respond.

Looking over our two sets of testimony, the main difference is not in the level of the impact in the long run. It is about 9 or 10 percent. That is toward the upper end of his impact calculations, but it is right on the center of mine. So there is no disagreement.

The big disagreement is on the short-run impact, what would happen next year, what would happen the following year, and so on.

The big difference between our calculations came out in his testimony, which was that he assumes that eliminating the income tax and imposing a consumption tax would leave the labor supply decision unaffected.

I disagree with that, with all due respect to my former collaborator and colleague, and the reason that I disagree is that the aver-

age marginal rate on labor income in this country is now around 28 percent.

The consumption tax, as I said before, that would have to be imposed is about 15 percent. In other words, there is a substantial increase in the incentive to supply labor. That, in a nutshell, is responsible for the differences.

Mr. AUERBACH. I think I would modify that only slightly to say that I think even at best there is a relatively small increase in the incentive to supply labor based on the parameters and the data that I use in my simulations.

I also think it is important to keep in mind, however, that a lot of the juice from apparent increases in the incentive to supply labor and reductions in marginal tax rates comes from a sharp decline in progressivity in the tax system. While that might be appropriate, there is an economic tradeoff here, and it is something that shouldn't be seen as a costless gain.

Mr. HUBBARD. If I could just add one thing, the sense in which short-run differences may not be innocuous is that transition issues matter. If you try to mitigate transition costs for everyone in the tax system, you will ultimately have to have a much larger, at least somewhat larger rate and lose some of your gain. So the two are somewhat connected.

Mr. CAMP. Thank you very much.

Chairman ARCHER. Mr. Hayes.

Mr. HAYES. Thank you.

I was looking at your start, Mr. Auerbach. In your testimony, one of the things I noticed in regard to border adjustments——

Mr. AUERBACH. Yes.

Mr. HAYES [continuing]. Was the statement that you made, which I think is correct if you think of it only in terms of a generic statement, about border adjustments can't change trade balance because the balance is basically residual, the difference between what we as a nation produce and consume, but it doesn't think in terms of individual industries. In other words, it talks about having a market of currency markets reacting back, but they don't react to a generic question, and they are too small on individual winners and losers to react if you pick, for example, petrochemicals and move an individual entity that can pick up gigantically through those adjustments.

So my question to you is, I don't disagree with your statement, but doesn't it, in effect, weigh both winners and losers and reach a conclusion without identifying who wins and who loses because you certainly can't adjust currency, item at a time, day by day, based on individual industries being treated differently than the whole?

Mr. AUERBACH. Perhaps I am not understanding your argument, but my point is that if we think of the difference between an origin base or a tax without border adjustments and a destination-based tax, that is, one with border adjustments, a movement in the exchange rate can offset entirely all changes in the cheapness of American goods or the higher price of foreign goods, and that will happen across the board.

That is, if we put in a 10-percent border adjustment and the exchange rate appreciated by 10 percent, then from every industry's

point of view, both American industries trying to export or competing against imports and foreign industries trying to sell in the United States, the relative price of American goods and foreign goods will be exactly the same as it was before. That will be true across industries.

So, unless I am missing something, I think I would disagree with you and say that there really won't be any effect across industries.

Mr. HAYES. The point I am making is that that is a generic statement, taking the whole. In other words, when you are looking at an interest rate, you are looking at its impact on the country under current tax law. Fine. That interest rate moves here and there, but if you start dividing it by individual entities, you are going to find where an interest rate move had a big difference on activity A versus activity Z.

The point I am making is that there will still be a substantial number of those who are able to take the border adjustment rate and dramatically improve their level of sales, and what we ought to be doing is looking at who those winners and losers are then determining our national interest from it.

Mr. AUERBACH. There is a big difference between this and the effect of an interest rate change, which really is going to affect different entities differently.

Mr. HAYES. No, no. I am using it as an example.

Mr. AUERBACH. But it is not an applicable example because, in the case of an exchange rate change, what matters to importers and exporters is a real exchange rate; that is, taking account of the taxes as well as the underlying price of the goods, what a foreign good costs, what a domestic good costs.

Putting in a border adjustment alters that relative price by alleviating the tax of domestic goods, and it does this proportionately under a uniform sales tax.

Having an exchange rate readjustment in response to that completely undoes it. The only circumstance in which I would agree with you is if the sales tax or the value-added tax were not applied in a proportional way; if it applied to some industries and not others.

A uniform value-added tax with border adjustment accompanied by a revaluation of the exchange rate will be completely offsetting and not have any effect on the relative competitiveness of different industries.

Mr. JORGENSON. Mr. Hayes, I would like to agree with you, and I would like to direct your attention to the last chart where I give the individual industry results. That is what you are looking for, and there it is.

What you will notice here is that in the long run, in fact, even in the short run, the industries that are adversely affected are those in which we have a major amount of imports, and those that are stimulated by a consumption tax are those in which we have leadership in exports.

So, even though I agree with Alan Auerbach that there will be essentially no net effect on the trade balance, there will be differential impacts on industries, and you can see them in this table. I agree with you that that is highly relevant especially in view of the fact that this Committee is going to be holding hearings in April

that deal with the circumstances of particular producers in particular industries.

Mr. HUBBARD. I strongly suspect that these differences probably relate to other aspects of the consumption tax rather than the border adjustment. An example would be differences in capital intensity. I don't think the border adjustments, per se, could be accounting for this.

Mr. HAYES. Gentlemen, thank you, and thank you for your indulgence, Mr. Chairman.

Chairman ARCHER. Let me just briefly jump in and piggyback on this issue. It is interesting that economists come down on the side that border adjustability makes no difference, because the surveys that have been run recently with foreign corporations report that up to 80 percent of them would build factories in the United States if we eliminated the income tax and went to a consumption tax.

So, in the real economic world, there are a lot of people who believe it will assist them competitively to build factories and to export from the United States of America. I mean, that is just a reality in today's world. Even though in the long term, the argument can be made, economically, that the monetary exchanges adjust to this. Certainly you can respond to this, but before you respond, let me add one other thing, and you can include this in your responses.

If, in fact, this economic theory works in practice, then the cost of government is basically no different than the cost of doing business in many, many other areas. It is an administrative cost. It is an economic cost that must be paid, and the price of the product, and I think you have alluded to this, Mr. Jorgenson, ultimately has to include that. It is a cost of doing business, just as much as hiring an accountant or any other administrative cost of doing business. Labor is also a cost of doing business, which must factor through into the price of products.

If this theory is accurate, why do we have any concern about countries that have lower wage rates than we do, as taking jobs away from this country? They are going to be offset by an adjustment in the monetary exchange rates. Those advantages, those cost advantages for businesses are going to be offset by the exchange rates.

So we need to have no concern about government subsidies overseas to companies competing with our domestic companies that don't have subsidies. We have no concern about the dollar-an-hour wage rates, which Charlie Rangel speaks of too frequently, in other countries that are costing us jobs and costing us exports. It all adjusts out in the monetary exchange rates. Now, how about that?

Mr. JORGENSON. The thing to focus on, Chairman Archer, is that, regrettably, economists merge two different arguments and, therefore, appear to be in disagreement with the arguments that you and Mr. Hayes have put forward.

Those two arguments have to do with the grade balance on the one hand and exports versus imports on the other.

Economists focusing on the trade balance will tell you, as Alan Auerbach just did, that any border tax adjustment can be undone from the point of view of the trade balance by a compensating change in the exchange rates, but a consumption tax has other im-

pacts; namely, that there will be a very, very pronounced differential change in the relative prices of different producers, and that is going to produce a very dramatic impact on the circumstances of particular producers, particular industries.

Exporters, people who are already in businesses where they specialize in exports, are going to be favored. People who are in the businesses where imports are very important, and as you know, there is no business in which imports are more important than the oil business, are going to be disfavored.

So what my chart shows is exactly that result; that even though the trade balance remains unchanged, as Alan Auerbach suggested, the circumstances of different industries are going to change, and it is not surprising that the kind of poll results that you just cited are cited over and over again, and they are very relevant to your deliberations. I am not saying they aren't.

Mr. AUERBACH. Two further points. I agree with everything Dale said, but these differential industry effects would occur even under a consumption tax without border adjustments. It is the movement to a consumption tax, not the border adjustments that are typically part of a consumption tax that lead to this differential.

The same point applies with respect to low-wage countries. We are now worried about low-wage countries reducing output in the United States. We are worried about the industries in the United States that compete; that is, low-wage jobs in the United States. That is what we are worried about. We are not worried about U.S. output, per se, when we are talking about U.S. trade with Mexico. We are worried about specific industries which depend very heavily on low-wage labor in the United States against which other countries will be competing. It is a relative industry effect, rather than overall effect.

Chairman ARCHER. Thank you, gentlemen.

I apologize to the other Members of the Committee for indulging me that little insertion.

Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman.

This is a question, I guess, for any of the panelists, and it really has to do with systems in other countries of the world.

It is my understanding that there is no other industrialized nation that has a consumption tax of the magnitude or in terms of the percentage of its income that we are thinking about generating with the changes, the reforms that we are considering here. Is that correct?

Mr. JORGENSON. No, that is not correct, Mr. Payne.

Typically, consumption taxes in the major countries of Europe—Germany, the United Kingdom, Italy, and France—are at about the same rate of 15 percent or higher than the rate that I described, but there is a very important difference in those countries from the United States. They have much larger public sectors when you take into account the Federal, State, and local versus their counterparts overseas.

So we are not talking about a consumption tax that is different in order of magnitude from that you already see in many industrialized countries.

Mr. PAYNE. In spite of the fact that a country such as Great Britain and other nations would find that a greater percentage of their revenues are derived from income taxes than from consumption taxes?

Mr. JORGENSON. That is the point; that these other countries combine the consumption tax, the value-added tax, in most cases, with an existing income tax, which is also quite comparable in scope to our income tax.

We are talking about something totally different here. We are talking about abolishing the income tax and replacing it with a consumption tax while maintaining the size of our government sector at the Federal, State, and local levels. That is a rather different situation from the ones that European countries face with public sectors that are, in many cases, twice or more the size of ours and a combination of consumption taxation and income taxation to finance those public sectors.

Mr. PAYNE. I think we Americans like our system the way it is now in terms of a smaller public sector, and in fact, the movement is for an even smaller public sector, but are there any models for us to look at, places where there has been a transformation from an income tax system to a consumption tax system? Are there places that have replaced their income tax systems with consumption taxes because they, like us, have realized over time that we are, perhaps, on the wrong track and need to change that?

Mr. JORGENSON. Not yet, but it is no small likelihood that this country would become, as it has been in so many cases previously, the model, and I wouldn't be surprised that other countries would follow in the footsteps of such a change.

Mr. AUERBACH. Under the Thatcher government in Britain, at the very beginning of the Thatcher government, they didn't replace the income tax with a consumption tax, but they did sharply reduce the top marginal income tax rates and raise the levels of the value-added tax.

To me, that is the closest experiment, although it is only a partial experiment in that direction.

Mr. HUBBARD. Also, going to something like a flat tax here is not unlike having a standard European-style VAT, with some differences in progressivity on top of it. So the differences are not as large as they might seem.

Mr. PAYNE. It seems that making a change such as the one that we are contemplating certainly implies there are risks involved, and to some extent, we can't quantify those risks because we are going into uncharted waters. Is that correct?

Mr. JORGENSON. Yes, exactly, and that is why it is so important for you to do what you are doing now, which is to try to chart those waters.

It is an unprecedented situation. I couldn't emphasize that more. This is a very drastic change in policy that we are discussing here.

Mr. PAYNE. In terms of the policy, the specifics of the policy, you have noted that if we make a change, imposition of a consumption tax would produce sharply higher tax rates on consumer goods and go on to say that by replacing both Federal-, State-, and local-level taxes, income taxes, that the tax then would be about 15 percent, rising to 21 percent on consumption, on goods, and services. That

is a much lower number than those that we have looked at in terms of others who have come to testify, and you are including not only the Federal, but State and local income taxes as well.

Why is there a difference between your numbers and others?

Mr. JORGENSON. There is a difference because most of the calculations that people do in this kind of tax analysis keeps the dollar value of government expenditures the same, the dollar value.

That overlooks a fundamental point, which is that the prices that will be paid by the government are going to change under this tax system, and government is a very labor-intensive activity. The prices that the government is going to have to pay to maintain its services are going to be materially reduced. That is the main reason.

When you take that into account, you can maintain government services at a much lower tax rate than people have discussed; for example, in the rate that you are going to hear from Mr. Armey this afternoon.

Mr. PAYNE. If, in fact, your analysis were revenue-neutral, as we know it today, what would the rates be in that instance?

Mr. JORGENSON. Approximately 20 percent at the Federal level, and maybe another 6 or 8 percent, but, again, the same amount of revenue is going to buy a lot more government services, and that is what you have to take into account. I think that that is fundamental in this discussion.

Mr. PAYNE. Thank you very much.

Chairman ARCHER. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Under our current tax system, we have a system that favors the savings through pension plans, through qualified plans, through IRAs. How much is the current system as far as savings in those areas?

I wanted to ask another question, and that would be, concerning the inside buildup of life insurance products, which a lot of Americans use as another savings vehicle, how do you tax and how do we propose to address the issue of the life insurance product?

Mr. AUERBACH. You are basically putting all savings on the same footing that pension savings and life insurance inside buildup currently are on, which might seem innocuous from the point of view of those industries. This is an example of one of the transition effects that one has to think about. This is likely to sharply curtail the whole-life insurance business, and it may also sharply curtail the business of entities involved in pension saving, and for that matter, pension saving as a whole because there will no longer be any tax advantage for firm and workers to join in having pension plans.

In fact, whatever restrictions continue to exist on pension plans, pension plans will be less attractive than saving outside of pension plans.

Mr. JORGENSON. I think there is another way to answer your question, Mr. Christensen, which is to say, what we are talking about here is deregulating the pension industry; in other words, having all providers, insurance companies and the other providers of these services, on an equal footing rather than have the insurance companies be tax favored.

With regard to your specific question about the life insurance area, we would have to tax the term portion of life insurance as opposed to the inside buildup which reflects investment. So it is very important to include that in the tax base, and that is not a very difficult thing to do. We have lots of sharp-penciled people out there who can tell you exactly what the term portion is.

Mr. CHRISTENSEN. Do you think there will be greater enhanced opportunities for savings with a consumption base rather than the current system?

Mr. JORGENSON. There will be a tremendous growth in savings. I estimate that the growth in investment is going to be about 80 percent. That is comparable to the growth in savings. Most of that would be financed out of domestic savings.

Mr. HUBBARD. The growth in savings is clearly good news for the financial services industry.

The piece of the industry that will take a hit will be whole life insurance, but for the financial services industry as a whole, the increase in saving is a boon.

Mr. JORGENSON. They are going to take a hit because they are going to be subjected to competition, not because their tax circumstances are going to be changed.

Mr. CHRISTENSEN. The transition question is the million-dollar question. How do we move to a consumption-based tax and treat the current products that already have the inside buildup protection? How do we treat the past products?

Mr. HUBBARD. Again, they would still have inside buildup. Everything has tax-free inside buildup under the consumption tax. That wouldn't be a problem.

The issue would be from the perspective of the insurance companies going forward. As Dale Jorgenson said, they would then have many more competitors to sell currently tax-favored products, but the policyholders aren't going to lose.

Mr. AUERBACH. There is a general question that applies to assets more broadly. You mentioned life insurance and pension assets. There are State and local bonds. There is housing. All of these things are currently tax-favored investments. They wouldn't be harmed directly by these changes, but the fact that there would be so much competition from other assets would reduce the value of these assets.

Mr. CHRISTENSEN. Mr. Auerbach, you mentioned housing. Do you think there would be a slowdown in the purchase of homes by first-time buyers if we don't have the interest deduction on the mortgage?

Mr. AUERBACH. I think it is not just the interest deduction, but it is also the loss of the deduction for State and local property taxes. It almost certainly would be, yes.

Mr. CHRISTENSEN. Mr. Jorgenson.

Mr. JORGENSON. I think there is another point here. What about the asset values? You have heard a lot of testimony about that. You are going to hear more.

The fact is that subjecting new construction—that is what you were talking about, first home buyers—to the sales tax, which I estimate at 15 percent, is something which is going to help maintain the value of those properties.

You might ask, what about the existing homes. They are going to be grandfathered. They are going to be subject to what is called prepayment treatment. All further taxes that would be due on the rental value of those properties are going to be forgiven at the outset, and therefore, existing assets will maintain their value.

That is a fundamental fact about housing that I think should be borne in mind, but you are absolutely right. If you think about the first home buyer, that first home buyer is now going to be confronted by a sales tax, and should be, because one of the important objectives of the consumption tax is to put businesses and households on an equal footing when it comes to competing for capital.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

People of the Third District of Georgia constantly speak to me about the need for balance in two areas. One is a balanced budget. In their minds, they think we can balance the budget by addressing spending habits of Congress and addressing the policy that governs those spending habits. I fully agree with them. I think we can do that, also.

The other is in the balance of trade, and in the balance of trade when you are importing more than you are exporting, you must address the area of export.

I don't know of a worker in the Third District of Georgia who would not like to manufacture a product and ship it worldwide.

We have no jurisdiction over the labor rates in other countries. So, therefore, we cannot do anything to affect how another nation governs their labor rates. We do have jurisdiction over areas of the government that impose additional cost on products that are manufactured in this country. Those areas include the area of taxation and regulations and costly litigation. We are holding these hearings to examine ways we can address the cost of taxation as it affects business, affects the manufacturing of products, the exporting of those products, which ultimately affect the jobs of the people of the Third District of Georgia and all across this country.

Having said that, my question to you is, If we implement a consumption tax, should we roll in the payroll tax, FICA tax, and an income tax? If so, what calendar year do you recommend as the implementation of the new tax?

Mr. HUBBARD. Your general question is very broad. I will make a couple of responses.

On the issue of the link between the balanced budget and the balance of trade, there is definitely a link between the difference between what we as an economy save and invest and the balance of trade.

To the extent that a balanced budget or a consumption tax raises the level of saving, that is clearly going to show up in the balance of trade as well through an accounting identity.

On the issue of the payroll tax being rolled into the consumption tax, the Social Security reform is itself a very important subject that ought not to be just tied into the general consumption tax discussion, and I would urge you to think about a lot of the proposals for partial privatization of Social Security that could dovetail with some of these consumption tax proposals.

Mr. JORGENSON. I would like to register my agreement. I think that one of the important responsibilities facing this Congress is how to respond to the report which you have heard testimony about in the Senate Finance Committee yesterday, or on Monday. It is very important to reform Social Security. It is very important to keep that separate from the tax debate. I think it is very important not to include FICA and payroll taxes in any kind of tax substitution.

Mr. COLLINS. As a followup to that, under the current system, EITC, the two purposes of implementing the EITC were to reimburse those who pay FICA tax.

However, upon reaching the age of qualification, even though all of those taxes have been refunded through the EITC, those same people are eligible for FICA tax programs, such as Medicare and Social Security. So they, in a sense, are already intermingled. Is that not true?

Mr. JORGENSON. That is true. If you regard Medicare and Social Security as part of the taxes, the EITC does commingle the two, and I think that is a weakness, not a strength, of the EITC.

Mr. COLLINS. I have one quick last question. As we go through the interim, and you never gave me a date—I don't know if you want to just evade that question or not, but in the interim, as we go from this date to an implementation date or a calendar year, what do you recommend we do to the current system that would stimulate economic growth and create jobs?

As we had testimony the other day in the Subcommittee on Human Resources, real paychecks, real jobs is real welfare reform, and it is also real economic reform.

Thank you, Mr. Chairman.

Mr. HUBBARD. As I mentioned in my remarks, there are many steps you could take prior to consumption tax reform that put you on the same path. So you could begin by doing anything that broadens the tax base and lowers rates or eliminates the double taxation of dividends and capital gains. Those would all put you on the path.

Mr. COLLINS. Thank you, Madam Chairman.

Mrs. JOHNSON [presiding]. Mr. Kleczka.

Mr. KLECZKA. No questions, Madam Chair.

Mrs. JOHNSON. Mr. Houghton.

Mr. HOUGHTON. Thank you, Madam Chairman.

Gentlemen, it is good to have you here, and thank you for your testimony.

I think I agree with what you are saying, but I am not sure. I'll tell you why I am not sure. I am worried about this thing called transition, and it has been referred to here several times, and, of course, the old law of unintended consequences. What we are trying to do is to dramatically change a system which has been in existence for a long time, and the goals are worthy. They are sound, and you can see some of the consequences, but you can't see some of the other consequences.

For example, we changed our real estate tax system a few years ago, and you could argue very cogently the fact that with a drop of about one-third in the real estate values, it created the S&L crisis.

So the question to me really is that bridge. You can look over the Grand Canyon and you see Eden on the other side. The question is what do you have to go through. Because in the process of going through where we are now into where we ultimately want to be, a lot of people could be hurt, and maybe you could describe or spell out some of the things which we really ought to be concerned with.

Mr. JORGENSON. We talked about housing, Mr. Houghton. I think that that is something that is often of concern in transition discussions, and I think there, attention tends to focus on the mortgage interest deduction and the possibility of retaining that deduction. That just doesn't make sense, and the reason is that rental values, which is the way we think of consumption, on owner-occupied housing are going to be totally exempted from the consumption tax, under the kind of scheme that I believe that you will adopt, and by that, I mean that only new construction will be subject to the tax.

That is referred to as the prepayment method. Every existing owner-occupied house will be treated as if all future taxes on that consumption will have been paid at the outset, and each new home buyer will have to pay a tax that will prepay all the taxes, will never face tax liabilities again.

It seems to me, that is exactly the right treatment. It provides exactly the right transition for the most mettlesome of all of the issues that you face having to do with transition; namely, owner-occupied housing.

This is something that requires careful thinking-through. It is not a trivial matter, as you suggested. It is not something that should be left unexamined, but I believe that when the chips are down, it will turn out that what I would like to refer to as the "cold turkey approach," which is do it now, don't worry about the transition rules, transition will take care of itself, if you use the prepayment method with regard to housing, that will turn out to be the simplest, fairest, and best way from the political point of view of achieving a transition in the housing area.

Another area that people are often concerned about——

Mr. HOUGHTON. Let's just wait 1 minute here.

Ms. JORGENSON. Go ahead. I am sorry.

Mr. HOUGHTON. We are sitting around here in a great big room intellectualizing about something, and obviously, you gentlemen are very creative and very knowledgeable, but you talk about cold turkey and you talk about the chips are down, and it doesn't make any sense.

What about the baby boomer who has just bought a house and is deducting the interest on that mortgage, and you say, hey, you know, we have got to face up to these things, we have got to go cold turkey, in the long run, it is going to be good for you? Tell me how that plays out.

Mr. JORGENSON. OK. Here is the way this is going to play out. People don't pay mortgage interest into a vacuum. They pay it to mortgage providers. Mortgage providers are currently subject to tax.

If I offer you a mortgage and you are willing to take it, I am going to be taxed on that. I am going to have to report the interest

payments on my form 1040. Even if it is a postcard size, it is going to be there.

If you focus on the fact that my tax circumstances have changed after the tax reform and you are going to be treated as if you have prepaid all of the taxes on the consumption value of your house forever, by the simple device of refinancing, going to a mortgage lender whose tax circumstances have changed, who will no longer be paying taxes on the interest, you will receive exactly the same benefits as you do for your existing deductions. That is why I mean what I say when I indicate that the prepayment method for treating housing is, I believe, the way to facilitate the transition.

It is a special treatment. I am not proposing to use the prepayment method for business assets, to give every corporation the right to, essentially, claim prepayment of all taxes on their business assets, but for housing, I think it makes sense, both from the administrative and the policy point of view. It happens to make sense from the political point of view as well.

Mr. HUBBARD. If I could follow up on that, the only consumption tax piece of this reform in the transition, if housing receives Dale Jorgenson's treatment, would be the issue of business assets, the expensing. The rest of these issues would have happened under broad-based income tax reform, too. The transition problems are not unique to any particular tax reform, but to tax reform, generally, and I think one reason to think about broad-based tax reform is so you don't keep changing the Internal Revenue Code so regularly and produce the kind of results that you have suggested.

Mrs. JOHNSON. Thank you, Mr. Houghton.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

Let me thank all of you for your testimony today. We are embarking on a major change in our tax structure. Obviously, it is controversial, and it is going to take a lot of time for us to get it done right.

I am one of those who support moving toward a consumption-based national tax and replacing some of our income taxes or all of our income taxes, but let me follow up on the issue of how it is going to affect State and local taxes.

I know Mr. Rangel touched on this, but let me just go into more detail, if I might. First, if we eliminate the Federal income tax, it is going to be extremely difficult for States to be able to maintain their income tax system as they have it today without the type of information that is available nationally on reporting income and without the Federal Government using an income tax base.

Second, if we move toward a national consumption tax, it is going to be difficult for States to be able to continue their retail sales tax revenues.

So it seems to me on two fronts directly, we impact on the ability of State and local governments to be able to finance their local needs.

When you put on top of that the difficulties of eliminating tax preference for State and local financing on tax-exempt bonds, it seems to me that we have some serious transition problems or serious fundamental problems that we need to be able to deal with before we move forward with these proposals.

Let me just state my own view. I don't look at State and local governments as special interests. They are our partners in government, and we have a responsibility to make sure that tax reform at the national level is mindful of the needs of State and local governments and financing their needs.

So I would appreciate any thoughts that you might have as to how you could integrate a reform of a national income tax to consumption tax with the problems that that could unveil with State and local governments.

Mr. JORGENSON. The one thing that I would like to focus on, Mr. Cardin, is something you didn't mention, but I think it is really central, and I tried to include this in my response to Mr. Rangel a few moments ago.

We have to ask ourselves the question, What will State and local governments, which provide very essential services in this partnership that you have just described, have to pay for the services that they provide, what will they actually have to pay out in terms of resources to finance those programs.

Remember now, that governments will not be subject to the consumption tax. The consumption tax pertains to individuals, households. So we are not talking about including governments in the tax. What does that mean?

That means that the providers of these services, whether they are providing them on contract or they are providing them by working in State and local agencies, are no longer going to be subject to the income taxes that they are now paying, and that means that the cost of State and local government is going to go down radically. That is the fundamental fact about State and local governments. Their costs are going to be decreased.

Mr. CARDIN. I might point out that it seems to me that the largest cost to government is labor.

Mr. JORGENSON. That is exactly right, and when you think of the implication of the fact that many State and local government officials are well above the poverty line, they are not part of the working poor, those folks are people who are paying marginal tax rates on their labor income of 30 percent. That is going to be replaced by a consumption tax of 15 percent if we look at it from the point of view of the consumer and zero if we look at it from the point of view of the governments. So taxes are going to be reduced, and cost of State and local governments are going to be radically reduced.

Mr. CARDIN. I want to give Mr. Auerbach a chance, but I am not sure I follow that logic. I don't want the record to reflect that that analysis would go unchallenged.

Mr. AUERBACH. I cannot comment on Dale's particular conclusions without knowing more about the simulation results. I would have thought that some States, particularly those with relatively high taxes now who benefit a lot from the deductibility of State and local taxes, might have been hurt more than others. That is one of the transition questions about which, no matter what simulation model results we present to you, there is a lot of uncertainty. There has to be a lot of uncertainty about it because we have never undergone a change of this magnitude before.

I wanted to make one other comment. You mentioned the difficulty of collecting taxes, saying it would be difficult to collect retail sales taxes if there was a national sales tax or a value-added tax.

That argument about tax competition, and I am not sure I understand it, though I have heard it made before. It seems to me, it would actually be easier because of the mutual enforcement of the Federal and State taxes that piggybacking would permit. It is true that existing taxes might have to be modified to conform more to a national one.

Mr. CARDIN. Wouldn't it be more efficient if we use a value-added tax built into the value-added tax rather than have two separate types of collections? Wouldn't that be a more efficient way to deal with the tax?

Mr. AUERBACH. If you used the value-added tax at the national level, it would make more sense to convert from a retail sales tax.

Currently, retail sales taxes at the State levels are much narrower than a national sales tax would be. They only apply to goods. They typically don't apply to services, and they often exempt many goods.

Mr. CARDIN. I am just wondering if when we are looking at tax reform, we should look at the State and local and see whether there is some way to integrate a consumption tax at the State level, also.

Mr. HUBBARD. The issue is not so much coordination because you could coordinate under either the national sales tax model or the flat tax, but States might have less—and likely would have less—flexibility in the kinds of taxes that they use.

For example, under the flat tax, it would be difficult for a State to decide to tax capital income if the Federal Government weren't collecting the information at the individual level. So I don't think that coordination necessarily is the issue, but States may be a little more limited in their choices about progressivity than they are now.

Mr. CARDIN. We need to continue this debate, and I appreciate your responses.

Mrs. JOHNSON. Thank you.

I am next to be recognized. However, I do have to leave. So I would just like to make a couple of statements on the record as to things I need to pursue with you over the course, and then I will pass both the gavel and the recognition to other Committee Members.

Mr. Jorgenson, I found your testimony very, very interesting, but you recognize a drop in consumption, though an increase in investment. The drop in consumption, it seems to me, is going to cause layoffs.

Mr. JORGENSON. Look at the results on the industries. I am sorry to refer you to these charts. I realize it is a little burdensome.

Look at the impact on individual industries in the chart labeled "Effect of a Consumption Tax on Industry Output in 1996." Remember, these simulations are based on a tax imposed on January 1 of this year. In other words, this is a hypothetical, not an actual prediction.

What you will find there is that industry outputs increased by an average of 20 percent. You are going to see the creation of jobs on an unprecedented scale. That is what these charts show.

Mrs. JOHNSON. I need to understand that more clearly. It is not unlike this issue of prices falling that you point to and the impact on State and local government. Are you assuming that cost will decline for State and local government because wages will go down?

Mr. JORGENSON. No. I am assuming that the costs are no longer going to include the taxes that are now being paid on those wages, and the aftertax wages are going to be skyrocketing. They are going to go up by about 15 percent. Real wages are going to go up by 15 percent. Why? Because you are trading off a 30-percent tax at the margin.

We are not talking about the working poor, Mr. Rangel. We are talking now about the middle class and upward.

Those folks face an average marginal tax rate of around 30 percent. They are going to be facing a consumption tax of around 15 percent, and if you look at it from that point of view, it is not surprising that prices are going to go down after you take out the tax because the producers only get the proceeds after the taxes have been paid, and that is the result.

So what happens is that there will be a boom, and that will be primarily a boom in investment, as you correctly point out. There is a big difference here. Consumption will decline. There is no other way to get more investment than to have consumption go down. That is the purpose of imposing a consumption tax.

Mrs. JOHNSON. I appreciate that. My concern is in the transition. Could we create problems that are so serious in the transition that government costs would escalate in such a way as to undercut?

Mr. JORGENSON. The transition problems are just the opposite of what you suggested, if I may respectively disagree. It is not that we are going to have problems with jobs. We are going to have problems finding people. We are going to have problems getting people into the jobs that are going to be created under this tax change. That is what is going to happen under the transition, and that is something to worry about.

It is not something that I think is reflected in the questions that we have heard today. People are concerned about creating jobs, as they always should be, but we are going to be creating jobs on an unprecedented scale.

Mrs. JOHNSON. The other thing that I think we do have to think about is, as we do more study, the kind of study that is being stimulated by the balanced budget initiative, looking at the real cost and the real impact of appropriated programs versus tax-incentivized actions, if we discover, as I think we may, that tax-incentivized benefits are much cheaper to administer and more effective in their delivery, that is, an earned income tax credit versus energy assistance or food stamps, then I think that has to be taken into account. What kind of leverage do we want for the tax versus its cost and the appropriated programs?

Mr. JORGENSON. There are two points here. One point is that you have to ask yourself what are the costs that Federal Government is going to face.

I have already made it a point in response to Mr. Cardin's question that State and local governments are going to be faced by lower costs. That applies with a vengeance to the Federal Government. The Federal Government costs are going to be lower because of the switchover. That is something that has extremely important ramifications for the budget debate. You are absolutely right about that. It should be taken into account.

So that just reinforces what your colleague, Mr. Houghton, was saying. We have to study this very, very carefully because it has many far-reaching ramifications.

Mrs. JOHNSON. There are certainly a lot of things that we need to understand better than I at least at this point understand them.

Mr. CHRISTENSEN. Will the gentlelady yield?

Mrs. JOHNSON. I am going to recognize Ms. Dunn and yield, to Mr. Ramstad, the gavel, since I really must leave.

Mr. CHRISTENSEN. Would the gentlelady yield for a moment?

Ms. DUNN. Yes.

Mr. CHRISTENSEN. Dr. Jorgenson, do you think we will ever get there?

Mr. JORGENSON. I am sorry?

Mr. CHRISTENSEN. Do you think we can ever get there?

Mr. JORGENSON. Yes, I do.

Ms. DUNN. A quick answer, please. I shouldn't have yielded.

Mr. JORGENSON. Yes, I do believe we can, Mr. Christensen.

Ms. DUNN. It could take a very long time.

Did you get your answer, Jon?

Mr. CHRISTENSEN. Yes.

Ms. DUNN. OK.

I wanted to ask the panel a question that comes up a lot in the townhall meetings that I have had on this particular topic.

The folks in my district in Washington State are very interested in what is going to become of the IRS. So I would like to ask each of you this. As we well know, nobody looks forward to an audit. A lot of folks think that the simplification relating to our replacement of the current income tax would include a streamlining or doing-away of the IRS. I wonder if you could take both the consumption and income-based taxes or the four or five major plans and tell me how you see the IRS, in reality, existing at the end of that time.

Mr. HUBBARD. The IRS will be here, for good or for bad, under almost any of these plans. Some of the complexity that occupies a lot of IRS staff time—international transactions, depreciation issues, and certain special provisions—would be greatly reduced. So, in that sense, a lot of the burden would be gone, but if you think about the information and monitoring requirements for something like a flat tax, for example, or the USA tax, for example, it is information and reporting that is currently being collected. So it would still have to be analyzed.

Even if we were to go to a national sales tax, there would still have to be a great deal of coordination and monitoring.

So I think the IRS as an institution, if it can be called that, would be here to stay, but I think some of its most intrusive aspects, at least in the cost of doing business, could be cut back.

Mr. AUERBACH. Under the sales tax or a value-added tax, certainly, individuals who are not in small businesses would cease to

have any contact with the IRS. But a lot of the complaints about the IRS come now from owners of small businesses. It is hard to believe that they would be complaining less if they were facing a value-added tax or a national sales tax, because they would have a lot of contact with the IRS under that plan.

Mr. JORGENSON. I think it is important to focus on the difference between a sales tax and a value-added tax. A sales tax would involve an administration very much like the States sales tax collection agencies. There would have to be a Federal agency to subcontract the collection of Federal revenues. I don't know if you are going to call that the IRS or give it a different name, but it is doing something totally different than it is now.

If we think about a value-added tax, the method that I think is going to be discussed the most among the major proposals—it is the only one that is represented—is what is called the subtraction method, which is the tax-on-a-postcard version that you are going to hear about from Congressman Armey. That is going to require a value-added type of administration that is very much like the IRS, and it is going to involve auditing individuals' returns.

One very important feature of a consumption-type tax is that it is possible to exempt small businesses because they essentially pay the taxes on everything that they purchase, and that is something that could be considered very seriously.

You heard testimony on that last year from a Dutch economist named Cnossen, and he talked about European experience with that kind of exemption. That would also apply to a small farmer, a small fisherman, and so on.

So I think that these administrative issues are very, very important, but there is a fundamental difference between a value-added tax that would preserve something like the IRS and a retail sales tax as advocated by Chairman Archer which would involve something more like the State agencies that now administer those taxes.

Ms. DUNN. I want to go back with a message of hope to my constituents, but not an unrealistic hope.

Let me ask you, on a second topic, about the area of barter or the underground economy. Do you have a sense of which of these areas of change would most discourage barter, why it would, and is there really a chance for us to get our hands around the problems that are created by folks who are not reporting income? Would it be better on the consumption?

Mr. AUERBACH. I think a misconception that exists is that a consumption tax, say a value-added tax or a retail sales tax, would get around the problem of the underground economy by taxing people on their consumption.

It is true that such a tax would tax their consumption, but it wouldn't tax them on their production. Imagine a small contractor. I won't choose a profession for fear of offending anybody, but imagine a small contractor who is not paying taxes under the income tax. That contractor ought to be subject to a retail sales tax if we had one because it would include services, ought to be subject to a value-added tax if we had one, and ought to be subject to the current income tax. Presumably, that person would continue not to pay taxes under any of the systems, and there is nothing fundamentally different about the different systems that is automati-

cally going to cause that person to bear taxes that aren't being borne today.

Mr. HUBBARD. The sense in which the tax reform is being discussed might help with the underground economies by lowering marginal tax rates. The incentive for evasion is much lower. That is not a consumption tax point, per se, but lower rates should shrink the underground economy.

Mr. JORGENSON. I think that is a very, very important point.

We are not going to be getting into the business, just to take an example, of taxing illegal activities. They are still going to be conducted by people who are going to be evading tax authorities, along with other authorities.

On the other hand, their consumption, what they do with the proceeds is, indeed, going to be subject to tax. So I would say that, from a practical point of view, the effect on the underground economy is there, but not unlimited.

Ms. DUNN. Thank you.

Thank you, Mr. Chairman.

Mr. RAMSTAD [presiding]. Thank you.

I, too, want to express my appreciation to this impressive and distinguished panel of witnesses for your insights and your excellent testimony. It is refreshing when academicians not only present the empirical data well, but also have such good common sense, and your recommendations certainly are important.

I also appreciate the fact that my colleagues on the other side of the aisle have been here this morning. I know it is important that we work together in a bipartisan, pragmatic way to enact tax reform, and I applaud them for their efforts as well.

I would just like to follow up on the line of questioning by my colleague from Michigan earlier this morning, Mr. Camp.

I was just listening the other day to a program on population growth on public radio, and the estimates are that by the year 2040, this Nation will have a population of 400 million. Somewhere between the year 2040 and the year 2050, we will grow from our current 225 million population to 400 million people. We have to, obviously, grow this economy, create the jobs necessary to put people to work.

I was impressed by your testimony, Professor Auerbach, and yours as well, Professor Jorgenson, that the long-term effect of a broad-based national sales or consumption tax would raise output by 9 percent.

I have also heard the chairman of the Commission, Mr. Kemp, say that his favored proposal, that is, the flat tax, and I have heard Professor Wininski, his economic guru, corroborate this, that it would possibly grow or double the growth of the economy, that we could go from a $7 trillion economy to a $14 trillion economy in the long run.

I would like your inputs in comparing and contrasting a consumption tax with the growth implications of a flat tax. Is this just hyperbolic rhetoric? I imagine you wouldn't dispute it, but that is very impressive, obviously. If we could double the output from a flat tax, why should we go with a consumption tax?

Mr. AUERBACH. A flat tax is a consumption tax.

As proposed, a flat tax would be a consumption tax that provides low-income relief and trades off that relief for a higher tax rate. Therefore, logically, compared to a national sales tax or a national value-added tax without that kind of low-income relief and, hence, with lower rates, the growth would have to be moderated. It would have to be lower because there would be larger distortions facing work decisions.

So whatever the ultimate growth would be under one tax system or another, you are trading off some growth for some progressivity in adopting a flat tax rather than adopting a national sales tax or a value-added tax.

I would find doubling of the economy a wonderful thing. I think it would be fairly unlikely.

Mr. HUBBARD. Also, you have to keep straight the difference between a change in the level of output and its rate of growth.

What Alan Auerbach and Dale Jorgenson were talking about were changes in the long-run level of output or output per worker. To get to a higher level, you obviously have to grow faster, and I think that is part of the difference, combined with some healthy hyperbole on the flat tax.

Mr. JORGENSON. I had the pleasure of testifying, Mr. Ramstad, before the Commission. In fact, the calculations that I have described here were presented to them in an earlier version, assuming implementation January 1, 1995. They even found their way into the report.

So it turns out that Mr. Kemp at some level has bought off on this idea, but the Wininski viewpoint that you can double the growth rate is perfectly correct if you are talking about a sufficiently short period of time.

If you talk about tomorrow, it turns out that you can have a huge increase. I estimate the initial increase to be 13 percent. If you talk about 5 years, you can double the growth rate, but the idea that you are going to double the economy requires allowing growth to take place over an extended period of time, and we will certainly see a doubled economy over the next, say, 20 years under a consumption tax, whether it is the flat tax variety or another one.

Beyond that, if we assume this is going to go on forever, we are fooling ourselves. That would be my view.

Mr. RAMSTAD. All of you concur that the status quo is unacceptable in terms of growth. I mean, the projections are hardly impressive under the current tax system.

Mr. JORGENSON. Exactly. Under the current tax system, the growth rate would be around 2 percent, declining over time to around 1 percent, and under any one of the consumption tax proposals, as Ms. Dunn said a moment ago, any one of the five major proposals, you would have a very, very substantial stimulus.

Mr. RAMSTAD. Thank you again, gentlemen. We look forward to working with you on a continuing basis as we go to, hopefully, enact tax reform next year.

Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Dr. Jorgenson, we are going through these hearings, as you know, for an educational purpose, so that people would better understand how important it is to get away from this present system.

You passed nonchalantly over this transition thing and talked about cold turkey. Perhaps I was too caustic in saying who is going to make the decisions. You said you, but you recognize that when you are bringing about this dramatic change, you are asking local and State governments, employers, and savers to just change everything, and we are now going to have to staple you to the bill to explain "not to worry," that everything is going to work out.

Have you put any paper together, questions that those who don't believe in the flat tax would like to ask, but never do, or are these the answers to these questions?

You just indicated in your document that there is going to be a dramatic jump in savings and a substantial rise in labor supply. Why would there be a rise and a reduction in the consumption of goods and leisure? Why would this happen?

Mr. JORGENSON. It would happen because the burden of the tax would be shifted from labor and from saving to consumption.

Mr. RANGEL. I thought that.

Would this not be a renegotiation of every labor contract we have in the United States of America?

Mr. JORGENSON. That is largely an administrative question, and let me indicate what I mean by that. If it turned out that we decided to administer the consumption tax by means of a two-part system, a business tax and a personal tax, as in the flat tax or the USA tax that you have heard so many times now, it would not be necessary to renegotiate every labor contract. The labor contracts would be written in such a way that they would take into account the fact that people were going to pay taxes on income under the current system and would be liable for paying part of the taxes not because that is an income tax, but because it is just a way that it is passed along.

Mr. RANGEL. When people negotiate a contract, they take into consideration the present tax system, and the wife or the husband or their friends and loved ones say, "That is nice, Darling, but how much money are we going to have left?"

Mr. JORGENSON. Bring home.

Mr. RANGEL. Exactly.

Mr. JORGENSON. Exactly.

Mr. RANGEL. If you are considering the deductions and all of the things that we have in the system and now all of a sudden they are removed and the cost of my labor has been dramatically reduced, how do I become whole again? What happens?

Mr. JORGENSON. Because your aftertax income has increased by 15 percent, Mr. Rangel.

Mr. RANGEL. What happened to my Social Security?

Mr. JORGENSON. The take-home pay is going to jump.

Mr. RANGEL. Do you take away the Social Security deduction? Will that not still be there?

Mr. JORGENSON. The Social Security deduction is certainly going to be there, at least under my version of the story.

Mr. RANGEL. Then you crowd on top of that a consumption tax. What is left? Where is this dramatic reduction in my expenses if the Social Security is there and your tax is there?

Mr. JORGENSON. Where is this benefit going to accrue? It is not going to accrue with regard to Social Security or FICA. It is going to accrue with regard to your individual income tax.

Mr. RANGEL. I know, but I am still talking about disposable income.

Mr. JORGENSON. You are now paying an average market rate.

Mr. RANGEL. It will not dramatically increase as a result of this if I still have FICA and the Social Security burden to carry.

Mr. JORGENSON. Still, your income is now your aftertax income. Your take-home pay is now affected by the individual income tax.

The thing to focus on, Mr. Rangel, is that that is going to be removed. You are not going to be paying the individual income tax again, and you might ask what does that amount to. It amounts to about 30 percent of your income, if you are the average American citizen. That is going to be replaced by a consumption tax of 15 percent. That is going to bring you a tremendous increase in your take-home pay.

Mr. RANGEL. I am a New Yorker. Of course, that is parochial when you are dealing with the national interest, but we have very high city and State taxes. You are going to remove my Federal tax, and my city and State taxes won't have that to piggyback on. So, are we going to mandate that they go to a consumption tax as well? What does my mayor and Governor do now that I have dramatically reached the decision that we are changing the Federal system?

Mr. JORGENSON. That is up to the New York City Council and the legislature of the State of New York, but I would predict that they are going to find it very convenient to move to exactly the same system that the Federal Government does now.

The New York State income tax is very closely modeled on the Federal tax, as you are well aware, and I am sure that there would be a movement in the legislature to shift the tax system in the same direction the Federal Government tax system is going to be shifted.

Mr. RANGEL. The reason we follow the Federal Government system now is because we do so much to give them a structure of information and enforcement, but once you pull the Federal Government out——

Mr. JORGENSON. No, no, no. The Federal Government is going to have a closer relationship.

Remember now that we are talking about the Federal Government subcontracting. I am just thinking now of Chairman Archer's proposal in particular, subcontracting its administration to the State collection agencies. There is going to be a very intimate relationship, as Alan Auerbach pointed out 1 minute ago. The two agencies are going to use basically the same enforcement mechanism. It is going to bring the two partners, to use Mr. Cardin's term, in our Federal system into a closer relationship with regard to taxation.

Mr. RANGEL. Have you written anything or can we get anything up there at Harvard or Columbia that would answer some of the questions that I know may sound political to you but has to get us through this transition? Do you have anything?

Mr. HUBBARD. There is a general point you are raising, Mr. Rangel, about transition that is common to most of the major tax reforms.

We have seen in ERTA and in the Tax Reform Act of 1986 also very large swings in the taxation of alternative assets. So the idea of these major tax changes is certainly not unprecedented. These issues are old.

Mr. RANGEL. Our transition rules have been the nightmare of every reform we have had.

Mr. JORGENSON. That is exactly why I will bet, Mr. Rangel, that after you deal with the prepayment treatment that I described for housing, that the rest of it is something that you will choose to go cold turkey on.

I am not being nonchalant, and I don't want to give you the impression that I am not worried about this. I am worried about it, and I hope you are.

Mr. RAMSTAD. The gentleman's time, yielded from the very generous Chair, has expired.

What we are going to do is recess the Committee after the next two questioners and resume the hearing at 1 o'clock.

The gentleman from Texas, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

You did speak about prepayment in housing, Mr. Jorgenson, and I was wondering how you are going to handle that. You indicated that if a loan is restructured a person would not pay new tax, but aren't you pitting new homes against old homes when you are talking about that sort of thing?

Mr. JORGENSON. Yes, we are, and I think that is a fundamental feature that new homes should be subject to the tax.

What that means is that a person who develops new residential real estate for sale to owner-occupiers, whether it is a home or an apartment or whatever, it would be subject to the tax at the rate that I have suggested, 15 percent. That would keep the asset values on residential real estate, more or less, where they are now.

People who already own existing homes or apartments would be treated as if they had prepaid all of their taxes. They would never be taxed, and that is the equivalent of the combination of the home mortgage interest deduction, plus a total exemption on any capital gains that people would have to pay when they sell their home or sell their apartment, as they would if they move to a smaller abode after their children have grown up and so on. That would be an added benefit.

So existing homeowners would be not only made whole, but they would be given an added advantage that they would never have to face capital gains taxes on their home should they decide to move into a smaller home, and I think that is going to be a very important feature.

Mr. JOHNSON. I sort of understand. If I am renegotiating a mortgage, and I am a new buyer and choose to buy an old home, am I paying tax on it?

Mr. JORGENSON. You are paying taxes on any new construction.

Mr. JOHNSON. I want to differentiate between new construction and existing homes and new buyers.

Mr. JORGENSON. No. You are not paying your taxes on existing homes. Those taxes are going to be paid by the developer. They are going to be paid at the time that the home is actually first brought on to the market. There will never be another tax.

Mr. JOHNSON. Are you saying that if I go buy a house, I am not going to pay the tax, the developer is going to pay the tax?

Mr. JORGENSON. Absolutely. Furthermore, the individual who is going to sell an existing home, who may have a substantial capital gain that would otherwise produce tax liability, they are not going to be faced with that tax liability. Therefore, they get the mortgage deduction and they get the capital gains exemption. They are going to be made whole.

Mr. JOHNSON. Yes, as we know it today, but as I understand you, a buyer is not going to pay the consumption or sales tax. The developer is going to pay it.

Mr. JORGENSON. The developer is going to pay it.

Mr. JOHNSON. So that is what you are talking about, keeping the price of the property up.

Mr. JORGENSON. Exactly, and that is what I mean by the prepayment method. The developer pays.

Mr. JOHNSON. I understand that.

Let me ask you one other question that has been alluded to, and all three of you can answer. If the collection agencies enter into some sort of contractual arrangement with the States in order to achieve a collection, why, then, do we need very much bureaucracy in Washington, so to speak? Why can't we get rid of the IRS, per se?

Mr. HUBBARD. That close partnership is really from the sales tax model.

If you were to go to the model of the USA tax or the flat tax, you would still need something, essentially, like the IRS. It is only the sales tax that you would be contracting out.

Mr. JOHNSON. You would be able to reduce the size of Federal Government considerably under that situation?

Mr. HUBBARD. Yes.

Mr. AUERBACH. Although under a sales tax, which would follow the model of the broad-based sales tax, you would be adding a lot of taxpayers who are service providers. For all of it to be done at the State level, there would be an increase in the burden.

Mr. JOHNSON. I understand you have got to have something up here.

Let me ask one other question. How do we prevent double taxation? In other words, if we went to a sales or consumption tax, how do we prevent an income tax from reappearing, as we know it today?

Mr. AUERBACH. Do you mean an income tax at the State level?

Mr. JOHNSON. Double tax.

Mr. AUERBACH. Federal level.

Mr. JOHNSON. Yes.

Mr. JORGENSON. There is a suggestion which has been, as we say, bruited about, which is having a constitutional amendment that there will never be an income tax, at least at the Federal level. I don't know whether you can have a constitutional amendment that would prevent that at the State level, but, certainly, that

has been suggested. So, if you are up for a constitutional amendment, you might think about that.

Mr. JOHNSON. I am glad you brought that up. I intend to file that next month.

Thank you very much.

Mr. RAMSTAD. Mr. Bunning.

Mr. BUNNING. Thank you, Mr. Chairman.

Last week, we had testimony about the compliance cost of the current income tax, and it was estimated that the compliance cost was about $225 billion. That is, I think, a very conservative estimate, if we include the IRS and all of those things that go along with it.

Can you as a panel see how much difference there would be as far as compliance? In other words, I am trying to ask you to compare the alternatives to the current Federal income tax as far as compliance cost to the average taxpayer and overall.

Mr. HUBBARD. Moving to lower rates, generally, would reduce compliance cost because many of the games that are played are rate-based games. They are trying to arbitrage situations in the Tax Code. To the extent that you simplify greatly international taxation, as the consumption tax models would, you eliminate a lot of complexity. These proposals would also eliminate alternative minimum taxes, a big source of complexity.

So many of the things that the business people can identify, at least, as the largest cost of complexity will be gone or greatly reduced. You will still have some complexity in any tax system, but many of the most egregious issues, at least, should be smaller.

Mr. BUNNING. What about the normal, average taxpayer, which I consider myself to be, and others who are sitting out here in our audience, who have to pay, generally, a CPA or a tax consultant, whoever that might be?

We had 50 returns. We had a case of 4 people, and we gave it to 50 accountants, and they all came back with 50 different tax liabilities. What I have tried to ask you is how much can we save for the average taxpayer if we go to a consumption-based tax.

Mr. HUBBARD. A Member of Congress probably isn't quite the average taxpayer, but you could certainly say for the average taxpayer, to the extent that forms and filing are very, very simple, a lot of people that complain about tax filing now already have very simple systems.

Part of this gets, I think, more to the issues that Chairman Archer has raised repeatedly that people have a fear of the IRS. It is not so much the reform.

Mr. BUNNING. I understand that. Therefore, they go out and have somebody else sign the bottom line, so that even though they are still responsible, they have a partner in crime to go help them defend themselves if they are called in.

Mr. JORGENSON. Mr. Bunning, there are still going to be 10 million retailers out there. If you think of a consumption tax in the narrow sense of a tax on sales, there are going to be 10 million retailers out there, and I include every service provider in this country, not just the retailers that provide goods and services, but medical offices, legal offices, and all the rest.

Mr. BUNNING. Right.

Mr. JORGENSON. Those people are going to have compliance cost.

You ask what is the appropriate figure to use to compare with your $250 billion or whatever. You have received testimony on this, and I believe that the figure is something like $6 billion. It is a lot less. That is the main point.

Mr. BUNNING. A lot less. Would you agree?

Mr. AUERBACH. I wouldn't venture a number.

Mr. BUNNING. Do you see compliance being less?

Mr. AUERBACH. Any tax system that removes individuals and households, except small businesses, from the tax base, it is obviously going to reduce compliance costs a lot, particularly among people who are not that educated about the tax system. A lot of people, even who file simple tax forms, 1040A, 1040E, are still using tax preparers, and they, obviously, are nervous about the tax system, even though their tax situations aren't that complicated.

Mr. BUNNING. I have a followup question. Since there is this cost that we know now, and when we have withholding, we have about a 99-percent compliance, and we have anything less than withholding, we have compliance overall at 82 percent. How many did you say?

Mr. JORGENSON. Ten million retailers.

Mr. BUNNING. Ten million retailers.

What percentage of compliance do you anticipate they have now at the retail level as far as the State sales tax is concerned?

Mr. JORGENSON. If you think about the two figures you mentioned between 80 and 90 percent, I would say that it is probably going to be closer to 80 than 90 percent.

A lot of those 10 million retailers are pretty small operations, and when you think about the enforcement problems that are involved, they obviously relate to the government's potential gain in generating tax revenues by audits and so on, by scrutiny of the taxpayers.

So I would say that there are certainly going to be very serious problems, and you are right to draw attention to them.

Mr. BUNNING. Thank you very much, Mr. Chairman.

Mr. RAMSTAD. Thank you, Mr. Bunning.

You might be just an average taxpayer, but nobody could ever accuse you of being just an average pitcher.

With that, I want to, again, thank all three of you distinguished professors for being here today, and for helping us as we start on the effort of tax reform. We are very grateful to you.

The Committee stands in recess until 1 o'clock.

[Whereupon, at 12:04 p.m., the Committee recessed, to reconvene at 1:10 p.m., the same day.]

Mr. SHAW [presiding]. Several of the senior Members of our Committee are in the Rules Committee this afternoon, and they will be coming in shortly. Chairman Archer asked me to go ahead and start off by introducing our distinguished Majority Leader, Dick Armey.

Mr. Armey.

STATEMENT OF HON. DICK ARMEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ARMEY. Thank you, Mr. Chairman.

Mr. Chairman, let me make some brief comments. I have a written statement that I will submit for the record.

I have for some time, Mr. Chairman, been aware of the fact that the American people are thoroughly disenchanted with the current Tax Code. It has been fairly evident to me for some time that the American people will not tolerate this Tax Code much longer, and well they should not.

As we examine the impact of the Tax Code as we know it today, we have to see this Tax Code as we have it, as a principal cause for the inability of this economy to achieve any respectable, lasting growth rate. The relatively high marginal tax rate, the complexity of the Tax Code that results in us spending a deadweight loss of $150 billion a year just for compliance, the treatment of the Tax Code as we have it today on both savings and investment, leaving us with a deficiency of both, which are the lifeblood of economic growth in any economy, all of these things are well understood by the American people, not to mention the personal aggravation they experience each year as they go through the Tax Code.

I was amused the other day while walking through a bookstore to find that for $39.50, I could buy a manual of some 350 pages that would make it possible for me to file my taxes and avoid an audit. It is amazing to me that Americans are buying such a manual, while we continue to believe that we have a voluntary Tax Code.

So the fact of the matter is the American people understand that they are experiencing a stagnation of economic growth, resulting in a decline of personal income that is coupled with an increasing share of taxes, to the point that today, the average taxpayer gives up 24.5 percent of his income in Federal taxes, leaving them with a falling real family income.

I have said many times that the reason you have a second wage earner in most families today is not to support the family, but to support the Federal Government.

This declining family income, coupled with this rising tax burden, has caught the American family in what I call the "Clinton crunch." They have been particularly aggravated since the tax increases of 1993 and are in a position where the American people are demanding relief.

Having studied these things, I devised in 1994, based on the work of two economists from the Hoover Institution, Professors Hall and Rabushka, a flat tax with a single tax rate.

If I may turn to one quote, "The single tax rate is extremely important if we are going to have the simplicity as well as fairness and the growth effects."

Joseph Stiglitz, President Clinton's chairman of the Council of Economic Advisers, in his own textbook, "Economics of the Public Sector," writes, "The uniformity of flat marginal tax rates means that income can be taxed at its source. Taxing income at its source will reduce compliance cost an increase compliance rates." This is an extremely important part of a flat tax and a part that is not properly focused upon. If you tax income at its source, you have the

avenue to simplicity that you cannot get anyplace else, and you cannot tax income at its source without a flat tax rate.

If we accept that proposition, we then can see that a growing number of scholars, both for and against the flat tax—in fact, even some scholars that are paid, expressly for the purpose of finding fault with a flat tax—are finding that under a flat tax, you are going to have economic growth. The growth is a result of increased investment activity, which comes back to the economy principally through increased productivity, which, in turn, has its major impact on the wage earners' increased wages and a direct correlation between fair treatment of savings and investment, increased investment, increased productivity, and increased wages. It means that the working men and women in this country are the first best beneficiaries of a flat tax and a growing economy.

The other point of consensus that we have found showing up in the literature is that in a flat tax world, there should be declining interest rates.

I will leave you with this thought before I conclude. So much of the current debate about the flat tax that we hear in America today focuses on the question of home ownership. I will argue that in a flat tax world, there will be more people more able to afford finer homes for their families than you will have today. And if I were a person who made my living out of real estate transactions, I would pray for the flat tax world because I would know I would have a better living, selling finer homes to more families.

With those comments, and if you will accept my written statement for the record, I will be happy to answer any questions.

[The prepared statement follows:]

STATEMENT BY REPRESENTATIVE DICK ARMEY
HOUSE WAYS AND MEANS COMMITTEE

March 27, 1996

Mr. Chairman and Members of the Committee, thank you for this opportunity to visit you again to discuss the issue of tax reform.

Mr. Chairman, I believe the hearings you are conducting on the subject of tax reform could not be more timely. Today, Americans are beleaguered by a tax regime that is depressing their wages and stifling economic opportunity. At the same time, Americans are forced to surrender a growing share of their stagnant incomes to the government.

Too many Americans are paying higher taxes while their incomes are stuck in place or even falling. This middle class squeeze of falling wages and rising taxes is what I call the Clinton Crunch.

Here are the facts:

1. During each of the last three years, the typical American family has had less real income. Last year alone, the typical family earned $790 less than in 1992.

2. As a result of recent tax increases, the typical family now devotes 24.5 percent of its hard-earned income to federal taxes -- a greater share than at any time in America's peacetime history.

Our current tax code is one of the leading causes of stagnant wages. Countless studies show that today's tax code is placing an unnecessarily high cost on the economy for the amount of revenue raised. Let me mention just a few.

- According to Dale Jorgenson, the chairman of the Department of Economics at Harvard University, who testified earlier today, under our current system 39 cents in output is lost for the marginal dollar of revenue raised.

- According to a study by Jane Gravelle, of the Congressional Research Service, and Larry Kotlikoff, of Boston University, the corporate income tax costs more in lost output than it raises for the Treasury.

- A Tax Foundation study found that the cost of complying with the income tax alone reaches $150 billion annually. More man hours, 5.4 billion, are spent complying with the tax system than building every car, truck, and van manufactured in the U.S.

The flat tax that I have introduced with Senator Richard Shelby would reverse the Clinton Crunch. Because the flat tax is a tax cut, it would let the American people keep more of their own income. Our proposal would reduce revenues by $33 billion in the first year, leaving middle-income Americans with more income in their own pockets. This modest tax cut is paid for with spending offsets.

The flat tax would also reverse wage stagnation and bring about higher levels of economic growth and greater take-home pay. This is what I will focus my testimony on today.

There are five main reasons why the flat tax that I have proposed will increase the standard of living for the American people.

First, by significantly reducing compliance costs, the flat tax would put to productive use resources that are now wasted complying with the tax code. As I mentioned, complying with the income tax alone costs Americans $150 billion. According to the Tax Foundation, these costs would be cut by 94 percent under a flat tax -- a savings of about $1,000 for the typical family of four.

A flat tax simplifies the tax code for a number of reasons, and one of the most important

is the single rate. The flat rate allows the tax on investment income to be collected at the business level, rendering unnecessary the one billion 1099 forms Americans file today. This is explained by Joseph Stiglitz, President Clinton's chairman of the Council of Economic Advisors, in his textbook *Economics of the Public Sector.* Stiglitz writes, "The uniformity of [flat] marginal tax rates...means that income can be taxed at its source; taxing income at its source will reduce compliance costs and increase compliance rates."

If further evidence of compliance savings was needed, one can stop in at any local H&R Block office and review the brochure explaining why the flat tax is too simple. There couldn't be a greater testament to the simplicity of the flat tax than the fact that it has invited the active opposition of H&R Block.

Second, by putting all economic activity on a level playing field, the flat tax will, as economist say, "allow resources to seek their most efficient use." When economic decisions are made based on underlying economic criteria, resources are used more efficiently and the nation is wealthier as a result. The flat tax ends the preferences in our current tax code which divert resources away from their most productive use. As Alvin Rabushka, the father of the flat tax, has observed, the goal of tax reform should be to take the tax system out of economic decision-making.

Third, by ending the bias against saving and investment, the flat tax will encourage more saving and free up additional dollars for investment. Investment, as you know Mr. Chairman, is the key to increased productivity and higher wages.

When workers are equipped with more advanced technology, their output is higher and they get paid more. This common-sense observation is one of the most important truths in economics.

This very point was made in the 1994 Economic Report of the President, which reported:

> *The reasons for wanting to raise the investment share of the GDP are straightforward: Workers are more productive when they are equipped with more and better capital, more productive workers earn higher real wages, and higher real wages are the mainspring of higher living standards. Few economic propositions are better supported than these--or more important.*

Last year administration officials testified before this committee that they believe it is unclear whether ending the double-taxation of saving would result in higher levels of saving. Before joining the Clinton Administration as the Deputy Secretary of the Treasury, Laurence H. Summers reached just the opposite conclusion in a number of different studies.

In a paper for the economic profession's leading economic journal, the *American Economic Review*, Dr. Summers found that "increases in the real after-tax rate of return received by savers would lead to substantial increases in long-run capital accumulation." Dr. Michael Boskin, a former chairman of the Council of Economic Advisors has also found a strong link between the return to saving and the level of saving.

Fourth, the flat tax lowers marginal tax rates, which will encourage more work effort, saving and risk-taking. Economists have long theorized and demonstrated empirically that higher tax rates lead to lower levels of economic activity, and thus a smaller economy. In fact, the economic evidence that higher taxes reduce entrepreneurial and work effort is rich.

A study by economist Robert Genetski shows that high marginal tax rates are inversely related to productivity gains. That is, productivity, and thus wages, tend to rise when marginal income tax rates are low, but productivity falls or grows very slowly when marginal income tax rates are high.

I should note that economists have also shown that higher tax rates lead to higher levels of evasion, resulting in lower-than-expected revenues to government.

Fifth, because the flat tax is a tax cut and would lower federal spending, it would raise the level of economic growth. A recent Joint Economic Committee study by economists Lowell Gallaway and Richard Vedder of Ohio University estimated that each dollar of federal spending restraint increases private sector spending by $1.38.

As federal spending rises, the benefit of that spending declines while the cost it imposes on the economy rises. After an optimal level, which we long ago surpassed, each dollar of new spending weighs the economy down with more costs than benefits. By shrinking the size of government, my flat tax will bring benefits more in line with the costs, thus stimulating growth and creating jobs.

For all these reasons the flat tax will increase the growth rate of the economy. Every study of the flat tax that I have seen, including those studies offered by paid opponents of the flat tax, has concluded that it would improve the performance of the economy. Here is what economists studying the flat tax have found.

Nobel Laureates Milton Freidman, Gary Becker, James Buchanan and Robert Lucas have indicated that a flat tax would improve the performance of the U.S. economy.

Dr. Dale Jorgenson, the chairman of the Department of Economics at Harvard University, testified before the Kemp Commission that under a flat tax the economy would be 15 to 20 percent larger within a decade than it would be if we did nothing.

Dr. Alan Auerbach, an economics professor from the University of California at Berkeley and an associate of the National Bureau of Economic Research, who testified earlier today, found that under the flat tax proposed by Hall and Rabushka the economy would be 2.9 to 5.9 percent larger within five years.

Dr. Michael Boskin, a former chairman of the Council of Economic Advisors, testified to this committee last year that the economy would be 10 percent larger under a flat tax than it otherwise would be.

Even DRI/McGraw-Hill, which was paid $70,000 by the National Association of Realtors to rough-up the flat tax, found that it would add tens of billions of dollars to the nation's GDP.

Mr. Chairman, I believe the economic evidence for a flat-rate tax, which taxes all income only one time, is overwhelming. And in this era of slow economic growth, it affords the best opportunity to raise the living standards of the American people.

Thank you again for this opportunity to appear before the committee today.

Mr. SHAW. Without objection, your complete statement will be placed in the record, as will the statement of all of the witnesses scheduled for today.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Congressman, thanks for testifying, and thanks for your lead in getting us focused in on an alternative tax system and ripping the Tax Code out by its roots.

I have heard the Chairman oftentimes say, though, that a flat tax would not necessarily eliminate the IRS from our lives like a consumption tax would. Could you respond to that question?

Mr. ARMEY. My favorite response comes from my mother who told me when I was a boy that there were two things that were certain, death and taxes. Death has the grim reaper, and taxes has the IRS. As long as there is a government, a government will have to raise revenue. As long as it raises revenue, there will be an enforcement agency. You can call it the IRS. You can call it what you like.

The best we can hope for is to make the Tax Code minimal and civil and, thereby, allow the agency that enforces it to be minimal and civil.

In a flat tax world—one of the things that we were amazed and pleased to find out—as I have written the bill, most of the data points now required to be traced by the IRS go away. Therefore, their enforcement ability is much greater.

There is less incentive for tax evasion, because the marginal rate is so low, and less opportunity for it.

So the experience we have had in 22 other nations that have tried a national sales tax has, strangely enough, resulted in increased tax evasion. The underground economy has actually grown. The enforcement agency has grown larger.

I know of no way to enforce a national sales tax except to ask the retailers of America to collect the taxes on behalf of the government, and I always point out to a retailer, you are going to have somebody from the IRS or some such-named organization in your shop. They are going to say, Let me see your sales receipts, let me see your purchase orders, let me see your inventory, and let me see if you are doing my job good enough to suit me.

My own view is that you are going to have a larger, less congenial enforcement agency under a national sales tax than what you will have under the flat tax.

Mr. CHRISTENSEN. How does the Armey flat tax address the life insurance aspect? How would you tax that?

The inside buildup of life insurance products, as you know, are tax free. How does the Armey flat tax address that savings vehicle?

Mr. ARMEY. We would not tax that.

The fundamental principle is that we would gather every dollar's worth of income earned in the economy in any year and tax that dollar in that year at the same rate as every other dollar.

If, in fact, you had an inside buildup in a whole life insurance policy—I assume this is what you are talking about—that policy would have been purchased with aftertax income.

Mr. CHRISTENSEN. No further questions, Mr. Chairman.

Mr. SHAW. Mr. Rangel.

Mr. RANGEL. You are the ultimate House leader in legislation, and here we are having these series of hearings before the election without knowing that we are going to mark up a bill. We are not taking anything to the floor. How does that fit into the leadership concept as to why we are having these hearings, knowing that it is not for political reasons?

Mr. ARMEY. I have no idea. The Chairman of the Ways and Means Committee does not consult with me before he schedules hearings. I had no idea this hearing was being held or that I was going to testify until I got up this morning and looked at my schedule.

Frankly, I would say, Mr. Rangel, I am not the person to whom you ought to address the question about the scheduling of hearings for this or any other thing.

Mr. RANGEL. I made a mistake. I didn't know that anybody scheduled anything without checking with the leadership, but having said that, this is one of the——

Mr. ARMEY. That may have been the way it was in the old days. I don't recall.

Mr. RANGEL. No. Listen, I welcome back at least that we have the authority, at least the Republicans have the authority to have hearings as long as we don't go beyond that, because it is my understanding that a tax bill is not on the agenda. That would be a part of your jurisdiction as to whether or not legislation is scheduled for this year.

So, even though you are not in charge of hearings that go nowhere, could you share with me whether or not we intend to have a tax bill, or is that up to Chairman Archer?

Mr. ARMEY. I would think that, obviously, especially if you were going to talk about a tax bill of the magnitude of major tax reform, such as a flat tax or a national sales tax, that the appropriate Committee, the Ways and Means Committee, would have to receive legislation, elect or mark the legislation up, hold the hearings, and then go through an appropriate markup and bring the legislation to the floor.

I, as a Member of this body, even given my status as Majority Leader, reserve the right to write legislation and submit it to the process. My bill has been referred to this Committee. I would hope the Chairman would choose to pick up my bill and mark it up, but should he fail to do so and bring another bill——

Mr. RANGEL. Is it within your legislative plans that we will take any bill, preferably, as you said, yours, to mark it up, for getting it out of the Committee this year? Is that a part of your plan?

Mr. ARMEY. I don't believe that is expected to be done this year, but I would think that the Chairman would be quite correct in saying that insofar as we plan to be prepared to do so next year, we ought to start holding hearings this year.

Mr. RANGEL. But he won't be the Chairman next year. That is why I am asking why we are doing this.

Let me move on, though.

Mr. ARMEY. We always proceed on the basis of great expectations.

Mr. SHAW. If want-to-be Chairman Rangel will yield to me for——

Mr. RANGEL. No, no. That is going-to-be Chairman Rangel.

Mr. SHAW [continuing]. One quick observation, Chairman Archer does not intend to mark up a tax bill as comprehensive as the one we are discussing today until next year, but he wants to continue a series of hearings to examine the existing code and to look at possible alternatives.

I thank the gentleman for yielding.

Mr. RANGEL. You said not this major bill. Could you share with me whether the Chairman intends to mark up any bill or to have any legislation?

Mr. SHAW. I don't know the answer to that.

Mr. RANGEL. Let's get back to this flat tax here. There has been some controversy as to the cost of this. I think Treasury would indicate that it is not revenue neutral. You have dealt with that before at some other forum.

Mr. ARMEY. We have had some studies that have been done about the scoring of the flat tax. Treasury has had a couple of false starts. There have been a couple of other organizations.

It is our assessment of the flat tax that I have written, as I have written it, that it would come within $33 billion of revenue neutrality.

I would argue, and will argue at the appropriate time, that when it is officially scored for consideration that the way you make up that difference in order to be deficit neutral is to cut government spending.

Mr. RANGEL. We don't do it that way on this Committee. We have to balance it out beforehand. You are saying that even though it appears as though it is costly, you just cut government spending and we balance it that way?

Mr. ARMEY. Mr. Rangel, for me to have a goal of revenue neutrality, it would presume that I would endorse the current levels of spending and taxation of the Federal Government, and I endorse neither.

Mr. RANGEL. We don't have jurisdiction over the other Committees, but you are the leader. So I know you would work out that package.

Let me ask about this earned income tax credit. You leave in the Social Security, but you take out the earned income tax credit. Is that supposed to be compensated for by the removal of the lower income people from the tax structure?

Mr. ARMEY. The earned income tax credit is a form of income supplement to low-income people.

I happen to have a very strong approval of extending the supplement to low-income people. I don't agree that the best and most effective way to do that is through the Tax Code. If you have a Tax Code that is already as cumbersome and confusing as the one we have, it is probably acceptable to use the Tax Code for that purpose, but if you are going to achieve the ideal of a flat tax, which is fair, it is better to move the supplementation of low incomes to the expenditure side of the ledger, which is what I propose.

Mr. RANGEL. Is the expenditure side of the ledger in your proposal? How would you bring up people below the poverty line to living decently?

Mr. ARMEY. As you know, now we have a very large number of programs designed to do that, none of which are typically counted in the lives of these people as we measure the extent to which they are not able to achieve the poverty line.

I think there needs to be a fairly comprehensive reform. We have talked about welfare reform as one part of that aspect, but as we move forward, I think we have to have a more realistic measure of the real income of the American people at different levels and then have a more realistic assessment of the kind of supplements to American low-income families as we go forward on the expenditure side. There should be some coordination on that.

Mr. RANGEL. You are really clear and articulate when you are talking about cutting taxes, but, boy, when it comes to what you are going to use to make up for the removal of the earned income tax credit, all I got was that you are going to cut back government spending and try to work out something and determine how we are going to do it. Right now these people are going to be in deep trouble until we figure out what we are going to do. Is that a fair understanding of your testimony?

Mr. ARMEY. Not altogether fair. Obviously, folks that are currently without work would be the first beneficiaries of a growing economy where more jobs were made available to them in the growing economy.

Mr. RANGEL. You mean those without work would be the people that would benefit the best under your proposal, right?

Mr. ARMEY. Absolutely.

Mr. RANGEL. Mr. Leader, you are making more and more sense. So the more people we have unemployed, the more beneficiaries we would have.

Mr. ARMEY. There seems to be a very general consensus that the primary cause of poverty is separation from the world of work. In a growing economy, you have the first opportunity to reunite people with the world of work experience.

Mr. RANGEL. And the flat tax is the best key to open up that door of opportunity?

Mr. ARMEY. I believe a flat tax is the best thing this government can do to allow the economy to achieve its more natural growth rates that are substantially higher than what we have today.

Mr. RANGEL. As long as it is coupled with a cut in Federal spending.

Mr. ARMEY. I agree.

Mr. SHAW. Mr. Collins is recognized.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Armey, I appreciate the fact that you have led the battle in this ongoing effort to change the Tax Codes. There are a lot of people in the Third District of Georgia who I have the honor of representing who really like the idea of a flat tax. There are also many people in the Third District of Georgia who favor the national sales tax. You can almost find unanimous agreement among the people of the Third District of Georgia that they would like to do away with the IRS.

In your proposal of the flat tax, how do you treat estate taxes?

Mr. ARMEY. In my proposal, estate taxes are eliminated under the principle of no double taxation of the same income. So there are no estate taxes in the flat tax.

Mr. COLLINS. That is good.

Did I understand you right on the earned income tax credit that you would eliminate the EITC?

Mr. ARMEY. Absolutely.

Mr. COLLINS. Is the basis for establishing poverty levels based on earned income or income?

Mr. ARMEY. As I understand it, the official measurement of the poverty level precludes an awful lot of the benefits that are being received currently by lower income persons. So that, with an incomplete measure of their real income, we have more people that are declared to be in poverty, given a level that is set, than what actually are because we do not count their full income. I think we ought to have a full and comprehensive accounting for that.

Mr. COLLINS. If I understand you right, you are saying in the judgment of how we determine poverty, we base it on earned income. Then, someone who has enough assets to live on for 1 or 2 years, from the interest on those assets, would not have any earned income as such and would not be eligible for the EITC under that type of setting. Is that what I understand you to be saying?

Mr. ARMEY. I am not quite sure about under the current system, but I do think that a lot of the benefits that they receive from the government are omitted from the accounting. To the extent to which they credit it against their income, income that is derived from sources of earning other than their own labor, is not something that I am technically qualified to answer.

Mr. COLLINS. Your flat tax would tax all income?

Mr. ARMEY. My flat tax taxes all income one time at the same rate as all other income at its source.

Mr. COLLINS. That is earned and unearned income?

Mr. ARMEY. I make no distinction between earned and unearned income. I believe what you are referring to is income that is earned by wages through labor as opposed to income that is earned by the provision of capital to the production process.

Mr. COLLINS. That is right.

Poverty is determined under the current system by earned income, not unearned income.

Mr. ARMEY. That may be the case. I am not sure.

Mr. COLLINS. Thank you, sir.

Mr. SHAW. Mr. Houghton.

Mr. HOUGHTON. No questions.

Mr. SHAW. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

I will try not to quiz you too tough today.

Mr. ARMEY. All right. I am still mulling over the last question you asked.

Mr. JOHNSON. I will have to tell you, I was disappointed at my interpretation of my colleague Mr. Rangel's statement that apparently your side doesn't think the IRS is intrusive and doesn't want to make any changes in our Tax Code. That disappointed me a little bit. I would have hoped you would have been a little more observant of how the IRS has responded.

Mr. RANGEL. The gentleman misunderstood me, but it is OK with me.

Mr. JOHNSON. I misunderstood you?

Mr. RANGEL. I think so.

Mr. JOHNSON. Bless you.

I would like to ask you this. You mentioned income here. How are you addressing dividends and interest, per se? Forbes got questioned pretty heavily on that.

Mr. ARMEY. Yes. This is a very difficult thing for some folks to grasp.

When you own stock or bonds in a productive enterprise, a business, that enterprise has its gross earnings, and those earnings are taxed with a corporate income tax. In my Tax Code, it is a 17-percent corporate income tax on gross earnings.

Dividends are the distribution of aftertax earnings to the owners of the corporation. They would not be taxed a second time in the flat tax.

It bothers a lot of people that the person who actually receives the income doesn't file the forms and pay the tax, that the forms are filed on their behalf by the corporation, but you get naturally drawn that way if you want to get the compliance savings that you get by collecting at the source.

There is a tax form. I make reference to it, the 1099 form. There are 1 billion 1099 forms that are sent out that will not be sent out under my proposal.

I am a little amazed that people find that difficult, and I will give you an illustration of why. I have filed my taxes every year of my life since I was 16 years old. I have paid my taxes every year of my life since I was 16 years old.

It just occurred to me last February when I filed my taxes, I have not once in my life written a check to the IRS. Why? Because my taxes are collected at their source, by my employer who withholds them, remits them on my behalf, and sends me a notification to that effect.

When I first wrote the flat tax, I wanted to end the withholding, but it was scored by the Joint Tax Committee as a $10 billion loss for all the cost it would be to process all this process over.

By the same token that I now say let's save the compliance cost that we now have associated with the double taxation of capital earnings by taxing again, a second time, at the point of distribution, I conceded that we should have to continue suffering withholding tax for wage earners because it reduces that compliance cost.

The basic fundamental question one has to ask, if I provide labor to production and you provide the capital, is it fair for your income to be taxed twice and mine to be taxed only one time? My answer is no, that is not fair.

If you think we ought to double tax the income earned by those who provide capital, then an alternative way to make it fair is to have the business withhold my taxes, send me my aftertax income, and have me pay tax a second time on that. I think most people would find that considerably unacceptable.

Mr. JOHNSON. Let me ask you another question. The three people who testified this morning before you indicated that a flat tax was

a consumption tax. You keep referring to it as income. What do you consider it as?

Mr. ARMEY. I think they are talking about the base on which the tax is built, and I believe that I would accept that. It is a rather esoteric thing.

Mr. JOHNSON. It is not esoteric in the fact that if we have a flat tax and we call it a consumption tax, how do we prevent having a second tax, an income tax laid on top of it.

Mr. ARMEY. My own view is we have very little danger of enacting a flat tax and then having a second tax.

Mr. JOHNSON. What is to keep it from expanding the way it has already under the current system?

Mr. ARMEY. I am sorry?

Mr. JOHNSON. What is to keep it from expanding the way the current system has?

Mr. ARMEY. If you enacted the flat tax as I have written it, you would put in a three-fifths vote requirement for both the House and the Senate to either raise the rate, lower the family exemption, add a second rate, or restore any of the personal deductions. That is the best way I know of to protect the Nation from a future Congress.

Mr. JOHNSON. Thank you.

Mr. SHAW. Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman.

I appreciate the testimony from our distinguished Majority Leader on behalf of the flat tax.

Let me ask you a question, though, Dick. You don't tax interest, dividends, or capital gains at all, right?

Mr. ARMEY. No. I don't tax them twice. They are all taxed at their source. That is 17 percent.

Mr. CRANE. How about estate taxes?

Mr. ARMEY. No estate taxes.

Mr. CRANE. No estate taxes.

Let me ask you a question, though, on one provision that I have spoken to you about in your proposal, and that is taxing business. Doesn't that end up as double taxation of the individual consumer?

Mr. ARMEY. Are you talking about small business?

Mr. CRANE. Any business. Businesses don't pay taxes. They gather taxes, and they have got to pass them through to you and me but still show a fair return on their investment or they are out of business.

Mr. ARMEY. Surely.

Again, irrespective of your structure, whether you are corporate, individual, or partnership, you would pay taxes on the gross earnings of the business as a business tax, and you would pay at 17 percent.

Mr. CRANE. Yes, but that is a cost of doing business.

Mr. ARMEY. Absolutely right.

Mr. CRANE. Who ultimately picks up that cost?

Mr. ARMEY. People do.

Mr. CRANE. Right. So it is only individuals who pay all of the taxes, even though you are affecting some of them indirectly through business operations.

Mr. ARMEY. The guiding principle of the flat tax is the recognition that all taxes are paid by people and all taxes are paid out of current income flows, but the fact of the matter is I can earn my income in one of two ways. I can either provide capital to the production process or I can provide labor to the production process, and both are essential to the process of production, and the earnings received from both should be taxed, but only one time. So the providers of capital are treated exactly the same as the providers of labor.

By the same token, if you say, All right, Armey provided labor to my production and that went into my cost of production not only what I paid him in his net pay, but the taxes I remitted on his behalf, that, too, must be covered in the end. So, this, I think, is going back to Mr. Johnson's point that you do have, then, in the end a consumption base to your Tax Code.

Mr. CRANE. That capital input was taxed already at the time you acquired it.

Mr. ARMEY. Again, in the flat tax, at the time you acquire capital or inventory, you expense it.

Mr. CRANE. My only concern with your proposal, and it is the concern I have with the consumption tax approach, too, is that there are hidden taxes, hidden directly from the consumer. It is a little bit like going to the gas pump and filling your tank, and I have always argued they should only indicate there the cost of your gasoline. Then when you go in to settle up, they will tell you what your tax bill is on top of that. Taxes, I think, should always be levied in the most simplified, easiest-to-understand, and, I might say, painful possible way, so people are acutely aware of what they are paying in taxes.

That same principle, kind of indirectly, applies, it seems to me, when businesses are paying taxes and, yet, you don't see that in terms of the purchase price of the commodity you are buying.

Mr. ARMEY. I agree with you on that. Taxes should be as visible as possible to people who pay the taxes.

Mr. CRANE. I commend you for your efforts in this, and I think it is a major educational battle to get people to fully understand.

I am sure you have probably seen the figures with regard to the home purchase mortgage deduction if you eliminate that. We have 64 percent home ownership here in the United States with that provision in our Tax Code. Canada has 63 percent home ownership without any such provision. Japan has 62 percent without any such provision. Australia is pushing 75 percent without any such provision. People buy homes not because of the motivation of that deduction. There are other compelling reasons to own a home.

I salute you for your efforts. Keep up the faith, and keep up the good fight.

Mr. ARMEY. Thank you.

If I could just comment, I am not eliminating the home mortgage from the Tax Code. I am eliminating the Tax Code in which you find it today.

Thank you.

Mr. SHAW. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Armey, I think one of your statements in your presentation was that if you were a home seller, you would pray that your proposal is adopted. The realtors and homebuilders I have talked to from my district are praying that it is not adopted, and their fears, as well as those of the people I represent, are about the issues of home mortgage interest deduction, property tax, and many, many people have written over the last few months since the Forbes proposal was out there about the charitable contribution deduction. So, know full well, there are people praying against you, also.

Mr. ARMEY. Would you like me to respond to that?

Mr. KLECZKA. Certainly.

Mr. ARMEY. If I may, as I wrote the bill, and I spent from January 1994 to June writing the bill, we studied these two because they were, obviously, important areas.

What did we discover about the home ownership? It was, frankly, quite surprising. Only 25 percent of tax filers take the home mortgage deduction. If you were to reinstate that in the new Tax Code, you would have to raise the rate on all tax filers.

Even more surprisingly, only 43 percent of homeowners take the deduction. That surprised me.

We also discovered in a recent poll that was commissioned by Citizens for a Sound Economy that 66 percent of new home buyers said that given the other benefits of a flat tax, they would be more than happy to give up their mortgage in order to have that.

We have had a lot of people try that. You heard the statistics cited by Mr. Crane.

Now we find a recent study by the Heritage Foundation, which I understand will be supported by a couple of other studies soon to come out, that home values are projected to go up anywhere from 7 to 14 percent over the next 5 years in a flat tax world because of the economic growth and falling interest rates.

A Kansas City Fed economist wrote an article in which he argued interest rates would fall by as much as 25 percent. So, if your income is going up and your interest rates are coming down, the two principal components of the home purchase decision are working in favor of home purchases.

On charitable contributions, as we studied that, we discovered that only one-half of charitable contributions are deducted by people under the current Tax Code, and during the eighties when we cut the tax value of a charitable contribution by more than one-half, charitable contributions more than doubled, and in fact, charitable contributions to religious organizations tripled during the eighties.

We deduce from that, that the reason people give is because they have, and when they have more, they will give more. I believe charitable organizations will thrive in a flat tax world because of the economic growth and increased incomes.

Mr. KLECZKA. The other major concern I have is the effects that a flat tax might have on employer-provided pension and health care benefits, and also, what I would like to ask you is to explain more fully for me the 20-percent tax on State and local governments who offer health care benefits to their employees.

As far as the employer-sponsored deductions for health care and pension, do you not believe that once that deduction is taken away

that the incentive to provide a decent health care benefit to employees and/or pensions would also be taken away?

Mr. ARMEY. I believe the incentive for employer-provided insurance would be taken away, but I believe it would be supplanted with a much more beneficial incentive, and that would be the incentive for the employee to say to the employer, Give me instead an increase in my salary that is equal to what you are now paying to give me more insurance than I want or need and can use, and I will go out and wisely buy insurance for myself.

Mr. KLECZKA. That might sound well, but I as an individual going to the market to buy a policy will not get the same rate as a group plan would, and so my employer gives me a couple more bucks and I have to shop around for my own plan and know full well I am going to pay a heck of a lot more than the 2,000 other employees that he is buying for in a group-type situation that is part of the benefit provided by the employer.

Mr. ARMEY. There is no doubt about it, it is a fascinating question, and I will give you a couple of points.

Mr. KLECZKA. The effects are scary, though.

Mr. ARMEY. First of all, in employer-provided group plans, we typically have people that are overinsured, and I will give you a quick example.

You won't believe this, but I am 55 years old.

Mr. KLECZKA. Oh, I believe it.

Mr. ARMEY. My wife is younger than I. We have both raised five children and put them all through college. We are 100 percent dedicated to the proposition that we will never again in our life use maternity benefits, but we get them because we are in a group.

Were we to buy our own insurance, we would not be buying benefits such as that, that we know we will never use. It is, like I say, a tricky proposition.

The fact of the matter is, that employer-provided insurance is such an institutionalized part of labor contracts these days that I dare say it would never be substantially changed by employers except by the initiative of the employees which I believe you would find expressed in a flat tax world where they found that I could get—let's say, give me the $5,000 you are now laying out for my insurance. I will pay the 17-percent income tax on that, and I will go out and buy me the kind of insurance I need for me and my family, and I will be better off.

Mr. KLECZKA. Would you address quickly the 20-percent tax on State and local governments?

Mr. ARMEY. That would be to make it uniform that all income that is received by an employee be taxed.

The health insurance that you currently receive from a private employer is part of your real income, and we would say to the private employer, You pay the tax on that. So we would say to the State and local government, You do the same.

Mr. KLECZKA. The effect of that would be for the local governments and State governments to reduce or eliminate that employee benefit?

Mr. ARMEY. I have to say, I don't share your concern about that.

Mr. KLECZKA. My realtors don't like it because of the loss of the mortgage interest deduction. Consumers who are in need of health care should be very, very fearful of this proposal.

Thank you very much.

Mr. ARMEY. Thank you.

Mr. SHAW. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

To the distinguished leader, it is always good to see you, and I appreciate your leadership in this area of tax reform.

I just want to focus a bit on the issue of economic expansion and job growth. I was quoting some statistics in the morning session of projected population growth for our country. People who study population trends and so forth are predicting that by the year 2040, this Nation will be comprised of about 400 million people. So, obviously, we have to grow the economy.

The projections of economic growth as far as economists project currently show for nothing more than 1 to 2 percent growth rate indefinitely. So, obviously, this is a big part of tax reform in addition to providing simplicity and fairness and all the other desirable elements of any tax system.

This morning, we heard from three distinguished professors who advocated a broad-based national sales or value-added tax, and it was their judgment that output could be increased by 9 percent in the long run.

Let me ask you with respect to the flat tax, and we have heard from the Chairman of the Commission, Jack Kemp, and Jude Wininski that at least in their judgment a flat tax would double the output in the long term. In other words, we could grow from a $7 trillion economy to a $14 trillion economy in their considered opinion.

Where do you see the growth rate, given a flat tax?

Mr. ARMEY. It is always hard to pin these things down exactly, but we cite in my testimony a good different many scholars. My favorite citation is Dale Jorgenson, the chairman of the Harvard Economics Department, who says that the growth rate could go as high as 5 percent per annum for 5 years.

There is no doubt, though, that everybody agrees that it will be growing.

Auerbach who, for example, is not particularly a friend of conservatives says the economy would be 5.9 percent larger within 5 years. So there is no doubt that everybody, even DRI/McGraw-Hill, says there will be economic growth.

I don't know. I believe that it is possible for this country to reach and sustain a growth rate of 4.5 to 5 percent for an indefinite period of time, but that can only be done with the vitality of the investment cycle, and if you are double taxing investment income, you are always going to have that working against you.

Savings and investment, for as long as we have had the discipline of economics, was identified even by Adam Smith in 1776 as a principal cause of economic growth, and the flat tax does that. I think a national sales tax would do that.

I don't know the extent to which a value-added tax might do that. My own view of the value-added tax is that it is such an insidious tax, it shouldn't be studied in the first place.

Mr. RAMSTAD. But you wouldn't argue, then, that a flat tax would necessarily promote more economic growth than a national sales tax. The key, you think, is not taxing investment income.

Mr. ARMEY. I think that is the key.

My own view is a flat tax has a higher degree of neutrality than the national sales tax. The national sales tax actually seeks to promote savings and investment by directly taxing consumption, and my own view is that if you leave people with a neutral Tax Code, you will probably get better activity than you will with any Tax Code that has any government bias built into it, but that is more predilection than an empirical observation.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Mr. SHAW. Mr. Houghton.

Mr. HOUGHTON. Yes.

I would like to follow up on this concept of growth because it bothers me. When you take a look at a company, there are three ways the company can grow, one through its earnings, two through its borrowing capacity, and three through its net worth.

If you apply that to this country, we are not earning any money, we are borrowing to the point where our capacity is going to run out, and our net worth, who knows what that is.

When you take a look at the statistics as far as growth is concerned, in the eighties, really, we had about a 3.9-percent growth rate. In the fifties and sixties, which were really very good economic years, we had less than 4.5 percent. So you are saying that now this will unleash something that we have never seen, even with the postwar boom, and it will increase our growth rate to over 4.5 percent?

Mr. ARMEY. Yes, I am, and I will tell you why. I know of no time in my lifetime when we did not double tax savings and investment. So this would be the first time since, Lord knows when, that we treated savings and investment in a nonprejudicial manner in the Tax Code.

So we should be able to achieve better growth rates than we did even in the fifties with all of the dynamics of the fifties and the sixties.

Mr. HOUGHTON. What difference does it make, Dick, from an economic standpoint whether the savings comes from this country or abroad? Clearly, our savings are low. So we don't have enough money to borrow from ourselves, but the point is that the cash is always available, and the cash has been available.

So, although we borrow it from Mr. X who lives in Japan versus Mr. Y who lives in the United States, economically, why does that make any difference?

Mr. ARMEY. It is not just a quantitative problem. It is a qualitative problem, too. For too much of our economic experience, the Tax Code has actually steered the investment of capital into second-best alternatives, alternatives that didn't get the best financial or economic score, but got a tax score that was high enough to put it over the top.

If you have neutrality, the quality of your investment, the investment decision will be based solely on economic or financial criteria and not at all on tax criteria.

So you have a greater availability of savings and investment, a greater incentive to pursue income through these two sources, and no tax bias that would cause you to direct your investment toward some option that would be an economic or financial second-best option.

Mr. HOUGHTON. Coming back to the original point, I am interested in transitions, and if you put in your flat tax or a flat tax was put in, whether it was the Forbes or the Kemp or yours or whatever it is, continuing your line of reasoning, with our borrowing now at the moment, we are not going to be able to generate any earnings until we get within reasonable destination of no borrowing. So I just don't understand how we can move from where we are with the present economic conditions to where you want to be without some tremendous intermediate upheavals.

Mr. ARMEY. First of all, I would argue that, immediately, there is an incentive for increased saving, and there is a decreased incentive for debt. You would probably find businesses expanding more on equity ownership and less on debt for example. So the interest rates will go down, and there is a generalized consensus on that.

Second, in your transition rules, you probably would have to be most mindful of current long-term capital investments under depreciation schedules that would have to be worked out, but you could begin immediately expensing inventory and capital, and particularly, in the high-growth sector of electronics and computers where obsolescence is almost an immediate phenomena, you would have a greater incentive to make the investments because you could have that expensing phenomena.

So I think the growth would show up more quickly than it would under a system where you left the structure of the current Tax Code in place and just lowered the rates because the changing structure has an enormous impact on the behavioral response of the people.

Mr. HOUGHTON. Suppose you just adjusted the capital gains, eliminate it, and at the same time took savings off the taxation roles, similar to the Nunn-Domenici plan. Wouldn't that do what you want?

Mr. ARMEY. If you did it the way the Nunn-Domenici plan has done it, you would have some beneficial effects on that side, but remember, the marginal tax rates went up incredibly under the Nunn-Domenici plan, and that was a major bother.

In the flat tax, you get the neutrality. You get the single taxation of capital and savings. You get the expensing of inventory and capital, and you get the lower marginal rates. So you have everything working in the same direction.

Mr. HOUGHTON. Thanks very much.

Mr. SHAW. Mr. Laughlin.

Mr. LAUGHLIN. Thank you.

Mr. Leader, as I travel around the 14th District of Texas, there is a great deal of interest in your flat tax, but at the same time, people generally express concern in two areas, and while they may sound simplistic, they are valid concerns.

First is their observation that the current Tax Code, that they consider an absolute mess, started out as a flat tax. How do you approach in your flat tax proposal the creep or the growth of the

tax increase and all of the deductions, exemptions, and the problems that create the mess that you are trying to correct with your flat tax?

Second, and probably of greater concern, how do you deal with the IRS in your flat tax? One of the things that appeals to most of the people I talked to about the consumption tax is their idea that you are going to abolish the Internal Revenue Service, and there is great concern about the flat tax retaining the IRS, which in the lives of the people I represent, it is intrusive and abusive, and we heard a lot of testimony on that last week before this Committee.

How do you address those two concerns of the people I represent?

Mr. ARMEY. The first thing, obviously, once you put in the flat tax, and my own view is you stay flat or die, it has got to be 100 percent, and it is no policy for the timid. So take it straight out.

Then you put in the safeguards in terms of the future vote requirement to either raise the rate, add back itemized deductions, add a second rate, or lower the family exemption. That is the only way I know. There is no 100-percent safe way to protect America from a future Congress. So we do the best we can, and I think that will be very useful.

Plus, the fact that you have got a single rate for the entire population, you can't hit one segment of the population this year and survive the reelection and come back and hit another section next year. You are going to have to hit everybody at the same time. I think people are going to be reluctant to do that.

The way I deal with the existence of the IRS is as I said before. I think we need to understand that as long as there is a government, a government will have to raise revenue, and no matter how they levy taxes, there is going to have to be an enforcement agency. Quite frankly, if somebody said to me, You take my plan and I promise you there will be no Federal tax enforcement agency, I would consider this to be a rather doubtful thing that would fall under the category, I'm from the government, I'm here to help you.

The realistic thing is, understand there will be an enforcement agency, so write a civil code. I get an awful lot of cards and letters from people who work in the IRS who say keep on with your flat tax, you guys have given us a Tax Code that you can't understand, we can't understand, and the taxpayers can't understand, and now you have said go out and enforce it.

People say IRS people are cranky. Every time I am given a job that is impossible, I get cranky in trying to do it, and they are saying we would like to be civil and we would like to get along with folks and we would like not to get up every morning with a headache trying to figure out this Tax Code you guys have written, so give us a simple Tax Code and we will be civil in the enforcement of it.

I believe that. I believe that the flat tax bets on the goodness of the American people, not the guile of the Federal Government.

Mr. LAUGHLIN. It is your viewpoint, then, under your flat tax proposal that you would operate with a substantially smaller IRS?

Mr. ARMEY. It would be much smaller. It would be much more civil.

It is my belief that a flat tax will give you a smaller and more civil enforcement agency than what you can get with a national sales tax.

I understand the attractiveness of the national sales tax, and I think it is a great idea compared to the existing Tax Code, but I think just about every objective you would try to achieve with a national sales tax can be more fully achieved with a flat tax.

Mr. LAUGHLIN. Is it your viewpoint that under your proposal, with a smaller and more civil Internal Revenue Service, the American citizens, when they deal with the IRS, would feel that the IRS starts the whole proceeding as if the individual American citizen is already guilty. How do you change that mentality?

Mr. ARMEY. I think you can change that mentality, but I think you could do that better with something like a taxpayer's bill of rights that we will try to bring forward even this year, which we can do.

Mr. LAUGHLIN. Thank you, Mr. Leader.

Mr. ARMEY. Thank you.

Mr. SHAW. Mr. McNulty.

Mr. MCNULTY. No questions.

Mr. SHAW. I just have a few, and Mr. Gephardt is supposed to be here, I believe, at any moment.

I have just one question. I noticed in reply to one of the earlier questioners, you mentioned that inventory would be written off when it is purchased, which I assume means that you put your merchant strictly on a cash basis and not on an accrual basis.

What do you do about depreciation of plant and equipment?

Mr. ARMEY. Obviously, we would have to have a transition period for existing depreciation schedules, but any new plant and equipment that would be purchased after the flat tax, you would have an immediate expensing of that.

If, in fact, you had an expensing that was great enough to give you a loss for the year, you would have a carryover. So you would be maintaining no depreciation and no inventory records.

Mr. SHAW. Do you think, though, that corporations should probably have two sets of books, one to account to their stockholders and the other to account to the Federal Government? You should set up some sort of depreciation. Quite frankly, just as I think the Federal Government should do, we are on the cash basis right now, and we should go to some type of budgeting where we depreciate buildings rather than just write them off immediately.

We are making a lot of bad business decisions as a Federal Government in renting these buildings—when we should be actually owning these buildings—because of the way that our budget process operates. It is capital budgeting that I think we ought to be going toward.

So I would anticipate that you would account to stockholders differently than you would account to the Federal Government.

Mr. ARMEY. My own view is that in a flat tax world, if I were running a corporation, I would keep my books in such a manner as to make my best decisionmaking information available to myself and for reporting to my stockholders.

My accounting department would be spending most of their time providing me with the information I need along the lines of mana-

gerial accounting and cost accounting, and they would be more productive contributors to the efficiency of my operation with the information analysis they could give me.

From that, which I desire to maintain my own records for my own purpose, I could easily garner any information I need to substantiate my tax filings.

Mr. SHAW. Would there be anything that would be detected? Somebody asked me just a few hours ago about how one would treat alimony where the wife now declares it. It used to be just the wife, but now the recipient of the alimony declares that as income, and the donor of the alimony takes that as a deduction. Would you change that, or have you thought that through?

Mr. ARMEY. It would be taxable to one or the other. I am not quite sure how we ought to tax it. Do you have any suggestions?

Mr. SHAW. I think there will be some. If we do get into a flat tax, I am sure there will be a lot of things such as that, which this Committee will have to look into, in depth, and make some decisions on.

Mr. ARMEY. I would hope that the question would not be something that I would have to deal with intimately at any time in my lifetime, but we will try to look after it. It would definitely be taxable income to either the payer or the payee.

Mr. SHAW. Dick, as always, it is a pleasure to have you before our Committee, and thank you for a very thoughtful testimony.

Mr. ARMEY. Thank you.

Mr. SHAW. We are ready now for Mr. Gephardt, the distinguished gentleman from Missouri, who is the Minority Leader in the U.S. House of Representatives.

Richard Gephardt, we have your prepared statement, which we have made a part of the record, and you may proceed as you see fit.

Welcome back, by the way, as a former Member of the Ways and Means Committee.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. GEPHARDT. Thank you, Mr. Chairman. You are very kind to have me here. I always appreciate the opportunity to come back to my Committee and have looked forward to entering into this debate on elemental tax reform which I think is very important for our country.

I will have a written statement that I will send over to the Committee. It wasn't quite prepared and enough copies, but we will have it here for your perusal. I will just talk for a few minutes off the top of my head about this, and then, if we could have any questions you would have, I would be happy to try to respond.

Let me first say that I think it is important to know that there is a good deal of agreement on a bipartisan basis about the need for tax reform. I agree with Dick Armey and Steve Forbes and Jack Kemp and lots of other people who have talked about the need for fundamental tax reform. I think the Code is too complicated. I think we have tried to engineer the economy too much from Washington. I think it is time that we had elemental tax reform, and I have felt that for a long time.

I guess where we all begin to differ is on exactly how to accomplish this tax reform, and the plan that we have put together is one that does get to a lower tax rate for all Americans. It does get rid of all of the deductions except for the home mortgage interest deduction, and it gets to a 10-percent rate for 75 percent of America's taxpayers, something that I think is very important in order to make the Code as simple and as fair for as many people as possible.

I do maintain four rates in addition to the 10-percent rate because, as you might expect, I believe in a progressive Tax Code. Since it has been progressive since 1912, I think it ought to remain that, and our rate system winds up with a top rate of 34 percent. We have a rate of 20, 26, 32, and then 34 percent. The 34-percent rate applies to dollars above $265,000 a year, which is a high amount, but, indeed, it would apply to those amounts.

The final thing I would say is that I think it is important as you review these proposals that we try to put all of the proposals on a level playingfield. That is, we can argue at a different time about how much money the government should take. That, to me, is really a different set of ideas, but we ought to make sure that all of these proposals do not increase the deficit.

I know we have complaints and disagreements over how to judge all of that, but just as we have pretty well put behind us for the budget a discussion whether it should be CBO or not, I think we have all agreed CBO should be the judge. I think we ought to decide at the outset that CBO or OMB or the Joint Tax Committee or somebody is going to make this decision about how much money these proposals bring in, and then judge all of them by that standard.

I think if that is done, the flat tax proposals at 17 percent will have to be adjusted.

I know that Mr. Armey adjusted his proposal. I just think we need to be on a level playingfield as we look at all of these proposals.

Finally, let me say that whether we get to this, this year or next year, I hope that we will seriously go about this. It is very hard to get tax reform done.

Some of you on the Committee did this in 1986. You will remember the difficulties we had. It is hard to do, but I think it can be done.

I do think we have got to try to reach some agreement on some common goals, like whether it will bring in as much revenue as we do today or not or whatever that number should be. I think we should try to agree on whether or not we want progressivity in the Code or not. That is an important issue. I think we have got to come to some agreement on investment income as opposed to so-called earned income. That may be an unfair term, but investment income versus income earned as a salary.

We have got to decide, obviously, if we want to take most of the deductions out. I get a little alarmed by some who say they are for tax reform and then they say they are for keeping this deduction and that deduction and the other deduction. Before long, you are back to the present code, and tax reform is really not, in my view, about trying to put everything back in, but it is about how much

we can get out of the Code in terms of deductions and exemptions, so that we can get to a real discussion of what this should look like.

I am very, very much for the idea that we can get a great majority of taxpayers on a 10-percent rate. I think that is an important goal to try to hit. It would mean to most Americans that if they did their withholding right, they would not even have to file a tax return, and I can't think of a better thing to say to people that the Federal Government needs 10 percent of your income, your gross income, and we will get out of your life. If we could reach for that, I think that would be a great goal to hit, and I urge you to take a strong look at that.

With that, Mr. Chairman, I am happy to be here and would be happy to try to respond to any questions.

[Mr. Gephardt's statement was not available at the time of printing.]

Mr. SHAW. Thank you, Mr. Gephardt.

Mr. Houghton.

Mr. HOUGHTON. Yes.

Mr. Gephardt, there has been quite a bit of talk about the reactions to a tax system and the impact on growth, the implication being that the only way we will get sufficient income into the Federal coffers to take care of our expenses is to count on a much higher growth rate.

How do you feel about that, either in regards to the Armey flat tax or to your own tax?

Mr. GEPHARDT. I think that while tax reform could have a positive impact on growth, I don't feel we should overstate the effect.

I think there are a lot of other issues that are probably more important to that issue than simply tax reform, and I think many people overstate its impact.

I think there are a lot of gains here in terms of people's faith and confidence in the government and their feeling about the country and their future.

I do think that we have gotten too sophisticated in trying to direct investment or direct activity in a particular way through what we do in the Tax Code. I think we wind up overcomplicating life and overdoing incentives to the detriment of other things that should be done.

I think the more we could leave investors on a level playingfield, workers on a level playingfield, and let them make their own decisions about things, the better off we will be.

I happen to believe that education and infrastructure and trade and scientific research and research and development are probably more important issues in the long haul to our long-term economic growth than simply fooling with the Tax Code.

Mr. HOUGHTON. Mr. Gephardt, how would you encourage increased scientific and technical activity? How would you increase, through this particular approach on taxation, productivity? Those are the critical issues that are going to determine whether we can grow and whether we can compete in the outside world.

Mr. GEPHARDT. In my plan, I don't affect the corporate side. I do try to take away some of what is known as corporate welfare and try to lower the rate with the use of that money for small corporations because I think we have got to encourage people to start their

own businesses in the world that we are in today, but I don't change the depreciation schedules, and I don't change the R&D credit for corporations. I leave all of that in place, and I think that is probably the best way to handle it.

Mr. HOUGHTON. Thank you very much, Mr. Chairman.

Mr. SHAW. Mr. Rangel may inquire.

Mr. RANGEL. Mr. Leader, let me thank you for attempting to bring something before us that simplifies the Code, which every American would want to do, but really doesn't pull up at the roots the existing system without having the slightest idea as to what impact it is going to have on the economy.

I think that, perhaps, in the next session, we will have much more time to discuss and work out something that is workable rather than merely having a vehicle for political comments.

I want to thank you very much for your contribution.

Mr. GEPHARDT. Thank you, sir.

Mr. SHAW. Mr. Laughlin.

Mr. LAUGHLIN. Mr. Gephardt, I wasn't here when you testified. So I apologize. I didn't hear what your approach is, but let me just share this with you. As I listened to the constituents that I represent in the 14th district, they have two very basic concerns that probably are shared by Americans nationwide.

One is the system is so complicated. They say it is unfair to them whether they are in the agricultural industry or small business or even big business. They want a more simplified system which would translate to being fair to them.

The second part that I hear a great concern about is the intrusiveness and the abusive nature of the Internal Revenue Service.

How does your proposal address those two concerns?

Mr. GEPHARDT. In my proposal, which is, again, a 10-percent proposal, I try to get to a 10-percent rate for 75 percent of the people. I do maintain progressivity. I have five rates. I throw out all of the deductions and exemptions, except for the home mortgage interest, and am able, therefore, to get rates down for everybody, but probably more for the so-called middle class than the rest.

I think that is where we ought to go. Again, if people withhold correctly, a lot of that 75 percent at a 10-percent rate could do away with a return at all. They wouldn't need a return at all, and that, to me, would really build confidence.

I think we add insult to injury with what we put people through in paying their taxes. It is enough to take the revenue we take away from them to run the government, but then when you put them through the torture of trying to file one of these returns, we really add insult to injury, and I am trying to figure out a way to get most people out of that bind, and I think my plan does that.

Other plans would undoubtedly do that as well. I think you are looking for simplicity and fairness, and we ought to go for the plan that gives us the most of both.

Mr. LAUGHLIN. We have constantly heard that savings by Americans is embarrassingly low. What is it about your plan that would stimulate or motivate us to save more to be available for capital investment?

Mr. GEPHARDT. I think if you put people on a level playingfield, and I try to do that—I don't discriminate between investment in-

come and salary income—I think people will make their own judgment about where to invest and how much to save.

Again, if you could get ordinary Americans, people under $65,000 a year at a 10-percent rate, I think they would feel like they, maybe, had a few more dollars of the income to put into savings. We do lower rates and lower taxes under my plan by some amount for most of those people under, say, $65,000 a year.

Mr. LAUGHLIN. In the first part of my first question, I asked you about the Internal Revenue Service and their impact.

Mr. GEPHARDT. Right.

Mr. LAUGHLIN. As I appreciate what you have told us, we will still, under your plan, retain the Internal Revenue Service as we know it.

Mr. GEPHARDT. I don't know of any plan that would do away with it. I think you would have to have a lot less of it because there would be a lot less trouble for the IRS in reviewing and auditing returns because the return would be vastly simplified.

Mr. LAUGHLIN. Thank you very much.

Mr. GEPHARDT. Thank you.

Mr. SHAW. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I wanted to ask you how would your proposal address the issue of the life insurance industry, and how would your bumpy flat tax address the proposed inside buildup and the tax ramifications of life insurance?

Mr. GEPHARDT. We don't affect that.

Mr. CHRISTENSEN. You don't affect it?

Mr. GEPHARDT. No.

Mr. CHRISTENSEN. That is all I have.

Mr. GEPHARDT. Thank you.

Mr. SHAW. Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman. I am sorry I couldn't have been here earlier. All of our schedules are so crazy.

I did have one question I wanted to ask. I hope it hasn't already come up, and that has to do with the mortgage interest deduction. I note you kept it in your plan, at least the previous versions that I had seen, and I wondered if you could give us an explanation why you think that is important to keep, given the fact that it will result in rates being higher at probably all the levels.

Mr. GEPHARDT. Right. That is a real good question, and I think I wrestled longer and harder over that than anything I had to decide in putting the plan together.

I came to the conclusion that we needed to keep it for a couple of reasons. First, I really believe that owning a piece of property is part of the American dream. I think people are more responsible when they own a piece of the rock, to be corny about it, and I think that that one incentive is very, very important, and focusing people on trying to buy a piece of property rather than renting.

Second, I became concerned about a number of studies that had been published that indicate if we took the deduction away, that the value of all real property in the United States would diminish rather quickly and for a long period of time.

I don't know whether those studies are right, but that worried me that we would take an action here that would diminish the value of what to most families is their most important asset.

Third, I believe that the home building industry and all that goes in a home is probably the most important part of our economy, and I got concerned that if we, again, diminished that activity in any substantial way that it would really diminish our economy.

Now that it has been in the Code for the period of time that it has been in the Code, it is a powerful incentive, as you know. It really is the deciding factor for a lot of people on whether to buy or rent, and I just got worried about what that would do to our economy.

This is an issue on which reasonable minds can come to different conclusions. There is a very good argument you could make that this ought to be simple and elegant. We should not allow anything.

I wrestled over whether or not to allow the exemption of health care premiums, and I didn't; whether to allow the exception for pension payments, and I didn't. You can make a lot of the arguments I have made here about that. This is not an easy question and one that this Committee will wrestle with and all of us will wrestle with when we get down to trying to do this.

Mr. CHRISTENSEN. Would the gentleman yield?

Mr. PORTMAN. Absolutely.

Mr. CHRISTENSEN. Congressman Gephardt, this morning, we heard testimony that Canada has no home mortgage interest deduction, but, yet, they have 63 percent home ownership in their country. Australia has no such interest deduction, and they have home ownership at 62 percent. We are at 64 percent. Do you really believe that the home interest deduction, if taken away, would stall home ownership and the first-time home buyer?

Mr. GEPHARDT. I don't know the answer. I don't think any of us know the answer, but I worry about it. I worry about its impact on property values over the near term, and I worry about whether people—especially in our economy where we have had trouble with savings, this is one area where we have been able to get ordinary people to really save. I just worry about its impact. I don't know that I am right.

Mr. CHRISTENSEN. I yield back.

Mr. SHAW. Mr. Gephardt, in questioning Dick Armey a few minutes ago on the deductibility of business expenses, he said that inventory, even buildings, plant investment, all of these deductions, would be taken at the time of the expenditure. Do you address that in your plan?

Mr. GEPHARDT. I don't change, again, on the corporate side anything but trying to close up a few loopholes to lower the tax rate of small corporations, even further than it already has been. I don't change depreciation schedules.

I must tell you that I have for a long time felt that we needed to quicken depreciation schedules, and I would love to figure out how we could get immediate expensing. I think it is a powerful incentive for investment in plant and equipment, and in today's competitive world, one of the things we desperately need is the most up-to-date technology and equipment in our plants and our businesses.

I also think the life of equipment has shortened, even in some cases below the schedules we got. So moving in that direction is a good idea.

Mr. SHAW. How about the 10-percent surcharge on alternative minimum taxes? Do you eliminate that and just go for the straight percentage?

Mr. GEPHARDT. We maintain the alternative minimum tax, and we don't have the surtax, as I remember. I may be wrong on that.

We keep the same progressivity that you have today. We just built it into the way we structured the rates.

Mr. SHAW. How would you handle something as a traveling salesman, for instance, the deduction of his lodging, the deduction of his automobile?

Mr. GEPHARDT. That is all capped, the cost of doing business.

Mr. SHAW. All of those are retained.

Mr. Johnson, do you have any questions?

Mr. JOHNSON. No.

Mr. SHAW. Mr. Gephardt, we have a few minutes before our next panel testifies. Do you have anything else you would like to bring up?

Mr. GEPHARDT. I can tap dance.

Mr. SHAW. We will take a pass on that one.

Mr. GEPHARDT. You are smart.

Mr. SHAW. I am afraid we all tap dance too much here.

Mr. GEPHARDT. I appreciate being here. I wish you well in this effort. I am glad your doing this seriously. I think this is a very important subject for our country, and I look forward to working with you.

I said I debated Jack Kemp on this at the American Enterprise Institute a few weeks ago, and one of the things I said there, and I really believe it, is that if this is to happen, Republicans and Democrats, liberals, moderates, and conservatives have got to come together at least on the goal of getting fundamental tax reform.

If we can come together on that, then I think it is possible to get to a bipartisan plan that can pass.

Mr. SHAW. Interestingly enough, I think the word "reform" is probably the buzz word of the 1996 election cycle. Everybody is for reform, but everybody has got a different definition of what reform is.

I agree with you. I agree with Mr. Armey and many of the other people that have appeared before us this morning or are about to appear. Our present Tax Code is absolutely ridiculous. It is far too complicated. The American people should not have to, in most instances, get professional help to figure out what they owe in taxes, and it is a terrible imposition on the American people.

You are so right in saying we do need reform. Now we have to figure out what reform is.

Mr. GEPHARDT. Right. The devils and the details.

Mr. SHAW. You got it.

Mr. GEPHARDT. Thank you.

Mr. SHAW. Thank you, Mr. Gephardt.

The Committee will now stand in recess for approximately 15 minutes or until the next panel arrives.

[Recess.]

Mr. SHAW. The witnesses are now here, and it is our pleasure to welcome Dan Schaefer of Colorado, Billy Tauzin of Louisiana, and Dick Chrysler of Michigan.

We will incorporate any written statement that you may have or may submit to the record, and please feel free to proceed as you see fit.

Mr. Schaefer.

STATEMENT OF HON. DAN SCHAEFER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. SCHAEFER. Thank you, Mr. Chairman and Members of the Committee, for inviting us to testify on what we think is one of the most ambitious plans on reforming our tax system that has ever been presented. We commend the Committee for delving into real comprehensive tax reform testimony.

Since we have a limited amount of time, I will outline the details of the Schaefer-Tauzin-Chrysler national retail sales tax, and my colleagues will address the important benefits of implementing a sales tax and the critical need to replace the current system of income tax.

Our legislation, H.R. 3039, completely replaces the current tax system with a national retail sales tax on the gross payments for the use, consumption, or enjoyment in the United States of any retail good or service. A number of strongly held principles guided our drafting of this bill.

My testimony today will highlight the most important of these principles. I would like to submit additional materials for the record that go into much more detail about the mechanics of our bill, including a forthcoming Cato paper written by David Burton.

The first principle of our bill is that the income tax should be "pulled out by the roots," to use the words of the Chairman.

The Schaefer-Tauzin-Chrysler legislation repeals the Federal, personal, and corporate income taxes, the estate taxes and gift taxes, and all nontrust fund excise taxes. The IRS is deauthorized after the 1999 tax year.

The States, who have 60 years of experience in collecting and enforcing the sales tax and already have all the necessary mechanisms in place, would largely administer the national retail sales tax. States choosing to administer the Federal sales tax would be permitted to keep 1 percent of the Federal tax collection to cover their costs. This amounts to an $8.5 billion payment to the States, roughly what the IRS costs to run today.

Texas, for example, would receive an estimated $300 million a year for the collection of the national sales tax.

The second principle is that no income, regardless of its source, should be taxed until it is consumed. The national retail tax ends the multiple taxation of economically productive savings and investment by imposing a single 15-percent consumption tax on the final retail sale of all goods and services.

Regardless of whether income is derived from wages, dividends, capital gains, or any other source, it is not taxed or withheld until it is used to consume a retail good or service. All income is ultimately taxed, but only one time.

The third principle of the bill is that the tax base should be as broad as possible. We believe that it is unwise to exempt any class of goods or services such as food from the sales tax in the pursuit of fairness.

First, we must recognize that Americans pay income tax on the purchase of the food. It is a hidden tax today since all consumer purchases are made in aftertax dollars.

Second, exempting broad classes of goods or services will only shrink the tax base and raise the sales tax rate, ironically, making the tax even more regressive.

Mr. Chairman, my light is on, and I would just ask that the remainder of this statement be put in the record, as well as other materials that I have, and I would now turn it over to Mr. Tauzin.

[The prepared statement and attachments follow:]

Testimony of

Representative Dan Schaefer (R-CO)

before the

House Ways and Means Committee

Hearing on the Replacing the Federal Income Tax

March 27, 1996

Mr. Chairman, thank you for inviting us to testify about the need to replace the current federal income tax.

We commend you for holding this series of hearings. The issue of comprehensive tax reform will dominate this nation's agenda in the coming years. You have shown great foresight in leading the debate.

Since we have a limited amount of time for verbal testimony, we thought we would split up our testimony among the three primary sponsors of our legislation. I will first outline the details of the Schaefer-Tauzin-Chrysler National Retail Sales Tax Act. My colleagues will then address the important virtues of implementing a sales tax and the critical need to replace the income tax.

Our legislation, H.R. 3039, completely replaces the current income tax system with a National Retail Sales Tax on the gross payments for the use, consumption or enjoyment in the United States of any retail good or service. Our bill is based on a number of strongly held principles that guided its drafting. My testimony today will highlight the most important of these principles and explain how our bill meets them. I have submitted additional materials for the record that goes into much greater detail about the mechanics of our bill.

The first principle of our bill is that the income tax should be pulled out by its roots, to use your words, Mr. Chairman.

The Schaefer-Tauzin-Chrysler legislation repeals the federal personal and corporate income taxes, the estate and gift taxes and all non-trust fund excise taxes. For individuals, this means no more hidden income tax withholding or complicated tax forms to file every year. For businesses, this means no more burdensome Alternative Minimum Tax, multiple depreciation schedules, international tax rules or deferred compensation rules. According to the Tax Foundation, switching to a National Retail Sales Tax would eliminate 95 percent of the $150 billion this country spends each year on tax compliance.

The IRS is de-authorized after the 1999 tax year. The Social Security payroll tax will continue to be collected as it is today, but by the Social Security Administration.

The states, who have 60 years of experience in collecting and enforcing a sales tax and already have all the necessary mechanisms in place, would largely administer the National Retail Sales Tax. This is not an unfunded mandate. States have a choice of collecting the federal tax or not. States choosing not to administer the federal tax could contract with a third state or allow the Secretary of Treasury to collect it. Administering states would be permitted to keep one percent of the federal tax collections to cover their costs. This amounts to a $8.5 billion payment to the states -- roughly what the IRS costs to run today. Texas, for instance, would receive an estimated $300 million a year for collecting the national sales tax.

The second principle is that no income -- regardless of its source -- should be taxed until it is consumed.

The National Retail Sales Tax ends the multiple taxation of economically productive savings and investment by imposing a single 15 percent consumption tax on the final retail sale of all goods or services. Regardless of whether income is derived from wages, dividends, capital gains or any other source, it is not taxed or withheld until it is used to consume a retail good or service. For example, the purchase of stock would not be taxed, but the brokerage fee would be, since it represents a service. Likewise, the proceeds from the sale of a stock would not be taxed as long as that money stayed invested in the economy. On the other hand, if those proceeds were consumed for personal enjoyment, they would be taxed.

The third principle of our bill is that the tax base should be as broad as possible.

We believe it is unwise to exempt any class of goods or services, such as food, from the sales tax in the pursuit of fairness. First, we must recognize that we pay income taxes on the purchase of food today, since all consumer purchases are made in after-tax dollars. Second, exempting broad classes of goods or services will only shrink the tax base and raise the sales tax rate -- ironically making the tax even more regressive.

The proper way to address fairness is to ensure that the basic necessities of all Americans remain untaxed. Our legislation accomplishes this by providing an automatic "Personal Consumption Refund" in the paycheck of every wage-earner each pay period. This refund, provided as a credit against the payroll tax, returns to taxpayers the sales tax they have paid on the basic necessities of life, calculated as consumption up to the poverty rate, adjusted for family size. The same mechanism can be applied to those receiving government benefits.

I have attached to my written testimony a chart showing the effective tax rate of the National Retail Sales Tax on different income categories and an estimate of how much each families' take home pay will increase after withholding is eliminated and the Personal Consumption Refund is made.

As a fourth principle, we believe that no taxes should be hidden from consumers.

We believe that, as a matter of economic reality, businesses do not pay taxes. Corporations cannot pay taxes because corporations do not exist, except on paper. Income taxes and compliance burdens are simply costs of doing business that must be passed along to consumers, hidden in the prices of every final good or service.

Our legislation eliminates these hidden taxes by eliminating the corporate income tax. To prevent sales taxes paid by businesses from being hidden in prices -- known as "cascading" -- sales at each intermediate stage of production are exempt (thereby avoiding the attributes of a value added tax [VAT]). In other words, any good or service that is purchased for resale, or for the production of another good or service for resale, is exempt.

In addition, we avoid hiding the compliance costs of retailers in the final prices of their goods or service by permitting them to keep one-half of one percent of the sales tax they receive to cover their administrative costs. This credit would provide nearly $4 billion to the retail industry to offset their tax compliance costs. We also provide a 50 percent credit to retailers for the costs of any new equipment such as cash registers needed to charge the federal sales tax.

In summary, no one at this table will say our bill is perfect as it stands today. We have, however, provided an initial answer for every problem we could foresee. We believe that our National Retail Sales Tax plan has all the advantages of any other plan on the table today. At the same time, it has fewer disadvantages than any other plan -- and what disadvantages exist are easier to deal with.

Again, thank you for this opportunity to testify.

THE WALL STREET JOURNAL.

The Case for a National Sales Tax

By Dan Schaefer

Despite the exploding number of comprehensive tax reform plans now on the table (10 at last count), a clear bipartisan consensus is emerging about the current income tax code's ultimate replacement. Every major reform plan to date uses consumption, rather than income, as its tax base, ending the economically ruinous bias in the current code against savings and investment.

The flat tax, for instance, applies only to income that has not been saved or invested. Likewise, the Unlimited Savings Account (USA) tax is a "consumed-income" tax. Even Vice President Al Gore has mused about the need to replace the income tax with a consumption-based tax.

Round Hole, Square Peg

Politicians and economists increasingly seem to acknowledge that moving to a consumption-based tax will, in the long run, raise our paltry savings rate, lower interest rates, increase economic growth and boost the standard of living for all Americans.

Each of these plans, while no doubt better than today's system, suffers from the same fundamental weakness. In vain, each attempts to hammer a square-peg (the income tax) into a round hole (a consumption tax). It just doesn't fit. As long as income must still be defined, deductions must still be sought and a taxpayer's every financial move must still be reported to the Internal Revenue Service, the promise of a consumption-based tax will never be fully realized.

Rather than simply simulating a consumption tax, why not introduce the real thing: a pure consumption tax that is simpler, flatter and fairer? Last week, Rep. Billy Tauzin (R., La.) and I unveiled the first detailed proposal to eliminate the income tax in its entirety and replace it with a National Retail Sales Tax.

Our plan is modeled on the state sales taxes that most Americans and businesses are already familiar with. It is a point-of-sale levy on the final retail sale of every good or service. It can be collected by the states using the same mechanisms they have in place today. Under our bill, both states and retail businesses will be able to keep a percentage of the taxes they receive to fully offset administrative costs.

The National Retail Sales Tax reverses the relationship between taxpayers and the government. Taxpayers—not the IRS—get the first crack at their paychecks. With no income tax withholding, workers take home every penny they earn. The government gets its cut only when the taxpayer chooses to consume.

No matter how we structure an income tax system or by what name we call it, the economic reality is that all income taxes are hidden consumption taxes in the end.

Our plan meets each of the six principles laid out by the Kemp Commission on Economic Growth and Tax Reform at least as well as, if not better than, the flat tax or any other reform proposal.

Every dollar paid in personal income tax, for instance, is one less after-tax dollar that can be consumed. Because of income tax withholding, however, that fact is hidden from consumers.

Even more covert is the hidden tax burden carried in the price of every consumer good or service. Businesses do not pay taxes—they collect them from consumers. Corporate taxes and compliance expenses are simply costs of doing business that must be passed on to consumers in the form of higher prices. Only the final consumer, who has no one else to pass them along to, ultimately pays all personal and corporate taxes and compliance burdens.

The National Retail Sales Tax exposes those hidden consumer taxes, making the true burden of the federal government plain for all to see in a single, flat, 15% rate with no exemptions.

Our plan meets each of the six principles laid out by the Kemp Commission on Economic Growth and Tax Reform at least as well as, if not better than, the flat tax or any other reform proposal. The Kemp Commission said any tax reform plan must meet the following tests:

• *Economic Growth.* The National Retail Sales Tax eliminates every disincentive to hard work, saving and investment that exists in the current income tax code. Economists estimate that replacing the income tax with any consumption-based tax, including the National Retail Sales Tax, will lower interest rates and increase family income. In addition, reduced compliance costs from a simplified tax system will allow the estimated $300 billion we spend annually on compliance costs—an amount equal to a full year's economic growth—to be put to productive uses.

• *Fairness.* The National Retail Sales Tax is a proportional tax, meaning equal treatment under the law for all Americans. Under our plan, those who spend the most will pay the most. Those who spend the least will pay the least. All loopholes for corporations and the rich are closed. Through a tax credit, our plan will create a level of tax-free income for all wage earners, ensuring that those below the poverty level will pay no taxes.

• *Simplicity.* On simplicity grounds, nothing can beat the National Retail Sales Tax. For the 66% of individual taxpayers who have no income tax liability, file the 1040 EZ form or do not itemize, the greatest promise of a flat tax—simplicity—has already been realized. Under the National Retail Sales Tax there would be absolutely no compliance burden for any individuals and net *zero* compliance costs for retail businesses (after they take their credit for record-keeping expenses).

• *Neutrality.* Under the National Retail Sales Tax, income is not taxed until it is consumed. Therefore, dividend, interest and capital gains income are not taxable as long as those dollars stay invested in the economy. Likewise, home mortgage interest—which, by definition, is not consumption—would be tax free.

• *Visibility.* The greatest strength of the National Retail Sales Tax is that it exposes the hidden tax burden on every American. Under the income tax, personal and corporate income taxes are hidden in each and every consumer transaction. First, personal income tax is withheld from the consumer's paycheck, requiring every purchase to be made in after-tax dollars. A second hit comes at the cash register, when the consumer pays the hidden business taxes and compliance costs of every business that had a hand in producing that good or service.

• *Stability.* As our experience with the 1986 Tax Reform Act has proved, the notion that we can have a "flat" income tax over the long term is the triumph of hope over experience. Since the 1986 tax reform—which started as a flat tax—the federal income tax code has been amended by 40 different acts of Congress. As long as the income tax exists in any form, it can and will grow back.

Growing Consensus

The National Retail Sales Tax "tears the income tax out by its roots," to use House Ways and Means Committee Chairman Bill Archer's words. Minus a nationwide income-reporting apparatus and an IRS, it would be very hard to recreate the complex monstrosity our tax code is today.

The consensus that the income tax should be replaced with a consumption-based tax system continues to grow. Once that decision has been made, the only relevant question becomes what is the most efficient, simplest and fairest way to collect a consumption tax. On that score, the National Retail Sales Tax wins, hands down.

Mr. Schaefer is a Republican congressman from Colorado.

Rocky Mountain News

March 18, 1996
27A

SPEAKOUT

Income tax has plagued us long enough

By Rep. Dan Schaefer

This coming April 15 could be the last time you ever face a tax deadline or a 1040 income tax form — if legislation I recently introduced is enacted by Congress.

America has suffered under the inequities and mind-boggling complexity of the income tax system for more than 80 years. Enough is enough. We need a new tax system that does not penalize hard work or double-tax savings and investment, does not need 480 different tax forms and 8,000 pages of IRS code and regulations to explain it, and does not allow special tax breaks for the rich or loopholes for corporations.

In short, America needs a national retail sales tax to completely replace the current income tax system. I have introduced legislation to do just that.

My plan would eliminate the current personal and corporate income tax, income tax withholding, estate and gift taxes, and most excise taxes. As a result, every taxpayer's take-home pay would increase by the amount in income tax that is currently being withheld from his paycheck.

In place of the income tax, the national retail sales tax imposes a levy modeled on the state sales tax with which every Colorado taxpayer and business is already familiar. It is a point-of-sale levy on the retail sale of every good or service. It can be collected by the state using the same mechanisms in place today. Under our bill, both states and retail businesses will be able to keep a percentage of the taxes they receive to offset administrative costs.

To protect the working poor, the income of every wage-earner up to the poverty level will be tax-free through a personal consumption rebate, ensuring that the basic necessities of life remain untaxed.

The powerful appeal of the national retail sales tax lies in the fact that it reverses the relationship between taxpayers and the government. Taxpayers — not the IRS — get first crack at their paychecks. With no income tax withholding, workers take home every penny they earn that formerly went to pay the income tax. The government only gets its cut when the taxpayer chooses to consume.

The fact is that every consumer already is paying taxes on every good or service he consumes today. Under the current system, however, those taxes, and the true burden of the government, is hidden. No matter how we structure an income tax system, or by what name we call it, the economic reality is that all income taxes are hidden consumption taxes in the end. Every dollar paid in personal income tax, for instance, is one less after-tax dollar that can be consumed. Because of income tax withholding, however, that fact is hidden from consumers.

> *'The national retail sales tax would expose those hidden consumer taxes, making the true burden of the federal government plain for all to see . . .'*

Even more covert is the hidden tax burden carried in the price of every consumer good or service. Businesses do not pay income taxes — they can only collect them from consumers. Corporate taxes and compliance expenses are simply costs of doing business that must be passed on to consumers in the form of higher prices.

The national retail sales tax would expose those hidden consumer taxes, making the true burden of the federal government plain for all to see in a single, flat 15% rate with no exemptions. We would eliminate two hidden consumption taxes and replace them with a single, visible tax. Taxing our consumption once is enough!

Moving away from an income tax and to a consumption-based tax, the national retail sales tax, would increase our paltry savings rate, lower interest rates and boost economic growth. It would ultimately increase the typical middle-class family's income between $4,000 to $6,000 annually, according to Harvard University economist Dale Jorgenson. As a result, most Americans would actually have more to both consume and save.

The national retail sales tax would also finally create a level playing field for American-made products around the world. Every exported good that leaves our shores carries with it the high burden of U.S. taxes and compliance costs hidden in its price. Because the national retail sales tax only applies to imports, not exports, our goods will finally be able to compete fairly in the world market, creating jobs here in the U.S.

As long as we retain an income tax system — flat or otherwise — we can never truly eliminate the potential for the income tax to grow back into the monstrosity it is today. As House Ways and Means Committee Chairman Bill Archer has said, we must "tear the income tax out by its roots." It is time to replace the income tax with a national retail sales tax.

Dan Schaefer represents Colorado's 6th Congressional District in the U.S. House of Representatives.

Take-Home Pay and Effective Tax Rates
Under the National Retail Sales Tax

Take a look at your paycheck. How much does the government take each month in income taxes? Without an income tax, you would get all of that in your pocket every month. Plus, under the National Retail Sales Tax (NRST), wage earners would get a "Personal Consumption Refund" automatically in each paycheck, designed to rebate the sales tax they have paid on the basic necessities of life.

To see an estimate of how much your take-home pay could increase under the National Retail Sales Tax, find your income level and the size of your family on the following chart. The effective sales tax rate for each family is also shown.

			Annual Family Income												
			12,000	16,000	20,000	24,000	28,000	32,000	36,000	40,000	44,000	48,000	52,000	56,000	60,000
FAMILY SIZE	2	Take-Home Pay Increase (%)	17.2	17.7	18.0	18.2	18.4	18.5	18.6	18.7	18.7	18.8	18.8	18.9	18.9
		Effective NRST Rate (%)	0	3.6	5.9	7.4	8.5	9.3	9.9	10.4	10.8	11.2	11.5	11.7	12.0
	3	Take-Home Pay Increase (%)	17.4	17.8	18.1	18.3	18.4	18.6	18.6	18.7	18.8	18.8	18.9	18.9	18.9
		Effective NRST Rate (%)	0	0.7	3.5	5.5	6.8	7.8	8.6	9.3	9.8	10.2	10.6	10.9	11.2
	4	Take-Home Pay Increase (%)	17.6	18.0	18.2	18.4	18.5	18.6	18.7	18.8	18.8	18.9	18.9	18.9	19.0
		Effective NRST Rate (%)	0	0	1.2	3.5	5.2	6.4	7.4	8.1	8.7	9.3	9.7	10.1	10.4
	5	Take-Home Pay Increase (%)	17.8	18.1	18.3	18.5	18.6	18.7	18.8	18.8	18.9	18.9	18.9	19.0	19.0
		Effective NRST Rate (%)	0	0	0	1.6	3.5	5.0	6.1	7.0	7.7	8.3	8.8	9.3	9.6

The take-home pay increase estimate assumes: 1) The "married filing jointly" standard deduction is taken, with no itemized deductions; 2) income tax withholding is calculated correctly, with no refund due or tax owed at the end of the year; and 3) no credits are claimed. Results will obviously differ in other situations. The effective NRST rate estimate assumes that all income is consumed. Savings or investment will lower effective rate.

THE NATIONAL SALES TAX: MOVING BEYOND THE IDEA[1]

Discussion about alternative tax systems have centered around three major proposals: The Armey-Shelby flat tax, the Domenici-Nunn USA Tax (which combines a consumed income tax and a business transfer tax) and the national sales tax. Although much has been said about a national sales tax, to date critics and supporters alike have had to settle for a theoretical discussion of its merits and flaws.

On March 6, the national retail sales tax moved from an abstract idea to a concrete proposal with the introduction by Reps. Dan Schaefer (CO), Billy Tauzin (LA) and Dick Chrysler (MI) of H.R. 3039 (the STC plan) As the only national sales tax plan on the table, H.R. 3039 serves as the basis for analyzing how a national sales tax might actually function. In summary, the STC plan would impose a non-cascading, single 15 percent flat rate tax on the final purchase of goods and services at the retail level. Intermediate purchases would be exempt. The STC plan is similar in many respects to the sales and use taxes in place in 45 states and the District of Columbia. The individual and corporate income tax, the estate and gift tax and most non-trust-fund excise taxes would be repealed.

In this article, the authors briefly describe how the STC plan would work and present the rationale for replacing much of the current tax system with a national sales tax. The article discusses the sales tax base, the provision for low income families, mixed-use property, used property (including homes), non-profit organizations, government services, financial intermediation services and transition considerations.

H.R. 3039 provides a useful vehicle for the tax policy community and the American public to begin analyzing how a national sales tax could be structured. A national sales tax along the lines of the STC plan would, in the authors' judgment, have a salutary impact on the U.S. economy, the standard of living of the American public, the compliance costs borne by our economy and on the degree of intrusiveness of the tax system in our lives.

By David R. Burton and Dan R. Mastromarco*

Although much has been said about a national sales tax, to date critics and supporters alike have had to settle for a theoretical discussion of its merits and flaws. Replacing the Federal income tax with a national retail sales tax was merely an idea. On March 6, 1996, Reps. Dan Schaefer (CO), Billy Tauzin (LA) and Dick Chrysler (MI)

[1] Oliver Wendall Holmes once said that taxes are what we pay for a civilized society; he did not say there is a rule against seeking to collect them in the most civilized way.

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introduced H.R. 3039 (hereinafter the "Schaefer-Tauzin-Chrysler or STC plan"), which provides a detailed framework for how a national sales tax could actually be done.[2] Senator Richard Lugar (IN), who has been a long-time advocate of replacing the Federal income tax with a national sales tax, is likely to lead a parallel effort in the Senate. Ways and Means Committee Archer remains committed to "pulling the income tax out by its roots" and replacing it with a consumption tax.[3] Although Chairman Archer has commended the authors of H R. 3039[4] and is widely viewed as sympathetic to a national sales tax, he remains officially uncommitted about which form of a consumption tax he will include in his plan (tentatively expected this fall).

The STC plan is the only national sales tax plan on the table provides a very useful vehicle for the tax policy community to begin analyzing how a national sales tax could best be structured. The STC plan is similar in many respects to sales and use taxes in place in 45 states and the District of Columbia.[5] In summary, the STC plan would repeal the individual and corporate income tax, transfer taxes and most non-trust funds excise taxes and replace them with a single 15 percent flat rate tax on the purchase of final goods and services at the retail level. It would accomplish this result by exemptions for sales at each intermediate stage of production.

In order to achieve certain social objectives, the STC plan would also effectively exempt purchases by taxpayers below the poverty level. It would accomplish this by administering a sales tax rebate through the payroll tax system so that workers may consume up to the poverty level sales tax free. As a necessary consequence of the destination-based approach, the tax imposed by the STC plan is border-adjusted. Since a sales tax is indisputably an indirect tax, this border adjustment should pose no difficulty under the General Agreement for Tariffs and Trade. The sponsors expect that, in most instances, the national sales tax would be administered by the states.

This article will briefly discuss the rationale for replacing the current income tax with a national sales tax. In addition, the article will discuss the mechanics of the legislation. What will be the tax base? How will the tax be administered? How will the tax be enforced? The article also highlights how the STC proposal disposes of several problems commonly associated with alternative taxing schemes, and some problems peculiar to the sales tax. For example, how does the tax treat used property or "old capital" that was purchased with after-income tax earnings profits? How does the tax treat financial intermediation services? Government services? Not-for-profit organizations? Finally, this article discusses some of the standards of transitional equity

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[2] Other original cosponsors included Reps. Bono (CA), Hefley (CO), Linder (GA) and Stump (AZ). Rep. Hall (TX) has since become a cosponsor.

[3] See "Archer Outlines Ways and Means Agenda", Bureau of National Affairs, Daily Report for Executives, March 7, 1996, p. GG-1.

[4] See, e.g. "Schaefer, Tauzin Offer Retail Sales Tax; Ways and Means Chairman Salutes Sponsors", Bureau of National Affairs, Daily Report for Executives, March 8, 1996, p. G-5.

[5] The states without general sales taxes are Alaska, Delaware, Montana, New Hampshire and Oregon.

that occur when a tax system based on income is replaced with one based on consumption, and some of the means by which the STC plan addresses the transitional problems.[6]

I. Why a National Sales Tax?

A national sales tax would promote higher rates of economic growth by dramatically reducing the tax bias against work, savings and investment. Moreover, economically inefficient distortions in the pattern of investments would decline as well. Although the magnitude of the impact on economic growth will undoubtedly generate much debate among economists, the large marginal tax rate reductions in the STC plan, combined with the complete elimination of savings and investment from the taxing net, will have powerful positive effects on the economy.[7] In fact, it would be difficult to conceptualize a proposal that raises an equal amount of revenue as the current tax system, reduces adverse economic impact, and still exempts the working poor from tax.[8]

One of the immediate consequences of a national sales tax scheme is that interest rates would drop toward the current tax-free interest rate as the tax wedge between the pre-tax and after-tax rate of return is removed.[9] The result would be to reduce Federal borrowing costs by more than $100 billion annually.[10] Industries and individuals that are sensitive to interest rates would also benefit. Moreover, as disincentives for savings and investment are removed, the supply of investment capital can be expected to increase further reducing interest rates. Finally, international capital is likely to flow to the U.S.. Although the portfolio interest exception[11] and numerous treaties have reduced or eliminated the withholding on passive income on foreign investment, the complete removal of all taxation of non-consumed income would increase the attractiveness of the U S for foreign investors. Expatriated U.S. investment dollars can also be expected to find their way home. Indeed, given the proposed tax treatment and political stability of the U.S., the U.S. would become the ultimate global tax haven -- to the benefit of U.S. industry, U.S. workers and U.S. consumers.

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[6] Section references, unless otherwise indicated, are to the new Internal Revenue Code sections as if the bill were enacted. Page numbers are references to H.R. 3039 as introduced.

[7] Other flat rate consumption taxes in their pure form, including the Armey-Shelby flat tax, are likely to have similar positive economic effects.

[8] See, e.g., "The Economic Impact of Replacing Federal Income Taxes with a Sales Tax", Laurence J. Kotlikoff, April 15, 1993, Cato Institute Policy Analysis, "The Economic Impact of Fundamental Tax Reform, Dale W. Jorgenson, Testimony before the House Ways and Means Committee, June 6, 1995.

[9] This, of course, is the same result that occurs with tax free bonds under Section 103, which are advantaged in after-tax return to taxable bonds. The market is unlikely to clear at the present tax-exempt rate because such a high proportion of existing capital providers are tax-exempt or tax-deferred (most notably, governments, pension funds, retirement savings accounts and, in selected circumstances, foreigners).

[10] Assuming roughly five trillion dollars in debt and a two point average reduction in interest rates.

[11] Current Internal Revenue Code Section 871(h).

Another consequence would be an expected windfall from the liberating capital unproductively spent on the costs of complying with the current, complex system.[12] Currently, the United States spends $140 billion to $250 billion complying with the Federal income tax system.[13] Thus, in 1995 alone, compliance costs averaged an estimated 19 to 33 percent of the total revenue raised by the tax system and 2.0 to 3.5 percent of the Gross Domestic Product (GDP). These compliance costs have greater insidious effects for existing small firms and potential start-ups, which disproportionately bear their burden. As noted in the Kemp Commission report, small corporations endure compliance costs 3.8 times the tax actually collected.[14] These high compliance costs are a pronounced drag on our standard of living and the international competitiveness of all U.S.-based firms. The STC plan would reduce tax compliance costs substantially, perhaps by more than 90 percent.[15] This is roughly the equivalent of adding one additional good year of economic growth in the year of implementation.

Monetary savings from the costs of complexity is but one means of measuring the advantages of simplicity. Another -- elimination of the tax hassle factor -- would be more viscerally felt, especially around this time of year, by most Americans. As a consequence of moving to a national sales tax, individuals who are not engaged in business would no longer file tax returns. The number of tax returns filed may fall as much as 80 percent.[16]

Businesses would experience a dramatic decline in compliance costs. Business-to-business purchases would be exempt from tax and therefore contribute little to the cost of compliance. Vendors would simply need to maintain a copy of the purchasers exemption certificate on file. Retailers would be required to determine the sales that they made to consumers. This, however, would be a much simpler task than complying with the existing income tax system. Among business compliance cost savings: there would be no more alternative minimum tax, no more multiple depreciation schedules, no more complex international tax provisions, no more complex pension and deferred compensation rules and no more uniform capitalization rules.

Moreover, if the plan works as the sponsors believe, the advantages in lower compliance costs and a more productive economy would be amplified as states conform their own sales taxes. To the extent that states did conform, retailers would no longer be

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[12] Although duly included in the national income and product accounts, and a source of employ to lawyers, accountants, IRS agents and other tax professionals, the payments extracted from the economy from the complexity of our system do not improve our collective standard of living.

[13] See, e.g. "The High Cost of Tax Compliance for U.S. Business", Arthur Hall, Tax Foundation Special Report, November, 1993. See also note 15. In March 20, 1996 testimony before the Ways and Means Committee, Dr. Hall presented his updated 1996 findings: $157 billion per year.

[14] "Unleashing America's Potential", The National Commission on Economic Growth and Tax Reform, January 1996, p. 9.

[15] See, e.g. "Compliance Costs of Alternative Tax Systems", Arthur Hall, Tax Foundation Special Report, June, 1995. See, also testimony of Arthur Hall, before the Ways and Means Committee, March 20, 1996 on "Replacing the Federal Income Tax" wherein he estimates that under the STC plan compliance costs would decline by 95 percent to $8.2 billion.

[16] Corporation, partnership and sole proprietor returns compared to all returns (1992) using IRS Statistics of Income.

required to cope with variegated exemptions and local rates. In jurisdictions that conformed and which already collect a sales tax, the marginal cost of complying with the Federal sales tax system would be quite low, conceivably producing net savings compared to complying with multiple state systems (particularly once the administration credit provided under the bill is considered).

The STC plan would also spread the hidden costs of compliance more equitably among all taxpayers. In an unprecedented step, the STC plan would pay firms for their compliance burden. The legislation provides an administration credit to retailers equal to one half of one percent of the revenue collected and remitted.[17] In 1995, this credit would have provided a credit of nearly $4 billion to the retailing community toward their compliance costs. The STC plan would also provide a compliance equipment cost credit equal to 50 percent of the cost that vendors incurred if they needed to purchase new equipment to comply with the receipt requirements.[18] This credit would ease considerably the costs of transition by retailers with less capable point-of-sale systems.

This is not to say that all complexity would disappear or that the STC plan is the administrative equivalent of nirvana. As discussed below, complex issues still arise in the context of mixed-use property, financial intermediation services, financing leases[19] and other transactions. Moreover, some of the problems regarding the underground economy that are problematic under the income tax would remain, particularly those involving cash transactions. Nevertheless, the costs of compliance will shrink and the benefit from lawful tax avoidance or illegal tax evasion will be much less at the margin relative to either the present system or competing alternative tax systems. Greater compliance from greater simplicity and lower temptation translates into additional revenue that will not be captured under current law.

Another benefit of the national sales tax is that it would be the most clearly visible tax to the consumer. The STC plan would require vendors to separately state and charge the tax imposed.[20] In this way, the consumer will see the full cost of government every time taxable property or services are purchased. Under the sales tax, hidden taxes and hidden tax compliance costs present in the income tax and existing value added tax systems would be exposed and quantified.

A sales tax that replaces the income tax has another important advantage (or flaw, depending on one's view) over consumption taxes that are collected through an income tax-based system. Once enacted, a sales tax will be much harder to reverse than either the flat tax or the USA Tax. While the STC plan would eliminate the Federal income tax infrastructure, other plans would not. Indeed, the flat tax could be *largely* converted into a graduated income tax by imposing a graduated rate structure, reinstituting depreciation

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[17] §11(e), p. 18. This credit is subject to a minimum of $100 per month provided that the credit does not exceed 20 percent of the tax due.
[18] §11(f), p. 18.
[19] §22(d), p. 34.
[20] §54, pp. 55-56.

rather than expensing for capital investment, taxing interest and dividends and restoring the deduction for interest expense.

Similarly, under the USA Tax, restricting the universal IRA, making wages and interest deductible (and interest taxable) to business and reinstating depreciation rather than allowing in expensing of capital investment would *largely* convert the USA Tax into a graduated income tax. The national sales tax best eliminates the need to think in terms of income. In all other options, the income tax infrastructure would remain in place, and the income tax would be constantly in the wings begging re-enactment. Because the income tax infrastructure would remain and because of the Congress' historical penchant for altering the tax code on a regular basis, these sorts of developments are likely. The developments following the enactment of the Tax Reform Act of 1986 are instructive on this score. With history as our guide, the outcome is nearly certain.

II. The Tax Base: Final Consumption of Goods and Services

The STC plan is imposed on the gross payments for the use, consumption or enjoyment in the United States of any taxable property or service.[21] Taxable property or services include any property (including rents and leaseholds)[22] other than intangible property and services (including financial intermediation services).[23] Interest, dividends, capital gains or other investment income is not taxable until used to purchase taxable property or services.[24] Exemptions are provided for purchases for resale, purchases to produce taxable property or services and for exports.[25] Property (or services) produced or rendered outside of the U.S. are taxed upon entry into the U.S. unless an exemption is available.[26]

'Purchased for resale' means purchased by a person in an active trade or business for the purpose of reselling the property in the ordinary course of that active trade or business.[27] 'Purchased to produce taxable property or services' is a general exemption meant to exempt business inputs generally. The exemption is available if the property or service is purchased for the purpose of employing or using property or services in the production or sale of other taxable property or services.[28] Property or services purchased in connection with research, experimentation or development in an active trade or business are included in this category, as are property or services purchased by an insurance company on behalf of an insured individual if the underlying premium has been taxed. Education and training services are also treated as falling in this category. Wages paid by

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[21] §1, pp. 6-8. Most states pair a sales tax with a use tax. The STC plan is, in effect, structured as a use tax with the seller collecting and remitting the tax if the sale is made in the United States.
[22] Rules for the disaggregation of interest and principal in connection with financing leases are provided. See §22(d), p. 34.
[23] §21(n), pp. 32-33.
[24] See §21(a)(2), p. 25 and §21(n), pp. 32-33.
[25] §2, pp. 8-10.
[26] §1(a) and (b), pp. 6-7.
[27] §21(d), pp. 28-29.
[28] §21(e), pp. 29-30.

an employer engaged in an active trade or business are not treated as taxable services. Wages paid by a household to a maid would be taxable services, however.[29]

These exemptions are designed with one overriding purpose in mind: to prevent any cascading of tax. The STC plan avoids cascading to ensure an equal effective tax rate across all types of property and services (horizontal equality), irrespective of the number of companies or stages of production that were necessary to bring the good or service to market (vertical equality). Avoidance of cascading also ensures that the final price paid by the consumer excludes hidden taxes. The exemption framework serves the same purpose as deductions in a flat tax, business transfer tax or subtraction method value added tax framework, or the credit for previously paid taxes in a credit-invoice method value added tax.

The bill would also modify the self-employment tax.[30] This is necessary because the self-employment tax base is currently in large measure determined by the income tax. The revised self employment base is gross payments received from the sale of taxable property and services (without regard to exemption) less all purchases of taxable property and services and any wages paid in furtherance of a business purpose. Loss carry-forwards are allowed. Self-employment tax transition rules are provided.

As discussed more fully below, financial intermediation services, government services, gaming services and the unrelated business activities of not-for-profit organizations are also included in the tax base.

III. Administration of the National Sales Tax

A. The Tax is to be Administered by the States

States would be the primary administrators of the Federal tax system as envisaged under the STC plan, with the Federal government acting as the administrator of second resort. As an inducement to function as administrators, states would be provided with a fee of one percent of the revenues collected and remitted to the Federal government.[31] Since the marginal cost to a state of collecting the Federal tax in addition to their own sales tax (for which they already incur costs) would be quite small, the one percent fee should constitute a strong incentive to become a conforming and administering state. In addition, the information sharing, allocation and destination rules would, for the first time, provide the states with a practical means of taxing mail order and other sales of goods shipped into their state from out of state vendors -- but only if they became conforming and administering states. Finally, the broader federal tax base would enable states to increase the breadth of their own tax base (and, presumably, lower the state sales tax rate).

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[29] §21(n)(2), pp. 32-33.
[30] §8 of the legislation.
[31] §31(e)(2), p. 40.

The combination of these three strong incentives, plus the certainty that the Federal government would administer the tax in their state if they choose not to do so, would probably lead most states to adopt conforming state sales taxes.[32] By the same token, a state could choose to become a conforming state but not an administering state because the bill allows one state (presumably a small one) to contract with another state (presumably a large one) to administer their state sales tax. States that currently do not collect sales taxes may also find this option attractive.

Of course, in the event the state does not conform or administer the tax, the Federal government will still function as the tax administrator. The bill also provides for Federal administration of the tax in the case of electing multistate vendors that maintain retail establishments in five or more conforming states.[33] For these electing vendors, the Federal government would serve in the place of the state tax administrator and allocate and remit conforming state sales tax revenues to the respective state governments.

Appropriations for the Internal Revenue Service would not be authorized after fiscal year 2000.[34] A new Excise Tax Bureau would be established within the Treasury Department to collect the remaining excise taxes.[35] The Social Security Administration would collect the Social Security and Medicare payroll taxes.[36]

B. Vendors Would Collect and Remit Taxes to State Authorities

The responsibility to collect and remit taxes would fall upon the vendor. Reports and payment of tax collected would be due on the 25th of each month.[37] Businesses collecting and remitting taxes or purchasing goods exempt from tax would be required to keep records for a period of three years after filing a report or asserting an exemption.[38] These records would allow audits of businesses; including, when appropriate, cross-firm audits such as occur in a value added tax regime or at the state level in connection with existing sales taxes. The state administrator would have subpoena power, the power to audit and the power to levy.[39] The state administrator is responsible for issuing exemption certificates and registering vendors,[40] and states must give full faith and credit to honor exemption certificates issued by other conforming states.[41]

At the same time, the proposal anticipates that some vendors would choose to collect sales tax even on otherwise exempt sales, rather than bother with an exemption

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[32] A similar system is presently employed by Canada in the province of Quebec where Quebec administers both the Federal and provincial goods and services tax (GST) and employs a single stage (retail) method.
[33] §33, pp. 42-43.
[34] §5 of the legislation, p. 57.
[35] §6 of the legislation, p. 57.
[36] §7 of the legislation, p. 57.
[37] §41(a) and (b), p. 44.
[38] §42, pp. 47-48.
[39] See §31, §49, and §51.
[40] §§43-44, pp. 48-49.
[41] §31(i)(1), p. 41.

certificate for its sales.[42] In this case, the buyer would then be eligible for a refund on the tax paid on the exempt sale.[43] Authority is provided to the U.S. Secretary of Treasury to require that certain industries or vendors selling certain services or products collect the tax if in the Secretary's judgment, 25 percent or more of sales in question were to consumers Buyers would remain eligible for the credit due on exempt purchases.

To ensure maximum visibility, the legislation would require that the sales tax be separately stated and charged on each sale.[44] Specifically, each receipt would be required to show the price of the property or service exclusive of tax paid, the tax paid, the tax rate, the price of the property or service including tax paid, the name of the vendor, the registration number of the vendor and the date of sale. An exception is provided for certain vending machine sales.

De Minimus rules are provided to exempt gross payments received in connection with casual or isolated sales by persons not engaged in an active trade or business and small purchases of property imported into the U.S. by persons not engaged in an active trade or business.[45] These provisions would prevent us from becoming a nation of small-time law-breakers merely due to the sale of a lawn mower to a neighbor or some used clothing at a garage sale.

C. A Modified System of Taxpayer Rights and Penalties Would be Incorporated into the Proposal

The STC plan, unlike other alternative tax system plans, provides a series of enhanced taxpayer rights provision. Under these enhancements, the burden of persuasion would rest with the government, but the burden of production of documents and records would rest with the taxpayer.[46] Each state administrator is required to establish a Problem Resolution Office and problem resolution officers would be provided authority to enjoin collection activity. This administrative injunction could only be lifted by the highest officer in that tax authority.[47] Taxpayers would be entitled to reimbursement for professional fees incurred in disputes unless the government's position was substantially justified.[48]

The STC plan establishes a series of civil and criminal penalties for non-compliance, including failure to register, failure to pay and failure to file. The penalties are structured so that there is a continuing incentive to comply with the law. This is in keeping with important reforms to the civil penalty structure that were added to the Code

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[42] §3(b), pp. 12-13.
[43] §11(a)(3), p. 14.
[44] §54, pp. 55-56.
[45] §2(b), pp. 8-9.
[46] §46, p.50.
[47] §50, p.51.
[48] §47, p.50.

after extensive hearings before the House Ways and Means Committee, Subcommittee on Oversight in 1989.[49]

D. Destination and Allocation Rules

In the current international tax system, two primary questions must always be raised. First, which state has the primary taxing jurisdiction? Second, if the U.S. can exercise jurisdiction to tax, what is the source of the income, foreign or U.S.? Both the income sourcing and expense allocation rules and the rules of juridical taxation in the international context can be quite complex, as international tax practitioners recognize. They can hinge upon questions of residency, where property is located, sold, or used, where services are performed, even where the property used to produce the goods is located. In the case of interest or research and development expenses, it can be determined under specific formulae.

Similar to jurisdictional notions under principles of international taxation, the destination rules under the STC plan seek to clarify the issue of primary taxing jurisdiction. However, the sales tax rules are far simpler. Allocation of taxable property and services (and therefore revenue) among the various states is based on the destination of the taxable property or service.[50] As the tax applies only to consumption, questions of how to source business-to-business transactions are irrelevant, as are determinations for the allocation of interest, research and development and other expenses.

The rules under the STC plan are as follows. The destination of tangible personal property (including property sold by "mail order") is the state in which the property was first delivered to the purchaser. The destination of real property is the state where the property is located. The destination of services is the state where the use, consumption or enjoyment of the services occurred. The destination of telecommunications services (including telephone, cable television and satellite services) is the residence of the purchaser. The destination of domestic transportation services is the destination of the trip (in the case of round-trips, the services are equally divided). International transportation services are deemed 50 percent attributable to the U.S. destination or origin. The destination of financial intermediation services is the residence of the purchaser. Gross payment for financial intermediation services purchased by a U.S. resident from a financial intermediation service provider that has a permanent establishment in the U.S. would be subject to tax.[51] The destination of rents and leaseholds are generally the location of the rented or leased property. In the case of vehicle rentals of one month or less, the destination is the location where the vehicle was

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[49] See §45, p. 49 and §41(c)-(f), pp. 44-47. See also, "Review of the Civil Penalty Provisions Contained in the Internal Revenue Code", Hearings before the Subcommittee on Oversight of the Committee on Ways and Means, February 21 and June 6, 1989, Serial 101-46.

[50] §53, pp. 52-55.

[51] §22(c), p. 34.

originally delivered to the lessee. In the case of vehicle rentals of more than one month, the destination of the lease is the residence of the lessee.[52]

While the taxpayer may remain relatively indifferent about which state imposes the Federal tax, the outcome of Federal jurisdictional questions will, as a matter of practicality, influence the outcome of state decisions concerning taxing jurisdiction. Of course, at the state level, rates can differ. Moreover, states may vie for taxing jurisdiction to enjoy the collection of administrative fees or to establish residency for other state tax bases. Consequently, a Federal Office of Revenue Allocation is provided to arbitrate any disputes that may arise among the states. This office is expected to serve the role in the role of Competent Authority.

Under the STC plan, the Federal government will facilitate information sharing, provide administrative support and regulatory guidance and, to the extent necessary, resolve destination/allocation disputes among the states.[53]

IV. Dominant Issues: How the STC Addresses Commonly Raised Problems

A. The Family Consumption Refund

1. Some Thoughts About Progressivity

A common assumption about the sales tax is that it is naturally regressive, since lower "income" individuals spend a greater percentage of their income on consumption of necessities. However, a sales tax is an altogether different paradigm of taxation, and any judgment on the equity of the tax must be accompanied by a different analysis of regressivity.

This article is not meant to provide a complete treatment of the many issues raised when examining distributional equities. Nevertheless, to examine how the STC plan addresses these concerns, a number of issues should be broached. First and foremost, taxing *income* at a graduated rate has always been a surrogate index of progressivity. A tax on income, no matter how steeply accelerated, does not necessarily make an income tax progressive. Moreover, taxable income may not be the best index by which progressivity or regressivity is measured. Even if progressivity is measured by the "ability to pay", taxation of an income stream only denotes taxation on a return to capital or productive labor, not necessarily wealth, or more equitably, consumption. Equally important, using taxable income as a surrogate to determine progressivity is necessarily based on a year-to-year analysis, where the ability to pay is measured as a function of income per unit time. An income tax does not capture consumption of older accumulated capital.

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[52] §53(i), p. 55.
[53] §§31-33, pp. 38-43.

Consumption over the life of a taxpayer is in many respects a better measurement of the ability to pay taxes. Under the sales tax, the more the taxpayer is able to consume for personal enjoyment, as opposed to savings or investing which generates benefits to the community beyond personal enjoyment, the more taxes he will incur. The greater the level of individual consumption, the greater the tax.

The "progressivity" of a sales tax therefore cannot be judged on the basis of whether or not those with larger income streams over a particular period are taxed more or less than those with lower income streams. The issue should not be defined by tax burden versus income, but rather by the sales tax burden over consumption. The level of consumption over the course of one's life, maybe a more important measure of equity in the world of consumption taxes.

The STC plan strives to make the tax less compulsory by making it inapplicable to the level of consumption required for necessities. One manner in which the tax could have sought to accomplish this objective would have been by delineating specific categories of goods or services as exempt, food and clothing for example. A better, less intrusive, less costly way is to simply provide each family a level of consumption free of tax by providing a rebate of the tax up to the poverty level. This is the device chosen in the legislation.[54]

Under the STC plan, the family consumption refund effectively exempts purchases of necessities by workers. Wage-earners would be entitled to a rebate equal to the sales tax rate times the lower of their wages or the poverty level. The poverty level is defined as the Department of Health and Human Services guidelines level grossed up by the sales tax rate.[55] For a family of the four, the HHS poverty level for 1996 is $15,600 so the sales tax poverty level would be $18,588. The annualized rebate amount would therefore be $2,788. Assuming the head of household was paid 26 times per year, the rebate amount included in each paycheck would be $107.23. Employers would pay less payroll tax and the Treasury would reimburse the Social Security Administration for the rebate amounts provided to families in order to ensure the balance of trust funds are unchanged.[56] Only the source of the payments into the trust funds would change. The rebate would then be administered at the family unit level (as the poverty level is defined by reference to the family unit).

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[54] The legislation actually provides the rebate only against wage income. Although rules are provided that would effectively exempt consumption from the sale of homes, those with wage income less than the poverty level whose consumption was financed by the sale of financial assets or passive income would not be fully protected. Those that receive government benefits can be protected to the extent necessary by adjusting benefit levels. The level of benefit adjustment is uncertain since the repeal of the income tax should reduce pre-sales tax prices to some degree. Finally, if the view commonly held among economists is correct that the actual incidence of a consumption tax is on the factors of production (labor and capital) it is not clear that any relief is appropriate.

[55] §15(c), p. 21-22. The HHS poverty level is divided by the quantity one minus the tax rate.

[56] An explicit provision to reimburse the Treasury for payroll taxes not remitted by employers, although included in earlier drafts of the legislation (as §6(b)), certainly intended by the sponsors and referred to in cross references in H.R. 3039, was ommitted from H.R. 3039. The legislation's sponsors believe that other existing statutory provisions ensure that the trust fund will be fully funded under current law.

The chart below indicates the applicable poverty thresholds and maximum rebates for 1996.[57]

Family Size	Applicable Poverty Level	Max. Rebate Amount
One	$ 9,106	$1,366
Two	$12,188	$1,828
Three	$15,271	$2,291
Four	$18,588	$2,788
Five	$21,435	$3,215

All workers would receive a rebate up to the maximum rebate amount shown in the table. Thus, the effective tax rate for a family of four earning and spending $37,176 would be 7.5 percent. The effective tax rate for a family of four earning and spending $74,352 would be 11.25 percent. This assumes that the incidence of the sales tax is on the consumer. The view that incidence falls on the factors of production is commonly, though by no means universally, held among economists.

The family consumption allowance approach seeks to accomplish several objectives. First, it makes the sales tax applicable only to consumption beyond the necessities of life. Second, it make the tax progressive, not only because it is based on consumption, a better index of true ability to pay, but because -- if one wants to continue to view progressivity through an income tax lens -- it exempts entirely lower income workers from tax. Third, it does not commence down the road, as most state taxes do, of determining what to tax and what to exempt, thereby minimizing administrative and compliance questions and costs and economic distortions.

B. Used Property (Including Homes)

The legislation provides a credit for tax previously paid on used property that is subsequently resold.[58] The basic idea is that the government should only tax an item once and that the sales tax should not cascade every time the same property is subsequently sold (as is the case under many state statutes).

The rules operate differently with respect to depreciating and appreciating used property. As more fully discussed below, transition rules are provided for property owned on the date of enactment. These rules are designed to ensure that property purchased from after-income-tax dollars is not then also subjected to a sales tax.

Let us take two examples to illustrate the application of the rules. In the first example, the consumer has purchased an automobile after enactment of the law, which is resold at a substantially lower amount to another consumer, similar to our example above.

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[57] See Federal Register, Vol. 61, no. 43, March 4, 1996, p. 8286 for 1996 HHS poverty level.
[58] §11(c), pp. 15-17.

Automobile	Purchased New	Subsequently Sold
Total Price	$23,529	$ 5,882
Tax	$ 3,529	$ 882
Net of Tax Price	$20,000	$ 5,000

In this example of a depreciating asset, the seller would be entitled to a credit of $882, which equals the amount of tax the buyer would pay.

In our second example, the asset appreciates in value. Let us assume that the reverse of our first example holds true.

Collectible	Purchased New	Subsequently Sold
Total Price	$ 5,882	$23,529
Tax	$ 882	$ 3,529
Net of Tax Price	$ 5,000	$20,000

Here, the seller would be entitled to a credit of $882, on tax liability of $3,529.[59] The seller would have to remit $2,647 to the tax authority, which is the difference between the tax paid by the subsequent purchaser on resale and the tax paid when the product was first purchased. In this way, the full value of the collectible, or $23,529, was ultimately taxed in two components: (1) consumption to the extent consumed by the original purchaser, and (2) consumption when resold. This mechanism can continue on from consumer to consumer without limitation if need be.

The general used property credit rules, including the transition rules, apply to primary residences. However, in the case of the primary residence, special rules may be elected which allow the purchaser of a primary residence to elect to pay the tax due ratably over thirty years with interest. In the event this election is made, the responsibility for remitting the tax rests with the buyer. If the primary residence is subsequently sold, then the entire tax is due (but any used property credit due would be allowed as well).

In summary, these rules operate to provide a tax credit on the equity in existing property, and compensate for increases or decreases in fair market value. Homeowners are allowed to pay any additional tax on subsequent purchases over thirty years. They are thus in a situation comparable to having to pay the principal payments on their mortgage from after-income-tax dollars. The sales tax rate of 15 percent will be lower than the marginal income tax rate most homeowners faced, especially when one considers the typical one-time spike of income from conversion of long-held capital assets. Moreover, under a sales tax, mortgage interest rates will drop considerably. Thus, while homes are in the sales tax base, given the general structure of the tax, the transition rules provided and the effect on interest rates, it would seem that homeowners can be expected to fare better under a national sales tax than under the present system.

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[59] unless an exemption or de minimus rule applied.

C. Financial Intermediation Services

The taxation of financial intermediation services poses a difficult problem for all consumption tax proposals. Interest rates may be viewed as having three components. The normal (risk-free) return to capital, the premium for the risk that the capital provided will not be repaid and the payment for financial intermediation services. Although some financial intermediation services are separately charged, in practice they are usually incorporated into the interest paid. Similarly, insurance premiums have a financial intermediation services component. Under the proposal, financial intermediation services (FIS) purchased by consumers are taxable services,[60] while FIS purchased by businesses are exempt as business inputs.

The legislation seeks to resolve the issue by defining FIS to include both explicit and implicit services. Explicit financial intermediation services include brokerage, banking, safe deposit box, trustees' and mutual fund management and exit fees as well as sales loads and insurance premiums to the extent that the premium is not allocable to the underlying investment account.[61] If the services are explicit, they are taxable.

The proposal then undertakes to define implicit FIS in order to tax the intermediation fees imbedded in interest rates. The implicit fee is the difference between the applicable interest rate and the interest rate provided or charged times the debt balance. In the case of deposits, it is measured as the excess of the applicable rate over the rate provided. In the case of borrowers, it is measured as the excess of the rate charged over the applicable rate. The applicable rate is defined as two percent plus the rate that the Federal government pays when it issues securities of like term and like issuance date to the transaction for which an amount is being imputed. The two percent rate is designed to be an arbitrary risk premium.[62]

Rules are provided allowing financial institutions to collect and remit the tax with the same frequency that statements are issued, provided the statements are issued at least quarterly. The option to account for financial intermediation services on other than an account-by-account basis is also provided.[63]

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[60] §21(n), p. 32 and §21(a), pp. 25-28.

[61] If an health or property and casualty insurer makes a purchase on behalf of an insured (e.g. medical services or automobile body work) and the premium giving rise to the obligation was taxed, then, as discussed above, the insurer's purchase is exempt. Thus a hospital invoicing an insurance company would collect no tax but if it were invoicing a consumer it would collect the tax. However, a mechanism should be provided to credit the insured for taxes paid if the insurance company reimburses the insured rather than making the purchase directly (again, assuming the premium was taxed). Similarly, a provision should probably be made to provide a credit to life insurance proceeds recipients if the life insurance policy were taxed.

[62] The netting rule in section 21(a)(4)(A), which provides that implicit fees are reduced to the extent of explicit fees, is probably wrong. The tax effect should not vary depending on whether the fees are implicit or explicit and this netting allows the effective tax burden to decline in certain circumstances if explicitly stated.

[63] §22(a)-(b), pp. 33-34.

The STC plan's treatment of FIS represents a very substantial simplification compared to other consumption tax proposals, including the USA Tax and the flat tax, which must provide rules for valuing financial intermediation service in relatively complex, and more numerous, business-to-business transactions.

D. Government Services and Purchases

The question of the proper treatment of government services presents special problems. Excluding government from the tax base would provide a tax advantage when government is competing with private providers of services. Also, as government services are a substantial portion of the GDP and are taxed by both the income tax and the flat tax, excluding them would require a substantially higher tax rate (since spending is unlikely to decline to compensate for the lower tax on government).

As it would be administratively impossible to tax government provided services as they were received, the proposal seeks to reach parity between government services and private services through the imposition of an excise tax on the receipt of government wages.[64] Government purchases from the private sector would be subject to tax as would the purchase by private persons of government goods or services (e.g. transit, publications).[65] However, exemptions otherwise available to business would be available to government. For example, government purchases used for resale or for the production of taxable property and services would be exempt. Thus, Amtrak's purchase of locomotives or sandwiches for resale would be exempt. The Government Printing Office's purchase of paper for printing books produced and sold to the public (and therefore taxed) would be exempt.

E. Not-For-Profit Organizations

The tax system ought not to discourage provision of goods or services that serve a public need or good, which cannot be provided by the for-profit sector and which can more effectively be provided by private not-for-profit organizations than government. Likewise, the system ought to encourage volunteerism and contributions to charitable purposes. On the other hand, not-for-profits' commercial activities should not be allowed an unfair competitive advantage vis a vis the business activities of the for-profit sector.

Under the legislation, as in current law, a balance is struck between permitting some commercial activity and preventing such activity from competing against the for-profit sector. Primarily, not-for-profit organizations, which roughly correspond to present law 501(c)(3)-(6) and 501(c)(8) organizations, are accorded special treatment under the legislation.[66] Dues, contributions and payments to qualified not-for-profit organizations are not taxable gross payments for services.

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[64] §22(I), p. 38.
[65] §3(a), p. 10.
[66] §3(a)(2), pp. 10-12.

However, if a qualified not-for profit organization provides property or personal services in exchange for dues or contributions, then the fair market value of the property or personal services provided are taxable. This is intended to replicate current law treatment, which denies a deduction for contributions to the extent of the fair market value of goods or services received in return. Moreover, gross payments to qualified not-for profit organizations for property or services that are not substantially related to the exempt purposes of the organization or that are commercially available would be taxable. This latter point is mean to incorporate the principles of an improved unrelated business income tax (which has been frequently criticized by small businesses as unworkable).

The organizations which fall within the rubric of the special rules are those organized and operated exclusively for religious, charitable, scientific, testing for the public safety, literary or education purposes; as civic leagues or social welfare organizations; as labor, agricultural or horticultural organization; as chambers of commerce, business leagues or trade associations; or as fraternal beneficiary societies, orders or associations.

F. Mixed Use Property

Mixed use property, i.e. property serving both business and personal consumption needs, presents problems in virtually all tax systems, including the income tax and the flat tax systems. The sales tax is no exception. Purchases of property and services may give rise to taxation or exemption depending on the use to which the property is put. The essential question presented is as follows: is the property used essentially for consumption or for production?[67]

The STC plan seeks to resolve this issue by providing that, in order for mixed use property to be exempt, it must be used more than 95 percent for exempt purposes. Otherwise, the person purchasing the property (or service) is entitled to a business conversion credit equal to the product of the tax rate, the business use ratio and the mixed use property amount. The business use ratio is determined by the ratio of business use to total use using mileage for vehicles, floor space for real property, time for machinery and equipment and a reasonable method for other items. Records substantiating the use must be maintained. The mixed property amount for any given year is one thirtieth of the purchase price for thirty years for real property, one seventh of the purchase price for seven years for machinery and equipment, one-fifth of the purchase price for five years for vehicles.[68] To illustrate, a $5,000 vehicle would give rise to a mixed property amount each year of $1,000. If the business use ratio were 50 percent, then the annual credit would be $75 (15 percent of $500).

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[67] §22(f), pp. 35-37.

[68] §22(g) provides rules preventing the assertion of a business exemption in the case of hobby activities made to appear as businesses.

Special rules are provided to tax property converted from business to personal use, and conversely, to provide a credit for property converted from personal to business use.[69]

V. Transitional Considerations

The questions about how best to structure appropriate transition rules, and the standards by which the fairness of these rules should be judged, pose difficult issues for policy-makers in any major change to the tax system. These question are of enhanced importance when we contemplate the complete replacement of the income tax system with one based upon consumption. Questions of equity, economic impact, revenue loss or gain and administerability must be balanced.

Possible standards for determining whether transition relief is appropriate might include: "Is a taxpayer's tax liability comparable to what it would have been under the law when an investment was made?" or "Is a taxpayer's after-tax rate of return comparable to what it would have been under the law when an investment was made?" These standards would rest on the equitable proposition that it is not fair to in "change the rules after the game has been played" or, stated differently, that taxpayers' reasonable expectations about the future tax law with respect to existing investments should be respected. Another possible approach would try to ensure that neither new and old investments receive competitive advantage due to tax changes. These issues require greater analysis and discussion.

With these concerns in mind, the STC plan provides a number of transition rules, some of which have already been mentioned in the context of the of the structure of the plan. Owners of existing property (e.g. homes and automobiles) are deemed to have previously paid sales tax to the extent of their equity in the property for purposes of the used property credit rules.[70] Equity is defined as the ratio of (a) the income tax basis in property as of the effective date less debt secured by the property divided by (b) the income tax basis in property times (c) the original purchase price. This rule means that a homeowner would receive a tax credit towards his or her next purchase in amount equal to their deemed paid credit. Thus, to the extent the taxpayer had made equity payments out of after-income-tax dollars, he or she would not incur additional sales tax liability.

Also, self-employed persons, for purposes of the self-employment tax, are allowed to deduct remaining basis in depreciable property and inventory (including amounts capitalized by virtue of present law section 263A) ratably over 10 years.

Gains and losses attributable to enactment of the STC plan or any other alternative tax plan would clearly be quite large for some individuals or businesses. Nevertheless, in the STC plan, income tax transition rules are not provided. It is questionable whether

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[69] §11(d), pp. 17-18.
[70] §11(c)(3), p. 16.

transition rules for remaining income tax basis, unused credits and the like are appropriate since the future income tax rate on individuals and corporations would be zero.

A scheme where a special refund equal to the income tax rate times the present discounted value of the stream of deductions plus any unused credits is conceivable. Were such an approach pursued, however, it would also seem appropriate to impose a corresponding tax on built-in capital gains and presumably even the capitalized value of future income streams. This revenue, in turn, could be used to fund the transition relief. Although it is clear that such an approach would be highly complex, it is far from certain whether the result would improve equity or economic efficiency. It would certainly do little to improve simplicity.

It may be appropriate to avoid a form of double taxation by providing some relief to persons consuming out of savings that were previously subject to the income tax. This relief may be particularly desirable since the STC plan family consumption refund benefits only wage-earners. Such relief is not appropriate for savings distributed from pension plans, Individual Retirement Accounts and other qualified plans because neither the original contribution nor the earnings on the plan would have been subjected to income tax. The STC deemed paid transition rule with respect to existing tangible property protects wealth or savings from double taxation. The problem primarily relates to financial instruments purchased with after-income-tax dollars. Qualified transition accounts could be established prior to implementation of the sales tax and spending out of those accounts (subject perhaps to an annual maximum) would result in a credit equal to the sales tax rate time times the distribution amount. Some sort of debt netting requirement would have to be paired with such an approach to avoid heavy borrowing to fund the transition accounts.

Another transitional issue, probably best handled through the authorizing and appropriations process, relates to government benefits programs. Those making their consumption purchases out of social security, veterans, AFDC, food stamp or similar benefits will pay tax on their purchases. However, it is not clear what the appropriate level of relief is to hold benefit recipients harmless. All other things being equal, the market should clear pre-sales-tax goods and services prices lower after the income tax is repealed since income taxes are costs that will no longer be imposed on suppliers of capital and labor.

Conclusion

The introduction of a practical national sales tax plan into the current political dialogue has far reaching implications. The plans represents a fundamental challenge to the current federal graduated tax on income. A national sales tax along the lines of the STC plan would, in our judgment, have a highly beneficial impact on the U.S. economy, the standard of living of the American public, the compliance costs borne by our economy and on the degree of intrusiveness of the tax system in our lives. Such a tax system is more compatible with the principles of a free society than our current tax system.

Mr. SHAW. Mr. Tauzin.

STATEMENT OF HON. W.J. "BILLY" TAUZIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. TAUZIN. Thank you, Mr. Chairman.

As my colleague, Mr. Schaefer, has said, we have put on the table now the second of two very important proposals to dramatically reform the current, outdated, complex, most hated tax structure in American history, the American income tax system.

The first proposal, of course, on the table is Mr. Armey's flat tax, which I know this Committee is giving very serious examination to. This proposal, unlike the flat tax, which we think, by the way, would be a vast improvement over the current system, actually eliminates the income tax completely, eliminates not only the income tax on personal and corporate income, but also the inheritance and gift taxes as well.

The value we think of doing that, if we are going to do national tax reform, is in ending and eliminating the business of constantly simplifying and flattening the tax rates, only to see them constantly raised again and made complex again over time.

For example, the last time tax rates were flattened was in the mideighties with Ronald Reagan's tax plan that lowered the rates from 14 different rates down to 2. We are now back up to 5 effective rates, 4,000 changes in the Tax Code later. We think it is time to eliminate and pull that Tax Code up by its roots, as Chairman Archer has said.

The second point I want to make is that the current Tax Code, as hated as it is, would be hated even more if Americans fully appreciated the fact that their income is being taxed twice under that Tax Code, once when they make it, whether from salary, investments, dividends, or capital gains, and then second, again, when they spend that income, because every product made in America carries the full burden of the income tax system on its back.

Every company, every employee, every person who contributes to the manufacture of American products pays income taxes. In the course of extracting raw material in America and eventually turning it into a retail product, so many hands have paid income taxes and so much cost of the current system is passed along to the consumer that some economists tell us somewhere between 10 and 15 percent of the price of every product made in America is the cost of the American income tax system.

In fact, small businesses spend $4 complying with the Code for every $1 they send the Federal Government, and all of that tax is passed on to the American consumer in the price of American-made products.

Coincidentally, foreign-made products brought into America don't carry that tax burden, and so you wonder why we have economic insecurity in this land, you wonder why we have a disadvantage in world trade. Our tax system double taxes our income and favors foreign-made products, and that is wrong.

What we say is that it is time to end the double taxation. Once ought to be enough. Hidden taxes ought to go away. We ought to have a simple, up front national retail sales tax to take the place of both the income taxes and the hidden taxes on American-made

products, and we ought to apply that national sales tax to products made in America and brought into America on an equal basis.

When you do that, you create tax fairness, simplicity. You create for the first time a real pro where American manufacturers can complete in world trade fairly without the disadvantage of the American tax structure riding on the backs of American products.

I suggest to this Committee, we have offered the second of two very good proposals. We think this one is superior. We have included in the 15 percent a rebate for sales taxes paid for the income made under poverty levels to take care of regressivity arguments. Please look at that carefully. It is a good proposal.

We include in that 15-percent rate enough to make sure that we treat the purchase of a home as good or better than the current Tax Code. Please examine that in our proposal, and when you get through evaluating these two good proposals, we hope this Committee will recommend to the next Congress and to the American public not just a rehaul, not just a flattening of the American Tax Code, but a complete repeal of the American income tax system, inheritance tax system, gift tax system, and a system that rewards work, income, and investment, and taxes only consumption in a very simple national sales tax.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF HON. W.J. "BILLY" TAUZIN
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. Chairman,

We just heard Dick Chrysler eloquently address some of the multitude of reasons why the present income tax is a disaster for our country and our people. Dan Schaefer has clearly explained the details of a national retail sales tax and how it will actually work in our country. It is my honor to address the Committee about the benefits of a national retail sales tax, a tax levied not on income as it is received before we have an opportunity to consume, but at the time of actual consumption.

Mr. Chairman, all taxes reduce our ability to consume and are really "consumption taxes." Everyone I know intends to consume all the money they make, now or in the future. Some of us want to defer the consumption until we retire or until our kids are ready to go to college. Others want to consume a part of their earnings by donating it to a church or other organization. Others just use their earnings to consume today. However, anything we decide to do with the money we earn is consumption.

Now, anytime government taxes away part of my money, it is reducing my ability to consume. Therefore, a 15% tax withheld from my income at 15% reduces the money I have with which to consume foods and services. For example, to purchase a $10 item of clothing with an income tax of 15%, I would actually have to make $11.80, pay 15% of this amount or $1.80 of income tax, and then use the remaining $10.00 to purchase the clothing.

With a 15% national retail sales tax, I would have to earn $11.50 in order to pay the $1.50 in national retail sales tax and net the $10.00 needed to buy the article of clothing. In the case of an income tax or of a national retail sales tax, the taxes reduced my ability to consume because I have fewer dollars to use for consumption.

My question to the Committee is this, if all taxes are really consumption taxes, shouldn't we replace the present failed income tax system with a national retail tax that accomplishes the following:

1. Frees individuals from filing any type of federal tax returns.

2. Requires only simple returns from retail business.

3. Abolishes the IRS and tears the income tax out by the roots.

4. Increases our competitiveness in the world economy.

5. Ensures that the members of the underground economy pay their share.

6. Eliminates the taxes on production, investment and savings.

7. Requires illegal immigrants and importers to pay taxes in the U.S.

8. Empowers all Americans by giving them the choice as to how much tax they pay.

I will now address each of these points.

1. **Frees individuals from filing any type of federal tax returns.** In 1994, there were 107,291,000 1040 individual income tax returns filed. 107,291,000 Americans were forced to spend in excess of 2 billion fours trying to calculate the amount of income taxes owed to the federal government. This is absurd.

The national retail sales tax requires no federal individual tax returns of any kind. Individual Americans will pay their taxes when we make purchases of retail goods and services. No receipts, no tax returns, no audits, no hassle. What a concept!

2. **Requires only simple returns from retail businesses.** Does anyone believe that businesses pay taxes? A businesses taxes are passed through to the consumer through higher prices and then paid to the government. All taxes are ultimately paid by consumers. In fact, many

economists believe that prices of consumer goods and services are between 12% to 20% higher than they otherwise would be because of our ridiculous income tax system.

A study released by the Tax Foundation revealed that corporations with assets of $1 million or less (more than 90 percent of all corporations and the ones that create the most jobs), paid a minimum of $382 in compliance costs for every $100 they paid in income taxes ($14 billion in compliance costs for $3.7 billion in income taxes.) Does anyone believe that these costs are not passed on to us in the form of higher prices? Not anyone in the 3rd district of Louisiana. Ironically, if this time and money could have been devoted to the production of goods and services and not to the preparation of non-productive paperwork, the economy would grow even more which would in turn lead to more taxes being collected.

With a national retail sales tax all this changes. Because the national sales tax will be collected by businesses selling retail goods or services, these are the only businesses which will file simple sales tax returns. In addition, in our bill, retail businesses are entitled to be reimbursed a 1/2 of 1% of the national retail sales tax they collect. No longer will the compliance costs and the actual income tax itself have to be passed on to you an me in the form of higher prices. Through competition, the savings to business will be passed on to us and we can expect retail prices to actually decrease.

3. **Abolishes the IRS and tears the income tax out by the roots.** My constituents regularly complain about how Washington has got messed up priorities. We have 24,000 employees in the FBI to fight crime and terrorism. There are 6,700 employees in the Drug Enforcement Agency to combat the polluting of our children and country by drug dealers. The Border Patrol has 5,800 employees who are supposed to protect our borders. How in the world do we justify the IRS having 111,000 employees? Is it to keep in line the terrorist taxpayers?

Unlike the other income tax based alternatives to the income tax, the national retail sales tax is the only proposal that will abolish the IRS and tear the income tax out by the roots. As my colleague Dan Schaefer explained, the national retail sales tax will be collected by the states who already collect state sales taxes at a fraction of the cost for collection of our present income tax or of any of the other proposals.

We can shift our emphasis from terrorizing taxpayers to terrorizing criminals and drug dealers. Finally, does anyone believe that once freed from the income tax, the American people will allow it to come back?

4. **Increases our competitiveness in the world economy.** The income tax seriously harms our ability to compete in the global marketplace. Our major trading partners around the world rely heavily on consumption taxes that are applied to all products sold in their countries, whether domestically made or imported, and are "border-adjustable," meaning that the taxes on exported goods are rebated to manufacturers within their borders. (GATT does not allow rebates of income taxes.)

Our income tax system has caused us to be a nation of exporter of jobs. High-paying American jobs are vanishing overseas at an alarming rate. Without a border-adjustable tax, we handicap our exporters because their goods contain the cost of our government, whereas imported goods do not pay any of the cost of our government. Therefore, the income tax penalizes American products and exports and subsidizes imports.

Why is this important? It is estimated that each $1 billion in exports supports 19,000 jobs in the U.S. While our OECD competitors' exports range from 15 percent to 30 percent of their GDP, our exports only total 6 percent of U.S. GDP. By increasing exports, the U.S. can create hundred of thousands of the type of high-wage jobs that our country desperately needs.

With the national retail sales tax, our international competitiveness will be greatly enhanced. The national retail sales tax is only levied on sales in the U.S. Our exports will pay no U.S. tax nor include U.S. taxes in their prices. Imports into our country that are sold at the retail level will be taxed in the same manner as U.S. retail products. Our companies will no longer be forced to

locate factories in other countries in order to compete in a global economy. Higher-paying jobs that would have otherwise gone to foreign citizens will stay in the U.S. With the national retail sales tax, we will no longer be exporting jobs to foreign countries, and our economy will l expand at a much more rapid rate.

5. **Ensures that the members of the underground economy pay their share.** We must remember the old adage that laws are no stronger than the devotion of the people to them. The present income tax is increasingly viewed as being anything but fair and the devotion of the people is becoming severely strained.

Using IRS estimates, the underground economy has grown at a rate of almost 8% per year since 1965 and is the fastest growing segment of our economy. The IRS estimates that $127 billion of taxes went uncollected in 1992 but many analysts believe that estimate is too conservative and that a figure of $200 billion is closer to the truth. The underground economy encompasses not only illegal sources of income, such as drug dealing, gambling and prostitution, but also the average ordinary citizen who accepts a lower price for cash payments and doesn't report the income.; the businessman who keeps two sets of books and pockets a portion of the sales or takes improper deductions; or the self-employed person who charges personal expenses through the business.

Will there be people who try to evade the national retail sales tax? Yes. There are always going to be people who refuse to pay any tax. However, it is much more difficult to avoid the national retail sales tax than an income tax. In California, the State Board of Equalization's statistics show that 90% of the state sales taxes are paid by 8% of the providers of retail services. California sales tax officials believe that there is little or no evasion from this 8% of the retailers because of their size and their accounting systems. Since it is unlikely that all of the remaining 92% of the retailers will be dishonest, the amount of evasion, even if the rate was increased to 18%, will likely be between 5% to 7%--far better than the 17% to 25% experienced under an income tax.

Finally, people who try to evade the national retail sales tax by obtaining a resale permit and purchasing all of their personal goods without paying sales taxes will be in for a big surprise. The states are now starting to enter into the computer the amount purchased with resale permits and the amount sold at retail. Unlike with the income tax, the cheats will be obvious.

6. **Eliminates the taxes on work, investment and savings.** Legislators understand that taxing something will produce less of it. By eliminating the income tax which penalizes work, investment and savings, we will get more work, investment and savings. Dr. Lawrence Kotlikoff and Dr. John Qualls both conducted detailed studies about the impact of replacing the present income tax with the national retail sales tax. They both found that the national retail sales tax causes the private savings rate (both personal and business savings) to rise substantially and produces faster economic growth and higher productivity. In both studies, the higher level of capital stock created under the national retail sales tax results in more job creation. More earnings by employees in the private sector fuels more consumer spending. Consumer spending thus rises from its current level but actually declines as a percentage of GNP.

There will also be what some economists call the "sponge effect". The US is the world's largest market and has the best infrastructure of any country on earth. When the income tax is replaced with the national retail sales tax, it will become the world's largest tax haven and a "sponge" for capital from around the world. According to Martin Armstrong of the Princeton Economic Institute, replacing the income tax with a national retail sales tax will create an inflow of foreign capital into this country like we have never seen. Mr. Armstrong points out that the nearest comparable period in modern history was in 1940. Seeking to avoid the ravages of World War II, capital flooded into the United States and government bond rates were at one percent.

A conservative estimate is that the adoption of the national retail sales tax will lower interest rates between 200 and 300 basis points. Overnight we will see the debt service on our national debt reduced, perhaps enough to bring the budget in balance. Our businesses will be more able to purchase equipment and rapidly increase productivity. Our citizens will be able to refinance their homes and save hundreds of dollars per month in interest payments. In short, the United States will experience the greatest economic boom in our history.

7. **Requires illegal immigrants and importers to pay taxes in the US.** Not only do we fail to enforce the laws with respect to our borders, we also allow illegal immigrants to work in our country and because they work for cash, to pay no taxes to our federal government. If we adopt a national retail sales tax then each time illegal aliens make purchases they will pay a federal tax. This will not cure our illegal immigration problem but it will ensure that everyone living in our country contributes to paying our government's expenses.

8. **Empowers all Americans by giving them the choice as to how much tax they pay.** Our present income tax system takes our money through withholding before we receive it. Most of us now consider that our wages are really the "take-home pay" that we get net of all the deductions. Under the present system, it doesn't matter if one of us is more frugal than the other because we all pay the same amount of tax. In fact, if we are more frugal than our neighbor we are actually going to pay more and more tax because our earnings on our savings will be taxed each year.

With the national retail sales tax we receive all of the money we earn. Our checks are increased by the amount previously deducted for federal income tax. With this money in hand, we have the power to determine the amount of federal tax we pay based on how much we choose to spend. We, not some bureaucrat or lawmaker in Congress, will have the power.

Also because of the way that the present income tax system hides the amount of taxes we pay in the price of goods and through withholding, I don't think any of us can really tell how much tax we are paying to the federal government. By eliminating the individual and corporate income tax, the estate and gift tax and all non-trust fund excise taxes and replacing them with a simple national retail sales tax, all of us will see the amount of federal tax we pay each time we make a purchase.

To each of us who really wants to make the government more accountable this is a compelling difference between the present income tax and the other income tax proposals and the national retail sales tax. When our citizens see how much they are paying in federal taxes they will demand that we become more efficient and deliver better services to them.

Mr. Chairman, in closing, I believe that we should re-examine the basic ideas on which this government was founded. Our Founding Fathers insisted on the use of indirect taxes on individuals and specifically forbade direct taxes like the income tax. They did this because they were students of history and they knew that every despotic country had one thing in common--direct taxation which helped enslave the people. We have an opportunity to eliminate the income tax, the IRS, tax returns, audits and the penalties on our exports, work, savings and investments and replace them with an indirect national retail sales tax. For us, our children and grandchildren we must free America from the income tax.

I leave you with these words from Federalist Paper XXI by Alexander Hamilton writing under the name Publius.

"Imposts, excises, and, in general, all duties upon articles of consumption, may be compared to a fluid, which will in time find its level with the means of paying them. The amount to be contributed by each citizen will in a degree be at his own option, and can be regulated by an attention to his resources, The rich may be extravagant, the poor can be frugal; and private oppression may always be avoided by a judicious selection of objects proper for such impositions... It is a signal advantage of taxes on articles of consumption that they contain in their own nature a security against excess. They prescribe their own limit, which cannot be exceeded without defeating the end proposed--that is, an extension of the revenue. When applied to this object, the saying is as just as it is witty that. "in political arithmetic, two and two do not always make four." If duties are too high, they lessen the consumption; the collection is eluded; and the product to the treasury is not so great as when they are confined within proper and moderate bounds. This forms a complete barrier against any material oppression of the citizens by taxes of this class, and is itself a natural limitation of the power of imposing them."

Mr. SHAW. Thank you, Mr. Tauzin.
Mr. Chrysler.

STATEMENT OF HON. DICK CHRYSLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CHRYSLER. Good afternoon. First, I would like to express my appreciation to the Chairman and to the Committee for taking time to discuss the tax reform our Nation desperately needs and the steps this Congress should take in terms of making reform a reality.

Simply put, our present income tax system has failed us miserably. It is time to rip the income tax system out by its roots and replace it with a national retail sales tax, while in the process eliminating the IRS, the inheritance tax, the estate tax, the capital gains tax, and the personal and corporate income tax.

The National Bureau of Economic Research issued a November report showing the massive 1993 tax increase resulting in decreased taxable income being reported, causing the Treasury to lose more than one-half of the extra revenues that had been projected. Indeed, taxpayer behavior was altered more than anticipated or desired.

Last year, we passed an immigration bill. It was interesting to note that we have 26,000 INS agents, while at the same time, we have 115,000 IRS agents. Are we more concerned about keeping illegal immigrants out of our country or squeezing taxes out of legal residents?

The American income tax system discriminates against savings and investment. Our income tax system increases the price of savings relative to consumption, directly opposite the economic message we should be promoting.

With an income tax, we initially tax income when it is earned, and then a second time on any return on investment or savings. On the other hand, the money spent on consumption, unlike the money going to savings, is not taxed again.

We have, in fact, a Tax Code that is systematically biased against savings, and as such, is detrimental to economic growth. Not only is our income tax biased against savings, it is a major impediment to productivity and business efficiency. Nationwide, individual taxpayers and businesses spend an estimated 5.4 billion man-hours complying with the Tax Code, more time than it takes to build every car, truck, and plane that we build in this country.

It is estimated that the compliance cost alone costs Americans $250 billion a year. The current Internal Revenue code is 90 times longer than its first edition and has more pages than the Bible.

As a small businessowner, I know that the statistic is true, if not conservative, that small businessowners spend over $4 in compliance cost for every $1 paid in taxes. The Internal Revenue Service is itself a bureaucratic monster with a license to intimidate. It is one of the most intimidating bureaucracies that we have in the Federal Government, and it has no place in a free country.

Fred Goldberg, a former IRS Commissioner, admitted the IRS has been a symbol of the most intrusive, oppressive, and nondemocratic institution in a democratic society. With a work

force of over 115,000, the agency is one of the Federal Government's fastest growing nonentitlement programs.

I speak for the majority of Americans who demand tax relief. I don't mean just lower tax rates. Our entire tax system needs an overhaul, and the Internal Revenue Service has become the grim reaper of the U.S. Government.

As Jack Kemp stated in the report of the National Commission on Economic Growth and Tax Reform, the problem in America today is that we are taxing work, savings, investment, and productivity, and we are subsidizing debt, welfare, consumption, leisure, and mediocracy.

Clearly, I side with Mr. Kemp in his analysis and willingly accept responsibility to change the tax system. Therefore, I urge the Committee to join my colleagues and I to move to a national retail sales tax.

Thank you for your time and effort to reform this badly broken system.

[The prepared statement follows:]

National Retail Sales Tax
Testimony Before the Committee on Ways and Means
March 27, 1996
Representative Dick Chrysler

The Need for the National Retail Sales Tax

Good afternoon. First, I would like to express my appreciation to the Chairman and the Committee for taking the time to discuss the tax reform our nation desperately needs and the steps this Congress should take in terms of making reform a reality.

Simply put, our present income tax system has failed us miserably. The income tax has failed this Congress and other Congresses before it by providing tax evaders and corporate welfare hawks a steady stream of opportunity in gaining unfair tax advantages. Our income tax has failed our government by fostering a counter-intuitive system which inhibits economic growth and discourages savings and investment. Finally, and most importantly, the income tax has failed the American people by becoming a nightmare of distrust and invasion of privacy. It is time to rip the income tax system out by its roots and replace it with a national retail sales tax, while eliminating the IRS, the inheritance tax, the estate tax, the capital gains tax, and the personal and corporate income taxes in the process.

The present income tax system is, to be politically correct, "economically challenged." Along with discouraging economic growth, savings, and investment, the income tax system is too complex and time-consuming. In fact, since the 1986 Tax Simplification Act, there has been 4,000 changes to the tax code. Congress has passively allowed the IRS to invade our privacy, and force the burden of proof on our citizens.

Mr. Chairman, this month the Joint Economic Committee laid out the persistent pattern of slow income growth plaguing the majority of middle class families, a situation described as the "Clinton Crunch." Without a doubt, much of this stagnation is attributable to bad government policies. Congressional history is full of our attempts to change or influence taxpayer behavior by giving special treatment to certain taxpayers or activities. However, with the incredible complexity of our income tax system, lawmakers have begun to baffle even themselves. The National Bureau of Economic Research issued a November report showing the massive 1993 Clinton tax increase resulted in decreased taxable income being reported, causing the Treasury to lose more than half of the extra revenue that had been projected. Indeed, taxpayer behavior was altered more than anticipated, or desired. I trust families to make decisions about how best to spend their money, not the federal government or the IRS. Last week, we passed an immigration bill. It was interesting to note that we have 26,000 INS agents, while at the same time we have 115,000 IRS agents. Are we more concerned about keeping illegal immigrants out of our country or squeezing taxes out of our legal residents?

It is ironic to watch lawmakers insist on the promotion of investment, job creation, and middle class family income growth, while at the same time adding to the matrix of tax provisions in the Internal Revenue Code. Such a tax system is itself a basic obstacle to economic growth.

An increasing consensus has emerged among tax experts and economists alike that moving to a consumption-based tax like the National Retail Sales Tax would provide incentives for savings and investment, lower interest rates, spur tremendous economic growth, and produce nearly a 14 percent increase in the standard of living for all Americans.

The American income tax system discriminates against savings and investment. Our income tax system increases the price of savings relative to consumption, directly opposite the economic message we should be promoting. With an income tax, we initially tax income when it is earned, and then a second time on any return on investment or savings. On the other hand, the money spent on consumption - unlike the money going to savings - is not taxed again. We have, in fact, a tax code that is systematically biased against savings, and as such, is a detriment to economic growth.

Not only is our income tax biased against savings, it is a major impediment to productivity and business efficiency. Nationwide, individual taxpayers and businesses spend an estimated 5.4 billion hours complying with the tax code. It is estimated that compliance alone costs Americans $250 billion a year. The current Internal Revenue Code is 90 times longer than its first edition, and has more pages than the Bible. As a small business owner, I know that the statistic is true, if not conservative in its estimate, that small business owners spend over $4 in compliance costs for every $1 paid in taxes.

The compliance cost of our present income tax system is yet another level of taxation on the American people. The burden of our tax system is reflected in the inflated cost of every good and service we purchase. Economists estimate that 14 cents of every dollar we spend goes to pay hidden direct and indirect costs of our income tax system. Not only do Americans spend countless hours and dollars complying with our income tax system, but we are also punished with inflated prices. What a waste of productive time, money and resources!

The Internal Revenue Service is itself a bureaucratic monster with a license to intimidate. Imagine being involved in a tax conflict, where as a citizen up against the IRS and its five-foot Code and miles of rulings, you bear the burden of proof. There is no room for this intimidation in a civilized world. While a "flat tax" would be a vast improvement over the present system, it would still require us to report personal information and our income to the IRS, leaving us subject to audits and property seizure. Fred Goldberg, a former IRS Commissioner, admitted, "The IRS has become a symbol of the most intrusive, oppressive, and nondemocratic institution in a democratic society." With a workforce over 115,000, the agency is one of the federal government's fastest growing non-entitlement programs.

I speak for the majority of Americans who demand tax relief, and I don't mean just lower tax rates. The entire tax system needs an overhaul, and the Internal Revenue Service has become the grim reaper of the U.S. government. We need tax relief from our intrusive, complex and burdensome tax system through an entirely new way of collecting taxes. Ladies and gentlemen, I hope you will join me in supporting a retail sales tax system that fulfills the Kemp Commission's six principles.

As Jack Kemp stated in the report of the National Commission on Economic Growth and Tax Reform, "The problem in America today is that we are taxing work, saving, investment and productivity; and we're subsidizing debt, welfare, consumption, leisure and mediocrity." Clearly, I side with Mr. Kemp in his analysis, and willingly accept responsibility to change the tax system. Therefore, I urge the Committee to join my colleagues and I to move to a national retail sales tax. Thank you for your time and efforts to reform this badly broken system.

Mr. CAMP [presiding]. Thank you very much, and I want to thank all of you for coming to testify.

Mr. Christensen, any questions?

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Yes, I do.

Mr. Chrysler, how do you see the national retail sales tax benefiting small business, labor, the consumers, in light of the fact that you would have a lot of retailers on Main Street say that the cost of their goods is going to go up and that you won't see as good of marketing, as good of sales at the cash register? Do you find that to be a true statement?

Mr. CHRYSLER. If you can lower the cost of doing business by eliminating the IRS by 10 to 14 percent, you will lower the cost of goods by 10 to 14 percent, and if you have a 14-percent sales tax, you are almost at a wash.

Then, if you are in a 15-percent tax bracket or a 25-percent tax bracket or a 40-percent tax bracket, that is like a 15-percent pay raise for every working American in America.

Businesses don't pay taxes, Jon. People pay taxes, and when you tax businesses, they add them into the cost of their product, and when you buy their product, you pay their taxes.

Mr. SCHAEFER. If I might intercede briefly, another thing besides the lowering of the price of the product is what it does for citizens' disposable income. You just have to ask people at town meetings how much they had withheld in their last paycheck in the Federal taxes, and you find that most of them don't remember. The NRST gives them a pay increase, because all of a sudden they are going to get that much money back, and if they have that much more money to spend—I think Billy mentioned something like $8,000 a year on the average—more money in their pocket, they are going to buy more.

The third thing is that we were giving retailers one-half of 1 percent for collecting this in the first place, and we are giving a 50-percent writeoff on any cash registers or software or anything else in which they would have to purchase in order to comply with this.

So, as for the retailers, I think once they begin to understand some of these things more, they are going to find out this is going to be a great thing for them, and for the economy in the country.

Mr. TAUZIN. If I can jump in, you have touched on a very serious concern, as 15 percent is a big rate. We admit that that is one of the handicaps of our proposal, and adding 15 percent at the end of a product cost is something retailers are first going to be a bit concerned about. They should be.

What we are pointing out is that the consumer is already paying that basically in the cost of their products. We eliminate that cost. We put more money in each consumer's pockets because they no longer have withholding taken from their paychecks, and that extra income is disposable income, part of which will go into purchases, part of which will go into savings.

Let me give you the biggest reason why I think this is critically good for retailing in America. Retailers operate on about a 1.25-percent profit margin. It is that thin. Many of them are hurting right now in an economy that is not doing that well, where job security is not exactly what we would like it to be, where workers aren't earning as much in real terms as they did a few years ago.

What if you all of a sudden had an economic boom in this country because we start treating manufactured products in America as favorably as we treat products brought in from other countries? What if we took away that 14-percent disadvantage to manufacturing in America and we created a job market again for this country, manufacturing again? We put not only more money in each worker's paycheck, but we have more workers out there earning more money. The economy is growing more rapidly. We create an environment for retail sales, the likes of which we haven't seen in a long, long time. That economic analysis needs to be done, and when it is done, I think it will speak well of this proposal.

Mr. CHRYSLER. Billy, how do you think that the national retail sales tax would address the underground economy? Would it be the best approach of the proposals out there?

Mr. TAUZIN. Let's talk about the pros and the cons because we ought to talk about both.

On the pro side, the underground economy is not paying taxes right now. Maybe as much as $100 billion is lost to your Committee's work. You have to raise taxes on somebody else to pick it up because somebody is not paying their taxes, maybe 100 billion dollars' worth, the legal underground economy.

The illegal underground economy may be another $100 billion or so. We don't know.

This bill says everybody pays taxes. It doesn't matter where you make your money. You made it legally or illegally. When you spend it, you will be paying, along with the rest of us, part of the burden of this government. So it speaks to the underground economy problem and creates some tax fairness there.

Let me tell you about the con side if I have 1 second, the negative side. The negative side is a 15-percent tax is going to create some incentive for some people to avoid it, to create an underground economy in sales. The answer is that there are fewer retailers to watch in America than there are American taxpayers right now. You don't need 114,000 IRS agents to regulate and maintain tax avoidance problems in a retail sales tax collection system, as 45 States currently do a good job of it. We can incentivize them to do even better.

So, on the positive side, we tax the underground economy for the first time, tax fairness. On the negative side, I think we can address the problems of compliance cost.

Mr. CHRISTENSEN. Would the Chairman indulge me for one quick question?

Mr. CAMP. Absolutely.

Mr. CHRISTENSEN. How does your national retail sales tax, though, go after that remodeler that is doing a rough job and the homeowner says here is the $500, let's just both work through this?

Mr. TAUZIN. Let's assume that happens. What happens when that guy goes to buy a boat with it or a new appliance with it? That money is going to eventually be taxed in this bill.

It doesn't matter, again, whether you earned it legally or illegally.

Mr. CHRISTENSEN. At some point, we are going to pick it up.

Mr. TAUZIN. Under current law, it is never taxed. You pay them in cash. No income tax is collected. There is no national sales tax today. So it is never collected.

Mr. CHRISTENSEN. I agree with you, but somebody said that the national retail sales tax would even drive more of a underground economy in terms of avoidance of taxes.

Mr. CHRYSLER. Can I address that really quickly, Jon, for you, and then we will go to Dan?

We have made a proposal in our plan to reward consumer informants. If that guy decided, hey, I am not going to charge a sales tax for putting the roof on your house, the person that didn't get charged could literally make a phone call to an 800 number. The person that didn't charge the tax would be fined and the informant would be rewarded.

Mr. CHRISTENSEN. There is going to have to be some enforcement mechanism.

Mr. CHRYSLER. So we wipe out most fraud by establishing a reward system.

Mr. SCHAEFER. If I might just add, no matter what kind of tax system that we put forth, there will always be some people trying to find loopholes somewhere. We know there are plenty of them in the one we have now, and the more affluent in this country are particularly able to figure out every loophole they can find.

In the surveys we have done, that has been done for us, the people who like this the most are the ones who are wage earners making between $25,000 and $50,000 a year, who do not have loopholes. These are the people that really like it because they know it will be more fair.

Mr. CHRISTENSEN. I applaud the Schaefer-Chrysler-Tauzin national retail sales tax. I think it may be the right approach. I think it could be good for this country. It allows people to save more money. It allows people to keep more of what they earn, and it takes us away from an egregious punitive tax system that is not going to take us anywhere in the 21st century.

So, Mr. Chairman, I want to thank this panel for testifying.

Mr. CAMP. Thank you, and I want to thank you all, too, for your work in this area.

I just have a question. What rate does your sales tax start out at, and does it stay that way or does it change as it is fully implemented?

Mr. SCHAEFER. Yes, Mr. Chairman. It is 15 percent. It started out at 12.9, and then we added in our personal consumption refund for everybody up at the poverty level, so that the working poor would virtually pay no taxes at all. So it is 15 percent.

I might add, it has woven into it a two-thirds vote of Congress in order to change it in any way, and you know how tough it is to get a two-thirds vote around here on anything.

Mr. CAMP. It is the majority, sometimes.

Mr. SCHAEFER. If somebody had proposed it, going from 15 to 16 percent, everybody in this country would know what you were doing. There wouldn't be any more of this hidden stuff being inserted here and there.

We are saying, in essence, we are going to give the right to pay taxes back to the American people, take it out of Congress' hands.

When they want to purchase something, they will know what they are paying in taxes.

Mr. TAUZIN. Let me add something quickly, Mr. Chairman. One of the biggest problems with tax systems around the world, including our own, is that so much of the taxes are hidden from the American public and from other citizens of other countries. That is the problem with the value-added tax, in my opinion. It is a hidden tax, much like the income tax cost is a hidden tax on products made in America.

The worst thing we do for our country is to hide what government costs. Our proposal says that our 15-percent rate is fixed and locked, cannot be changed without a two-thirds vote, and that 15-percent rate must be shown on the purchase price of the products purchased in America.

In short, we make sure it is not hidden anymore, that Americans know what the cost of government is, and that politicians who come to Washington to represent them are going to have a serious problem on their hands if they try to raise that 15 percent in the future.

So we try to avoid the business of hidden taxes that can be increased in the dead of night so easily, without the public ever knowing what hit them.

Mr. CAMP. Could you just elaborate a little bit, Dan, on the accommodation you make for the working poor?

Mr. SCHAEFER. Yes. Again, that is why we had to go to 15 percent outside of the 12.9. We felt we had to do this because of the regressivity of it.

Up to the poverty level, and it depends on the size of your family, you are going to get a personal consumption refund coming back on your FICA in your paycheck.

We feel this was very important to incorporate. It was important enough to raise this up to 15 percent. We can take away this argument and now say that the people who are the working poor up to that poverty line really aren't going to pay any taxes on anything because they get that refund in their check.

Mr. CHRYSLER. The other thing that is important is, that whatever the gross domestic product is on the day it is instituted is really what will set the rate, ultimately.

Also, I think it is important to add to what Dan said. Home mortgage deductions are treated, essentially, as they are today, and also charitable contributions. Charitable contributions are not consumption. Interest on your home mortgage is not consumption. So they would not be taxed.

Mr. TAUZIN. In fact, we have another vision for home purchases that I think is really, really excellent. What we provide in this is that if you have already purchased a home or already are purchasing a home, you are considered as having paid those taxes already. You did. You paid income taxes already.

If in the future you purchase a home, you will not pay taxes on the mortgage interest you pay. The taxes you do pay on the principal will be spread out over the life of your mortgage, whether it is 25, 30 years, whatever it is.

Whatever payments you make on that house over the years, when you sell it and repurchase another house, you will get a used

property credit for the taxes already paid. So you never will pay but once for the purchase of the value of the home.

What we have done is created a more favorable condition for home purchases in America than even the current Tax Code, and keep in mind, by eliminating the income tax, we are eliminating up to 14 percent of the cost of a home which is the cost of compliance with the IRS Code for all those people who manufacture things that go into home building in America.

Mr. CAMP. Thank you. Thank you all very much.

Mr. SCHAEFER. Thank you. We appreciate it, Mr. Chairman.

Mr. CAMP. Our next panel includes Hon. Nick Smith of Michigan and Hon. Sonny Bono of California. Mr. Smith is at the Rules Committee. Sonny Bono is detained.

So, without objection, we will permit those two Members to submit their testimony for the record.

[The prepared statements of Mr. Bono and Mr. Smith follow:]

TESTIMONY OF CONGRESSMAN SONNY BONO (R-CA, 44th)
WAYS & MEANS TAX REFORM HEARINGS - MARCH 27, 1996

Thank you Mr. Chairman, it is a pleasure to join today's distinguished witnesses and testify. Over the last year, there has been considerable talk and hype about tax reform. I commend you, Mr. Chairman, for scheduling the first of the many comprehensive hearings necessary to begin to comprehend this fundamental issue – tax reform. In addition, I must congratulate Representatives Tauzin and Schaefer on their hard and smart work on a bold proposal for a National Retail Sales Tax.

Certainly, our country was born on the issue of tax reform. Every student knows the history behind the revolution that brought our Republic to life was, in large part, fought against a tyrannical and unjust tax collector, the British monarch. Essentially, this question is about fairness and independence.

Unfortunately, as the saying goes, people who forget history are doomed to repeat it. Today, many Americans find themselves subject to a similar plight, an undemocratic and intrusive federal bureaucracy called the Internal Revenue Service (IRS). While I applaud the IRS reforms that the House has begun, it is important to remind ourselves what they are -- a band-aid on a congenital wound. Beyond any procedural changes, there must be a fundamental change. Our economic survival and stability requires this.

The IRS administers our national income tax, an out-of-date idea that stifles personal savings and adds hidden costs to products and services. In addition, the IRS operates in a distinctly oppressive fashion, disregarding the rights of citizens and due process, and scrutinizing the taxpayer's every financial move.

This year, tax reform is certainly in vogue. The Presidential campaign brought the issue to the national spotlight once again. Millions in advertising dollars were spent promoting different plans. Although a number of tax reform alternatives have been proposed, in reality, none is as simple and fair as a National Retail Sales Tax.

Virtually all the other plans offered as replacements for the current tax system are consumption based. Unfortunately, they all share a common weakness. Each of these plans attempt to solve only a part of the problem. Under the flat tax, the Unlimited Savings Account Tax and an array of other proposals, income must still be defined, deductions must still be sought and taxpayers must still report to the IRS.

A National Retail Sales Tax is a genuine consumption based tax. It turns the current system upside-down and changes the relationship between the consumer and government. Under this plan, taxpayers, not the IRS, will get first crack at their paychecks. In fact, the IRS would be abolished under the National Retail Sales Tax legislation I have co-sponsored with Reps. Tauzin (R-LA) and Schaefer (R-CO). This proposal would eliminate income tax entirely and replace it with a National Retail Sales Tax of 15%.

The plan is simple. It is levied only at the final point of sale, on every product and service purchased. My experiences as a former businessman also confirm the soundness of the national sales tax. Many states already administer a sales tax, and businesses are familiar with the concept. Under the bill, both states and retail businesses would keep a percentage of the taxes they receive as a means to offset fully administrative costs. This is not an unfunded mandate. States would use their existing systems to collect the revenue generated from sales -- the government would only get its share when the taxpayer chooses to consume. Studies estimate that the national economic growth under this plan would be, conservatively, between 7 to 9%.

Under the existing income tax system, hidden taxes are passed on to the consumer in higher prices. Economists will tell you that corporations do not pay taxes, consumers do. Its simple, taxes and the reporting compliance are factored into the price of any item produced and then passed on to the consumer. No matter what we call it, any income tax becomes a hidden consumption tax in the end. Every dollar paid in personal income tax

is one less after-tax dollar that can be consumed. But, because of income tax withholding, that fact is hidden from consumers.

The Schaefer-Tauzin bill will repeal the income tax, abolish the IRS, install a National Retail Sales Tax, protect taxpayers, provide tax credits to those at or below the poverty level, and help make American products more competitive abroad. Home mortgage interest will not be taxed, and a used property tax credit is created to protect home buyers. Investors are also protected, since investment and savings are not consumption. Individuals will no longer have to itemize deductions or seek exemptions. To safeguard against future tax increases, the bill requires a 2/3 supermajority vote in both Houses of Congress to raise the sales tax rate and create any new exemptions.

The Kemp Commission on Economic Growth and Tax Reform laid out six principles that any tax reform plan should meet. The NRST qualifies on all counts. It will stimulate economic growth, it is fair, it is simple, it is revenue neutral, it is visible and it is stable. When the income tax was instituted in 1914 the tax code was 14 pages long. Today the code has been amended by 40 different acts of Congress, and comprises thousands of pages of law and rules, and hundreds of thousands of pages of rulings and interpretations. Tax preparers and income tax experts admit that they do not fully understand all the provisions and ramifications -- how can we expect the average consumer to deal with it. We can, and must, do better.

Join me in supporting the National Retail Sales Tax movement. For this type of radical change, the people must send a message to their representatives that the time has come for action. This should be a mandate from the people, for the people -- not a government mandate to the people.

Again, I thank you Mr. Chairman for this opportunity to address the Committee, and I yield the balance of my time.

Statement of Congressman Nick Smith

House Committee on Ways and Means
March 27, 1996

Mr. Chairman, members of the committee:

Thank you for the opportunity to provide the committee with some of my thoughts regarding tax reform. As I was Chairman of the Senate Finance Committee in Michigan, which is the only state in the nation to have a value added tax, and which also has a retail sales tax and a flat rate income tax on individuals, I have followed with great interest the debate on tax reform.

You are well aware of the problems with our current system of direct taxation. Economists Robert Hall and Alvin Rabushka estimate the cost of collecting the tax and taxpayer compliance at $625 billion for the 1993 fiscal year. Economists have long known that the double taxation of dividends and capital gains that mark the current system creates a bias against capital. This bias leads to a distortion in the capital/labor ratio which leads to reduced wages. The intrusive nature of the system creates a concern about the diminution of our individual rights. Tax avoidance and evasion lead other taxpayers to feel that the system is unfair. The time has long past for a revamping of the entire system.

What I would like to talk about today is the similarities among the three basic options for a complete reform of the tax system--the flat tax, a consumption-based value added tax, and a national retail sales tax. What has not been emphasized in this debate is that all three of these taxes have essentially the same tax base, and thus will have nearly the same economic effects.

The sum of the value added of individual firms is the value of retail sales. Thus, a value added tax which allows for immediate expensing of capital, has the same tax base as a retail sales tax. To see this is true, consider the simple example of a farmer growing wheat, which is then sold to a miller, who then sells flour to a baker, who sells bread at retail. Value added is a firm's sales minus what it purchases from other firms. To simplify the example, suppose the farmer has his own seeds, fertilizer, etc., so he doesn't purchase anything from another firm. He then grows wheat and sells it for $150 to the miller. The farmer's value-added would be $150. The miller turns the wheat into $200 of flour, which she sells to the baker. The miller's value added is $50, the $200 minus the $150 she paid for the wheat. The baker then bakes the bread and sells it for $300. The baker's value added is $100, the $300 of bread minus the $200 of flour. Now, the total value added is the farmer's $150, plus the miller's $50, plus the baker's $100, or $300. This is the exact same value of the retail sale--$300. Thus, a tax on value added will give you the same tax base as a true retail sales tax.

Now we will see that the flat tax gives the same tax base as a value added tax, except for the personal deduction. The flat tax taxes all business firms on their business profit. But business profit is defined as sales minus what is purchased from other firms minus expensing of capital minus wages. But, this is simply the firm's value added minus wages. The individual then pays his or her tax on wages. Since the tax rate is the same for businesses and individuals, if we ignore the personal exemption, the tax base of the value added tax and the tax base of the flat tax are the same. The only difference is that under the value added tax the tax is collected completely from businesses and under the flat tax the compensation part of value added is collected from the individual.

There are two differences between the flat tax and the value added tax. One is that under the flat tax individuals are allowed a personal exemption (around $32,000 per family of four, depending upon whose plan is being discussed). Obviously, since a value added tax is collected from businesses, it is not possible to give individual exemptions. The second difference is the administration of the tax. Under a flat tax the individual taxpayer is aware of the amount of the tax on his compensation, since he pays the tax directly. Under the value added tax, the individual does not pay the tax directly and therefore is spared the burden of filing the tax and the intrusion of the IRS in finding out how much each individual is paid.

The difference between the retail sales tax and the value added tax is its administration. The value added tax would be collected from each firm, rather than only those that make retail sales. Thus, more firms are involved in a value added tax. Under a retail sales tax, it is possible for each individual to be made aware of the amount of the tax by separating the tax from the purchase price of the good. Under the value added tax, there is no direct information to the consumer of the amount of the tax, since it simply shows up in the price of the product.

The point of this discussion is two-fold. First, it is easy for the press to underestimate the degree of agreement among those who are seeking elimination of the current system. Those who advocate the national retail sales tax differ from those who advocate a consumption based value added tax primarily in the collection and administration of the tax. Those who offer a value added tax differ from flat tax advocates only in the administration of the tax and the personal exemption. It is even possible to mimic a personal exemption in the value added tax through a payment to individuals on an annual basis. The same can be done for a retail sales tax.

Second, I would like to offer some thoughts on the issues that need to be considered in deciding on reform. With regard to the retail sales tax: it will be necessary to ensure that the tax does not turn into a pyramiding turnover tax. As an example, if I hire an accountant to do the books for Nick Smith's farm, this should not be a taxable transaction, since it is a business to business transaction. However, if this accountant does my personal finances, then this will be a taxable transaction, since it is a retail sale. There are many lessons that can be learned from talking with those who currently administer retail sales taxes in the various states, especially those that have, as Michigan does, an exemption for goods-in-process.

With regard to the value added tax, will it be too easy to increase the rate? The experience in the industrialized countries has been that the rate has gradually increased. However, this was not the case in Michigan. The Single Business Tax was enacted in 1975 and the rate remained stable for 20 years at 2.35%. In Michigan, the SBT rate was actually decreased slightly to 2.3% in 1994. Increased consumer awareness that it is ultimately the consumer that pays this tax has been a factor in keeping the rate from rising.

With regard to both the value added tax and the retail sales tax, will they become a tax that is placed on top of the current income tax system, or will they be enacted in conjunction with a repeal of the 16th Amendment and complete elimination of the current system?

With regard to the flat tax for individuals: will it be possible to truly reform the tax without the eventual return of the complicated system that we now have? Already there is a debate about a deduction for home mortgage interest and charitable contributions. Also, the transition costs of the flat tax are a little more obvious than for a value added tax or the sales tax.

In particular, the remaining depreciation will be a major issue. Of course, as I pointed out, since the tax base of all three taxes is essentially the same, the existing depreciation is also lost under a VAT or retail sales tax, but it is not so obvious since it appears that the tax is very different.

In summary, each of the major proposals for tax reform would be a major improvement over the current system. Each would reduce the intrusion of the federal government into the personal lives of our citizens. Each would lead to a more efficient use of capital and labor in this country with an increase in the standard of living for all Americans. Mr. Chairman, your leadership in detailing the failings of our current system and the possibilities we have to set our economy on the right path and restore some of our individual liberty is to be commended. Thank you for allowing me to add my thought to the debate.

Mr. CAMP. The Committee stands adjourned.
[Whereupon, at 3:15 p.m., the hearing was adjourned.]
[Submissions for the record follow:]

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Statement Of John William Kurowski
Founder Of The
American Constitutional Research Service
Before the
Committee On Ways And Means
United States House Of Representatives

Topic: Replacing the Federal Income Tax

March 1996

Thank you Mr. Chairman and members of this committee for holding this second round of hearings to tear the income tax out by its roots, and examining alternative tax systems that would replace federal taxation calculated from profits, gains, interest, wages, salaries, tips, gross receipts, estates, gifts, or other, periodically or randomly received lawful monies.

The word "reform", found in Webster's Seventh New Collegiate Dictionary, tells us the idea of "reform" is "to put an end to (an evil) by enforcing or introducing a better method or course of action."

Chairman Archer unequivocally laid the ground rules for true reform when he declared his aims were "... the total elimination of the IRS from the individual lives of every single American Citizen...the American people should never again have to keep records for the IRS to audit, proving to the government that they are indeed honest people...the people should never again have to fill out a tax form...withholding taxes from people's paychecks should stop...the government should not have first dibs on the money that people earn...if you make it, you should be able to have the discretion to spend it, all of it, in the way that you see fit."

Judging from last years' hearings on this topic and the public's subsequent focus on two primary alternatives to current income taxation, namely a flat tax or national sales tax, and a number of faults having been identified in each of these proposals, perhaps it is wise to address such faults and find remedies if possible in order to accomplish the stated aim of genuine tax reform.

The flat tax proposal does not even come close to accomplishing Chairman Archer's tax reform guidelines and will not end the following list of complaints associated with current taxation which were made known to this Committee during last years hearings:

* Businesses and self-employed individuals will still have to keep time consuming and costly records for the IRS.

* The IRS will still be allowed to exercise intrusive inquisitorial powers, including that of random audits of individuals and businesses.

* The IRS will still exercise an arbitrary power to impose fines and penalties upon those who may make an honest mistake in computing taxable income, which continues the need for businesses and individuals to retain expensive tax attorneys and accountants.

* The proposed flat tax "reform" will also preserve a government bureaucracy capable of reaching almost every adult and business in America, a bureaucracy known to be used by folks in government to harass and subjugate political opposition, including members of Congress, under the guise of collecting taxes!

In addition, the flat tax idea is based upon the same questionable principle as a progressive income tax. For example, those in our nation's labor force who find it necessary to work overtime and/or on weekends to pay for their children's college tuition, family medical bills which may arise, or other such necessities, and are thus more productive in their community during a calendar year than fellow employees working at the same job who do not work overtime and enjoy their weekends, will be singled out (based upon their annual earnings) and compelled to finance government, not through an equal contribution in harmony with *"equal protection under the law"*, but forced to finance the federal government based upon law which penalizes these individuals for their superior production, i.e., work more, earn more . . . pay more.

There is no formula in the flat tax proposal to compensate our nations' most productive people for the overtime they work or their lost weekends . . . only a penalizing increase in their taxes for daring to be productive. Is this what the architects of the flat tax desire?

The suggestion that the flat rate tax is designed upon a principle of equality (every person bears the same burden by paying the same rate) is far from being true. If the object of the flat tax is to insure fairness by having every person contribute to financing government based upon a fixed percentage of their wealth, then the calculation for each taxpayer's share under the proposal would have to be computed from *actual wealth in real and personal property,* (total accumulated wealth) and not limited to a taxpayers' annual earnings which only represents a fragment of some peoples wealth.

The omittance of actual wealth in real and personal property from the flat tax formula, and its focus on annual earnings, seems to be an intentional attempt to place a disproportionate burden of the tax upon those with the least total accumulated wealth. In many instances a working person's total annual wages will almost equal the person's entire accumulated wealth, while the opposite is generally true for our nation's most successful citizens, i.e., their annual earnings generally represents a minuscule portion of their total accumulated wealth.

A taxpayer, under the flat tax proposal, may adjust his financial affairs so he may own millions, even billions of dollars in jewelry, luxury automobiles, marine and air vehicles, summer and winter homes and other real estate holdings, etc., and also have annual investment income in the millions of dollars, and wind up contributing less to the federal government under the flat tax proposal than a carpenter, plumber, doctor, or person engaged in a similar working type occupation.

And what is the stated principle for making income from monied investments tax free, while earned wages are not? Why is there a tax exempt status created for those who have money working as opposed to those who work for their money? Why are those who make monied types of investments, as contradistinguished from labor intensive investments, even if the monied investments do not benefit the community (investments in corporate stocks financing manufacturing facilities on foreign soil, or, investments in government securities, which is an investment in Congress' power to tax America's domestic labor, businesses and industries, and is nothing more than an investment in Congress' decision to increase the national debt), to be tax free upon such earnings? Surely the proponents of the flat tax must be eager to answer such questions and enlighten this Committee in their method of fairness.

Another glaring inequity in the flat tax proposal is immediately identified by its two different tax forms: one is for individuals and the other for businesses, as if our nations' laboring class citizen is not engaged in a business transaction

when marketing their time, labor, skills, personality, etc. The reason why two different forms are necessary is because of the dishonest method by which taxable income is calculated for wage earners.

Under the flat tax plan businesses are to subtract all expenses and outlays from gross receipts when computing the profit or gain from which their tax will be measured. For those unfamiliar with the definition of the word income as it appears in the Sixteenth Amendment, and to provide the reason why businesses under the flat tax proposal are to deduct all expenses and outlays when computing their "taxable income", the following quote from the United States Supreme Court decision, Eisner v. Macomber, 252 U.S. 189, (1920), is here given along with another tax case occurring eight years afterwards:

"Income may be defined as the gain derived from capital, from labor, or from both combined," provided it be understood to include profit gained through a sale or conversion of capital assets . . ."

In Sullenger v. Commissioner, 11 T.C. 1076 (1948), a case involving a tax imposed upon the income received from the sale of meat, the judge stated that Section 162 of the regulations of the Office of Price Administration, a World War II agency, made no provision for the deduction of the cost of goods sold:

> "but the Commissioner has always recognized, as indeed he must to stay within the Constitution, that the cost of goods sold must be deducted from gross receipts in order to arrive at gross income. No more than gross income can be subjected to income tax upon any theory. The income from a business which is wholly illegal was held subject to income tax in United States v. Sullivan, 274 U.S. 259. Nevertheless, it was necessary to determine what that income was, and the cost of an illegal purchase of liquor was subtracted from proceeds of the illegal sale of the liquor in order to arrive at the gain from the illegal transactions which were subjected to income tax in that case . . . No authority has been cited for denying to this taxpayer the cost of goods sold in computing his profit, *which profit alone is gross income for income tax purposes.*" [emphasis added]

So, now we see "income" is not all money which comes in, but refers only to that portion which constitutes a "profit", or "gain", and thus, even a person engaged in an illegal profit making operation is entitled (as stated by the Court), to certain deductions in order to compute the profit from which the tax is measured. Such deduction are not a matter of grace granted by Congress, they are constitutionally mandated!

The architects of the flat tax seem to obey the Supreme Court's definition of the word "income" when it comes to calculating a businesses income (profit or gain), but disregards the Court in reference to working people by promoting a system in which the necessary expenses and outlays of the working person such as transportation to and from work, the market value of eight hours of life given up and placed at the disposal of an employer, the food which fuels a working person's body during working hours, and other costs and outlays which makes a person's labor possible (especially the necessities of life) are not to be subtracted from annual wages in order to compute *"profit, which profit alone is gross income for income tax purposes."*

The irrefutable fact is, wage earning people are not normally engaged in a profit or gain (income making) venture when employed by business, industry or otherwise. Their relationship with an employer amounts to nothing more than a *conversion of human capital* (labor, skill, time, etc.) into earned wages, while those who employ the wage earner do in fact seek to realize a profit by

purchasing and then utilizing and managing the wage earner's human capital.

With so many obvious inequities attached to the flat tax proposal, including the continuation of class warfare and its failure to fulfill the goals as stated by Chairman Archer in June of 1995 at the opening of last years session, the stated goal being to rip income taxation out by its roots, it appears this Committee has no choice but to acknowledge the countless irreconcilable deficiencies contained in the flat tax proposal, and move on to other alternatives in search for sincere tax reform.

One such alternative is the Founding Founder's original tax reform plan which taxes consumption. An outline of the Founder's plan appears on pages 687-692 of last years' Hearings book titled "REPLACING THE FEDERAL INCOME TAX" JUNE 6, 7, AND 8, 1995.

Not only does the Founder's plan contain Chairman Archer's stated goals, but it also contains an exact method to extinguish annual deficits should Congress continue to borrow money to meet annual expenses. Moreover, it has already proved to be a successful system. Was not America the economic marvel of the world when Congress abided by the Founder's original tax reform plan?

For the benefit of this Committee, I will now provide the text of the Founder's plan, as reported in last year's hearing book:

Mr. Chairman and Members of this Committee:

The subject of tax reform was extensively debated by the Founders of our country. I do not know if other participants in these Hearings have taken the time to research the accounts of these historical debates when formulating the suggestions they will present to this Committee, but, having researched the Founders' original tax reform package, I am inclined to believe its fundamental principals are as valid today as when they were put into practice over two hundred years ago.

Our nation's first revenue raising Act was "...in a certain sense a second Declaration of Independence; and by a coincidence which could not have been more striking or more significant, it was approved by President Washington on the fourth day of July, 1789." [See, Twenty Years of Congress, James G. Blaine, 1884, Vol. 1, page 185]

James Madison, in discussing this Act before Congress identified a fundamental principal concerning the power delegated to Congress to lay and collect taxes:

> "...a national revenue must be obtained; but the system must be such a one, that, while it secures the object of revenue it shall not be oppressive to our constituents."

The Act went on to imposed taxes, not on Congress' constituents, but on specific "goods, wares, and merchandise, imported into the United States", and not one dime was raised under the Act by internal taxation! Internal taxes were frowned upon by the Founders, especially when a national revenue could be had by requiring foreigners to pay for the privilege of doing business on American soil!

Jefferson, in his Second Annual Message (December 15, 1802) states:

> "In the department of finance it is with pleasure I inform you that the receipts of *external duties* for the last twelve months have exceeded those of any former year, and that the ratio of

> increase has been also greater than usual. This has enabled us to answer all the regular exigencies of government, to pay from the treasury in one year upward of eight millions of dollars, principal and interest, of the public debt, exclusive of upward of one million paid by the sale of bank stock, and making in the whole a reduction of nearly five millions and a half of principal; and to have now in the treasury four millions and a half of dollars, which are in a course of application to a further discharge of debt and current demands." [emphasis added]

Imagine...all this in consequence of "external duties"!

In Jefferson's Second Inaugural Address (March 4, 1805), he points out:

> "At home, fellow citizens, you best know whether we have done well or ill. The suppression of unnecessary offices, of useless establishments and expenses, enabled us to *discontinue our internal taxes.* These covering our land with officers, and opening our doors to their intrusions, had already begun that process of domiciliary vexation which, once entered, is scarcely to be restrained from reaching successively every article of produce and property...
>
> "The remaining revenue on the consumption of foreign articles, is paid cheerfully by those who can afford to add foreign luxuries to domestic comforts, being collected on our seaboards and frontiers only, and incorporated with the transactions of our mercantile citizens, it may be the pleasure and pride of an American to ask, what farmer, what mechanic, what laborer, ever sees a tax-gatherer of the United States?"[emphasis added]

Although the national sales tax proposals appear to be somewhat fairer than existing taxation, each would do ill to our nation as they are all based upon internal taxation, which would ultimately increases the cost of goods manufactured on American soil; burden the American Citizen in its collection; and, are to be paid by the "farmer, mechanic, laborer", etc., who will continue to see the intrusion of the "tax-gatherer of the United States" if such a system is adopted!

In view of the undesirable effects of an internal national sales tax, perhaps it is wise to further study the Founder's plan and learn how imposts and duties (external taxation) were successfully used to fill the national treasury, encourage domestic manufacturing and assist in building a strong industrial base.

In addition to imposing a specific amount of tax on specific articles of consumption imported, the first revenue raising Act also imposed an across-the-board tax on imports which was higher for imports shipped in foreign owned foreign built vessels, and discounted the tax for imports arriving in American owned American built ships:

> "...a discount of ten percent on all duties imposed by this Act shall be allowed on such goods, wares, and merchandise as shall be imported in vessels built in the United States, and wholly the property of a citizen or citizens thereof."

This patriotic and skillful use of external taxation not only filled our national treasury, but gave American ship builders a hometown advantage and predictably resulted in America's merchant marine becoming the most powerful on the face of the planet. Unfortunately, today when I visit the docks in New York's Hell's Kitchen area, I am saddened that I can no longer read the names on the docked ships as they all seem to now be foreign owned foreign built vessels...an irrefutable sign of America's decline traceable to the acceptance of thirty pieces of silver.

Yes, there was a day when our national treasury was gladly filled by foreigners paying for the opportunity to do business on American soil. But this was when members of Congress, and those running for Office, put American interests first and would have considered the NAFTA, GATT and the WTO as acts of sedition, and would have tarred and feathered those participating in the surrender of America's sovereignty.

A national sales tax plan which omits external taxation as a principal source to fill our national treasury, is in fact a surrender of national sovereignty to the advantage of foreign interests!

A Second Source To Fill The Treasury

Having identified imposts and duties (external taxes) as being the Founder's intended primary source to fill our national treasury, I will now turn to their intended internal consumption tax plan.

An across the board national sales tax would unquestionably increase the cost of production on American soil, as previously pointed out. To avoid this, and other unwanted effects of an across the board national sales tax, common sense dictates we must exclude from the list of taxable items, tools of production, supplies necessary to conduct business, services needed to sustain business, and the necessities of life (food, shelter, clothing, medical expenses) i.e. all those items which makes labor possible must be excluded.

In simple language, a consumption tax plan ought to be limited to articles of luxury, and each article must be individually selected by Congress and the appropriate amount of tax must be determined for each specific item chosen, just as was done in the first revenue raising Act of our country!

By limiting the tax to articles of luxury, and requiring each article to be specifically chosen and the appropriate amount of tax determined by Congress, a self regulating check and balance is imposed upon Congress. If Congress does its job properly and the nation as a whole is productive and prosperous, the sale of articles of luxury will undoubtedly increase, and with it, the flow of revenue into the common treasury! But, if Congress' policies become burdensome and its regulatory requirements upon business, industry and our nation's labor force inhibit a hearty economy, or any particular article is excessively taxed, the first sign would be is a decline in the flow of revenue into the national treasury! Thus, the free market place determines the limit of taxation under the Founder's internal consumption tax plan, and it establishes a self regulating gauge beyond the reach of Congress' manipulation!

As Hamilton said, in regard to taxes on consumption, they:

> " . . . may be compared to a fluid, which will in time find its level with the means of paying them. The amount to be contributed by each citizen will in a degree be by his own option, and

> can be regulated by an attention to his own resources. The rich may be extravagant, the poor can be frugal; *and private oppression may always be avoided by a judicious selection of objects proper for such impositions* . . . It is a signal advantage of taxes on articles of consumption that they contain in their own nature a security against excess. *They prescribe their own limit, which can not be exceeded without defeating the end proposed__that is, an extension of the revenue.*" [No. 21 of the Federalist, emphasis added.]

Balancing The Budget

Still one more question remains to be answered: what is to be done if insufficient revenue is raised from external and internal taxes on consumption?

Once again the Founder's plan shines bright above all contemporary suggestions. Careful research into our Nation's early legislative history reveals the Framers did in fact provide Congress with an emergency power to be used if deficits should arise. And the wisdom of the Framer's method, unlike the proposed balanced budget amendment (S.J. RES.1), contains a brilliant mechanism which would abruptly end Congress' current profligate spending habits!

Under the Framer's plan, whenever the monies arising from Congress' normal taxing powers (imposts duties and excises) are found insufficient to fund federal expenditures during a fiscal year, and a deficit is produced by Congress borrowing to finance expenditures, Congress must then use its direct taxing power at the beginning of the next fiscal year to raise an amount sufficient to retire this deficit.

Congress is required to follow the rules of apportionment when imposing this tax, and bills each state for a share of the deficit. Each State must contribute a share of the total deficit in proportion to its allotted number of Representatives as set forth in Article 1, Section 2, clause 3, of the United States Constitution. The more votes a State exercises in the House, the larger is its share toward extinguishing a deficit . . . *representation with proportional obligation!*

The chart below is based on a total House membership of 435:

STATE	NO.OF REPRESENTATIVES	SHARE OF DEFICIT
NEW YORK	31	31/435's
MARYLAND	8	8/435's
CALIFORNIA	52	52/435's
IDAHO	2	2/435's
FLORIDA	23	23/435's
etc		

FOUNDING FATHERS' FAIR SHARE FORMULA

The states are left free to raise their share of the tax in their own way, within a time period set by Congress. But if any state shall neglect to pay its share, then Congress must send forth its officers to assess and levy that state's apportioned share, together with interest thereon.

Legislative History

This method of extinguishing deficits appears in seven of the ratification documents which gave life to the United States Constitution. The first emergency *direct tax* was imposed in 1798, to extinguish part of the Revolutionary War debt. It was later

used during the War of 1812, and also to extinguish deficits during the Civil War.

The Sixteenth Amendment to the United States Constitution did not repeal or alter Congress' power, or *obligation*, to impose the emergency direct tax should a deficit arise. The power of Congress to impose a direct tax still exists, and direct taxes are still required to be apportioned among the states, as pointed out by the United States Supreme Court [see Stanton v. Baltic Mining Co., 240 U.S. 103, (1916); Eisner v. Macomber, 252 U.S. 189 (1920); and, Bromely v. McCaughn, 280 U.S. 124 (1929). Also see Congressional Research Service Report No. 84-168 A 784/275, which was updated September 26, 1984].

Big Advantages

There is no smoke and mirrors with the 'FAIR-SHARE' method of balancing the budget. The emergency direct tax is required to be imposed whenever Congress closes a fiscal year with a deficit. The structural mechanism which would immediately bring fiscal sanity to Congress is the requirement of having Congress send a bill to the governor of each state, notifying him to remit his state's *apportioned share* toward extinguishing the deficit created during the year by Congress; the governors and state legislators being left with the burden of having to raise this money, and to send it off to Washington, D.C.

Picture, for a moment, the expression on the faces of the Governor of New York and the New York State Legislature, if New York should receive a bill for its apportioned share [31/435] of the 1995 federal deficit. This threat would create a compelling incentive for the Governor of each state, and the various state legislatures, to keep a jealous eye on the spending habits of their Congressional Delegation . . . it would require the fiscal accountability which the state governments once *demanded* from their Senate and House Members!

In addition, because each state's share of the tax burden is determined by a fixed rule, similar to that which determines the House membership size of each state, a barrier is erected preventing the kind of mischief which Congress now practices, i.e., discriminatory tax legislation; pork-barrel favoritism; special interest lobbying, etc.

Bottom Line

The Framers of our Constitution provided a specific method to extinguish anticipated deficits through an emergency direct tax. Hamilton, in No. 36 of The Federalist Papers, reminds us:

> "Let it be recollected that the proportion of these taxes *is not to be left to the discretion of the national legislature, but is to be determined by the numbers of each State, as described in the second section of the first article* [United States Constitution]. An actual census or enumeration of the people must furnish the rule, a circumstance which effectually shuts the door to partiality or oppression. The abuse of this power of taxation seems to have been provided against with guarded circumspection." (EMPHASIS ADDED)

The rule of apportionment was written into our constitution to remedy a major defect associated with "democracies", which Madison points out in No. 10 of The Federalist Papers:

> ". . . have ever been spectacles of turbulence and contention; have ever been found incompatible with personal security or the rights of property; and

have in general been as short in their lives as they have been violent in their deaths."

And so, the Founding Fathers formed a Constitutional Republic to avoid the predictable disastrous consequences of democracy.

The intended use of the emergency direct taxing power to extinguish deficits is not only far superior to any of the proposed balanced budget amendments being offered . . . it is already part of our Constitution. The method in text form is as follows:

The Fair Share Balanced Budget Method

"A R T I C L E__

"SECTION 1. Congress ought not raise money by borrowing, but when the money arising from imposts duties and excise taxes are insufficient to meet the public exigencies, and Congress has raised money by borrowing during the course of a fiscal year, Congress shall then lay a direct tax at the beginning of the next fiscal year for an amount sufficient to extinguish the preceding fiscal year's deficit, and apply the revenue so raised to extinguishing said deficit.

"SECTION 2. When Congress is required to lay a direct tax in accordance with Section 1 of this Article, Congress shall immediately calculate each State's apportioned share of the tax based upon its number of Representatives as allotted by the Constitution, and then notify the Executive of each State of its apportioned share of the total tax being collected and a final date by which said tax shall be paid into the United States Treasury.

"SECTION 3. Each State shall be free to assume and pay its quota of the direct tax into the United States Treasury by the final date set by Congress, but if any State shall refuse or neglect to pay its quota, then Congress shall send forth its officers to assess and levy such State's proportion against the real property within the State with interest thereon at the rate of___ per cent per annum, and against the individual owners of such property. Provision shall be made for a 15% discount for those States paying their share by___ of the fiscal year in which the tax is laid, and a 10% discount for States paying by the final date set by Congress, such discount being to defray the States' cost of collection.

Conclusion

There are participants at this Hearing, and many political pundits appearing on talk shows across our country, who are far more articulate than I in identifying the glaring defects and dishonest nature of income taxation, whether flat or progressive. Likewise, there is also an abundant supply of those presenting well rehearsed arguments against an across the board national sales tax, and have displayed their rhetorical skills quite admirably. But who, I ask, has made a substantial argument against the Founding Father's original tax reform package?

Perhaps our only problem in regard to tax reform is that we, as a nation, have lost touch with the original intent and wisdom of those who framed and ratified our Constitution...such negligence culminating in our current dilemma.

In closing Mr. Chairman, I would like to take this time to thank you and your staff for allowing me this opportunity to present my humble opinion on a subject of such great importance.

April 5, 1996

Philip D. Mosely
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20516

Dear Mr. Mosely:

I would like to comment on the possibility of replacing the federal income tax system. I do not think that we should replace the federal income tax system. None of the alternatives to our tax system work with the framework that is in place. The framework of our income tax system has arisen as needs have arisen and should be repaired and kept in good working order in the same manner. None of the alternatives offered to our tax system have the ability to promote public policy, stimulate the public good and morals as does our current system. I think our tax system should have the ability to stimulate correct behavior in U.S. citizens.

I do think that certain changes are in order. Changes should be made to correct the framework of our taxes. My example is the area of Passive Losses. A small transaction can generate a string of forms and probably should be ridiculed. By the time you can record the activity of a Publicly Traded Partnership (my specific example) you have been through a decision-tree that few would ever understand. Areas such as these should be simplified. I could not see the point for having to create this type of format. I would probably try to simplify our system where a given point could never generate more than a certain number of forms. An item could never generate a string of forms greater than a certain length or a simpler treatment should be sought. The decision-tree should have only a certain number of branches.

I also think that the double-taxation of corporations should be eliminated. I think corporate growth would be stimulated. Investment in corporations would increase and possibly reverse our export deficit. I don't think we should even consider alternative ways to tax or exempt dividends. Simply tax the corporations, not the distributions and keep this in line with simplifying the tax system. From what I have heard this will give the United States parity with other tax systems anyway.

I would also take the stance that whenever a problem arises in regard to our tax laws when implementing future changes, the rules should lean toward favoring our basic three types of business organizations: the proprietorship, the partnership, and the corporation (not including the S-Corporation). I have noticed our tax laws work well with these organizations. All other business forms are hybrids and complicate our basic tax structure. They should not be favored.

These thoughts are not much but might help simplify our current tax system and help develop a clearer picture of where our taxes need more simplification in the future.

Please note my comment is limited only to our federal income tax and not to our Social Security and Medicare system which should probably be reformed separately and with separate comments.

Thank you so much.

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Mark Borsuk
Managing Director

March 22, 1996

Chairman William Archer (R-TX)
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SUBJECT: INFOTECH's Impact on Tax Policy

Dear Chairman Archer and Committee Members:

Your consideration of tax code revision should incorporate the impact of information technology on the economy. Specifically, the Committee should examine the negative impact of tax policy and INFOTECH on commercial real estate values. INFOTECH refers to the integration of computer hardware, software and telecommunications.

INFOTECH severs place from activity: work no longer needs a workplace and shopping does not require a shop. This has profound implications for commercial real estate. First, INFOTECH already is a factor in the office building market. In three to five years on-line shopping will impact retail properties. Second, millions of individuals, by investing indirectly through public and private pension funds, insurance companies and other financial institutions, and directly through REITs, could suffer from an erosion in property values. Third, falling collateral values put lenders at risk. The cumulative impact on equity and debt investors could make the savings and loan crisis pale in comparison. However, unlike their imprudent investing, the impact of INFOTECH is unavoidable.

INFOTECH also challenges the industrial age assumptions underlying the tax code created in 1913 by the 16th Amendment. Falling commercial demand induced by INFOTECH combined with the present taxation scheme will exacerbate real property losses. One approach to stemming the fall in value is to modify the Code's provisions related to real property. Even the present policy is not economically neutral. In the information age the tax law is stacked against commercial property.

There is a serious discontinuity between an economy in the information age and a tax system rooted in the industrial era. The Code's rigidities influence all phases of the investment cycle: acquisition, ownership and disposition. One example of changing the Code to comport with the information age is to accept that INFOTECH creates "extraordinary obsolescence" for buildings. IRS Regulation Sec. 1.167(a)-9 permits this outcome, albeit not to the degree required. If the regulation incorporates INFOTECH's impact on commercial property, then taxpayers would have a deduction for the balance of their unamortized costs. Adding this safety valve could offset some of the problems created by INFOTECH, like the North American legacy office building. Many contemporary office buildings have floor layouts incompatible with the space needs of organizations. When buildings no longer serve a useful purpose, what happens to their value and the property tax base? Other examples of the mismatch between INFOTECH and the Code are:

-the very long, 39 year, depreciation period taken for improvements;
-the requirement to capitalize demolition costs;
-the six month limit on IRC 1031 exchanges; and
-the type of building eligible for rehabilitation credits.

Thus, the present tax policy distorts market efficiency and economic growth by hampering the reuse of existing properties.

The present tax law is a product of a bygone era. The Committee's efforts to reform the tax code should encourage the economy's transition to the information age. Acknowledging INFOTECH's impact on commercial property represents a positive step in tax reform. The Committee's challenge is to develop a responsive tax policy in an era of continuous discontinuity.

Thank you for considering my proposal for tax reform. If I may provide the Committee with additional information, please contact me.

Sincerely yours,

Mark Borsuk

Attachments:
-Real Estate Tax Policy for the Information Age, Real Estate Review, Vol. 25, No. 4, Winter, 1996.
-Don't Be A Cyberputz, California Real Estate Journal, March, 1996.
-James Denn, High Tech Means Big Changes For Cities, Real Estate, Albany Times Union, March 13, 1996.

cc: Committee Members
Philip Moseley, Chief of Staff
Stuart Brown, Chief Counsel, IRS
Alvin and Heidi Toffler

Message: 640
To: mborsuk@ix.netcom.com (Mark Borsuk)
Cc: tdurkin@vfr.net, gcrick@sqi.utexas.edu, kircher@bga.com
From: jgreen@friday.houston.net (Jonathan Green)
Subject: Real Estate Changes
Date: Mon, 18 Mar 1996 19:06:17 -0600
Here's a copy of the article, the orginial's URL is:
http://nytsyn.com/live/Features1/073_031396_070011_11404.html

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HIGH TECH MEANS BIG CHANGE FOR CITIES, REAL ESTATE (03/13)
By JAMES DENN
Albany Times Union

ALBANY, N.Y. - The winds of change, stirred by the rapid emergence of technology, are blowing through America's skyscraper canyons and office parks. These changes eventually may have a dramatic and financially painful effect on the mammoth commercial real estate market, according to new research. Linked computers, high-speed faxes and powerful computers capable of digitizing documents by the roomful, are rewriting the rules of how business operates, studies say. Not only is technology reducing the need for workers in some fields, it is giving companies the option to house workers at less costly sites through interconnecting computer systems.

Historically, cities grew as centers of transactions and commerce largely because of the need for physical proximity among firms, suppliers and customers. Massive office buildings - the skyscraper - were built to meet this need. But companies may no longer have to house employees in a central location.

``The economics that drove the development of real estate for the past three decades aren't there in today's information age," said Barry Libert, managing director of Arthur Anderson & Co.'s real estate transformation group in Boston.

``In the old days, all business was done in buildings," he said. ``But companies are expanding globally, using fewer people to do more work in less space with the help of electronic connections. Location - the proximity to customers - no longer drives the bottom line." By the turn of the century, the value of commercial real estate in the U.S. may plummet $660 billion, or 20 percent, according to a new study by Anderson, a national consulting company.

Anderson reports there is 100 million square feet of unneeded retail space in the U.S., or about 20 percent of the total. There is 3 billion square feet of unneeded office space, or about 10 percent of the total. And there is 40 percent extra industrial space.

Anderson is only one group among many that has noted the pending changes in the U.S. commercial real estate market. Last year, the federal Office of Technology Assessment, just before it was disbanded, issued a stirring report on the technological reshaping of America. ``The United States is in the midst of a technological revolution, driven in large part by rapid advances in microelectronics,'' wrote OTA's analysts. ``These technologies will form the basis of a new technology system that is giving shape to the next wave in urbanization ... the post-industrial metropolis.''

Many of the early applications of information technology improved internal operations and often created ``islands of automation'' with little interconnection between components. Only recently has technology been widely adopted that facilitates real-time connections and allows widespread linkages and communication among dispersed operations. Technology now connects economic activities, enabling these activities to be physically farther apart, reducing the once competitive advantage of high-cost, congested urban locations and allowing people and businesses more freedom to choose where they will live and work.

``There is no question technology is having an impact on real estate,'' said Hugh Johnson, chief investment officer with First Albany Corp. ``The economy is becoming less labor intensive. There is going to be less need for commercial real estate.''

Henry C. Lucas, a professor at Stern School of Business in New York, says managers can now remain in contact and supervise significantly more subordinates. Technology may also reduce the need for warehousing. Years ago, corporations leased huge warehouses to store paper documents. Today, most of those documents can be stored electronically, reducing both space needs and costs. Experts predict modern technology may also have an equally dramatic impact on retail space. If enough people grow used to ``virtual shopping malls'' it could eliminate the need for a substantial portion of existing retail space. The changes technology is having on the marketplace go far beyond the impact on owners of commercial real estate. Not only could it reduce property values for municipalities and school districts, it also may change commuting patterns.

The federal study suggested that urban centers will have trouble adapting and will face greater disinvestment, job loss and fiscal difficulties than suburban markets. ``Businesses and people will be freer to choose where they will locate,'' said the OTA. ``And many will choose to locate in lower-cost, higher-amenity areas.''
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COMMENTARY

DON'T BE A CYBERPUTZ

TO UNDERSTAND INFOTECH'S IMPACT, DON'T PRETEND IT'S NOT HAPPENING

BY MARK BORSUK

A significant shift is coming for commercial real estate — a result of information technology. "Infotech," the widespread use and integration of computer hardware, software and telecommunications, severs place from activity and can reduce property values by lessening the premium paid for location. Infotech has already had an impact on the office market and in three to five years it will exert an impact on the retail market. Infotech's cumulative impact will profoundly shift the demand for commercial property.

Infotech changes how, when and where we work. It changes consumption, shopping and leisure time patterns. In the very near future, there will be a large and growing cadre of consumers banking and shopping on-line. In the real estate market, infotech will create new winners and losers.

Market participants need to understand the impact and challenges of infotech. The *putz* will dismiss infotech as a fad. However, others will seek to understand the shift and align themselves with the imperatives of the information age. They will benefit in this changing environment while the *cyberputz* will be asking "what happened?"

WHAT IS HAPPENING: The transition from the industrial to the information age is upon us. In the information age knowledge and its manipulation become the engines of growth.

Infotech allows organizations to move from hierarchies (vertical) to networks (horizontal) for decision making. The network removes layers of management, permits work outside the office and promotes outsourcing of functions. It also reduces "monkey work": the review of work by ever higher levels of checkers.

Infotech is fueling the rapid expansion of home computers and Internet use. Today, approximately 9.6 million households are on-line. By 1999 that number will double or triple. The wired consumer base necessary for on-line banking and shopping is fast approaching critical mass.

If organizations and governmental entities are more productive with less space, what does this portend for office space demand? If consumers can shift their purchases on-line, how does this impact the need for retail space?

HOW IT'S HAPPENING: In the private sector several factors are working to reduce commercial space requirements. In their drive to improve performance and shareholder value, companies are aligning their real estate holdings with their corporate goals. This thinking is revolutionary.

> **'In the information age, knowledge and its manipulation become the engines of growth.'**

Mark Borsuk is managing director of The Real Estate Transformation Group: property strategies for the information age™ (mborsuk@ix.netcom.com). The firm advises property owners, lenders and tenants on infotech's impact and develops offensive and defensive strategies. Borsuk is also a commercial broker and attorney practicing in San Francisco. "Infotech," "cybersurgeon" and "cyberputz" are terms copyrighted by the author.

Corporate America knows there is a critical need to actively manage its real estate, for occupancy costs are the second largest expense. Two studies published in 1995 give organizations the impetus to substantially reduce their property holdings with less emphasis on Class A space while improving productivity, profitability and customer satisfaction.

The International Development Research Council study "Reinventing the Workplace" provides the academic justification. The Harvard Business Review article "Managing Real Estate to Build Value" (Nov.-Dec.) legitimizes the issue and offers methodologies for implementation. They add to other research demonstrating significant cost savings and productivity gains from infotech. For example, PacBell is reducing its administrative office space by 28 percent — from 9.5 million square feet to 6.8 million square feet over five years with an expected 25 percent drop in occupancy costs.

If managers will not implement these strategies, then the cybersurgeons will. Cybersurgeons are a new class of corporate raiders using infotech to sharpen their valuation models. Cybersurgeons will seek companies with large holdings of space, amenable to downsizing. They will substitute software for staff to reduce headcount, impose telework programs on employees to cut back on space needs, sell corporate holdings and renegotiate leases, all to improve shareholder value. Cybersurgery will force landlords and lenders to become unwilling participants in corporate takeovers.

A similar restructuring could face government. How long before the private sector heuristics port over to the public sector? Will corporate successes whet the taxpayers' appetite for equal staff and space reductions? If a political mandate occurs, many will seek to implement these ideas. A government space retrenchment would place downward pressure on office rents.

The retail property market presents an analogous situation. However, instead of separating work from the workplace, shopping will require fewer shops. Cybersales require two prerequisites: the use of the new retail distribution channel, and consumers learning a new shopping pattern.

Retailers are not in the real estate business, although stores are their primary marketing channel. Rather, location is one of several distribution avenues. Retailers in the software, computer and name brand goods business are candidates for the transition to cyberselling. Retailers have a very compelling reason to generate sales in cyberspace: lowering their rent and overhead expense. Wal-Mart's intention to start selling on-line indicates "location, location, location" is losing its appeal.

In order to change their distribution channel, retailers will need to persuade consumers to get on-line and choose their cyberstores. Skeptics argue there are too many impediments to on-line shopping. *See* CYBERPUTZ *page 34*

CYBERPUTZ

from page 4

like access, security and selection. Today, they are correct. Tomorrow? We forget destination shopping is a learned pattern. Thus, on-line banking may be the catalyst to convert consumers to on-line shoppers. Once consumers bank on-line, shopping will be natural.

Today, many goods and services are amenable for cybershopping. Commodity items like books, computers, software, electronics, car parts and recorded music are good candidates for on-line purchases. They are fungible and consumers for the most part are presold or just need information. Location based retailers add very little value to the transaction.

Similarly, restocking items may also be ripe for cyberization. Why is it necessary to go to the grocery store or the warehouse club to buy aspirin, toilet paper and ketchup? They all can be ordered on line and shipped to the consumer's door. Again brand, quality and price are givens with the merchant adding no value.

From the retailer's standpoint, a growing volume of sales generated in cyberspace will quickly call into question the store as a distribution channel. Reaction may include going to a catalog format with no space devoted to inventory, eliminating locations or changing functions. Along with reconfiguring their space needs, retailers will fundamentally change lease terms. The use of a short term, pure gross lease with multiple options is possible. All this spells trouble for retail property owners.

The tax law does not bless property made redundant by infotech. Taxation is economically not a neutral factor. The system reflects an industrial age bias of treating bricks and mortar as wealth without adjusting for a rapidly decreasing life span. In the information age, wealth will increasingly come from knowledge (Netscape) instead of goods (General Motors). Put another way, it will take less space to create wealth.

The tax code works against commercial property. It inhibits transition to the information age by stretching deductions over long periods, limiting rehabilitation credits to a small class of structures, not permitting the expensing of demolition costs, and not recognizing that infotech causes "extraordinary obsolescence" to buildings. Witness the North American office building legacy problem — the floor plate does not correspond to organizational needs.

A tax revision targeting existing commercial structures will protect them from the full price decline induced by oversupply. The existing policy requires investors to demand steep price concessions to justify the risk. This makes microeconomic sense but given the large number of public and private pension fund investors it may not make much macroeconomic and political sense.

WHAT HAPPENS TO YOU? The impact of infotech on commercial property is an emerging issue. Most market participants are likely to dismiss the phenomenon. It's easy to believe the acceptance of infotech in the home and office will not change organizational needs or consumer habits. Besides, it's somewhat counter intuitive to think this when office vacancies are falling and developers are constructing spec buildings.

The abstract nature of infotech is another reason for the market to have a recognition lag. The abstraction masks a ubiquitous presence. Unfortunately, all the signposts point in the same direction: change is here and accelerating.

The market will adjust to infotech in a number of ways. For instance brokerage and investment strategies will undergo change. Commercial brokers need to provide greater service. Much of their proprietary information will become available on the Internet. For example, the Building Owners and Managers Association's Web page will have member building information. This is the harbinger of a public national MLS. In addition, deals will require more rigorous financial analysis. Brokers will have to understand the economic impact of lease clauses to properly advise their clients. Just introducing the parties is no longer enough.

Tenants benefit from infotech. It offers them flexibility and lowers their real estate costs. Owners and lenders are at risk. Their investment environment is more volatile. Infotech will likely cause a shorter real estate cycle with more frequent tenant turnover. However, new uses and users will appear to offer attractive investment opportunities for those following the trend. ■

REAL ESTATE
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Real Estate Tax Policy for the Information Age

with the compliments of

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WG&E

REAL ESTATE TAX POLICY FOR THE INFORMATION AGE

The federal government should recognize the coming decline in demand for commercial properties.

MARK BORSUK

Cyberspace strikes at the heart of commercial real estate by radically diminishing the value of location. Presence and activity are no longer synonymous. "Information technology" (INFOTECH), the integration of computer hardware, software, and telecommunications, severs the link between work and the workplace and between shopping and retail stores. The impact of INFOTECH has changed the American economy fundamentally. The transition from an industry-based to a knowledge-based economy will be rough and painful, and it will significantly lower the values of many commercial real estate investments.

A significant factor preventing commercial real estate from adapting to the information age is the federal tax law. The static nature of federal tax policy make it a powerful negative influence on the market. Changing the tax law may not forestall the financial losses facing real estate developers, investors, and lenders as the information age takes hold, but the transition would be eased by a tax system that promotes development, investment, and disposition of property consistent with the new forces driving the economy.

This article, however, is not about tax law per se. It is about how tax policy influences economic decisions concerning developing, investing in, and disposing of commercial properties. Tax policy is never market neutral; present tax policy is a product of the rapidly disappearing industry era, it sends the wrong signal to the commercial real estate market and inhibits the market's adjustment to the imperatives of the information age.

This article, therefore, suggests tax code revisions that would generate tax benefits for developers and investors. Because the suggested revisions apply only to existing commercial properties and not to new development, they are not an attempt to return to the "golden age" of real estate tax shelters.

The analysis in this article ignores any positive impact that INFOTECH may exert on commercial space demand. The dynamic nature of the American economy could offset the projected fall in demand for commercial space by creating new tenants.

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THE CONSEQUENCES OF TECHNICAL ADVANCE

INFOTECH, by separating work from the workplace, enables office tenants to slash their space needs or to postpone expansion. Additionally, INFOTECH alters how retailers and service providers do business. It breaks the connection between retailers and property owners who until now have shared a common destiny based on location. Rapid advances in INFOTECH make home shopping not only possible but preferable for a growing number of consumers. Thus, for office and retail property owners, INFOTECH reduces the value of location.

THE ELEMENTS OF INFOTECH

Information technology is not new, but its recent advances will soon make it a significant competitor for retail and service tenants as well as for office

space tenants. The most prominent of the new developments are the following:

- The development of powerful sub-notebook computers;
- The acceptance of easy Windows-based software;
- The availability of access to the Internet; and
- The popularization of cyberspace.

Hardware. The miniaturization of computer hardware has made generally available powerful, fully functional, modem-equipped, battery-operated computers weighing less than five pounds, and costing about $5,000. Each unit is literally an "office in a box." It performs like a desktop machine but its portability makes it ideal for working outside the office.

Software. Windows-based software can perform most office functions, including telecommunications. The graphical user interface for word processing, financial analysis, accounting, and other tasks flattens the learning curve and makes the programs relatively easy to master.

Telecommunications. The opening of the Internet to the public for commerce is by far the most important development. Internet service providers offer users full access for about $20 per month. Popularization of the Internet makes E-mail available to everyone. The development of World Wide Web (WFB) page format for displaying text and graphics is a phenomenal draw for goods and service providers. The Internet supplements the older on-line membership services like Prodigy, CompuServe, and America Online.

Cyberspace. Cyberspace is the world behind the monitor. Cyberspace enables individuals to communicate with others worldwide at little cost, reaching individuals through E-mail and groups via discussion circles. Cyberspace contains a vast amount of information on every imaginable subject provided by individuals, governments, universities, research institutes, private businesses, and policy groups. In cyberspace there are cybermalls and virtual storefronts in which computer users may shop. Cyberspace equalizes big and small companies, individual retailers and national chains. Many national retailers already have a WEB presence.

The Diffusion of INFOTECH. The diffusion of INFOTECH is extraordinary. Eighteen million households can now connect to cyberspace.[1] In 1993 and 1994, personal computer shipments for the home exceeded 10 million units.[2] Many more households will embrace the technology over the next several years, enticed by continually decreasing real prices, more powerful systems, easier software, and the allure of cyberspace. The more consumers there are on-line, the greater the incentive for retailers and service providers to attract them to cyberspace instead of to the mall.

INFOTECH'S IMPACT ON SOCIETY AND BUSINESS

It is a frequently stated truism that society has entered a post-industrial era that observers call the "information age." The transition to a period in which knowledge has become the central economic resource is having as profound an impact on society as the invention of movable type and industrialization.[3] What distinguishes the information age from earlier periods is the speed with which change is occurring. Centuries transpired before the impact of the printing press and literacy was diffused through European society. Industrialization evolved over 200 years; however, INFOTECH will change society within decades. Each generation of faster computer processing chips and telecommunications improvements speeds the flow of information for analysis and use.

The earlier innovations, mass literacy and industrialization, brought severe disruptions to medieval and agrarian societies and upset the established hierarchies. New skills and classes arose to create and acquire wealth. The transition to the information age is creating similar upheavals. New classes and skills are supplanting the older knowledge and techniques to exploit the opportunities inherent in the information age. Most importantly, wealth creation will take less space.

HOW INFOTECH CHANGES THE NATURE OF WORK

Advances in INFOTECH permit work outside of the office: "telework." Work that was previously confined to offices has become portable and may be done on the road, from the home, from

a customer's office, at a field office, or at a telecenter (satellite office). Developments like "telecommuting" (working from home or a telecenter) and "hoteling" and "nonterritorial offices" result in more employees' spending more worktime outside the office. "Virtual office" and "mobile office" describe other developments that enable employees to work anywhere. Taken collectively, these new concepts translate into less space demand.

The impact of INFOTECH on the demand for commercial space is potentially devastating.

Development of Telework

Conceived of in the 1970s, telework has only recently been implemented by business and government. The advent of personal computers in the 1980s made it feasible to move a substantial amount of work out of the office. Businesses sought increased employee productivity and reduced space costs through the wider use of personal computers.

In 1994, 9.1 million people regularly telecommuted from home. As a group they averaged 40 hours per month (almost one-quarter of their total work month) away from the office. Many telecommuters are professionals, executives, managers, teachers, sales, marketing, and customer support personnel. As would be expected, telecommuters have above-average incomes. One study reports that their average household income is $53,000, that 75% belong to two-income households and 55% hold college and advanced degrees.[4] However, another study found that three-quarters of telecommuters work for small businesses and only 5% work for large companies.[5] This suggests that, as corporate America adopts telecommuting, the number of employees in this category will escalate dramatically.[6]

THE IMPACT OF INFOTECH ON REAL ESTATE

Every advance in computing power, mobility, and telecommunications network integration is an additional reason for office building tenants to reduce their space needs. INFOTECH will not empty offices overnight. The rate at which the decline in demand will occur is the subject of some debate, but the impact will be cumulative. In time, more buildings will have chronically high vacancy rates leading to negative cash flows. A similar pattern is likely to be repeated in the occupancy of retail and service space. Information technology provides many benefits to society, but its effect on commercial real estate is negative.

INFOTECH, environmental regulations, and the telecommunications industry are all factors that reduce the demand for commercial space. INFOTECH reduces the demand for space, environmental regulations promote telework, and telecommunications firms tell organizations that by substituting technology for space, they can save on rent and comply with the environmental laws.

The impact of INFOTECH on the demand for commercial space is potentially devastating. From 1992 through 1994, IBM, using a combination of technology and mobile employees, eliminated approximately 20 million square feet of office space worldwide.[7] Verifone, a leading supplier of electronic credit card verification equipment, exists almost totally in cyberspace, minimizing a physical presence.[8]

Retailing Without Stores

On-line shopping breaks the connection between the consumer and store locations and will ultimately lead to a significant reduction in demand for retail and service space. Cyberspace has no use for the real estate mantra of "location, location, location." It invalidates the belief that goods and service providers need a physical location to conduct business. On-line retailing and the provision of services on-line are so new that they do not yet compete with retail property owners. But they will!

People shop on-line by joining an on-line membership service or connecting to the Internet. CUC International, Prodigy, CompuServe, and America Online are membership services. The user must be a member and provide credit card information. Numerous companies offer access to the Internet for a monthly fee.

Membership Services. About 100,000 of CUC International's nearly 34 million members shop on-line.[9] The CUC database offers 250,000 products with guaranteed low prices. CUC carries no inventory; it merely takes the order and informs the manufacturer who ships directly to the customer. Profits come from membership fees

and a small mark-up on each transaction. The three other services mentioned above rent their cyberspace to those providing goods and services.

Bulletin Boards System (BBS). Members of a BBS (a forum for discussing specific topics or interests) are potential on-line shoppers. There are approximately 60,000 BBSs in operation with a combined membership of 17 million. Anyone with a computer may start a BBS. BBS participants may also subscribe to the commercial member services or access the Internet.

Internet. The Internet dwarfs the commercial membership services and dramatically expands the potential size of the on-line shopping market. In 1994, Internet users increased to an estimated 36 million worldwide. In the United States alone, 18 million households were able to connect to the Internet.[10] The Internet is evolving into a secure payments medium that will permit anyone, anywhere, to purchase goods and services on-line with a credit card.

The Internet's merchandising vehicle of choice is the World Wide Web. Each WEB page has a unique address. The shopper goes to the site, browses and, possibly, purchases the merchandise. The shopper needs no special knowledge to use the software. The WEB is the Internet's "killer" application.

Many questions remain about consumer attitudes toward on-line shopping. Much will depend on making the technology accessible to more households and designing appealing virtual storefronts and cybermalls.

The Effect of Competition From Cyberspace on Traditional Stores

A recent study concluded that electronic shopping could shift 10%–20% of sales away from retail stores.[11] Another analysis translated the amount of redundant space from lost sales, obsolescence, and shifting demographics to the equivalent of over 100 regional shopping centers of one million square feet each by the end of the decade.[12]

The shopping center industry believes that it is already losing sales to catalog sellers, TV shopping channels, and on-line services. A recent survey done for the International Council of Shopping Centers disclosed that 60% of consumer respondents stated their activities conflicted with store hours. The time conflict was greatest among younger shoppers; these consumers were considering the benefits of home shopping.[13]

Technology and the Sellers of Retail Services

Many other problems face retail property owners: technological change, improved space utilization by tenants, and excess space.

Technology. The ubiquitous one-hour photo shop is heading towards extinction. Digital (electronic) cameras may soon eliminate the development and finishing cycle. The camera can make a direct transfer to the computer without the need to develop film.

Reducing or Eliminating Tenant Presence. Technology is also likely to reduce or eliminate tenant space requirements for businesses like travel agents and retailers of software and recorded music. Consumers may obtain trip information and book the flight on-line. On-line shoppers can browse a far larger selection of software and music than is available at most stores.

Technology is assisting banks to reduce branches. On-line banking is one way for banks to meet customer needs and reduce costs. Wells Fargo's entry onto the Internet for banking transactions portends a massive shift from branch banking to home banking.

Other Problems. Excess retail space haunts property owners. A recent forecast estimated that up to 20% of the regional malls that were in business in 1990 will close by the end of the decade.[14] An observer, writing in *Real Estate Review*, believes that up to 50% of retail space is unnecessary because of advances in marketing and inventory controls.[15] The growth of on-line shopping merely exacerbates existing tendencies.

Implications for Warehouse and Distribution Space

Warehouses are at risk in any shift to on-line shopping. If the CUC International strategy of cybermiddlemen is accepted, then on-line retailers will not need either storage or distribution facilities. Customers will order on-line and manufacturers will ship. Advances in manufacturing and distribution are also eroding the demand for intermediate distribution and warehousing space.[16]

REAL ESTATE TAXATION FOR THE INFORMATION AGE

Current tax law does not favor the reuse of commercial space. It recognizes that property owners invest in change, but it stretches deductions over long periods, limits rehabilitation credits to a small group of structures, and does not permit expensing demolition costs.

The impact of INFOTECH on property uses and space demands invalidates many of the assumptions underlying the taxation of commercial property. Existing policy assumes a continuing demand for space so Congressional debates have been confined to the issue of raising revenue versus offering tax benefits. The prospect of long-term stagnant or falling demand shifts the debate. The current tax structure does not make available the financial incentives needed to convert the substantial quantities of office, retail, and warehouse space that are being made redundant by INFOTECH. But, tax policy has long been used to advance governmental objectives.

The Federal Tax Code applies to each phase of the real estate cycle: development; ownership; and disposition. Following are a number of suggested changes to each phase of the cycle that will help the market to adjust to the new conditions. (The proposals are not comprehensive, and there may be other ways to achieve the same goals.)

Change the Rules for Development

Offer Tax Credits for Rehabilitating Contemporary Structures. This benefit is already enjoyed by buildings of historic value, a laudable but limited purpose. Expanding the definition to include the upgrading and reuse of newer structures will ease the problems of commercial owners and their communities.

Make Demolition and Renovation Period Costs Deductible. The cost of demolition and renovation period expenses like interest and taxes should be expensed in the year taken and not added to the value of land or written off.

Change Ownership Rules

Reduce the Deduction Period for Commercial Property Improvements. The write-off period for residential property is 27 ½ years, and for nonresidential property 39 years. Depreciable lives of such length effectively negate depreciation as an incentive to convert offices, shopping centers, factories, and warehouses. At this writing, Congress is considering adding to the Code a nonresidential leasehold improvement write-off period of ten years. Expanding the provision to benefit existing (not new) commercial properties that are unleased and making 10-year write-offs applicable to commercial properties that are converted to residential use would ease the transition to the information age.

Eliminate the Passive Income Category for Properties That Are Being Readapted. The passive activity rules were enacted in 1986 to curb abusive tax shelters. They prevent losses from certain real estate activities from offsetting other taxpayer income. Today these rules eliminate incentives for investors to readapt commercial property. These rules should be changed to allow passive activity losses and credits generated from existing readapted commercial property to offset ordinary income.

Change the Tax Rules for Dispositions

Extend the Period to Complete a Deferred Exchange. The present rule, which gives an exchanger a maximum of six months to acquire replacement property, is too short. The period should be lengthened considerably; for example, to two years, the same as for personal residences.

Defer Tax on the Discharge of Indebtedness. Under certain circumstances, relief from mortgage debt may create taxable income. Consideration should be given to deferring a seller's tax liability to assist the taxpayer to transfer the property for reuse.

Adjust the Capital Gains Tax to Promote Change. Real estate owners have little incentive to sell aging properties outright because a sale triggers large taxable gains created by inflation. A reduction in the inflationary component of the gain would revive the incentive to sell and give the market a better opportunity to convert older properties into productive use.

Sanction an Exit Strategy. A taxpayer may take an ordinary loss for the "extraordinary obsolesence" of a building. INFOTECH represents the "extraordinary obsolesence" of property.

CONCLUSION

INFOTECH is inducing widespread, fundamental changes in the economy and society that challenge the commercial real estate market. Market participants, developers, owners, and lenders will have to adapt their investments to the new conditions and will encounter financial loss. Unfortunately, the present tax policy impedes change; it recognizes neither commercial reality nor the radically changing economy and penalizes owners of commercial real estate who seek to convert their properties to more productive forms. Although the problem is not yet urgent and has received little public attention, perhaps this is the best time to start thinking about what changes are desirable. ■

NOTES

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13. C.F. Kaufman and P.M. Lane, "Shopping 24 Hours a Day: A Consumer Need or a Losing Strategy," *J. of Shopping Ctr. Res.* (Fall 1994), pp. 81–159.
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Memo of March 18, 1996

To: Persons interested in tax reform

Attached is the typed version of my paper: "Qualities of Tax Plans". The original hand-written version was published (p. 1001-1027) in Replacing The Federal Income Tax, including hearings before the U.S. House Ways and Means Committee June 6, 7, 8, 1995, Serial 104-28, U.S. Government Printing Office, Washington, D.C., 1996 (ISBN 0-16-052327-3). The original hand-written version was as legible as I could write. The reproduction by the U.S. Government Printing Office was excellent, but the reduction in size made some parts barely legible. Thus this typed version is prepared to provide a more readable text. In the typed version, each page is the same as the hand-written version, but individual lines may be different. A few minor revisions were made.

A highlight of my paper is my proposal for a Unified Retail Sales Tax (p. 1012 ff), in which all Federal, State, and Local taxes on retail sales of goods and services are combined into one rate of say 10-20% and collected by the local business. The business retains a collection fee of say 1% and sends the remainder to the Local Tax Office; only the latter has the authority to audit the business. The Local Tax Office retains its portion of the revenue, say 40%, and sends the remainder to the State Tax Office. The State Tax Office retains its portion of the revenue, say 30%, and sends the remaining 30%, to the Federal Tax Office.

My Unified Retail Sales Tax is similar to the National Retail Sales Tax proposed by Senator Richard Lugar and others. However, some proponents of the latter have indicated that the business would send the tax directly to the Federal Tax Office (or even an unabolished IRS!), implying that it may directly audit the business. I strongly oppose such a policy. Other proponents have indicated that the business would send the tax to the State Tax Office, a system that already is established in 45 states. I now see that procedure could be implemented more readily, and would modify my proposal to allow each State that option. However, I dislike the term "National"; my dictionary defines it as "belonging to or mandated by the federal government." Even if the plan says otherwise, the term "National" connotes direct payment to and auditing by the federal government. I strongly recommend that the "National" term be dropped and that my term "Unified" (or perhaps a better one) be adopted so that those of use who support the basic concept of replacing the present income tax with a combined Federal-State-Local retail sales tax can join together and help convince others that our plan is the best for the country.

Some proponents of the National Retail Sales Tax have proposed exemptions for necessities such as food and medicine. I object to such exemptions (p. 1019) because they would open the door to endless complexities that would be promoted by social engineers. The only purpose of the tax code should be to raise revenue to cover legitimate government expenditures. Some have

proposed that a cash advance or rebate of say $5,000 be sent to all citizens, so that the "regressive" impact of the sales tax on those with lower incomes be alleviated. I am opposed to such direct payments from the Federal government. They would be as wasteful and counterproductive as the current welfare program. I believe it is better to give money to the needy on the local level, either through a local government agency and/or a private charity, so that only individual needs are targeted. Money may be provided to the local agency or charity on a matching funds (or other) basis by the State and Federal governments.

In my paper, I presented a preliminary chart (Fig 1, p. 1008) showing the damage to the economy produced by increasing government revenue. In the same Ways and Means book (Serial 104-28), Dr. Richard W. Rahn presents a documented chart (p. 629) with a different shaped curve (more "bell" like) but with an optimum 25% of government revenue that would not seriously damage economic growth; this determination is not far from my intuitive estimate of 20%. This should be one of the basic tenets of any tax reform -- that government revenue should be kept below a maximum of say 30%, and at or below the optimum of 25%, in order to avoid serious damage to the economy.

Although I am still reading the Ways and Means book (received March 7), one of the best papers is by Steven L. Hayes, President, Citizens for an Alternative Tax System, (p. 646-655): "Replacing the Income Tax with a National Retail Sales Tax." I wish I had information from this and other good papers in the book when I was writing my paper. However, I offer some key points that I have not yet seen addressed in the others.

We all owe a deep debt of gratitude to Representative Bill Archer (R-TX), the Chairman of the House Ways and Means Committee, for beginning and continuing the current intensive debate on tax reform. No longer are we talking about tinkering with the present income tax system. Rather, we are on the verge of throwing the whole thing out and substituting a much more reasonable consumption tax, preferably a combined Federal-State-Local retail sales tax, that will greatly encourage economic growth and provide other benefits for our country.

Chairman Archer encourages input from the general public as well as from experts. He realizes that such a sweeping change in tax policy must have public acceptance if it is to be successful. I suggest that every interested citizen (and every citizen should be interested!) study the different tax reform proposals, then let your Congressman and the Ways and Means Committee know which one you prefer and why.

ST III

June 22, 1995

Mr. Phillip Moseley, Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Sir:

On the Michael Reagan Radio Talk Show (June 8, 1995), I heard that your Committee is inviting citizens to send comments and suggestions on the various tax reform plans. I understood Mike to say that they should be sent in by June 27. However, when I called your office on June 20 to find out more about the procedure, Walter (who was very helpful) told me that the target date was June 22!

So I worked night and day, June 20-22, to finish this paper: "Qualities of Tax Plans." Hope it gets to you in time. Walter said hand-written copies are O.K., so I hope you can read my left-handed, arthritic handscrit! If you will give me some extra time, I'll be glad to have a typist (or word processor specialist or whatever you call them these days) to get a printed copy.

Enclosed are the six copies that were requested by Walter. He said my report will be reproduced along with suggestions from other citizens. The record of the June 6-8 hearings will also be included. (They were excellent; I heard most on replays by C-SPAN 2.) He said the copies will be available in the late summer and will sell for about $40. Please send me one when ready.

Congratulations to you, your staff, Chairman Bill Archer and other members of the Committee for the excellent job you are doing on comprehensive tax reform. (Just wish you all had been in charge in 1986!) Thanks also for letting us plain but interested citizens participate.

Sincerely yours,

Sam Thompson, III
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P.S. One of my hobbies is writing political lyrics. Enclosed is my creation of April 28, 1995: "The Ultimate Tax Reform" (to be sung to the tune of "America the Beautiful"). Thought you and the others might enjoy it.

THE ULTIMATE TAX REFORM
(Tune: "America the Beutiful")

1) We're hopeful now the income tax may be repealed at last
For many years the Supreme Court said it should not be passed
Repeal the Sixteenth Amendment, admit that it was wrong
And substitute the retail tax, to make our country strong.

2) An evil tool of socialists to redistribute wealth
The income tax is hazardous to economic health
It punishes successful work, incentives it devours
Discouraging the savings and investments that are ours.

3) When we abolish income tax, we won't need IRS
We'll dump their complex maze of rules and bureaucratic mess
No more invade our privacy, no guilt will be presumed
And end their mean Gestapo raids, such policies are doomed.

4) The ultimate of tax reform -- A tax on retail sales
So all you earn you now can keep, no April 15th wails
You're only taxed on what you spend, at one low rate renown
Consumer votes scare Congressmen, that rate they will hold down.

5) Some liberals claim the retail tax will mostly hurt the poor
Until they're told a cash advance will ease the pain for sure
The underground economy at last will pay their share
By buying goods and services, taxation will be fair.

6) Each local business will retain a portion of the haul
With such incentive to report, they won't hide sales at all
To local and state governments the revenues will flow
Then trickle up to federal -- they'll carefully spend our dough.

7) At last our great economy will bask in freedom's glow
The saving and investment boom will help good business grow
We'll waste no time on long tax forms, productive work will rise
We'll have more jobs and higher pay -- the retail tax surprise!

Sam Thompson, III
April 28, 1995

QUALITIES OF TAX PLANS

A preliminary analysis of the current income tax system and seven proposed tax-reform plans based on twelve qualities defined for an ideal plan.

by:
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Qualities of Tax Plans

Table 1 summarizes the twelve qualities of the ideal tax plan. They are based on my studies as an interested citizen of publications, television, (C-SPAN, etc.), and radio programs. Table 2 contains my preliminary ratings of qualities of the present income tax and the most prominent of the proposed reform plans. Many of the plans are in their formative stages and I have studied some of them more thoroughly than others. Nevertheless. my preliminary analysis may help to reject the inferior plans, and select and improve the better ones.

1) Sufficient - An ideal tax plan will raise sufficient revenue to pay for legitimate government expenditures. Much of the current spending by the federal government is wasteful, counterproductive, and in some cases unconstitutional. Thus, the level of sufficient revenue (and that part to be raised by taxation) will be significantly lower and cannot be determined accurately until the current budget reform process is completed. (If the ill-conceived "entitlement" programs such as Social Security, Medicare, and Medicaid can be privatized or phased out and replaced by targeted subsidies for the truly needy, the budget total may be brought down to a modest level.)

In the IRS booklet for 1994, the total Federal revenue for fiscal year 1993 was $1,154 billion and the total expenditures were $1,408 billion (deficit of $255 billion). Most reasonable people consider these figures to be astronomically high. About 51% of the revenue was raised by personal and corporate income taxes, excise taxes etc., or about $589 billion. To replace the current tax plan, a reform plan needs to raise revenue on this order of magnitude, or somewhat less if budget reform is successful. However, the static concept that a tax-reform plan must be "revenue neutral," that is raise the same amount as the current system, should be discarded.

Table 1: Desirable Dozen Qualities of the Ideal Tax Plan

1) Sufficient - Will raise sufficient revenue to pay for legitimate government expenditures.

2) Undamaging - Will do minimum damage to the economy.

3) Encouraging - Will encourage saving and investment.

4) Enforceable - Can be enforced without oppressive government intervention

5) Simple - Can be paid simply and easily; avoidance is not worth the trouble

6) Inexpensive - Can be enforced and paid at low cost.

7) Understandable - Can be understood easily and is so obvious that all tax payers can be aware of the tax base, tax rate, and amount paid.

8) Fair - Will be perceived as fair by most reasonable people; no escalating ("progressive") tax rates, no loopholes (no exemptions or deductions), no priviledges (no credits). (Will help needy with subsidies.)

9) Quick - Will be passed into law so rapidly, will be implemented so easily, and will be accepted so readily, that the transition time to change from the current system is minimal.

10) Rigid - Will be so rigidly constructed that there is no room for political manipulation (vote buying, pork barreling, log rolling, etc.); no longer use tax code for social engineering, only to raise revenue.

11) Stable - Will be so well prepared that no other tax reform plan will pass for at least 30 years. (May have minor adjustments of tax rates.) With such long-term stability, individuals and businesses can do more accurate financial planning. (Still have unknown rate of inflation.)

12) Liberating - Will result in abolition of the Internal Revenue Service and repeal of the 16th Amendment to the U.S. Constitution (which brought us the income tax in 1913).

Note: A unified (Federal, State, and Local) retail sales tax is the most ideal plan.

ST III
95-6-20

Table 2: Preliminary Ratings of Qualities of Current Income Tax and Proposed Reform Plans
5=Excellent, 4=Good, 3=Fair, 2=Poor, 1=Lousy, 0=Awful

		(1) Sufficient	(2) Undamaging	(3) Encouraging	(4) Enforceable	(5) Simple	(6) Inexpensive	(7) Understandable	(8) Fair	(9) Quick	(10) Rigid	(11) Stable	(12) Liberating	Non-Weighted Total
1)	Current income tax (IRS)	4	2	1	1	0	0	0	0	5	0	0	0	13
2)	Progressive income tax (Gephardt)	3	3	1	2	1	1	1	0	2	0	0	0	14
3)	Consumed income tax (Nunn & Domenici)	3	3	3	2	1	1	1	2	4	0	0	0	20
4)	Flat rate tax on wage income (Armey)	3	4	4	3	3	3	3	3	4	3	3	2	38
5)	Flat income tax + VAT (Brown)	4	2	2	2	2	2	1	1	2	1	1	0	20
6)	Value added tax (VAT) on Wholesale and Retail Sales (Gibbons, others)	3	4	5	3	4	2	2	3	3	3	3	2	37
7)	National Retail Sales Tax (Lugar, others)	3	4	5	4	5	3	5	4	3	4	4	3	47
8)	Unified Retail Sales Tax (collected locally) (ST III)	3	4	5	5	5	5	5	5	2	5	5	5	54
													(Maximum	60)

Notes: See Table 1 for explanation of qualities
See text for discussionof current income tax and proposed reform plans.
Non-weighted total of ratings may not be an accurate appraisal because some qualities are more important than others. However, the relative ranking of: 1 No. 8-54; 2 No. 7-47; 3 No. 4-38; 4 No. 6-37; 5 and 6 tie between No. 3 and No. 5 at 20; 7 No. 2-14 and 8 No. 1-13 appears reasonable.

The current tax plan and all of the proposed reforms are capable of raising sufficient revenue if their rates are high enough. The current plan is rated as a 4-Good (out of 5) because it does not raise enough revenue to eliminate the deficit. The reform plans that would continue to tax income (Nos. 2-4) are rated 3-Fair because they propose lower rates. However, as dynamic scoring becomes available they may indeed raise more revenue than the current system.

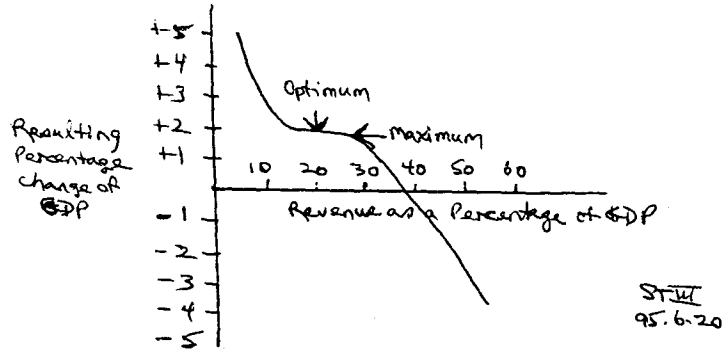
The reform plans that would change the tax base from income to consumption (Nos 6-8) are also tentatively rated 3 because they too aim for low rates. Total retail sales in the U.S. during 1993 are reported to have been $2.1 trillion. A consumption tax rate of 20% would have raised about $420 billion in 1993. To get to the $589 billion of the present system, the rate would have to have been 28%. Although these calculations are only crude approximations, they show that a consumption-based tax is in the ballpark when it comes to raising sufficient revenue. The plan suggested by ex-Governor Jerry Brown (D-CA) to combine a flat income tax and a VAT is rated as a 4 because it may raise as much or more revenue as the present system, but it should be rejected on other grounds.

2) Undamaging - An ideal tax plan will do minimum damage to the economy. Any amount of revenue taken out of the economy by government will do proportional damage to it.

Combining 1) and 2), I submit that the most important goal of tax reform is to choose a plan that will raise sufficient revenue to pay for legitimate government expenditures but also will not do serious damage to the economy. If the economy is seriously damaged, most if not all of the people in the country will suffer.

Figure 1 is offered as a first step in the assessment of economic impact. It is a preliminary chart showing a plot of total revenue (Federal, State, and Local) as a percentage of real Gross Domestic Product and the resulting change of GDP. A statistical analysis should be made to see what part of a change in GDP is the result of the change in total revenue. Also, the proper time lag should be determined.

Figure 1. Preliminary chart of total revenue (Federal, State, and Local) as a percentage of real Gross Domestic Product and the resulting percentage change of GDP. The maximum is the revenue percentage above which serious damage will be done to the economy. The optimum is the percentage at which the most revenue will be raised while doing the least damage to the economy (inflection point on curve).



The maximum is defined as the revenue percentage above which serious damage is done to the economy. The optimum is defined as the percentage at which the most revenue will be raised while doing the least damage to the economy. Intuitively, I believe that the maximum is around 30% (certainly 50% or above) and the optimum is around 20% (between 10 and 30%).

A select panel of experts, including professionals from both inside and outside of government, should plot such a general curve with appropriate documentation. They may also plot general curves to see if there are significant differences as to whether total revenue is collected from an income or consumption base, or is collected only by the Federal government or by State or Local governments.

Finally, they should plot specific curves for each of the tax reform proposals to see what rates will result in maximum and optimum revenue percentages and compare them to those of the present system. (The revenue raised by the tax plan may be combined with revenue from other sources to determine the total.) Those proposals which have reasonable tax rates that will raise sufficient revenue at an optimum percentage of GDP may be selected; those which do not may be rejected.

In my preliminary ratings I show the present system as a 2-Poor regarding the quality of undamaging. The tax increase of 1993 is starting to have its effect after the normal two-year time lag. I judge that the Brown plan (No 5) would not be much better. Those plans that will continue to tax income at escalating ("progressive") rates, No. 2 being proposed by House Minority Leader Richard Gephardt (D-MO) and No. 3 proposed by Senators Sam Nunnn (D-GA) and Pete Domenici (R-NM), are rated as 3-Fair because they at least are proposing lower rates. The No. 4 plan submitted by House Majority Leader Richard Armey (R-TX), to tax only wage and pension income at a low flat rate of 17% (and exemptions of $13,100 for a single person; $36,800 for married couple with two children) is given the best rating of 4-Good. The consumption tax plans, Nos. 6, 7 and 8 would have been rated as 5-Excellent except for the fact that they will raise the cost of living for everyone, and even the elimination of income taxes and the instigation of subsidies

for the needy may not offset the economic impact, so they are optimistically rated as 4-Good.

3) Encourging - An ideal tax plan will encourage saving and investment. Investment is the life blood of a growing economy, providing jobs and increasing the standard of living. Thus any improvement in this quality will help to offset any damage done by taxation (Quality No. 2).

In the current system, savings are taxed at a marginal rate up to 39.6% (some 41%), and capital gains on investments held longer than one year are taxed at 28%. Because the USA has an abysmal savings and investment rate compared to other developed (and some developing) nations, I believe a rating of 1-Lousy is justified. It would be 0-Awful except for the fact that some reduction is given on capital gains taxes.

However, consider my personl situation. As I became a serious investor in mutual funds in the early 1980's, I got used to paying a capital gains tax on investments (outside of IRA's, 403b's, etc.) of 14%. After the Tax-Reform Act of 1986, my rate doubled to 28%. I consider that rate to be very high. Since then, I have been reluctant to invest in stock funds and have kept most of my nest egg in money market funds. I would guess there are millions of others like me. Thus elimination of taxes on savings and investments should unleash a torrent of activity, including a significant input from foreigners, that an economic boom probably will result.

Because Gephardt is so committed to escalating ("progressive") rates and redistribution of wealth (and he says he is "not a socialist"!?), I doubt that his plan (No. 2) will give much encouragement to savings and investment, so I have given it also a rating of 1-Lousy. Because Brown has a similar political philosophy, I give his plan a slightly better 2-Poor because he implies a flat rate tax on savings and investments (however, he has spoken of a possible higher additional rate on the "rich").

The consumed-income tax plan of Nunn and Domenici (No. 3) would subtract the amount put into savings and investment from total income and tax the remainder as a consumption equivalent. Because they keep savings and investment in the tax equation, and thus subject to federal abuse, I give their plan only a rating of 3-Fair. The much better Armey plan (No. 4) takes savings and investments

completely off the table, but the fact that he taxes any income at all allows for a return to taxes on savings and investments in the future, so I rate it as only a 4-Good.

All of the consumption tax plans (Nos. 6, 7 and 8) are rated as 5-Excellent because they eliminate taxes on all income and thus greatly encourage savings and investments into the foreseeable future and maybe beyond. Hooray!

4) Enforceable -- An ideal tax plan can be enforced without oppressive government intervention. In fact, an ideal plan should be self-regulating with only minimum of governmental spot-checking.

For many decades, there have been horror stories of abusive intervention, some armed and violent, by the Internal Revenue Service into businesses and personal lives. Even the initials, IRS, send shudders through all taxpayers. That is why the Chairman of the House Ways and Means Committee, Bill Archer (R-TX), is so determined in his drive to abolish the IRS. If anyone has any hope that the IRS can or will improve they should read the recent report by Daniel J. Pilla, "Why You Can't Trust the IRS" (Cato Institute, Policy Analysis No. 222), with the timely date of April 15, 1995. Because I have been generally well treated by the IRS, I believe I am entitled to give the current tax system a generous rating of 1-Lousy in this category.

The Gephardt (No. 2) and Nunn-Domenici (No. 3) plans remain so dependent upon the IRS for enforcement, I give a rating of 2-Poor. The same is given to the Brown plan (No. 5) because he depends on the IRS to collect both the income tax and the VAT. The Armey Plan (No. 4) is relatively simple, so enforcement by the IRS should be less involved; but the risk remains , so it is given a 3-Fair. The Value Added Tax (VAT) on wholesale and retail sales proposed by the Ranking Member of the House Ways and Means Committee, Sam Gibbons (D-FL), (No. 6) is also given a 3 because at least two collections on each item of consumer goods or services must go to the IRS.

The National Retail Sales Tax (No. 7) proposed by Senator Richard Lugar (R-IN) and others does what it says, but incredibly the payments are sent to the IRS, so I rate it only a 4-Good. For this and other reasons, I am compelled to introduce (hasn't anyone else?) the idea of a Unified Retail Sales Tax (No. 8) in which all Federal, State, and Local sales taxes are combined into one rate, are collected by the local business and sent to the Local Tax office (City, County, etc.). In my plan, the business would keep a portion of the collection, say 1% or 2% to cover administrative costs plus a small profit, and may even be given the "float" while earning interest in a bank account before making quarterly payments to the tax office. Thus, each business would have good incentive to report all sales and collect taxes on them, the system would be practically self-regulating, and only rare spot checks would be needed by inspectors from the Local Tax Office (and they would be the friends and neighbors of the business people). At the Local Tax Office their share of the revenue would be retained and the remainder sent to the State Tax Office, which in turn would retain their share, and the remainder sent to the Federal Tax Office. In this age of computers and wire transfers, the time for the tax money to go from the business to the Federal Tax Office may be measured in nannoseconds. The Federal Tax inspectors may check on the State Offices and the State Tax inspectors may check on the Local Tax Offices, but the latter would buffer the business people from both of the former. What could be more easily and pleasantly enforceable? So I give my plan a 5-Excellent!

5) Simple - An ideal tax plan is so simple that the taxes can be paid simply and easily; avoidance is not worth the trouble. Because enforceability and simplicity of compliance are so closely related, I give my plan (No. 8) a 5 in this category also. I may be too generous in giving a 5 to the National Retail Sales Tax Plan (No. 7); a businessman who misses a quarterly tax payment to the IRS, has a helicopter land on his roof, and from it come jack-booted thugs who shoot up his storefront with AK-47's, may not think that plan is so simple!

Similarly, the VAT plan (No. 6) cannot be considered so simple if at least two business people, the wholesaler and the retailer, must send payments to the IRS, so it is rated 4. The addition of an income earner sending payments to the IRS further complicates the Brown Plan (No. 5) so it is rated only a 2.

At first glance, the post-card sized reporting form proposed in the Armey Plan (No. 4) appears to be the epitome of simplicity. But the worst feature of it is that the payments must be sent once per month with an annual return to make any adjustments. Sending even 13 postcards to the IRS per year cannot be considered simple and easy, and will drastically increase the potential for problems. The 3 rating could be raised to a 4 with only 1 report per year.

A spin-off from the Armey Plan, called "MC-Flat" by the Congressman (R-IA) who introduced it, is similar except it retains the deductions for mortgages (M) and charitable contributions (C). Such a move is politically popular, but it could wreck the tax-reform process. Restoring such goodies to the tax code would increase the complexity exponentially.

Several of the plans have proposed designating home ownership and other real estate as capital investments. Thus purchases and sales would not be taxed in those plans (at least Nos. 3, 4, 6, 7, and 8). As for charities, won't they be happy to know the contributions they receive are straight from the heart and are not the result of some tax dodger playing games with the IRS?

The Nunn-Domenici Plan (No. 3) involves so many complexities that it can hardly be called simple, so I rate it a 1-Lousy. The Gephardt Plan, which also will have several tax brackets, is also rated a 1. With over 17,000 pages of law and regulation (Pilla, 1995, p.2) the current IRS tax code is generously rated a 0-Awful! That is one reason why Chairman Bill Archer wants to "... tear up the present income tax system by its roots."

6) Inexpensive - An ideal tax plan can be enforced and paid at low cost. Inside the beltway of Washington, D.C., the operating budget of the IRS in 1993 at $7.07 billion doesn't sound like much, but it is an increase of 84% over 1986 ($3.84 billion), and is expected to increase to $21 billion by 2008 (Pilla, 1995, p23). Incredibly,

the IRS could not account for $4.3 billion, or 64% of its operating budget, when the Government Accounting Office tried to audit that agency's budget for 1992 (Pilla, 1995, p. 25). (If any of us taxpayers kept records like that, the IRS would throw us in the Federal Prison at Fort Levenworth!) Even worse, the cost to all taxpayers (individuals and businesses) to comply with the complex IRS code is $600 billion to $1 trillion annually, plus 6 billion hours in work time (W. Kurt Hauser, Wall Street Journal, May 14, 1993). All that to collect $800 billion in revenue (William Grace, Wall Street Journal, Feb 11, 1993). Now is that expensive or what? How about another generous 0-Awful rating in this category for the current tax system.

With their deep attachment to the IRS, I doubt that the Gephardt (No. 2) and Nunn-Domenici (No. 3) plans are much better, so I rate both as a 1-Lousy. The Brown (No. 5) and Gibbons-VAT (No. 6) plans may be slightly better, so they are rated 2. The Armey (No. 3) and Lugar (No. 7) plans have less to do with the IRS and the cost of compliance should be reduced, so they are rated as 3 (maybe 4). In the Unified Retail Sales Tax Plan (No. 8), the cost of compliance for the consumer is practically zero, the cost to businesses to collect the tax is offset or better with the 1% to 2% fee, and only the expenses of the Local, State, and Federal Tax Offices count toward the cost of enforcement, I believe another 5 rating is justified.

7) Understandable - An ideal tax plan can be understood easily and is so obvious that all taxpayers can be aware of the tax base, tax rate, and amount paid.

The present tax code gets another generous 0-Awful rating, this time because it is not understandable. Each year from 1987 to 1991, Money magazine prepared a hypothetical set of data about a typical family and sent it to 50 professionals, asking them to prepare a tax return. They received 50 different answers, none of them correct. Money also discovered that about 60% of the members of House Ways and Means and Senate Finance, the tax-writing committees, do not prepare their own tax returns, but have their expert lawyers employed by the committees prepare their returns at taxpayer expense. (Our hero, Bill Archer, is a notable exception.) The IRS answers only about 63% of taxpayer questions correctly (Pilla, 1995, p. 5-7).

Anyone who has ever struggled with an IRS form and booklet more complicated than 1040EZ should not expect the Gephardt (No. 2), Nunn-Domenici (No. 3) or Brown (No. 5) plans to be much more understandable, so I rate them a 1-Lousy.

If a Value Added Tax (No. 6) is passed, it may be poorly understood when first introduced. Although the tax is levied only on consumption goods and services, it is applied at both the wholesale and retail levels. For some manufactured goods, there may be several levels of taxation. For each level of taxation there would be some administrative cost, so the total price including the VAT may be higher to the consumer than if a single tax were levied at the retail level. In some countries. especially in Europe, the wholesale parts of the VAT are not shown so that much of the tax is hidden from the consumer. To avoid that problem, an American VAT could require that all levels of taxation be printed on the retail receipt, but at a higher cost. The Europeans also exempt some items from their VAT, such as food and medicine; such practice has produced a cumbersome nightmare of misunderstanding. Tax-reform insiders, especially those who favor the VAT, use the new buzz word "border adjustable" to indicate that the tax may be imposed on imports and rebated on exports with the hope that the balance of international trade may be improved. (They like to point out gleefully that corporate taxes in the Armey plan are not border adjustable.) The VATs adopted by Europeon countries have failed to improve their trade balances (Bruce Bartlett, Wall Street Journal, April 16, 1993). Because all this may not be so understandable, I rate No. 6 as a 2.

The worst thing about the VAT (or any other Federal consumption tax) is that it may be imposed in addition to the income tax, as in Europe. Thank goodness the "Hillary VAT" to finance her radical health-care reform plan never materialized. One of the real dangers of the Brown Plan (No. 5) is that it would introduce double-based Federal taxation on both income and consumption, perhaps starting at low rates but soon mushrooming as the politicians begin tinkering with one then the other. The unwary citizen would have a doubly hard time understanding what is being taxed, what the rate is, and what the total amount of taxes is per year.

The Armey Plan (No. 4) with its relative simplicity should be generally understandable, especially the flat rate and the total tax. However, the tax base may not be so well understood. The plan is to tax individuals and families only on the income from wages, salaries, and pensions (not Social Security). Some may have to be taught carefully that income from savings and investments are not to be included on the postcard to the IRS (who may not give it back!). On the other hand, the more astute may understand the Armey Plan too well and begin taking their entire salary in stock and changing their pensions into IRA's, etc. That would help economic growth but could play hell with expected Federal revenues. I rate this plan a 3 in this category.

The National Retail Sales Tax by Lugar and others (No. 7) is more understandable and is top rated as a 5. On each receipt of a retail sale, the rate and the amount of the Federal tax should be shown. The customer should clearly understand that the tax base is consumption. He or she may not understand the problems the store owner may have with reporting directly to the IRS.

The Unified Retail Sales Tax (No. 8) is equally understandable and is also rated as a 5. As with the National one, I expect the Federal tax rate to be shown on the receipt and to be the same across the nation. However, I would hope and expect that each State and/or Locality would try to set a lower tax rate than its neighbor, which would help keep those rates down by competition. The different rates and amounts should be shown on the receipt. In many States, a combined State and Local sales tax is already in effect, thus the addition of the Federal would only add one more line to the receipt. The same is true with the National Plan. Thus the main difference in the two is that in the Unified Plan, the tax is sent to the Local Tax Office instead of the IRS. The customer may be very pleased when he or she understands that the tax money first goes to the tax office in the community.

Dick Armey's objection to a Federal sales tax is that he doesn't like the idea of forcing business people to be tax collectors for the Federal government. In those areas where there is no sales tax at the present time, the sudden introduction of a

Federal sales tax would be quite a shock. However, my proposal for a 1% or 2% portion of the total tax collection to be given to the business people, as well as the possibility of getting the "float" on the interest, should ease the pain considerably. For the many who are already used to a State and/or Local sales tax, there should be no problem.

8) Fair - An ideal tax plan will be perceived as fair by most reasonable people. There should be no escalating ("progressive") tax rates, no loopholes (no exemptions or deductions), and no priviledges (no credits). The needy may be helped with subsidies on the spending side, but should not be used as an excuse to complicate and politicize the tax code on the revenue side.

For many decades, the liberal concept of fairness has gone practically unchallenged. It asserts that the "rich" (rarely defined) should pay escalating, "progressive" (toward what -- socialism?) rates on their taxes because they can afford it, because they don't need the money, because they didn't really earn it, because they are greedy (politics of envy), because they are too successful and need to be punished (zero sum fallacy), and probably some other "reasons" we haven't heard yet.

Many liberals are also extreme egalitarians. So why don't they insist that everyone pay the same amount in a per-capita tax? Don't they believe that everyone's life and liberty are worth the same and should be protected by government for an equal charge? Won't they at least compromise and agree that everyone pay the same rate in a flat tax (on income or sales)? Gephardt, Brown, and others have said they are proposing a "flat tax" at one low rate for most people and then a higher rate or surcharge for the "rich"! Isn't that deceitful, trying to capitalize on the buzz word "flat tax" and then sneak in a "progressive" one?

After "soaking the rich", the liberal's next step in the "fairness" process is to take the tax dollars

and spread them among their bureaucratic buddies in the Federal government. Finally, they distribute the remainder to the "poor" (also rarely defined), which include welfare addicts (several generations on the dole), substance abusers (alcoholics and drug addicts), homeless (many are wandering schizophrenics turned out of mental hospitals), fatherless families (teenage mothers with several illegitimate children) etc., and some truly needy people. For many years, estimates indicate that out of each tax dollar designated for welfare, about 80 cents goes to the Federal bureaucratic overhead and only about 20 cents reaches the "poor". (Is this "trickle-down" economics?) And yet liberals scream the loudest when conservatives propose that Federal welfare programs be devolved back to the State governments where they can do a better job at less cost.

In regard to the tax code, the liberal concept of fairness demands that the "poor" be exempted from paying any taxes and that low income workers be given a tax credit. In recent years, they have promised (but not yet delivered) tax cuts for the "middle class" (whoever they are).

Even the social conservatives get into the act. They request tax deductions for families with children, home mortgage interest payments, charitable contributions, etc. Even a firm economic conservative like Jack Kemp proposes "enterprise zones" to encourage development within the devastated inner city areas by giving tax breaks to businesses who locate there.

If we are ever to arrive at the ultimate tax reform -- abolition of the current income tax code, repeal of the 16th Amendment, dismantling of the IRS, and establishment of a simple Federal retail sales tax, we need to convince at least a majority of reasonable people that the strict economic conservative view

of fairiness is correct. In most basic terms, to be fair to everyone in the country, the only purpose of the Federal tax code should be to raise revenue for legitimate government expenditures. Thus the code should be strictly an economic document, not a political or social one. Because a growing economy benefits everyone, only the minimum amount of necessary revenue should be extracted, because any amount of revenue taken from the economy will do damage to it. Also, to be completely fair, everyone should pay the same tax rate and no consumption items should be exempted (such as food or medicine.) A logical definition of fairness does not allow punishment of good, hard working, productive people to give benefits to anyone, much less to lazy parasites. Those who truly need and deserve financial assistance may be given subsidies from the Federal spending budget, but the strict economic conservative view is that such help is best provided through State or Local government agencies or private charities.

The current tax code, even after the valiant reform effort of 1986, is so unfair to so many people that we at last have a majority of reasonable people who are convinced it should be thrown out and replaced with something much better. It is so broken it cannot be fixed. Some stop-gap measures may be needed if we have a severe economic downturn, but complete replacement should be delayed until we have thought through the tax-reform process. Does anyone disagree with my rating of 0-Awful fairness for the current code?

If we can convince an intelligent liberal like Dick Gephardt that his plan (No. 2) with its escalating, "progressive" tax rates is inherently unfair, we will make a great leap forward in the tax-reform process. One of the best arguments on this point I have heard was given by Representative John Ensign (R-NV) during the hearings on "Alternatives to the Federal Income Tax" held by the House Ways and Means Committee (June 8, 1995,

rebroadcast on C-SPAN 2). In a one-on-one debate with Gephardt about his plan, Ensign asked if it is fair to tax Farmer A at a higher rate if he worked hard 7 days a week to make $100,000 in a year, and to tax Farmer B at a lower rate if he goofed off and worked only one day a week to make $10,000 in a year. Gephardt had no direct answer to that excellent question. Yet he and other liberals could become real statesmen if they would admit that their long-held advocacy of escalating tax rates is wrong and unfair, and that for the good of the country they now favor one low flat tax rate. In the meantime I must give the Gephardt plan a 0 rating in fairness.

Senators Nunn and Domenici also continue the unfair practice of escalating rates in their plan (No. 3). However, they make a giant step forward in their attempt to eliminate taxation on savings and investment. I do not approve of their method because it keeps income from savings and investment in the tax formula. Nevertheless, the fact that these prominent moderate conservatives have reached this milestone is an indication that we only have to convince the liberals that taxing what they term as "unearned" income on savings and investments is wrong and unfair. Hopefully they will soon realize that capital investment is needed to keep an economy growing, which in turn creates new jobs and increases standards of living, and that taxing capital or the gains from investment will slow or reverse this process. Regrettably, I must give the Nunn-Domenici Plan a 2 rating.

If the Armey Plan (No. 4) were to pass in its present form it would be a major achievement in tax reform from the fairness and other standpoints. It would prove that we have reached the goals of eliminating escalating tax rates and replacing them with one low flat rate, eliminating taxes on savings and investments, and eliminating many deduction, credits, etc. One problem I have with his plan: he gives exemptions of $13,100 to single people, of $36,800 to married couples with two children, etc. Thus he will enlarge the class of non-taxpaying voters who naturally will use their increasing political clout to support elected officials who promise to maintain their status or increase their level of exemption and their numbers in a never ending assault on the the tax base, with increasing unfairness to the remaining taxpayers. I

fully realize that such large exemptions produce a "progressivity" such that those with higher incomes will pay higher effective rates. That point alone may garner enough votes for passage from liberals who remain convinced that the only fair tax is one that taxes the "rich" at ever higher rates. The large exemptions also are a concession to social conservatives who want tax incentives for families, etc.; however, instead of a continuing set of headlines as each deduction is passed, they get only one large exemption in a lump sum. No doubt they will vote in favor of the initial plan, but will continue to tinker around the edges. Is it fair to give a big deduction to a handsome hunk who got a homely rich girl pregnant, had a shotgun wedding, and wound up in a cushy vice-president job in her father's office, and not give one to a hard-working, ugly guy who cannot get a date much less get a girl to marry him? (I call that "facial discrimination.") Armey proposes a tax rate of 17% which is reasonable. However, because it is an income-based tax, I would expect the liberal-conservative tug of war to raise or lower the rate to continue indefinitely. Also I see an ongoing battle to add escalating rates and to reinstate a tax on savings and investments. With these problems, I can give the Armey Plan only a 3 rating.

The Brown Plan (No. 5) is rated a 1 because it is slightly fairer than the current tax code, but unfairly hits the public with a double-based tax on both income and consumption. Instead of answering the important question as to whether income or consumption should be taxed on the Federal level, Brown takes the chicken way out and proposes to tax both. One of the greatest fears in the current tax reform debate is that a VAT will be introduced at a low rate in addition to the income tax, and that neither will be eliminated in spite of promises to the contrary. The Brown Plan starts out both with relatively low rates, but the risk is high that one or both will be raised routinely and unfairly.

If the Value-Added Tax Plan (No. 6) passes, and the income tax is eliminated, a great victory in the battle of income vs consumption taxes will have been won. If the income tax with all its inherent problems can be buried forever, the focus of the debate can shift to which is better, the VAT or a retail sales tax. A VAT may be designed that could be resonably fair to all concerned. However, if some European tricks are introduced, the total tax may be hidden from the customer, some items may be exempted (food, medicine, etc) which would be unfair to producers of other goods or services, and a bookkeeping nightmare

may hit the wholesalers and retailers. If the total cost to the consumer would be the same with either the VAT or retail tax, both may appear to be fair. However, I expect that the costs to the wholesalers of paying their part of the VAT may be significant, especially if they have to tangle with the IRS or a Federal VAT office, so they would legitimately add those costs to their prices. Thus the customer would pay a higher price under the VAT plan. Even if the price and the tax would be the same, why not save the wholesaler the grief of calculataing, recording, and transmitting their taxes (to the IRS), and have only one tax at the retail level? Because of the potential problems with the VAT, I rate it a 3.

If the National Retail Sales Tax Plan (No. 7) passes (and the income tax is eliminated), it would mean that the VAT lost in the consumption tax debate. The customer should be better off than with the VAT. However, the retail business may be unfairly impacted by the entire weight of the new tax. Adding Federal Sales tax of say 20% to a State/Local tax of 5% to 10% may scare away a lot of potential customers, at least initially. One suggestion under this type of plan is to send a cash advance of $5,000 to every low income person in the country. That may be fine to recipients in small towns, but it would be grossly unfair to those in big cities where the cost of living is higher. Moreover, it would be unfair to the high income people, and the line between low and high cannot be drawn fairly on the national (or even the local) level. Another suggestion under this plan is to exempt some necessities from the sales tax, such as food, medicine, rent, etc. Not only would that be unfair to producers of other goods and services, but also the tax dodgers would have a field day re-classifying all brandy as "medicinal", etc. Some who advocate this plan indicate that the taxes would be sent from the retail businesses to the IRS. The number of IRS agents (probably in the form of secret police) spying on businesses may be much less than with the VAT, but there still would be too many roaming the country, and even a small number would put an unfair burden on the retailers. Even with these problems, I rate this plan as a 4.

Finally, we come to the fairest of them all, the Unified Retail Sales Tax Plan (No. 8), rated as a 5. If it passes, the income tax, the IRS, the 16th amendment, the VAT, and many other taxes would be eliminated.

All consumer goods and services, with no exceptions, would be taxed at a uniform Federal rate throughout the country. All consumers would pay that tax, along with the State and Local tax with no exceptions. However, two serious problems remain -- the heavy economic impact on retailers and the crushing blow to low income people who may no longer be able to afford bare necessities without economic assistance.

The degree of the impact on retailers will depend on the general economic condition at the time the tax is implemented. If budget reform is successful and Federal spending is reduced down to a reasonable level, the needed revenue would not be so great. Also and probably closely related, the dual success of both budget and tax reform may allow the GDP to rise a major amount. Thus instead of 20%, the Federal sales tax may only need to be 10% or less. There still would be an impact on the retailers, but at such a low tax rate, it should not be so severe and should not last long.

If the Federal sales tax is to be 20%, at least those who previously paid income tax at an effective rate of 20% or more should break even or do better. Those who had an income tax rate of below 20% may need financial assistance. If the ill-conceived Social Security program could be phased out, low income workers may be exempted early, so the 7.5% FICA tax taken out of their paycheck, plus the 7.5% in matching funds sent by the employer, could be added to their paychecks with the instant effect of a 15% raise. Retirees who depend on Social Security for most of their income may get a 20% cost of living increase to be paid out of the new sales-tax revenue (not the trust fund). Any of the above who still need help, low income workers who do not pay the FICA tax, and non-workers may apply for assistance at a local Community Aid Agency. The CAA can determine what is an adequate amount of assistance based on the need of the individual applicant (not give a flat amount or "entitlement"). Funds may be provided by the Local, State and/or Federal revenues; other help may be provided by charities. Again, if the Federal sales tax rate can be lowered to say 10%, the amount of financial assistance would be much less.

9) Quick - An ideal tax plan will be passed into law so rapidly, will be implemented so easily, and will be accepted so readily, that the transition time to change from the current system is minimal. Of course, the current tax code (No. 1) has already been passed, so it gets maximum 5 rating by default. The Gephardt (No. 2) and Brown (No. 3) plans do not appear to have much support, so they probably will not be passed and are given a 2 rating.

The Nunn-Domenici Plan (No. 3) already has been written and submitted to the Senate as bill number S-722. Because these two moderate conservatives are popular leaders in the Senate, and because they keep an income-based tax, their bill has a fairly good chance of passage, implementation, and acceptance in a fairly short time, so I rate it a 4. However, I would be disappointed if their bill is considered the best tax reform we can get.

The Armey Plan (No. 4) has been discussed widely, and has much support, especially among House Republicans. It also is an income-based tax, so it too has a good chance of passage, implementation, and acceptance in a short time, so I rate it a 4 also.

The push for a change to a consumption-based tax is led by the Chairman of the House Ways and Means Committee, Bill Archer (R-TX). Although he has not yet decided on sales tax, a VAT, or even a Nunn-Domenici type consumed income plan, he will have a strong voice in the direction of tax reform from his position in charge of that tax-writing committee. The Ranking Member Sam Gibbons (D-FL) is working on a Value Added Tax (No. 6). Senator Richard Lugar (R-IN) has prepared a plan for National Retail Sales Tax (No. 7) (but I have not seen it yet). However, I rate both of these plans as a 3-Fair, because in spite of the compelling logic to switch to a consumption-based tax, such a radical change from the current system will need to be widely debated both inside and outside of Congress before passage. My proposal for a Unified Retail Sales Tax (No. 8) is the most radical departure from the current plan, and until it gets a sponsor in Congress, I can rate it only as a 2.

The VAT and Retail Sales Plans (Nos. 6, 7, and 8) could be implemented quickly, but if they would have a high rate of 20% or more, they would raise everyone's cost of living by that amount, and thus would not be readily accepted. Acceptance would be better if the rate is 10% or less, but that would require favorable economic conditions.

Acceptance of the switch to a consumption tax may come hard to some of us senior citizens who have paid a lot of taxes through the years on our hard-earned savings and investments. As we enter our retirement years, we now would be faced with an unexpectedly high tax when we use our nest egg for necessary consumption. Those of us who have appreciable investments should feel that their exemption from taxation is a fair tradeoff. Those who do not may be bitter. In the discussion on fairness (p. 1023), I proposed that retirees who depend on Social Security for most of their income may get a 20% (or whatever this consumption tax rate is) cost of living increase to be paid out of the new consumption tax revenue (not the trust fund). That action may bring the others down the road to acceptance.

Many of the tax-reform plans include provisions for eliminating taxes on savings and investments. Such a policy is long overdue. However, before such plans are implemented some arrangement must be made regarding tax-deferred investments with pre-tax money that have been placed in IRA's, 401k's, 403b's, etc. I suggest that all such money be taxed at a flat rate of 10%, and then all investment money should be treated the same under the new tax law.

10) Rigid - An ideal tax plan will be so rigidly constructed that there is no room for political manipulation (vote buying, pork barreling, log rolling, etc.), and that no longer will the tax code be used for social engineering, only to raise revenue. Again the current tax code rates a 0. I fear that the Gephardt (No. 2) and the Nunn-Domenici (No. 3) Plans would be subject to such manipulation, so I rate them also as 0. I suspect that the Brown Plan (No. 5) is not much better, so I rate it a 1.

The Armey (No. 4) and VAT (No. 6) plans are much more rigidly constructed, so I rate them each as a 3. However, they could be subjected to some manipulation. The National Retail Sales Tax (No. 7) could be twisted out of shape with a lot of exemptions etc., but I rate it a 4. I see my Unified Retail Sales Tax as being rock-solid rigid, with no room for political manipulation. A few years ago, I would not have had any hope that such a plan could be passed by Congress. But with the new leadership, I am wildly optimistic.

11) Stable - An ideal tax plan will be so well prepared that no other tax plan will pass for at least 30 years. (May have minor adjustments of tax rates.) With such long-term stability, individuals and businesses can do more accurate financial planning. (Still have unknown rate of inflation.)

The current tax code is doomed amid the current fever for tax reform, so it is rated a 0 again. The Gephardt (No. 2) and Nunn-Domenici (No. 3) plans appear to me to be so vulnerable that they probably would not last as much as five years, so I rate them also as 0. If the Brown Plan (No. 5) ever passed, it might last a while longer because many would want to give the VAT part a chance, so I rate it a 1.

The Armey Plan (No. 4) has at least a fair shot at longevity, so I rate it a 3. However, I fear that a liberal-conservative tug-of-war would break out with wide swings of raising and lowering of tax rates, depending upon who is in power. The swings would have to be at least a year or two apart, because it would take that much time to pass new laws on an income-based tax.

The VAT Plan (No. 6) is also rated 3. If it is passed, it may last a few years, but I foresee so many problems with regulation by the IRS, that there may be a nationwide revolt, especially by wholesalers to have it replaced.

The National Retail Sales Tax (No. 7) is given 4 because it could last many years if the regulation of the retailers by the IRS does not get out of hand. The Unified Retail Sales Tax (No. 5) is given a 5, because as the ultimate in tax reform it could last forever.

The income-based tax plans are not stable in the long run, but they are in the short run because the political process moves so slowly. On the other hand, the VAT and sales taxes are more stable in the long run, but the rates may be changed often, if economic conditions dictated, and the tax law would permit such adjustments by an independent board of reasonble experts. Market forces would keep any such adjustments in a narrow range.

Wouldn't it be wonderful if we could make our financial plans and have some hope that the tax code would last 30 years or more? (We would still have the unknown evil of inflation, but does anyone want to join my movement to phase out the Fed and reinstate the gold standard?)

12) Liberating - An ideal tax plan will result in the abolition of the Internal Revenue Service and repeal of the 16th Amendment to the U.S. Constitution (which brought us the income tax in 1913.)

The current tax code, the Gephardt Plan (No. 2), the Nunn-Domenici Plan (No. 3) and the Brown Plan (No. 5) are so tied to both the IRS and the income tax concept that they all are rated as 0-Awful. The Armey Plan (No. 4) is based on the 16th Amendment, but it could reduce the role of the IRS, so it is rated as 2-Poor. The VAT Plan (No. 6) is more dependant on the IRS, but not the 16th Amendment, so it is rated also as 2. The National Retail Sales Tax (No. 7) is less dependent upon the IRS, so it is rated as 3.

Only under the Unified Retail Sales Tax Plan (No. 8) would it be possible to both abolish the IRS (may replace it with a Federal Tax Office to collect the revenue from the States) and repeal the 16th Amendment. Under this plan, it would be possible to abolish the IRS and keep the 16th Amendment on the books, but we would always dread the possibility of the return of the income tax. We need to get rid of both to restore some of our lost liberty and increase our freedom from fear.

Chairman Bill Archer is our heroic leader and standard bearer in this movement to "pull the present income tax system up the its roots", abolish the IRS, and repeal the 16th Amendment. These goals appear to be so important to him that it seems as if he wants these to be the first priorities of tax reform. However, I believe they belong at the end of the analysis of the qualities of tax reform in logical order. Thus they will be magnificent rewards at the end of the glorious tax reform process!

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APRIL 13, 1996

MR. PHILIP D. MOSELY, CHIEF OF STAFF
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DEAR SIR:

PLEASE THANK YOUR CHAIRMAN FOR ADVOCATING A CONSUMPTION TAX. AS A TAX PREPARER FOR MOSTLY SMALL BUSINESS AND WORKING CLASS CITIZENS, I BELIEVE THAT THE FLAT TAX PROPOSALS ARE NOTHING BUT POLITICAL SNAKE OIL, AND THAT PAYROLL TAXES AND SELF EMPLOYMENT TAXES CREATE ALL THE WRONG INCENTIVES. BELOW IS A COPY OF A LETTER I WROTE TO THE LOCAL EDITOR THAT I OFFER BY WAY OF COMMENT:

Thursday, September 21, 1995

LETTER TO THE EDITOR
The Daily Tribune News
P.O. Box 70
Cartersville, GA 30120

SUBJECT: SOCIAL SECURITY

Social security is the most regressive tax we have and is largely responsible for our underground economy. It taxes the working poor first and the nonworking rich last. The low income, self employed can't afford to pay the tax and support themselves and their families so they don't. Some low income people simply decide that welfare is a better option--perhaps, supplemented by unreported and maybe even illegal income.

The Democrats sold us social security under the guise of an insurance fund when in fact it was welfare paid by the workers to retirees. This pyramid scheme worked (as they all do) as long as there were more workers than retirees. But now the retirees are about to outnumber the workers, and social security will break us if we do not do something about it. The Republicans are afraid to take up the fight because they know it will create a worse political fire storm than they have now with the Medicare debate.

Americans worthy of the name believe in helping those in need and letting those that don't fend for themselves. Our parents and grandparents have made many sacrifices for us and our country. They deserve a safe and secure retirement. However, the working poor do not need to be supplementing the retirement of the rich. Political posturing will not solve the problem, but calmly assessing all of the facts and working together will.

In my opinion, a consumption tax combined with a negative income tax (in place of income, social security and Medicare taxes) would go a long way toward solving our deficit, welfare and tax problems. What's yours?

Sincerely,

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