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PRESIDENT'S FISCAL YEAR 1992 BUDGET PROPOSALS

HEARINGS

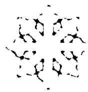
BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

MARCH 19 AND 20, 1991



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PRESIDENT'S FISCAL YEAR 1992 BUDGET PROPOSALS

TUESDAY, MARCH 19, 1991

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:45 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Pryor, Rockefeller, Daschle, Packwood, Danforth, Chafee, Heinz, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-8, Mar. 14, 1991]

SENATOR BENTSEN ANNOUNCES HEARINGS ON PRESIDENT'S 1992 BUDGET; CHAIRMAN SEEKS REASONS FOR MEDICARE CUTS, OTHER PROPOSALS

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Thursday that the Finance Committee will hold two days of hearings next week on President Bush's budget for fiscal year 1992.

The hearings will be on *Tuesday, March 19 at 9:30 a.m. and Wednesday, March 20, 1991 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Bentsen said the hearings will examine the proposals in the President's budget affecting Federal revenues and health and income security programs within the Committees jurisdiction. He said he especially wants to hear the Administration's rationale for proposing additional cuts in Medicare.

"These hearings will provide the opportunity for the Administration to explain in greater detail the proposals contained in the President's budget for fiscal year 1992," Bentsen said.

"I am particularly concerned about the Administration's proposed Medicare cuts. Last year's deficit reduction agreement included $45 billion in reduced Medicare spending, yet the President's 1992 budget includes reductions of an additional $25 billion over the next 5 years. I am strongly opposed to further deep Medicare cuts, as were an overwhelming majority in Congress during the budget debate last year," Bentsen said. "We will also want to explore a number of issues in the revenue proposals," Bentsen said.

The March 19 hearing will be on health and income security issues. Witnesses will include Louis Sullivan, M.D., Secretary of Health and Human Services and representatives of the Prospective Payment Assessment Commission and Physician Payment Review Commission. The March 20 hearing will begin with testimony by Assistant Secretary of Treasury for Tax Policy Kenneth Gideon on the President's revenue proposals. His testimony will be followed by additional witnesses on health and income security issues. "It is also important that the public be heard on these issues. The Committee would appreciate the views of affected individuals, groups and state and local governments on the President's budget, and on expiring tax provisions not included in the budget," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. Good morning. We are here today to discuss the administration's budget for 1992. I can recall last year what a long tough set of negotiations we had on the budget as we tried to make a meaningful cut in the budget. It was a rather messy process but we finally accomplished that.

One of those things that was the most contentious, the most difficult for us to arrive at, was the recommendations of the administration in the cutting of Medicare. We finally came up with a cut over the 5 years of approximately $45 billion.

In my opinion one of the reasons that Congress finally agreed to it was because we thought that settled it. At least I certainly did. But apparently not as far as the administration was concerned.

Now I see the President's budget calling for approximately $25 billion in additional cuts over the next 5 years. I thought we had a deal. But apparently the administration does not agree.

Frankly, I doubt you are very enthusiastic about those additional cuts and I will not ask you to get into that in great detail. But I do want to talk about some of those things the administration is proposing in its budget—a list of cuts in many instances that I think probably neither of us think will be accomplished.

I would like to talk about the positive major proposals and your recommendations for changes in Federal financing of graduate medical education—infant mortality initiatives, placement of children in foster care. In addition, I would like to know more about the administration's plans for implementing an income-related premium. I will look forward to your testimony.

I now yield to Senator Packwood first for any comments he has.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, thank you.

Mr. Secretary, I apologize. I am going to have to go to the Commerce Committee where we are marking up the automobile mileage standard bill this morning, which if it passes and is effective, it will certainly help the environment in this country.

I will not comment on the Medicare proposals you have. This committee, this Congress, this government has tried every year since Medicare has passed to try to find a way to restrain costs. We have, by and large, been unsuccessful at whatever we've tried. We tell a doctor we are going to pay you $75 instead of $100 a test; the doctor does two tests and now we pay the doctor $150. I do not envy your job.

I understand the agreement we made last year. If there is more than can be rung out of Medicare fairly, that is worth considering. I like your means test. I see no reason why people who make $125,000 a year should not pay a bit more for their Part B premium than somebody who makes $10,000 a year in retirement.

But the particular issue I want to talk about is the Social Security earnings limit. Because every now and then you get a letter that really hits it on the nose. I want to read this letter:

Dear Senator Packwood: I really appreciate the efforts being made in trying to solve the problem I found disturbing. I have been working at the Dairy Queen for many years and I am still employed. I just entered the Social Security age group and I am very grateful for it.

But I find it troublesome having to count every hour I work so I can be productive all year long. I have voluntarily cut back my hours, but there are people who call in sick or extra help is needed.

I am in good health and I really enjoy my job. I have never made very much, but even going over the limit by perhaps a few hundred dollars and then having to pay half of it back does not make much sense.

Thank you again and I hope your bill to raise this limit is effective soon.

Sincerely,

NORMA PURDY.

Senator PACKWOOD. This is the kind of person that is affected by the Social Security earnings limits. The argument is always made that it is millionaires and zillionaires. It is people that are making $9,000, $10,000, $11,000 a year and are willing to work 20 hours a week and they are healthy.

I hope that not only will the administration's proposal be adopted but the proposal that has been introduced by Senator Dole and myself and dozens of others in the Senate and on both sides of this committee is adopted, so that people who have retired are not discouraged from working at a time when we frankly need them in the labor force.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moynihan?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I am sure we all want to hear Dr. Sullivan. I know that both of you may have to get off to that Commerce Committee. I look forward to the testimony, sir.

The CHAIRMAN. Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Mr. Chairman, I have several concerns about the proposal from the administration. My first concern is with the Medicare proposals. Last year we achieved substantial savings in the Medicare program in the Budget Reconciliation Act. I think that many who were more or less parties to that agreement believed that we would leave the Medicare program alone for a time.

The President's budget is asking us to take about $2.9 billion out for fiscal year 1991 and then, of course, cumulatively, $25 billion over the next 5 years. The 5-year total is fully half of what Congress achieved last year in the budget reconciliation legislation after months of very difficult discussions.

Much of this comes from teaching hospitals. So those of us with major teaching facilities in our States are going to have to take a very hard look at that proposal.

I also have concerned, Mr. Chairman, about proposals to reallocate and redirect funds from the maternal and child health care program and the community and migrant health programs to 10 sites around the country.

While I very much appreciate what the proposal is trying to accomplish, I am unable to forget that we have serious maternal and child health care and infant mortality problems in my State.

Recently the Director of the Iowa Department of Public Health wrote to me that the numbers of low income children seen in child health programs funded with block grant monies has increased 35 percent from 1987 to 1990, while the actual Federal funds available for child health have decreased by 8 percent.

The number of pregnant women using maternal health services has increased by 59 percent, while funding has increased only 20 percent. Most of the increase in funding as been, of course, from State Government.

I have had the Iowa Community Health Center Directors in my office already, expressing concerns about the reduction in their budget that implementation of this proposal could cause. I suppose, Mr. Chairman, I could go on and on, but I will not. But I do want to present to the committee and also take this opportunity to present to the Secretary for his information that, even on this side of the aisle, some of us have some concerns about this proposal.

The CHAIRMAN. Thank you for your comments, Senator.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, I appreciate your coming here today and giving us the administration's view on its budget request. As you might anticipate many of us have great difficulty in agreeing to Medicare budget cuts that significantly hurt and cut into rural health care even more.

I appreciate the progress we have made in rural health care, but I must say that it is a bit disappointing when we come here again and go over this same problem again trying to make sure that rural health care is not unfairly hurt.

What I am really getting at is this. This is a little bit of deja vu here. I get the sense we are kind of working around the edges. That we are not really hitting the core of the problem here in America. I think you will agree that more and more Americans, whether consumers or providers, are beginning to think that our Nation's health care system is so flawed it is going to need some fundamental reform.

Now we have made some reforms already. The physician payment reform, I think, is an area that is helpful. But one-third of the counties in Montana have no doctors—we have 56 counties in my State and one-third have no physicians. In addition, a third of the deliveries in my State are Medicaid deliveries and where Medicaid pays roughly half of the cost of delivery. There are many, many communities in my State which just have no obstetricians. There are no doctors there to deliver babies.

Women have to drive many miles—sometimes hundreds of miles—to give birth in safety.

Now the situation is so acute that the Montana State Legislature has just passed a resolution calling for a single-payor health care

system. Montana is very intrigued with the Canadian system, very intrigued. We are on the Canadian border. We hear a lot from Canadians. They like their health care system.

So I urge you in the administration because life is short—we are only here on this earth for a certain number of years—to get on with it, to get to the heart of the matter. There are many proposals to reform our Nation's health care system. I urge you to work more aggressively than you already are during your term as Secretary to be sure that we finally get on the road to establishing a good solid universal health care system in this country.

The CHAIRMAN. Thank you.

Senator Pryor?

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Yes, Mr. Chairman. I would like to ask your permission to include my full statement in the record.

The CHAIRMAN. That will be done.

Senator PRYOR. Mr. Chairman, I just have a couple of observations. I am going to have to leave and perhaps I can return after awhile. But a couple of observations while Secretary Sullivan is here relate to prescription drugs and to the law that we passed last year on trying to get a fairer price for the Medicaid programs in the prescription drug arena.

Since the passage of that law the pharmaceutical manufacturers have attempted to circumvent this law. They have attempted to raise the prices on the Department of Defense. They have raised the prices and cancelled contracts with the Department of Veteran Affairs.

It is my opinion, my strong opinion, that last year we sent as strong a message as we could to the pharmaceutical manufacturers. They are continuing to raise prescription drugs at three times, three times, the rate of inflation. And I am just absolutely astounded at their insensitivity to what the Congress said and also I would just say the arrogance by which they do it.

After awhile I hope we will have a chance to have a little exchange on this to see what the administration will propose.

Thank you, Dr. Sullivan.

Thank you, Mr. Chairman.

[The prepared statement of Senator Pryor appears in the appendix.]

The CHAIRMAN. Senator Heinz?

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, I want to join in welcoming Secretary Sullivan back to the Finance Committee. There are several issues, Lou, that I will want to address to you during our discussion. The principal ones involve some more attention, first to children and second to senior citizens.

I would, Mr. Chairman, simply ask that the balance of my statement be put in the record at this point.

The CHAIRMAN. That will be done. Thank you.

Dr. Sullivan, if you would proceed.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SULLIVAN. Thank you very much, Mr. Chairman and members of the committee.

I am pleased to be here with you again today to discuss our priorities for fiscal year 1992 for the Department of Health and Human Services. I look forward to working with all of you and the other members of the Congress in forging a budget which meets the diverse needs of our citizens.

A fundamental objective of our Department is strengthening the American family. Today I would like to address some of the concerns of the American family and some of the proposals in our budget that are directed to those concerns. Our families are our most important and vital institutions in our society because it is in our families where our future is shaped, our values are learned. We learn the difference between right and wrong and what loyalty and fidelity mean.

I was recently reminded of the centrality of the family when at the request of the President I visited some eight nations in Africa in January to assess the catastrophic rates of illness and mortality on that continent. In many countries the family structure has been completely shattered, shattered by disease and by despair.

Until the family structure is reinforced and reinvigorated in those countries, solutions to the problems facing that continent will remain elusive.

Upon my return I told the President that we must do more to broaden our support for Africa. But a reading of our morning papers reminds us that the problems of family dissolution, of breakdown and disrepair afflict many Americans here at home. And just as in Africa the tragic victims of family dysfunction are our children.

In no country can government replace the family. Our job as public officials is to help ensure that an environment exists in which the family flourishes. A primary purpose of our families is to raise the next generation, our children. I am particularly proud that the administration's budget commits resources to programs that help provide children with a healthy start and a head start on life.

Now some of these programs are not under this committee's jurisdiction. But each of these programs is important in helping families provide a better future for their children. The care that is given before birth will shape a child's development. As a society, we must work to ensure that each child has a healthy start in life.

While the rate of infant mortality has declined modestly in our country each year, I am outraged at the continuing shockingly high level, particularly in our minority communities. As you well know, in the black community the infant mortality rate is twice that of the white community. And compared with other nations, we do not do very well. We are outdone by 23 other nations who have lower rates of infant mortality.

But last year we devoted more than $5 billion for infant and child health services and research. This is expected to increase to $5.5 billion in 1992. And within this total the Department will target $171 million on communities where the infant mortality is extremely high.

This initiative will organize and develop community oriented programs which will reduce barriers to appropriate prenatal and perinatal care for pregnant women an children; and it will reduce an unacceptably high level of infant mortality.

Also, the 1992 budget projects an additional $350 million to be spent on low-income pregnant women as a result of the recent Medicaid eligibility expansions. Unfortunately, far too many children start life at a disadvantage because their parents are caught in a cycle of dependency or drug abuse.

Fortunately, though, we have forged a consensus, with this Committee playing a major role, about what we need to do to fight dependency and to move our families toward self-sufficiency.

Increasingly it is being recognized that the true measure of our success is not how many people we can put on the welfare roles, but rather how many people we can move out from under the cloud of despair and dependency into the sunshine of financial and social independence.

The new anti-poverty consensus is embodied in the Family Support Act. The act and its provisions in the job opportunities and basic skills training program or JOBS, these represent a watershed in our thinking on welfare and on dependency.

We recognized in the law that education, job training, work experience, child care and child support were all interrelated variables in our efforts to end welfare dependency.

I am pleased to report to you that all of our States are now operating the JOBS Program. We will spend $867 million to support current Aid to Families With Dependent Children in our recipients' efforts to participate in JOBS activities.

Complimenting the efforts of the JOBS Program is Headstart, a program to which this administration has demonstrated an unparallel commitment. And although it is not under the jurisdiction of this committee, I believe that it is a model Federal program, a program that truly works.

We want to help create an environment where parents find that the JOBS Program and Headstart are complimentary services that make self-sufficiency possible. To that end, we have entered into an agreement with the Nation's JOBS Program to develop local model partnerships between Headstart and county welfare offices.

Our budget calls for an increase of $100 million for the Headstart Program, which will allow us to expand services to over 30,000 additional children, thus reaching a total of more than 633,000 children. This represents an increase of over 180,000 children since President Bush and I came into office.

At the same time efforts in 1992 will be devoted to assuring consolidation and improvement of the gains achieved over the past 2 years by properly managing the large infusion of funds for the program received in 1990 and 1991.

As members of this committee are acutely aware, the drug epidemic has had a devastating impact upon far too many families

and children. State welfare agencies, foster care and adoption assistance programs assist dysfunctional families and create homes for many of our Nation's children.

My first priority is to keep families together, which is why we are requesting an increase of $90 million for child welfare services. This new money will allow States to focus on preventive services, to strengthen families and help children who are suffering as a result of parental substance abuse. Hopefully, with more home-based family services, we can prevent children from being placed in foster care.

At the same time we recognize that some children will need to enter foster care and we will continue to fully fund the maintenance payments for foster care families. Any family, indeed any society, has a deep concern that its older citizens can have a life of economic and social dignity.

One of my primary objectives as Secretary is to ensure the continuing fiscal integrity of Social Security and Medicare. Social Security outlays—almost 55 percent of total departmental spending—will increase by $19 billion over fiscal year 1991 because of 560,000 new beneficiaries and an estimated 5.2 percent cost-of-living adjustment.

In all, the Social Security Administration's funds will provide cash benefits to over 42 million citizens in 1992. We are proposing to modify the retirement earnings test for Social Security. The modification will provide an incentive for older Americans to continue the valuable contributions they make in the workplace without penalty to their monthly Social Security check.

An issue of concern to American families and to this committee is improving our Nation's health delivery system. As you are aware, the President asked me to lead a review of recommendations on the quality, accessibility and cost of our health care system, and to suggest to him ideas for improvement.

While we move to reform our health care system, experience dictates that we should not act rashly. I believe that an invaluable lesson learned of past efforts in health care reform is that it is critical to inform the American people about reform options and to build a consensus about what needs to be done.

One principle that we can agree on is that every American should have access to needed medical care. Logic and realism tell me that the answer to improved access has to rely in Federal, State and local programs targeted to the needs of the poor, in refined priorities, favoring access and delivery, in consensus development and coalition building around the effective integration of services and management of care and in a growing partnership among citizens, taxpayers and providers. Hard decisions and compromises will be required of all of us.

Our budget proposals move us in this direction. They do so in part by proposing to extend flexible resources to the States, in part by helping to fill current gaps; and in part by making a first move toward increased responsibility for the wealthy to pay more of their own way.

A moment on this latter point. Under current law all taxpayers subsidize physician services under Medicare. These subsidies

amount to 75 cents on the dollar for everyone over the age of 65 who voluntarily enrolls in Part B of Medicare.

So regardless of their individual circumstances and income, anyone enrolled only pays 25 cents on every dollar of Medicare cost. Now this seems neither sensible nor necessary and it is certainly not equitable to taxpayers.

We are proposing, therefore, that those Medicare beneficiaries whose adjusted gross incomes exceed $125,000 for an individual or $150,000 for a couple no longer be so greatly subsidized, that the subsidy be reduced from 75 percent to 25 percent. Those with very high income will have to pay more for Medicare. That is not unreasonable, nor unfair.

More importantly, it frees more public resources for uses where they are needed, namely for those who simply cannot pay for access to care. Our administration is clearly committed to improving access to care.

For example, our important infant mortality initiative. But while the Federal Government can help and has a real role to play, the problem cannot be solved simply by the Federal Government writing a check. We must find innovative solutions that combine the best efforts of the public and the private sectors, while we take a back seat to no one in recognizing that government must play a role in helping our families.

I also strongly believe that as a society we must reinforce basic values, for values have consequences.

I have spoken around the country for the past 2 years about the need for a culture of character. By that I mean individuals have responsibilities as well as rights. Americans must cultivate values like self-discipline, integrity, moderation and a commitment to serving others.

We must reinvigorate and shore up institutions that teach and nurture values and principals of healthy behavior, especially the institutions of family and community. Regardless of how much money we spend on social programs, our safety net will be weak unless our moral fiber is strong.

I am particularly outraged about the carnage on the streets of many of our cities with our young people, in some cases very young people being the victims. Often they are murdered as a result of a drug deal gone bad or over a coveted sports jacket.

It is ironic that some of our youth were indeed safer in the midst of a battle on the sands of Kuwait than they are in the war raging on the streets of our cities. All of us have heard recently about a specific instance of a soldier in Detroit, having just returned, being gunned down by someone robbing him to take his car.

We must not avert our eyes from this tragedy. Yes, we need social programs and tough law enforcement. But just as important, we need parents spending time with their children. We need our neighbors in our communities concerned about what Johnny is doing down the street. We need communities that care. We need, in short, to be more committed to our children's health and welfare.

As has been said, State craft is sole craft. The programs that we initiate will affect the character of our citizens. Therefore, we should promote self-sufficiency and resist dependency. We should empower our families and our communities, rather than bureauc-

racies, and we must exhort individuals to take responsibility for their behavior.

Headstart, the Family Support Act, and the recently passed child care legislation are but three examples that embody those principles. And our guiding principal should be that which I recited when I first became a physician. First, do no harm.

Thank you, Mr. Chairman, for the opportunity to address these important concerns. I look forward to continuing to work with you and the members of this committee to fashion a budget responsive to those citizens most in need.

Thank you.

[The prepared statement of Secretary Sullivan appears in the appendix.]

The CHAIRMAN. Mr. Secretary, I have been reading the reviews on some of your speeches and some of your preaching. I think it is long overdue. You are in a unique position to have extraordinary influence in that regard. I am talking about the value of the family and what can be done there and the disintegration of family support in this country with 14 and 15 year olds having children, and the limitations and disadvantages to such a child.

Drug abuse, not enough programs to warn those young mothers of those concerns; and what it does to that child, often having a child born with physical and sometimes mental limitations.

I sincerely and strongly agree with what you are saying in that regard. But I think the foster care system in this country is in as troubled a state as you do. That is one of the reasons we introduced S. 4, to try to give counseling to these young mothers, to let them understand the problems of drug abuse and what they are doing to that child they are carrying, and what they are doing to their own lives.

Just as you, we are trying to not take care of the problem after they are in the foster home, but to keep them from going into that foster home if we can. I understand that the administration and some of my colleagues do not totally agree with S. 4 that I have introduced. But that is much of the thrust of it. I would be delighted to hear what you think we should do in addition to that, and your reaction to S. 4.

Secretary SULLIVAN. Thank you, Mr. Chairman.

We certainly are very much interested in your bill. I do believe that there are many things that we agree on, that we certainly can work together with you and this committee in fashioning a better approach to foster care. We certainly do look forward to the opportunity of working with you towards that end.

The CHAIRMAN. Well, we have seen foster care rolls increase by a third in the last 3 years; and in some States as much as 50 and 100 percent. So it is an increasingly difficult problem.

Let us talk for just a minute about preventive health care services. You have a longstanding commitment to that and I commend you for the thrust of the initiatives that you have included in the present budget. But, you know, Medicare normally does not include preventive service.

If we had to legislate it bit by bit as we are doing, it is going to take a long time, I think, to get the job done. We established a number of demonstration projects to test the cost effectiveness of

various types of preventive care, such as influenza vaccine. I would like for you to comment on the status of those demonstration projects.

Secretary SULLIVAN. Yes, Mr. Chairman.

Those projects are still underway. I believe the first one will be completed in 1993 and we are following that very closely. The other is scheduled to be completed in 1995. So it is too soon for us to have definitive responses or data yet on that.

But we are firmly committed to those demonstrations and, indeed, as you have stated, I am firmly committed to a broader prevention, health promotion effort because we have increasing data from a variety of sources that prevention not only saves dollars but keeps our citizens healthier, self-sufficient and active. So we are committed to that.

As you know, we, last August, announced our health goals for the Nation for the year 2000 in our document, "Healthy People 2000." But we certainly will keep you informed of the results of the demonstrations that are underway now.

The CHAIRMAN. Mr. Secretary, in your reference to an income-related premium, we have been down that road in this committee and we have been down that road with you. We tried that with catastrophic illness at the recommendation of the administration. I thought it was a good one. But I bear all the scars of fighting that fight. And so it was reversed, largely because it was income-related.

I also understand that what you're talking about is not using the income tax return for that $125,000 for the single person, or what was it $150,000 for a couple, something on that order. But to have their statement as to what qualifies them, what is their income.

How do you determine what that income is? What if you have someone that includes in that the sale of an asset, the sale of a home? Is it a gross income? Is it a net income? It seems to me that's awfully soft and you have a great deal of subjective judgment, particularly by lay people who would not know how a CPA or their tax attorney would rate that.

What do you do about the auditing of it? How about people that understate it to try to avoid the increased premium? I think you can have a great many problems in its administration. I would like to get your reaction to it.

I might say one other thing, too, as I recall that fight last summer on that budget. I can recall about midnight one night one of the administration's negotiators stating that they wanted to go to income-related and that they would save some, as I recall, $24 billion by doing it. And some of us said, that is very interesting, let us get the detail of it. And the next morning that same person came back and said, well, no, it is closer to $1.5 billion.

Now, do you want to tell me about it? [Laughter.]

Secretary SULLIVAN. Yes, Mr. Chairman.

Let me say this, I think that is an example that there should be a limit to the amount of hours spent in hard negotiations. [Laughter.]

The CHAIRMAN. I would have voted that way at that time, I should say.

Secretary SULLIVAN. All kinds of fuzzy things come out after a certain time. But as you know, Mr. Chairman, one of the first

things I confronted after I was sworn in as Secretary was the same battle on the catastrophic insurance. As you know, I stated then that I felt we should not repeal that.

I stated that if we repeal the law we still do not repeal the need.

The CHAIRMAN. Mr. Secretary, you are hanging in there pretty well. I can recall that. But there were forces that were overruling you finally.

Secretary SULLIVAN. Yes.

So, indeed, we did not prevail on that. But I believe that this is different. I think this is a different time for several reasons. First of all, what we are pointing out here in proposing this is that every taxpayer earning $15,000, $20,000, $25,000 is subsidizing 75 percent of the Medicare costs for individuals earning $125,000.

What we are proposing is not a complete elimination of that subsidy, but really a reduction, so that it would be subsidized only 25 percent. So high income individuals still would be subsidized by the general taxpayer; and I think we need to stress that to our citizens. That in the name of fairness, why should someone earning $20,000 a year have to subsidize someone earning $125,000 or more.

The other difference with catastrophic is this: the premiums of wealthy individuals were increased without any added benefit.

But in this proposal, individuals certainly have the benefits, but those benefits are being paid for by the general taxpayer who is generally less affluent. It would still be a good bargain for affluent citizens, even with the changes that we propose.

So we are proposing this from two standpoints. One is, it is more equitable. And, it would help us to have a more rational system, so that those who are more affluent would pay more.

On the issue of the sale of assets, I think those and other details we would want to work out. But our general concept has been really the annual projected income of an individual, rather than the sale of, or what I would consider in one sense as a transfer of an asset to a liquid form.

But I think those details we would want to work on with this Committee and with our HCFA administrators so that we could iron out those kinds of questions beforehand.

So I do believe that if the American public understands this, they will support it, in contrast to the experience we had with the catastrophic insurance.

The CHAIRMAN. Well, Mr. Secretary, as a tax accountant you are a very good doctor. [Laughter.]

Senator Moynihan?

Senator MOYNIHAN. Mr. Secretary, I think I have known every Secretary of Health and Education and Welfare and Health and Human Services since Arthur Flemming was Secretary under President Eisenhower. I would simply say that this is the most extraordinary testimony we have ever heard.

It will remain for the historians to record it, but you made history. We finally heard from a Cabinet member directly responsible for the subject that the central, social problem facing our country is the condition of our families, a new condition.

It did not exist 25 years ago at the time of the Great Society. It did not exist 50 years ago at the time of the New Deal. It is new. It is absolutely central. I mean I think you would agree as a doctor

that up until a certain age is passed, the preponderance of health problems today are behavioral in their origin.

Would you not say that, Doctor?

Secretary SULLIVAN. Oh, very definitely.

Each of the top 10 causes of death in our society—every last one of them—is significantly influenced by personal behavior and lifestyle, and we have the data to show that.

Senator MOYNIHAN. Would you send that over at your convenience, the top 10 health problems that are all significantly affected by behavior? That is the thanks you get for having gotten rid of typhoid.

Secretary SULLIVAN. Yes, I would be happy to send that over to you, Senator Moynihan.

[The information follows:]

PREVENTABLE RISK FACTORS FOR THE LEADING CAUSES OF DEATH*

Cause of Death	Risk Factors
Heart Disease	Smoking, high blood pressure; elevated serum cholesterol; improper diet (excess fat, sodium); obesity, lack of exercise; diabetes; coronary prone behavior
Cancers	Smoking, improper diet, alcohol, infectious agents; workplace hazards; ionizing radiation, solar radiation, environmental pollution; medications
Stroke	Smoking, high blood pressure; improper diet; elevated serum cholesterol, alcohol
Unintended Injuries	
• Not including motor vehicle-related	Alcohol, smoking (fires) product design, home hazards, handgun availability
• Motor-vehicle-related	Alcohol, nonuse of safety restraints, speed, automobile design; roadway design
Chronic Lung Disease	Smoking, workplace hazards, environmental pollution
Influenza and Pneumonia	Vaccination status; smoking
Diabetes	Obesity (for adult on-set)
Cirrhosis of Liver	Alcohol
Suicide	Alcohol and drug misuse, handgun availability, uncontrolled depression, stress
Homicide	Alcohol and drug abuse; handgun availability, and stress

*J M McGinnis, A D Mickalide, A E Barnato "Major Health Issues Facing Families in the '90s The Vital Role of Patient Education", ***Papers from the 11th Annual Conference on Patient Education,*** November 16-19, 1989, Orlando, Florida, pp 1-16 American Academy of Family Physicians, 1990

Senator MOYNIHAN. Now this was extraordinary. We have been trying to deal with this in our committee, trying to tease it out. We are trying to measure it. We think that, as a rule, you never do anything about a problem until you learn to measure it; and there's another rule that you never learn to measure a problem until you decide to do something about it, and you can take your choice.

But Secretaries Barnhart and Gerry have been here talking about our trying to produce some social measurements of dependency of the kind you describe. We do have an early longitudinal reading, sir, which would, I think, give you a sense of what we know, a numerical sense.

We can tell about the life time experience of dependence on AFDC for the cohort of children born 1967 to 1969. This comes out of the Michigan Panel Study of Income Dynamics which OEO funded in 1966. We now have about 25 years. Of the children born

in those 3 years, 22 percent were on welfare before age 18; 72 percent of all black children.

Now we can take that cohort forward by using 0 to 7, as we don't have 18 years for anybody born in the 1980's. It takes a big jump, such that in thc 1970's, from 0 to 7, you already have 22 percent of all children. By the 1980's it is about 23 percent. But it looks to be stable. It looks to be sort of asymptotic. If you project 18 years, you get about 30 to 31 percent of all children are on AFDC before age 18.

That means that after public schools, the program you administer has more impact on children than any other program.

Would you want to comment on that? And having asked you to comment, I will now comment. We think we are into something post-industrial. We think the measurements that we developed for the industrial age—employment, wages, occupational safety—do not get this; and we would hope to produce something like a regular report out of your Department.

You know about these. I wonder if I could ask you to comment on them.

Secretary SULLIVAN. Yes, Senator Moynihan.

We are very interested in that index and we are very pleased to have our staff working with you and other members of this committee in looking at this, because we are concerned about what is happening to our society, what do these indices mean, what prediction value do they have, what strategies can we develop to modify this or to improve the future prospects for these children.

So, clearly, we are interested in working with you and the other members of this committee on this.

Senator MOYNIHAN. Well, I am obviously happy to hear that and we expected to hear it because your associates have been so helpful.

May I say we do think we begin to spot what we think might be some leading indicators, just like you as physicians know there are precursors to disease that you can sometimes learn about. If it takes us a long time, then let us get started right away. Would you not agree?

Again, sir, there has not been such testimony in the history of this committee. I hope you know that and that somebody else tells you besides me. The Chairman said as much.

Thank you.

Secretary SULLIVAN. Thank you very much, Senator Moynihan. As you know, I have stated many times that the first priority of the Department of Health and Human Services is the family. We have some 250 programs in my Department. As you look at those programs and see what they are designed to do so often they are designed to substitute for the family or to make up for some family disruption.

While those programs are necessary and we are committed to them, it is very clear that if we are able to keep the family strong there will be less need for those programs. The ultimate outcome in terms of the development of our children into productive, self-sufficient adults would be greater if we have a strong family structure.

So we are committed to working with you and others on these indices.

Senator MOYNIHAN. Thank you, Doctor.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

Mr. Secretary, I would like to turn attention to your coordinated care initiative. In this instance does that term basically mean involving risk-sharing HMO's and other PPO type organizations?

Secretary SULLIVAN. Yes. It means having those kinds of organizations that really have the purpose of seeing that care is comprehensive, that it includes appropriate followup services, that it includes preventive services, and it also is an effort to control costs, to make sure that services that are provided are appropriate and that appropriate preventive measures are undertaken as well.

Senator GRASSLEY. I would like to refer to a recent Aging Committee meeting that your Department was represented at. You were not there. It seemed to show at this hearing that there were quality assurance problems in the risk sharing HMO programs.

So, that brings me to my question to you as the head of the Department, which is: how are you going to ensure that there is quality of care in this new program? I think that there was a general feeling expressed that there had been problems, but maybe they had been taken care of. I do not think that the Aging Committee shared that. So I have that concern about this part of your initiative.

Secretary SULLIVAN. Yes, Senator Grassley, we are concerned about the reports, the audits, that have been done. I believe that you will find that we are concerned about some of the findings; and there are a number of things that we are doing to make sure that the program works well.

First of all, we reorganized our Office of Prepaid Health Care to address the oversight function more effectively. With some of the things that have occurred in the past, we have learned from them. We readily admit that there have been problems. But we believe that with a stronger oversight of these programs, we will be having a better performance from them.

Senator GRASSLEY. Okay.

There is a feeling that maybe those proposals could be a little bit better. I am not going to argue that with you at this point. But at the very best it is going to take some time to accomplish the results that you seek.

So I guess that I ask you to take those points of view into consideration as you think of this initiative from your Department.

On another point on the proposal dealing with infant mortality, and I share your concern, but I do have some additional concerns about the proposal for maternal and child health care block grants. Even in States that are considered rural we have problems. In Iowa, as I said in my statement, Des Moines tends to have a problem.

Furthermore, my State is having increasing difficulty in serving those dependent upon maternal and child health care program. The Director of the Iowa Department of Health tells me that the number of low-income children seen in child health programs

which draw on the maternal and child health program has increased 35 percent, while Federal funds have decreased 8 percent.

So I am concerned with the potential impact that the shift of the current appropriations will have on the community health centers in my State and on the Iowa programs funded by the maternal child health block grant.

Can you tell me how these Iowa programs may be affected by your proposal? Is it possible that these programs will receive less than originally appropriated for the current year? If so, would you have any idea of the magnitude?

Secretary SULLIVAN. Well, Senator Grassley, as I noted in my opening remarks, we have a major problem in the United States with infant mortality rates.

What is bothersome is not only that we rank 24th among nations of the world, but that we do that in spite of having the highest per capita expenditure for health care. As I noted in my opening statement, we are spending some $5 billion now for infant and child health and welfare services. That will go up by half a billion if our budget is approved.

But what all of this says is that in spite of this great expenditure, there are still problems with what we are doing or how we are doing it. So the effort that we propose is to give a concentrated effort in some 10 demonstration projects to find better ways of delivering services so that we will be more effective.

That will include, by the way, not only urban areas, but rural areas among those demonstration projects.

How we propose to fund it is as follows: For fiscal year 1992 we propose an increase of $105 million in new monies, and to have monies that are reprogrammed for several areas, including maternal and child health, the National Health Service Corps and community health centers.

Those dollars will still be spent in those programs, but they would be focused on the infant mortality initiative. Now it does mean that for these 5 years that the demonstration project would operate, some community health centers would get greater funding if they are in the demonstration project, while others would have level funding.

We are not decreasing the funding of the centers, but rather taking the proposed increased funding in the program to focus that on infant mortality.

Now I am aware of the fact that this has created quite a bit of discussion and disagreement. But from my perspective, I am concerned about the infant mortality level of the whole Nation. We need to find answers regarding how we can better deliver services to bring the infant mortality level down. And if we are successful in that, then everyone will benefit—not only those 10 demonstration centers, but all 550 of our community health centers, all 5,000 of our hospitals, all 550,000 of our physicians, et cetera. So while I know that there are immediate concerns that have been expressed by some specific health centers about their budget, they in the long run, will be better off like the rest of us if we are allowed to move forward with this demonstration.

Now I am also aware that the House has appropriated $25 million in their supplemental appropriation, and I believe a similar

measure is moving through the Senate now. Certainly that would help with our effort to get started on the demonstration this year.

But we need a total of $57 million this year for an early start on this program. Under the budget agreement that the Congress and the President agreed to last year, all of us are constrained in trying to find dollars for major problems. This is a major priority, and we have had to decide how to order our priorities.

It does not mean that we are not committed to our community health centers or our maternal and child health programs. Those are important. But I think that what is overriding is a problem that sticks up like a sore thumb, that we're not doing well on. So that is the reason for the demonstration. But in the final analysis, if there are ways found to give us $57 million this year, that we are proposing to get by reprogramming, without running into the budget ceilings we will take that. But this is the way we have proposed to do it.

But if there is a better way we would certainly accept that.

The CHAIRMAN. Thank you, Doctor.

Senator Heinz?

Senator HEINZ. Mr. Chairman, thank you very much.

Mr. Secretary, I note with considerable interest and some slightly constrained degree of pleasure that the President's budget contains a temporary increase in the Social Security earnings test. My enthusiasm is constrained because it is temporary.

I have long believed, and I think this goes for Senator Dole and Senator Packwood, who made a reference to this in his opening statement that our present policy on the Social Security earnings test where in effect Social Security benefits are literally taken away $1 for every $3 of earnings, really represent a direct contradiction of the work ethic that our Nation believes in.

At the same time what we're sanctioning is age discrimination. It amounts to nothing less than, in my judgment at least, a callous, unfeeling, short-sighted, unfair punishment for millions of Americans who want to continue to work for reasons of either mental or physical health to supplement their income. Yet we single them out for very special, specific punishment through the earnings test. In effect, it is a form of taxation.

I am delighted that the administration seems to recognize this. But since it is a temporary increase, because you end up back at current law within 3 years, I want to ask you, does this mean that the administration recognizes that as a matter of principal the earnings test is indeed an unfair tax that discourages older Americans from continuing to work and that the administration does indeed support the principal, even if phased in over a number of years, of the elimination of this discriminatory earnings test?

Secretary SULLIVAN. Well, thank you, Senator Heinz.

As you know the cap on earnings is something that has been around for a long time. And, indeed, we are a different society now in that a larger percentage of our citizens are not only living longer, but also being very productive and very active in their senior years. At the same time, they have financial constraints under which they are living.

We are interested in finding ways that we can address this and this is one such way. This is what we propose within the budget

ceiling that we have. So clearly I think the principal here is that our seniors can be productive and can earn. This is a recognition of that.

At the same time we are operating under constraints as to the extent to which we can propose a modification of that.

Senator HEINZ. Would it be a fair characterization to say that what you are saying is, you do feel that the earnings test, certainly at anything close to current levels, is unfair and discriminatory, and that you would like to raise the limit as much as you possibly can, but you are constrained by the budget from doing so? Would that be a fair characterization of what you just said?

Secretary SULLIVAN. Yes. I think that is a fair characterization. We obviously operate with a number of competing vectors here. We propose to make sure that they have as minimal negative impact as possible in terms of our budget.

But, yes, we are saying that the rules here concerning the cap on earnings really was enacted a number of years ago and we really do have a different society now and it is going to be even more dramatic in future years. So we would like to see how this works and see if we can find ways to help address this problem.

Senator HEINZ. Mr. Secretary, I commend you on a start. It is a model start. We would like to work with you to see that it does indeed accomplish the goal we think we both agree on.

A very quick question as I see an orange light out of the corner of my eye. The administration has proposed that Medicare beneficiaries who have incomes over a certain amount, as I recollect it is around $135,000, would pay a higher share of their Part B premium that comes out of general revenues.

My question is: Does the administration propose to apply what you might call any of the savings from doing that to reach out to the poorest senior citizens who are Medicare beneficiaries, that is to say the 85 percent of qualified Medicare beneficiaries who are eligible for Medicaid, but who do not receive it at all right now?

Secretary SULLIVAN. Yes. We think this is one measure that can be helpful in that regard. I stated a few minutes ago that our first principal is to try to have a system that is fairer and more equitable. Because with the subsidy that presently exists of 75 percent of the Medicare premium from the general taxpayer, it means that the worker earning $20,000 a year is helping to support the costs for individuals earning $125,000 a year or greater.

Senator HEINZ. Just to clarify the question, if you want to answer it for the record because my time has expired, my question was: Do you intend to apply the savings from high premiums for those with income over $135,000 to reaching out to improve our affective inclusion of the qualified Medicare beneficiaries? These are typically the poorest of the poor elderly who under the 1988 catastrophic coverage age, a small portion of which we left in tact, namely extending Medicaid to these very poor elderly, and only one in seven or eight of whom are currently receiving the benefits as QMB's—qualified Medicare beneficiaries—do you have a program to improve that performance of actually helping them receive those benefits?

Just if you could answer that for the record.

The CHAIRMAN. If you would answer that for the record.

Secretary SULLIVAN. Fine.

The CHAIRMAN. If you would send us a statement on that.

[The information follows:]

Our purpose in proposing to relate Medicare Part B premiums to income is to make the financing of Medicare more fair and to reduce the subsidy for high-income people. It is too early to speculate about using Medicare savings for additional benefits; we have to keep in mind the importance of the budget deficit. However, the budget agreement does permit savings to be redirected into other areas if the Congress chooses.

The CHAIRMAN. Thank you.

Senator Pryor?

Senator PRYOR. Thank you, Mr. Chairman.

Dr. Sullivan, I have read your oral and your written statement that you have submitted this morning. I would like to first comment that I see a total absence about any mention of prescription drugs. Prescription drugs for three out of four elderly people in this country today is a representation of the highest out-of-pocket medical cost that they have. There is no mention of prescription drugs, and the spiralling cost of prescription drugs in your statement.

Let me also state, if I might, that just in the past several weeks—I'll just cite a couple of examples. DuPont Merck, they manufacture Percocet and Percodan. They have raised their prices, this manufacturer, to the Department of Veterans Affairs and to the Department of Defense, from a cost of $5.11 a bottle to $47.60 a bottle.

Now that is an increase of 832 percent—an 832 percent increase in these two drugs

The Upjohn Co. has just notified the Veterans Administration people that they are going to totally eliminate the low prices for Halcion, Xanax and Ansaid, drugs that are used as pain relievers and tranquilizers.

Smith, Kline, Beechman, they just notified all the agencies that Tagamet has now been raised from $16.92 a bottle to $34.29 a bottle, a 100-percent increase in prices. It goes on and on and on; and the manufacturers today are totally going to circumvent the law that we passed last fall and made it a part of reconciliation.

Now it appears to me that there is only one sector, only one part of the health industry, as we might call it today, that is totally immune. They have a total immunity from any cost containment. We have the hospitals, and the HMO's, and the clinics, and the doctors, and the pharmacists and right down the line.

But the pharmaceutical manufacturers today have an immunity and they are not part of cost containment. They have never been a part of cost containment. THe Congress stated its will last October that at least in Medicaid they were going to participate, small as it might be, in cost containment. Today they are circumventing the law.

I wonder if you have a comment about what this administration is going to do about it.

Secretary SULLIVAN. Yes, Senator Pryor, we are concerned about these changes that you have articulated because like you, we share great concern for the high costs of our health care system; and you have heard me speak about this before.

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We want to do everything we can to restrain those costs. I have had already some discussions with Secretary Derwinski about these changes and I intend to also speak with Secretary Cheney to see if the three of us, since we represent a significant part of the market, can work together to try and find some responses to these changes.

But also, I do think that the pharmaceutical companies must be responsible corporate citizens, and I certainly want to look at this to see what things we can do.

When we look at the pharmaceutical industry, and I am not an apologist for them at all, but we have some problems in that we are losing some of our innovation and research capability abroad with some of the restraints that we have placed on our pharmaceutical companies. I mention that simply to say that what we would like to do, is to try to be sure that we get responses, good responses, from our pharmaceutical companies, without compromising the ability for research and innovation to develop new drugs that all of us would be dependent upon for continued improvement in our citizens.

But I am very concerned about that and we will have more specific responses for you once we have had a chance to analyze that.

Senator PRYOR. Dr. Sullivan, I know you have expressed your concern about it, but I want it to go a step further than that.

My time is up. I will get off of my soap box for the moment.

Thank you, Mr. Chairman.

Thank you, Dr. Sullivan.

The CHAIRMAN. Senator, we will come back to you if you would like to ask that. Senator Chafee?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Chairman, I have a statement for the record I would like to submit here if I might. I would just like to read one brief portion of it.

"Our health care system is not the only challenge we face. The status of children in this Nation are worse than ever. The magnitude of these problems—infant mortality, teen pregnancy, violence in the schools, and drugs, to name a few—demands that all sectors of our society respond. These are not just family problems, or just educational problems, or just government problems. We are all affected by these problems and we must all bear the responsibility of developing comprehensive solutions."

[The full statement appears in the appendix.]

Senator CHAFEE. Mr. Secretary, I would like to congratulate you on your efforts to address the multitude of health problems.

I have read that the principal cause of death amongst black youth between the age of 16 and 26 is gun fire.

Am I correct in that?

Secretary SULLIVAN. That is correct. That is the recent study published by our Centers for Disease Control.

Senator CHAFEE. Which is just an absolutely frightening figure. The incident you pointed out of the young man who came back from the Gulf War and was murdered in Detroit points out those problems.

Now I would like to address, if I might, the Part B premium issue that you have raised. Because it seems to me we have to get this in a context. Now I represent constituents who are making $4.50 an hour, living in Central Falls, RI in three deckers, working in the textile industry and the jewelry industry. Their annual incomes average $9,360.

Now from these individuals' taxes goes money to pay for 75 percent of the doctor's bills of millionaires who are basking in retirement in Palm Springs or in Bocca Raton. Am I correct?

Secretary SULLIVAN. That's correct, Mr. Chafee. Rather dramatic.

Senator CHAFEE. Well, it is the truth. Seventy-five percent of the Medicare Part B program costs come from the general treasury. The doctor's bills, of retired millionaires—and they are not basking in Central Falls, RI, I will tell you are being paid out of the general treasury.

So what you are saying is, that is not right; and I agree with you. We can argue about where the cutoff should be, but to me that is not the toughest issue.

My question to you is this: If we make these changes and generate some savings—and indeed, you are not even saying that they should pay 100 percent of the Part B premium, yo: say just 75 percent, my constituent will still continue to subsidize 25 percent of their Part B premium.

Now we are going to generate savings if this proposal is enacted. You say in your statement that those savings will be used to help provide greater access to medical services. Will that be true for children in our society, 10 million of whom are among the 30 to 35 million Americans who have no health insurance. Ten million children in the United States of America have no insurance, and thus limited access.

Are they going to be helped under the savings?

Secretary SULLIVAN. I would certainly anticipate so, Senator Chafee, because our projections are that this would cost approximately $50 million to administer over a 5-year period, but it would save about $1.2 billion. Those are dollars that could be redirected into other areas, including the needs of children. Yes.

Senator CHAFEE. Well, I believe that all the savings should go into the health field. I do not think they should be diverted back into the general fund.

Now on Thursday, I am going to introduce legislation to assure that individuals living in medically undeserved areas have greater access to health care services. What this legislation will do is set up a Part B under the Medicaid program. Those monies will be used not just to entitle individuals to services, but will allow the facilities, namely community health centers to expand their capacity to serve individuals by using these funds to serve additional patients, to recruit and train personnel and for capital expansions as determined by you.

I think that basically what we are trying to do is to expand the capacity of the community health centers and some of the outpatient hospitals facilities. I would like you to take a look at that proposal when it comes along.

Secretary SULLIVAN. I would be very pleased to do that, Senator Chafee.

Senator CHAFEE. Now I just also want to stress—well, there goes my bell. I have another question for you if we get another shot.

The CHAIRMAN. Senator, you go right ahead and ask it. The ways these fellows have been abusing their time limitations, we will let you have some more time.

Senator CHAFEE. Well, I have noted a little abuse around here too in that time business. [Laughter.]

Everybody starts off by saying, I see my time is up, however, and then launches into a question. [Laughter.]

The CHAIRMAN. And then they make a 3-minute speech. But go ahead. [Laughter.]

Senator CHAFEE. That is right.

I think we have to do more to deal with the increase in the number of children who are in foster care or are border babies or who are in need of adoptive homes. I stated in my opening remarks that I believe the most fundamental flaw in the child welfare system is the very definition of child welfare. That means a child already in crisis.

What we are doing is taking care of those who are already experiencing significant difficulties. I think that child welfare reform should be about proposals to enhance education, health care, nutrition and family support. What do you think we can or should do to lend new definition to the subject of child welfare? All in 2 minutes.

Secretary SULLIVAN. Thank you, Senator Chafee.

We are committed to programs for strengthening children's health and welfare and we have proposed in our budget a $90 million increase in child welfare services which I think would total $364 million.

That is because we are seeing unprecedented numbers of children in distress. Greater numbers, as Senator Bentsen mentioned earlier, going into foster care. We want to prevent that eventuality if we can by greater preventive services in our child welfare program, working with families. So we are committed to that, as shown by our proposal to increase our dollars by some $90 million.

Senator CHAFEE. Well, I am very supportive of that and I am very supportive of using any savings we make under the Medicare proposal, which I noticed the Chairman indicated peril ahead for that proposal.

Yes, I went through the catastrophic. Senator Mitchell and I were the chief negotiators with the House on that proposal at the time with Dr. Bowen. I regret what transpired with that subsequently.

However, I think this is a different situation where we have the lowest income earners in our society's taxes going to subsidize the wealthy. I think I could sell that. I could explain that. And maybe I will get an opportunity to. [Laughter.]

The CHAIRMAN. Senator, we fought that fight together of trying to sell it.

Senator CHAFEE. I think the last vote was something like four of us hanging out.

The CHAIRMAN. That's right.

Senator Pryor?

Senator PRYOR. Mr. Chairman, I will try to take just a few moments here. I hope I will not use all my time.

Dr. Sullivan, we are very fortunate, and this administration is very fortunate, to have you in the position that you now occupy. I do not think there is anyone more qualified to address some of the health issues that we face and comment on some of the concerns that we have in upcoming battles on a way to have greater access to the health care system.

There is an area that I would, however, like to bring to your attention that I am sure that you have qualified experts in your Department dealing with. That is the tax issues regarding some of the thrust that we have had in this committee in the last several years, in the last 15 years especially.

For example, we have said to the pharmaceutical manufacturers that we are going to give you a tax write-off for your research and development. We are going to give you a program known as the 936 Program, whereby if you produce drugs in Puerto Rico, we are going to make sure that those profits are not taxed.

I think it is time we reexamine some of those inducements and incentives. We have as a policy said to the drug manufacturers in the research community we have to find a cure for cancer, for Alzheimers, for AIDS, for Parkinsons, and we want to give you this inducement to do it.

I would like for you to commission a study. I respectfully request that you look into how much of these so-called tax benefits are being used really to market new drugs called "me too" drugs, which are really after their competitor's patent runs out they just basically redo the capsule and spend a lot of advertising, and a lot of marketing, and a lot of public relations.

I think they are abusing the system; and I think we have to look at it. I think we have to get the attention of the drug manufacturers in this area.

Dr. Sullivan, finally, in 1910 the Congress of the United States passed a very unique little law that no one ever makes reference to. It is an amazing power that you have as the Secretary of HHS. If we would look at 28 U.S.C. 1498, it has been held in this Section 1498, authorizes the government to take through exercise of its power of eminent domain a license in any United States patent.

We have done this in time of war. We have used this statute in time of war. But we have never used it, to my knowledge, in pharmaceutical or drug patents. I am not suggesting that you do, but I am suggesting that you have a unique power that you might want to examine if we see these manufacturers are increasing their prices at the rate of three times what the inflation rate is—832 percent since January in some of these drugs.

They are vital to survival for some of these poor citizens out here. I think we have to reexamine our relationship with the pharmaceutical manufacturers. I hope maybe you can do a little study that might help us and assist us along this road.

Thank you, Mr. Secretary.

Secretary SULLIVAN. Thank you, Senator Pryor.

I will be happy to review those questions that you have raised. Because as I indicated before, I believe that all of our companies, including our pharmaceutical companies must be corporate citi-

zens. Certainly they are to business to earn a profit, and we are an entrepreneurial society. But they also are given license by the public and through the Congress, to do business.

I will review that. I would again want to simply say as I indicated before, I don't have all of the data here about the rationale, I would hope that we are able to find some answers to these problems in a way that will preserve the innovation and the creativity within our pharmaceutical industry as part of our overall approach to biomedical research.

Because one example that I cite often about improvements in health care is the development of the polio vaccine. The research was carried out by Dr. Thomas Enders and his group at the Harvard School of Medicine. Of course, they received the Nobel Prize for their work in learning how to grow the polio virus in culture.

But the ability to translate that into a product was done primarily by Cutter Laboratories. Cutter may still exist. I do not know, but that was a marvel of taking an idea from the research laboratory and gearing up a commercial product that could then be used. In contrast to what I experienced as a medical student, taking care of patients with paralytic polio, last year we did not receive a single report of a case of paralytic polio in the United States.

So I simply mention that we need to make sure that our pharmaceutical companies behave appropriately, but hopefully we could do it in a way that doesn't tend to dampen the contributions that they can continue to make to improve our health care system.

Senator PRYOR. Thank you, sir.

The CHAIRMAN. Mr. Secretary, I would like, because we have other witnesses waiting, I would like for you to answer a number of questions that I will propound to you in writing if you will respond to them for the record.

One in particular, I am deeply concerned about the cuts that have been proposed by the administration on teaching hospitals, on indirect medical assistance, cutting it from 7.7 down to about 4.4 on the average per case; and then finally down to 3.2 by 1996.

I don't think you can take just the narrow look at the cost of Medicare by itself. I think you have to look at the fact that they are on the leading edge of technology, that they have some of the most severe cases that they have to deal with. But I will get into the detail on that.

You have been helpful and we are appreciative of your testimony.

Secretary SULLIVAN. Thank you very much, Mr. Chairman. It is always a pleasure to appear before you. I will be pleased to respond in writing to your other questions.

The CHAIRMAN. Thank you very much, Mr. Secretary.

Secretary SULLIVAN. Thank you.

The CHAIRMAN. Our next witness is Hon. Chet Brooks, who is representing the Texas Senate and who is chairman of the Senate Health and Human Services Committee, from Pasadena, TX. He is an old friend of mine who has had a distinguished career in public service in Texas, and I believe he is the dean of the Texas Senate. Are you not, Senator?

STATEMENT OF HON. CHET BROOKS, DEAN, TEXAS SENATE AND CHAIRMAN, SENATE HEALTH AND HUMAN SERVICES COMMITTEE, PASADENA/GALVESTON, TX

Senator BROOKS. Thank you, Mr. Chairman. I want to express appreciation for your allowing us to make a statement today on behalf of the National Conference of State Legislatures. As you know, it is an organization representing legislatures in all 50 States, and also some Commonwealths and territories.

I appear to discuss specifically some issues in the fiscal year 1992 budget and the tax matters over which your committee has jurisdiction.

I have a written statement filed with the committee and I will just try to touch on some highlights in the interest of time.

The CHAIRMAN. That's fine, Senator. We'll take it in its entirety for the record.

[The prepared statement of Senator Brooks appears in the appendix.]

Senator BROOKS. In the child welfare area I would like to note that my testimony certainly would be incomplete if I failed to thank you and Senator Moynihan for your efforts on behalf of children at risk, and particularly those vulnerable to abuse and neglect.

As you are well aware the number of abused and neglected and abandoned children has overwhelmed our current capacity to care. While trying to respond to daily emergencies States are struggling to continue family preservation strategies and to adequately protect these vulnerable children.

NCSL believes that your recently introduced S. 4, the Child Welfare and Preventive Services Act, will help States preserve families and add critically needed reforms and funds to help these children.

As you schedule hearings on S. 4 I would respectfully urge that NCSL be permitted to testify and provide more detailed comments on this very essential legislation.

The CHAIRMAN. Thank you.

Senator BROOKS. Children at risk, just by the term, is perhaps one of the key needs and also one of the potentially key solutions to the problems that confront our States and the Nation.

As you know, Mr. Chairman, if we could successfully intervene in families at risk and help children at risk we could have a profound effect in a variety of areas, not the least of which would be the criminal justice system, the corrections system, and the cost of that system. Certainly in other areas such as health care, education and many other programs that failing to do so will cost us tremendously in the out years—dropouts, the cost of dropouts, the cost of not having a trained work force in the future for all of our industrial States and for the whole Nation for that matter is critically important to us.

I want to touch briefly, Mr. Chairman, on the part of the administration budget which cites an unacceptable rate of Federal payment for administrative costs to the States. The budget specifically proposed redefining the definition of administrative costs, limiting them to foster care eligible services and precluding preplacement services costs.

NCSL strongly opposes this change in definition because we believe it is contrary to the goals of Public Law 96272, the Adoption Assistance and Child Welfare Act of 1980. The congressional intent of this program was to reduce the number of children in foster care, which is precisely what preplacement services accomplishes.

Mr. Chairman, we appreciate your efforts in the Omnibus Budget Reconciliation Act of 1990 which amended the statute to state explicitly that child placement services are considered a legitimate and reimbursable category. NCSL urges you to continue to strongly oppose efforts to limit the Title 4(E) funds to only foster care eligible children.

In the area of adoption, NCSL believes that children need permanent placements. Last session the Texas legislature examined ways to increase the number of adoptive families for children with special needs. We found that the payments for families who adopt these children are limited.

Parental substance abuse, particularly crack cocaine, has damaged many of these children. Your proposal to continue a child's eligibility for the special needs allotment after a disrupted adoption has our very strong support.

We also support your proposal for a tax credit for families who adopt these children. There is a significant financial commitment, a very heavy financial commitment, that accompanies the children. And families who are willing, and caring, and want to help these children, and want to take these children in, help them, love them, care for them, nurture them, should get whatever support we could possibly afford to extend.

In the area of child care, again, we are dealing with children at risk. Mr. Chairman, as you know, we have talked about the Federal role and how it interfaces with the States' roles. On behalf of NCSL, I want to thank you for enacting legislation that will increase the amount of affordable quality care available for our children.

In Texas we are particularly pleased with the $300 million entitlement for at-risk child care. It will fill a gap in our system for low-income working families and we are grateful for that.

Aid to families with dependent children, another one that is very directly involved with children at risk and trying to help families who also are at risk. We believe that a substantial portion of our $225 million shortfall in Texas for fiscal year 1991 is something that we absolutely must address and we are trying to move to address that.

Mr. Chairman, I had only one other statement if you would allow me to close.

The CHAIRMAN. Sure.

Senator BROOKS. I wanted to just touch briefly on the fiscal condition of our States and how States throughout the Nation are facing similar problems in that regard.

The 1992 Federal budget cycle begins at the outset of the ninth recession in the post-World War II period. At no time since the recession of the early 1980's have States confronted as bleak a fiscal outlook as they now face. Up to 30 States are grappling with deficits or shortfalls this year and more are expected for fiscal year 1992.

In Texas we have a $4 billion shortfall and we are, as you know, having considerable difficulty trying to develop consensus on taxing and revenue strategies.

In 1990 many States reduced their reserves and increased taxes. Total State tax increases as a percentage of tax collection were the largest since 1983. States will increase taxes by $8.6 billion for fiscal year 1991, which is equal to 3 percent of State tax collections. They will raise an additional $2 billion in revenue from accelerating the collection of existing State taxes, increasing fees and changes and postponing schedule cuts.

Despite collections, over half of the States expect revenue collections to be more than 1 percent below the level on which they built their current budgets. Revenues are not the only problem.

An NCSL survey found that although half of the States are experiencing revenue shortfalls a greater number are facing potential deficits due to spending pressures that require supplemental appropriations. I know the Chairman is all too familiar with the shortfalls we have encountered in Health and Human Services in our State, and have had to have emergency appropriations both in fiscal year 1991 special sessions and again in the current regular session.

Revenues below estimates, pressures to increase spending, and low budget reserves add up to overwhelming State deficits. These fiscal pressures definitely are challenging us as policy makers to ensure that each tax dollar is utilized as effectively and efficiently as possible.

We need for members of this committee and all Federal policymakers to be as mindful of our fiscal capacity as we are. Unfunded mandates, blanket transfers and responsibility in dismantling of existing administrative funding structures have been and remain very counterproductive and disruptive.

We are prepared to work with you to develop and expand State/Federal efforts to address needs for our most vulnerable populations and our most difficult domestic problems. We want to be, and we feel we are, the Federal Government's partners, full partners, in that effort.

On behalf of the National Council of State Legislatures I think you for your kind consideration of our interests and concerns. It is extremely valuable to be able to work together and I want to compliment particularly this committee which has been sensitive to the economic conditions in the States and the local economies and I will be happy to respond to any questions.

The CHAIRMAN. Thank you, Senator.

On a personal note, let me thank you for your cooperation, your work and your help with Family-to-Family network.

And Dr. Brewer and Tina Ann Smith. The fact that I happened to mention Tina Ann Smith has nothing to do with the fact that she is my daughter. [Laughter.]

But I do know of the severe limitations in Texas and the problem that you've had in fulfilling some of these things that we have mandated on you. We appreciate your doing the best you can with it.

I am concerned with the administration's talking about reprogramming the funds from the material and child health block

grant to a few new infant mortality initiatives targeted primarily to a few urban areas. I might say as I look that over I do not find one of them in Texas at this point. At this point.

I know that in Texas that they have taken some of those funds for chronically disabled children, for maternity services, pediatric care, among other services, and that in some of the rural areas the health centers are funded through that program.

What do you think the impact would be on Texas with that kind of reprogramming?

Senator BROOKS. Frankly, Mr. Chairman, I think it would be a very adverse affect for us. We are in many ways just hanging on with chewing gum and baling wire, as you know in our programs. If it were not for a significant number of volunteers who are willing to help, we are able to recruit, and what incentives we have been able to put out to try to keep Medicaid providers available in the undeserved areas of our State, we would not be doing even as well as we are today.

There are tremendous gaps in our health care system and we understand that. We have the situation in Texas where most of our Medicaid providers are actually delivering health care services below cost. By the time they wait up to 120 days for their reimbursement and all of the other paperwork and other disincentives to the providers I am sometimes amazed that we have as many as we do.

But if you start transferring money within the fund to try to initiate a new program and you take that away from a program that is working now, obviously you are probably going to wind up with two programs that are insufficiently funded.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I have no questions. I want to thank the Senator for making the trip here and appreciate his testimony.

Senator BROOKS. Thank you very much.

The CHAIRMAN. Thank you very much, Senator.

Senator BROOKS. I certainly do appreciate it, Mr. Chairman.

The CHAIRMAN. Next we will have a panel consisting of Dr. Stuart Altman, chairman of the Prospective Payment Assessment Commission (PROPAC) from Waltham, MA; Dr. Philip Lee, the chairman of the Physicians Payment Review Commission, from San Francisco, CA; and Mr. Gary Stangler, from Jefferson City, MO, who is the director of the Missouri Department of Social Services, who will be testifying on behalf of the American Public Welfare Association.

Dr. Altman, if you would proceed.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WALTHAM, MA, ACCOMPANIED BY DR. DONALD YOUNG, EXECUTIVE DIRECTOR

Dr. ALTMAN. Mr. Chairman, thank you for inviting us to testify this morning. I am accompanied today by the executive director of the commission, Dr. Donald Young.

As you know, we are responsible for submitting to the Congress each year our report of the annual update factor as well as other

issues relating to the in-patient hospital payment system under Medicare, and I am pleased that on March 1 we did submit to you and to the other members of the Congress our seventh annual report.

I would like to briefly summarize my testimony, and if you would not mind, having the full testimony placed in the record.

The CHAIRMAN. That will be done.

[The prepared statement of Dr. Altman appears in the appendix.]

Dr. ALTMAN. First, let me focus on the status of hospitals in the American health care system. Since PPS began in 1983, Medicare in-patient hospital spending has slowed dramatically. Before PPS began spending was going up at an annual rate of about 17 percent a year.

For the first 6 years PPS, spending growth rate has fallen to a little over 7 percent. Unfortunately, though, hospital costs have not adjusted downward nearly as rapidly as we had hoped or as advocates of PPS had hoped.

In fact, hospital in-patient costs per admission have been growing at about 10 percent a year. As a result, the financial position of many hospitals has deteriorated although some hospitals do continue to do very well under PPS and overall.

Focusing on rural hospitals for a minute, as a group Medicare margins of these hospitals were a minus 2.3 percent in 1988-89. However, even in the rural areas a quarter of the hospitals had Medicare margins, or profit margins, in excess of 8.5 percent. But the special problems of rural hospitals, which this committee has focused on in the past several years, is an area that we at PROPAC have also been spending much time on.

We, as you, have favored a number of changes in PPS which should be just coming on line. So the numbers that I gave you are a little out of date. Nevertheless, our expectations are that even with the adjustments that you have made, it will still probably be necessary to make some other special adjustments for rural hospitals.

We will be submitting to you later this year a focused report on rural hospitals. We expect to make a series of recommendations, not so much for a broad-based change in rural payments, but for a targeted set of adjustments.

Focusing on the major problems for the fiscal consideration of hospitals, you quickly find yourself looking at the issue of uncompensated care. As you know well, Mr. Chairman, at least 37 million Americans have no health insurance at all and millions more have very inadequate insurance.

That is a general health system problem, but it manifests itself in the amount of free care that hospitals are forced to provide. We just recently did a study and found quite remarkably that when you look at uncompensated care it is no longer just focused in a few hospitals in our urban areas.

As a matter of fact, it is broadly distributed throughout the United States and hits rural as well as urban hospitals. Our study suggests that the problem is getting more serious for hospitals because State and local governments, which used to pick up a large proportion of this uncompensated care, now are picking up a smaller amount. As a result, hospitals are being forced to turn to other

revenue sources and those other sources often are either the Medicare program or private insurance, depending on the kinds of patients they treat.

In our recommendations for this year the commission was very mindful of OBRA 1990, which established for the next several years the update factor. But we decided instead to use our own methodology to come up with an update recommendation.

It might sound like it was a cooked deal, but it turned out our method led to very, very similar results. Now I think it shows some insight on the part of some people. Since the differences were so trivial we made the recommendations which were in OBRA 1990. This would give an average update factor for all hospitals of about 3.4 percent, with urban hospitals getting 3.2 percent, and rural hospitals getting 4.2 percent.

Now the reason for the 4.2 percent or higher increase for rural hospitals is also consistent with OBRA 1990 which phases out the difference between urban standardized rates and rural standardized rates by 1995. This higher rate will do that, consistent again with OBRA 1990.

One of the more complicated aspects of our new system—or it is not so new anymore, PPS—is what to do with teaching hospitals. The Congress in my mind correctly indicated that teaching hospitals would need a special adjustment to deal with higher costs.

And you put into law a teaching adjustment. There has been a lot of debate over the last couple of years because if you take a very technical view you would suggest that the rate is too high. However, teaching hospitals in this country do disproportionately treat uncompensated care, AIDS patients, a whole variety of our especially serious, complex patients.

So we were very mindful of the fact that if the Medicare program were to simply cut that teaching adjustment down to the technical definition we would do serious financial harm. Nevertheless, we did believe some small adjustment was needed and made a recommendation that the teaching adjustment go down from 7.7 percent to 7 percent. But before you make any further adjustment we need to again look at the financial condition of these important members of our health care system.

One small, but crucial, aspect of PPS is the adjustment we make for wages in different parts of the country. As it turns out, the wage adjustment also builds in an extra payment for hospitals that have higher mixes of more complex personnel. The current system works to the negative detriment of rural hospitals. We have made a recommendation for an adjustment in the wage index which would bring more equality between urban and rural hospitals.

An important subject which I know you are going to deal with in this session is capital payments. As you know well, capital has been excluded from the DRG/PPS system since its beginning. But there is strong urging on the part of the administration and in the law to fold capital into the PPS system.

We are analyzing the HCFA proposed regulations and their impact, and we will be making a recommendation to you no later than May 15. We would welcome the opportunity to talk to you about capital payment policy.

We are particularly concerned that the system maintain appropriate incentives regarding the use of in-patient versus out-patient capital as well as operating versus capital costs. And again, I will be glad to furnish our recommendations to you as soon as they are completed.

Finally, let me focus again on the issue of rural residents. We have been very concerned that PPS could have negatively affected access to care. In a recent PROPAC study we have found that the hospital pattern of use, of urban and rural beneficiaries under Medicare is remarkably similar.

Also, technological innovations and complex procedures are received by rural residents roughly in proportion to urban residents. More and more rural residents are seeking these complex procedures in rural referral centers, often bypassing their smaller community hospital.

But overall, rural residents do appear to be getting care in proportion to their urban brethren.

I would now like to complete my testimony and of course would be pleased to answer any questions you may have.

The CHAIRMAN. Well, Dr. Altman, that is helpful. I have another commitment I have to get to so I will intervene at this point.

Again, a question concerning the folding in of the capital payments. And I had asked you via letter for PROPAC to give me a report back on that to be helpful to us. Do you have any initial reaction to what they have proposed? Are you prepared at this time to make any statement on the parts that concern you the most or not?

Dr. ALTMAN. Well, I can say this, I, and Don Young, and those of us who have reviewed the regulations are quite impressed with the level of detail and the care with which HCFA addressed a number of issues that were of concern in the previous set of regulations. While we have not completed our analysis it is clear that they have moved the discussion much closer to where more and more of us could support it and actually be a firm supporter.

But there are still balancing considerations, and I don't want to speak for the Commission that has not yet considered the proposal. But I will tell you this, it is a very thoughtful set of regulations and we are quite impressed.

The CHAIRMAN. Dr. Lee, if you would proceed, please. Senator Rockefeller is going to chair in my absence.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, SAN FRANCISCO, CA, ACCOMPANIED BY DR. PAUL GINSBERG, EXECUTIVE DIRECTOR

Dr. LEE. Thank you, Mr. Chairman. I am pleased to testify on behalf of the Physician Payment Review Commission with respect to the President's budget proposals, and to provide an overview of the annual report of the commission which will be submitted later this month.

I am accompanied by Dr. Paul Ginsberg, who is the executive director of the commission.

I will comment briefly on the budget proposals and the commission's report and submit for the record my testimony reviewing the

major issues considered and the recommendations presented in the report.

Although the commission has not formally reviewed the President's budget for fiscal year 1992, I want to comment on several policy issues raised in the budget. First, it is important to note that in its proposals, the administration states that because of the major changes in the scheduled January 1992 implementation of Medicare's new fee schedule for physician services, the budget contains only a limited number of proposals affecting physician payment. The commission agrees with this judgment. We believe that the implementation issues, including: (1) refining the scale of relative work; (2) the determination of practice expenses; (3) calculating the malpractice expense component of the fee schedule; (4) constructing the geographic adjustment factor and replacing the 237 payment localities with an improved list—the commission in its report proposes 94 payment areas—and (5) determining the fee schedule conversion factor for 1992, all discussed in detail in my testimony submitted for the record, are sufficiently complex and important to warrant little change in policy through the budget process.

In its 1992 budget submitted to Congress the administration proposes a change for anesthesia services that is similar to the commission's recommendations. You will note on page 8 of my testimony that the commission recommends that per case payments to the anesthesia care team, consisting of the anesthesiologist and two or more certified registered nurse anesthetists, be capped at the rate paid to a solo anesthesiologist for the same service.

This policy would require changing the OBRA 1990 payment levels for CRNA's because reduced payment for the team would lead to anesthesiologists earning less per hour for supervision than for solo services; and we do not think that is a wise decision.

The second policy proposed by the administration would limit payment for surgeons when the surgeon elects to use an assistant. This is a proposal that was rejected last year by the Congress and the Commission does not support it.

Instead, we believe that separate payments for the assistant should continue and that that assistants should be paid based on resource costs. To reduce the unnecessary utilization of assistants at surgery, which is a problem, the commission recommends profiling use of assistants in conjunction with educational feedback. That is described in more detail on page 9.

The administration also proposes a reform of reimbursement for graduate medical education that would increase payments for primary care residents and reduce payments for all other residents. The issue has not been dealt with by the Commission, but I personally believe that it is a sound direction.

I would, however, want the commission to carefully review this proposal, which we will do at our May meeting, and give you a definitive recommendation after that review. The commission will, of course, comment on the other aspects of the administration's budget proposals following that May review as well.

Let me turn briefly to our 1991 report. We cover 17 different issues in three broad areas: First, major issues concerning implementation of the Medicare Fee Schedule; second, specific policies

and technical issues related to the fee schedule; and third, new areas of responsibility included in OBRA 1990.

The commission is currently reviewing the scale of relative work to ensure that it accurately reflects physician work. Activities include evaluating phase II of the Hsiao study and soliciting comments from medical specialties and scientists.

The Commission is in close communication with HCFA on these matters and will share recommendations with the Congress in June. The commission continues to support a time-incorporating coding system for evaluation and management services that allows accurate assignment of relative values. We think the simplest coding system that could be adopted should be adopted, and we are working with HCFA to achieve this goal.

OBRA 1989 specifies that the practice expense and malpractice expense components of the relative value scale be based on historical charges. That, of course, differs from the work component which is based on resource costs. The commission supports basing these components on resource costs and has developed and tested the feasibility of such a method. For malpractice expense, for example, the component, we believe, should be based on risk of service rather than, for example, on specialty.

The commission reviewed the measures used in constructing the geographic adjustment factor and concluded that the choices were appropriate. The commission recommends replacing the 237 current localities with statewide areas in all States, except the 15 with the highest degree of within State variation in input prices. In each of these 15 States, up to five payment areas would be created by the Metropolitan Statistical Area categories. This plan would create 94 payment areas.

In light of uncertainty about the magnitude of the volume response to the changes in payment, and the ability of the volume performance standard to correct errors, the commission recommends a modest reduction of 1 percent in 1992 fee levels to reflect induced changes in volume. This would require reducing the conversion factor by 3 percent. That is noted on pages 4 and 5 of the testimony.

Senator ROCKEFELLER. Dr. Lee, you know my anxiousness to hear every single word of your testimony. But we have a little bit of a time problem and it is all going to be in the record.

Dr. LEE. Right.

Why don't we just go to questions?

Senator ROCKEFELLER. Just like that?

Dr. LEE. Absolutely. It is in the record; it is there for you to see. The other issues we deal with are access, nonphysicians, limited license practitioners, Medicaid, and impact on the private sector. They are all in the testimony.

Senator ROCKEFELLER. All right.

[The prepared statement of Dr. Lee appears in the appendix.]

Senator ROCKEFELLER. Mr. Stangler.

I would also address the same kind of anxiety, your statement will be in the record so you are welcome to try to just touch the highlights of it.

STATEMENT OF GARY J. STANGLER, DIRECTOR, MISSOURI DEPARTMENT OF SOCIAL SERVICES, JEFFERSON CITY, MO

Mr. STANGLER. Well, I would rather do that, Senator. Thank you.

I am Gary Stangler. I am director of the Missouri Department of Social Services, representing also the American Public Welfare Association, Health Care Committee, of which I am chairman. I have two or three issues that I would like to briefly bring to your attention today regarding the proposed budget.

I will start with the most insignificant sort first. That is a proposal that we assess fees against facilities for survey and certification inspections and then allow those facilities to charge back to Medicaid.

Being a State administrator you would know right away my attitude toward more cost shifting or more mandates in terms of the Medicaid program where I have seen my caseload grow by 40,000 people over the last 12 months, where we now pay for one out of every three babies born in the State.

As a result of that, the real issue that I would want to bring before the committee today, two issues, is the whole issue of voluntary contributions and donated funds, which we are aggressively seeking in the State of Missouri, and I know some other States are as well. And we are seeking your clear injunctive relief in allowing us to proceed with such programs, as the Congress has seen fit to add some 14 odd mandates in the last 2 years on top of nursing home reform, et cetera, that you allow us in our situations in the States to work out those ways to finance the system.

With all the other dilemmas besetting us, I would urge you to not close the door on us in terms of finding creative ways to finance the system, both to pay for what we are mandated and morally obligated to pay for, but also to fund expansions and improvements.

Those improvements I believe are in two areas. One, we are seeking greater flexibility in the program. I need to experiment more with Medicaid at the local level. I need to try things out with Managed Care in North St. Louis and the inner cities so I can skew the system to primary care and to continuity of care.

I need to do things differently in those rural areas of the State that are depressed economically. Ten years ago welfare recipients said, do not put us in managed care programs, that is a second tier system. I would say to you now, that we are all in HMO's and PPO's and IPA's and ASO's and that it is a better way to go and now I have got the other pressures from the welfare advocates.

Finally, and with some help and thanks to Senator Chafee, we are pushing for reform of the audit and disallowance system. As an administrator of a regulatory agency among other things, I need to have an array of administrative remedies in front of me to deal with situations. Our current situation with the Health Care Financing Administration is for them to either do nothing or the nuclear option. I would like something in between. I have situations where literally, the error of a clerk typist three in my department who did not file a proper piece of paper—nobody complains, service is delivered. Everybody is fine except I am facing an $8 million disallowance from HCFA. And there ought to be some way to ap-

proach that on a more rational basis in terms of making the punishment fit the crime and to not exercise a nuclear option.

Those are the highlights of my testimony, Senator. And I would be happy to answer any questions. I know these are non-controversial topics in the Congress. So I would be happy to answer any questions.

[The prepared statement of Mr. Stangler appears in the appendix.]

Senator ROCKEFELLER. Thank you, Mr. Stangler.

Let me just start, Senator Chafee, with your permission with a question for Stuart. You indicated that in its first year PPS had a substantial effect with respect to hospital costs, but that since then, expenses have grown by almost 10 percent a year.

Dr. ALTMAN. Yes, sir.

Senator ROCKEFELLER. First, I would like to get your comments on why you think hospital expenses are growing at that rate and why the change. And secondly, you noted in your testimony the rate of increase in capital spending has moderated over the past few years by comparing the rate of increase in capital costs to increases in operating costs.

And I want to know if that is a fair comparison and if it is, then I would assume that you are saying that the 10 percent annual increases in hospital operating costs are reasonable increases.

Dr. ALTMAN. Well, on the last question—no. Let me start with your first question about why hospital costs continue to grow as quickly as they do and why PPS's has not had the impact that we would have hoped on costs. I think it has to do primarily with the fact that PPS affects only part of the payments going to hospital and for many hospitals, only a small part, 10 or 20 percent.

Many hospital administrators have told me they still listen to two groups: one, their doctors and two, their private patients. And they are prepared to take a loss on Medicare provided they can get their doctors to continue to put private patients into their hospitals. So basically they are saying, you people in Washington do not control our life. Of course, that may be under their breaths.

The issue then comes to this—if Medicare is going to have the force that we hoped, it needs to develop a partnership with the private payers. And the private payers have not been there on that partnership. The second issue——

Senator ROCKEFELLER. Can you explain? Can you quote that?

Dr. ALTMAN. Well, because many payers are basically still paying charges. When all gets said and done, they have these discount-off charges—but they pay what the hospitals ask plus/minus a little bit, and for a lot of reasons. They just do not have the clout individually and collectively to do what the Medicare program has done on hospitals.

The second, and maybe even more important, hospital administrators have told me time and again, you have put the controls on the wrong people. We do not control our costs—the doctors do. The doctors decide what tests are to be ordered. They decide what the treatment looks like. They decide how long the patients will stay in. We follow the doctors orders and until you bring together the set of incentives between the hospital and the doctors, you will

never gain control over the hospitals. That is what they tell me and I am persuaded. And, therefore——

Senator ROCKEFELLER. How is that possible to do? I mean——

Dr. ALTMAN. It is possible to do it. It is very complicated. Originally, PPS was stage one. That was going to be for the hospital and then we were going to follow with doctor DRG's. And, of course, we never got that far.

We need to work together between the hospital side and the physician side to develop a set of incentives that are at least consistent and we are trying to do that between our two commissions. The Physician Payment Review Commission has been focusing on physician payment. Much of it is on the out-patient side, but when it gets to the in-patient side, we need to work more together. Now, the incentives are not the same. And unfortunately, they drive hospital costs as well as physician payments. And until we do those two things—bring a more uniform way of paying hospitals regardless of the payer source and two, bring a more comparable set of incentives between the hospital and the physician, we will not be able to control hospital costs.

Senator ROCKEFELLER. What is perplexing about that, Stuart, is that if one takes the position that cost-containment from the view of big business and small business, the labor movement and a lot of other people, cost containment has now sort of become the gateway or the litmus test for access—that we are not going to get to access unless we can show simultaneously efforts toward cost-containment.

So in a sense what you are saying is discouraging because generically—I guess you could pay doctors under a DRG system. That would not necessarily mean there would be cooperation between doctors and hospitals. Generically, it would seem to be very difficult to have that cooperation. I am still sort of interested how that could work without a DRG system. What is going on as hospitals and doctors look at each other across this table knowing that cost-containment—knowing that they have got to do better on cost containment.

Dr. ALTMAN. Well, again, my own position is not necessarily that of the commission. But I do believe hospitals should face total budgets from all payers and that the budget should include, not only the hospital payment but also the total bill including the amount that goes to the physicians when they are in those hospitals.

Now you do not need a DRG system for physicians to do that. You could work within the system that has been put into law. You can have the relative value scale system. I do not have any problem with that. What I have a problem with, and what I think the system has a problem with is really, when all gets said, the open-endedness of the payment.

Now Medicare—the combination of the DRG system for in-patients and the relative value scale for physicians is going to do a good job overall. But remember, Medicare is only part of a puzzle and as long as the other part is in an open-ended phase, and that is what is driving the system, you are never going to gain control over costs. So somewhere along the line we have to come to grips

with the fact that these multiple payers, which are going to continue, need to work together and right now they are not.

And so the end result is that hospital costs, physician costs, outpatient costs continue to go up. And you know the numbers as well as I do. For 1990, we are up. The increase was to 12.4 percent of GNP, over $700 billion. Our old estimates of $1.5 trillion by the year 2000 are out the window. We are now talking about $1.8 or $2 trillion dollars. We are now talking beyond 15 percent of GNP.

We will never gain a true access system until we gain control over these costs. And my testimony in that respect is discouraging.

Senator ROCKEFELLER. Thank you, Stuart. I am embarrassed I did not get here earlier. We had a markup in Commerce which I had to be at and I do have to leave.

And Senator Pryor—Dr. Lee, I have a slew of questions which I will forward to you.

Dr. LEE. We will be glad to answer for the record.

Senator ROCKEFELLER. Great. And also some more for you, Stuart.

Dr. LEE. Thank you, sir.

Senator ROCKEFELLER. Thank you very much.

[The questions appear in the appendix.]

Senator PRYOR. I do not know which comes first now, Senator Durenberger or Senator Chafee.

Senator CHAFEE. He has broken time but I think he was here earlier. Go ahead.

Senator PRYOR. I will tell you what, I will referee fights on this side of the aisle. You all do it on that side of the aisle. How is that? Thank you. [Laughter.]

Senator Durenberger?

Senator DURENBERGER. Yes. Thank you very much, Mr. Chairman and John Chafee.

Stu, I would just like to ask you a question about the status of the proxies that we designed in the early 1980's. And maybe it is a question about your general feeling about those proxies. I know where you are on the specifics on education and on disproportionate share and issues like that.

Senator CHAFEE. I do not understand what a proxy system is.

Senator DURENBERGER. Well, they are the payments for indirect medical education; teaching; disproportionate share, all the lobbyists that come to us every year saying, do not cut any of these payments because we have a greater severity and tougher cases—all of that sort of thing.

Dr. ALTMAN. Well, it depends on what you expect the Medicare payment system to do. If you take a very narrow definition that says the Medicare payment system should only pay for Medicare costs, there is no question that all of these adjustments tend to distort that picture.

However, if you take a broader view of the Medicare program as an arm of the government's financing system, whether it is based on careful analysis or some degree of shooting buckshots in the right direction, we have developed a set of rough justice throughout our hospital system in the sense that when you look at the bottom line—when I call the bottom line—the total margins or the profits by hospital group—not Medicare, but total, we have a similarity

that has developed between the component groups; teaching hospitals, disproportionate share, rural hospitals, urban, for profits. We have developed a rough equality between those margins.

If you just focus on Medicare margins, there are wide swings. So in a sense, I have become a supporter of these adjustments or proxies as a way of government using its financial leverage to bring a stability within the hospital system, even though when you focus just on the Medicare program, you wind up where it looks like you are paying too much to some hospitals and too little for others.

Senator DURENBERGER. All right. You have been at this so long that I am looking for an instinct, I guess. Should we——

Dr. ALTMAN. Well, this is instinct based on a lot of good staff analysis from my friend over here, Dr. Young and his staff.

Senator DURENBERGER. Yes. Thank you.

Phil, my question of you has to do with the implementation of the relative value system. We hear a lot of rumors and a lot of stories about what you have learned in the last 6 months and how that is affecting your judgment about the bill that we put together in 1989. Could you just in summary form in terms of the main elements of that bill, tell us, were we on target? Have we set up the right framework for the performance standard scheme that we concocted to substitute for the dreaded—gee, I forgot what they call that thing with the red line through it—expenditure targets?

Were we generally on the right track and/or have you learned something that you might recommend to us by way of some legislative changes that we might need this year to facilitate your——

Dr. LEE. Well, I think we would feel basically that we are on track, that the decisions that were made in OBRA-89 were the right decisions. The subsequent decisions that were made in OBRA-90 with respect to the budget have had greater impact on evaluation and management services than I think anyone intended initially.

We would have expected, for example, with the reforms in OBRA-89, that there would be a 30-percent increase in the fees for evaluation and management services. Those will now be about 10 percent based on our analysis. So that is a significant reduction. And if in future budget decisions there are further squeezes, it could then, I think, reduce the acceptance of the payment reforms. And it is that balance between the relative values of surgical and procedural-based services and evaluation and management services that is really critical.

But up to now, we think we are still on track. We think that we can proceed and do it quite successfully. But it does require particular monitoring of access for the elderly. HCFA has got a system developed for that. We have also established an advisory committee to help us monitor access because that is really the crucial question: Can we achieve the changes and continue to assure access when we are making the kind of shifts in payments both by specialty and by geographic area.

Senator DURENBERGER. I am sorry I missed your opening statement but in case you did not cover the importance of the work that is being done at the AHCPR, maybe you ought to speak for the record about how much progress has been made and how important their work is.

Dr. LEE. We think it is very important. We think that it is very important that Congress continue to provide adequate financial support, both for the health services research generically, which is what we drew on in making our commission recommendations, and also for the outcomes and effectiveness research and the development of practice guidelines.

Personally, I would like to see them put more emphasis on practice guidelines that relate to diagnostic procedures and some therapeutic procedures, but principally diagnostic procedures. It has not gotten the emphasis yet that I think it deserves because that is the area where we are seeing the volume increases having the biggest impact on expenditures.

Senator DURENBERGER. Thank you, very much. Thank you, Mr. Chairman.

Senator PRYOR. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

First of all, I would like to salute all of you gentlemen because what you are doing is extremely important to the rest of us who are trying to control medical costs.

Just a word to Mr. Stangler. Of course, Senator Danforth is here so he will mention it, but I just wanted to pay tribute to him and to Senator Bond for the work that they have done on our Republican Task Force dealing with access for health care. Both of them have been extremely effective. Senator Bond gave an excellent presentation on Medicaid, particularly dealing with the Managed Care Program of Jackson County and which I think began in a demonstration program in 1984.

Mr. STANGLER. That is correct.

Senator CHAFEE. Around about then.

And I also want to thank you for the support for the legislation I will be introducing dealing with Medicaid audits and disallowances. Often States have funds withheld due to technical and procedural errors. So I have got some legislation on that and I hope we can get a lot of support from members of the Finance Committee in connection with that.

I would like to address a couple of questions to Dr. Altman. As I understand your testimony, somehow rough justice is being worked out so that the teaching hospitals are surviving—those with a disproportionate share of Medicaid and uninsured patients as well as those with a more severe case mix. But nonetheless, when all is said and done, you recognize that it is not the Federal Government that is controlling costs, but the doctors.

And I wish you could comment a little bit more on that. As I understand it, the doctors can order the tests and discharge patients. What incentive is there for a doctor to discharge patients on a timely basis?

Dr. ALTMAN. Well, it depends on the relationship between the medical staff and the hospital. I do not want to go too far in a negative way. I think there has been a change in focus somewhat and in some hospitals a lot between what the medical staff views their responsibilities are in the hospital. Clearly, it is not in the medical staffs' interest to see their hospital financially go under or financially be so put at risk that they lose their ability to function. So many hospitals do have good relationships with their medical

staffs, where the medical staffs do work on taking hard looks at whether patients need to be there as long as they are.

And in the early stages of PPS, we did see a dramatic reduction in length of stay, as well as a dramatic reduction in hospital admissions. That has pretty much leveled out and, in fact, has begun to creep up a little bit. My concern and the concern that is addressed to us often by hospital administrators, is that there is not a strong medical staff hospital relationship in all situations and, in fact, in many, the set of incentives are quite different.

And I think as you were inferring, a physician still gets paid on a different set of scales. They get paid by the number of times they visit the person in the hospital. They get paid by the procedures often. It depends on what the payment mechanism is. My own view is that is a problem. The bigger problem though, is that Medicare is not the only payer and even with the criticisms I had, the combination of the PPS system for hospitals and the physician relative value scale is working for Medicare in the sense that those payments are being held down. It is the other side of the equation that is more serious and that is, hospitals—only 25 to 30 percent of their revenue comes from Medicare. And they view their payment and cost system related more to the private patients, than the public patients. And that is what is driving the system.

Senator CHAFEE. Well, Mr. Chairman, I just want to say, I think we are in with the heavy hitters who are looking for solutions to the problems in the Medicare program; problems we are wrestling with around here. And I am so glad you both testified. Thank you for your testimony.

I would just like to ask a question of you, Dr. Altman and then quickly one to Dr. Lee.

The IME adjustment recommended by the administration drops from 7.7 to 3.2 really has Rhode Island principal teaching hospital—Rhode Island hospital very, very worried. You recommend that it be lowered to 7 percent. And this is the single biggest issue for our teaching hospitals.

I understand from your testimony that you were concerned that the reduction would have an adverse effect on continued operations. Could you just address that briefly?

Dr. ALTMAN. Well, there is no question that—just like the Rhode Island hospital, which I know well. I know that hospital and I know what kind of services it provides beyond Medicare and Medicaid, the uncompensated care, and that is true across the United States. If we would have dropped from 7.7 to 3.2 or 3.5, it would have a devastating impact on large numbers of teaching hospitals. And that is why we have recommended two very substantial changes.

First of all, you ought to take a different look technically at this teaching adjustment; on a technical basis, it should be higher—4.2 percent. But more importantly, I think the government needs to recognize that its Medicare program is a vehicle for assuring access. It is not only a cost-reimburser and, therefore, it needs to use its leverage. And in this case, by paying teaching hospitals higher than what the technical definition is, it is assuring access to most complex hospitals. So that is why we recommended a slight

adjustment, but nowhere near the level that is in the administration's proposal.

Senator CHAFEE. Senator Danforth said I am on his time. I might ask if I could over a bit here, Mr. Chairman.

To Dr. Lee, I have received several letters from Rhode Island Physicians who historically received a lower reimbursement rate than practitioners in the adjacent States—Massachusetts, for example. And they thought that the physician payment reform would solve their problems, their anxieties. Now they seem to feel that the inequity will not be corrected through the RBRVS.

You recommend changes in geographic adjustment factor. Would those changes address the concerns of my constituents?

Dr. LEE. Well, I think that they would, Senator Chafee. But I think, as I noted in response to Senator Durenberger's question, that the OBRA-90 budget decisions did put a greater squeeze on evaluation and management services. So those physicians who anticipated an increase are receiving much less of an increase. With a recommendation that we will make in the future related to practice costs which we believe should be resource based, that could add a further corrective factor and increase payments for office based services. That is a recommendation that will be forthcoming. We simply analyzed in our report the approach to this method. But I think that is a second step downstream that can be taken that would help to correct the present problems that they perceive, I think, quite correctly.

Senator CHAFEE. But it is more a geographic disparity.

Dr. LEE. Well, the geographic factor will be corrected as we go forward with the implementation of the fee schedule.

Senator CHAFEE. Dr. Ginsberg, any comments?

Dr. GINSBERG. Yes. What we are doing with the fee schedule is going from a system where payment areas have their own prevailing charge screens based on the historical charges and they are very different from one area to another. And that is being replaced with what is called the geographic adjustment factor which attempts to measure the practice costs that physicians face in different areas.

And I do not know specifically the difference between Rhode Island and Massachusetts, but in general this geographic adjustment factor varies much less than the price variation that we see today prior to the implementation of the fee schedule. So I would imagine that, whereas Rhode Island might not be the same as Massachusetts, I suspect it is very close.

Senator CHAFEE. Well, thank you. Mr. Chairman, I think that what has come out of today is that—at least what I have gained from the testimony, is the point that Dr. Altman is making. It all well and good for us to do what we can to reduce costs under Medicare, but that is not the driving force in all hospitals—physicians play a significant role in utilization of services and length of stay.

And in my State, I have a feeling that probably different from many States, Medicare costs and reimbursement is a far greater factor than perhaps in other States.

Dr. ALTMAN. It is.

Senator CHAFEE. Because we have had prospective reimbursement for so long. But if we are going to get a handle on this, we have got to go further than Medicare.

Thank you.

Senator PRYOR. Thank you, Senator Chafee.

Senator Danforth?

Senator DANFORTH. Thank you, Mr. Chairman.

Dr. Altman, just finishing Senator Chafee's sentence, we have to go further to what?

Dr. ALTMAN. Well, that is a long discussion but basic and simplifying it, we need a partnership plan between public and private payments. I am not suggesting one payment system or one source of payment. But I do not think we can go much——

Senator DANFORTH. Would you oppose that?

Dr. ALTMAN. I think there is value in some diversity, yes, and in sources of funds. But I do believe we need to come up with a common payment approach that links all of the payers to all of the deliverers of care and it need not be one—there could be modifications. I am not suggesting a strangle-hold. But the current system is like lots of spigots of funds and the providers are not any different than anybody else. They go to where the biggest spigot is and if one spigot temporarily is blocked, they go to another one.

And the Medicare program over the last couple of years has become a much more constrained spigot and so they are going after the private patients and the private insurers. And that is why you are seeing 20 and 30 percent increases in insurance premiums when hospital costs and others are not going up nearly as fast, because they are going after those spigots in a big way.

Dr. LEE. Senator, if I could add a comment to that and be a little bit more explicit. I think the Congress first of all has to deal with the private sector as well as with the public programs. That means either all-payer regulation with Federal policies and goals established—you can have the implementation at the State level or you can go to a single payer. This is what the experience of every other country tells us; all of the industrialized countries which cover all their populations control costs far more effectively than we do. We cannot continue with this totally fragmented system and the open-ended system which exists in the private sector and drives up the cost.

And I think that the time has come for Congress really to address that overall cost issue, because otherwise we cannot control the costs in Medicare.

Senator DANFORTH. All right. Thank you both very much.

Mr. Stangler, your reputation in our State is just outstanding for what you have done with Medicaid.

Mr. STANGLER. Thank you.

Senator DANFORTH. You have a problem with Medicaid mandates, I understand? You like to swing at that hanging curve ball?

Mr. STANGLER. The 14 or so mandates that the Congress has put on us in the last 2 years have created a situation where the Governor and I sit down and do Medicaid and then he does the entire rest of the State budget.

And to follow up on the analogy of the spigots, I have less of a problem with the number of spigots than whose hands are on the

spigots. So the issue then turning it to donated funds—yes, I believe there is some poetry in terms of us being able to maximize Federal participation to help pay for the mandates.

Senator DANFORTH. What would you like us to do or not do?

Mr. STANGLER. I would like you to continue the moratorium on HCFA promulgating regulations to tighten down voluntary contributions in Medicaid. I would also very much like greater flexibility. Senator Chafee referenced the Republican Task Force. I think that is one of their priorities. I need to be able to experiment more in Medicaid. We are a major payor and the situations we face, the best minds in the country cannot figure it out. I need to try some different things.

I would also plead for relief on the audits and disallowances reform legislation. But your staff has been very helpful in terms of getting to a more rational basis.

Senator DANFORTH. Are you familiar with the bill that Senator Moynihan and I introduced with respect to the mentally ill homeless?

Mr. STANGLER. I am.

Senator DANFORTH. What is your view of that? I mean it does tell you to do something. Is that a bad idea?

Mr. STANGLER. It is not a bad idea. From a policy standpoint, I think it is an excellent idea and I think you have put your finger on a problem in terms of the homeless mentally ill. And I think on an optional basis with more flexibility—Keith Schaffer, director of mental health in Missouri, is an outstanding administrator who has made great strides in getting Medicaid to work for that system. I think we can accomplish the objectives that you have set out in that bill.

Senator DANFORTH. All right. Now finally, you have a program on, at risk children and their families. And it is my understanding that it is a very fine program. And is there anything that we should be doing with respect to that?

Mr. STANGLER. Senator Bentsen has a bill, S. 4, that would push something that Governor Ashcroft and I have pushed for in Missouri, and that is to re-direct and get Federal policy aligned toward building families instead of trying to replace families and to remove the risk from situations instead of removing the child from harmful situations. I believe it is a cultural shift and a policy shift for which we need Federal policy direction.

Governor Ashcroft has sponsored a large restructuring effort that aims at building families and keeping kids in their families because it is the right policy option and I would appreciate your help and support.

Senator DANFORTH. Mr. Chairman, thank you very much.

Senator PRYOR. Senator Danforth, that is fine. Did you have further questions?

Senator DANFORTH. No.

Senator PRYOR. Thank you. I think I only have one or two. Today before you came, Senator Danforth, we discussed or at least I have, and I think everyone thinks I am just a one track record on this issue of prescription drugs. We are trying something new. I would like to address a question or two to Mr. Stangler from Missouri as

to how the problem is working. I have read your statement on this and some of your concerns about it.

First, I would like to say are you getting any cooperation from the drug manufacturers in carrying out what I believe to be the intent of the Congress?

Mr. STANGLER. Well, a lot of that has been delegated up to the Federal level in terms of negotiating the rebate agreements. I do not think it was any great surprise for us to find out suddenly that best price was the price we were getting at the time.

It is a very thorny issue for us particularly in Missouri, and now we have a letter from the HCFA Medicaid Administrator saying we have 2 weeks now to go completely to an open formulary and yet, we do not have regulatory guidelines and I am concerned. There has been some effort in my State of Missouri by certain companies to try and restrict our ability to prior authorize drugs and to keep some controls on the program. And I resisted those efforts because I think if we are going to move to a system that does not just do away with the generics. They have no incentive to come to the table on these rebates and I believe that the physicians will go straight to the name drugs. And we will lose something there in the ability to prior authorize and maintaining some rationality in the system is very important.

It is a difficult issue with which I know you have wrestled hard with.

Senator PRYOR. Well, I think the intent was clear. We were trying to provide for the Medicaid programs—let us say the same deal or the same prices or the equivalent thereof that the Veterans Administration had gotten——

Mr. STANGLER. Right.

Senator PRYOR [continuing]. Huge discounts—Department of Defense and others. And somehow or another, it seems that the manufacturers are intent on sort of subverting the system. And we need really the immediate input not only of yourself, but of your counterparts out in the other 49 States to see how we can step in at this moment before this thing gets worst because it appears right now the manufacturers are going to continue to raise prices.

Mr. STANGLER. At the same time, I am trying to implement average wholesale pricing. I have a temporary restraining order issued against me in Federal court. I would say the pharmacy program is the number one issue on my plate right now and Medicaid and then the entire department.

Senator PRYOR. Have you visited with your counterparts in the other States? Are they sharing the same experiences that you are having with the implementation of the program?

Mr. STANGLER. By and large because we sort of saw how it was shaping up after the legislation was passed and sort of our worst fears came into existence. And now we are struggling because of the latest letter from Tina Nye says that, retroactive payments back to January 1st, only if we have got the rules in place by the end of next week. And it has just put us in a difficult situation trying to bring everything up at once and make sure that we do not step in it on the way, to be blunt.

Senator PRYOR. Well, we have got a tough ones on our hands here with the implementation of this and we want to assist. We do

not want to be an impediment nor an obstacle. We want to work with you but we are going to need your input and we are going to need it pretty soon.

Mr. STANGLER. Well, we are very grateful for your leadership on this.

Senator PRYOR. Thank you, sir.

Now to our other panelists, I want to apologize. I did not get to hear all of your testimony. We have about 5 more minutes. I wonder if there might be any comments or panel observations by any of the panelists this morning?

Dr. ALTMAN. Well, one of the issues that I was going to address to my friend over here, Phil Lee, is we talked a lot about this interface between the hospital and the physician side. And I know we are working hard to work together in this area. And since I said a lot of things about physicians and my friend is over here—I thought I would at least give him some time to respond. I do not know whether he supported what I said or not.

Dr. LEE. I agree with you, Stu. I think that it is very important that the two commissions work closely together, which we are doing, because there are issues where we have collective interests. One is overall expenditures. A second relates to hospital out-patient increases which have been substantial. Another relates to leveling the playing field between sight of service—in-patient, hospital out-patient, and doctor's office. Those are issues that we need to work with the ProPAC and we are doing so and we will continue to do so.

Senator PRYOR. Great. Any further observations or comments? As we say, speak now or forever hold your peace.

We want to thank all our panel this morning, a very distinguished group of Americans and we look forward to working with you in the future.

Our meeting will stand adjourned.

[Whereupon, the meeting was recessed until Wednesday, March 20, 1991 at 10:00 a.m.]

PRESIDENT'S FISCAL YEAR 1992 BUDGET PROPOSALS

WEDNESDAY, MARCH 20, 1991

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Daschle, Breaux, Packwood, Chafee, Heinz, Durenberger, and Grassley.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order. The hearing this morning on the President's budget will consist of two parts. First we will ask the administration to explain its revenue proposals. For for the second part, we will continue with the health and income security proposals that we discussed yesterday.

Most of the revenue proposals that have been recommended by the administration are leftovers from last year. There are only a few new items that the administration has not previously submitted.

I understand the problems the administration had following the constraints imposed by last year's budget agreement. We are facing the same constraints in this committee.

As I said yesterday, one point of last year's budget agreement was to avoid having to revisit some of the difficult decisions made about overall spending and revenue totals. But that does not mean we should not examine how those totals will be met. On that score, I am not totally satisfied with what the administration has chosen to include this year in its budget, and I want to take a close look at some of those proposals.

For example, the proposal to impose Medicare taxes on State and local employees is one we have been through several times. While it was in the budget agreement last year, it did not make it through the Congress, and I am not sure its chances are any better this year.

The capital gains proposal has certainly developed considerable controversy in the Congress over the past several years. I think the administration has a tough row to hoe on that.

I also note that the administration's own revenue estimates for the fiscal years 1991 through 1996, as well as those provided by the

Joint Tax Committee, show that the revenue-losing items in the President's budget will be essentially paid for through spending cuts in such crucial areas as Medicare. I think I have made my views known on that.

We went to great lengths to try to settle that last year. The budget legislation provided some $45 billion in cuts, as I recall, in Medicare over 5 years. Frankly, I thought that Medicare cuts were off the table this year. But the administration has brought it back, proposing an additional $25 billion in cuts in Medicare. I personally will not be supporting such draconian cuts in Medicare.

I certainly commend the administration on its recommendation to extend the research and development credit and the 25-percent deduction for health insurance costs of the self-employed individuals. At the same time, some other important expiring tax provisions are conspicuously absent.

Many of these, such as the mortgage revenue bond program provide important benefits to average Americans and therefore have a great deal of support in the Congress. We want to question the administration to see whether they intend to let those provisions simply expire at the end of this year.

I would also like to commend the administration for recognizing the importance of increasing the Nation's savings rate by encouraging families to save so that interest rates can move down some more. Hopefully we can build up capital in this country and thereby improve productivity.

Last week, 75 Senators from both sides of the aisle joined Senator Roth and me in co-sponsoring the Bentsen-Roth IRA bill. That bill would bring back and improve the IRA for all Americans. It would also offer a new type of IRA somewhat similar to what the administration has proposed, a so-called back-loaded IRA, to give people further incentives to save.

So I am glad the administration shares our goal of stimulating family savings.

I am hopeful we can work with the administration to reach a bipartisan agreement on some of these critical areas for the Nation, within the budgetary limitations. That will not be easy. With this in mind, I look forward to your testimony.

I would like to yield now to my colleague, Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Thank you, Mr. Chairman.

As usual, Mr. Secretary, there is good news and bad news. I think there is a computer error also in your recommendations. I am glad to see that you have put in the proposal to allow the tax deduction for the adoption of special needs children. Senator Bentsen and I, and others, have introduced that before and we are glad to have the administration with us.

I like all of the extenders that you put in, but I think the computer error is that you dropped off the extension of employer-provided educational assistance, and employer-provided group legal services. I am sure that was just an error when the printout came and you will take care of that in a subsequent period.

I share with the Chairman some of your savings proposals, and especially the withdrawal for a first-time homebuyer. I think that would help my State and would help this country.

With that, and with the knowledge that you will correct the computer error, I am happy to hear the Secretary's testimony.

The CHAIRMAN. I have a few to add, too.

Senator Heinz?

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, first I want to register my strongest possible—I do not know whether to commend you on your opening remarks or to object because you stole my speech.

The CHAIRMAN. As long as you feel that way, take as long as you like. [Laughter.]

Senator HEINZ. Mr. Chairman, that is good because I will not speak very long.

But, Mr. Secretary, we do welcome you. I agree with Senator Packwood I think your computer could have done better. But before I explain why, first I want to commend you on having at least proposed the extension of several important expiring provisions.

You have proposed to extend the solar and geothermal energy credits. You have proposed to extend health insurance for the self-employed, the low-income housing credit, the research cost allocation rules, the targeted jobs tax credit, all of those for 1 year, plus you have made the research and experimentation credit permanent.

I particularly want to commend you on making the research and experimentation credit permanent. Without making it permanent it just becomes impossible for those who want to invest and take risks in these long pay back kinds of investments, the kind of assurance they need when they try and figure out whether investments really will be worth it or not.

However, I am puzzled as to why the research cost allocation rules which determine how U.S. corporate expenditures will be allocated among various countries and, therefore, subject to the research and experimentation credit to a greater or lesser degree, why you did not make that permanent. It seems to me that you need to make them both permanent.

In terms of items that you have left off the list I am concerned in particular about employer-provided educational assistance. I am concerned about all the ones that are left off the list. I have a bill in to extend them all, as you know. But it seems to me that the employer-provided educational assistance, particularly for President Bush who has indicated that he wants to be the education President is a serious computer error or oversight, because this is one of the best known and most proven ways to upgrade the knowledge and skills of people currently in today's work force.

Every study this and previous administration's have done have shown that the skills have to improve among current workers. This is an effective way to improve the skills. And if we care, as I know we all do, about making sure that we do have a more productive

work force and a country that is more competitive, I cannot think of too many other policies that would advance that particular goal.

So I hope that the administration will come out with a new printout. I hope it will have at least 12 expiring provisions on it; and I would like to see them all made permanent of course.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Secretary, we are pleased to have you. If you would proceed.

STATEMENT OF HON. KENNETH W. GIDEON, ASSISTANT SECRETARY FOR TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

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

I am pleased to discuss with you today the revenue proposals contained in President Bush's fiscal year 1992 budget. The administration's 1992 budget abides by the terms of the budget agreement developed last year. We view the budget process reforms, particularly the pay as you go provisions, as an integral part of that agreement.

It is essential that the Congress and the administration adhere both to the letter and to the spirit of these reforms. The revenue proposals in the budget which I will discuss today address the need to promote long term economic growth as well as addressing current problems. These proposals are financed through a combination of initiatives which raise revenues and decrease spending.

Mr. Chairman, I am going to abbreviate some of the written statement and I would ask that the full statement be printed in the record.

The CHAIRMAN. That will be done.

[The prepared statement of Secretary Gideon appears in the appendix.]

Secretary GIDEON. First of all we recommend that the 20 percent research and experimentation tax credit—the R&E credit—which is set to expire at the end of 1999 be extended permanently. In addition, the current allocation rules for R&E under Section 861 should be extended for another year.

We hope to improve our country's low rate of personal savings by creating a new savings vehicle, the family savings account. Nondeductible contributions to an FSA of up to $2,500 per taxpayer would be permitted with a maximum of two accounts per family.

After meeting the required 7-year holding period, all savings, including the accumulated earnings, can be withdrawn tax free. FSA's are explicitly a savings and not a retirement program. The time limit to obtain full benefits is short enough to focus attention on specific personal goals—saving to buy a home, preparing for educational costs, building a financial reserve to protect against unexpected events, or any other high priority objectives of the person with the account.

FSA's will not undermine the basic retirement focus of existing IRA's and pension plans. They will supplement those long-term savings plans with a vehicle suitable for shorter term needs.

To help economically distressed areas enjoy the benefits of economic growth, we recommend the designation of up to 50 Federal

enterprise zones, which will benefit from targeted tax incentives and Federal, State and local regulatory relief. The Federal tax incentives that we propose are a wage credit of up to $525 per worker, elimination of capital gains taxes for tangible property used in an enterprise zone business, and expensing by individuals of contributions to the capital of corporations that are engaged in the conduct of enterprise zone business.

We propose to allow individuals to withdraw amounts of up to $10,000 from their IRA's for a first-time home purchase without payment of the 10 percent additional tax on early withdrawals.

The budget also contains proposals to extend for 1 year the following programs that otherwise would expire at the end of 1991. These include: the low-income housing credit, the geo-thermal and solar energy credits, the targeted jobs tax credit, and the 25 percent deduction for health insurance costs of self-employed individuals.

We again urge the enactment of an income tax deduction up to a maximum of $3,000 per child for expenses incurred in connection with the adoption of special needs children.

Reducing the capital gains tax rate for individuals is important to restore economic growth and competitive strength by promoting savings, entrepreneurial activity, and risky investment in new products, processes and industries. Under our proposal the capital gains tax rate would be reduced by means of a sliding scale exclusion. Individuals would be allowed to exclude a percentage of capital gain realized upon the disposition of all assets qualifying as capital assets under current law, except for collectibles. Assets held 3 years or more would qualify for an exclusion of 30 percent; assets held at least 2 years, but less than 3, would qualify for a 20-percent exclusion; and assets held at least 1 year, but less than 2, would qualify for a 10-percent exclusion. Excluded gains would be subjected to the alternative minimum tax and prior depreciation deductions would be recaptured in full.

The administration believes that this capital gains proposal would lower the cost of capital and stimulate investment, reduce the lock-in effect, and lower the double tax on corporate stock investment. Given that there are divergent opinions on the relative strength of these effects, however, President Bush requested Federal Reserve Board Chairman, Alan Greenspan, to study these matters.

We hope that Congress will work with Chairman Greenspan and the administration to illuminate and resolve the disagreements surrounding the revenue, distributional and macroeconomic effects of a capital gains tax rate cut.

The President's budget contains several additional proposals to increase revenues. I would like to mention three of those today. Other proposals are described in the Treasury's "General Explanations of the President's Budget Proposals Affecting Receipts," which was released with the budget in February.

The budget calls for an increase in Internal Revenue Service funding for tax law enforcement. Two initiatives, one in the field of field examinations and the other in the area of collection of accounts receivable, are expected to add approximately $700 million to receipts over the budget period.

We propose extending coverage by Medicare hospital insurance to all State and local government employees. State and local government employees are the only major group of employees not assured Medicare coverage. The addition of $2 million State and local government employees as contributors to Medicare would increase revenues by $7.3 billion over the budget period.

To increase compliance rates and revenues, distributors of alcoholic beverages would be required to verify prior to sale that their retail customers paid the special taxes in connection with liquor occupations. It is expected that this measure would increase revenues by about $100 million over the budget period. The proposal would be effective beginning October 1, 1991.

Recognizing the controversy which has surrounded the capital gains estimates, the budget has been formulated to meet the pay-as-you-go requirements without relying on the revenues that we believe would be generated by our capital gains proposal.

The reductions in mandatory program outlays outlined in the budget, together with the proposals increasing revenues which I have described, are more than sufficient to fund the items which reduce receipts, even if revenues from capital gains are disregarded.

Mr. Chairman, we too look forward to working with the Congress and this committee to enact a budget which fully complies with last year's budget agreement. We believe that our budget proposals meet that goal and we urge the committee to report legislation embodying those proposals.

Now I would be pleased to answer any questions that you and other members of the committee may have.

The CHAIRMAN. Mr. Secretary, let's start with Medicare. Even with your more favorable estimate on capital gains revenues, the revenue losses in your budget are partially offset with Medicare cuts. What makes you think we can take additional Medicare cuts?

Secretary GIDEON. Mr. Chairman, I think that I would refer you to others who are more expert than I and the specific policy substance of those cuts. But responding to your general question we tried to be very careful to target areas where we felt that those cuts could be sustained.

The CHAIRMAN. Let me tell you, Mr. Secretary, that was one of the toughest fights we had in the Summit. We went over them, and over them, and over them again and finally we agree on a $45 billion cut over 5 years. I do not know how you can come back and talk about another $25 billion.

I have hospitals closing all over my State, more than any other State. In my State, over 75 percent of the hospitals are losing money on Medicare patients. You are going to have real problems with those proposals, problems with me, frankly.

Let me get to another question since you are not in a position to respond specifically on Medicare. But I want answers from the administration.

[The following information was subsequently received for the record:]

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, DC.

Hon. LLOYD BENTSEN,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC
ATTN: Mr. Van McMurtry

Dear Mr. Chairman: During Assistant Secretary Gideon's appearance before the Finance Committee, you expressed your concern about the difficulty of making further reductions in the Medicare program. I am writing to provide for the record the Administration's rationale for additional efforts to constrain the cost growth of the Medicare program. I should note at the outset that, in general, the Administration's proposals would not adversely affect beneficiaries (other than the wealthy); and that even with our proposed savings, Medicare would grow at 11% in 1992.

In the Part B program, costs are growing at rates greatly in excess of the nation's productivity and wages. For example, aggregate physician expenditures in Part B are projected to increase by 12%, on average, in each of the next 5 years, while average wages are projected to grow by about 3.5%. SMI costs are growing at a pace that bears no relation to the ability of the nation's taxpayers and our elderly and disabled citizens to finance them. Slowing the rate of growth in health care is vital to the continued viability of the system. Further, Part B cost restraint reduces the copayments that our senior citizens will pay and minimizes the increase in the premiums seniors must pay

The Administration further wants to assure that the SMI program is administered in a fair and equitable manner Under current law, all working taxpayers subsidize SMI premiums, including the premiums of individuals with high incomes. As a result, we have proposed increasing the premium for individuals with incomes above $125,000 to 75% of actual Part B costs

The hospital program, Part A, is also projected to grow at an average of almost 11% per year for the next five years We do not wish to minimize the difficulties that some hospitals face, but the successful control of health care costs will ultimately require more efficient use of hospital facilities By reducing incentives for excess capacity, it will be possible for needed hospitals to operate more effectively. At the same time, we recognize that there are special problems associated with rural hospitals and the Administration has supported a variety of special operating and capital payments to address those legitimate needs Further, numerous independent studies including those of ProPAC and GAO have indicated that the support of teaching hospitals through indirect medical education payments has been excessive. The Administration continues to support these payments to teaching hospitals, but at a rate that is more representative of the actual cost incurred by these facilities.

In sum, you have correctly identified the difficulty of controlling Medicare spending that the Congressional leadership and the Administration jointly addressed in the Budget Agreement. Nevertheless, with Medicare costs increasing at just under 12% per year, we believe that we must continue mutual efforts to restrain health care costs and manage the Medicare program at funding levels that are economically sustainable. The overall Medicare annual growth rate of 11% proposed in the FY 92 Budget is consistent with these efforts.

The Administration looks forward to working with you to develop a strategy that slows the rate of growth in Medicare in ways that benefit the nation's senior citizens, now and in the future.

Sincerely,

THOMAS A. SCULLY,
Associate Director for Human Resources, Veterans and Labor.

The CHAIRMAN. Let's talk about extending mortgage revenue bonds. We have seen a drop in home ownership in this country, a reversal of fulfilling the American dream of owning one's own home. That is particularly true for young couples.

Can you tell me why 78 Senators are co-sponsoring a measure to extend mortgage revenue bonds? Are they wrong?

Secretary GIDEON. Senator, we believe that other measures would be more effective. Specifically, we proposed to the withdrawals for first-time homeowners. It is targeted specifically at that.

The CHAIRMAN. Well, I support that too. I fee very strongly about it, as do Senator Roth and other members of this committee. I think that is a supplement, though.

Secretary GIDEON. In general though we have had concerns about tax-free bond programs such as this one and in terms of their effectiveness versus the Federal revenues lost. That has been a continuing concern of ours in prior budgets as well.

The CHAIRMAN. Well, we have been through the fight over mandatory coverage of State and local workers on Medicare. My State would take a particularly tough hit. About 50 percent of Texas's government work force would be affected by that proposal, almost a half a million workers. As of 1985, 93 percent of school teachers in Texas were not Medicare participants.

Other States would also be particularly hard hit—California, Colorado, Illinois, Louisiana, Maine, Massachusetts, and Ohio. That proposal did not make it through the conference last year. What makes you think it will be accepted this time?

Secretary GIDEON. It remains good policy, Mr. Chairman; and I think that you can expect to see us back until that one remaining large exception to HI coverage is filled. I mean we stand by the arguments in favor of it I am hopeful that at least at some point in time Congress will see the wisdom of those arguments.

The CHAIRMAN. I must say the wisdom escapes me.

The administration's energy policy has incentives, which are needed, for domestic production. But it will not do the job on conservation; it's half a loaf. We have just fought a war, and one of the reasons for that war was the stranglehold the Middle East can put on oil markets. In that light, why would you cut back the 5-cent increase in the gasoline tax?

That promotes conservation. Certainly, more than any other country, we have avoided putting additional taxes on gasoline. This increase is on the books. Why would you let it expire and have to find other sources of revenue to offset the loss?

Secretary GIDEON. Well, first of all, Mr. Chairman, what we were doing in terms of the 1996 extension, we proposed that the tax be extended at the levels necessary to fund the highway programs. And so that is the budget proposal. It is not an expiration. It is an extension. Although as you note, an extension at old rates.

The CHAIRMAN. That is right. But you are dropping the 5-cent rate increase, are you not?

Secretary GIDEON. That is correct.

The CHAIRMAN. So to that degree, there would be a reduction in conservation; isn't that not right?

Secretary GIDEON. I think that to the extent that the gasoline tax at those levels encourages conservation that would be a correct statement. I think that the impact on conservation of a gasoline tax at those levels is open to question. I mean obviously——

The CHAIRMAN. It must have some influence.

Secretary GIDEON. It must have some influence. I agree with that statement.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Mr. Secretary, the administration has announced that it is going to expand the employer-provided mass transit benefit. How much and what are you going to do about the cliff? Under present law, if you go over the $15 maximum, entire benefit is taxed.

Secretary GIDEON. We are going to do what we can do administratively there. What we can do administratively is revisit the de minimis amount that was set in the regulations in 1984. Nothing has been done about that amount since then. We think we can take account of the fact that inflation has occurred since 1984 and reset that amount.

Senator PACKWOOD. That puts you up around $21.

Secretary GIDEON. I was going to say, I would not want to quote a specific figure, but $20 or $21 is about right.

The cliff, however, is a function of the law and that is not something we can do something about.

Senator PACKWOOD. Would you support getting rid of the cliff?

Secretary GIDEON. It is not in our budget proposal and we would have to come up with an offset to fund that. In other words, that would be a scored provision.

Senator PACKWOOD. That I understand. But you have no philosophical objection to getting rid of the cliff?

Secretary GIDEON. I think that we probably do not have a philosophical objection to getting rid of the cliff, but I do think that as in all good things there is a cost involved.

Senator PACKWOOD. Thank you.

I have no other questions, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you very much, Mr. Chairman.

Mr. Secretary, two or three things that are on my mind that deal with the recommendations of the Department to our committee. The first one would deal with the $40 million increased compliance request that you have made in your budget. I want to relate that to a GAO study that recently came out that said IRS can improve its program to locate high-income taxpayers who might be under reporting income.

This report from the GAO emphasized that improved computer matching and better data would be the tools that could accomplish this. Commissioner Goldberg, to his credit, generally agreed with the GAO recommendations.

So my question is whether or not any of the $40 million would be going to seek the goals of the General Accounting Office report. I suppose maybe out of fairness I ought to ask you if you generally agree with the GAO recommendations.

Secretary GIDEON. I certainly agree with Commissioner Goldberg's response to the GAO recommendations; and I think that, if you note, the GAO thought that was a good response as well; and that they noted in their printed report that they thought that the Commissioner's implementation plan was one that was promising.

The CHAIRMAN. I missed that, Mr. Secretary. You turned your head and I could not hear you.

Secretary GIDEON. I am sorry.

Commissioner Goldberg wrote a response to the draft of the GAO report in which he indicated specific things that he and the IRS would do in response to the GAO recommendations. It is my understanding that the GAO thought that that approach would be fruitful in meeting its recommendations.

Senator GRASSLEY. Will some of the $40 million you are asking for for increased compliance be used for the computer match being suggested by the GAO for increasing collections from high-income taxpayers who are under reporting?

Secretary GIDEON. For that level of detail on the IRS budget, I would have to refer you to the IRS. I would note, however, that the largest portion of the requested increase is in the area of collection, which is the area that would do the sort of thing that you are discussing.

Senator GRASSLEY. I think that it would help me if you would look at that and then respond to that in writing, please.

Secretary GIDEON. I would like to have the IRS respond if that is acceptable to you.

Senator GRASSLEY. I believe as long as they speak for you.

Secretary GIDEON. They certainly speak for the administration with regard to their own budget.

Senator GRASSLEY. Okay.

[The information appears in the appendix.]

Senator GRASSLEY. Are any of these funds, referring again to the $40 million, going to be dedicated towards addressing the transfer pricing problems that have come up regarding foreign taxpayers?

Secretary GIDEON. I think that I really could not respond on that. There are additional funds in the budget for field examination. The Commissioner has been, as he noted last year in the House hearings, been allocating more resources to the transfer pricing issue on his own.

Senator GRASSLEY. Okay.

Maybe you could address that too in writing. I am not suggesting that the $40 million needs to be done in that area, but I want to express my concern that the direction that the IRS is taking is fully implemented. Because I think it is a very important source of income for our government and some income tax that we are being cheated out of.

Secretary GIDEON. I think that both of those areas are areas that I know the Service is pursuing. I think as always we would hope to avoid earmarking specific funds for specific purposes because that inhibits management flexibility.

Senator GRASSLEY. Okay.

I would like to turn to the President's Family Savings Account measure. Of course, I am generally supportive of his program. I am interested in what kind of thought has been put into allowing, other than just financial institutions, and specifically I would be referring to insurance companies and the instrument of insurance, maybe qualifying for the family savings plan so that we do not direct this new plan just toward certain financial institutions.

Would insurance companies be a player in that game under your proposal?

Secretary GIDEON. I believe that the answer here, and I would like to make sure that I am correct and respond to you further in writing, I believe that the answer is that they can participate in FSA's to the same degree that they would be able to participate in IRA's today.

Senator GRASSLEY. Okay.

The Chairman mentioned the National Energy Strategy. I am concerned that not enough emphasis was put on renewable fuels. Senator Daschle of this committee, and I, have introduced legislation basically tracking what the Energy Department recommended.

Do you know why others in the administration oppose those incentives? They went from Energy included in the program and then they were deleted, presumably, at the White House level. I just wondered if maybe Treasury opposed them as well.

Secretary GIDEON. Could you clarify the specific provisions you are talking about?

Senator GRASSLEY. Yes. It would be tax incentives for alternative fuels for the generation of electricity—wind, solar, biomass, and maybe alternative fuels, like ethanol and methanol.

Secretary GIDEON. We did have concerns about that, Senator. Specifically, that would be quite expensive. You will note that despite our reluctance in past years we have, in response to the National Energy Strategy changed our position on the solar and geothermal credits.

Senator GRASSLEY. Cost is your reason then?

Secretary GIDEON. Cost is a very significant component.

Senator GRASSLEY. It would help—and I am not saying that is not legitimate; if that is your reason—I guess then could you submit in writing maybe a figure that you had on that so that we would know that if your rationale is cost how costly you thought it would be.

Would you please do that?

Secretary GIDEON. We will do that.

Senator GRASSLEY. Thank you.

[The information follows:]

REVENUE COST OF PROPOSED RENEWABLE ENERGY TAX CREDIT

The Treasury Department reviewed a proposal to provide a tax credit of 2 cents per kilowatt hour to producers of electricity generated from renewable sources of energy. The credit would be provided during the first 7 years of operation of a qualifying new facility. The credit rate available to facilities built after the first year of the program would be adjusted for inflation from the 2 cents per kilowatt hour level, but the credit rate would also be phased-out for facilities placed in service during the 5th to 10th year of the program. Eligible renewable technologies include geothermal (except dry steam), biomass (except those using wastes for fuel), wind, solar thermal, and photovoltaics.

The estimated revenue cost of this proposal depends on the pace at which such renewable technologies are developed and utilized. Based on the Department of Energy's estimates of the projected growth of capacity that might be expected under such proposal, the Treasury Department has estimated the resulting revenue loss to be about $1.7 billion over the fiscal year 1992-1996 period.

Senator GRASSLEY. Mr. Chairman, I am done.

The CHAIRMAN. Well, I must say, I certainly agree with you, Senator Grassley, concerning the report of the General Accounting Office.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Mr. Secretary, this is an excerpt from the General Accounting Office report: "IRS does not fully investigate high income, non-filers which creates an ironic imbalance. Unlike lower income non-filers in the Substitutes for Returns Program, high-income non-filers who do not respond to IRS' notices are not investigated or assessed taxes. Even if high-income non-filers eventually file tax returns the returns receive less scrutiny than those who file returns on time."

How can such a screw-up happen?

Secretary GIDEON. Well, Mr. Chairman, I think that I do not believe that the tone of the report is one of screw up. It is simply a suggestion for a further improvement in processing.

The CHAIRMAN. That surely cannot be by intent.

Secretary GIDEON. It certainly was not an intention to let anybody do that.

The CHAIRMAN. I would not think so. But it sure looks and sounds like a screw up to me.

Secretary GIDEON. Well I would prefer that the Commissioner be able to respond to this question rather than me, Senator, because he has more of the facts. But I think that what you will find is an effort to improve these programs generally.

The CHAIRMAN. Well, there had better be. Because, there is no equity in that policy, and there is no commensurate return to taxpayers for the money expended for these audits, to spend more time on low-income, rather than high-income, non-filers.

Senator GRASSLEY. I appreciate the emphasis that the Chairman as brought to that. I think it would affirm my belief that was implicit in my question that maybe some of the $40 million ought to be spent in that direction.

The CHAIRMAN. Good.

I have no further questions. Thank you very much, Mr. Secretary.

Secretary GIDEON. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is Dr. Margaret Dixon, who is a member of the board of directors of the American Association of Retired Persons, from Washington, DC.

Dr. Dixon, we are pleased to have you.

STATEMENT OF MARGARET A. DIXON, ED.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Dr. DIXON. Thank you, Mr. Chairman.

I am Margaret Dixon, a member of AARP's Board of Directors. Thank you for inviting the association to testify today on the President's budget and its impact on older Americans. You have received a copy of our statement and rather than try to summarize it, I would like to focus on the health care aspects of the budget.

True to form the President's budget again takes a big bite out of Medicare. Charts 1 through 4 in our testimony show the extent of

cuts already enacted in the Medicare program generally, on both providers and beneficiaries. From 1984 through 1990 over $80 billion has been saved or cut from Medicare's hospital program.

Under last year's major deficit reduction bill another $43 billion was cut from the Medicare program for 1991 through 1995; and now under the President's proposed budget another $25 billion would be cut from 1992 through 1996.

Mr. Chairman, if Medicare is to continue serving the growing needs of beneficiaries it needs a respite from this continuous barrage of deficit reduction-driven assaults. Moreover, we are now at a critical stage of implementation of physician payment reform. AARP supported Part B reform, only to see beneficiary protections which were an integral part of that reform eroded last year. Additional Part B reductions could further erode those beneficiary protections and ultimately jeopardize support for the reform itself.

As this committee knows, AARP has supported reductions in Medicare, both on providers and beneficiaries, as part of responsible deficit reduction efforts in the past. We recognize that further changes may be warranted; but we believe that this is not the time for further cuts.

Rather, it is a time to assess the affects of past cost-cutting measures on the program's ability to provide quality health care to its aged and disabled beneficiaries.

Mr. Chairman, as disappointing as what is in the President's budget is what is not there. That is, a recognition that the problems which plague the Medicare program and Federal health spending in general are merely symptoms of the problems of runaway health care costs throughout our society. We all know the statistics.

As a nation we spend over $600 billion annually on health care or over 11 percent of our GNP. Yet, over 30 million of our fellow citizens, 9 million of them children, lack any health insurance. Another 20 million have inadequate protection and few have any protection against the overwhelming costs of long-term care, particularly the devastating costs of a nursing home stay which may run from $25,000 to $50,000 per year.

Even more ominous is the annual rate of increase in health care costs. Health care costs increased by over 11 percent between 1988 and 1989. Medicare costs will increase almost 12 percent under the President's budget. Medicaid, which still does not serve many of our most vulnerable, will increase by 16 percent. And indicative of the costs employers face, tax expenditures—something in which this committee is keenly interested—for employer-provided health insurance, will increase by almost 12½ percent.

Despite the need, the urgent need, to restrain runaway health care costs and assure all Americans access to the care they need, the administration's budget offers little in the way of solutions. Indeed, the one so-called "new idea" in the budget, income-relating Medicare premiums, is not new at all. It has been tried out before, as recently as last year's budget summit; and was rejected with good reason.

It does nothing to address the causes of rising costs and it would add enormous administrative problems. Mr. Chairman, that dog won't hunt. Some might even say it would be catastrophic.

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After many frustrated attempts at controlling health care costs, we believe there is a valuable lesson: to achieve real cost control we need to develop a comprehensive health care reform plan that ensures that everyone has coverage, that establishes a fair and uniform method of provider reimbursement that avoids cost-shifting and encourages efficient service delivery.

We must build a consensus on the need for comprehensive reform of our health care system. To do so, we must have a better public understanding of the problem, the cost of health care, and its pervasive effects of all Americans.

To this end, AARP is conducting forums and debates around the country using a set of principles on health care reform. We will be increasing this activity between now and the 1992 elections to help promote a greater public understanding of the problems facing us as well as the trade-offs that will be necessary to address them.

AARP believes that to achieve meaningful health care reform, Congress must establish a blueprint, the broad architecture of a reformed system. To this end, we hope that this committee's debate over Medicare and Medicaid budget proposals will be done in the broader context of discussing the more comprehensive problems of our current health care system.

Most important in building broad public support, however, is a solid commitment by the President to make health care reform a national priority. The President's budget proposal, as a statement of national goals and priorities, should start the process.

Thank you.

The CHAIRMAN. Thank you, Dr. Dixon.

[The prepared statement of Ms. Dixon appears in the appendix.]

The CHAIRMAN. Dr. Dixon, as you know, over the last several years the costs of Medicare Part B—physician services, laboratory tests—have escalated dramatically. In fact, the Congressional Budget Office found that between 1985 and 1989 those costs increased almost 90 percent.

When we have had provider groups in here to testify, particularly physicians, they have testified that the beneficiaries are demanding more, that they want more services, and that the way to cut back on demand for services is by higher balance billings, by increased co-payments.

Often, those statements are based on a study by the Rand Corp., which, incidentally, I understood included no elderly patients. Do you agree with that view? And, what role do you think the beneficiary can play in holding down costs? I think you know your answer to the first part. You will tell me that old dog will not hunt. But I want to know if there are ways the beneficiary can help in holding down costs.

Dr. DIXON. Yes. Well, I think we must first must be aware that it is the physician who determines what the treatment should be; and certainly the patient should not be dictating to the physician just what services he should get. However, we feel that the general public needs a great deal of education. They need to be aware of these spiralling costs of medical care.

AARP has been conducting forums throughout the country and we find that people simply are not aware of just how great the overall increases in medical services are. They only know that per-

haps they have to pay more. But they do not know how pervasive rising costs are. That is why we feel that we need a broad architecture for health care system reform in which we can look at each part of the picture. Within the context of this broad reform, we should institute mechanisms to control this rising cost.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Let me follow up on Part B a moment and the President's means testing of it. Part B is costing the general fund about $40 billion a year. The beneficiaries are paying roughly one-quarter of it and the government is paying three-quarters of it.

Dr. DIXON. Yes.

Senator PACKWOOD. The $40 billion comes out of the general fund and it is paid from taxes on lots of people who make $20,000 and $30,000 and $40,000 a year. Where is the unfairness in asking somebody who is retired and has income of $125,000 a year to pay three-quarters of the cost of Part B so that somebody who is working and making $20,000 a year does not have to subsidize it as much?

Dr. DIXON. AARP is very much in favor of fairness in financing. And within the context of a broad comprehensive system of reform we feel that persons who are more able should pay more. But we object to picking out one particular segment of the problem, such as Part B, and saying this is where these people should pay more because it will just result in cost shifting. We feel that this does nothing to reduce the overall costs of health care.

Senator PACKWOOD. I think you are right. It is cost shifting. What you are saying is, if we cannot find a way to reduce the costs of health care—and Lord knows we have tried unsuccessfully—until we find that way, the poor are going to subsidize the rich.

Dr. DIXON. Well, we are saying if we get a comprehensive plan everybody will be entitled to the same services. Everybody will be entitled to the basic health care. However, the rich will pay more in the form of premiums or social insurance than the poor will pay.

Certainly in America we have always protected our most vulnerable and we want our poor, as well as our rich, to be able to be eligible for basic health coverage. But within this system, those who are able to pay more will be expected to pay more.

Senator PACKWOOD. Now our present system of Medicare, serving those over 65, is reasonably comprehensive. It covers a great portion of the population, much more than the working poor. Medicare comes as close to a comprehensive medical system as we have. It is limited in terms of age, but it is as comprehensive as we have. You would agree with that, would you not?

Dr. DIXON. Yes.

Senator PACKWOOD. And as comprehensive as we are likely to get, because relatively few people are not eligible for Medicare assuming they are of the age group

Dr. DIXON. But we still have these 30 million people who have no health insurance whatsoever.

Senator PACKWOOD. I understand that. Most of them are not 65.

Dr. DIXON. Yes. Yes.

And we are looking at coverage for people of all ages. We are looking at a comprehensive system where people can get basic health care regardless of their age or their income.

Senator PACKWOOD. And you are saying, until we get one comprehensive system for everyone, like what we now have for those over 65, that Medicare should not be changed so that those who are rich should pay more than those who are poor.

Dr. DIXON. We are saying that we need to stop making piecemeal applications. We need to get a broad framework of a system and then we can begin to make incremental changes. But it should be within the framework of this broad system.

Senator PACKWOOD. I understand that.

Are you saying that until we get to the broad system the rich should continue to be subsidized by the poor?

Dr. DIXON. No, I am not saying that.

Senator PACKWOOD. But you are opposed to the President's suggestion that those who have $125,000 a year of income should pay more for Part B than those who are poor?

Dr. DIXON. We feel that just to concentrate on that one item is not justified because we have to think about the fact that it is really not helping to bring down costs. If they are just going to pay more there is no incentive there to reduce the costs.

Senator PACKWOOD. I understand what you are saying. You want a comprehensive system that controls costs. We all do.

Dr. DIXON. Yes.

Senator PACKWOOD. And you are saying that until we get there the poor should continue to subsidize the rich?

Dr. DIXON. Well, we are saying that we need to work toward that comprehensive system, that we have got to get started on it sometime.

Senator PACKWOOD. I will ask it once more. Until we get to that comprehensive system, the poor should continue to subsidize the rich?

Dr. DIXON. I do not feel that the poor are subsidizing the rich.

Senator PACKWOOD. You do not? Somebody who is working and making $20,000 is paying part of their taxes to the general fund to pay $40 billion for Part B; and somebody who is making $125,000 has the government pay three-quarters of their premium. That is not the poor subsidizing the rich?

Dr. DIXON. Well, I think we have to think about what expenses people have in addition to their income. This will cause—we need to look at it administratively.

Not only must we look at a person's income, we have to look at their liabilities as well as their assets. When we are talking about saving money, we have to think about the administrative costs; and also we must think about the fact that most people, 80 percent of the people who are on Medicare have incomes of under $25,000 per year.

Senator PACKWOOD. Incomes of what?

Dr. DIXON. $25,000 a year, 80 percent of the people on Medicare.

Senator PACKWOOD. Have what?

Dr. DIXON. Incomes.

Senator PACKWOOD. Of what?

Dr. DIXON. Incomes of $25,000.

Senator PACKWOOD. Of more or less?

Dr. DIXON. $25,000 or less.

Senator PACKWOOD. Okay. That's what you are saying.

Dr. DIXON. Yes.

So that we are looking at a very small population.

Senator PACKWOOD. And they will not be required to pay anymore.

Dr. DIXON. And within the context of this broad comprehensive system we want to have fairness all the way.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, I have nothing to add to Dr. Dixon's very forceful statement. But I would like to ask a more general question.

I see that you have your new headquarters rising over on 6th Street.

Dr. DIXON. Yes.

Senator MOYNIHAN. I think it will be the largest institutional headquarters in the City. I mean the Chamber of Commerce and the AFL-CIO do not come near. I must, I suppose, send a general warning about that iron law that institutions build their great buildings at the moment they begin to decline. [Laughter.]

Dr. DIXON. Well we certainly hope that that will not be our case. [Laughter.]

Senator MOYNIHAN. It was observed of St. Peters and others like that. [Laughter.]

I just wanted to make a note.

But I wonder if I could ask a question that interests me about which I know nothing, and we never hear anything, Mr. Chairman. I would love to hear someone like Lewis Thomas up here to talk to us about what is happening to medicine.

Obviously, we have this great problem with medical costs. There is a possibility that we are on a great "S" curve, that starts out that, then soars up and then goes flat again.

I was thinking about that when Dr. Sullivan was here yesterday. He is a hematologist and blood types, which are the foundation of all hematology, were discovered in the 1920's by Carl Landsteiner. Safe blood transfusions became possible for the first time, and the Nobel Prize was given to Landsteiner in 1930.

It may be that in the first flush of the discovery of great technology, you go through a period of escalating costs, followed by a period of cost efficiencies that might amaze you. Are you doing any work on that? I mean you are the largest organization I think in the country, other than the Southern Baptist Conference. [Laughter.]

What are you about 33 million members?

Dr. DIXON. Thirty-two million.

Senator MOYNIHAN. Thirty-two million, that is more than twice the membership of the AFL-CIO.

Are you doing anything like that? Are you trying to teach us, learn a little bit for us? Because you all got started on the basis of a very able statistician in New York who judged that the changes in health care were such that you could start giving insurance for older persons—health insurance, life insurance.

Something new has happened in the world. Are you doing any work like that? It would be wonderful if you were.

Dr. DIXON. Are we doing any work like what?

Senator MOYNIHAN. Like, asking yourself if we are in a temporary moment in an "S" curve, a slack, that will then go up and then go flat again.

Dr. DIXON. Well, Senator Moynihan, we try to keep abreast of the trends in our society at all times. We have a research department that tries to determine where we are going and how long it is going to take to get there and what is going to happen on the way. We are an education organization, as well as advocacy, and we try to be constantly educating our membership, you know, as well as the public.

Senator MOYNIHAN. I guess what I was saying is, could you think of a little research as well? Because if all you do is keep abreast of the times you will soon be behind them.

Dr. DIXON. Yes.

We also have a program called "New Roles in Society" that is looking ahead to the next 25 years.

Senator MOYNIHAN. Good. Thank you.

The CHAIRMAN. Thank you very much.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you very much.

Ms. Dixon, along the lines of sort of looking ahead with regard to this particular question with regard to Medicare, it struck me that from the experience of dealing with catastrophic that a lot of people who have been the beneficiaries of the Medicare program over the years probably would not mind exploring different ways of financing access to the program, providing it did not look like they were losing benefits in the process, or losing access or something in the process.

So my question is whether or not at AARP there has been any recent look at major restructuring of the Medicare program. I am well aware that in the last election cycle, or the second last election cycle, there was a great effort to convince all of us of the need for long-term care and that the social insurance system ought to play some role in long-term care.

However, the basic insurance plan called Medicare is a great difficulty to a lot of people. It is a Part A; it is a Part B. It has wide open spaces for Medigap abuse, as we all know. Without addressing myself to the issue of long-term care of chronic care access my question is the degree to which AARP would encourage the Federal policy makers to look at a restructuring of the basic insurance plan so that it looks much more like the kind of health insurance that Americans buy at work before they retire.

Dr. DIXON. I think that that is really what AARP has in mind in advocating a comprehensive health care reform plan for all Americans. We would like to see all Americans have access to acute care services and long-term care. We would like for it to be a social insurance program in which everybody pays in and everybody is eligible to receive services when they need them.

So I would say that at this point AARP is stimulating debate and is stimulating discussion and visiting sites around the country to create an awareness of the problem and to get people thinking about what services they would like and especially how much they are willing to pay in order to receive those services.

Senator DURENBERGER. On the issue, and I apologize to my colleagues for not having been here for their questions, but on the issue of relating access to this program to income, I think we all know that until the reconciliation last year the notion of the Medicare payroll tax related to the notion of a premium on health insurance.

In other words, there was a cap on your income; and it was not necessarily an income-related access system. It was between zero and 50,000. But we have always had an income cap on an access to it. And on the Medicare side the notion was always that, well, we do not really means test most health insurance premiums so why should we means test the Medicare payroll tax.

Well that went out the window last year when we ended up with $125,000 cap. So in effect the part of the premiums or the price paid for Medicare will no longer be—excuse me, will be income related. Because the more money you make the more you pay into the system.

Dr. DIXON. Yes.

Senator DURENBERGER. Now the administration and in the catastrophic bill of several years ago we proposed that additional premium payments also be income related.

Dr. DIXON. Yes.

Senator DURENBERGER. It occurred to me at the time that a lot of people in the AARP were not opposed to the notion of income relating some portion of the new post-retirement premium.

Dr. DIXON. Yes.

Senator DURENBERGER. But I am wondering out loud if we income relating the going in stuff, the payroll tax, can we also then income relate the rest of the premiums as well.

Dr. DIXON. AARP is not opposed to income related financing. We would like to see this broad system of reform; and it should be financed on an income-related basis. We do object, however, to taking one little piece of it and saying, this is where you can pay more. We want those who can pay more to pay more for the whole service which everybody—all Americans—are entitled to receive.

Senator DURENBERGER. All right.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Dixon, for your testimony. We are pleased to have you this morning.

Next we will have a panel consisting of Dr. Paul Rettig, executive vice president of the American Hospital Association; Dr. Jerome H. Grossman, chairman and chief executive officer of the New England Medical Center and chairman, Association of American Medical Colleges Council of Teaching Hospitals; Dr. Joseph Painter, chairman of the board of the American Medical Association of Houston, TX; and Mr. Alfred "Skip" Wilkins, Jr., testifying on behalf of the National Association of Medical Equipment Suppliers.

Gentlemen, we are pleased to have you.

Mr. Rettig, if you would proceed with your testimony, please.

STATEMENT OF PAUL C. RETTIG, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. RETTIG. Thank you, Mr. Chairman. I am Paul Rettig, executive vice president of the American Hospital Association and Director of the Washington office. I appreciate the honor of being called Doctor, but I am a mister.

The CHAIRMAN. Well, I backed off of that after I looked again at the titles.

Mr. RETTIG. Hospitals have responded positively to the incentives of the Medicare prospective payment system and unfortunately despite that, they are today in a precarious financial position. In terms of their responding positively, let me just give you one set of figures, which is that in-patient and out-patient care together over the last several years have stayed flat when expressed as a percentage of the gross national product. So that hospital care, both in-patient and out-patient, is on the average 4.5 percent or less of GNP while all other forms of health care costs are rising much more rapidly.

For hospitals, Medicare payment shortfalls and unsponsored care losses have become an increasingly significant source of financial difficulty. Now the President's proposed budget cuts, particularly the deep and we feel unwarranted cuts in the indirect medical education adjustment, would only serve to exacerbate this situation.

We do applaud you and your committee's determination not to reopen the 5-year budget law which has already established Medicare and other budget cuts over the period of 5 years. We commend you for that. In our view, and I guess it is the view of many on Capitol Hill, a deal is a deal and that should be kept.

Further danger, however, we feel lies in the new pay-as-you-go budget enforcement provisions in the sense that the need to finance desirable increases in entitlement programs, or the desire to reduce taxes in some way, can lead to further cuts in entitlement programs such as the Medicare program; and we feel that we need to continue to be vigilant to avoid back-door Medicare budget cuts through the pay-as-you-go system.

We do believe that many of the problems in the current health care system should be addressed in an overall fashion rather than a piecemeal fashion. In that sense my testimony is similar to some you have just heard. We, ourselves, are engaged in a process within the American Hospital Association of examining what we think the health care system should look like some years out.

We are definitely among those who believe that overall health care reform is a subject whose time has come. We appreciate the committee's willingness to work with us as we adjusted to the Medicare prospective payment system to support, for example, the elimination of the urban rural differential and a number of other desirable adjustments.

Nonetheless, our concern is that Medicare PPS in effect represents a series of broken promises where expectations about payment have in fact not been fulfilled.

Just a further word about hospitals' financial situation. We have reached the point in fiscal year 1990 where aggregate net patient margin is negative. That is, in caring for patients hospitals in the

aggregate are losing money, about a minus 0.2 percent. About 20 percent of all U.S. hospitals have negative total margins. That is, their income from all sources, patient and non-patient revenue, is negative.

In Medicare the problem is even worse. The AHA projects that in fiscal year 1992 aggregate Medicare PPS operating margins will be between minus 10 percent and minus 15 percent.

In the area of Medicaid we appreciate the good work that the Committee and many of its members have done to improve eligibility especially for women and children and to preserve adequate payment levels in some respects.

Nonetheless, Medicaid payment shortfalls are becoming of increasing concern. By 1989, payment overall for Medicaid, hospital payment, was about 78 percent of cost. So what has happened to us is that Medicaid payment shortfalls are becoming an increasing area of concern in addition to the area already of concern on compensated or unsponsored care.

Despite the fact that hospitals are under severe financial pressure in many cases their commitment to serving their communities remains steadfast and my prepared statement has some illustrations of efforts in that regard.

We are concerned, in summary, that persistent financial pressures on hospitals will eventually impair their ability to adequately serve their communities and for that reason, among others, we must object to the President's proposed Medicare budget cuts.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rettig appears in the appendix.]

The CHAIRMAN. Dr. Grossman, if you would proceed with your testimony, please.

STATEMENT OF JEROME H. GROSSMAN, M.D., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, NEW ENGLAND MEDICAL CENTER, BOSTON, MA, AND CHAIRMAN, ASSOCIATION OF AMERICAN MEDICAL COLLEGES COUNCIL OF TEACHING HOSPITALS

Dr. GROSSMAN. Thank you, Mr. Chairman. I am Jerome Grossman, M.D. and I am representing the AAMC as its chairman of the Council of Teaching Hospitals, as well as the chief executive officer of New England Medical Center in Boston.

I would like to concentrate on the two administration proposals related to teaching hospitals. Half or $1-billion of the administration's proposed 1992 savings would be achieved by changes targeted at reductions in the graduate medical education payments to teaching hospitals.

They are first the reduction of the indirect medical education allowance from 7.7 percent to 4.4 percent. And the second is a change in Medicare direct medical education payments. This latter proposal is, I think, critical in two ways. One, we move from a system whose payment includes the full range of allowable costs of faculty benefits and institutional overhead to a pro-resident amount derived only from a national average resident salary; and second, three differential payment weightings based on the resident specialty choice are proposed.

I would like to comment on these two points first and then discuss indirect medical education adjustment.

With reference to the issue of changing the basis of payment not to include the full cost of a resident—only the salary—I think all of us are aware that the method of training is by a resident participating in the care of patients under the supervision of a faculty.

There has been great concern of late in the nature of that supervision and its availability, and we have been making efforts to be sure that quality supervision is available.

Indeed, in these pressured times of short hospital stays that is additional burden for our faculty. Thus, any direct reduction in payment for faculty supervision I think flies in the face of a quality training program.

The second is an issue that I am particularly familiar with. That is the issue of how to improve the numbers in primary care physicians in America. I come to you the battle-scarred survivor of 20 years in primary care medicine. I was among the team that started the first primary care training program at the MGH in 1971. I used to be 6'4", 280; I am now 5'8", 150 pounds heading south.

The issue of how we get young men and women to participate in primary care is not related to the way the institutions in which they train are paid. It is related to the nature of what their life will be like after their training. Right now we have more than enough positions in primary care and family medicine; they are not filled. They are not filled for a number of reasons, I believe.

One is that the young men and women have an increasing financial burden. So as they look forward to their lives and their capacity to repay their loans, the income they can generate from the work of primary care does not allow them to do that. So it is rather, I think, a message to support physician payment reforms that will allow the payments for hours of work for primary care doctors to be improved so that the revenue for work done will improve to allow them to sustain the loan interest expenses.

In addition, the approaches to reducing the indebtedness through loan forgiveness programs, a number of which exist, represents a very clear and forceful way of helping the individual to be able to choose that career. Changes in tax policy might yet be a third.

But I think that we feel strongly that a program ought to be directed at individuals and not institutions. It is through the help to individuals that they will choose the primary care programs. I think we feel strongly, and we have debated this for years inside the profession, that attempting to find ways to change the way residencies work through changes in payments to institutions puts us on a slippery slope and it is very difficult to see how it could contribute to the outcome desired.

We could begin endless discussions about who is primary care; what is a shortage; who should be benefited? Training programs really are based on the institutions, patients and faculty as much as on a decision about what training program to have. The patients who seek their help are the ones in which we are engaged with both faculty, doctors and programs.

So I think those are the reasons we strongly oppose that set of proposals.

Finally, and with just a minute left, I would like to comment on the indirect medical education adjustment. As I think you have mentioned so well, the careful thinking that went into the 5-year budget agreement included a discussion of that issue, and no cut was made. The issue of the indirect medical adjustment really needs to be viewed in the context of total payments to hospitals and their margins. We feel that there is a major case to be made for keeping the adjustment at its current level.

Thank you.

[The prepared statement of Dr. Grossman appears in the appendix.]

The CHAIRMAN. Thank you, Doctor.

Dr. Painter?

STATEMENT OF JOSEPH T. PAINTER, M.D., CHAIRMAN OF THE BOARD, AMERICAN MEDICAL ASSOCIATION, HOUSTON, TX

Dr. PAINTER. Thank you, Mr. Chairman. My name is Joseph T. Painter. I am a physician with a specialty in the field of cardiovascular disease and I am a vice president at the M.D. Anderson Cancer Center in Houston. I am also chairman of the board of the AMA.

The AMA is pleased to express its appreciation for the steadfast support of you, Mr. Chairman, and others for last year's 5-year budget agreement. We share the indignation that the new Medicare cuts are a breach of that landmark deficit reduction package.

As you consider the 1992 Medicare budget, we hope that you will agree that it is not appropriate to institute payment cuts for physicians even before the physician payment reform legislation has a chance to begin. We are concerned that the piecemeal cuts and the lack of Medicare contractor administration funds will weaken the benefit to be accomplished by the new Medicare physician payment system. The Association asks that this new reform legislation not be tampered with further.

Specifically, the AMA is concerned that further cuts in the Medicare program will decrease access to, and the quality of, health care services for the Medicare beneficiary as well as exacerbate the growing physician and patient frustration with the Medicare program.

First, we oppose the reductions in reimbursement for direct and indirect graduate medical education contained in the administration budget and request full funding for Medicare's share of medical education costs. The cuts would curtail residency programs to such a degree that public and other teaching hospitals across the country may be unable to provide the much needed care that is so important to the health care safety net for the poorest and the sickest.

As you are aware, these teaching hospitals, such as the Truman Medical Center in Kansas City, Parkland Memorial Medical Center in Dallas, Cook County Hospital in Chicago, Los Angeles County General Hospital in California are particularly vital to the care of the poor and the uninsured; and a GME cutback would hit this population hardest of all because of the service the residents provide.

Second, the AMA is opposed to basing reimbursement on a desired frequency of use of radiology and diagnostic tests as the administration proposes. Such a proposal is likely to penalize rural and underserved areas that would be most likely to have the most infrequent use of these tests.

A cutback in reimbursement, simply because the test is used infrequently in a remote area would limit access to these tests in those rural and underserved areas. Moreover, the resource based relative value scale takes many of these factors into consideration in its calculation of the resource costs.

Third, the Association is opposed to the suggested limitations on reimbursements for anesthesia services and assistance at surgery. The administration's proposal to limit reimbursement for services provided by anesthesia care teams and assistant surgeon is contrary to the new physician reimbursement system which bases payment on the resource costs of the services provided. The AMA would oppose modification of the payment reform legislation.

Furthermore, we are concerned that these proposals would encourage medical decisions to be based on financial considerations rather than what is the best for optimal patient care.

Fourth, we are concerned that the administration's proposals provide insufficient Medicare contractor administration funds. We believe the administration's proposal of $5 million above fiscal year 1991, an increase smaller than 1 percent, is really insufficient.

In justification of the appropriations for fiscal year 1992, the Health Care Finance Administration admits that the budget proposal for administrative funds is insufficient and will result in a large case backlog, an estimated number of 7 million appeals that would be occurring.

In addition, the complex legislation from 1990 still must be implemented. We believe that because the contingency funds were used this year for bail out of that system, additional funds will be required.

Finally, we support the administration's interest and leadership role in encouraging States to adopt professional liability reform. But we believe that Federal preemptive law, rather than a budget neutral system of incentives and disincentives would be more appropriate. We urge your support of the liability initiatives set forth in Ensuring Access Through Medical Liability Reform Act—S. 489—introduced by Senators Hatch and Jeffords.

This concludes my statement, Mr. Chairman. I would be pleased to answer your questions at the appropriate time.

[The prepared statement of Dr. Painter appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Painter.

Mr. Rettig, could you help me with some of your numbers?

Mr. Wilkins, they tell me I have overlooked you. I apologize for that. If you would proceed, sir.

STATEMENT OF ALFRED T. "SKIP" WILKINS, JR., TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, VIRGINIA BEACH, VA, ACCOMPANIED BY RANDAL CALDWELL, BOARD MEMBER, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS ASSOCIATION

Mr. WILKINS. Thank you, Mr. Chairman and members of the committee. My name is Skip Wilkins. I was well on my way to accomplishing the all-American dream at 17 years old. I had twenty-some football scholarships, a car, a job, a good home, and I was headed for a bright future when 3 days following my high school graduation an accident changed my life. It shattered my dreams and caused me to be a quadriplegic, using a wheelchair for the rest of my life.

Since that time I have married, obtained a college degree is psychology, and became an author, lecturer, and businessman. I am very proud of these accomplishments. But I am most proud of the fact that I have the opportunity to help, encourage, and motivate disabled people to recognize their potential in life.

I have served as a special consultant to Quickie Designs, a national wheelchair manufacturer that is a member of NAMES, who I represent today, for the past 8 years.

With me today is Randal Caldwell, president of United Medical, Inc., in Wynne, AR, a company specializing in home medical equipment, products and services. Randal serves on the board of directors of the National Association of Medical Equipment Suppliers (NAMES), whose members consist of over 2,000 independent ethical suppliers of home medical equipment (HME). Randal also serves as president of the Medical Equipment Suppliers Association of Arkansas.

I will address two primary topics: the role HME plays in providing quality of life for millions of Medicare beneficiaries; and the impact that recent budgetary reductions and proposed additional cuts may have on the ability of the elderly and people with disabilities to have access to high-quality equipment and services in the future.

I cannot underscore enough the importance to people who have imitated physical mobility of continued access to quality equipment that empowers them to better control their own lives and become productive members of our society.

Consider for a moment the importance of having an appropriate wheelchair to accommodate a specific disability. Persons with severe disabilities do not ordinarily select wheelchairs from a range of mass-produced models as if they were selecting clothing in a department store.

People with disabilities rely completely on experienced HME suppliers to recommend and fit a wheelchair that will best meet their own personal needs. To do otherwise could easily result in an incorrect "fit," which could then lead to severe short- and long-term health problems. Such a person may not be aware of problems with posture immediately, due to defects in wheelchair seating and positioning. If uncorrected, such problems intensify over time and evolve into more serious—sometimes life-threatening—conditions.

Now I understand sometimes this is hard to understand. A wheelchair is not just a wheelchair. It is a way of life. I focus on this today as but an example of HME because I do live my life in a wheelchair. It is the same wheelchair that has allowed me to take shattered dreams and recreate new ones. The one dream I thought would be left behind on the bottom of a lake involved sports. Instead, I have gone on and competed in wheelchair sports representing our country 12 times in the United States wheelchair teams in Pan American and Olympic events. I have become a world champion in the shot put. And I thought all I wanted to do was to play for the Redskins.

The disability community is by no means the only segment of the population that relies so completely on the HME industry to meet very specific needs. Many ill or elderly Medicare beneficiaries now can be cared for in their homes, thanks to HME. Home health care usually can be provided for far less money than similar care provided in an institution.

In fact, a soon to be released study conducted by the well-respected research firm of Lewin/ICF adds further credence to the fact that caring for people at home in almost every instance is the least costly method for the Federal Government to provide needed health care.

While this argument is undeniably persuasive in light of the ever burgeoning Federal deficit, I submit that, even if home care in all cases was not found to be fiscally conservative, we should not lose sight of the social gain achieved by allowing people to live, recuperate, and continue their lives with families at home.

I know if it had not been for my family I would not be where I am today. Despite the critical role which home care plays in the entire health care spectrum, HME has been singled out for budgetary reductions over the last few years to such a severe level that the unforeseen effect may well be the dismantling of the entire HME industry.

HME is a small segment of the health care industry, accounting for only 2 percent of the overall Medicare budget. Yet over 7 percent of the Medicare cuts in OBRA 1990—some $215 million—came from HME. This $215 million in cuts, which is in addition to the $80 million in HME payment reductions in 1989, represents over three times the industry's proportional share of reductions.

Significantly, over a 5-year period, effects of OBRA '90 will be to reduce outlays for HME by $2.2 billion, an amount that exceeds expenditures for HME for the entire fiscal year 1990. In its fiscal year budget, the administration is proposing yet another series of drastic budget cuts that directly affect the HME industry. These proposed cuts, totalling $45 million for fiscal year 1992 alone, would come from the following areas: an additional 5-percent reduction in oxygen reimbursement; a national cap on reimbursement for HME, including orthotics and prosthetics, set at the national median; and a reduction in payment for enteral and parenteral nutrients.

I urge you, in strongest terms possible, to oppose these proposals in their entirety. My written statement describes in some detail the recent legislative changes affecting the HME industry and how these fiscal year 1992 budget proposals will further erode the HME

Medicare benefit. At present, let me simply state that access to needed equipment and services already has been limited in certain markets across the country. Preliminary figures obtained from Medicare carriers show some 1991 payment levels falling to 50 percent below the amount suppliers actually pay to purchase the equipment from manufacturers.

I am very concerned that the cumulative of all these budget reductions will cause an adverse impact on the very population this industry originally was created to serve—the sick, the elderly, and people with disabilities. Simply put, HME is a vital benefit under the Medicare program which cannot sustain further budget cuts and remain viable.

The vast majority of the HME industry provides a high level of quality equipment and services. HME companies which are NAMES members operate under strict standards of integrity and ethical business practices. The industry acknowledges that there have been some instances of fraudulent and abusive practices.

In response, NAMES has developed several proposals which, if enacted into legislation, would move toward the mutual goals of Congress and the HME industry to strengthen the industry's ethical standards. NAMES will be pleased to discuss the details of its proposals at your convenience.

In closing, I would ask that you consider the integral role that HME plays in the home health care system in our country. This industry makes homecomings possible for so many people who still need a competent level of care after they are discharged from a hospital or other institution. The HME industry provides the level of service required to assist people with severe disabilities in leading productive lives in the mainstream of society.

As our Nation's elderly population increases and as further technological advances are made to assist people with disabilities to maximize their own unique potential, HME services should be preserved and expanded to meet these diverse needs. Congress should reject outright any further budget cuts to HME.

Thank you for this opportunity.

[The prepared statement of Mr. Wilkins appears in the appendix.]

The CHAIRMAN. Well, Mr. Wilkins, I am so glad you came. You are a powerful witness, pretty gutsy.

Mr. Rettig, help me understand some of these numbers. Over 70 percent of the hospitals in my State are losing money on Medicare, and yet AHA's own data indicates that the total aggregate revenue margin, taking into account not only Medicare but all hospital business, has leveled off at around 5 percent.

In fact, PROPAC has reported that total margins are now higher than they were in the 1970's. You referred to the negative 0.2 percent margin on patients, but I am talking about total margins. How do you reconcile the Medicare losses with total margin data? Are not the other payors tightening their reimbursements too? Would you respond to that?

Mr. RETTIG. Yes, Mr. Chairman, the total margins, as you are aware, represent expenses meshed against revenue from all sources, wherever the hospital is able to get that.

The CHAIRMAN. I suppose charitable contributions and everything else.

Mr. RETTIG. That includes contributions. It includes payments by government entities that are otherwise not factored in as patient care revenues. It includes interest on funds held by hospitals. It includes income from parking lots or whatever other ventures there are that surround the hospital. To some degree it includes income from ventures that hospitals, some of them, have embarked on over recent years, that are in the profitmaking area and in some cases only tangentially related to their main line of business.

Hospitals have been criticized in some cases for that; and in some cases they have withdrawn.

Our position is that these other sources of income are by and large not really reliable and that one should not count on them for the long run. Hospital margins overall are as you have indicated comparable to those before Medicare prospective payment began or better.

But before PPS hospitals were assured payment of their costs. So it was a zero risk kind of situation. Whereas prospective payment was deliberately planned as a way to put hospitals into a situation that did include an element of risk, and in a case like that, a somewhat higher margin is almost necessary.

The CHAIRMAN. Dr. Grossman and Dr. Painter, you might want to join in this. I appreciate the comments that you have made concerning the administration's proposal to modify payments to hospitals for direct medical education costs.

That is of real concern to me. I see, for example, in Texas some of our teaching hospitals that are really out on the leading edge of medical technology get a disproportionate share of severe cases sent to them.

Then we get into this question of the treatment of primary care residencies as apart from other specialties that you referred to directly. You have argued that many primary care residencies are currently going unfilled, so that if we are trying to encourage more residents to choose primary care, a change in hospital payments will not necessary improve the supply of these physicians.

But the proponents of shifting payments to primary care residencies from those for specialized fields argue that even if there is only a small effect on increasing the number of primary care physicians it would be worthwhile. What is the harm in trying? What is the negative?

Dr. GROSSMAN. I guess I think there are two parts to that answer. It is that I think it will be of harm to other programs and it will not even have any impact on the choices of young men and women in that we are looking at, they have the opportunity now to choose these specialties and they are not using the slots available to them now.

As you alluded to, Senator, the issue of training people in complex specialties in which the supervision and care of those patients is very difficult, anything we would do that would diminish the capacity to have the training programs remain of high quality and supervised, I think would be detrimental.

I do not believe there is any likelihood of improvement and there is likelihood of harm from moving in this direction.

The CHAIRMAN. Dr. Painter, do you have any comment on that?

Dr. PAINTER. Yes. I would agree with Dr. Grossman that I do not believe the impetus for giving more dollars to the institution for primary care resident would have a significant effect on the decisions being made by individual physicians to choose primary care versus other specialty.

I think the second part is that what is needed is a support for the general graduate medical education program in the teaching facilities. These facilities have to have a broad array of services if they are going to continue to provide a quality training program in each of the specialties, and most importantly provide the type of service that their patients, and particularly the ones who are indigent and uninsured, need.

The CHAIRMAN. I see we have a vote on the floor. So we are going to have to wrap this up.

Senator Grassley, any comments that you want to add.

Senator GRASSLEY. Thank you.

I would like to ask one question.

The CHAIRMAN. Fine.

Senator GRASSLEY. My one question I will ask is to you Dr. Painter.

Senator GRASSLEY. The reason I want to ask you this is because I read an article in the Cedar Rapids Gazette about how some doctors, because of red tape, are not going to take anymore Medicare patients. My question is—I know you do not know about the article, but I am sure you know about the problem. The physicians, who are now non-participating physicians, complain of low reimbursement and harassment by Medicare rules and regulations.

On the reimbursement side the eight sub-State areas in my State of Iowa, for purposes of medical reimbursement, rank from 184th to 222nd of the 226 areas of the country. On the harassment side, the physicians are complaining about, and I quote from the paper, "a bureaucratic, complex and ever-changing rule system."

One of the physicians claims that he may be subject to a $2,000 fine for an error he claims was made by the earner, and he is probably going to go to court over that. So this leads me to these two questions.

First, does it still appear that physician payment reform is going to lead to more equitable reimbursement on a regional basis so that for physicians in my region reimbursement will become fairer? Second, how general is this unhappiness over hassles caused by Medicare rules and regulations? Is it just a sole practitioner or small clinic in rural areas that have this problem? And finally, how general is this phenomenon of physicians not wanting to see Medicare patients?

Dr. PAINTER. Let me respond first to one of the three parts of your question. The resource-based relative value scale that is under development now and will go into effect January 1, 1992, represents a consensus among the specialties on how the basic allotment of physician Medicare payment could be done.

Using a conversion factor this immediately converts it into a payment schedule. Not everybody is going to be happy with the readjustments, but we think it is the way to go. The AMA strongly supports a physician payment reform.

Secondly, in terms of the hassle factor, there is no question but what there is a pervasive underlying concern among physicians about the detail and the exquisite degree of regulations. These regulations are so detailed it is very difficult to keep up with what is required of each of them.

In the last session of Congress "anti-hassle" legislation was enacted that helped. We hope that we can bring to your attention other "hassles" this session. We hope that this legislation will simplify the process, make it more understandable and reduce the cost.

I think the final part of your question would primarily relate to the administrative costs. Obviously, administrative costs are shifted down the line. The physician's office is doing more in terms of the cost of running the office, such as the cost of personnel, et cetera, but most importantly the added burden of having to do many of these additional administrative procedures.

The CHAIRMAN. Could I interrupt. We have 7 minutes left on this vote. Could I ask that we defer and see if Senator Breaux would like to ask a question.

Senator GRASSLEY. Yes. If he want to continue he can do that in writing.

The CHAIRMAN. We will take it all for the record. Whatever you want to submit.

Dr. PAINTER. Thank you.

Senator GRASSLEY. Then I will submit these other questions.

The CHAIRMAN. Good.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman.

I do not have a question. I apologize for being detained with another committee and missing the testimony of the witnesses and the panel. My staff has reviewed it and we will be discussing it.

I share the chairman's view. We have an incredibly large health crisis as far as payments are concerned in this country, but we do not feel that a continued whacking of the Medicare reimbursements and Medicaid reimbursements is the answer or the solution to the problem. We can no longer continue just to look in this area as a means of balancing the budget.

We had a deal last year, I thought, Mr. Chairman, and am very surprised to see us back here talking about the same efforts to reduce Medicare. I do not think that is going to fly. Thank you for an opportunity to make that comment.

The CHAIRMAN. Gentlemen, your testimony has been quite helpful to us and we are very appreciative of that. I apologize for having to terminate the hearing, but we have to be on the floor to vote.

Thank you.

[Whereupon, the hearing was adjourned at 11:50 a.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Stuart H. Altman

Good morning, Mr. Chairman, I am Stuart Altman, the Chairman of the Prospective Payment Assessment Commission. With me today is the Commission's Executive Director, Dr. Donald A. Young. I appreciate the opportunity to testify before the Committee this morning. On March 1, 1991, ProPAC delivered its seventh annual report and recommendations for updating and improving Medicare payment policies for hospitals and other facilities.

As you know, the Commission was created in 1983 as part of the legislation establishing the Medicare prospective payment system (PPS). In our early years, we devoted most of our time and resources to updating and improving Medicare payment policies for inpatient hospital services.

In recent years, however, the Congress has greatly expanded our responsibilities. Thus, our mandate now includes the facility component of all inpatient and outpatient hospital services as well as skilled nursing facilities, home health services, and freestanding units such as end stage renal disease facilities.

OBRA 1990 also required us to study and report on Medicaid payments and their relationship to Medicare payments and the financial condition of hospitals. The Congress has also asked us to examine the financial burden placed on hospitals as a result of furnishing care to millions of Americans who lack health insurance or other means to cover the costs of medical care. Our March 1, 1991 report to Congress reflects this broadened mandate.

STATUS OF HOSPITALS

This morning, I would like to begin by briefly describing some findings regarding Medicare payments and hospital financial condition. Mr. Chairman, I know that you and the members of this Committee are especially interested in the problems of rural health care, and I will highlight this subject in particular.

Since the implementation of PPS, the growth in Medicare inpatient hospital spending has slowed dramatically. During the 6 years before PPS, Medicare inpatient spending was growing at an annual rate of 17 percent. Over the first 6 years of PPS, the annual growth rate fell to 6.1 percent (see Table 1). This decrease in the rate of growth was due in part to Medicare's ability to control the level of per-case payments. It also resulted from a lower level of inflation and a decrease in hospital admissions.

In the first year of PPS, the growth in hospitals' expenses per admission dropped significantly. Since then, however, expenses have grown almost 10 percent a year. Because costs per case are now growing faster than payments, many hospitals, urban as well as rural, are experiencing a decline in their financial condition. One way to assess a hospital's financial condition is to examine its financial margins. The PPS margin compares the PPS payments that hospitals receive with their Medicare operating costs. By the fifth year of PPS, the aggregate PPS margin was 2.6 percent (see Table 2). There as a difference, however, in PPS margins for urban and rural hospitals. In the fifth year, the average PPS margin for rural hospitals was −2.3 percent. All rural hospitals, however, are not doing poorly under PPS. A quarter of all rural hospitals had PPS 5 margins of at least 8.5 percent (see Table 3). In additions, these findings do not take into account many of the recently adopted changes in rural hospital payment policy. These changes include higher annual update factors for rural hospitals since 1988, changes in the financing of other rural cases, and changes in payment methods for sole community and certain other rural

hospitals. As the effects of these changes become apparent, the gap between urban and rural margins will continue to decrease.

Another measure of the financial performance of a hospital is the total margin which describes hospitals' overall financial status. The total margin compares hospital revenues and expenses for all inpatient and outpatient care and non-patient care activities. This includes Medicare and Medicaid patients, covered by private insurance and those who are uninsured. Non-patient care activities are also included.

As with the PPS margin, the total margin declined over the first five years of PPS (see Table 4). This decrease, however, was not as steep as for the PPS margin. The decline in total margins has now leveled off and remains at about the same level as immediately before PPS. Total margins today, however, are considerably higher than they were at any time during the 1970s. Further, rural hospitals' total margins, are significantly higher than their PPS margins. In fact, rural hospitals' total margins are generally the same as the total margins of urban hospitals.

These mixed results for rural hospitals may reflect the broad nature of many of the policy changes adopted to date. More needs to be done, however, to target policy improvements to the special problems facing those hospitals in most need. The Commission is especially concerned about isolated rural hospitals and small hospitals facing large declines or fluctuations in admissions.

REPORT TO SENATE APPROPRIATIONS COMMITTEE

At the request of the Senate Appropriations Committee, we will be submitting a report to you in mid-1991 identifying policy approaches to further assist those rural hospitals for which current PPS policies may not be appropriate.

The report will include the findings from our estimate of the impact of changes in rural hospital payment policy over the years of PPS, including the more recent changes. In addition, we are examining the role of declines and volatility in admissions and assessing the impact of a possible automatic volume adjustment for hospitals experiencing large changes in admissions.

We also continue to seek a better way to identify and improve payments to small, isolated rural hospitals that require special protection to ensure rural beneficiary access to care.

UNCOMPENSATED CARE

There is another factor, Mr. Chairman, that is affecting the financial condition of hospitals and that is the problem of uncompensated care, which OBRA 1990 asks us to consider. As you and the members of the Committee know, many Americans lack health insurance or other means to cover the cost of medical care. ProPAC is concerned about the effects of this problem on access to care for millions of Americans and the increasing financial burden it places on hospitals and other providers that care for the uninsured population.

From 1980 through 1989, uncompensated care costs in PPS hospitals increased an average of 12 percent per year. Further, the portion of uncompensated care costs that is not offset by state and local government subsidies increased even faster during this period—by 13.5 percent per year. In 1980, state and local governments covered 29 percent of all uncompensated care costs. This proportion had dropped to 20 percent by 1989.

Uncompensated care continues to be a significant problem for large, inner-city and publicly-owned institutions. Over the course of the last decade, however, the problem has increasingly affected the entire industry. After offsetting government subsidies, uncompensated care commands the some proportion of hospital resources in rural areas as in urban areas (see Table 5). Public hospitals continue to provide the most uncompensated care, but the proportion of all unpaid care borne by these hospitals has declined from 27 percent in 1980 to 16 percent in 1989. Similarly, the proportion provided by major teaching hospitals has decreased from 23 percent to 18 percent.

Further, there is substantial variation in the proportion of hospital resources devoted to uncompensated care in both urban and rural areas and among regions of the country. There is also great variation among both teaching and non-teaching hospitals and even among government hospitals. This tremendous diversity complicates the task of addressing uncompensated care in payment policy.

Before drawing any conclusions about the pattern of uncompensated care across hospitals or what might be done to mitigate its negative effects, we plan to add to our analysis the impact of providing care to Medicaid patients, often at payment levels below costs. As you requested, we will report to you the findings from this analysis by October 1, 1991.

Mr. Chairman, I would now like to briefly describe some of our recommendations for Medicare hospital payment in fiscal year 1992.

UPDATE FACTOR FOR 1992

As you know, Mr. Chairman, the fiscal year 1992 update has been set by law. Nevertheless, as requested by Congress, the Commission followed its past approach of examining individual factors that together determine its update recommendation.

Our average update factor recommendation for 1992 is 3.4 percent, based on the current HCFA market basket forecast of 4.8 percent. We are recommending a 3.2 percent update for large and other urban hospitals and 4.2 percent for rural hospitals. The detailed components of these recommendations are shown in Table 6.

Thus, the Commission's update recommendation is the same as the current law 1992 update for both urban and rural hospitals. The increase in Medicare payments to hospitals, however, will be more than the average update of 3.4 percent. We estimate that average per-case payments to hospitals in 1992 will increase an additional 2.3 percent due to continued increases in reported case mix. Our recommendations, therefore would result in a total increase in average PPS per-case payments of 5.7 percent (see Table 7).

When expected increases in Medicare admissions are factored in, we expect total Medicare payments for inpatient hospital care to increase between 7 and 8 percent.

Since the beginning of PPS, per-case payments have increased faster than the update factor as shown in Table 8. As you can see, over the first seven years of PPS, the cumulative increase in the update factor was 24 percent. Per-case payments, however, increased by 70 percent. In comparison, the hospital market basket measure of inflation increased by 35 percent over this period.

This year, as we have each year since our 1987 report, we are recommending a higher update factor for rural hospitals than for urban hospitals. As you will recall, Mr. Chairman, in our report last year we recommended that the differential between the rural and the other urban standardized amounts! be eliminated over three years through higher updates to rural hospitals. In our report this year we indicate our support for the OBRA 1990 provision to eliminate this difference by 1995.

TEACHING AND DISPROPORTIONATE SHARE HOSPITALS

Mr. Chairman, I would like to turn now to teaching and disproportionate share hospital payments. This year, as previously, we have attempted to balance Medicare's responsibility to provide an appropriate level of payment for the costs associated with teaching intensity and the care of indigent patients with a broader Federal responsibility to maintain access to high quality care for Medicare as well as other patients.

Each year, ProPAC estimates the relationship between teaching intensity and Medicare operating costs per discharge. To arrive at this estimate, we adjust for other factors that also influence payment, such as urban or rural location, the level of the wage indexes, and the hospital's case-mix index. Our most recent analysis is based on cost data from the fifth year of PPS and payment rules for fiscal year 1991.

This year, the Commission estimated this relationship without first adjusting for DSH payment. We used this approach because we believe the IME and the DSH adjustments are designed to meet different policy objectives, even though there is substantial overlap in the hospitals receiving these adjustments. Omitting the DSH adjustment from the analysis increased the estimated teaching intensity effect from 2.1 percent to 4.2 percent. We believe this 4.2 percent figure, based on the method we used this year, is the most appropriate measure of the added costs related to teaching intensity.

The current 7.7 percent IME adjustment is substantially higher than the 4.2 percent indicated by our most recent analysis. As a result of this and other factors, PPS operating margins consistently have been higher for teaching hospitals than for non-teaching hospitals. However, the overall financial performance of major teaching hospitals has been poor relative to other hospitals, in part because these hospitals treat large numbers of patients without private insurance. These findings led us to conclude that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care would be impaired without continued Federal support.

Therefore, the Commission is recommending a modest reduction in the IME adjustment from its current level of 7.7 percent to 7.0 percent for fiscal year 1992. This recommendation would reduce the IME adjustment by one-fifth of the difference be-

tween the current level and the Commission's empirical estimate of 4.2 percent. This reduction should be implemented in a budget neutral fashion with the reduction in indirect medical education payments returned to all hospitals with corresponding increases in the standardized payment amounts. Before recommending any further cuts in the IME adjustment in future years, the Commission will examine the financial status of teaching hospitals to determine whether reductions would have serious deleterious affects on Medicare patients' access to high quality care.

ProPAC will continue to work to improve the IME adjustment so as to better target these extra Medicare payments to those teaching hospitals most in need. At the same time, improvements may also be necessary in the disproportionate share adjustment to fulfill the broader social responsibilities of the Medicare program as efficiently as possible.

PPS EXCLUDED HOSPITALS AND DISTINCT-PART UNITS

As you know Mr. Chairman, psychiatric and rehabilitation hospitals and distinct-part units as well as long-term, children's, and cancer hospitals are exempt from PPS. These hospitals and units are subject to payment policies established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) They are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per-case costs.

The TEFRA target rate-of-increase limits are updated annually. Until 1989, these excluded facilities received the same update provided to PPS hospitals. The PPS update, however, was constrained because PPS hospitals also received increased payments due to case-mix index increases. For the first seven years, PPS payments increased nearly 70 percent while the market basket increase was 35 percent. At the same time the TEFRA target rate increased only 27 percent. PPS excluded providers, therefore, received substantially lower payment increases than PPS hospitals.

In addition, facilities excluded from the beginning of PPS were at a greater disadvantage than facilities that were excluded at a later date. The Commission's analysis indicates that the earlier a provider was excluded from PPS, the more financially vulnerable it has become.

The Commission believes that these excluded providers should have received the full increase in the market basket each year they were excluded prior to 1989. Therefore, the Commission's update factor recommendations for excluded providers has two components.

First, we are recommending an average update factor for all excluded hospitals and distinct part units of 4.2 percent. We arrived at this figure using the HCFA PPS-excluded hospital market basket forecast of 4.9 percent, and adjusting this market basket to better reflect increasing labor costs, which are not adequately captured in HCFA's market basket. As with PPS hospitals, an adjustment was made to correct for an error of 1.0 percent in the 1990 market basket forecast. We then added an allowance of 0.1 percent for scientific and technologic advancement.

Second, we are recommending an additional positive allowance to some hospitals to compensate them for the years the TEFRA facility payment was subject to the PPS update factor. This additional allowance reflects the difference between the updates given in earlier years and the actual market baskets for those years.

IMPROVING THE AREA WAGE INDEX

As requested by OBRA 1990, we are also recommending improvements in the area wage index. The current area wage index used to adjust PPS payments reflects both the price of labor and geographic differences in the mix of occupations employed by hospitals. As a result, hospitals in areas that furnish a more complex set of services, requiring a more complex mix of occupations, receive higher payments due to a higher case-mix index and to a higher wage index. In essence, the current wage index double counts these added costs. Thus, we believe the wage index should be adjusted so that it measures the price of labor but not the effects of differences in the mix of occupations. Such an adjustment would generally increase the wage index values in rural areas and decrease the values in large urban areas.

CAPITAL PAYMENT

I would now like to turn briefly to the subject of Medicare payment for capital costs. Since the beginning of PPS, it has been intended that hospital capital costs would be incorporated within the DRG payment system. Capital continues to be paid on a cost basis, however, for technical as well as other reasons. The major problem is that capital costs, more than operating costs, vary significantly across similar

institutions. This variation is due to many factors, including differences in the timing of major capital investments and various financing methods and rates. The capital costs associated with major projects extend over many years. Therefore, hospital managers have limited ability to adjust existing costs to adapt to changing financial incentives or patient demand.

The Commission had originally planned to submit our capital policy recommendations to you in our March 1 1991 report. We made these plans believing that the Secretary's proposal would be available for our analysis and evaluation. However, we have not had the opportunity to review the Secretary's proposal. Therefore, we deferred our recommendations. As you requested, Mr. Chairman, the Commission will submit a capital report and recommendations to you by May 15, 1991.

During the past year, however, we have conducted extensive analysis and discussions of capital payment issues. Our subsequent recommendations will be guided by our belief that Medicare capital payment policy should generate appropriate incentives for hospitals to limit their capital expenditures and that there should be no extra incentive to increase capital spending as an alternative to labor or other categories of operating expenses. The policy should also, where appropriate, recognize hospitals' prior capital obligations.

We have been encouraged to find that in the past few years, the rate of increase in capital spending has declined significantly. As inflation in the early 1980s waned. Interest costs declined. More recently, however, we have also seen less growth in depreciation indicating that hospitals are decreasing the amount of capital investment.

As a result, capital costs are now increasing at about the same rate as operating costs (see Table 9).

This decrease in the rate of growth in capital spending seems to be a response to both the current policy of paying less than full capital costs and the increasing financial pressures facing hospitals as Medicare continues to control payments for operating expenses.

HOSPITAL OUTPATIENT PAYMENT

Finally, Mr. Chairman, in our March 1, 1991 report we lay out the framework for improvements in payment for hospital outpatient services. As you know, OBRA 1990 further reduced payments for many hospital outpatient services. Thus, rural as well as urban hospitals will feel increasing financial pressure from these reductions. The impact of these reductions, however, will particularly affect rural hospitals, since outpatient services are responsible for a much larger share of total revenue for rural hospitals than for urban hospitals. Therefore, the Commission is carefully examining the impact of alternative hospital outpatient payment policies on rural hospitals.

ACCESS TO CARE FOR RURAL RESIDENTS

As you are aware, Mr. Chairman, many factors, in addition to Medicare payment policies, have affected the use of services and the financial condition of hospitals in rural areas. Because these changes in rural health care delivery have been so extensive, we have not limited our analyses to Medicare payment and hospital financial condition. Other analyses have focused on the services received by Medicare beneficiaries living in rural areas. We have found that, in recent years, rural beneficiaries have increasingly received services in rural referral and urban hospitals.

ProPAC has investigated two different aspects of access to care for rural beneficiaries: access to ambulatory services and differences in patterns of hospital care. In examining differences in utilization of ambulatory health services, ProPAC found little difference in service use between rural and urban beneficiaries. In 1982, urban beneficiaries were more than twice as likely as rural beneficiaries to have visited a hospital outpatient department. By 1988, these differences in use did not exist: the same percent of elderly had a hospital outpatient visit, regardless of whether they lived in an urban or rural area. Likewise the rural elderly do not seek their care disproportionately in hospital emergency rooms when compared with the urban elderly. In addition, rural beneficiaries received care in physicians' offices and other ambulatory settings as frequently as the urban elderly.

In another study, which we updated this year, ProPAC investigated differences in the patterns of hospital care for urban and rural beneficiaries. This work also found that access to inpatient care for rural beneficiaries does not appear impaired. Hospital admission rates continue to be somewhat higher for rural beneficiaries than urban elderly. In addition, technology intensive treatments and procedures are now performed on rural beneficiaries at about the same frequency as urban residents.

This work indicates that the hospital utilization patterns of rural elderly appear to becoming more like those of urban beneficiaries. Rural residents, however, are obtaining more of their care for complex conditions in rural referral centers and urban hospitals.

Table 1. Estimated Inpatient Hospital Payments

Fiscal Year	Inpatient Hospital Payments (In Billions)	Inpatient Hospital Percent Change
1977	$14.429	–
1978	16.719	15.9%
1979	19.176	14.7
1980	23.129	20.6
1981	27.706	19.8
1982	32.554	17.5
1983	36.950	13.5
1984	40.385	9.3
1985	43.618	8.0
1986	45.280	3.8
1987	46.579	2.9
1988	49.570	6.4
1989	52.642	6.2
Annual rate of change:		
1977-1983		17.0
1983-1989		6.1

Note: Payments reported in this table are incurred expenditures, rather than outlays.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Table 2. PPS Operating Margins for the First Five Years of PPS, by Hospital Group

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5
All hospitals	14.5%	14.4%	10.1%	5.7%	2.6%
Urban	15.8	15.5	11.3	6.8	3.6
Rural	8.4	8.8	3.1	-0.3	-2.3

Note: Data for each PPS year (PPS 1, PPS 2, etc.) correspond to each hospital's cost reporting period beginning in that year. For instance, the PPS 1 year includes data from each hospital's cost report beginning during the first year of PPS (Federal fiscal year 1984). Excludes hospitals in Maryland and New Jersey; includes hospitals in Massachusetts and New York, beginning with PPS 3.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Table 3. Distribution of PPS Operating Margins in the Fifth Year of PPS, by Hospital Group (In Percent)

	Percentile				
Hospital Group	10th	25th	Median	75th	90th
All hospitals	-28.3%	-12.2%	-0.5%	9.8%	18.6%
Urban	[illegible]	-9.3	1.2	10.7	19.7
Rural	33.9	-15.5	-2.6	8.5	17.2

Note: Excludes hospitals in Maryland and New Jersey.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Table 4. Total Hospital Margins for the First Five Years of PPS, by Hospital Group (In Percent)

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5
All hospitals	7.6%	6.7%	4.9%	3.8%	3.8%
Urban	8.0	7.0	5.1	3.8	3.8
Rural	5.3	4.8	3.3	3.4	3.8

Note: Data for each PPS year (PPS 1, PPS 2, etc.) correspond to each hospital's cost reporting period beginning in that year. For instance, the PPS 1 year includes data from each hospital's cost report beginning during the first year of PPS (Federal fiscal year 1984). Excludes hospitals in Maryland and New Jersey; includes hospitals in Massachusetts and New York, beginning with PPS 3.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Table 5. Uncompensated Care Costs as a Percent of Total Costs, by PPS Hospital Group, 1984-1989

Hospital Group	Without Offset for Government Subsidies	Amount of Government Subsidies	With Offset for Government Subsidies
All hospitals	6.1%	1.4%	4.7%
Urban	6.2	1.5	4.7
Rural	5.5	0.7	4.8
Large urban	6.2	1.7	4.5
Other urban	6.1	1.1	5.0
Rural referral	5.5	0.2	5.3
Sole community	5.3	1.0	4.3
Other rural	5.4	0.8	4.6

Table 6. Recommended PPS Update Factors for Fiscal Year 1992

Components of the Update Factor		
Components applied to all hospitals		
Fiscal year 1992 PPS market basket forecast*		4.8%
Adjustment to reflect ProPAC version of PPS market basket*		0.2
Correction for fiscal year 1990 forecast error		-1.0
Components of discretionary adjustment factor		
Scientific and technological advancement	0.7	
Productivity	-0.5	
Total discretionary adjustment factor		0.2
Adjustments for case-mix change (fiscal year 1991)		
Total DRG case-mix index change	-2.5	
Real DRG case-mix index change	1.3	
Within-DRG case complexity change	0.2	
Net adjustment for case-mix change		-1.0
Additional adjustments to the standardized amounts		
Adjustment for large urban areas	0.0	
Adjustment for other urban areas	0.0	
Adjustment for rural areas	1.0	
Total Update Factor		
Large urban	3.2	
Other urban	3.2	
Rural	4.2	
Average update factor		3.4

* Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1990. The market basket forecast is subject to change as more current forecasts become available.

Table 7. Estimated Fiscal Year 1992 Average Increase in Per-Case PPS Payments

PPS update factor	3.4%
Estimated case-mix index change (fiscal year 1992)	2.3
Total increase in average PPS payments*	5.7

* Most of the increase in payments resulting from case-mix index change will be offset by the increased costs of treating sicker patients.

Table 8. Changes in PPS Payments

Fiscal Year	Market Basket	PPS Update	Increase in PPS Payments Per Case
1984	4 9%	4.7%	18.9%
1985	4.0	4.5	10.3
1986	3.1	0.5	3.4
1987	3.5	1.2	4.6
1988	4.8	1.5	5.8
1989	5.5	3.3	5.4
1990	4 5	6.0	7 0
Cumulative			
1983-1990	35	24	70

Table 9. Capital/Total Cost and Capital/ Operating Cost Ratios 1980 - 1990 (Annual Percent Change)

Year	Capital/ Total Cost	Annual Percent Change	Capital/ Operating Cost	Annual Percent Change
1980	6 2%	-1.6%	6.6%	-1.5%
1981	6.3	1.6	6.7	1.5
1982	6.5	3.2	7.0	4.5
1983	6.9	6.2	7.4	5.7
1984	7 9	14.5	8.6	16.2
1985	8.3	5.1	9.1	5.8
1986	8.4	1.2	9.2	1.1
1987	8.5	1.2	9.3	1.1
1988	8.5	0.0	9.3	0.0
1989	8.5	0.0	9.3	0.0
1990*	8.4	-1.1	9.2	-1.2

* Data through August 1990 compared to data through August 1989.

SOURCE. ProPAC analysis of American Hospital Association National Hospital Panel Survey

RESPONSES OF DR. ALTMAN TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. You testified "that in the first year of PPS, the growth of hospitals' expenses per admission dropped significantly. Since then, however, expenses have grown 10% a year."

First, I would like for you to comment on why you think hospitals' expenses are growing at a rate of 10% a year after initial declines following the implementation of the Medicare prospective payment system?

Second, you noted that the rate of increase in capital spending has moderated over the past few years by comparing the rate of increase in capital costs to increases in operating costs. Is this a fair comparison? If $0, then I would assume that you are saying that 10% annual increases in hospital operating costs are reasonable increases.

Answer. There are three factors that account for the increase in hospital expenses. From 1985 to 1989 operating costs per admission increased 8.9 percent a year for the general population and at a somewhat higher rate for the Medicare population. For the general population, inflation in the general economy as well as inflation which is specific to hospitals accounted for 5.0 percentage points or 5.7 percent of the increase. Increases in the number and type of services furnished each patient accounted for 3.7 percentage points or 41 percent of the increase. About half of the increase in services per patient was due to increases in the complexity of patients treated. The other half, however, was not related to changes in patient complexity. The final factor accounting for annual increase in expenses is changes in the skill mix of employees and in the non-labor inputs used to provide services. These increases, however, were partially offset by improvements in labor productivity for a net contribution of 0.2 percentage points or 2 percent of the expense growth.

In the first year of PPS hospitals faced great financial uncertainty and responded by reducing length of stay, as well as the inputs to patient care. Beginning in the second year, however, they realized that Medicare PPS payments were substantially above their expenses. For several years, most hospitals therefore did not feel any financial pressures to reduce expenses. The situation has recently changed, however, and hospital PPS expenses are now exceeding payments for the majority of hospitals. As a result, we may see a decline in expenses.

Hospitals have little control over inflation and increases in patient complexity. Together with their physician, they do, however, have control over the total amount of services furnished each patient and the mix of inputs they use.

In regard to the second part of your question, I am not saying that an annual increase of 10 percent in capital costs is an appropriate increase. A ten percent increase, however, is an improvement compared with 18 percent annual increase in 1985 and 1986.

The Commission will be presenting more information regarding capital payment in a report that we will deliver to you on May 15, 1991.

Question No. 2. Lately there seems to be a lot of anecdotal speculation that inadequate Medicare payment rates are responsible for a significant amount of cost shifting to private payers. Do your know of any evidence or data that demonstrates this? Do you think that Medicare payment rates are generally inadequate across the country? If not, why not?

Answer. For a number of years, Medicare payments excluded hospital expenses. As a result, hospitals had "extra" revenue. Recently, however, for many hospitals, expenses now exceed revenue. Hospitals, therefore, must generate additional revenue from other sources, and it is this need to generate revenue from other sources that is being called cost shifting. Hospitals, however, have another choice and that is to reduce their expenses so that they don't need to generate additional revenue. It is my opinion, and that of the Commission, that the Medicare program should continue to put financial pressure on hospitals to control their expenses, and that the current payment levels are appropriate. As I described previously, hospital expenses are increasing at more than twice the rate of inflation in the general economy. Reductions in the rate of expense growth will be beneficial to Medicare and to private payers.

PREPARED STATEMENT OF CHET BROOKS

Mr. Chairman and members of the Senate Finance Committee: My name is Chet Brooks and I am a member of the Texas State Senate and Chairman of the Senate Health and Human Services Committee.

I appear on behalf of the National Conference of State Legislatures to comment on various Fiscal Year 1992 budget and tax matters over which the Committee has

jurisdiction. As you know, NCSL represents the legislator of the nation's 50 states, its commonwealths, and territories. My testimony is based on policies adopted by NCSL's State-Federal Assembly, the policymaking body that guides our advocacy activity with Congress, the courts, and Federal administrative agencies. NCSL policies reflect our dedication to preserving a strong Federal system of government, maintaining effective intergovernmental programs, protecting our nation's most vulnerable populations, and developing creative and constructive domestic initiatives.

CHILD WELFARE

Mr. Chairman, my testimony would be incomplete if I failed to thank you and Senator Moynihan for your efforts on behalf of children at risk, particularly those vulnerable to abuse and neglect. As you are well aware, the number of abused, neglected and abandoned children has overwhelmed our current capacity to care. While trying to respond to daily emergencies, states are struggling to continue family preservation strategies and to adequately protect these vulnerable children. NCSL believes that your recently introduced Senate Bill 4, The Child Welfare and Preventive Services Act, will help states preserve families and add critically needed reforms and funds to help these children. As you schedule hearings on S. 4, I would urge that NCSL be permitted to testify and provide more detailed comments on this essential legislation.

I would like to tell you that we in the State of Texas are able to protect all of our children. As Chairman of the Senate Health and Human Services Committee, I recently received from our Department of Human Services an estimate of 424,800 children at risk of abuse and neglect. Yet, in FY 1990, we only investigated 200,000 cases. Of the 85,000 children in confirmed cases, only 30,000 received services. Only 36% of the children in confirmed cases of abuse and neglect received some service from the state ranging from a caseworker visit to foster care to parent counseling. Our caseworkers are overloaded.

We cannot and should not tolerate any child in danger, yet, we do not have the funds to increase services, despite general revenue contributions that have increased over the years. We increased child protective services last year and it will receive a substantial increase this year. We have done our share and need Federal assistance and program reform.

NCSL believes that the provision of support services, including in-home family services to at-risk families is the key to reducing the number of children in the foster care system. Unfortunately, state efforts to seek cost effective alternatives to foster care have been hampered by inadequate funding, confused Federal guidelines and tardiness for reimbursement to states for mandated program expenses.

TITLE IV-B CHILD WELFARE SERVICES

NCSL supports the increased and full funding for child welfare services and supports the provisions in S. 4 to increase the Title IV-B Child Welfare Services appropriation. We oppose efforts to limit Title IV-E entitlement funds (either by capping or limiting their use) in order to transfer them to provide a Title IV-B increase.

TITLE IV-E ADMINISTRATIVE COSTS

Citing an "unacceptable rate" of Federal payment of administrative costs to states, the President's budget proposed redefining the definition of administrative costs, limiting them to foster care-eligible services and precluding preplacement services costs. NCSL strongly opposes this change in definition that we believe is contrary to the goals of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980. The congressional intent of this program was to reduce the number of children in foster care which is precisely what "preplacement services" accomplishes. Mr. Chairman, we appreciate your efforts in the Omnibus Budget Reconciliation Act of 1990 which amended the statute to state explicitly that child placement services are considered a legitimate and reimbursable category. NCSL urges you to continue to strongly oppose efforts to limit Title IV-E funds to only foster care eligible children.

FOSTER CARE MAINTENANCE BACK CLAIMS

The backlog in foster care maintenance payments from the Federal Government has resulted in a $22 million deficit in the Texas foster care program. The administration proposes to fund $118 million in back claims owed to states through FY 1991. While NCSL supports funding all back claims owed to the states, we question if this amount is sufficient to fund all unpaid state foster care claims through FY

1991. We encourage the Committee to investigate the amount of back claims owed to states.

Unfortunately, in Texas, the average foster child spends time with five families during his or her time in foster care. While we have shortened the time a child spends in this temporary care, we must recognize that foster families need support. NCSL believes that efforts to increase the numbers of foster parent families and provide respite services for foster families are critical for the foster child and family's well-being.

ADOPTION

NCSL believes that children need permanent placements. Last session, the Texas Legislature examined ways to increase the number of adoptive families for children with special needs We found that the payments for families who adopt these children are limited. Parental substance abuse, particularly "crack" cocaine, has damaged many of these children. Your proposal to continue a child's eligibility for the special needs allotment after a disrupted adoption has our support. We also support your proposal for a tax credit for families who adopt these children.

DATA COLLECTION

S. 4 requires that states submit all claims for Title IV-E expenditure reimbursement (maintenance and administration) within one year of expenditure, rather than the current requirement of two years. While the intent of this provision is to help HHS more accurately project the Federal funds to reimburse entitlement claims and prevent the backlog of claims that often places a fiscal burden on states, the reduction in the claiming time may not solve the problem. The Federal Government appears reluctant to propose supplemental appropriations to cover past unreimbursed Title IV-E claims and has not proposed sufficient funds to meet the actual amount of back claims owed NCSL believes that county administered systems may have difficulties meeting this deadline due to different fiscal years, contracts with private providers, and administrating claims Therefore, NCSL opposes any reduction in claiming time

Texas, like many states, is still working on creating an acceptable state plan to automate the child welfare system It currently takes a monumental effort to find out the name of a child's case worker The Texas Senate is currently examining our Department's automation proposal Your proposal to provide a 90 percent Federal match for statewide information and data collection systems has my and NCSL strong support

CHILD CARE

Mr Chairman, as you know, we spoke numerous times regarding the Federal role in child care policy On behalf of the NCSL, I want to thank you for enacting legislation that will increase the amount of affordable, quality care available for our children. In Texas, we are particularly pleased with the $300 million entitlement for at-risk child care It will fill the gap in our system for low-income working families. Your decision to extend eligibility for this program to those not on AFDC who need child care in order to work, as determined by the state, respects state authority to set eligibility requirements We are now challenged with how to coordinate different child care programs This requires a state-Federal collaborative effort that will, at NCSL's urging, involve you and the members of this committee

NCSL will submit comments on regulations for the new child care programs when they are proposed We hope to work together with you to ensure that the regulations comply with congressional intent and protect state flexibility. We remain concerned, however, about the President's budget proposals for the child care licensing grants and the child care and development block grant. Despite the authorized amount, the FY 1992 Administration budget proposes $13 million instead of $50 million for the licensing grants and $745 million instead of $825 million for the block grant. We urge you to support the authorized amount. Furthermore, it was never Congressional intent to forward fund this program. We urge you to ensure that states be reimbursed for block grant costs prior to this year's September 7, 1991 release date and that the FY 1992 appropriation begin on October 1, 1991, not September 19, 1992 as proposed.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

A substantial portion of our $225 million deficit in Texas for FY 1991 is a $60 million shortfall in our share of the AFDC program. Unemployment and a worsening economic outlook have led to a caseload increase this year from 560,000 individ-

uals to 720,000 individuals on AFDC. This does not include our new AFDC-Unemployed Parent program, which we passed in accordance with the Family Support Act of 1988. We began our AFDC-UP program in October 1990 and already have 75,000 recipients. Nationwide, the situation is no better. The AFDC national caseload was at a record high of 4.1 million recipients on January 1, 1991.

These caseload increases impact on several programs within the Committee's jurisdiction. These include the Jobs-Opportunities and Basic Skills Program (JOBS), JOBS child care and child support enforcement programs. The caseload increases will certainly affect AFDC quality control error rates and JOBS participation rates as well as other state social services programs. As our clients increase, the capacity of states to serve them simultaneously decreases. States are having to impose hiring freezes, furloughs and lay-offs of intake and caseworkers to meet balanced budget targets. NCSL stands ready to work with you and the Committee to examine these economic conditions and caseload impacts and to work together to devise creative solutions and possible regulatory and legislative relief.

CHILD SUPPORT ENFORCEMENT

The child support enforcement program is a Federal, state, and local partnership that supports locating absent parents, establishing paternity, and setting and enforcing support orders. State legislatures have reviewed their income guidelines, are dealing with the impact of child support collection and paternity cases on the state courts, and are creating systems to pursue automatic withholding mandates, particularly the 1994 automatic wage withholding for all noncustodial parents. The President's FY 1992 proposals for child support enforcement, rather than supporting state efforts, appear to be merely designed to raise Federal revenues From charging states a user fee for using the Federal Payment Locator Service, which states use to track absent parents, to mandating states to either pay or charge user and application fees for child support services, the Administration's proposals would serve as a disincentive for working poor families to access child support. Child Support enforcement helps keep these families off public assistance

State legislators believe that the current incentive system is in need of change. However, the Administration's proposal to reduce the maximum incentive payment for states operating a cost effective program is once again a way for the Federal government, which shares in the recovery of costs, to reduce its state commitment.

NCSL is greatly disturbed by the proposal to mandate how states spend incentive payments. The role of the state legislature is to determine where incentive payments should be spent. While requiring states to reinvest these funds in programs which benefit children sounds like a simple request, in effect it preempts state's authority. Further, state legislatures' budget cycles do not coincide with incentive awards. Most states invest in child support up front with general revenue funds.

NCSL strongly opposes requirements to mandate cooperation with child support as a condition of eligibility for the food stamp program, particularly with no additional administrative or incentive funds.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (Title XX of the Social Security Act) provides flexible funds to states that are distributed at the states' discretion to fund the diverse needs of the elderly, children and the handicapped. In Texas, we spend Title XX funds on child care and on our child protective services efforts. Unfortunately, Title XX has fared poorly over time. Its current authorized level of $2.8 billion represents a 50 percent loss over the 1980's in inflation-factored dollars. We support Senator Riegle's efforts to increase funding for this critical program. Title XX was created in P.L. 96-272. NCSL urges the Committee to increase funding for Title XX as part of their revisions to P.L. 96-272 in S. 4.

HEALTH CARE

Today in Texas we have 3 million people, 1 million of them children, with no health insurance. The growing crisis of Americans without basic health care demands the immediate development of a national health care reform strategy. The National Conference of State Legislatures is committed to developing a national health care reform strategy that will guarantee basic health care services to all Americans. We believe that any national reform strategy should include a strong role for states and should include: (1) a basic benefit package to which everyone is entitled; (2) an equitable financing mechanism that is progressive, broad-based, and has potential for growth; and (3) a cost containment and quality assurance component.

Important first steps have been taken at the Federal level to explore ways to extend health care coverage to all Americans. We urge you to continue these efforts and to join with states as partners to develop and implement health care reform. At the same time, NCSL is committed to a continuing effort to improve our existing health care programs and to serve as many people as possible.

Approximately 1.2 million Texans are currently receiving health care services through the Medicaid program, administered by the Texas Department of Human Services. Our basic Medicaid program, excluding nursing home care, will cost $2.8 billion this fiscal year. Last year the Texas Legislature passed a supplemental appropriations bill in special session to cover a deficit of approximately $220 million. This year the Medicaid program will require an emergency appropriation of $200 million. The Texas Department of Human Services is requesting $5.1 billion for the Medicaid program for 1993.

NCSL urges you to continue to increase the number and range of options within the Medicaid program, but to refrain from imposing additional mandates. Recently I read that the Medicaid mandates included in the 1990 Omnibus Budget Reconciliation Act (OBRA) accounts for only about 7 percent of the program growth this year. That may be so, but that figure does not include the costs of implementing mandates enacted in previous years (i.e. nursing home reform requirements and EPSDT). The seven percent figure also fails to account for the increased cost to Medicaid arising from the "Zebley" decision, estimated to cost between $513 million and $703 million over the next five years. It is the cumulative effect of Federal mandates, the downturn in the economy, health care inflation, and the growing number of uninsured that has put the Medicaid program in many states in crisis. We are experiencing tremendous increases in caseloads at the same time we are having to downsize government to meet our fiscal obligations. Seven percent is no small matter this year.

States need flexibility, administrative relief and increased authority to explore program innovations. We urge you to (1) expand the demonstration authority under the Medicaid program, (2) establish an expedited waiver process to enable states to more effectively continue in the role as laboratories for innovation; and (3) continue to put pressure on the Health Care Financing Administration (HCFA) to promulgate regulations in a more timely manner. We also believe that states should not be required to implement administratively complex program requirements until final regulations have been promulgated.

MATERNAL AND CHILD HEALTH BLOCK GRANT

NCSL urges you to reject Secretary Sullivan's proposal to reprogram funds from the Maternal and Child Health Block Grant and to reallocate funds from existing Community Health Centers to provide the resources for a new infant mortality initiative. NCSL supports increased emphasis on child and maternal health and is particularly supportive of efforts to reduce the incidence of infant mortality. NCSL rejects the notion that state block grant funds should be considered a funding pool for new initiatives.

Both the Maternal and Child Health Block Grant and Community Health Centers are vital components of Texas' effort to improve maternal and child health and other health services to low-income individuals and families. Already unable to meet all the need, the Administration's proposal to divert funds from the block grant and from existing centers would create a serious hardship in Texas. We have many counties in Texas where a public health nurse, funded through the Maternal and Child Health Block Grant, is accessible only 1/2 day per week and is the only publicly-funded health service available to low-income families.

Our mutual goal as policymakers should be the preservation of existing programs, especially those that have been proven effective, as well as the expansion of services to low-income mothers, their children, and other needy individuals. The Secretary's proposal represents a redistribution of funds already serving the targeted population. More importantly, the loss of funds to existing programs and facilities will severely jeopardize their ability to maintain current services to the low-income individuals they serve. We find no justification for this shift in funding. Both the House and Senate Appropriations Committees have rejected the Secretary's proposal for the current fiscal year, however, the Secretary has indicated he may still go forward with the same proposed funding scheme for FY 1992. We urge you to oppose this effort.

MEDICAID DRUG REFORM/PRIOR AUTHORIZATION

The Medicaid prescription drug reforms adopted in OBRA 1990 were designed to improve access by: (1) making drugs more available by requiring states to open their formularies and to reduce prescription drug prices; and (2) requiring pharmaceutical manufacturers to provide discounted prices to states. States are now required to cover all drugs, with some limited exceptions, of participating pharmaceutical manufacturers. The new program left intact a states' ability to require prior authorization on covered drugs. The legislation did add some quality assurance requirements. States must provide a response within 24 hours of receiving a request from a practitioner and must permit the dispensing of a 72-hour supply of a drug when it is impossible to receive approval from the states, for instance on weekends and late at night. These were the only restrictions provided for in the law.

Under current law, states may require prior authorization for approved and unlabeled indications, and may require a physician to provide medical justification for using a particular drug within a therapeutic class. States may place a drug on a prior authorization list for medical or economic reasons.

Subjecting drugs to a prior authorization requirement is a widely accepted practice among other health care providers, such as health maintenance organizations (HMOs), hospitals and managed care plans. Prior authorization is a legitimate strategy for promoting the appropriate use of high cost drugs or off-label indications. The prescription drug reform program was designed to bring Medicaid on par with other large prescription drug purchasers. Limiting states' ability to use prior authorization would make the Medicaid program the most broad and unregulated prescription drug program in the nation, a blank check, a program with no cost controls.

There is considerable interest within the U.S. Department of Health and Human Services (DHHS) in adopting sweeping restrictions on states' ability to establish and operate prior authorization programs by regulation, despite the lack of legislative authority. Such an action not only goes beyond the intent of the law with respect to increasing access, but also runs counter to good health policy. Strategies used by other providers to ensure appropriate utilization and quality care should be equally available to states. We seek your assistance to clarify Congressional intent with respect to prior authorization for the Secretary and his staff and to work with state elected and administrative officials to curb HHS intended restrictions.

Clearly states believe the prescription drug option is an important one and we join you in supporting expanded access and reduced drug prices for Medicaid beneficiaries and the Medicaid program. It is extremely unlikely that every state will choose to establish a prior authorization program and we have no reason to believe that any state will use their authority to operate a prior authorization program to deny Medicaid clients necessary medication. States are permitted by law to establish and operate prior authorization programs and should not be restricted by regulation in the absence of legislative action.

PROVIDER-SPECIFIC TAXES AND VOLUNTARY CONTRIBUTIONS

OBRA 1990 finally ended the Health Care Financing Administration's efforts to limit the ability of the states to tax providers to increase state Medicaid matching funds. This has proven to be an important strategy for states to expand eligibility and to enhance and improve services.

For example, the Texas Department of Human Services has almost 200 eligibility workers outstationed at over 60 health care facilities. The state's share for the administrative cost is being borne by the facilities. The facilities are also donating office space and supplies at no cost to state or Federal governments. This program has been invaluable to many localities in Texas. Texas has also taken a first step in using tax revenue to support Medicaid spending. As we continue to search for additional resources, we urge you to stand by us and help us retain needed flexibility in this area.

We urge you to codify the current prohibition on HCFA from promulgating regulations that would prohibit states from using voluntary contributions from providers towards the state Medicaid match. The moratorium on the HCFA regulation expires December 31, 1991.

States must be given the flexibility to use state and local tax resources to help finance the Medicaid program and to continue to try to provide a safety net of basic health care services for the uninsured until such time as a national solution can be agreed upon.

PROPOSED STATE ADMINISTRATIVE BLOCK GRANT

The President has included funds that states receive as Federal matching payments, for the administration of the Medicaid, Food Stamps and Aid to Families with Dependent Children (AFDC) programs on the list of suggested programs for inclusion in the proposed single block grant to states. The President believes that significant savings through administrative streamlining can be achieved through combining these programs. While NCSL supports the overall concept of the President's block grant proposal and continues to work with the White House on the details, it does not support the inclusion of these entitlement funds.

The costs associated with the administration of these programs are almost all beyond the control of states. These programs are sensitive to national, state, and local economic conditions, with both benefit and administrative costs increasing as caseloads grow during economic downturns. Federal mandates also drive the costs of program administration as administrative complexity and new requirements create systems and personnel costs.

Some states believe they can successfully merge the administration of these programs and reap savings through administrative streamlining. NCSL would support a *demonstration* program for those states that wish to pursue this program consolidation, but would oppose any requirement to do so.

TAX EXTENDERS

The President's proposed Fiscal Year 1992 budget extends for one year both the low-income housing tax credit and the targeted jobs tax credit. A similar extension is not recommended for the mortgage revenue bond program. NCSL's position on these tax matters has been and remains steadfastly in favor of making each of these permanent. State and local governments rely heavily on these special tax provisions. The low-income housing tax credit has emerged as the primary tax incentive for stimulating low-income housing production and rehabilitation with state agencies. Targeted jobs tax credits are claimed by employers for qualified wages paid to individuals who begin work before January 1, 1992 and who are certified as members of various targeted groups. Mortgage revenue bonds are issued by state and local governments to raise private investment capital to expand the homeownership opportunities available to potential first-time homebuyers.

Many of you on this committee would appear to concur. Senator Boren has introduced S. 581 to make the targeted jobs tax credit permanent. Senators Mitchell and Danforth have again introduced legislation, S. 308, to extend permanently the low income housing tax credit. Finally, Senator Riegle seeks, in S. 167, to make the mortgage revenue bond program permanent. NCSL has sent letters in support of each of these bills and is prepared to work with this Committee to see that they are enacted.

MEDICARE PAYROLL TAX

This Administration again proposes to mandate Medicare hospital insurance coverage for all state and local government employees. The proposal is effective January 1, 1992 and is estimated to raise $1.1 billion in Fiscal Year 1992. Currently, states are phasing in Medicare coverage which allows for gradual budget adjustments. Immediate Medicare coverage would cost states between $300 thousand and $263 million annually.

For example, the fiscal impact for the state of Texas would be $129 million. The fiscal climate in Texas remains extremely tenuous, as is the case in many states and this proposal will strain our ability to provide services to the public, including those services that the Federal Government mandates. The cost of Medicare coverage also would be extremely burdensome on nine other states: California, Colorado, Florida, Illinois, Louisiana, Massachusetts, Minnesota, New York and Ohio.

Since the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), NCSL has resisted efforts to accelerate coverage of all state and local employees on the following grounds: (1) all parties have agreed to phase-in new hires. Forty percent of all state and local employees are now covered through an estimated job attrition rate of 9 percent per annum; and (2) the additional tax would impose a negative fiscal impact on state budgets, budgets that are exceptionally strained this year.

NCSL stands by the agreement worked out in 1986 and strongly believes that the proposal breaches an accord reached with Congress and the Administration. We ask your help in rejecting this proposal.

STATE FISCAL OUTLOOK

The 1992 Federal budget cycle begins at the outset of the ninth recession of the post-World War II period. At no time since the recession of the early 1980s have states confronted as bleak a fiscal outlook as they now face. Up to thirty states are grappling with deficits this year and more are expected for Fiscal Year 1992.

In 1990, many states reduced reserves and increased taxes. Total state tax increases, as a percentage of tax collections, were the largest since 1983. States will increase taxes by $8.6 billion for Fiscal Year 1991, which is equal to 3 percent of state tax collections. They will raise an additional $2.0 billion in revenue from accelerating the collection of existing state taxes, increasing fees and charges, and postponing scheduled cuts. Despite collections, over half of the states expect revenue collections to be more than 1 percent below the level on which they built their current budgets.

Revenues are not the only problem. An NCSL survey found that although half of the states are experiencing revenue shortfalls, a greater number are facing potential deficits due to spending pressures that require supplemental appropriations. Due to the national economic recession, states are collecting fewer revenues while encountering an increased demand for services. A recession brings caseload growth in health and income-support programs; thus Medicaid state indigent health care programs, and AFDC cost more than originally expected.

Revenues below estimates, pressures to increase spending, and low budget reserves add up to overwhelming state deficits. These fiscal pressures definitely are challenging us as policymakers to ensure that each tax dollar is utilized as effectively and efficiently as possible. We need for members of this Committee and all Federal policymakers to be as mindful of our fiscal capacity as we are. Unfunded mandates, blanket transfers of responsibility, and dismantling of existing administrative funding structures have been and remain counterproductive and disruptive. We are prepared to work with you to develop and expand state-Federal efforts to address needs for our most vulnerable populations and our most difficult domestic problems.

On behalf of the National Conference of State Legislatures, I thank you for your kind consideration of our interests and concerns. I would be happy to respond to any questions

PREPARED STATEMENT OF SENATOR JOHN H CHAFEE

Mr. Chairman, There is no doubt that this Committee has its work cut out for it. As a nation, we face troubling domestic problems. Many of those problems can be addressed through programs under the jurisdiction of the Finance Committee.

These two days of hearings are about more than the Administration's budget proposals. They are about how we view the problems facing us as a nation. Two of our most critical challenges: the status of our children and the inadequacy of our health care system will come up frequently over the next two days.

First, let me address health care issues. In recent years, we have had to make significant changes in the Medicare program to ensure the long-term solvency of the part A trust fund, and to contribute to deficit reduction by slowing the growth of part B, 75% of which is paid for through general revenues. During last year's budget negotiations, we made a successful, if sometimes agonizing, effort to develop a package of Medicare changes which represented, for the most part, reasonable policy decisions. Through that process, we enacted changes that will result in savings to the Medicare program of $28 billion.

I commend the Administration's desire to save money in the Medicare program, and realize that many of these proposals help enhance the solvency of the Medicare trust fund as well as reduce the Federal deficit. However, I do not think that it would be prudent to enact significant new changes at this time.

By the same token, however, many of us are involved in the discussion of how to reform our health care system—an issue I believe will be one of the most important domestic challenges we face in this decade. In this context, we may have to consider changes in Medicare as well as other Federal health programs to help us devise a solution to the growing problem of those individuals without access to health care services. For that reason, the President's proposal to increase the amount paid by individuals with incomes over $125,000 for their part B premium, deserves our serious consideration. There is no reason why Lee Iacocca should pay the same amount that a low-income widow in Pawtucket, RI does for Medicare Supplemental Insurance, 75% of which is financed through the general treasury.

In order to ensure that adequate health care services are available for every American, and I believe that they should be, we may have to spend more Federal

dollars. We may also have to reallocate some of the $660 billion that we expect to spend as a nation on health care this year. Some old and young wealthy Americans may have to sacrifice through tax increases, changes in the deductibility of health insurance premiums, or higher part B premiums.

Our health care system is not the only challenge we face. The status of children in this nation is worse than ever. The magnitude of these problems—infant mortality, teen pregnancy, violence in the schools and drugs to name a few—demands that all sectors of our society respond. These are not just family problems, or just education problems or just government problems. We are all affected by these problems, and we must all bear the responsibility of developing comprehensive solutions.

For our part, as policy makers, I believe we must look at how and when we deal with the problems of children and their families. Take for example the child welfare program. It is clear that this program is in need of both reform and additional resources. While I do not believe the Administration's proposals in the Administration's budget go far enough in addressing this problem, what concerns me more is how we define child welfare. Under our current system, children are only eligible for so-called child welfare benefits if they are already in crisis. It is at that point that the government becomes concerned about their welfare. This is wrong. We should be concerned about their welfare at a much earlier stage and we should have a comprehensive plan to enhance their growth and development.

Mr. Chairman, there is no doubt that we must continue to reduce the deficit. But we cannot allow equally critical problems to take a backseat. We found the wherewithal and the compassion to uphold the principles of freedom in the Persian Gulf. Surely that same will can be applied to find the resources to solve these equally threatening domestic problems.

Prepared Statement of Margaret Dixon

Good morning. I am Margaret Dixon, a member of the Board of Directors of the American Association of Retired Persons (AARP). I am pleased to have this opportunity to discuss the President's fiscal year 1992 (FY 92) budget proposal and its effect on the growing health care needs of Americans.

We are all greatly relieved that the war in the Persian Gulf has ended and look forward to the safe and speedy return of the courageous men and women that served our country in the Gulf. With this crisis behind us, it is time to turn our attention to a growing crisis here at home—the failure of our health care system to provide affordable access to quality health and long-term care for all Americans.

Approximately 34 million Americans under the age of 65 and 300,000 over the age of 65 have no health insurance. At least another 20 million have inadequate protection. Access to health care coverage is decreasing primarily due to the phenomenal increase in health care costs. Health care expenditures in the United States totaled $604 billion in 1989, an 11.1 percent increase from the previous year (and they continue to consume an ever-increasing share of our GNP). As a nation, we spend more on health care, no matter how you measure it, than any other nation in the world.

The substantial increases in Federal outlays for health care, which represent some of the most significant increases in the Administration's FY 92 budget proposal, are symptomatic of escalating health care costs across the Federal budget and the national economy. Consider, for instance, the FY 91-FY 92 increase, as estimated in the Administration's proposal, in Federal outlays for programs within this Committee's jurisdiction:

- Total Medicare current spending increases *11.8 percent*, with Part A (Hospital Insurance) increasing *10.6 percent*, and Part B (Physician Services) increasing *13.6 percent;*
- Medicaid current spending increases *16.2 percent.*

Even the business community's increased spending on health care is quite evident in the Federal budget. Tax expenditures for employer contributions for health care benefits will increase by *12.4 percent* between FY 1991 and FY 1992, according to the Congressional Budget Office, and will cost the treasury an estimated $210 billion over FY 1991-1995.

We are all adversely affected by the uninhibited growth in health care costs. Health care spending has become a growing concern for businesses, governors, and a broad range of American families, as well as for the Federal Government and this Committee.

Despite the urgent need to contain runaway health care costs, the Administration's FY 92 budget proposal offers little beyond the same proposals seen so often

over the last decade. More than a year ago, the President, in his State of the Union Address, cited the problem of health care cost. Little if anything has followed. In short, the Administration has yet to respond to our health care crisis as a pervasive problem that affects all segments of our society, not just Medicare providers and beneficiaries. It is our hope that the Administration will frame a comprehensive—not piecemeal—solution to the serious problems posed by rising health care costs and declining access to care.

After many frustrated attempts at controlling health care costs, AARP believes we have learned a valuable lesson: to achieve real cost control, we need to develop a comprehensive health care reform plan that (1) ensures every one has coverage, (2) establishes a fair and uniform method of provider reimbursement to avoid cost-shifting, and (3) encourages efficient service delivery. Only when we take these steps can we have confidence that all Americans will have access to the quality, affordable health and long-term care that they need, and we can begin to assure value for our health care expenditures.

To constructively move toward comprehensive reform of our health care system we must build a consensus on the need for reform. The place to start this process is through developing a better public understanding of the nature of the problem—the cost of health care—and its pervasive effects on all Americans. Until the increase in health care costs as seen in

—rising insurance premiums burdening employers and workers,
—premiums and deductibles for Medicare beneficiaries,
—government payments for Medicare and Medicaid and other health care programs, and
—the cost of care for the uninsured or those needing long-term care

are seen as part of a common problem, reform will come slowly—if at all.

In an effort to build a better public understanding about the nature of our health care crisis and move us closer to reform, AARP has adopted principles of health care reform. These principles (included at the end of our written testimony) establish a framework for reform of our acute and long-term health care systems. The Association is also continuing to hold hearings and forums to further our members' and the public's understanding of this issues, its causes and possible approaches.

AARP believes that to achieve meaningful health care reform, Congress must establish a blueprint—the broad architecture—of a reformed system which reflects these principles and begins building public consensus toward comprehensive reform. To this end, we hope that this Committee's debate over Medicare and Medicaid budget proposals will be done in the broader context of discussing the more comprehensive problems of our current health care system.

Most important in building broad public support, however, is a solid commitment by the President to make health care reform a national priority. The President's budget proposal, as a statement of national goals and priorities, should start the process. As the President said in his budget message, "I look forward to working with the Congress in developing a budget that lays the groundwork for a brighter future . . . " Unfortunately, the President's budget proposal offers no vision of comprehensive health care reform and provides little promise of a brighter future for the millions of Americans who lack access to basic health care services.

THE ADMINISTRATIONS'S FISCAL YEAR 1992 MEDICARE BUDGET PROPOSALS

As in past years, the Administration's FY 92 budget proposal turns to the Medicare program to achieve greater deficit reduction. But before addressing the President's specific Medicare proposals, it is important to recognize the enormous contribution to deficit reduction that the Medicare program has made, and continues to make.

From 1984 through 1990, substantial cuts in the Medicare Part A (Hospital Insurance) program have saved nearly $82 billion in Federal spending (see Chart I). In addition, under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) enacted last year, Medicare Parts A and B will contribute $43 billion more toward deficit reduction over the next five years (see Chart II) on top of the savings generated from pre-FY 1991 reductions.

Now, for the sake of further deficit reduction, the Administration's FY 92 budget proposes to cut the Medicare program by an additional $2.9 billion in FY 92, and $25.2 billion over five years (FY 92-96). Further, if the income generated by the President's proposal to require participation of all state and local workers in the Medicare program (which adds $1.1 billion to the Hospital Insurance Trust Fund in FY 92 and $7.3 billion over five years) is included, Medicare's total contribution to deficit reduction under the Administration's FY 92 budget proposal is *$4 billion* in

FY 1992 and *$32.5 billion* over five years—all of which is additional deficit reduction on top of that required by OBRA '90 (see Chart III).

If the Medicare program is to adequately serve the growing needs of beneficiaries, it needs a respite from this continuous barrage of deficit reduction-driven assaults.

AARP believes that it is time for the Administration and the Congress to assess the cumulative and interactive effects of current and past Medicare cost-cutting measures on the program's ability to provide quality health care to Medicare beneficiaries.

AARP has, in the past, supported reductions in Medicare as part of responsible cost containment efforts. The Association recognizes that there may still be areas in which good Medicare program management would justify changes. But now is not the time for additional cuts solely for the purpose of deficit reduction or to offset tax cuts.

Greater Medicare Beneficiary Cost-Sharing

The Administration's FY 1992 budget proposal increases Medicare beneficiary out-of-pocket costs by *$541 million* on top of the $690 million additional beneficiary cost-sharing required in FY 1992 under OBRA '90. Specifically, the budget includes $91 million in new revenue from *tripling* (from $29.90 per month to $89.70 per month) the cost of the Medicare Part B premium for beneficiaries with annual incomes over $125,000 ($150,000 for couples). Under this proposal, these beneficiaries would have $89.70 deducted from their monthly Social Security check, *beginning October 1, 1991*, to cover the higher Part B premium.

This proposal does not address the need for comprehensive reform of our health care system generally and would do nothing to curb the uninhibited growth of the Medicare program.

In addition, the Administration's proposal is similar to proposals opposed by AARP and rejected in last year's budget summit for good reason: it offers no change to Medicare that justifies asking beneficiaries to pay more, particularly when beneficiaries have little control over escalating health care costs. In fact, the proposal substantially increases administrative costs which, in the first year, account for more than half of the revenue generated by the premium increase (an estimated $50 million of the $91 million in new revenues). The Administration's proposal, however, does not indicate what program(s) will be reduced by $50 million to pay for these additional administrative costs which are subject to the domestic discretionary spending limit.

Ultimately, adoption of such a proposal would lead to further income-relating of the Medicare premium by lowering the income thresholds, or, even further, to means-testing benefits—steps which would inevitably erode public support for Medicare.

The budget proposal also includes $450 million in new beneficiary cost-sharing in FY 92 by reinstituting a 20-percent coinsurance for clinical laboratory services. The Congress specifically rejected this proposal last year on the grounds that beneficiaries were already shouldering enough of the burden of deficit reduction due to Part B premium and deductible increases. Under OBRA '90, beneficiary cost-sharing grows substantially through FY 95 (see Chart IV), leaving little justification for any additional cost-sharing proposals.

In addition, reapplying a 20-percent coinsurance for lab services would create substantial administrative costs which, under the new budget rules established in OBRA '90, would have to be "paid for" under the domestic discretionary spending limits. To pay for these administrative expenses, reductions in other programs within that budget category might be necessary to avoid a sequester.

Additional Medicare Provider Reimbursement Constraints

As in the past, the President's new budget proposes significant reductions in Medicare payments to hospitals and physicians totalling *$2.4 billion* in FY 1992. AARP is not opposed to changes in provider reimbursement which improve the efficiency of Medicare, but reductions of this magnitude must be justified, particularly in the wake of significant provider cuts over the last eight years and those already planned for FYs 1991-1995.

The most significant portion of the proposed provider cuts is from the Part A program, and the largest single reduction is in Medicare payments for medical education. The Administration's budget would cut payments for direct and indirect medical education by $1.19 billion in FY 92, significantly reducing payments currently made to teaching hospitals across the country.

While the vast majority of hospitals affected by these reductions are in urban areas, these cuts will also impact teaching hospitals in rural areas. AARP is particularly concerned that, in those cases where hospitals are forced to curtail their training programs as a result of these cuts, the number of health care providers available to treat many Medicare beneficiaries, in both urban and rural communities, may be severely limited.

The President's budget also proposes $170 million in reductions in physician reimbursements under the Part B program. The bulk of these cuts come from reducing Medicare payments to nurse and physician anesthesia teams, and from establishing a single fee for assistants at surgery. While a payment reduction for these services may be justified, it should not be made solely for the purpose of deficit reduction. Any changes in the level of payment for physicians should occur within the context of physician payment reform.

Implementation of the new Medicare fee schedule will begin early next year, and the final refinements to the payment schedule are already underway. Further reductions in physician's fees that do not reflect the overall strategy of physician payment reform could have a detrimental affect on the success of the program and also result in cost-shifting to Medicare beneficiaries. Beneficiaries lost some critical protection against out-of-pocket expenses last year when Congress adopted provisions, originated in this Committee, increasing the balance billing limits which restrict the amount a physician can charge a beneficiary over Medicare's approved amount. AARP cautions Congress to carefully consider any Part B provider reductions which may jeopardize physician payment reform.

There is one particular health care proposal in the budget which AARP believes warrants serious consideration by the Congress. To help reduce cost-shifting from private, employer-provided health insurance plans to Medicare and Medicaid, the Administration's budget proposes a national clearinghouse on third-party liability. The clearinghouse would collect employment-based health coverage information and bill the insurance company directly if a claim is made for a Medicare or Medicaid beneficiary with private coverage.

THE ADMINISTRATION'S FISCAL YEAR 1992 MEDICAID BUDGET PROPOSALS

The Medicaid program is intended to serve as the health care "safety net" for our nation's impoverished citizens. As the major source of funding health care for poor and low-income persons, it is—for better or worse—a symbol of America's commitment to provide for its most vulnerable people.

The President's FY 92 budget proposes a total of *$25 million* in new Federal Medicaid spending, primarily to allow states to expand medically-needy eligibility to pregnant women and children. AARP supports the goals embodied in these improvements but, with regard to the initiative on infant mortality, questions which programs would lose money through the redirection of these funds.

The Association continues to support expansions in the Medicaid program—such as those made in OBRA '90 for pregnant women and children, qualified Medicare beneficiaries and the frail elderly—as responsible short-term means of increasing access to needed health care services for some poor and near-poor Americans.

Although AARP is pleased that the President's budget proposal includes additional short-term improvements in Medicaid, these proposals still do not address the fundamental inadequacies of the Medicaid program which limit its ability to provide a uniform safety net for low-income Americans. Among the most significant of the systemic problems with Medicaid is the inadequate provider reimbursement, the unreasonably restrictive income and asset requirements for eligibility, and the administrative barriers in the application process.

AARP recognizes that many states face budget crises and, as a result, are attempting to postpone implementation of recent Medicaid improvements. Rising program costs or declining revenues must not be used as an excuse for failing to provide needed health care services.

Clearly, the dilemma state and Federal governments face in providing health care for our poorest citizens dramatizes the growing need for comprehensive health care reform. Medicaid alone will never serve the full range of health care services needed by low-income Americans. Ultimately, access to basic health and long-term care services demands a comprehensive solution.

THE ADMINISTRATION'S SOCIAL SECURITY AND SSI PROPOSALS

The budget proposes a modest, but welcome, two-year increase in the Social Security earnings limit. Currently, working Social Security beneficiaries ages 65-69 lose a dollar in benefits for every three dollars they earn over the earnings limit—$9,720

in 1991. The budget proposes raising the limit by $1,000 with the increase phased-in over the next two years. The $1,000 would be in addition to the annual inflation index for the earnings limit.

In the SSI program, the Administration would reduce spending by approximately $1 billion over a five-year period. To achieve this reduction, the proposal would require recouping SSI overpayments from Social Security beneficiaries and requiring the states to pay the costs of administering their SSI supplements,a proposal which Congress has previously rejected.

The President has requested a two-year supplemental increase of $232 million for SSA in order to fund the review of previously rejected childhood disability benefit claims mandated by the Supreme Court in *Zebley* v. *Sullivan*. (The House of Representatives has passed a supplemental appropriations bill including this request; Senate action is expected shortly.) AARP is concerned that this request may not be sufficient because the number of cases for review may be underestimated.

CONCLUSION

The minimal Medicaid improvements and piecemeal Medicare proposals the President offers in his FY 1992 budget do little to enhance the ability of these programs to provide quality health care to their beneficiaries. Moreover, the various proposals offered by the Administration do not even begin to move us closer to assuring affordable access to health care services for the millions of Americans who lack health insurance coverage. Indeed, if the President's new budget does anything, it will likely exacerbate cost-shifting and add to the complexity of our already fragmented health care system.

The only answer to these problems lies in a comprehensive reform of our nation's health care system. Only through reforming our current system can we guarantee Americans of all ages access to quality health and long-term care, and achieve cost containment.

AARP believes that health care reform must be a national priority. We recognize that broad public consensus about the problem and the need to share the risk of health care costs are key ingredients in achieving this goal. In discussing this issue with AARP members nationwide, we have found that continued public education will be essential for building a consensus on this important issue.

AARP is increasing its public education efforts to develop a better understanding of this crisis and find realistic solutions. We urge the Congress to help lay the groundwork by convening public hearings around the country to explore the scope and complexity of the problem and focus public attention on the tough choices that must be part of the solution. We must build a consensus on the answers to several important questions:

- What elements of a health care system are most important to Americans?
- Are we, as health care consumers, willing to adjust our patterns of use and coverage, and are we willing to make the trade-offs that will be necessary to ensure access for all Americans?
- Are we willing to pay the cost of these benefits, not only in the aggregate, but as individual taxpayers?

Ultimately, this last question is the focal point in the debate over health care reform. AARP believes that any financing of health care reform should be broad-based, equitable, and affordable to all. Programs which are based on social insurance principles, like Social Security and Medicare, enjoy considerable public support. In our view, comprehensive health care reform will only be achieved if it commands broad support which can best be attained through a social insurance structure.

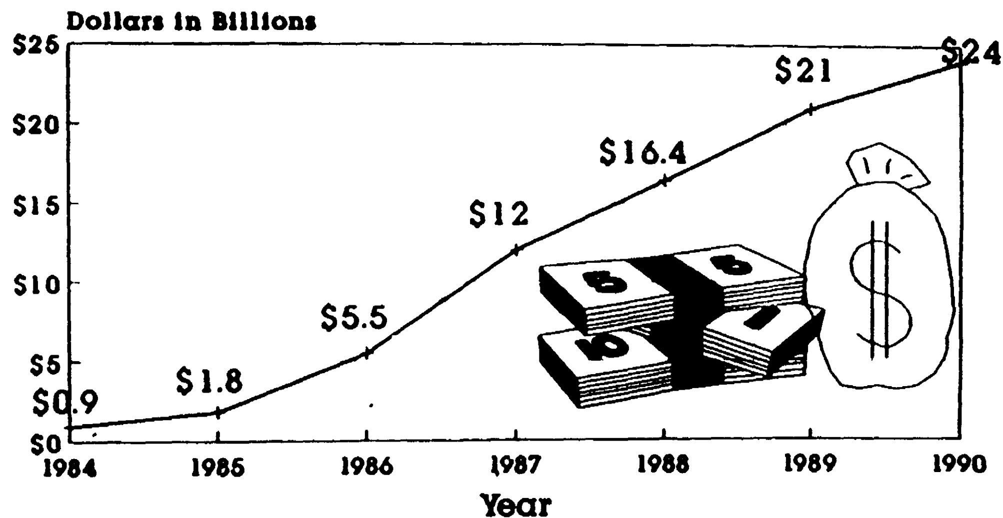
We have an obligation to raise these questions with the American people. Comprehensive reform of our health care system will only be possible when the American people understand the need for protection and recognize the inherent danger involved in continuing a piecemeal approach to a comprehensive problem. We are confident that, with your help, we can answer these questions and form clear and strong messages to our elected officials. Clearly, the 1992 Presidential election will offer an important opportunity to engage in a national debate that can help solidify America's commitment to health care reform.

Mr. Chairman, I appreciate the opportunity to address your Committee today. AARP stands ready to work with you and your colleagues in achieving the goal of comprehensive and affordable health care for all Americans.

Attachment.

CHART 1

Medicare Part A
Contribution to Deficit Reduction
1984-90 = $81.6 Billion

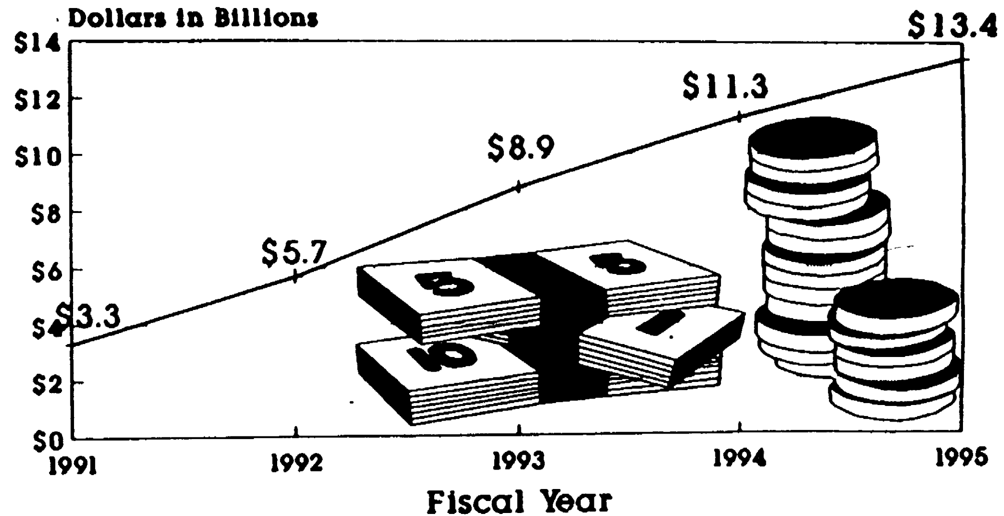


Source: Catholic Health Assoc., 1990
Spending Below Pre-TEFRA/PPS Baseline
DD-2-MEDDEF-2/2

CHART 2

Medicare's Continuing Contribution to Deficit Reduction

Fiscal Years 1991-95 = $42.6 Billion

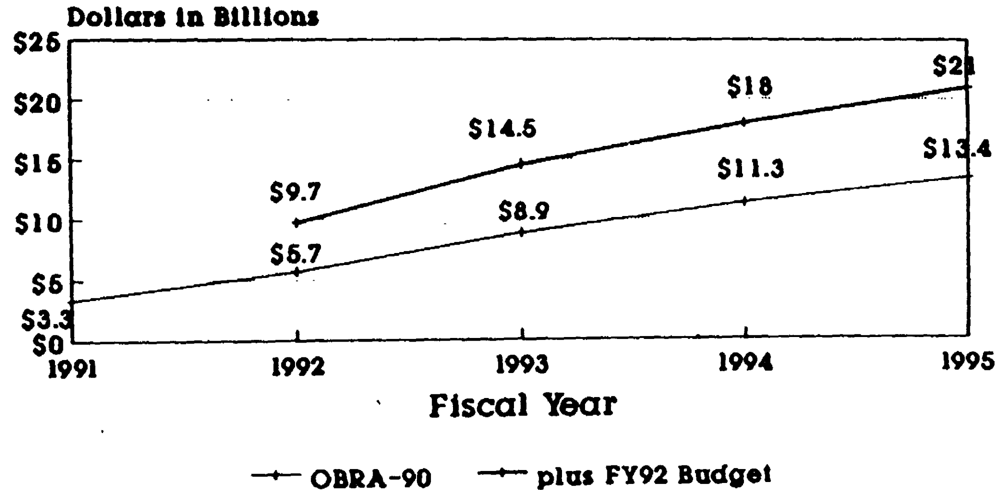


Source: CBO OBRA-90 Estimates, Oct 1990
Medicare Parts A and B: Ben. + Providers
DD-2-MEDDEF2-2/2

CHART 3

Medicare's Continuing Contribution to Deficit Reduction FY1991-95

$42.6 Bill OBRA-90/$63 Bill Pres. Budget



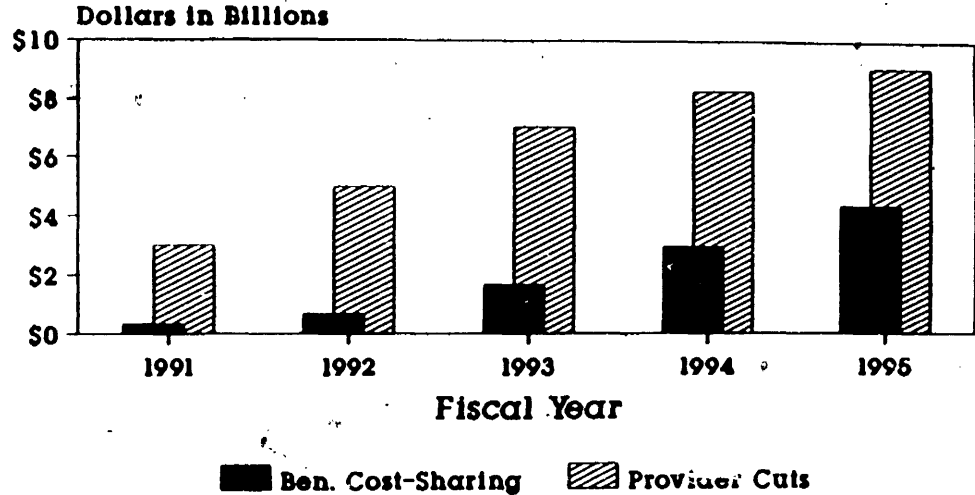
Source: CBO OBRA-90 Est; Pres FY92 Bud.
Medicare Parts A and B: Ben. + Providers
Pres. FY92 Bud Est Incl. St & Lcl Gov.

DD-2-MEDDEF3-2/2

CHART 4

Medicare Beneficiaries' Growing Contribution to Deficit Reduction

Beneficiary Costs vs. Provider Cuts



Source: CBO OBRA-90 Estimates, Oct 1990
Ben. Cost-Sharing = Part B Prem + Deduct
DD-2-BEN-2/2

AARP

Health Care Reform Principles

for

Acute and Long Term Care

Preamble

AARP believes that the United States has the resources to ensure access to acute and long-term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long-term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprhensive, affordable acute and long-term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long-term care systems. The principles do not address every specific issue relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Acute Care Principles:

1. All individuals have a right to receive health care services when they need them.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed health care services for all individuals.

2. All individuals have a right to reasonable access to health care coverage that provides adequate financial protection against health care costs.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

3. All individuals have a right to high quality health care.

   The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

4. All individuals should have a reasonable choice of health care providers.

   Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

5. Financing of the health care system should be equitable, broadly based, and affordable to all individuals.

   Government, employers, and individuals share the responsibility to participate in health care financing. Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

6. Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly.

   Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

7. Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination.

   The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

8. <u>Health promotion and disease prevention</u> efforts should be strengthened.

   The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; (3) conduct health, environmental, and safety-related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental, and safety standards.

9. <u>Individuals</u> share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety, and well-being.

   The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

10. The acute and long-term care systems should be coordinated tc ensure a <u>continuum of care</u> across an individual's lifetime.

<u>Preamble</u>

AARP believes that the United States has the resources to ensure access to acute and long term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprehensive, affordable acute and long term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long term care systems. The principles do not address every specific issues relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Long Term Care Principles:

1. Long-term care services should be available to all people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive functioning, including limitations in performing

activities of daily living (e.g., eating, bathing and dressing) and a person's need for supervision. Uniform, national assessments should determine whether a person meets the eligibility criteria for the program and the type and level of care that a person needs.

2. A national long-term care program should provide a comprehensive range of services. These services should include: (1) in-home assistance; (2) community services; (3) long-term care services in a full range of supportive housing options (4) institutional care; and (5) rehabilitative services. Long-term care should be provided in the least restrictive setting possible.

3. The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

4. Implementation of the public program must be phased-in to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community and institutional services.

5. The principles of social insurance (e.g., Social Security or Medicare), and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

6. The new long-term care program should be financed primarily through taxes earmarked to a trust fund. Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

7. The new public program must provide a solid foundation for protection, upon which the private sector can build. The private sector could supplement the public program by covering the program's copayments and deductibles, as well as services that the public program does not provide. Any private sector approach (e.g. long term care insurance) should be subject to strong standards to protect consumers from inadequate products.

8. Payment to providers of long-term care services must be reasonable and provide financial returns to providers who deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

9. Cost containment mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also should be included. However, people with low incomes should be protected.

10. The federal and state governments should assure delivery of quality care under the new long-term care program. Recent improvements in the quality assurance systems for nursing homes and home health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

PREPARED STATEMENT OF KENNETH W. GIDEON

Mr. Chairman and Members of the Committee, I am pleased to discuss with you today the revenue proposals contained in President Bush's FY 1992 budget.

The Administration's 1992 Budget abides by the terms of the budget agreement developed last year. We view the budget process reforms, particularly the "pay-as-you-go" provisions, as an integral part of the agreement. It is essential that Congress and the Administration adhere to both the letter and spirit of these reforms.

The revenue proposals in the budget which I will discuss today address the need to promote long-term economic growth as well as addressing current problems. These proposals are financed through a combination of initiatives which raise revenues and decrease spending.

INCENTIVES FOR RESEARCH AND EXPERIMENTATION

We recommend that the 20 percent research and experimentation (R&E) tax credit, which is set to expire after 1991, be extended permanently. Research is inherently a long-term process. To obtain full value for this incentive, it must be reliable and dependable—not subject to the uncertainties of an annual debate on renewal. In addition, the current allocation rules for R&E under section 861 should be extended for another year.

FAMILY SAVINGS ACCOUNTS

We hope to improve our country's low rate of personal savings by creating a new savings vehicle, the Family Savings Account (FSA). Nondeductible contributions to an FSA of up to $2,500 per taxpayer would be permitted with a maximum of two accounts per family. After meeting the required 7 year holding period, all savings, including the accumulated earnings, can be withdrawn tax free. Withdrawals of savings within 3 years of the time the contribution was made will result in a 10 percent excise tax penalty and an income tax on the accumulated earnings. Earnings on funds withdrawn between 3 and 7 years after contribution will be subject only to income tax with no excise tax penalty.

FSAs are explicitly a savings—not a retirement—program. The time limit to obtain full benefits is short enough to focus attention on specific personal goals—saving to buy a home, preparing for education costs, building a financial reserve to protect against unexpected events, or any high-priority objectives. FSAs will not undermine the basic retirement focus of existing IRAs and pension plans; they will supplement those long-term savings plans with a vehicle suitable for shorter term needs.

From the Government's perspective, the FSA does not cause large revenue losses at the beginning of the program because the contributions are not tax deductible.

Instead, the earnings created by the contributions to FSAs will be exempt from taxes. This approach is prudent because we can evaluate the impact on revenues and savings as we proceed without incurring large front-end revenue losses.

ENTERPRISE ZONES

To help economically distressed areas enjoy the benefits of economic growth, we recommend designation of up to 50 Federal enterprise zones which will benefit from targeted tax incentives and Federal, state, and local regulatory relief. The Federal tax incentives would be: (i) a wage credit of up to $525 per worker; (ii) elimination of capital gains taxes for tangible property used in an enterprise zone business; and (iii) expensing by individuals of contributions to the capital of corporations engaged in the conduct of enterprise zone businesses. The willingness of states and localities to "match" Federal incentives will be considered in selecting the enterprise zones to receive these additional Federal incentives.

PENALTY-FREE IRA WITHDRAWALS FOR FIRST-TIME HOME BUYERS

We propose to allow individuals to withdraw amounts of up to $10,000 from their IRAs for a "first-time" home purchase. The 10 percent additional tax on early withdrawals imposed under current law would be waived for eligible individuals. Our proposal is designed to enhance the attractiveness of deductible IRAs by making them more flexible. Since home equity is itself a significant form of retirement saving for many Americans, we do not believe that allowing withdrawals for this purpose undermines the retirement saving objectives of IRAs.

PROPOSALS ON EXPIRING PROVISIONS

The budget contains proposals to extend for one year the following programs that would otherwise expire at the end of fiscal 1991:

1. The low-income housing credit encourages the private sector to construct and rehabilitate the Nation's housing stock and makes it available to low-income families. In addition to tenant-based housing vouchers and certificates, the credit is a mechanism for providing Federal assistance to rental households.
2. Geothermal and solar energy credits are intended to encourage investment in renewable energy technologies. Increased use of solar and geothermal energy would reduce our Nation's reliance on imported oil and other fossil fuels and would improve our long-term energy securityl while also reducing air pollution.
3. The targeted jobs tax credit is intended to encourage employers to hire disadvantaged workers who otherwise might be unable to find employment. We do not believe job creation incentives should be reduced in the current economic climate.
4. The 25 percent deduction for health insurance costs of self-employed individuals reduces the disparity in the tax treatment of such costs between self-employed individuals and owners of incorporated businesses.

SPECIAL NEEDS ADOPTION

We again urge the enactment of an income tax deduction (up to a maximum of $3,000 per child) for expenses incurred in connection with the adoption of special needs children. When combined with the current outlay program under the Adoption Assistance program, the proposal would assure that reasonable expenses associated with the process of adopting a special needs child do not cause financial hardship for the adoptive parents.

CAPITAL GAINS TAX RATE REDUCTION FOR INDIVIDUALS

Reducing the capital gains tax rate for individuals is important to restore economic growth and competitive strength by promoting savings, entrepreneurial activity, and risky investment in new products, processes and industries. At the same time, investors should be encouraged to extend their horizons and search for investments with longer term growth potential. To encourage Americans to invest for longer periods of time, we believe that the tax rate for capital gains on assets such as real estate, timber, homes, farms, land and corporate stock should be reduced based on the length of time an asset has been held.

Under our proposals, the capital gains tax rate would be reduced by means of a sliding-scale exclusion. Individuals would be allowed to exclude a percentage of the capital gain realized upon the disposition of all assets qualifying as capital assets under current law, except for collectibles. Individuals would apply their current marginal rate on capital gains (either 15 or 28 percent) to the reduced amount of taxable gain. The amount of the exclusion would depend on the holding period of

the assets. Assets held 3 years or more would qualify for an exclusion of 30 percent. Assets held at least 2 years but less than 3 years would qualify for a 20 percent exclusion. Assets held at least 1 year but less than 2 years would qualify for a 10 percent exclusion.

For example, individuals subject to a 28 percent tax on capital gains (i.e., taxpayers in the 28 and 31 percent tax brackets for ordinary income) would pay rates of 25.2, 22.4 and 19.6 percent for assets held 1, 2, or 3 years, respectively. The corresponding figures for individuals subject to a 15 percent rate would be 13.5, 12.0 and 10.5 percent.

For the balance of 1991, the 30 percent exclusion would apply to all qualified capital assets held at least 1 year. For assets disposed of in 1992, the 30 percent exclusion would apply to assets held at least 2 years, and the 20 percent exclusion would apply to assets held at least 1 year but less than 2 years. The general rule would apply in 1993 and all years thereafter. The excluded gains would be subject to the alternative minimum tax. Prior depreciation deductions would be recaptured.

The Administration believes that this capital gains proposal would lower the cost of capital and stimulate investment, reduce the lock-in effect, and lower the double tax on corporate stock investment. Given that there are divergent opinions on the relative strength of these effects, however, President Bush requested Federal Reserve Board Chairman Alan Greenspan to study these matters. We hope that the Congress will work with Chairman Greenspan and the Administration to illuminate and resolve the disagreements surrounding the revenue, distributional and macroeconomic effects of a capital gains tax rate cut.

The President's budget contains several additional proposals to increase revenues. I would like to mention three today. Other proposals not discussed in my written statement are described in the Treasury's "General Explanations of the President's Budget Proposals Affecting Receipts" which was released with the Budget in February.

ADDITIONAL INTERNAL REVENUE SERVICE FUNDING

The budget calls for an increase in Internal Revenue Service funding for tax law enforcement. Two initiatives—one in the area of field examinations and the other in the area of collection of accounts receivable—are expected to add $700 million to receipts over the budget period.

MEDICARE HOSPITAL INSURANCE (HI) FOR STATE AND LOCAL EMPLOYEES

We propose extending coverage by Medicare Hospital Insurance (HI) to all State and local government employees. State and local government employees are the only major group of employees not assured Medicare coverage. One out of six State and local government employees are not covered by voluntary agreements or by law. However, an estimated 85 percent of these employees receive full Medicare benefits through their spouse or because of prior work in covered employment. Over their working lives, they contribute on average only half as much tax as paid by workers in the private sector. Extending coverage would assure that the remaining 15 percent have access to Medicare and would eliminate the inequity and the drain on the Medicare trust fund caused by those who receive Medicare without contributing fully. The addition of two million State and local government employees as contributors to Medicare would increase revenues by $7.3 billion over the budget period.

SPECIAL OCCUPATION TAXES

To increase compliance rates and revenues, distributors of alcoholic beverages would be required to verify prior to sale that their retail customers pay the special taxes in connection with liquor occupations. It is expected that this measure will increase revenues by about $100 million over the budget period. The proposal would be effective beginning October 1, 1991.

CONCLUSION

Recognizing the controversy which has surrounded capital gains estimates, the budget has been formulated to meet "pay-as-you-go" requirements without relying on the revenues which we believe would be generated by our capital gains proposal. The reductions in mandatory program outlays outlined in the budget together with the proposals increasing revenues which I have described are more than sufficient to fund the items which reduce receipts, even if revenues from capital gains are disregarded.

Mr. Chairman, we look forward to working with the Congress and this Committee to enact a budget which fully complies with last year's budget agreement. We believe that our budget proposals meet that goal and urge the Committee to report legislation embodying those proposals.

Attachment.

General Explanations

of the

President's Budget Proposals Affecting Receipts

CAPITAL GAINS TAX RATE REDUCTION FOR INDIVIDUALS

The Budget again includes a reduction of the capital gains tax rate for individuals on long-term investments. The Budget provides for a 10, 20, or 30 percent exclusion for long-term capital gains on assets held by individual taxpayers for one, two or three years, respectively. The three-year holding period requirement will be phased in over three years.

In his State of the Union Address on January 29, 1991 the President asked Congressional leaders to cooperate with the Administration in a study led by Federal Reserve Chairman Alan Greenspan to sort out technical differences over the distributional and economic impacts of a capital gains reduction.

A reduction in capital gains taxes should benefit all Americans by providing incentives for saving and investment that would result in higher national output and more jobs.

Current Law

Under current law, the full amount of capital gains income is generally taxable but the rate on such gains is capped at 28 percent. Capital gains are generally subject to 15 percent or 28 percent statutory tax rates. When capital gains taxes interact with other provisions in the income tax code, however, the actual tax cost of an asset sale can be significantly higher. Interacting provisions include the requirement that itemized deductions for medical and miscellaneous expenses exceed a percentage of adjusted gross income, the phase-outs with increasing income of IRA deductions, passive activity loss limitations, and the phase-out of personal exemptions and the three percent floor on itemized deductions enacted in 1990.

While the Tax Reform Act of 1986 eliminated the capital gains exclusion of prior law, it did not eliminate the legal distinction between capital gains and ordinary income, or between short-term and long-term capital gains. These distinctions currently serve to identify those transactions eligible for the 28 percent maximum rate and subject to the limitations on deduction of capital losses. Capital assets effectively include all property except inventories or other items held for sale in the ordinary course of business and certain other listed assets. Examples of capital assets include corporate stock, a home, a farm or business, real estate, and antiques. Gains or losses from the sale or exchange of capital assets held for one year or longer are classified as long-term capital gains or losses.

Individuals with capital losses exceeding capital gains may generally deduct up to $3,000 of such losses against ordinary income. A net capital loss in excess of the deduction limitation may be carried forward. Special rules allow individuals to treat losses of up to $50,000 ($100,000 on a joint return) with respect to stock in certain small business corporations as ordinary losses.

Depreciation recapture rules recharacterize a portion of capital gains on depreciable property as ordinary income. These rules vary for different types of depreciable property. For personal property, all previously allowed depreciation not in excess of the realized capital gain is generally recaptured as ordinary income. For real property using straight-line depreciation, there is no depreciation recapture if the asset is held at least one year. For real property acquired before 1987, generally only the excess of the depreciation claimed in excess of straight-line depreciation is recaptured as ordinary income. There are also recapture rules applicable to the disposition of depletable property and to certain other assets.

Capital gains and losses are generally taken into account when "realized" upon the sale, exchange, or other disposition of the asset. Certain dispositions of capital assets, such as transfers by gift, are not generally realization events for income tax purposes. In general, in the case of gifts the donor does not realize gain or loss, and the donor's basis in the property carries over to the donee. In certain cases, such as the gift of a bond with accrued market discount or of property that is subject to indebtedness in excess of the donor's basis, the donor may recognize ordinary income upon making a gift. The capital gain in a charitable contribution of appreciated property (other than tangible personal property donated in 1991) is included as a preference item in calculating the alternative minimum tax. Gain or loss is not realized on a transfer at death, and the beneficiary's basis in the inherited asset is generally the fair market value of the asset at (or near) the date of death.

Reasons for Change

Restoring a capital gains tax rate differential is important to restore economic growth and competitive strength by promoting savings, entrepreneurial activity, and risky investment in new products, processes, and industries. At the same time, investors should be encouraged to extend their horizons and search for investments with longer-term growth potential. The future competitiveness of this country requires a sustained flow of capital to innovative, technologically advanced activities that may generate minimal short-term earnings but promise strong future profitability. A preferential tax rate limited to longer-term commitments of capital will encourage business investment patterns that favor innovation and long-term growth over short-term profitability. The resulting increase in national output will benefit all Americans by providing jobs and raising living standards. In addition to the improvements in productivity and economic growth, a lower rate on long-term capital gains will also improve the fairness of the individual income tax by providing a rough adjustment for the taxation of inflationary gains that do not represent any increase in real income.

Incentives for Longer-Range Investment. A capital gains preference has long been recognized as an important incentive for capital investment. The first tax rate differential for capital gains in this country was introduced by the Revenue Act of 1921. For the next 65 years there was always some tax rate differential for long-term capital gains. The preferential treatment for capital gains has taken various forms, including an exclusion of a fixed portion of the nominal gains, an exclusion that depended on the length of time a

taxpayer held an asset, and a special maximum tax rate for capital gains. But at no time between 1921 and 1987 were long-term capital gains ever taxed at the same rates as ordinary income. In 1990, Congress set the maximum marginal tax rate on capital gains at 28 percent, or three percentage points below the maximum marginal rate on ordinary income. Nevertheless, as shown in Figure 1, the average effective tax rate on realized capital gains is currently substantially higher than it has been in the past.

By eliminating the capital gains exclusion and lowering tax rates on ordinary income, the 1986 Act increased the incentives for short-term trading of capital assets. This occurred because the tax rate on long-term capital gains was increased while the tax rate on short-term capital gains was reduced. By providing for a sliding scale exclusion that provides full benefits only for investments held at least three years after a phase-in period, the Budget proposal would increase the incentive for longer term investing.

The Cost of Capital and International Competitiveness. The capital gains tax is an important component of the cost of capital, which measures the pre-tax rate of return required to induce businesses to undertake new investment. Evidence suggests that the cost of capital in the United States is higher than in many other industrial nations. While not solely responsible for the higher cost of capital, high capital gains tax rates hurt the ability of U.S. firms to obtain the capital needed to remain competitive. By reducing the cost of capital, a reduction in the capital gains tax rate would stimulate productive investment and create new jobs and growth.

Our major trading partners already recognize the economic importance of low tax rates on capital gains. Virtually all other major industrial nations provide much lower tax rates on capital gains or do not tax capital gains at all. Canada, France, Germany, Japan, the Netherlands, and the United Kingdom, among others, all treat capital gains preferentially.

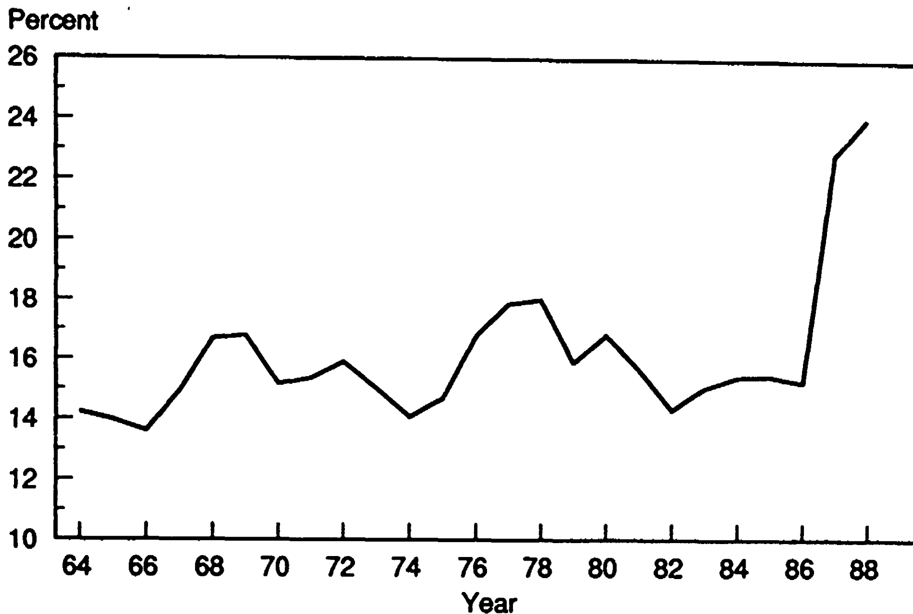
The Lock-In Effect. Under a tax system in which capital gains are not taxed until realized by the taxpayer, a substantial tax on capital gains tends to lock taxpayers into their existing investments. Many taxpayers who would otherwise prefer to sell their assets to acquire new and better investments may instead continue to hold onto the assets rather than pay the current high capital gains tax on their accrued gains.

This lock-in effect of capital gains taxation has three adverse effects. First, it produces a misallocation of the nation's capital stock and entrepreneurial talent because it distorts the investment decisions that would be made in the absence of the capital gains tax. For example, the lock-in effect reduces the ability of entrepreneurs to withdraw from an enterprise and use the funds to start new ventures. Productivity in the economy suffers because entrepreneurs are less likely to move capital to where it can be most productive, and because capital may be used in a less productive fashion than if it were transferred to other, more efficient, enterprises. These effects can be especially critical for smaller firms which may not have good access to capital markets and where ownership and operation frequently go together. Second, the lock-in effect produces distortions in the investment portfolios of individual taxpayers. For example, some individual investors may be induced to

FIGURE 1.

AVERAGE EFFECTIVE TAX RATE ON CAPITAL GAINS

1964-1988



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assume more risk or hold a different mix of assets than they desire because they are reluctant to sell appreciated investments to diversify their portfolios. Third, the lock-in effect reduces government receipts. To the extent that taxpayers defer sales of existing investments, or hold onto investments until death, taxes that might otherwise have been paid are deferred or avoided altogether. Therefore, individual investors, the government, and other taxpayers lose from the lock-in effect. The investor is discouraged from pursuing more attractive investments and the government loses revenue.

Substantial evidence from more than a dozen studies demonstrates that high capital gains tax rates in previous years produced significant lock-in effects. The importance of the lock-in effect may also be demonstrated by the fact that realized capital gains were 16 percent lower under the high tax rates in 1987 than under the lower rates in 1985, even though stock prices had risen by approximately 50 percent over this period. The high tax rates on capital gains under current law imply that the lock-in effect is greater than at any prior time.

Penalty on High-Risk Investments. Full taxation of capital gains, in combination with limited deductibility of capital losses, discourages risk taking. It therefore impedes investment in emerging high-technology and other high-risk firms. While many investors are willing to take risks in anticipation of an adequate return, fewer are willing to contribute "venture capital" if a significant fraction of the increased reward will be used merely to satisfy higher tax liabilities. A tax system that imposes a high tax rate on gains from the investment reduces the attractiveness of risky investments, and may result in many worthwhile projects not being undertaken.

In particular, it is inherently more risky to start new firms and invest in new products and processes than to make incremental investments in existing firms and products. It is therefore the most dynamic and innovative firms and entrepreneurs that are the most disadvantaged by high capital gain tax rates that penalize risk taking. Such firms have traditionally been contributors to America's edge in international competition and have provided an important source of new jobs.

Double Tax on Corporate Stock Investment. Under the U.S. income tax system, income earned on investments in corporate stock is generally subjected to two layers of tax. Income on corporate investments is taxed first at the corporate level at a rate of 34 percent. Corporate income is taxed a second time at the individual level in the form of taxes on capital gains and dividends at rates ranging from 15 to 31 percent. The combination of corporate and individual income taxes thus can produce effective tax rates that are substantially greater than individual income tax rates alone. To the extent the return to the investor is obtained through appreciation in the value of the stock (rather than through dividend income), a reduction in capital gains tax rates provides a form of relief from this double taxation of corporate income. While a lower capital gains tax rate reduces the cost of capital for both corporate and noncorporate business, the greater liquidity of shares in publicly-traded companies suggests that the overall effect would be to reduce the bias towards noncorporate business that results from our dual-level tax system.

Description of Proposal

General Rule. The capital gains tax rate would be reduced by means of a sliding-scale exclusion. Individuals would be allowed to exclude a percentage of the capital gain realized upon the disposition of qualified capital assets, and would apply their current marginal rate on capital gains (either 15 or 28 percent) to the reduced amount of taxable gain. The amount of the exclusion would depend on the holding period of the assets. Assets held three years or more would qualify for an exclusion of 30 percent. Assets held at least two years but less than three years would qualify for a 20 percent exclusion. Assets held at least one year but less than two years would qualify for a 10 percent exclusion. For example, individuals subject to a 28 percent tax on capital gain (i.e., taxpayers in the 28 and 31 percent tax brackets for ordinary income) would pay rates of 25.2, 22.4, and 19.6 percent for assets held one, two, or three years, respectively. The corresponding figures for individuals subject to a 15 percent rate would be 13.5, 12.0, and 10.5 percent.

Qualified assets would generally be defined as any assets qualifying as capital assets under current law and satisfying the holding period requirements, except for collectibles. Collectibles are assets such as works of art, antiques, precious metals, gems, alcoholic beverages, and stamps and coins. Assets eligible for the exclusion would include, for example, corporate stock, manufacturing and farm equipment, a home, an apartment building, a stand of timber, or a family farm.

Phase-in Rules and Effective Dates. The proposal would be effective generally for dispositions of qualified assets after the date of enactment. For the balance of 1991, the full 30 percent exclusion would apply to assets held at least one year. For dispositions of assets in 1992, assets would be required to have been held for two years or more to be eligible for the 30 percent exclusion, and at least one year but less than two years to be eligible for the 20 percent exclusion. For dispositions of assets in 1993 and thereafter, assets would be required to have been held at least three years to be eligible for the 30 percent exclusion, at least two years but less than three years for the 20 percent exclusion and at least one year but less than two years for the 10 percent exclusion.

Additional Provisions. In order to prevent taxpayers from benefitting from the exclusion provision for depreciation deductions that have already been claimed in prior years, the depreciation recapture rules would be expanded to recapture all prior depreciation deductions. All taxpayers would be able to benefit from the proposed exclusion to the extent that a depreciable asset has increased in value above its unadjusted basis. The excluded portion of capital gains would be added back when calculating income under the alternative minimum tax, however, the special rule relating to contributions of tangible personal property in 1991 would not be modified. Installment sale payments received after the effective date will be eligible for the exclusion without regard to the date the sale actually took place. For purposes of the investment interest limitation, only the net capital gain after subtracting the excluded amount would be included in investment income. The 28 percent limitation on capital gains not eligible for the exclusions would be retained.

Examples of the Effects of Proposal

Example A. Taxpayer A is a single individual earning $16,000 whose mutual fund investments have a reported long-term capital gain of $500 in late 1991.

Under current law, her tax on the $500 capital gain would be 15 percent of the full $500 gain, or $75.

Under the proposal, her tax would be reduced to $52.50, which is 15 percent of $350 ($500 less the 30 percent exclusion).

Example B. Example B is a two-earner couple with combined taxable income other than capital gains of $40,000. In 1993, they sell corporate stock realizing a $1,500 capital gain on stock held 15 months and a $2,500 capital gain on stock held 5 years.

Under current law both gains would be subject to taxation at a tax rate of 28 percent. Tax on the $1,500 gain would be $420, and tax on the $2,500 gain would be $700, for a combined tax of $1,120.

Under the proposal, the gain from the sale of stock held 15 months would be eligible for a 10 percent exclusion and the gain on the stock held 5 years would be eligible for a 30 percent exclusion. The tax on the stock held 15 months would be $378 and the tax on the stock held 5 years would be $490, for a combined tax of $868, which would be 22 percent lower than their liability under current law.

Example C. Taxpayer C is the founder of a five year old computer software company who would like to sell the company in order to start a new company making a new product. Taxpayer C has a salary of $380,000 and $20,000 in dividend and interest income. Taxpayer C sells the stock in the computer software company for $2 million, resulting in a capital gain of $1.8 million after deduction of his $200,000 cost basis.

Under current law, Taxpayer C would pay a capital gains tax of about $523,840 (depending on the level and composition of his itemized deductions), leaving him with net proceeds of $1,476,160 from the sale of the company.

Under the proposal, the capital gains tax, including the alternative minimum tax, would be about $427,915 (again, depending on the level and composition of his itemized deductions). The net proceeds from selling the company would now be about $1,572,085. Thus, Taxpayer C would have about $95,925 of additional funds that could be invested in the new business.

Revenue Estimates

Capital gains realizations are highly responsive to changes in stock prices and general economic conditions as well as to capital gains tax rates. Furthermore, taxpayers may adjust their purchases and sales of capital assets and their other income sources and deductions in response to new tax rules. Since 1978, Treasury revenue estimates of capital gains have taken into account expected changes in taxpayer behavior.

These behavioral effects are the subject of continued empirical research. Treasury's Office of Tax Analysis (OTA) incorporates all effects believed to be important and presents its best estimate of the expected effects. The proposal is expected to increase Treasury receipts as compared to current law receipts due to increased realizations. The revenue estimates noted below assume a February 15, 1991 effective date. The increase in revenues is expected to be greatest in fiscal year 1992, due to the unlocking of existing capital gains, and smaller thereafter. The expected changes in revenues are modest in comparison to the magnitude of the expected total amount of revenues from the capital gains tax (in excess of $40 billion per year).

Details of Revenue Estimates

The details of the revenue estimates are shown in Table 1. Line I of Table 1 shows the revenue loss that results from a flat 30 percent exclusion on the amount of capital gains that would be realized at current law tax rates; i.e., "baseline" realizations that would have occurred without a change in tax rates. This loss is what a "static" revenue estimate for a 30 percent exclusion would show. This "static" revenue loss is estimated to be $11.3 billion in fiscal year 1992, gradually increasing to about $18 billion by 1996.

Line II of Table 1 shows the estimated revenue from additional realizations that would be induced by a flat 30 percent exclusion. These induced gains arise from several sources. They represent realizations accelerated from future years, realizations due to portfolio shifting, or realizations that would otherwise have been tax-exempt because they would have been held until death, donated to charity, or not reported. As indicated by a comparison of line I and II, revenues from induced realizations are estimated to be sufficient to offset the static revenue loss on current gains for several years, but not in the long run. This conclusion is based on Treasury's analysis of the findings of numerous statistical studies of the responsiveness of capital gains to lower tax rates, and is consistent with the revenue experience of previous capital gains tax rate changes.

Line III shows the revenue effects of limiting the exclusion to 20 percent for assets held two years and 10 percent for assets held one year, and the phase-in of these holding period limitations. The estimates reflect a reduction in static revenue losses, the effects of induced realizations, and the effects of deferring realizations of assets not yet qualifying for the full 30 percent exclusion. These provisions, which are aimed at promoting a longer-term investment horizon, produce revenue gains in the long run, although a small net revenue loss over the budget period.

TABLE 1

REVENUE EFFECTS OF THE PRESIDENT'S CAPITAL GAINS PROPOSAL

	Item	Fiscal Year ($ Billions)						
		1991	1992	1993	1994	1995	1996	1991-96
I.	Static effect of 30% exclusion	-1.7	-11.3	-13.0	-14.6	-16.2	-18.0	-74.7
II.	Effect of taxpayer behavior 1/	2.2	14.9	15.1	14.7	15.1	16.3	78.3
III.	Effect of the 3-year holding period	0.0	-0.1	-0.8	-0.8	0.3	0.3	-1.1
IV.	Effect of full depreciation recapture	0.0	-0.2	0.4	1.0	1.5	1.7	4.2
V.	Effect of treating excluded gains as a preference item for AMT purposes	-0.1	-0.5	0.1	0.8	1.2	1.4	2.7
VI.	Effective date of proposal 2/	0.0	0.3	0.0	0.0	0.0	0.0	0.3
VII.	Total revenue effect of proposal	0.4	3.0	1.7	0.9	1.8	1.7	9.5

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Note: Details may not add to total due to rounding.

1/ This line reflects an estimate of the net effect of an increase in budget receipts attributable to taxpayer decisions to realize more capital gains, and a decrease in receipts resulting from conversion of ordinary income into capital gains and deferral of short-term gains as a result of lower tax rates.

2/ Lines I-V reflect January 1, 1991 effective date. Line VI represents an adjustment to these lines to reflect an assumed effective date of February 15, 1991.

Lines IV and V show the revenue effects of expanded depreciation recapture and treating excluded capital gains as a preference item for purposes of the alternative minimum tax. These two provisions are critical to turning the proposal from one that would otherwise probably lose revenue in the long run to one that is revenue-raising even beyond the budget period. Over the budget period, these two provisions raise $6.9 billion in revenue. The full depreciation recapture proposal means that if a depreciable asset is sold, the exclusion will apply only to the amount by which the current selling price is higher than the original cost. Treating excluded gains as a preference item for purposes of the alternative minimum tax primarily affects high-income individuals and raises $2.7 billion over the budget period. Line VI shows the revenue effect of making the effective date of the proposal February 15, 1991.

The total revenue effect of the proposal is shown in line VII. The proposal is expected to raise revenue in every year and $9.5 billion over the budget period. Treasury's estimates indicate that the Administration proposal would produce increased revenues not only throughout the budget period, but for the foreseeable future.*

These estimates do not include the effects of potential increases in long-run economic growth expected from a lower capital gains tax rate. This conforms to the standard budget and revenue estimating practice of assuming that the macroeconomic effects of revenue and spending proposals are already included in the economic forecast.

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* Because the methodological differences between OTA, Congressional estimators, and outside experts have not yet been resolved, the Budget reflects the deficit impact of the Administration's Pay-As-You-Go proposals with the Administration's estimates and with a zero (neutral) entry for capital gains rate reduction (see Table II-8, Part One, p. 18, of the Budget of the U.S. Government, Fiscal Year 1992).

FAMILY SAVINGS ACCOUNTS

Current Law

Taxation of Investment Income and Saving. Investment income earned by an individual taxpayer is generally subject to tax. The funds saved out of each year's income, which are used to make additional deposits to savings or other investment accounts, additional purchases of stocks or bonds, or to acquire other investments, are generally not deductible in calculating taxable income. The major exception is the tax treatment of retirement savings under certain tax-favored retirement savings arrangements, contributions to which are generally deductible and investment earnings of which are generally excludable from gross income. These investments are generally taxed when the amounts contributed and earned are later distributed.

Individual Retirement Accounts. The current law for Individual Retirement Accounts (IRAs) generally grants married taxpayers who do not participate in a qualified retirement plan or who have adjusted gross incomes (AGI) below $50,000 the right to make deductible contributions to an IRA. There is a lower income threshold of $35,000 if the taxpayer is unmarried. The deductibility of contributions for taxpayers participating in a qualified retirement plan is phased out as their AGI increases from $10,000 below the income threshold up to the threshold. Taxpayers who do participate in a qualified retirement plan and who have adjusted gross incomes above these thresholds may make only nondeductible contributions to an IRA. Both deductible and nondeductible IRA contributions are limited to the lesser of $2,000 or the individual's compensation for the year.

Married individuals who both work and otherwise qualify may each contribute to an IRA, so if each spouse has compensation of $2,000 or more, each may contribute $2,000. If only one spouse works, qualifying married individuals also have the opportunity to contribute an additional $250 to an IRA for the nonworking spouse. The limit on deductible contributions to the IRA of a nonworking spouse is proportionately reduced for adjusted gross incomes in the applicable phase-out ranges.

Withdrawals from an IRA prior to age 59-1/2 are generally subject to a 10 percent additional tax. Except for distributions of amounts which were not deductible when contributed, IRA withdrawals are subject to regular income tax, and withdrawals must begin by age 70-1/2.

In economic terms, deductible IRAs effectively exempt investment income from taxation. (The income tax imposed on withdrawals merely recaptures the tax saved from deducting the contribution, plus interest on that tax savings; the investment income itself is effectively exempt from tax.) This favorable tax treatment provides an incentive to save; IRAs are designed to provide this incentive specifically for retirement savings. The tax exemption of investment income is also a feature of section 401(k) and other tax-qualified retirement arrangements. Nondeductible IRAs allow only a deferral of taxes on investment income, not an exemption.

Reasons For Change

There is general concern that the rate of national saving and investment is too low relative to that needed to sustain future growth and to maintain our relative economic position in comparison with the performance of other industrial nations. Addressing this problem requires that both public dissaving (the budget deficit) be reduced, and that private saving be increased. Incentives provided by the proposed Family Savings Accounts will provide an important incentive to encourage private saving.

The availability of savings accounts in the form of IRAs was sharply curtailed by the Tax Reform Act of 1986, which resulted in a large decline in IRA participation. Prior to the Act, any individual under the age of 70-1/2 could make deductible contributions, up to the current limits, to an IRA. One of the goals of the current proposal is to expand the availability and attractiveness of tax-exempt saving to a large segment of the population.

An additional goal of the current proposal is to expand savings incentives to income that is saved for other than retirement purposes, while not eroding incentives for retirement saving. The proposal recognizes that individuals save for many reasons: for down-payments on homes, for educational expenses, for large medical expenses, and as a hedge against uncertain income in the future.

Description of Proposal

The Family Savings Account (FSA) differs from a deductible current-law IRA in two respects: the contributions are not deductible, but if the account is maintained for at least seven years, neither the contributions nor the investment earnings are taxed when withdrawn. As in the case of IRAs, the economic effect of an FSA is to exempt investment income from taxation. The proposal would allow individuals (other than dependents) to make nondeductible contributions to an FSA up to the lesser of $2,500 or the individual's compensation for the year. Contributions would be allowed for single filers with adjusted gross income (AGI) no more than $60,000, for heads of households with AGI no more than $100,000, and for married taxpayers filing joint returns with AGI no more than $120,000. Contributions to FSAs would be allowed in addition to contributions to current-law qualified pension plans, IRAs, 401(k) plans, and other tax-favored forms of saving.

Earnings on contributions retained in the FSA for at least seven years would be eligible for full tax exemption upon withdrawal. However, withdrawals of earnings allocable to contributions retained in the FSA for less than three years would be subject to both a 10 percent additional tax and regular income tax. Withdrawals of earnings allocable to contributions retained in the FSA for three to seven years would be subject only to regular income tax. The proposal would be effective for years beginning on or after January 1, 1991.

Effects of Proposal

The proposal would increase the total amount of individual saving that can earn tax-free investment income. Generally, individuals would be able to contribute to FSAs, IRAs, 401(k) plans, and similar tax-favored plans, and would receive tax exemption on the investment income from each source.

The ability to contribute to an FSA would significantly raise the total amount of allowable contributions to tax-favored savings accounts. The contribution limit is $5,000 for joint return filers as compared to the $4,000 IRA limit for a working couple. These higher total contribution limits for FSAs will provide additional marginal incentives for personal saving. The higher eligibility limits on FSAs also expand the incentives to more taxpayers.

Despite the difference in structure, the value of the tax benefits in present value of an FSA per dollar of contribution is equivalent in terms of its tax treatment to the value of current-law deductible IRAs, assuming that tax rates are constant over time. Both FSAs and deductible IRAs effectively exempt all investment income from tax. The contributions to FSAs are not deductible, but the income tax imposed on withdrawals from an IRA effectively offsets the tax savings from the deduction of the contribution (plus interest on the tax savings). Individuals who expect higher tax rates when the funds are withdrawn would generally prefer the tax treatment offered in an FSA to that in an IRA. Conversely, individuals who expect lower future tax rates would generally prefer an IRA as a vehicle for retirement savings. However, the FSA offers more flexibility, because full tax benefits are available seven years after contribution and the account need not be held until retirement. This gives individuals an added degree of liquidity.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Family savings accounts:	-*	-.3	-.8	-1.3	-1.8	-2.3	-6.5

-* Revenue loss of less than $50 million.

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PENALTY-FREE IRA WITHDRAWALS FOR FIRST-TIME HOME BUYERS

Current Law

Married taxpayers who do not participate in a qualified retirement plan or who have adjusted gross incomes below $50,000 generally may make deductible contributions to an Individual Retirement Account (IRA). There is a lower threshold of $35,000 for unmarried taxpayers. The deductibility of contributions for taxpayers participating in a qualified retirement plan is phased out over the last $10,000 below the income threshold for each income tax filing status. Taxpayers who do participate in a qualified retirement plan and who have adjusted gross incomes above these thresholds may make only nondeductible contributions to an IRA. Both deductible and nondeductible IRA contributions are limited to the lesser of $2,000 or the individual's compensation for the year. Married individuals generally may contribute an additional $250 to an IRA for a nonworking spouse.

Withdrawals from IRAs must begin by age 70-1/2. IRA withdrawals, except those from nondeductible contributions, are subject to income tax. In general, withdrawals from an IRA prior to age 59-1/2 are subject to a 10 percent additional tax.

Reasons For Change

The intent of this proposal is to expand savings incentives to income that is saved for first-time home purchases. Increased flexibility of IRAs would help to alleviate the difficulties that many individuals have in purchasing a new home.

The attractiveness and eligibility of IRAs for many taxpayers was sharply curtailed by the Tax Reform Act of 1986. This resulted in a large decline in IRA participation. Prior to the 1986 Act, any individual under the age of 70-1/2 could make deductible contributions, up to the current limits, to an IRA. The current proposal is designed to enhance the attractiveness of deductible IRAs by making them more flexible. This increased flexibility would provide an incentive for more taxpayers to save for the purchase of their first home.

Description of Proposal

The proposal would allow individuals to withdraw amounts of up to $10,000 from their IRAs for a "first-time" home purchase. The 10 percent additional tax on early withdrawals would be waived for eligible individuals. Eligibility for penalty-free withdrawals would be limited to individuals who did not own a home in the last three years and are purchasing or constructing a principal residence that costs no more than 110 percent of the median home price in the area where the residence is located. The proposal would be effective for years beginning on or after January 1, 1991.

Effects of Proposal

This proposal will help encourage individuals to save for the purchase of a first home.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Penalty-free IRA withdrawals for first time home buyers:	-*	-.1	-.1	-.1	-.1	-.1	-.4

-* Revenue loss of less than $50 million.

PERMANENT RESEARCH AND EXPERIMENTATION TAX CREDIT

Current Law

Present law allows a 20 percent tax credit for a certain portion of a taxpayer's "qualified research expenses." The portion of qualified research expenses that is eligible for the credit is the increase in the current year's qualified research expenses over its base amount for that year. The base amount for the current year is computed by multiplying the taxpayer's "fixed-base percentage" by the average amount of the taxpayer's gross receipts for the four preceding years. A taxpayer's fixed-base percentage generally is the ratio of its total qualified research expenses for the 1984-88 period to its total gross receipts for this period. Special rules for start-up companies provide a fixed-base percentage of 3 percent. In no event will a taxpayer's fixed-base percentage exceed 16 percent. A taxpayer's base amount may not be less than 50 percent of its qualified research expenditures for the current year.

In general, qualified expenditures consist of (1) "in-house" expenditures for wages and supplies used in research; (2) 65 percent of amounts paid by the taxpayer for contract research conducted on the taxpayer's behalf; and (3) certain time-sharing costs for computers used in research. Restrictions further limit the credit to expenditures for research that is technological in nature and that will be useful in developing a new or improved business component. In addition, certain research is specifically excluded from the credit, including research performed outside the United States, research relating to style, taste, cosmetic, or seasonal design factors, research conducted after the beginning of commercial production, research in the social sciences, arts, or humanities, and research funded by persons other than the taxpayer.

The credit is available only for research expenditures paid or incurred in carrying on a trade or business of the taxpayer. A taxpayer is treated as meeting the trade or business requirement with respect to in-house research expenses if, at the time such in-house research expenses are incurred, the principal purpose of the taxpayer in making such expenditures is to use the results of the research in the active conduct of a future trade or business of the taxpayer or certain related taxpayers.

Present law also provides a separate 20 percent tax credit ("the university basic research credit") for corporate funding of basic research through grants to universities and other qualified organizations performing basic research. The university basic research credit is measured by the increase in spending from certain prior years. This basic research credit applies to the excess of (1) 100 percent of corporate cash expenditures (including grants or contributions) paid for university basic research over (2) the sum of a fixed research floor plus an amount reflecting any decrease in nonresearch giving to universities by the corporation as compared to such giving during a fixed base period (adjusted for inflation). A grant is tested first to see if it constitutes a basic research payment; if not, it may be tested as a qualified research expenditure under the general R&E credit.

The R&E credit is aggregated with certain other business credits and made subject to a limitation based on tax liability. The sum of these credits may reduce the first $25,000 of regular tax liability without limitation, but may offset only 75 percent of any additional tax liability. Taxpayers may carry credits not usable in the current year back three years and forward 15 years.

The amount of any deduction for research expenses is reduced by the amount of the tax credit taken for that year.

The R&E credit in the form described above is in effect for taxable years beginning after December 31, 1989. However, the credit will not apply to amounts paid or incurred after December 31, 1991.

Reasons for Change

The current law tax credit for research provides an incentive for technological innovation. Although the benefit to the country from such innovation is unquestioned, the market rewards to those who take the risk of research and experimentation may not be sufficient to support the level of research activity that is socially desirable. The credit is intended to reward those engaged in research and experimentation of unproven technologies.

The credit cannot induce additional R&E expenditures unless its future availability is known at the time firms are planning R&E projects and projecting costs. R&E activity, by its nature, is long-term, and taxpayers should be able to plan their research activity knowing that the credit will be available when the research is actually undertaken. Thus, if the R&E credit is to have the intended incentive effect, it should be made permanent.

Description of Proposal

The R&E credit would be made permanent.

Effects of Proposal

Stable tax laws that encourage research allow taxpayers to undertake research with greater assurance of the future tax consequences. A permanent R&E credit (including the university basic research credit) permits taxpayers to establish and expand research activities without fear that the tax incentive would not be available when the research is carried out.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Permanent R&E tax credit:	0	-0.5	-1.0	-1.3	-1.6	-1.8	-6.2

RESEARCH AND EXPERIMENTATION EXPENSE ALLOCATION RULES

Current Law

The tax credit allowed for payments of foreign tax is limited to the amount of U.S. tax otherwise payable on the taxpayer's income from foreign sources. The purpose of this limitation is to prevent the foreign tax credit from offsetting U.S. tax imposed on income from U.S. sources. Accordingly, a taxpayer claiming a foreign tax credit is required to determine whether income arises from U.S. or foreign sources and to allocate expenses between such U.S. and foreign source income.

Under the above limitation rules, an increase in the portion of a taxpayer's income determined to be from foreign sources will increase the allowable foreign tax credit. Therefore, taxpayers generally receive greater foreign tax credit benefits to the extent that their expenses are applied against U.S. source income rather than foreign source income.

Treasury regulations issued in 1977 described methods for allocating expenses between U.S. and foreign source income. Those regulations contained specific rules for the allocation of research and experimentation (R&E) expenditures, which generally required a certain portion of R&E expense to be allocated to foreign source income. Absent such rules, a full allocation of R&E expense to U.S. source income would overstate foreign source income, thus allowing the foreign tax credit to apply against U.S. tax imposed on U.S. source income and thwarting the limitation on the foreign tax credit.

Since 1981 these R&E allocation regulations have been subject to seven different suspensions and temporary modifications by Congress. The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) adopted allocation rules which were in effect for only four months. For 20 months following the period when the TAMRA rules were in effect, R&E allocation was controlled by the 1977 Treasury regulations. The Budget Reconciliation Act of 1989 subsequently reintroduced the TAMRA rules, once again on a temporary basis. These rules were extended to taxable years beginning on or before August 1, 1991 by the Omnibus Budget Reconciliation Act of 1990.

Under the R&E allocation rules enacted by TAMRA (and temporarily recodified in 1989 and 1990), a taxpayer must allocate 64 percent of R&E expenses for research conducted in the United States to U.S. source income and 64 percent of foreign-performed R&E to foreign source income. The remaining portion can be allocated on the basis of the taxpayer's gross sales or gross income. However, the amount allocated to foreign source income on the basis of gross income must be at least 30 percent of the amount allocated to foreign source income on the basis of gross sales.

Reasons for Change

As evidenced by its continued support for a R&E credit, the Administration believes in the provision of tax incentives to increase the performance of U.S.-based research activities. The allocation rules in this proposal provide such an incentive. Although the proposal benefits only multinational corporations that are subject to the foreign tax credit limitation, it will provide an effective incentive with respect to such entities. By enhancing the return on R&E expenditures, the proposal promotes the growth of overall R&E activity as well as encouraging the location of such research within the United States.

Description of Proposal

The proposal would extend for one year the R&E allocation rules that were first enacted by TAMRA and were re-enacted on a temporary basis in 1989 and 1990. The proposal would be effective for all taxable years beginning after August 1, 1991 and ending on or before August 1, 1992.

Effects of Proposal

Under the proposal, the automatic allocation of 64 percent of U.S.-performed R&E to U.S. source income generally permits a greater amount of income to be classified as foreign source than the rules applicable under the 1977 regulations. As discussed above, this will increase the benefits of the foreign tax credit for many taxpayers.

The operation of these rules is best illustrated through an example. Assume that an unaffiliated U.S. taxpayer has $100 of expense from research performed in the United States, that 50 percent of relevant gross sales produce foreign source income, and that 30 percent of the taxpayer's gross income is from foreign sources. Subject to certain limitations not applicable to these facts, the 1977 regulations would have required the taxpayer to allocate at least $30 of R&E expense to foreign source income ($100 x 30% gross income from foreign sources).

Under the proposal $64 is automatically allocated to U.S. source income based on the place of performance ($100 x 64%). The remaining $36 may be allocated either on the basis of gross sales or on the basis of gross income (subject to the limitation described below). A gross sales apportionment of the remainder would result in $18 ($36 x 50%) being allocated to foreign source income, while a gross income apportionment would result in $10.80 ($36 x 30%) being allocated to foreign source income.

The amount allocated to foreign source income using the gross income method must be at least 30 percent of the amount so allocated using the gross sales method. That limitation will not affect the result here since the $10.80 apportioned to foreign source income under the gross income method is greater than $5.40 ($18 apportioned under gross sales x 30% limitation).

As a result of the allocation rules in the proposal, the taxpayer in this example must allocate at least $10.80 of U.S.-performed R&E expense to foreign source income, compared to the $30 required to be so allocated under the 1977 regulations.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
One year extension of R&E expense allocations:	0	-.3	-.3	0	0	0	-.6

ENTERPRISE ZONE TAX INCENTIVES

Current Law

Existing Federal tax incentives generally are not targeted to benefit specific geographic areas. Although the Federal tax law contains incentives that may encourage economic development in targeted economically distressed areas, the provisions generally are not limited to use with respect to such areas.

Among the existing general Federal tax incentives that aid economically distressed areas is the targeted jobs tax credit. This credit provides an incentive for employers to hire economically disadvantaged workers and often is available to firms located in economically distressed areas. A Federal tax credit also is allowed for certain investment in low-income housing or the rehabilitation of certain structures that may be located in economically distressed areas. Another Federal tax incentive permits the deferral of capital gains taxation upon certain transfers of low-income housing. In addition, tax-exempt state and local government bonds may be used to finance certain activities conducted in economically distressed areas.

Reasons for Change

To help economically distressed areas share in the benefits of economic growth, the Administration proposes to designate Federal enterprise zones which will benefit from targeted tax incentives and regulatory relief. The tax incentives and regulatory relief provided by this proposal will stimulate government and private sector revitalization of the areas.

Description of Proposal

The proposed enterprise zone initiative would include selected Federal income tax employment and investment incentives. These incentives will be offered in conjunction with Federal, state, and local regulatory relief. Up to 50 zones will be selected over a four-year period.

The incentives are: (i) a 5 percent refundable tax credit for qualified employees with respect to their first $10,500 of wages earned in an enterprise zone (up to $525 per worker, with the credit phasing out when the worker earns between $20,000 and $25,000 of total annual wages); (ii) elimination of capital gains taxes for tangible property used in an enterprise zone business and located within an enterprise zone for at least two years; and (iii) expensing by individuals of contributions to the capital of corporations engaged in the conduct of enterprise zone businesses (provided the corporation has less than $5 million of total assets and uses the contributions to acquire tangible assets located within an enterprise zone, and limiting the expensing to $50,000 annually per investor with a $250,000 lifetime limit per investor).

The willingness of states and localities to "match" Federal incentives will be considered in selecting the special enterprise zones to receive these additional Federal incentives.

Effects of Proposal

Enterprise zones would encourage private industry investment and job creation in economically distressed areas by removing regulatory and other barriers inhibiting growth. They would also promote growth through selected tax incentives to reduce the risks and costs of operating or expanding businesses in severely depressed areas. A new era of public/private partnerships is needed to help distressed cities and rural areas help themselves.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Enterprise zone incentives:	0	-0.1	-0.2	-0.3	-0.5	-0.8	-1.8

SOLAR AND GEOTHERMAL ENERGY CREDITS

Current law

A tax credit is allowed for investment in solar or geothermal energy property. The amount of the credit is 10 percent of the investment. Solar property is equipment that uses solar energy to generate electricity or steam or to provide heating, cooling, or hot water in a structure. Geothermal property consists of equipment, such as a turbine or generator, that converts the internal heat of the earth into electrical energy or another form of useful energy. The credits for solar and geothermal property have been scheduled for expiration a number of times in recent years, but have been extended each time. The credits are currently scheduled to expire on December 31, 1991. A number of other energy credits, such as the credits for ocean thermal and wind energy property, have expired in recent years.

Reasons for Change

The geothermal and solar credits are intended to encourage investment in renewable energy technologies. Increased use of solar and geothermal energy would reduce our nation's reliance on imported oil and other fossil fuels and would improve our long-term energy security. Use of geothermal and solar energy resources also reduces air pollution.

Description of Proposal

The solar and geothermal credits would be extended through December 31, 1992.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
One year extension of solar and geothermal energy credits:	0	-*	-*	*	*	*	-*

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* Revenue gain of less than $50 million.

-* Revenue loss of less than $50 million.

TARGETED JOBS TAX CREDIT

Current Law

The targeted jobs tax credit (TJTC) is available on an elective basis for hiring individuals from nine targeted groups. The targeted groups are: (1) vocational rehabilitation referrals; (2) economically disadvantaged youths aged 18 through 22; (3) economically disadvantaged Vietnam-era veterans; (4) Supplemental Security Income (SSI) recipients; (5) general assistance recipients; (6) economically disadvantaged cooperative education students aged 16 through 19; (7) economically disadvantaged former convicts; (8) eligible work incentive employees; and (9) economically disadvantaged summer youth employees aged 16 or 17. Certification of targeted group membership is required as a condition of claiming the credit.

The credit generally is equal to 40 percent of the first $6,000 of qualified first-year wages paid to a member of a targeted group. Thus, the maximum credit generally is $2,400 per individual. With respect to economically disadvantaged summer youth employees, however, the credit is equal to 40 percent of up to $3,000 of wages, for a maximum credit of $1,200.

The credit is not available for wages paid to a targeted group member unless the individual either (1) is employed by the employer for at least 90 days (14 days in the case of economically disadvantaged summer youth employees), or (2) has completed at least 120 hours of work performed for the employer (20 hours in the case of economically disadvantaged summer youth employees). Also, the employer's deduction for wages must be reduced by the amount of the credit claimed.

The credit is available with respect to targeted-group individuals who begin work for the employer before January 1, 1992.

Reasons for Change

The TJTC is intended to encourage employers willing to hire workers who otherwise may be unable to find employment. Job creation incentives are required in the current economic climate.

Description of Proposal

The TJTC would be extended for one year. The credit would be available with respect to targeted-group individuals who begin work for the employer before January 1, 1992.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
One year extension of targeted jobs tax credit:	0	-.1	-.1	-.1	-*	-*	-.3

-* Revenue loss of less than $50 million.

DEDUCTION FOR SPECIAL NEEDS ADOPTIONS

Current Law

Expenses associated with the adoption of children are not deductible under current law. However, expenses associated with the adoption of special needs children are reimbursable under the Federal-State Adoption Assistance Program (Title IV-E of the Social Security Act). Special needs children are those who by virtue of special conditions such as age, physical or mental handicap, or combination of circumstances, are difficult to place for adoption. The Adoption Assistance Program includes several components. One of these components requires States to reimburse families for costs associated with the process of adopting special needs children. The Federal Government shares 50 percent of these costs up to a maximum Federal share of $1,000 per child. Reimbursable expenses include those associated directly with the adoption process such as legal costs, social service review, and transportation costs. Some children are also eligible for continuing Federal-State assistance under Title IV-E of the Social Security Act. This assistance includes Medicaid. Other children may be eligible for continuing assistance under State-only programs.

Reasons for Change

The Tax Reform Act of 1986 (the 1986 Act) repealed the deduction for adoption expenses associated with special needs children. Under prior law, a deduction of up to $1,500 of expenses associated with the adoption of special needs children was allowed The 1986 Act provided for a new outlay program under the existing Adoption Assistance Program to reimburse expenses associated with the adoption process of these children. The group of children covered under the outlay program is somewhat broader than the group covered by the prior deduction. The prior law deduction was available only for special needs children assisted under Federal welfare programs, Aid to Families with Dependent Children, Title IV-E Foster Care, or Supplemental Security Income. The current adoption assistance outlay program provides assistance for adoption expenses for these special needs children, as well as special needs children in private and State-only programs.

Repeal of the special needs adoption deduction may have appeared to some as a lessening of the Federal concern for the adoption of special needs children.

An important purpose of the Adoption Assistance Program is to enable families in modest circumstances to adopt special needs children. In a number of cases the children are in foster care with the prospective adoptive parents. The prospective parents would like to formally adopt the child but find that to do so would impose a financial hardship on the entire family.

While the majority of eligible expenses are expected to be reimbursed under the continuing expenditure program, the Administration is concerned that in some cases the limits may be set below actual cost in high-cost areas or in special circumstances. Moreover, inclusion in the tax code of a deduction for special needs children may alert families who are hoping to adopt a child to the many forms of assistance provided to families adopting a child with special needs.

Description of Proposal

The proposal would permit the deduction from income of expenses incurred that are associated with the adoption of special needs children, up to a maximum of $3,000 per child. Eligible expenses would be limited to those directly associated with the adoption process that are eligible for reimbursement under the Adoption Assistance Program. These include court costs, legal expenses, social service review, and transportation costs. Only expenses for adopting children defined as eligible under the rules of the Adoption Assistance Program would be allowed. Expenses which were deducted but reimbursed would be included in income in the year in which the reimbursement occurred. The proposal would be effective January 1, 1992.

Effects of Proposal

The proposal when combined with the current outlay program would assure that reasonable expenses associated with the process of adopting a special needs child do not cause financial hardship for the adoptive parents. The proposed deduction would supplement the current Federal outlay program. In addition, the proposal highlights the Administration's concern that adoption of these children be specially encouraged and may call to the attention of families interested in adoption the various programs that help families adopting children with special needs.

There is currently uncertainty regarding whether Federal and State reimbursements are income to the adopting families. The proposal would clarify the treatment of reimbursements by making them includable in income but also deductible, up to $3,000 of eligible expenses per child. Additionally, qualified expenses up to this limit would be deductible even though not reimbursed.

While the costs of adoption of a special needs child are only a small part of the total costs associated with adoption of these children, the Administration believes that it is important to remove this small one-time cost barrier that might leave any of these children without a permanent family.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Deduction for special needs adoption:	0	-*	-*	-*	-*	-*	-*

-* Revenue loss of less than $50 million.

LOW-INCOME HOUSING TAX CREDIT

Current Law

A tax credit is allowed for certain expenditures with respect to low-income residential rental housing. The low-income housing credit generally may be claimed by owners of qualified low-income buildings in equal annual installments over a 10-year credit period as long as the buildings continue to provide low-income housing over a 15-year compliance period.

In general, the discounted present value of the installments may be as much as 70 percent of eligible expenditures. Eligible expenditures include the depreciable costs of new construction and substantial rehabilitations. They also include the cost of acquiring existing buildings which have been substantially rehabilitated so long as they have not been placed in service within the previous 10 years and are not already subject to a 15-year compliance period. The basis of property is not reduced by the amount of the credit for purposes of depreciation and capital gain.

The annual credit available for a building cannot exceed the amount allocated to the building by the designated State or local housing agency. As originally enacted, the total allocations by the housing agency in a given year could not exceed the product of $1.25 and the State's population. A State credit allocation is not required, however, for certain projects financed with tax-exempt bonds subject to the State's private activity bond volume limitation.

States could not originally allocate the low-income housing credit after 1989. The Omnibus Budget Reconciliation Act of 1989 extended each State's allocation authority through 1990, but at a reduced annual level of $0.9375 per state resident. The Omnibus Budget Reconciliation Act of 1990, however, increased the allocation authority for 1990 to $1.25 per State resident and extended allocation authority through 1991 at the same annual level.

Reasons for Change

The low-income housing credit encourages the private sector to construct and rehabilitate the nation's rental housing stock and to make it available to the working poor and other low-income families. In addition to tenant-based housing vouchers and certificates, the credit is an important mechanism for providing Federal assistance to rental households.

Description of Proposal

The proposal would extend the authority of States to allocate the credit through 1992 at an annual level of $1.25 per State resident.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
One year extension of low-income housing tax credit:	0	-0.1	-0.2	-0.3	-0.3	-0.3	-1.3

HEALTH INSURANCE DEDUCTION FOR THE SELF-EMPLOYED

Current Law

Current law generally allows a self-employed individual to deduct as a business expense up to 25 percent of the amount paid during a taxable year for health insurance coverage for himself, his spouse, and his dependents. The deduction is not allowed if the self-employed individual or his or her spouse is eligible for employer-paid health benefits. Originally, this deduction was only available if the insurance was provided under a plan that satisfied the non-discrimination requirements of section 89 of the Code. Section 89 has since been repealed retroactively, however, and no non-discrimination requirements currently apply to such insurance. The value of any coverage provided for such individuals and their families by the business is not deductible for self-employment tax purposes. The deduction is scheduled to expire after December 31, 1991.

Reasons for Change

The 25 percent deduction for health insurance costs of self-employed individuals was added by the Tax Reform Act of 1986 because of a disparity between the tax treatment of owners of incorporated and unincorporated businesses (e.g., partnerships and sole proprietorships). Under prior law, incorporated businesses could generally deduct, as an employee compensation expense, the full cost of any health insurance coverage provided for their employees (including owners serving as employees) and their employees' spouses and dependents. By contrast, self-employed individuals operating through an unincorporated business could only deduct the cost of health insurance coverage for themselves and their spouses and dependents to the extent that it, together with other allowable medical expenses, exceeded 5 percent of their adjusted gross income. (Coverage provided to employees of the self-employed, however, was and remains a deductible business expense for the self-employed.) The special 25 percent deduction was designed to mitigate this disparity in treatment. Further, the Tax Reform Act of 1986 raised the floor for deductible medical expenses (including health insurance) to 7.5 percent of adjusted gross income.

Description of Proposal

The proposal would extend the 25 percent deduction through December 31, 1992.

Effects of Proposal

The proposal will continue to reduce the disparity in tax treatment between self-employed individuals and owners of incorporated businesses, compared to prior law.

Revenue Estimate

	Fiscal Year						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
One year extension of health insurance deduction for the self-employed:	0	-.1	-.2	0	0	0	-.4

EXTEND TAX DEADLINES FOR DESERT SHIELD/STORM PARTICIPANTS

Current Law

Section 7508 of the Internal Revenue Code generally suspends the time for performing various acts under the internal revenue laws, such as filing tax returns, paying taxes or filing claims for refund of tax, for any individual serving in the Armed Forces of the United States or in support of the Armed Forces in an area designated as a combat zone. The designation of a combat zone must be made by the President of the United States by Executive Order.

The suspension of time provided by section 7508 (prior to its recent amendment, discussed below) covers the period of service in the combat zone, including any period during which the individual is a prisoner of war or missing in action, any period of continuous hospitalization outside the United States as a result of injuries suffered in such service, and the next 180 days thereafter. The spouse of a qualifying individual is generally entitled to the same suspension of time, regardless of whether a joint return is filed. No interest is charged during the suspension period on underpayments of tax, and (prior to the recent amendment, discussed below) no interest is credited during the suspension period on overpayments of tax. Special rules apply if the collection of tax is in jeopardy.

On January 21, 1991, the President signed Executive Order 12744, designating as a combat zone the Persian Gulf, the Red Sea, the Gulf of Oman, a portion of the Arabian Sea, the Gulf of Aden, and the total land areas of Iraq, Kuwait, Saudi Arabia, Oman, Bahrain, Qatar and the United Arab Emirates. This designation is retroactive to January 17, 1991 (January 16 in the United States), the date specified as the commencement of combatant activities. As a result of this action, qualifying individuals serving in the combat zone will have the benefit of section 7508 beginning on January 17, 1991. Under regulations, members of the Armed Forces serving outside the combat zone in direct support of military operations in the combat zone, under conditions qualifying for compensation under 37 U.S.C. § 310 (relating to duty subject to hostile fire or imminent danger), are also entitled to the benefit of section 7508.

On January 30, 1991, the President signed into law legislation (P.L. 102-2) which amends section 7508 in several respects, effective August 2, 1990. First, it extends the coverage of section 7508 to include individuals serving in the Armed Forces or in support of the Armed Forces in the "Persian Gulf Desert Shield area" (to be designated by Executive Order) at any time during the period beginning August 2, 1990 and ending on the date on which any part of the area is designated by the President as a combat zone. As under current law, relief also extends to spouses of qualifying individuals. Second, the Desert Shield legislation reverses the prior rule in section 7508 regarding interest on overpayments of tax, so that interest is generally credited during the suspension period. Finally, the Desert Shield legislation extends the suspension period to include periods of continuous hospitalization in (as well as outside of) the United States. Not more than five years of hospitalization in the United States can be taken into account for this purpose, however, and hospitalization in the United States is not taken into account in determining the suspension period for the individual's spouse.

Reasons for Change

At the time the proposal was developed, the Persian Gulf area was not a combat zone and the Desert Shield legislation had not been enacted. There was accordingly a need to extend the coverage of section 7508 to individuals participating in the Desert Shield operation, many of whom were sent to the Middle East on short notice with little time to make provision for the filing of tax returns and payment of taxes.

Description of Completed Action

Enactment of the Desert Shield legislation and the promulgation of Executive Order 12744 have implemented the proposal discussed in the Budget.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Extend tax deadlines for Desert Shield/Storm participants	-*	*	*	0	0	0	-*

* Revenue gain of less than $50 million.
-* Revenue loss of less than $50 million.

Note: This revenue estimate was prepared prior to the designation of the Persian Gulf area as a combat zone and the enactment of the Desert Shield legislation. Because this proposal is now a feature of current law, the revenue loss is zero, but the baseline receipts forecast must be adjusted by a corresponding amount.

MEDICARE HOSPITAL INSURANCE (HI) FOR STATE AND LOCAL EMPLOYEES

Current Law

State and local government employees hired on or after April 1, 1986, are covered by Medicare Hospital Insurance and their wages are subject to the Medicare tax (1.45 percent on both employers and employees). Unless a State or local government had a voluntary agreement with Social Security, employees hired prior to April 1, 1986, are not covered by Medicare Hospital Insurance nor are they subject to the tax.

Reasons for Change

State and local government employees are the only major group of employees not assured Medicare coverage. One out of six State and local government employees are not covered by voluntary agreements or by law. However, an estimated 85 percent of these employees receive full Medicare benefits through their spouse or because of prior work in covered employment. Over their working lives, they contribute on average only half as much tax as is paid by workers in the private sector. Extending coverage would assure that the remaining 15 percent have access to Medicare and would eliminate the inequity and the drain on the Medicare trust fund caused by those who receive Medicare without contributing fully.

Description of Proposal

As of January 1, 1992, all State and local government employees would be covered by Medicare Hospital Insurance.

Effects of Proposal

An additional two million State and local government employees would contribute to Medicare. Of these, roughly 300,000 employees would become newly eligible to receive Medicare benefits subject to satisfying the minimum 40 quarters of covered employment.

Revenue Estimate*

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Extend Medicare hospital insurance coverage to State and local employees:	0	1.1	1.5	1.5	1.5	1.5	7.3

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* Net of income tax offset.

MOTOR FUELS EXCISE TAX

Current Law

The Omnibus Budget Reconciliation Act of 1990 raised the motor fuels excise tax by 5.1 cents from 9 to 14.1 cents a gallon on motor gasoline and from 15 to 20.1 cents a gallon on diesel fuel. One-tenth of a cent is deposited into the Leaking Underground Storage Tank Trust Fund, and half of the remaining 5 cent increase is deposited into the General Fund. The remaining 2.5 cents are deposited into the Highway Trust Fund. The General Fund and Highway Trust Fund portions of the tax are scheduled to expire at the end of fiscal year 1995.

Current services forecasts incorporate extension of the trust fund portions of the tax at their current rates through the end of the budget period, but provide that the General Fund portion of the tax expires as scheduled at the end of the fiscal year 1995. Thus, the highway portion of the motor fuels excise tax rates in fiscal year 1996 underlying the current services forecasts are 11.5 cents per gallon on gasoline and 17.5 cents per gallon on diesel fuel.

Reasons for Change

The current motor fuels excise taxes expire at the end of fiscal 1995. While the current services forecasts incorporate extension of the highway portion of the motor fuels tax at their current rates of 11.5 cents for gasoline and 17.5 cents for diesel fuel, the Administration Budget proposal incorporates extension in 1996 at the prior rates of 9 cents for gasoline and 15 cents for diesel fuel. The lower rates in 1996 will be sufficient to finance the Administration's proposed increase in highway and transit programs.

Description of Proposal

In contrast to the current services forecasts, under the Administration's proposal the portion of the motor fuels excise taxes which is dedicated to the Highway Trust Fund will be extended for fiscal year 1996 at the level of 9 cents per gallon on gasoline and 15 cents per gallon on diesel fuel.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Limited extension of motor fuels excise taxes:	0	0	0	0	0	-2.7	-2.7

INCREASE IN IRS FY 1992 ENFORCEMENT FUNDING

Current Law

The IRS currently allocates substantial resources to direct enforcement of the tax laws. Direct enforcement encompasses activities designed to encourage accurate reporting of taxable income and to assess or collect taxes, penalties, and interest which are owed but not paid. In allocating resources to these activities, the IRS does not simply seek to collect the maximum amount of taxes through direct enforcement activities; the additional objective is to increase tax revenues indirectly by encouraging and enhancing voluntary compliance.

Reasons for Changes

The IRS has identified a number of enforcement areas in which specific problems exist that could be resolved by the application of additional resources. In addition, the gap between taxes owed and taxes voluntarily paid contributes to the Federal deficit and undermines the system of voluntary compliance.

Description of Proposal

The proposal calls for additional IRS funding for tax law enforcement, and for the collection of delinquent taxes, penalties, and interest. The specific programs, new budget authority, and estimated FY 1992 receipts are as follows:

- o Examination Field Audit Initiative--An additional 94 staff years are to be applied to income tax audits. Total budget authority for the initiative for FY 1992 is $6.0 million.

- o Collection of Accounts Receivable--This initiative will apply an additional 671 staff years with total FY 1992 budget authority of $34.0 million, to the accounts receivable inventory.

Effects of Proposal

All affected activities are in the area of direct enforcement. Consequently, the proposal should enhance the level of revenue collection, encourage taxpayers to correctly report their income for tax purposes, and expedite the collection of past due taxes.

Revenue Estimate

	Fiscal Years						
	1991	1992	1993	1994	1995	1996	1991-96
	(Billions of Dollars)						
Increase in IRS FY 1992 enforcement funding:	0	*	0.1	0.2	0.2	0.2	0.7

* Revenue gain of less than $50 million.

MISCELLANEOUS PROPOSALS AFFECTING RECEIPTS

Description of Proposals

Extend abandoned mine reclamation fees. The abandoned mine reclamation fees, which are scheduled to expire on September 30, 1995, would be extended. Collections from the existing fees of 35 cents per ton for surface mined coal and 15 cents per ton for under ground mined coal are allocated to States for reclamation grants. Extensive abandoned land problems are expected to exist in certain States after all the money from the collection of existing fees is expended.

Improve retail compliance with the special occupation taxes. To increase compliance rates and revenues, wholesalers would be required to ensure that their retail customers pay the special taxes in connection with liquor occupations that are levied on retailers. The proposal would be effective beginning October 1, 1991.

Increase HUD interstate land sales fee. The Interstate Land Sales Full Disclosure Act gives HUD the responsibility of registering certain subdivisions that are sold or leased across state lines. A fee is charged when a developer files a statement of record about the subdivision with HUD. The fee charged cannot exceed $1,000 for any one developer. The fees collected cover only a portion of administrative costs. The proposal would remove the $1,000 fee limitation to help fully offset the direct administrative costs of the program.

Amend railroad unemployment insurance (UI) status. Under present law, all railroads, including Amtrak and other public commuter railroads, make experience-rated UI contributions that are based partly on industry-wide unemployment costs and partly on their own line's unemployment costs. To prevent public subsidies from being diverted to pay for the high unemployment cost of the private sector railroads, public commuter railroads were exempt from the full railroad unemployment tax rate in 1990. Instead, they reimbursed the UI trust funds for the actual unemployment and sickness insurance costs of their employees. Under the proposal, Amtrak and other public commuter railroads would reimburse the trust funds for the actual unemployment costs of their employees after January 1, 1991.

Revenue Estimate

	Fiscal Year						
	1991	1992	1993	1994	1995	1996	1991-1996
	(Billions of Dollars)						
Extend abandoned mine reclamation fees:	0	0	0	0	0	.3	.3
Improve retail compliance with liquor occupation taxes:	0	*	*	*	*	*	.1
Increase HUD interstate land sales fee:	*	*	*	*	*	*	*
Amend railroad UI status:	-*	*	*	*	-*	-*	*

* Revenue gain of less than $50 million.
-* Revenue loss of less than $50 million.

RESPONSES OF KENNETH W. GIDEON TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. How will IRS spend the $46 million increase for compliance initiatives included in the FY 1992 budget?

Answer. The $46 million increase for FY 1992 compliance initiatives will be distributed as follows:

- *Accounts Receivable*—$34 million increase for the Collection function to increase collection of delinquent accounts to lower the inventory and value of outstanding accounts receivable.
- *Examination Field Revenue Agents*—$6 million increase to enhance audit coverage of high-asset individual and corporate tax classes.
- *Counsel—Bankruptcy and Large Case Accounts Receivable and Docketed Cases*—$950,000 increase to deal with increasing volume and complexity of bankruptcy cases—particularly those involving large corporations, resulting from IRS multi functional efforts to address accounts receivable.
- *Counsel—Large Case Management*—$3 million increase to cover costs for training, travel and expert witness fees resulting from increased activity in settling remaining cases generated from the FY 1991 large case management initiative.
- *Criminal Investigation*—$670,000 increase to review questionable tax forms submitted by electronic return filers—enhance IRS's efforts to detect fraudulent return preparer and illegal tax protester schemes.
- *Employee Plans Determinations (Pensions)*—$1.3 mill ion increase to help IRS respond to determination letter requests from local and state government retirement plans and to provide guidance on rules changes involving these type plans

Question No. 2 Has IRS spent any money to address the transfer pricing issue?

Answer. While IRS has not requested specific initiatives to address the transfer pricing issue, international examiner staffing is being increased by 10 percent and economist staffing is being increased by 50 percent for both FY 1991 and FY 1992.

PREPARED STATEMENT OF JEROME H GROSSMAN

Mr. Chairman, it is an honor to be invited to testify before the Senate Finance Committee on the Administration's fiscal year 1992 budget proposals for Medicare hospital payments I am Jerome H Grossman, M D, Chairman of the Council of Teaching Hospitals, AAMC, and Chairman and Chief Executive Officer of the New England Medical Center. The Association of American Medical Colleges (AAMC), represents all of the nation's medical schools, 92 faculty societies, and over 350 major teaching hospitals that participate in the Medicare program. In Federal fiscal year 1989, nonFederal members of the AAMC's Council of Teaching Hospital (COTH) accounted for nearly 2 million Medicare inpatient discharges.

The Administration's budget proposals would reduce the growth in Medicare program expenditures by $2.8 billion in fiscal year 1992 Payments for hospital inpatient services under Medicare Part A provisions would be reduced by over $2 billion in fiscal year 1992. Of that amount, more than half or over $1 billion would be saved by targeted reductions in payments to teaching hospitals While all of the Administration's health care budget proposals are of concern to the nation's hospitals, the following two proposals to change Medicare graduate medical education payments are of particular concern to teaching hospitals:

- The reduction in the Medicare indirect medical education (IME) adjustment in fiscal year 1992 from 7.7 percent to 4.4 percent.
- The proposed change in Medicare direct medical education (DGME) payments from a per resident payment amount that includes the full range of allowable costs to a per resident amount derived from the national average resident's salary. Three differential weighting percentages are then applied to the base salary amount depending on the resident's specialty choice.

Both of these proposed changes would result in substantial reductions in Medicare revenues for teaching hospitals, by saving in excess of $1 billion in fiscal year 1992, and would seriously threaten the financial stability of teaching hospitals, affecting access to care and quality of care received by Medicare beneficiaries and other patients.

The AAMC opposes both of these proposals to reduce payments to teaching hospitals. Teaching hospitals perform multiple missions, including basic and tertiary care services and the education of health professionals. These hospitals are a critical

component in our health care delivery system, and they could easily be damaged unless any changes are carefully crafted and are based on an extensive understanding of both the nature of teaching hospitals and of graduate medical education itself.

DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

In addition to providing care to individual patients, teaching hospitals provide the resources and the environment for the clinical education of physicians, dentists, nurses, and allied health professionals. To provide this experientially-based clinical training, hospitals incur educational costs related to patient care. These added costs include resident stipends and benefits, salaries and benefits for faculty who supervise residents in the care of patients, classroom space, supplies, clerical support, and allocated overhead. Historically, Medicare has shared in the costs of these approved education activities on a reasonable cost basis. The Medicare program makes a payment to teaching hospitals for its share of allowable direct health professions education costs which is separate from and should not be confused with the purpose or methodology of the IME adjustment in the prospective payment system.

The existing system of residency and fellowship education is marked by several fundamental characteristics:

- It is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service;
- It is organized primarily in hospitals and has been focused mainly on inpatients, but involvement with ambulatory patients is increasing;
- It has responded to the growth in medical school graduates to provide training positions for all graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) and for numerous foreign graduates; and,
- It has been funded primarily by patient services revenues, with significant appropriations supporting some municipal- and state-supported hospitals and all military and Veterans Administration hospitals

These characteristics have produced a relatively strong and stable system of graduate medical education. However, there are four major factors that characterize the current environment for graduate medical education:

- In the past two decades, the number of primary care specialists has grown more rapidly than the population. However, the number has not grown as rapidly as the number of physicians in other specialties;
- In the face of growing physician supply and pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even fail to earmark payments for graduate medical education;
- As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings will need to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training; and,
- As hospitals are increasingly pressured to improve efficiency, the mixed educational and service roles of residency programs will be under constant pressure to emphasize service.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. The program must recruit faculty, develop educational processes, and sustain an organizational commitment to maintaining a stable educational environment in the midst of an often hectic patient service setting.

DGME -- Medicare's Current Financing Role

The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99-272) in 1986 changed the method of payment for direct graduate medical education costs and placed limitations on Medicare reimbursement for physicians in graduate medical training (residents). COBRA replaces a cost pass-through methodology with the calculation of a hospital-specific per resident amount, based on the 1984 or 1985 cost reporting year and updated by an inflation factor. Each hospital's per resident amount is determined by dividing its allowable base year costs by the number of full-time equivalent (FTE) interns and residents at the hospital during that base year. The per resident amount is then updated for inflation and multiplied by the number of FTE interns and residents in the hospital complex in the payment period. Residents are weighted at 1.0 FTE for the residency period required for initial board certification plus one year, not to exceed a total of five

years. Beyond the lesser of these two limits, residents who remain in approved programs are to be weighted at .5 FTEs. Medicare's share of the aggregate payment amount is based on the ratio of Medicare inpatient days to total inpatient days. The AAMC did not oppose this payment change.

These per resident payments are effective retroactively to July 1, 1985. Audits are currently being conducted to implement the COBRA provisions. Because the audit instructions were published 5 years after the change in the law, some institutions have been assessed with substantial overpayments. OBRA 1990 prohibits DHHS from recouping any overpayments during fiscal year 1991. Beginning in fiscal year 1992 and during the next four years, the secretary may not recoup more than 25 percent of the total amount of the overpayment in any one year. Although COBRA limits payments of allowable direct medical education costs, it still acknowledges the historical scope of direct medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

The Administration's fiscal year 1992 DGME Budget Proposal

The proposal in the Administration's fiscal year 1992 budget document is stated as follows:

> Base graduate medical education payments on the national average salary of residents. Pay 240 percent of this figure for primary care residents 140 percent for non-primary care residents in their initial residency period, and 100 percent for non-primary care residents beyond this period.

The Administration's fiscal year 1992 DGME proposal is similar to the Administration's fiscal year 1991 DGME proposal. The Administration believes its proposal will decrease the present diversity in DGME payments that has resulted from the historical patterns in hospital financial support and accounting differences. The Administration also believes this proposal will increase the supply of primary care physicians in the United States by providing relatively favorable payment amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies. The Administration's proposal does not define primary care residency programs and it does not indicate the national average resident's salary.

To estimate the impact of this proposal for AAMC membership, it is assumed that the national average resident's salary is $28,894. This is the 1990 average salary/stipend for the 3rd Post-MD Year based on the Council of Teaching Hospitals (COTH) Survey of Housestaff Stipends, Benefits and Funding, 1990. After adjusting for inflation, the fiscal year 1992 national salary is $31,281. Three differential weighting percentages are then applied to this amount ($31,281) depending on the resident's specialty:

- Primary Care residents would be weighted at 240 percent of the national average resident salary. $31,281 x 240% = $75,074
- Non-primary care residents in their initial residency period would be weighted at 140 percent. 31,281 x 140% = $43,793
- Non-primary care residents beyond the initial residency period would be weighted at 100 percent. $31,281 x 100% = $31,281

Medicare's share of the aggregate payment amount is based on the hospital's ratio of Medicare inpatient days to total inpatient days.

AAMC Position and Reasons for Opposition

The AAMC strongly opposes any changes in the current payment system for direct graduate medical education payments for the following reasons:

- The Administration's proposal, with estimated savings of $140 million in fiscal year 1992, is an aggregate reduction in DGME payments.

The AAMC believes the Administration's proposal to make payments based solely on residents' salaries, thus reducing Medicare's funding of graduate medical education, is an inappropriate public policy. Based on AAMC 1989 data from 155 COTH Member hospitals, adjusted for inflation using the Consumer price index, the estimated average per resident cost in 1992 is $69,923. Reduced support for supervising faculty would have a significant adverse effect on the quality of both patient care and residency training programs in the nation's teaching hospitals. Graduate medical education is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Residents are major contributing members of the professional team that cares for patients and ample supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing practice patterns.

Recent public and media attention to the issues of residents' supervision and working hours has led to state governmental as well as voluntary accreditation efforts to set more explicit requirements for supervision and to restrict residents' working hours. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated. The AAMC believes that all third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs.

• The Administration's proposal would reduce graduate medical education payments at a time when the effects of the COBRA 1985 changes remain uncertain.

The regulations implementing COBRA 1985 were published in the September 29, 1989 Federal Register and are currently being implemented. Final audits of the base-year costs were scheduled to be completed by February 28, 1991; however, they are not completed. Payments would be "indexed" at a time when the base payments are not finally determined.

• The Administration assumes there is a shortage of primary care residency positions.

Medical students' failure to choose primary care residency training is not based on the unavailability of residency slots in these specialties or on the level of hospital payment. Their reasons for choosing specialties other than primary care are complex and only partially understood, but are based on a combination of personal and professional factors. If the objective is to produce more primary care physicians, then the issue is how to encourage medical students to select primary care residency positions. Data from the 1990 National Resident Matching Programs (the Match) show that primary care residency positions are available:

- 64 percent of the "primary care" internal medicine residency positions were filled by graduates of U.S. medical schools. If foreign graduates are included, then the number of filled positions increases to 85.6 percent.
- 46.3 percent of the "primary care" pediatric residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 80.5 percent.
- 59.3 percent of the family practice residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 70.4 percent.

• The Administration's proposal assumes a relationship exists between medical student specialty choice and hospital per resident payments.

Medical students' selection of residency training programs is not affected by Medicare payments to hospitals. While strongly supporting more individuals entering primary care, the AAMC does not believe this result can be achieved by manipulating hospital payment. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements are more likely to result in greater numbers of U.S. medical school graduates entering the primary care disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

• If the Administration's proposal is adopted, it is likely to cause divisiveness within the institution (among different departments and divisions) and it will be detrimental to residency training programs.

Those disciplines with an increased weighting factor will argue that they deserve "more" of the DGME funds for their residency programs. It is very likely that primary care programs already receive more supervisory salary support for education because patient fees in those disciplines do not allow a physician to become a volunteer teacher. At the same time, other disciplines will exert increasing pressure for more faculty salary support. In an "AHA News" article dated Oct. 15, 1990, Arthur Boll of Deloitte & Touche says, "No matter what approach is taken, physician specialists who lose out under the RBRVS fee structuring are likely to expect hospitals to pick up the difference. Hospitals might hear physicians asking for more academic support, or physicians may want to be compensated for the supervision and instruction of residents in graduate medical education."

• While supporters of this proposal indicate that a higher payment differential will be enacted to make higher payments only to the primary care disciplines, it is likely many clinical specialties will argue they deserve a "special weighting factor."

The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal last year, and physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

The historical characteristics of graduate medical education, coupled with changes in physician manpower supply, pressure from both Federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship programs. Proposals to yet again alter Medicare payments for graduate medical education contribute to instability and are detrimental to the nation's medical education system. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

In addition to producing primary, secondary, and tertiary patient care, teaching hospitals provide an environment for biomedical research and medical education. Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education adjustment in the PPS. However, the IME adjustment is mislabeled and frequently misunderstood. While its label has led many to believe this adjustment to DRG prices compensates teaching hospitals solely for education, its purpose is much broader. Both the Senate Finance and House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts . . . about the ability of the DRG classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of resident . . . the adjustment for indirect medical education costs is a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98-23, March 11, 1983. House Ways and Means Committee Report, Number 98-25, March 4, 1983.)

The Administration's Fiscal Year 1992 IME Adjustment Budget Proposal

Last November, the Congress and the Administration agreed to a five-year deficit reduction budget agreement. One issue agreed upon in OBRA 1990 maintains the IME adjustment at 7.7 percent for each 0.1 increase in a hospital's resident to bed ratio. However, in its fiscal year 1992 budget proposal, the Administration proposes to impose further reductions in the Medicare program and, more specifically, achieve major Medicare savings by dramatically reducing the IME adjustment to 4.4 percent in fiscal year 1992 and continuing to gradually reduce the IME adjustment over the next four years. As stated in the Administration's fiscal year 1992 budget document:

> Gradually reduce the IME adjustment factor for prospective payment hospitals from 7.7 percent to 3.2 percent, starting in fiscal year 1992. Percentages would be: fiscal year 1992, 4.4 percent; fiscal year 1993, 4.1 percent; fiscal year 1994, 3.8 percent; fiscal year 1995, 3.5 percent; and, fiscal year 1996, 3.2 percent.

AAMC Position and Reasons for Opposition

The AAMC strongly opposes any proposed reduction in the IME adjustment below its current level of 7.7 percent for each 0.1 increase in a hospital's resident to bed ratio for the following reasons:

• The proposed reduction would substantially harm the financial viability of teaching hospitals.

Included with this testimony are tables showing the impact of this proposal. Table 1 (attached), shows the impact of reducing the IME adjustment on the 1990 PPS margins of 65 members of the COTH using five different levels of the adjustment.

To estimate the effect of reductions on PPS margins, each hospital's 1990 IME payment was adjusted using the various IME proposed reductions.

The first column in Table 1 shows 1990 PPS margins using all 1990 PPS revenues and all Medicare inpatient operating costs, including the current IME adjustment percentage. PPS margins in column 2 are calculated using the Prospective Payment Assessment Commission's (ProPAC) fiscal year 1992 recommendation of 7.0 percent for the adjustment. Column 3 shows resulting PPS margins if the adjustment were to be reduced to 4.4 percent, as proposed by the Administration for fiscal year 1992. PPS margins in column 5 represent the Administration's final objective of achieving an IME adjustment of 3.2 percent in fiscal year 1996.

• The PPS margins of these hospitals are highly sensitive to decreases in the level of the IME adjustment.

Table 1 shows the average 1990 PPS margin was 3.8 percent using the current 7.7 percent IME adjustment, but declines to 1.7 percent, a reduction of 2.1 percentage points or approximately 71 percent, at the 7.0 percent IME adjustment level. It should be noted that these margins overstate the overall Medicare margins because capital and some other expenses are paid at less than full costs. Individual hospitals' PPS margins decline at different rates depending on the relative contribution of the IME payment to the total PPS payment If the IME adjustment is reduced, hospitals that are heavily dependent on IME payments will experience greater decreases in their PPS margins than hospitals that rely less on IME payments.

• Hospitals that receive DSH payments have consistently higher PPS margins and lower total margins than hospitals that do not receive DSH payments.

Table 2 presents an analysis, by level of DSH payments, of the trends in PPS and total margins for 110 COTH member hospitals that provided data for 1987-1989. When these hospitals are grouped based on DSH payment as a percentage of total PPS payments, substantial differences in PPS and total margins across the subgroups are apparent. Using 1989 data, average PPS margins varied from 2.3 percent in hospitals that received no DSH payment to nearly 20 percent in hospitals that received relatively high percentages of their total PPS payments from the DSH adjustment. However, hospitals with relatively high DSH payments had the lowest total margins of any group.

In recent years, Congress has indicated the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Total margins have remained consistently lower than PPS margins because factors other than PPS payments, such as uncompensated care, affect the overall financial performance of teaching hospitals. The AAMC strongly supports the consideration of overall financial performance, as measured by total margin, in determining the level of the IME adjustment.

• Hospitals that do not receive DSH payments tend to have low or negative PPS margins at the current IME adjustment level.

Five of the eight hospitals receiving no DSH payment in Table 1, reported negative PPS margins in 1990 with an IME of 7.7 percent. The AAMC is concerned that recent increases in the disproportionate share (DSH) adjustment, as mandated by OBRA 1989 and OBRA 1990, and analyses of the overlapping relationship between the IME and DSH adjustments have led some policy makers to conclude that teaching hospitals would not be harmed by a reduction in the IME adjustment. A reduction in the IME adjustment affects all teaching hospitals, reducing the margins for institutions regardless of their low-income patient share.

• The AAMC believes financial success or failure of hospitals could affect access to care and quality of care received by Medicare beneficiaries and other patients.

ProPAC has consistently taken the same position. The Commission has traditionally viewed the overall financial viability of teaching hospitals as one of several factors in making a recommendation on the level of the IME adjustment.

The Congress should consider the financial impact of a reduction on teaching hospitals that get small or no DSH payments and the effect of a reduction on quality and access to care. Hospitals that receive a relatively small share of their PPS payments from DSH will be more adversely affected by a cut in the IME relative to hospitals that receive DSH payments. A reduction in the IME adjustment would hinder teaching hospitals' future capability to support adverse selection within DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units.

TABLE 1: 1990 PPS MARGINS OF SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS AT VARYING LEVELS OF THE IME ADJUSTMENT RANKED BY PPS MARGIN WITH IME @ CURRENT 7.7 PERCENT

	1990 PPS MARGINS WITH IME AT				
HOSPITAL	7.7%	7.0%*	4.4%**	4.1%	3.2%
A	39.9	39.2	36.0	35.6	34.5
B	37.7	36.4	31.1	30.4	28.3
C	34.8	33.6	28.7	28.1	26.2
D	34.4	33.3	28.4	27.8	25.9
E	33.7	32.4	27.3	26.7	24.7
F	32.3	31.1	26.3	25.7	23.9
G	31.3	29.8	23.8	23.1	20.7
H	30.5	28.8	21.9	21.1	18.3
I	26.0	24.3	17.0	16.0	13.1
J	25.7	23.6	14.9	13.8	10.2
K	22.2	20.4	13.0	12.1	9.1
L	21.2	20.2	16.1	15.6	14.1
M	20.4	18.3	9.2	8.0	4.3
N	18.6	16.6	8.0	6.9	3.4
O	16.4	13.9	3.5	2.1	-2.3
P	16.2	13.9	3.8	2.5	-1.6
Q	15.0	13.7	8.4	7.8	5.8
R	14.3	12.1	3.2	2.1	-1.5
S	13.9	12.1	4.6	3.7	0.8
T	13.1	10.6	0.2	-1.1	-5.5
U	12.9	10.9	2.4	1.3	-2.1
V	12.5	10.0	-0.7	-2.1	-6.5
W	12.5	10.4	1.6	0.5	-3.0
X	11.8	9.6	0.5	-0.7	-4.4
Y	10.7	8.8	0.9	-0.1	-3.3
Z	9.4	7.5	-0.5	-1.5	-4.6
AA	9.4	7.5	0.1	-0.8	-3.7
BB	8.4	5.8	-5.4	-6.8	-11.5
CC	7.4	5.1	-4.6	-5.8	-9.7
DD	7.3	4.9	-5.5	-6.8	-11.1
EE	7.0	5.0	-3.2	-4.2	-7.5
FF	6.9	4.9	-3.6	-4.6	-8.0
GG	6.2	3.9	-5.7	-6.9	-10.8
HH	4.8	2.6	-6.5	-7.6	-11.2
II	4.3	2.0	-7.4	-8.6	-12.3
JJ	2.3	1.0	-4.3	-4.9	-6.9
KK	2.0	-0.6	-11.5	-12.9	-17.4
LL	1.5	0.1	-5.6	-6.3	-8.5
MM	1.2	-1.3	-11.4	-12.7	-16.8
NN	1.1	0.8	-0.1	-0.3	-0.6

TABLE 1: **1990 PPS MARGINS OF SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS AT VARYING LEVELS OF THE IME ADJUSTMENT**
RANKED BY PPS MARGIN WITH IME @ CURRENT 7.7 PERCENT

	1990 PPS MARGINS WITH IME AT				
HOSPITAL	7.7%	7.0%*	4.4%**	4.1%	3.2%
OO	0.5	-1.6	-10.2	-11.3	-14.7
PP	0.2	-2.4	-13.0	-14.4	-18.7
QQ	-0.3	-1.1	-4.6	-5.0	-6.3
RR	-0.6	-2.6	-11.1	-12.2	-15.5
SS	-1.2	-3.6	-13.2	-14.5	-18.4
TT	-3.1	-6.3	-20.1	-22.0	-27.8
UU	-3.5	-5.9	-16.0	-17.3	-21.3
VV	-3.8	-6.1	-15.5	-16.7	-20.4
WW	-4.7	-6.5	-13.6	-14.5	-17.2
XX	-4.8	-7.0	-16.1	-17.2	-20.8
YY	-5.0	-7.3	-17.2	-18.4	-22.4
ZZ	-5.1	-5.7	-7.9	-8.2	-9.0
AAA	-6.2	-8.9	-19.8	-21.2	-25.7
BBB	-6.6	-9.4	-21.1	-22.6	-27.3
CCC	-7.3	-10.3	-23.2	-24.9	-30.3
DDD	-8.7	-10.9	-20.0	-21.1	-24.7
EEE	-9.1	-11.7	-22.7	-24.1	-28.5
FFF	-9.2	-12.3	-25.6	-27.3	-32.9
GGG	-11.6	-14.5	-26.7	-28.3	-33.3
HHH	-13.7	-15.8	-24.2	-25.3	-28.5
III	-14.1	-16.9	-28.6	-30.1	-34.8
JJJ	-14.5	-16.9	-26.9	-28.2	-32.1
KKK	-21.0	-23.7	-34.8	-36.3	-40.7
LLL	-22.6	-25.0	-35.0	-36.3	-40.2
MMM	-25.5	-27.5	-35.7	-36.7	-39.8
MEDIAN	6.2	3.9	-4.6	-5.8	-8.5
AVERAGE (WEIGHTED)	3.8	1.7	-7.0	-8.0	-11.5

* ProPAC recommendation for FY 1992.
** Administration budget proposal for FY 1992.

SOURCE: *ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS AND FY 1989 AND FY 1990 SURVEY OF HOSPITALS' FINANCIAL AND GENERAL OPERATING DATA.*

TABLE 2

MEANS PPS AND TOTAL MARGINS OF SELECTED ACADEMIC MEDICAL CENTER MAJOR AFFILIATED HOSPITALS BY PERCENTAGE OF DSH PAYMENT: FY 1987 - FY 1989

	NUMBER OF HOSPITALS	PPS MARGINS			TOTAL MARGINS		
		FY 87	FY 88	FY 89	FY 87	FY 88	FY 89
ALL HOSPITALS	110	16.83%	11.96%	9.11%	3.54%	2.48%	2.43%
DSH AS % OF TOTAL PPS PAYMENTS							
No DSH Payment	18	13.52	2.18	2.26	5.26	3.94	4.35
Low (2.3 - 5.1%)	31	16.77	11.70	6.56	4.89	3.40	4.33
Med (5.3 - 9.3%)	31	15.89	12.71	9.64	3.10	1.85	1.27
High (9.4 - 17.2%)	30	22.02	21.29	19.83	1.22	1.07	0.15

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2) (continued)

	HOSPITAL	CITY, STATE
•	Beth Israel Hospital	Boston, Massachusetts
	Massachusetts General Hospital	Boston, Massachusetts
	New England Medical Center, Inc.	Boston, Massachusetts
•	Brigham and Women's Hospital	Boston, Massachusetts
•	University Hospital	Boston, Massachusetts
•	Baystate Medical Center	Springfield, Massachusetts
	University of Massachusetts Hospital	Worcester, Massachusetts
	University of Michigan Hospitals	Ann Arbor, Michigan
•	Henry Ford Hospital	Detroit, Michigan
	The University of Minnesota Hospital and Clinics	Minneapolis, Minnesota
	University Hospital, University of Mississippi Medical Center	Jackson, Mississippi
	University of Missouri Hospital and Clinics	Columbia, Missouri
	Truman Medical Center	Kansas City, Missouri
	St. John's Mercy Medical Center	St. Louis, Missouri
•	The Jewish Hospital of St. Louis	St. Louis, Missouri
•	The University Hospital	St. Louis, Missouri
♦	Barnes Hospital	St. Louis, Missouri
•	St. Joseph Hospital	Omaha, Nebraska
	University of Nebraska Hospital	Omaha, Nebraska
	Mary Hitchcock Memorial Hospital	Hanover, New Hampshire
	University of New Mexico Hospital	Albuquerque, New Mexico
•	SUNY Health Science Center, University Hospital	Brooklyn, New York
•	Montefiore Medical Center	Bronx, New York
•	Buffalo General Hospital	Buffalo, New York
•	Nassau County Medical Center	East Meadow, New York
•	Beth Israel Medical Center	New York, New York
•	Presbyterian Hospital in the City of New York	New York, New York
•	St. Luke's-Roosevelt Hospital Center	New York, New York
•	The Mount Sinai Hospital	New York, New York
•	Tisch Hospital, New York University Medical Center	New York, New York
•	University Hospital	Stony Brook, New York
•	University Hospital, SUNY Health Science Center, Syracuse	Syracuse, New York
	University of North Carolina Hospital	Chapel Hill, North Carolina
	Duke University Hospital	Durham, North Carolina
	North Carolina Baptist Hospital, inc	Winston-Salem, North Carolina
	University of Cincinnati Hospital	Cincinnati, Ohio
•	MetroHealth Medical Center	Cleveland, Ohio
•	University Hospitals of Cleveland	Cleveland, Ohio
	The Ohio State University Hospitals	Columbus, Ohio
	Medical College of Ohio Hospitals	Toledo, Ohio
	Oklahoma Medical Center	Oklahoma City, Oklahoma
	Oregon Health Sciences University Hospital	Portland, Oregon
	PennState University Hospital, The Milton S. Hershey Medical Center	Hershey, Pennsylvania
•	Hahnemann University Hospital	Philadelphia, Pennsylvania
	Hospital of the Medical College of Pennsylvania	Philadelphia, Pennsylvania
	Hospital of the University of Pennsylvania	Philadelphia, Pennsylvania

♦ Table 1 only.
• Table 2 only.

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2)

	HOSPITAL	CITY, STATE
•	University of Alabama Hospitals	Birmingham, Alabama
•	University of South Alabama Medical Center	Mobile, Alabama
	University Medical Center	Tucson, Arizona
	The University Hospital of Arkansas	Little Rock, Arkansas
•	Loma Linda University Medical Center	Loma Linda, California
+	Cedars-Sinai Medical Center	Los Angeles, California
	Los Angeles County-USC Medical Center	Los Angeles, California
	UCLA Medical Center	Los Angeles, California
	University of California, Irvine, Medical Center	Orange, California
	University of California, Davis, Medical Center	Sacramento, California
	University of California, San Diego, Medical Center	San Diego, California
	The Medical Center at the University of California, San Francisco	San Francisco, California
	Stanford University Hospital	Stanford, California
	Harbor-UCLA Medical Center	Torrance, California
•	University Hospital	Denver, Colorado
•	John Dempsey Hospital, University of Connecticut Health Center	Farmington, Connecticut
•	Saint Francis Hospital and Medical Center	Hartford, Connecticut
	Yale-New Haven Hospital	New Haven, Connecticut
	Georgetown University Hospital	Washington, D.C.
	Howard University Hospital	Washington, D.C.
•	The George Washington University Hospital	Washington, D.C.
	Shands Hospital	Gainesville, Florida
	Mount Sinai Medical Center	Miami Beach, Florida
•	Grady Memorial Hospital	Atlanta, Georgia
	Crawford Long Hospital of Emory University	Atlanta, Georgia
•	Emory University Hospital	Atlanta, Georgia
	Medical College of Georgia Hospital and Clinics	Augusta, Georgia
•	Illinois Masonic Medical Center	Chicago, Illinois
	Mercy Hospital and Medical Center	Chicago, Illinois
	Michael Reese Hospital and Medical Center	Chicago, Illinois
•	Northwestern Memorial Hospital	Chicago, Illinois
	Rush-Presbyterian-St. Luke's Medical Center	Chicago, Illinois
	University of Chicago Hospitals	Chicago, Illinois
	Foster G. McGaw Hospital	Maywood, Illinois
+	Lutheran General Hospital	Park Ridge, Illinois
•	William N. Wishard Memorial Hospital	Indianapolis, Indiana
	Indiana University Hospitals	Indianapolis, Indiana
	University of Iowa Hospitals and Clinics	Iowa City, Iowa
	University of Kansas Hospital	Kansas City, Kansas
	University Hospital, University of Kentucky Medical Center	Lexington, Kentucky
	Humana Hospital-University of Louisville	Louisville, Kentucky
	Tulane Medical Center Hospital	• New Orleans, Louisiana
	Louisiana State University Hospital	Shreveport, Louisiana
	The Johns Hopkins Hospital	Baltimore, Maryland

+ Table 1 only.
• Table 2 only.

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2) (continued)

	HOSPITAL	CITY, STATE
*	Temple University Hospital	Philadelphia, Pennsylvania
	Thomas Jefferson University Hospital	Philadelphia, Pennsylvania
	Allegheny General Hospital	Pittsburgh, Pennsylvania
+	Mercy Hospital of Pittsburgh	Pittsburgh, Pennsylvania
	Presbyterian Medical Center University Hospital	Pittsburgh, Pennsylvania
	Medical University Hospital	Charleston, South Carolina
*	Regional Medical Center at Memphis	Memphis, Tennessee
	Vanderbilt University Hospital	Nashville, Tennessee
+	Baylor University Medical Center	Dallas, Texas
*	Dallas County Hospital District, Parkland Memorial Hospital	Dallas, Texas
*	The Methodist Hospital	Houston, Texas
	Hermann Hospital	Houston, Texas
*	The University of Texas Medical Branch Hospitals at Galveston	Galveston, Texas
	University of Utah Hospital	Salt Lake City, Utah
*	Medical Center Hospital of Vermont	Burlington, Vermont
	University of Virginia Hospitals	Charlottesville, Virginia
	Medical College of Virginia Hospitals	Richmond, Virginia
	University of Washington Medical Center	Seattle, Washington
*	University of Washington Hospitals, Harborview Medical Center	Seattle, Washington
*	Charleston Area Medical Center	Charleston, West Virginia
*	West Virginia University Hospital, Inc	Morgantown, West Virginia
	University of Wisconsin Hospital and Clinics	Madison, Wisconsin
*	Froedtert Memorial Lutheran Hospital	Milwaukee, Wisconsin
*	Milwaukee County Medical Complex	Milwaukee, Wisconsin

\+ Table 1 only.
* Table 2 only.

Prepared Statement of Philip R. Lee

Mr. Chairman, I am pleased to testify on behalf of the Physician Payment Review Commission on the President's budget proposals affecting Medicare physician payment and to provide an overview of the Commission's 1991 annual report that will be transmitted to the Congress later this month. I will comment briefly on the budget and devote most of my testimony to reviewing major issues and recommendations presented in the report.

Although the Commission has not formally reviewed the President's budget for fiscal year 1992, the Administration has noted that its budget contains only a limited number of proposals affecting physician payment. This may be appropriate in view of the many cuts made in the past two years and with the transition to the Medicare Fee Schedule slated to begin in January 1992. Because the Congress has mandated that the Commission formally comment on the budget, we will be discussing these proposals at our May meeting and will present formal comments to the Congress at that point.

The Commission's 1991 report covers 17 different issues in three general categories:

- major issues concerning implementation of the Medicare Fee Schedule;
- policy and technical concerns about specific aspects of the fee schedule, and
- new areas of responsibility created under OBRA90.

The Commission's recommendations concerning Volume Performance Standards (VPS) will be discussed in a separate report to be submitted to the Congress by May 15.

THE MEDICARE FEE SCHEDULE: MAJOR IMPLEMENTATION ISSUES

A substantial portion of the report is devoted to major implementation issues. These include refining the scale of relative work, modifying the methods of determining practice and malpractice expense relative values, defining geographic payment areas and calculating the conversion factor.

Refining the Scale of Relative Work

OBRA89 directed that Medicare pay physicians based on a relative value scale reflecting physician work. The Commission is currently reviewing this scale to ensure that it accurately reflects work. This refinement process is designed to ensure that the relative value scale is credible and equitable, both to secure acceptance of

reform and to protect beneficiary access to care. The Commission is evaluating Phase II of the Hsiao study and soliciting comments from medical specialty societies on surveyed work values, cross specialty links and the different methods developed by the Hsiao team and the Commission for assigning work values to surgical global services and evaluation and management (EM) services. The Commission is in close communication with the Health Care Financing Administration on these matters and will share its recommendations with the Congress in June.

The Commission continues to a time-incorporating coding system for EM services that allows accurate assignment of relative values. It has proposed such a coding system based on the work of a consensus panel it convened jointly with the American Medical Association. The CPT Editorial Panel is currently pilot testing its own version of this system. The Commission is concerned that this system is more complex than necessary, and hopes that revisions based on the pilot test result in codes suitable for resource-based payment.

Practice Expense

Just as OBRA89 directed that the work component be resource-based, the Commission supports basing the practice expense component on resource costs and has developed and tested the feasibility of such a method.

Under the Commission's approach to practice expense, data from large multispecialty practices are used to determine the direct costs (for example, a nurse who assists the physician and medical supplies) associated with specific services. Indirect costs, such as rent, utilities, and management costs (such as accounting), are allocated across all services based on physician work.

One result of this method is application of site-of-service differentials to more services. For example, the practice expense component for an office procedure includes direct and indirect costs while the component for the same service provided in the hospital includes only indirect costs plus direct billing cost, reflecting that the hospital pays for the other direct costs. HCFA recently authorized carriers to reduce charges by 40 percent for 282 procedures when provided outside the office. Our estimates suggest that this percentage is probably too large and that the differential should vary substantially from service to service. The Commission will issue a report later this year that includes a more detailed discussion of its methodology, data, and simulations of payment changes. This approach must be reviewed critically by others. If it proves sound, and is adopted by the Congress, it will have a major impact on physician payment, increasing payment for EM services provided in the office and reducing payment for most procedures performed in the hospital.

Malpractice Expense

The Commission also supports basing the malpractice expense component of the relative value scale on resource costs, in this case, estimates of the risk of service (ROS). Preliminary analysis suggests that under OBRA89, physicians in lower professional liability risk classes will receive payments that more than cover Medicare's share of their malpractice premiums while those in high risk classes will receive payments that do not cover Medicare's share of their premiums. The Commission's method would reduce these payment distortions and will be easier to update.

Geographic Adjustment Factors and Payment Areas

The Commission has reviewed the measures used by HCFA in constructing the Geographic Adjustment Factor (GAF) and concluded that the choices were appropriate given the available data. Its analysis focused on whether the GAF understates input prices faced by rural physicians; the Commission found no evidence for such a bias. The weakest part of the GAF is use of a residential, rather than commercial, rent index. The Commission recommends that the Congress direct an appropriate Federal agency to collect data on commercial rents for use in the GAF.

The Commission recommends replacing the 237 current localities (17 of which are statewide) with statewide areas in all states except the 15 with the highest degree of within-state variation in input prices. In each of these 15 states, up to five payment areas would be created by Metropolitan Statistical Area categories. This configuration of 94 payment areas balances tradeoffs among accurate tracking of input price variation, minimization of fee differences at boundaries, and administrative simplicity. For example, the recommended areas capture price variation as well as the current localities but with far fewer boundaries. Large differentials at state borders are avoided by allowing some intra-state variation in states with the highest price variation. The recommended areas are based on familiar geographic units and so are simple to understand and administer.

Conversion Factor

OBRA89 requires that the fee schedule conversion factor be calculated so that projected outlays under payment reform in 1992 match outlays that would have occurred under the existing system. A difficult aspect of this task is projecting physician and beneficiary responses to fee changes. If volume increases, budget neutrality requires that this be offset through a lower conversion factor.

After reviewing the literature on the effect of price changes on volume and conducting its own research, the Commission concluded that in the short run, volume changes partially offset moderate price cuts. But there is great uncertainty in extrapolating from these results to what may happen during the transition to the fee schedule. First, the price reductions are generally larger than those previously studied and will come after years of previous reductions. Second, many prices will increase, and there is little research on volume responses to price increases. Volume may also be affected by changes in assignment rates, which are hard to project.

Fortunately, the VPS provides a tool to correct errors in projecting the behavioral offset. While this mechanism is not perfect, its presence transforms the decision on the appropriate assumption into whether physicians or the Medicare program should bear the immediate consequences of projection errors. In light of the available evidence, the uncertainty about the magnitude of the volume response, and the ability of the VPS to correct errors, the Commission recommends a modest reduction of 1 percent in 1992 fee levels to reflect induced changes in volume. This will require reducing the conversion factor by 3 percent.

The budget neutrality provisions of OBRA89 will have lasting and substantial effects on physician fees that stem from technical features of the legislation's drafting. First, the five-year transition to payment under the fee schedule is asymmetric. That is, services that will increase under the fee schedule move toward their final relative values more rapidly than services scheduled to decrease. This asymmetry must be offset to achieve budget neutrality in 1992 by reducing fees by 2 percent in that year. But the law specifies that this reduction be made entirely by adjusting the conversion factor, as opposed to adjusting that portion of payment that will still be based on historical charges. Since many 1992 fees will be based on such blended payments, the conversion factor must be reduced by 6 percent to reduce fee levels by 2 percent. This adjustment will result in a much lower conversion factor by 1996 than would have been the case if the fee schedule had been implemented in one step. For example, the conversion factor would be 6 percent lower if no behavioral offset is assumed, and 9 percent or 15 percent lower with a 1 or 3.3 percent behavioral offset, respectively.

These fee reductions will come on top of budget cuts made by the Congress that have cumulatively reduced the conversion factor by 15 percent.[1] This may undermine a basic goal of payment reform: increasing fees for E/M services. Estimates of the effect of policy changes since 1988 indicate that while E/M fees will increase by 29 percent in nominal terms, after adjusting for inflation (as measured by the Medicare Economic Index), the increase will be only 10 percent from 1988 levels.[2] In other words, increases in relative values appear to be offset by reductions in the conversion factor. The Commission is concerned that the combined effects of these reductions will undermine physician acceptance of payment reform.

The Medicare Fee Schedule: Specific Aspects

The report considers other specific policy and technical issues concerning the fee schedule. These include payment to podiatrists and optometrists, to nonphysician

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[1] This is roughly equivalent to the increase in the MEI suggesting that the 1992 conversion factor will be roughly the same (about 1 percent lower) as what the conversion factor would have been if the fee schedule had been fully implemented in 1988.

[2] This analysis reflects fee changes from OBRA87 that took effect in 1989 and all fee changes from OBRA89 and OBRA90 (including the 0.4 percent reduction in the 1992 update and payment for electrocardiograms. It does not reflect projections of the decision on the 1992 update to be made as part of the VPS process or reductions in the conversion factor to address potential behavioral offsets. Relative values from Phase I of the Hsiao study were used in this analysis. While data from Phase II suggest higher relative values for E/M services, the Hsiao team is currently revising these values. This uncertainty about the magnitude of fee increases and physicians' responses to payment reform reinforces the Commission's view that substantial efforts to monitor the impact of changes on beneficiary liability and access are essential. The Commission recently created a panel of physicians, beneficiaries and academic experts to assist it in developing monitoring strategies and commenting on HCFA's analyses. The panel met for the first time in February and will meet again in April to develop its plan for monitoring payment reform's effects on utilization by specific procedures, geographic areas, and vulnerable populations.

practitioners; and for anesthesia, assistants-at-surgery, and electrocardiograms (EKGs).

Payment to Limited License and Nonphysician Practitioners. The Commission considered the impact of payment reform on two groups of practitioners who bill Part B for services: podiatrists and optometrists, who are defined as "physicians" by the Medicare statute; and nonphysician practitioners (NPPs) such as physician assistants, nurse practitioners and clinical psychologists.

The Commission found little evidence on the comparability of services billed under a procedure code by different practitioners. Without such information, it sees little basis for recommending a change in current policy. The Commission therefore recommends that podiatrists and optometrists should not be distinguished from doctors of medicine and osteopathy in implementing payment. It does, however, have reservations about use of the term "physician" to describe these health professionals.

The Commission also recommends that the current policy of differential payment be continued for nonphysician practitioners. These differentials, however, should be resource-based. For the work component, the differential should reflect differences in investments in human capital: tuition expense and foregone earnings. No differential is proposed for practice expense, since NPPs face similar rent, supply, and personnel costs. The differential for malpractice should reflect premium differences. Separate differentials should be calculated for each category of NPP.

The Commission also recommends that NPPs practicing in Health Professional Shortage Areas receive the same percentage bonus to their payments as physicians practicing in those areas. Expenditures for NPPs should be included in the VPS and their fees should be updated through the VPS process.

Anesthesia Payment. The report addresses two anesthesia payment issues: payment to the anesthesia care team and the use of anesthesia time units. The Commission recommends that per case payment to the anesthesia care team, consisting of an anesthesiologist and two or more certified registered nurse anesthetists (CRNAs) be capped at the rate paid to a solo anesthesiologist for the same service. This policy would require changing the OBRA90 payment levels for CRNAs because reduced payment to the team would lead to anesthesiologists earning less per hour for supervision than for solo practice.

Anesthesia services have been paid based on relative value guides that include base and actual time units. HCFA is concerned that anesthesia start and end times are difficult to determine and that payment for actual time is inconsistent with the way Medicare pays other physicians.

The Commission recommends continued use of actual time. Using either median time, or actual surgical time and median pre- and postoperative time, would be inequitable to many anesthesiologists because, within a given anesthesia code, time varies greatly as a function of the difficulty of the surgical procedure, patient needs, and the surgeon's speed. Pre- and postoperative time data are also unavailable. Current policy may be best improved by developing a better operational definition of anesthesia time and more rigorous validation procedures.

Assistants-at-Surgery. Wide variations in utilization of assistants for some surgical procedures indicate that this use is often discretionary and that Medicare may be paying for medically unnecessary services. To reduce inappropriate use, the Commission recommends profiling use of assistants in conjunction with educational feedback. The Commission also recommends that payments for assistants should be based on resource costs. Results from Phase II of the Hsiao study suggest that it would be appropriate to return payments to assistants-at-surgery for all procedures to 20 percent of the surgical payment under the Medicare Fee Schedule until resource-based relative values are developed for more surgical procedures.

Payment for Electrocardiograms. The Commission supports the congressional goal of ensuring that the price and utilization of EKGs are appropriate but it believes that payment for EKGs could be made more consistent with the principles of a resource-based fee schedule. While some interpret OBRA90 as mandating bundled payment, this would be inequitable unless visit payment varied by diagnosis or other factors. The Commission will examine other methods of equitably bundling EKG, laboratory, and procedural services with visits. While these methods are being developed, the Congress should modify OBRA90 and pay for EKGs separately from visits at a resource-based price for both the professional and technical components. This would substantially reduce the current payment for EKGs. To maintain budget neutrality, the remainder of the cost of restoring payment could come from speeding the transition to fee schedule values for procedures surveyed for the first time in Phase II of the Hsiao study that are considerably overvalued.

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Beyond the Medicare Program

The 1991 report also reflects a turning point for the Commission by introducing work in several new areas of responsibility spelled out in OBRA90.

Physician Payment Under Medicaid. As part of its congressionally mandated study on Medicaid physician payment, the Commission surveyed state Medicaid programs on payment methodologies, the frequency of fee updates, physician participation, and fee levels. Nationally, Medicaid fees are 69 percent of Medicare prevailing charges but this ratio varies widely across states. These data will inform the Commission's consideration of policy options. These options involve altering physician fees, encouraging alternative delivery mechanisms, and changing the Medicaid program's administrative structure. The Commission will report its recommendations to the Congress in July.

Improving Delivery of Health Services in Rural Areas. The Commission advocates continued Federal assistance to improve access to care in rural areas and supports actions such as revitalizing the National Health Service Corps, expanding rural health clinics, and developing state offices of rural health. Future work will focus on assessing policy options to reinforce these efforts.

Private Payers and the Medicare Fee Schedule. While many private payers are supportive of payment reform and are contemplating changes, public policy changes may be needed to coordinate their efforts with other payers. To stimulate discussion, the report describes an all-payer system based on the Medicare relative value scale that is compatible with cost containment efforts

Profiling of Physicians' Practice Patterns. Profiling physicians' practices can help achieve goals of cost containment and improved quality The report explores the promise of profiling and discusses technical and policy issues that must be resolved before it can be used effectively

Medical Malpractice Reform. The report considers whether the present malpractice system achieves any of its purported goals such as improving quality, compensating injured patients, and holding physicians accountable for negligence. The Commission plans to assess whether this system can be improved or whether other mechanisms would be more effective in meeting these goals

RESPONSES OF PHILIP R LEE TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No 1 Dr Lee, Your testimony on the outlook for the conversion factor is sobering The Senate physician payment reform bill provided for a smooth and gradual transition with budget neutrality adjustments made each year Had that position prevailed in conference, we would not be facing these problems today, isn't that correct?

Answer. Yes, that is correct The Senate bill's transition provisions were both symmetric and included annual adjustments for budget neutrality

Question No 2 How important is it for the conversion factor to have this behavioral offset? Is Medicare's experience with PPS, where we overestimated what payments should have been, instructive here?

Answer. In theory, the behavioral offset is an element of the policy of budget neutrality. In practice, however, since there is so little basis for making an accurate offset, the provision does provide an opportunity for the Administration, should it choose to do so, to depart m the direction of budget reduction.

The experience in implementing PPS shows how difficult these calculations are to make and the virtue of planning for a correction In PPS, HCFA overestimated both the base level of cost reimbursements and the change in case mix coding. When the Federal Government moved to hold down rates to compensate for these overestimates, the hospital industry labelled it as reneging on a commitment to pay adequately. The PPS transition would have worked more smoothly if a technical adjustment for errors in estimation had been planned from the beginning

Question No. 3. PPRC has recommended a 1% behavioral offset for 1992—which would actually need to be a 3% offset to achieve budget neutrality. But there have been reports of behavioral offset factors as large as 3% (which would be tripled to 9% to achieve budget neutrality). What would happen if a behavioral offset of that magnitude were to be implemented?

Should we be more worried about overestimating the level of budget neutral payments in 1992 or underestimating?

Answer. The technical provisions of OBRA89 that prescribe how to achieve budget neutrality appear to magnify the behavioral offset. In order to achieve a 1 percent reduction in payment, the conversion factor must be reduced by approximately 3 percent. This is partly offset by the fact that behavioral offsets for price changes that occur after 1992 are not reflected in the conversion factor.

A behavioral offset that reduced the conversion factor by 9 percent could have a number of negative consequences. First, such a large drop in the average fee level, coming on top of the large reductions from OBRA90, would pose risks to beneficiary access to care. Second, it would create a large amount of ill-will toward the Federal Government on the part of physicians, who thought they had agreed to a budget neutral payment reform. A large offset would, in a sense, assume the worst concerning how physicians will respond to the new payment system.

Setting the level of payments below what turns out to be the budget neutral amount is of somewhat more concern than setting them too high. In either case, the Medicare Volume Performance Standards provide the mechanism to rectify the error. But given the difficulty of adjusting to a new payment system in the context of overall constraint on fees, I am particularly concerned about setting fees too low.

Question No. 4. Does PPRC recommend an offset for the behavior of physicians whose payments will *increase* under RBRVS? What evidence argues for a behavioral offset that cuts in both directions?

Answer. The single research study that addresses fee increases does suggest a volume offset for fee increases, though not as large an offset as for fee decreases. This study by Sandra Christiansen of the Congressional Budget Office played a role in the Commission's recommendation. But our advice that the offset should be 1 percent does not include specific assumptions about the offsets for fee increases or decreases.

Question No. 5. The whole notion of a physician behavioral response is just a guess, right? Do we have any way to actually measure what portion of volume increases are due to behavioral responses, to technology advances, to quality advances, etc.?

Answer. Projecting the offset is subject to enormous uncertainty because little past experience that can be studied is relevant to the change that will be occurring. The projection is a guess. While it is an informed guess, it is less informed than other guesses that have been required to implement health policies.

Question No. 6 [Related to above question] The MVPS program is designed to compensate for "unacceptable volume increases—regardless of their cause. Of course, the MVPS does call for careful monitoring of the cause of volume increases, and hopefully the data will improve so that we can someday know better what the various contributing cause of volume growth are. But for now, we do nonetheless have a mechanism in place for setting what we believe to be reasonable volume increases and then for "recouping" increases above that performance standard. And that MVPS program affects the update for all physician payments, not just those determined by the RBRVS during the transition.

Do you think it wise to consider that MVPS program and its ability to "correct" for unacceptable volume growth in setting the 1992 conversion factor for the RBRVS?

Answer. Yes. Given the uncertainty, it is very valuable that a mechanism is in place to adjust for excessive volume increases. The presence of the MVPS permits using a small offset assumption.

Question No. 7. Because we are worried about moving fees precipitously and because we wanted to have an opportunity to correct mistakes in the new fee schedule, Congress enacted a 5-year transition. However, now we find out that this transition may have the unintended effect of "compounding" adjustments made in the first year and possibly reducing payments below what we intended.

Should we consider a faster transition?

Answer. I would not blame the five-year transition but the way the budget neutrality requirement was drafted. Some technical changes could solve this problem, but the problem is the subsequent budget scoring. Concerning the five-year transition, there were sound reasons for it and they remain. Stretching the payment change over a number of years gives physicians more time to adjust to fee changes and provides time for private payers to follow Medicare before the Medicare changes are fully implemented. This reduces the risks to beneficiary access from Medicare payments being too far below payments by private insurers.

PREPARED STATEMENT OF JOSEPH T. PAINTER

Mr. Chairman and Members of the Committee: My name is Joseph T. Painter, MD. I am a physician with a specialty in the field of cardiovascular disease and am Vice President for Physician Referral, Development and Extramural programs at the M. D. Anderson Cancer Center in Houston, Texas. I am also Chairman of the

Board of Trustees of the American Medical Association. With me today is Janet Horan of the AMA's Division of Federal Legislation.

The AMA is pleased to express our personal appreciation, Mr. Chairman, for your steadfast support of last year's five year budget agreement, particularly of those provisions affecting the Medicare program. We share your indignation that the new Medicare cuts are a breach of that landmark deficit-reduction package.

The AMA wishes to make two main points before addressing the specifics of the Administration's budget proposal:

> *First*, with the expanding numbers and increasing average age of the Medicare population, the AMA continues to object strongly to additional cuts in the Medicare program.
>
> *Second*, the AMA strongly supported the physician payment reform legislation recently enacted by Congress, and scheduled to begin January 1, 1992. As you consider the 1992 Medicare budget, we hope you will agree that it is not appropriate to institute physician payment cuts even before this reform legislation has a chance to begin.

We will now address the specifics of the budget proposal.

We are troubled that once again yet another series of Administration proposals to make further Medicare program cuts. These have been advanced with little regard to the very real threat to access to care that further program slashes will have by cutting up to $3 billion from the projected Medicare budget for fiscal year 1992 and up to $25 billion over a five year period. The Administration's budget violates the 1990 five year budget agreement when the ink is barely dry.

Mr. Chairman, the AMA recognizes the necessity for the Congress to continue working to achieve the goal of a balanced Federal budget. We know this Committee has made and will continue to make tough decisions about numerous programs, including Medicare. In this context, however, it must be pointed out that under the budget reconciliation process, the Medicare program has suffered massive cuts throughout the decade of the '80s.

Between 1981 and 1990, physician and laboratory services accounted for 27.7% of the Medicare budget but were hit with 33.9% of the estimated savings resulting from budget reconciliation. In 1989 and 1990, physicians and laboratories were hit particularly hard: they accounted for about a 30% share of the Medicare budget, yet they bore about 58% of the cuts.[1]

Even though Part B cuts are less than Part A in the Administration's proposal, the AMA is particularly concerned that more piecemeal cuts and the lack of Medicare contractor administration funds will threaten the implementation of the new Medicare physician payment system (scheduled to begin January 1, 1992). We ask the Finance Committee to reject proposals that would further tamper with the physician payment reform legislation, which the AMA strongly supported.

Moreover, the Administration's proposed massive cuts in funding for medical education will decrease access to and quality of health care services for Medicare beneficiaries. All of this will only exacerbate the growing physician and patient frustration with the Medicare program.

Mr. Chairman, as I mentioned above, we urge you to reject any Medicare budget cuts this year. In support of this request, I will now address some of the specific concerns that the AMA has with the Administration's Medicare budget proposals. (Comments on other items will be found in Appendix I of our statement.)

REIMBURSEMENT FOR INDIRECT AND GRADUATE MEDICAL EDUCATION (GME)

The Administration's budget proposes to reduce the indirect medical education adjustment factor from 7.7% to 4.4% in fiscal year 92 and to 3.2% by fiscal year 96, with the adjustment factor ratio changed from the ratio of interns and residents to average daily occupancy rather than being based on the numbers of beds. In addition, the budget proposes to base direct GME reimbursement on the national average salary of residents. Payments would be set at 240% of this figure for primary care residents, 140% for non-primary care residents in their initial residency, and 100% for non-primary care residents beyond initial board eligibility.

The AMA opposes these proposals and requests full funding for Medicare's share of direct and-indirect medical education costs. The cuts would curtail residency programs to such a degree that public and other teaching hospitals across the country may be unable to provide the much needed care that is so important to our coun-

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[1] CBO, "Impact of Legislation (1981-1990) on Federal Spending for Medicare," February 4, 1991.

try's health care safety net. As you are aware, these teaching hospitals are particularly vital to the care of the poor and the uninsured and a GME cutback will hit this population hardest of all.

Without adequate Medicare reimbursement for graduate medical education costs, public teaching facilities such as Truman Medical Center in Kansas City, Missouri; Parkland Memorial Medical Center in Dallas, Texas; Cook County Hospital in Chicago, Illinois; and Los Angeles County General Hospital in Los Angeles, California will show increased financial losses. (A list of affected medical teaching centers is set forth in Appendix II.)

In testimony before another body on March 13, 1991, James J. Mongan, MD, Executive Director of Truman Medical Center and Dean of the medical school at the University of Missouri in Kansas City, stated that teaching hospitals provide 75% of all charity care and incur 59% of all bad debts. Dr. Mongan further stated that his medical center will lose an average of $1.5 million a year operating under the Administration's proposals. Truman Medical Center would be forced to lay off 5% of their work force. Obviously, the quality of health care will suffer as a result.

In addition, the AMA believes that restructuring direct GME payments based on specialty is not an effective way to encourage residency programs in primary care. Congress has created a national Council on Graduate Medical Education and has directed the Physician Payment Review Commission (PPRC)[2] to investigate graduate medical education financing. In light of the strong service and education component of residency programs and the ongoing studies, we recommend no action in this area.

RADIOLOGY AND DIAGNOSTIC TESTS

The Administration proposes to collect data to determine efficient levels of operation for radiology and diagnostic tests, with Medicare payments adjusted accordingly. The AMA opposes this proposal.

The Association is particularly concerned that setting payment levels based on a desired frequency of use of a test, which is implied in the term "efficient levels of operation," will have an adverse affect on the availability of radiology and diagnostic tests in rural and underserved areas. These areas would be most likely to have the most infrequent use of tests, with Medicare reimbursement reduced accordingly. Thus, access to these medical services could be in jeopardy for Medicare beneficiaries in rural and underserved areas.

ANESTHESIA SERVICES

The Administration proposes to limit total payments to the anesthesia care team (an anesthesiologist medically directing two or more certified registered nurse anesthetists (CRNA)) to no more than would have been paid had an anesthesiologist personally provided the service. The Association is opposed to this proposal.

The combination of reductions in payment for anesthesiologist services under the new physician payment system and significant payment increases to CRNAs mandated by OBRA-90 makes the single fee unworkable. It would not be financially possible for anesthesiologists to provide medical direction services based on the residual between the CRNA fee schedule and the solo physician rate.

We believe that the recommendation of the PPRC for a single fee is appropriate, contingent upon revisiting OBRA-90 and redividing the anesthesia care team payment. While payment for the anesthesia care team should not necessarily be more than payment allowed for just the services of an anesthesiologist, the payment at least should be consistent with and based on the resource costs of the services provided.

ASSISTANTS AT SURGERY

With some exceptions, the Administration proposes to pay the same amount for surgery regardless of whether or not an assistant at surgery is involved in providing care. Where an assistant surgeon is providing services, Medicare payment for the services of the primary surgeon would be reduced by the payment for the assistant at surgery.

The AMA opposes this proposal. Both the assistant and the surgeon provide distinct services, and the RBRVS recognizes the services each brings to patient care.

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[2] A copy of AMA comments on the PPRC's 1991 Report to Congress can be found in Appendix III.

We are in agreement with the PPRC recommendation that payment be based on the resource costs for such services.

MEDICARE CONTRACTOR ADMINISTRATION

Total projected fiscal year 92 Medicare contractor administration is set at $1.557 billion, $5 million above fiscal year 91. The Administration projects that average processing time will increase, but remain within statutory limits of 24 days for claims from non-participating physicians and 17 days from participating physicians.

The AMA questions the adequacy of the current contractor budget. Given a past history of needing to spend contingency funds, we question whether a $5 million increase in budgets will be sufficient. In the justification of appropriations for fiscal year 92, the Health Care Finance Administration (HCFA) stated that:

> ". . . hearings and reconsiderations workloads are projected to total 10.2 million in fiscal year 1992, a 5 percent increase over fiscal year 1991. Contractors will process 3.3 million reconsiderations and hearings. There will be a backlog of 6.9 million cases."

Thus, HCFA admits that the Administration's budget proposal for administrative funds is insufficient and will result in a large case backlog.

The total number of claims (Part B) and bills (Part A) have grown much faster than have real (inflation adjusted) payments to these contractors. The number of claims and bills grew 97.8% over the 1983-1990 period, compared to only 37.6% for real payments. Contractors have been squeezed in recent years and contractor payments must be increased more than the 0.32% allowed in the Administration's budget proposal.

PROFESSIONAL LIABILITY REFORMS

The AMA supports the Administration's objective of encouraging states to adopt the following professional liability reforms

- place a cap on the amount of allowable noneconomic damages,
- eliminate joint and several liability for noneconomic damages,
- eliminate the collateral source rule;
- require structured payments of awards,
- promote pretrial alternative dispute mechanisms, and
- implement procedures to enhance quality of care

This proposal would be funded by "budget neutral incentive pools" created by allocating a portion of the projected hospital payment increases under Medicare (1% of total payments or $800 million) and a portion of the state Medicaid match for staff salaries and expenses (about $90 million) These funds would be available in 1995.

Medical liability costs were the fastest growing component of physicians' practice costs in the 1980s. It is our firm belief that cost-containment objectives cannot be reached in the absence of strong nationwide medical liability reform

Although the Association supports the Administration's interest and leadership role in liability reform, we suggest that these reforms be implemented by Federal preemptive law rather than through a "budget neutral" system of incentives and disincentives that is perceived to be punitive by the sectors whose funds are being withheld.

The AMA suggests that the liability initiatives set forth in the Ensuring Access Through Medical Liability Reform Act (S 489) introduced by Senators Hatch and Jeffords be enacted. We believe that this legislation, which mandates state implementation of basic liability reforms and provides limited funding to support demonstration projects to evaluate the merits of alternative dispute resolution systems, is the most effective approach to meaningful liability reform.

CONCLUSION

In conclusion, Mr. Chairman, we are extremely concerned about the long-term implications in the Administration's Medicare budget proposals. The Medicare program cannot continue to be cut on a yearly basis yet continue to provide quality medical services to the nation's elderly and disabled.

We strongly disagree with the Administration's contention that:

> "The budget continues a policy of reducing unnecessary and unwarranted spending and cost increases, while at the same time improving equity in

payment levels for services and maintaining quality services to Medicare and Medicaid beneficiaries."

The Administration has provided no evidence of "unnecessary and unwarranted spending" to justify the continued policy of raiding the Medicare program. The truth is that these budget proposals are solely designed to achieve budget savings. It is time to stop the cycle of annual Medicare program cuts.

The AMA requests that you reject these Medicare budget proposals submitted by the Administration.

Attachment.

APPENDIX I

AMA Analysis of Selected Administration Medicare Budget Proposals for Fiscal Year 1992

During the 1980s, the Medicare program has been subjected to numerous, and often arbitrary spending cuts. The Association continues to be concerned that such cuts threaten access to and quality of care for Medicare beneficiaries. The Association opposes any additional arbitrary reductions in either Part A or Part B of Medicare. However, the Association continues to support certain revenue enhancing proposals, including reasonable means testing of the Medicare and other government programs as well as requiring all state and local government employees to pay hosptial insurance taxes.

The following AMA position on Medicare budget provisions are items in addition to those discussed in the AMA testimony presented to the Senate Finance Committee:

1. Covered Drugs (savings of $10 million in FY 92) - A uniform payment policy would be established across the country for Medicare payment of covered drugs. Payment would be set at the average wholesale price less 15%.

> AMA Position: The AMA has not supported a specific price level for covered drugs under Medicare or Medicaid. The Association maintains that drug prices have to be sufficient to assure access and the ability to continue research and development. This proposal could be especially difficult for physician administered drugs since individual physicians or even most group practices would not have access to wholesale drug discounts. The AMA, however, is concerned about the pricing of drug products and urges constraint in such pricing.

2. Payment Update (savings of $20 million in FY 92) - "Apply the 2% payment update in FY 92 and FY 93 only to clinical lab fees below the existing cap on carrier fee schedules."

> AMA Position: This proposal is contrary to the OBRA-90 agreement which provided a 2% update for all clinical laboratory fee scheduled amounts. Under the Administration's proposal, only those laboratory fees falling under the national median (cap) would receive the 2% update. All those above the cap would be frozen. The Association recommends opposition to this proposal as it violates a prior 1990 agreement.

3. DRG Payment Window (savings of $30 million in FY 92) - Diagnostic services and other services defined by the Secretary provided in hospital outpatient departments would be deemed to be included in the DRG payment where those services are provided within 15 days of discharge and where the services are related to the hospital admission.

AMA Position: This proposal is contrary to the incentives of the DRG system to have patients leave the hospital as soon as it is reasonable. Also, a period 15 days post discharge may bundle too many services into the hospital DRG payment. The Association recommends opposition to this proposal.

4. Duplicate Payment Offset (savings of $10 million in FY 92) - Hospital payments would be offset by the amount of separate payments made to direct billing non-physician practitioners whose services are considered in setting the PPS update.

AMA Position: The AMA supported this proposal in the 1991 budget process and again recommends support.

5. Multiplicative MVPS (no cost or savings for FY 92, forecast $90 million in savings for FY 93) - The current additive specification of the FY 91 MVPS would be replaced with a multiplicative specification.

AMA Position: The Association has previously supported a multiplicative methodology for setting the MVPS. However, the Administration's proposal which affects the 1991 MVPS only, is inappropriate because Congress specified that the 1991 MVPS should be 2% less than the Secretary's best estimate of expenditure growth for 1991. The 1991 MVPS issued by the Secretary on December 28, 1990, appears to have met this requirement and we see no basis to revise this promulgated MVPS because of a concern with the form of the default MVPS. The Association recommends opposition to this proposal.

6. Medicare Economic Index (savings of $30 million in FY 92) - Through a regulatory process, the MEI would be recalculated to incorporate a revised methodology.

AMA Position: While the Association has pointed out problems with the MEI methodology, this proposal does not provide adequate specificity for detailed review. However, it appears as if the proposal is designed to achieve an arbitrary budget target. The Association recommends support for legitimate improvements to the Medicare Economic Index to reflect real increases in providing medical care, but opposition to modifications designed to achieve arbitrary budget targets.

7. Medicare Coverage (Revenues of $1.2 billion in FY 92) - The Administration proposes requiring state and local government employees hired before April 1, 1986 to be included under Medicare.

AMA Position: The Association previously has supported universal Medicare coverage for all people eligible by reason of age and previously has supported this provision. The Association recommends support for this proposal.

8. Laboratory Services Coinsurance (savings of $450 million in Fy 92) - The Administration proposes to impose a 20% coinsurance for clinical laboratory services.

AMA Position: The AMA opposes this provision. It will raise costs to beneficiaries and will be a substantial administrative burden on those providing such services. The cost of collecting coinsurance on laboratory services frequently would exceed the coinsurance. This fact, along with the diminishing Medicare payment for laboratory services, would force many physicians to pass these costs on to other non-Medicare patients.

APPENDIX II

Major Teaching Hospitals with High Percentages of Underinsured Patients

Hospital Affiliate	Medical School
San Francisco General	U. Cal-San Francisco
Los Angeles County Hospital	U. Southern California
Jackson Memorial Hospital	U. of Miami
Denver General Hospital	U. of Colorado
District of Columbia General Hospital	Howard University
Grady Memorial Hospital, Atlanta	Emory University & Morehouse School of Med.
Cook County Hospital	Univ. of Health Sciences/ Chicago Medical School & Univ. of Illinois
Charity Hospital, New Orleans	Louisiana State U. & Tulane University
Boston City Hospital	Boston University
Detriot Medical Center	Wayne State University
St. Louis Regional Medical Center	Washington University
Truman Medical Center	Univ. of MO-Kansas City
UMDNJ-University Hospital	Univ. of Med. and Dentistry of New Jersey - Newark
Lincoln Medical Center	New York Medical College
Metropolitan Hospital	New York Medical College
Bellevue Hospital Center	New York University
Metro Health Medical Center, Cleveland	Case Western Reserve
Regional Medical Center - Memphis	Univ. of Tennessee-Memphis
Ben Taub General Hospital	Baylor College of Medicine - Houston Texas
Lyndon B. Johnson General Hospital	Baylor College of Medicine & Univ. of Texas - Houston
Parkland Memorial Medical Center	Univ. of Texas - Southwestern-Dallas
Bexar County Hospital Dist.	Univ. of Texas - San Antonio

APPENDIX III

AMERICAN MEDICAL ASSOCIATION

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JAMES S TODD MD
Executive Vice President

February 20, 1991

Philip R. Lee, MD
Chairman
Physician Payment Review Commission
2120 L Street, NW
Suite 510
Washington, DC 20037

Dear Doctor Lee:

Thank you for providing the American Medical Association with the opportunity to comment on the Commission's draft 1991 Report to Congress. The Commission and its staff continue to produce reports that are well written, timely, and professional. We have come to greatly appreciate the opportunity that you have provided the AMA to comment on these draft reports. Our views on many of the chapters are outlined below. AMA staff will follow-up with Commission staff on the Malpractice chapter and any additional technical points. In addition, we refer you to our statement to the Commission of December 5.

Evaluation and Management Services

The AMA continues to be disturbed by the tenor and substance of the Commission's approach to revision of evaluation and management (E/M) codes. As we have documented extensively in correspondence, staff discussions, and testimony, the AMA CPT Editorial Panel has proceeded in a serious and thorough fashion to revise the CPT E/M codes to ensure that they are appropriate for an RBRVS-based payment system. This effort has involved careful consideration of the recommendations of the AMA/PPRC Consensus Panel, extensive consultation with the Harvard RBRVS research team and PPRC experts, and close coordination with HCFA staff.

We categorically reject the chapter's assertion that the current CPT proposal is unnecessarily complex and unworkable. No meaningful evidence is presented to support this allegation and it is abundantly clear that the Commission has not been accurately informed of the entirety of the Editorial Panel's proposals and rationale. Preliminary results from pilot study focus groups of 110 physicians in five specialties indicate that, although specific changes may be warranted in the current proposal, undue complexity was simply not an issue. The caricature of the CPT proposal of "26 different definitions ... 13 different encounter times ... [and] six classes of visits" ignores major commonalities in structure and wording as well as the fact that most physicians will rely on a subset of these codes.

Recognizing that physicians in many specialties (e.g., radiology, pathology, orthopedic surgery) use hundreds of codes in their practices with little difficulty, it seems illogical and demeaning to suggest that physicians in medical specialties would be "hopelessly confused" in having more than five levels. Ultimately, the question boils down to which approach is adequate to the task, not which is simplest. Careful analyses of the data that HCFA will be using to establish relative values suggests unequivocally that fair and uniform payments for physicians' services cannot be accomplished with a five descriptor system without creating a de facto time-based system

Also, we remain puzzled that what is simply one result of the AMA/PPRC consensus process (CP) - a single set of descriptors for all classes and levels - has been elevated to the defining principle of your proposal. A careful reading of the CP report gives little hint of this principle. Moreover, we disagree with the statement that "no specialty that uses generic visit codes noted problems applying the refined levels to different classes of visits" (p. 26). To the contrary, many of the comments to the PPRC from key societies indicate considerable discomfort with the CP proposal on its lack of site of service distinctions, a concern that clearly relates, at least in part, to use of the same descriptors for all classes/sites.

The chapter claims that the current CPT proposal does not meet the goals of a resource-based payment system. We totally reject this assertion. To the contrary, we have relied heavily on both the CP and (unlike the Commission) on the Phase II Harvard RBRVS data to develop a system that meets these objectives. For example, the current CPT proposal is designed to reflect RBRVS data that indicate different ranges of time and work for different classes and sites of service. We have designed a system in which all of the levels of service applicable to a particular class and site are actually relevant to that class and site.

Moreover, the joint AMA/HCFA pilot test is explicitly designed to evaluate the appropriateness of this system for an RBRVS. The PPRC has developed no such evidence for its proposal. Finally, we draw your attention to p. 35, lines 11-16: "The [PPRC/AMA Consensus] panel was not confident, however, that these times accurately reflect the time it takes physicians, on average, to perform the encounter portion of the content of each level of service." In light of this statement, we are perplexed by your confidence that the same times and levels apply to all classes and sites, and especially with your belief in the coincidence that the same times are relevant to hospital and office visits, with one using encounter and the other using floor time.

In sum, the AMA continues to be disappointed with the Commission's unwillingness to participate within the context of the CPT Editorial Process, in which HCFA participates directly and has expressed so much confidence. Nevertheless, the Editorial Panel will, as it has throughout this process, take quite seriously specific suggestions made by the PPRC as it evaluates pilot study results and comments from specialty and state medical societies. AMA's repeated offers to provide the Commission with a complete and accurate description of the CPT maintenance process and proposals for visit code reform continue to go unanswered. These offers remain open.

In light of this analysis we see no valid reason to delay implementation of the new visit codes. Such a delay would, in itself, seriously jeopardize a smooth transition to the Medicare payment schedule (MPS) and the entire payment reform effort.

Assigning Relative Work Values to EM Services

This chapter is a serious attempt to identify a method for the accurate assignment of relative values to EM codes. We believe, however, that its conclusions raise important concerns about accurate and equitable assignment of relative values for these services.

First, although the Phase II RBRVS report used mean data to predict physicians' total work, it used individual level data in most of the analyses exploring the work/time relationship. The chapter neither acknowledges the Phase II report's preference for individual level data, nor, more importantly, the serious methodological concerns with individual data raised in its Appendix M. Until such methodological issues are fully addressed, the statements in the chapter about the relative distortions in mean versus individual data can not be considered definitive.

Second, the discussion of the extent to which the Phase II data over estimate pre- and post-work does not report that the Phase II ratios of pre/post time to total time (approximately 30%) already reflect a correction by the Harvard investigators from higher estimates in their data. Thus, the Phase II report (p. 728) arrived at the 30% estimate based on consideration of the 20% figure from its survey of weekly practice as a "lower bound." It thus concludes that pre/post time may be overestimated by 5% and that correction of this minor error is not needed if revised EM codes contain encounter time information. In addition, the emphasis in the RBRVS surveys was on estimating total and intra-work, not pre/post time.

We are disturbed by the chapter's ad hoc departures from those RBRVS data that do not comport with either the Visit Survey or Commission instincts. Given the concerns expressed in the chapter with using the Visit Survey as a major source of primary data to establish relative values for EM services, it is surprising that the chapter proceeds to do just that. This mix of data from two different studies, one of which (the Visit Survey) only reflects three specialties, raises serious issues. We look forward with interest to the Commission's report on the Visit Survey, which will certainly provide a firmer basis for evaluating the approach in this chapter.

In addition, it would be useful for the chapter to report on and discuss the amount of variation in total work explained by encounter time when analyses are conducted with individual level data. In the Phase II Report, the percentage of total work variation explained was about 50% for prediction models applied to all sites and classes of service. For models developed for specific sites and classes, the percentage of variation explained dropped substantially, generally to between 20-30%. Although these results still suggest that time is an important predictor of total work, they reflect a far less striking relationship than was presented in the Harvard and PPRC analyses of the Phase I data. These findings clearly have important implications for EM code revision, especially in the degree to which such codes should contain descriptor components, like severity of illness, that may be strongly associated with work but not necessarily with time (see p. 28 of Chapter D.).

Finally, the RBRVS study identifies differences in work for EM services depending on whether they are provided by primary care physicians. Because the proportion of primary care survey vignettes for each class of E/M codes (e.g., office visits) does not necessarily correspond to the proportion of visits provided by these specialties, the data used to predict physician work for each visit may require adjustment to produce a single relative value that reflects the specialties providing these services.

In summary, an accurate and equitable method for assigning relative values to EM services requires much more analysis. Resolution of the associated methodological issues requires involvement of relevant experts, including the Harvard research team, HCFA, the PPRC, and the AMA.

Geographic Adjustment Factors/Geographic Payment Areas

The Commission conducted a useful evaluation of the current geographic practice cost indices (GPCIs) used in the Medicare payment schedule's geographic adjustment factor (GAF), based on available theory and data. Although we welcome the call for expanded collection of data on commercial rents, we believe that the Commission should support broader data collection of actual medical practice input prices for all GPCI components. We agree that indices based on actual expenditures are inappropriate. We do, however, strongly believe that data based on the input prices actually experienced by physicians should, at a minimum, be used to validate the GPCIs and perhaps be used for certain GPCI components. Such data could be obtained by new or expanded surveys of physician practices. We are also pleased that HCFA is constructing an improved index of PLI costs.

Consistent with the OBRA 90 mandate for GPCI updates at least every three years, we support your call for regular GPCI updates as data are available, including 1990 Census data. We will submit a comprehensive review of the GPCIs and related issues to the AMA House of Delegates in June, which we will share with you when it is available.

Like the Commission, the AMA supports additional geographic adjustments based on access considerations and related factors. We agree, therefore, that other MPS adjustments may be needed to account for factors like special costs associated with solo rural practitioners, but that these adjustments should be kept separate from the GAF. As one such adjustment, it may be appropriate to consider a payment floor of 80% of the national median payment for a service to offset any GPCI biases peculiar to rural or low-GPCI areas.

In its excellent analysis of payment localities, the Commission was consistent with current AMA policy that localities need not be defined in a uniform fashion across the country, but rather should reflect inter- and intra-locality variation in costs. In general, the option that the Commission recommends appears appropriate, although additional analysis may be necessary to arrive at final locality definitions.

Conversion Factor

As the Commission is well aware, the AMA attaches the highest possible importance to the initial (1992) MPS conversion factor (CF). There are three main threats to this CF: a possible behavioral offset, the OBRA 89 transition asymmetry, and the update applied to the 1991 budget neutral conversion factor. Individually and together, they pose a major risk to acceptable implementation of the MPS.

The chapter is an excellent summary of the OBRA 89 conversion factor process and the issues surrounding volume offsets. As we testified in December, the evidence on the nature and size of behavioral responses is inconsistent and unsuitable for assigning any volume offset. The chapter rightly points out that, with 1992 changes following nearly a decade of "fee freezes, low fee updates, and reductions in fees for overvalued procedures....[t]he volume response at the end of such a period might be quite different from other times" (p. 11). It also notes that "It is not clear that the evidence that small fee changes lead to small volume responses implies that large fee changes will lead to proportionally larger volume responses" (p. 12). Your review of the evidence on this issue is quite balanced, especially in Appendix A. Unfortunately, the statement that time series studies "suggest the presence of a volume offset" (p. 10, line 9) does not reflect the critical review of these studies in the Appendix.

Although the Commission has approached this issue with care, the recommended 1% volume adjustment is inappropriate given the substantial uncertainty regarding the existence, magnitude, and direction of potential behavioral responses. This "small offset" is still one third of the 3.3% conversion factor reduction implied by the discredited HCFA 50% behavioral assumption. It is only slightly lower than the 1.2% reduction from the CBO behavioral assumption. (Although the CBO assumes a volume reduction where payments increase, it does rely on the 50% assumption for payment cuts.) We are uncomfortable with the Commission's assurance that, if the offset is incorrect, payments will be increased in later years due to the MVPS. We have little confidence that below MVPS expenditure growth will increase payment updates. In contrast, the broad MVPS process seems well suited to allowing a response to any identified behavioral changes.

Finally, we applaud your excellent analyses of the transition asymmetry and its negative effect on budget neutrality, especially via the amplification of any behavioral adjustments. Your estimate that a 3.3% volume offset could actually reduce outlays by 12.5%, with no way for the default MVPS to correct this error, is very troubling. Although we appreciate the proposal to correct this departure from Congressional intent, we are dismayed that your preferred solution would still produce

a 2% reduction from budget neutrality. We utterly reject the rationalization (p. 22, line 3) that "The Commission's original intent that resource-based payment be implemented in a budget neutral fashion must be tempered by its concern over the continued growth in Part B outlays." We urge the Commission to pursue alternate feasible solutions to the transition problem, including a one time adjustment to the 1996 conversion factor to compensate for the fully predicable and measurable departure from budget neutrality created by the transition. Such an essentially algebraic correction would require no behavioral assumptions.

The bottom line is that a 1% volume offset, plus a 2% further outlay reduction due to the transition, plus a 2% default reduction of the 1992 CF update (with the potential for further outyear limits on updates) will undermine the remaining promise of payment reform.

Practice Expenses

The Commission has conducted sophisticated work on an alternative to the OBRA 89 practice cost approach. Like the PPRC, the AMA believes that revision of the OBRA 89 practice cost methodology to more accurately reflect the practice costs of individual specialties and physicians is desirable.

At the same time, the Commission's method requires much more exploration and refinement before a decision can be made about its implementation. Areas needing attention include the basis for allocation of indirect costs, establishment of assumed utilization rates for medical technologies and equipment, and development and validation of data for all affected services. For example, allocation of indirect costs on the basis of physician work may unduly amplify RBRVS associated payment redistribution. Similarly, assumptions about "efficient" utilization rates for equipment used in estimating costs must be approached with great care if access is not to be severely compromised.

Moreover, we disagree with the Commission's statement that the OBRA 89 method is "not resource based". Although this method, based as it is on specialty practice cost data, reflects relative practice costs only crudely, it captures important dimensions of current practice cost experience. It provides a better assurance than does the PPRC method that average actual practice costs of different specialties will be covered under the MPS. Indeed, the OBRA 89 practice cost estimates may underestimate practice costs for those services where the current Medicare discount is the greatest.

In particular, OBRA 89 practice cost relative values for services generally provided by one specialty are likely to closely reflect service and specialty specific practice costs for those specialties who concentrate their practices on such services. Many of the specialties that the chapter suggests are likely to lose from the Commission's approach do concentrate on procedures unique to their specialty and bill for few visits outside of a global package.

The Commission's proposed approach essentially ignores current information on the actual practice costs of these specialties. Rather than seeking a more resource-based allocation of current specialty practice costs, it takes the major step of reallocating a medicine-wide pool of indirect costs on the basis of physician work, which is itself subject to major cross specialty redistributions.

Comparisons of projected payments under the OBRA 89 and PPRC cost methods suggest that this method could produce practice cost allocations that bear no relation to actual specialty practice costs and could cause potentially untenable payment dislocations. In fact, the projected payment reductions for some services in Table 5 closely resemble projected cuts under the original Harvard practice cost method, changes of a magnitude that led the Commission to question the face validity of

this method. Although the Commission suggests a transition between the OBRA 89 and PPRC methods, a major goal of payment reform is stability. A perpetual transition to a constantly receding "final RBRVS value" is inconsistent with this goal, especially given the specter of continued "overpriced procedure" cuts based on these new cost estimates.

In light of these concerns, we are pleased that the Commission has adopted a recommendation in principle that does not reach closure on the specific resource-based method to be used or the manner and timing of its implementation. We look forward to continued work on this issue so that there will be a firmer base for such policy decisions.

Professional Liability Insurance Expense

The AMA continues to believe that PLI costs should be included in the payment schedule. The "risk-of-service" (ROS) method recommended by the Commission is consistent with the OBRA 89 approach while providing potentially more accurate relative values. Several points can be made, however. First, although PLI premiums for physicians in different risk classes reflect the "risk" of different services, they do not do so with the precision implied in your analysis. As a result, the goal of this system, to fairly reflect the PLI expenditures of specialties and physicians, is sometimes lost in the focus on service risk. Also, the chapter should clarify how the pool of overall Medicare PLI expenses is estimated. Finally, any biases inherent in spreading PLI costs over work should be identified.

In general, however, the chapter suggests that the ROS method would be more accurate and equitable than the OBRA 89 method. Given the relatively simple version of this approach currently available, we do however, urge caution in consideration of the 1992 implementation of ROS.

Assistants at Surgery

In general, the AMA commends the PPRC recommendations on use of and payment for assistants-at-surgery. In particular, we agree that profiling with feedback is the best of the options you considered. The AMA is also pleased that the PPRC rejected a policy of lump sum payments for surgery that include the assistant as well as expansion of the onerous and inefficient policy of mandatory prior authorization for surgical assistants. We agree strongly with your statement that ". . . the costs of expanding prior authorization appear to outweigh the benefits." (p. 12, lines 21-22.) At the same time, we disagree that scarce HCFA funds should be wasted on a demonstration of the lump sum payment option. Finally, we agree that payment should be based on resource costs.

We would like to underscore our view that profiling should target those services with the greatest potential for appropriate changes in physician behavior and Medicare savings. In addition, we believe that current limitations in the state of the art of profiling require an intermediate step based on discussions between the profiled physician and the carrier or PRO regarding outlier situations prior to any formal audits. Finally, we find no precedent or justification for requiring the primary surgeon to make refunds to Medicare for "unjustified utilization" of assistants.

Private Payers

This chapter provides an excellent description and analysis of the current environment in which private payers are considering whether and how to adopt elements of the new Medicare payment schedule. Our major concern is with the assumption that not only is an all-payer system desirable, but that the current Medicare payment schedule and policy-making process are directly applicable to private payers. These assumptions follow from a logic that loosely combines a perception that major Medicare changes are untenable without associated private sector

changes with a vague assumption that an all-payer system would somehow serve universal cost containment goals. What is never articulated is exactly why an all-payer system is needed or what major social goals it would advance, and at what cost.

It makes no sense to hold an entire health care system hostage to changes in Medicare or to the policymaking process used to make these changes. Moreover, policy decisions made for Medicare, including the enactment of balance billing limits, are inextricably bound up in the context of a social insurance program for a protected population that must establish payment rates.

Why should all private payers adopt one RVS or a single set of conversion factor/charge limit policies? Why, in an era of growing similarities among indemnity plans, PPOs, and HMOs, should only so-called "competitive" health plans and HMOs be permitted to depart from the all payer rates, and only downward? Nor do we understand why these health plans should only compete on the basis of utilization controls rather than physician payments, nor why such plans could not fund higher payment levels out of effective utilization review. Finally, the notion that balance billing should be centrally controlled for all health insurance plans ignores the particular circumstances of the Medicare and Medicaid populations, as well as the fact that any balance billing used to offset payment cuts would in fact reduce distortions in physician charges imposed by health insurance. We are profoundly troubled by the Commission's vision of physician payment in the United States. This issue requires far more discussion of whether and what kinds of changes should be made.

EKG

We are gratified that the PPRC has repudiated the last minute OBRA 90 provision to limit Medicare payment for EKG interpretations. We are especially pleased with the acknowledgement that EKG interpretation differs from other test interpretations in that the physician's professional skills are needed to produce a test result. Thus, although we applaud the proposal to pay for EKG interpretation on a resource cost basis, we strongly disagree with the associated recommendation that EKGs be singled out for immediate RBRVS implementation, with no transition period. This concern is heightened by the further recommendation to apply the Commission's exploratory practice cost values to these services alone, again with no transition, further reducing payments.

No one disagrees that EKGs should be paid on a resource cost basis. What we do dispute is the illogic and unfairness of continuing the "overpriced procedure" approach for this one set of services, with savings removed from the Medicare budget. If Congress acted in haste and error, there is no reason that EKGs must shoulder the budgetary consequences of a repeal of this mistaken policy. Moreover, the footnote on the CBO savings estimates for the OBRA 90 provision (p. 14) clearly indicates that projected savings were overstated, ignoring anticipated outlay reductions due to payment schedule implementation. Real savings due to severe single year payment cuts should not be used to replace illusory savings.

Beneficiary Issues

Consistent with the Commission's framework for evaluating beneficiary issues, this chapter provides a useful and straightforward analysis of several key issues of concern to the Commission. We would, however, like to make several observations. First, the New York assignment law does not merely "speed up" the OBRA 89 limits. With final limits of either 110% or 105%, it goes far beyond the very strict OBRA 89 limits and, like other state assignment laws, is in our view inconsistent with the policy decisions made by the Congress regarding proper Medicare charge limits. With respect to the Explanation of Medicare Benefits (EOMB), the AMA agrees that this form should provide understandable and relevant information to patients. At the same time, we believe that it must not intrude upon physicians' relationships with their patients. In that

regard we have consistently requested that HCFA delete inflammatory language from the EOMB (e.g., "You could have avoided paying $___ if the claim had been assigned.").

Regarding "limitation of liability", we appreciate the Commission's kind words regarding the AMA's publication: Medicare Carrier Review: What Every Physician Should Know About Medicare Carrier Review (note correct title). Nevertheless, we are concerned that the chapter's conclusions regarding knowledge of and compliance with this provision are based on unspecified and potentially non-representative anecdotal evidence.

Medicaid

The two chapters on Medicaid provide an excellent context for considering changes to this program to improve access to health care. We are especially pleased with the discussion of the need to raise payments to appropriate levels and to reduce programmatic "hassles." As part of its overall strategy for expanding access to health care, the AMA continues to support a four-pronged approach to improving Medicaid: uniform (state adjusted) standards of eligibility for all persons below the poverty level; basic national standards of uniform minimum benefits; elimination of existing categorical requirements; and payment at appropriate (e.g., Medicare) levels to assure broad access to care. We look forward to providing more detailed comments on your draft July 1 Report to Congress on this issue.

Payment to Podiatrists and Optometrists

Although we recognize that the Commission made a serious, albeit largely unsuccessful, attempt to identify data to establish resource based payment levels for optometrists and podiatrists, we remain concerned with the recommendation that these limited license practitioners (LLPs) should receive the same payment levels as physicians under the MPS based on a policy of "same payment for same service". (The similar recommendation for clinical psychologists is also of concern.) We are, however, pleased that the Commission shares the Association's concerns with Medicare's use of the term "physician" to apply to these LLPs.

Nonphysician Practitioners

The AMA has already commented on issues in this chapter via a letter and testimony, and will highlight just a few points. First, we are pleased with the recognition that NPP services cannot be considered the same as physicians' services. Although the principle that payment differentials should reflect resource costs is reasonable, we are unconvinced that human capital comparisons of NPPs to physicians should distinguish among NPP professions when they are compared to the same specialty. Such differential treatment is inconsistent with your decision to ignore opportunity cost differences among physician specialties. Also, NPP services not under the direct control of a physician should not be in the MVPS. The fact that these services "often complement and/or partially substitute for physician services" (p. 26, line 5) does not mean that they should be included in a standard whose aim is collective medical profession responses.

Finally, we strongly oppose your recommendation to abolish payment for NPP services provided "incident to" the services of a physician. Although current interpretations of this provision are woefully antiquated, especially given developments in the physician assistant (PA) profession, this statutory provision must be retained for two reasons. First, it reflects the fact that NPPs, especially PAs, can practice in close collaboration and integration with physicians in a manner that does not readily permit distinctions between physician and NPP practice.

Second, in the absence of legislative expansions in the circumstances in which identified NPP services will be paid for,-the Commission's recommendation would eliminate a major Medicare benefit and cause significant disruptions in medical care.

As always, we appreciate the opportunity to provide our views to the Commission. The AMA looks forward to a continued productive working relationship with the Commission.

Sincerely,

James S. Todd MD

James S. Todd, MD

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good morning. Chairman Bentsen, I would like to commend you for holding this very important hearing on the President's fiscal year 1992 budget proposal.

Just last year, Congress passed an unprecedented 5-year, $490 billion deficit reduction package. We have never cut that large an amount out Of Our deficit and we have yet to get a good sense as to what impact the cuts and tax increases will have On the economy and the constituents we serve. In the absence of this information, I am troubled by the Administration's willingness to continue to propose major cuts in a wide variety of areas, and particularly within the Medicare program.

Specifically, the President's fiscal year 1992 budget proposal includes a reduction of $2.1 billion in Part A of the Medicare program and a reduction of $2 billion in Medicare Part B. In the wake of the $43 billion in Medicare cuts contained in last year's five-year budget agreement, the Administration's proposed Medicare cut Of $4.1 billion is nothing short of unacceptable. Though Medicare is a major component of Federal spending, it cannot continue to absorb huge cuts without limiting access to essential, high quality care

The Part A savings of $2.1 billion is in addition to the savings of $13.7 billion in payment changes (primarily on the back of hospitals) that was agreed to by Congress under last year's budget agreement. The Part B savings of $2 billion is in addition to last year's five-year reduction of $14.2 billion.

When the budget agreement was reached this past fall, it was with the understanding that no additional major cuts would be made to hospitals and other providers under the Medicare program. I strongly believe it would be both unwise and unfair to submit these providers, once again, to significant reductions in their Medicare payments.

In addition to provider cuts, the President proposes that Medicare beneficiaries be targeted for increased premiums and additional coinsurance. The President has proposed that higher income individuals pay a much greater share of the cost of Part B coverage, and that all beneficiaries pay a laboratory coinsurance. In these times of overwhelming budget constraints and growing health care demands, few of us are in a position to reject every beneficiary cost-sharing proposal. However, I believe that any such proposals should be closely evaluated to determine their impact on beneficiaries in terms of out-of-pocket expenditures and the elderly's and their children's support of the program.

I would also like to point out that the President's budget for Medicare program contractors is a classic example of being penny wise and pound foolish. His proposal to cut funding for communications with program beneficiaries by 57 percent would drastically narrow beneficiary access to Medicare, blocking inquiries on the status of claims, program coverage, and other important matters. As beneficiaries are the primary source for identifying provider fraud and abuse, this cut would cost the program far more than would be saved. Likewise, his proposal to reduce funding for resolution of beneficiary and provider appeals by 63 percent would result in two out of every three appeals to be neglected, an impact that is unjust and financially harmful to claimants.

Of similar concern is the Administration's proposal to require Medicare/Medicaid-certified health care providers to pay for the costs of their annual surveys and certifications. According to the Administration, these so-called "user-fees" would generate about $265 million in fiscal year 1992. I believe this proposal sets a dangerous precedent of decreased Federal involvement in quality assurance and oversight of providers, which is particularly troubling at a time when extensive nursing home

reforms are being put into place. I am also concerned that it would create an incentive for providers to shift the costs of the user fees to private pay patients, thereby further increasing the out-of-pocket costs the elderly must already bear for their health care.

A recent development which has profound implications for Federal health program expenditures is drug manufacturer price increases to private citizens as well as Federal Government health care programs. Left unchecked, these price increases will substantially increase Federal outlays for pharmaceutical products in 1991 and beyond. Hardest hit will be the programs of the Departments of Defense and Veterans' Affairs, which purchase over $700 million in drugs each year. Preliminary estimates are that these price increases could cost the DVA up to $150 million this year in additional drug outlays, effectively negating the Federal savings that were expected under the new Medicaid drug rebate law enacted this past year. These first-year Medicaid savings were projected to be about $70 million.

Strong evidence suggests that drug manufacturers are increasing their low prices to the DVA and DOD to circumvent the new Medicaid law's provisions. These provisions require the drug makers to give Medicaid some of the same low prices they give to the DVA. I am concerned about these recent unintended developments, and want to work with the Administration and the Finance Committee to insure that savings from Federally-funded prescription drug programs are fully realized and cost shifting is obviated.

The President's budget proposes $25 million in new Medicaid spending, primarily for expansion of medically-needy eligibility for pregnant women and children. While I applaud this effort, I am concerned about its adequacy. The Medicaid program falls far short of providing health care to our nation's poor and disabled, and the Congress and the Administration need to closely examine ways to strengthen the program while not overburdening the states.

I would like to point out my concern about the lack of any policy or budget proposals that begin to address the Nation's over 31 million persons under the age of 65 who are without insurance. Similarly, I have great concerns about the lack of progress we have made to date in addressing the many long-term care challenges that confront us today and will overwhelm us tomorrow. And, at least as important as these concerns of access to health care are, is the issue of how we control ever-increasing health care costs.

It is my belief that we can introduce all the legislation our creative minds can come up with to address these staggering health care challenges. However, in the absence of leadership exhibited by our President and his Secretary of Health and Human Services, it would seem virtually impossible to see how we can achieve comprehensive health care reform. It is my sincere hope and desire that we will receive a signal from the Administration today that the President will use the same commitment and creativity he illustrated during the Persian Gulf war in a similar effort to address our nation's many health care shortcomings.

On the income security front, I am concerned that the President's budget does not provide adequate resources to meet the administrative needs of the Social Security Administration (SSA). A number of disturbing trends have recently come to my attention. Individuals telephoning SSA routinely face busy signals more than half of the time. I have also learned that SSA's processing times have in some cases doubled. The time between application and decision on an initial disability claim takes much longer than expected.

The Department of Health and Human Services has stated that under the President's budget for fiscal year 1992, these problems will worsen. I believe that the President's budget is unacceptable insofar as it explicitly provides for, in HHS's words, "a decline in service."

I am pleased that last week OMB saw fit to release $100 million in contingency funds that HHS had requested. It took a lot of pressure from Congress, but OMB's action will keep SSA afloat until next year. SSA is going to remain in a difficult position, however, as it goes into fiscal year 1992. In this regard, it is unfortunate that HHS continues to insist that SSA's administrative expenses remain on-budget, even though Congress took all trust fund expenditures off-budget last year. This places SSA in a difficult position to rebuild itself into providing top-quality public service.

Mr. Chairman, these and many other issues will be raised during today's and tomorrow's hearing. You have assembled a fine collection of witnesses. I commend you for calling this important hearing and look forward to working with you and these witnesses on developing a budget that is both economically sound and responsive to the many needs that confront our nation.

Prepared Statement of Paul Rettig

Mr. Chairman, my name is Paul Rettig, executive vice president of the American Hospital Association (AHA) and director of its Washington Off ice. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to testify on the status of health care and hospitals in the United States and on funding issues for Fiscal Year 1992.

Health care and the future of hospitals in the United States are at a crossroads. In the past decade, spending for health care has more than doubled. Our nation now spends over 11 percent of its gross national product (GNP) on health care services and research. While restraint has been shown in some sectors of the health care market, costs in other sectors have continued to spiral. Since 1982, spending for hospital care—both inpatient and outpatient—has grown more slowly than spending in any other category of health care expenditures. (See Chart 1)

Even though hospital spending has remained a constant percentage of GNP, hospitals are experiencing financial pressures. These financial difficulties are compounded by the growing Federal budget deficit and trillion-dollar-plus national debt. Current estimates suggest an fiscal year 1991 deficit of over $318 billion, depending on the ultimate costs of our military efforts in the Middle East. Policymakers are trying to control Medicare and Medicaid spending. Employers are battling rising health benefit costs. Similarly, consumers' concerns about rising health care costs continue to grow while the costs associated with and the lack of access for the 33 million Americans without health insurance affect everyone. All of these participants—consumers, hospitals, physicians, business, insurers, and the Federal government—have expressed dissatisfaction with the current health care delivery system, particularly with the way in which health care services are financed.

The current health care system is a jumble of individual programs that have evolved by default, not by design. The "guick fix" approach has contributed to the fragmentation of health care services. Similarly, budget-driven decisions produce health care policy that not only ignores the need for reform but also redistributes health care resources in a haphazard fashion and discriminates against the financially weak on the basis of their financial situation. Furthermore, maintaining the solvency of the Medicare Trust Fund and its commitment to beneficiaries cannot be ensured solely by extracting savings from providers. Any effort to resolve the problems of the health care system must be developed in the broad context of systemwide reforms.

This nation needs to move toward broad reform of our health care system. We need to redirect current financial incentives and to clarify our health care goals. AHA has been working with hospitals and others to broaden the discussion and debate on future reform of the health care system. We have been working toward the development of proposals to significantly improve the U.S. health care system by the year 2000. Preliminary outlines of our plan include universal coverage, catastrophic protection, and a realignment of provider incentives. AHA looks forward to bringing this plan to the table and sharing our thoughts on health care system reform with you in the near future. While AHA is looking ahead toward reform of the health care system, we are haunted by the promise and failure of past efforts. The hospital industry was a willing partner in the most recent effort to reform its portion of the health care system. The prospective payment system has not only yielded significant budget savings, thus extending the life of the Hospital Insurance trust fund, but it also has led to improvements in the efficiency of health care delivery. Hospitals have responded to PPS incentives by reducing the average length of stay; increasing the productivity of their staffs, hospitals' most costly resource; and, when appropriate, shifting an increasing proportion of care to the outpatient department, often the most efficient and cost-effective setting. (See Chart 2) Furthermore, hospitals have continued to meet the needs of their communities, providing state-of-the-art care, training health care professionals, and caring for the poor.

We appreciate the committee's willingness to work with us as we adapted to PPS, to make adjustments to the system as they were warranted, and for attending to the concerns of hospitals serving rural Americans, particularly eliminating the differential between the standardized amounts for urban and rural hospitals by fiscal year 1995. Moreover, we applaud the committee's role in last year's budget reconciliation, which mandated development of an adjustment to standardized amounts to reflect variations in non-labor prices among hospitals. AHA strongly supports the committee's view this year that the Congressional budget for 1992 not be based on the expectation of further deep reductions in the growth of Medicare spending. I would like to thank Chairman Bentsen and members the committee for their leadership in resisting the cuts proposed in the President's budget this year.

Despite the accomplishments of PPS, many problems remain. PPS has come to represent a series of broken promises. The system pledged to provide payments that kept up with the rate of inflation plus 1 percent for technology. In reality, PPS payments per case have not kept up with costs. (See Chart 3) PPS established incentives for hospitals to keep costs down by allowing them to keep the difference between Medicare payments and their costs. However, as soon as a hospital is deemed to have made more than its costs, the entire Medicare program becomes a target for major cutbacks.

Technical problems with prospective payment persist. The PPS market basket, for example, does not take fully into account price increases, specifically hospital wage increases. The area wage index, which is constructed by Metropolitan Statistical Areas, does not recognize the changing shape of hospital labor markets and is increasingly unrepresentative of the wage differentials paid by hospitals across the nation. While we are optimistic that the newly created Medicare Geographic Classification Review Board will address some of these concerns, the larger issue remains to be resolved.

Perhaps the most significant failure of PPS is that it has not been allowed to work; it has become a victim of budget-driven policy. This has led to a lack of predictability within the program. Continual budget-driven policy changes have denied hospitals the opportunity to adequately plan for their financial future. Hospitals have already experienced the effects of nearly a decade of budget-driven policy decisions. The result has been a slow erosion of hospitals' financial stability and a redistribution of health care resources that sometimes has unintended consequences. AHA has addressed this committee in the past concerning Medicare payment shortfalls. It is not news that hospitals have been losing money treating Medicare and Medicaid patients for some time. What is new is that these losses, the driving force behind hospitals' overall financial performance are now reflected in the overall financial status of hospitals. For the first time in over a decade, hospitals' net patient margins are negative. In fiscal year 1990, hospitals' aggregate net patient margin was *negative* 0.2 percent. That is, for all patients treated, hospitals' expenses exceeded their patient revenue. As a result, hospitals have had to rely increasingly on other, shrinking sources of revenue such as state tax dollars, grants, contributions, and interest on cash balances to make up for the unpaid care of patients. Even with these additional sources of non-patient revenue, hospitals' financial positions are precarious. In fact, even after including revenue from all sources, patient and non-patient, at least 20 percent of all U.S. community hospitals report negative *total* margins.

Government payments for care provided to Medicare patients have gone from bad to worse. Hospitals have been losing money treating Medicare patients for the past three years. In fiscal year 1989, hospitals lost 3 cents on every dollar of care delivered to Medicare patients. In fiscal year 1990, they lost more than 6 cents on every dollar of care; and in 1991 they are expected to lose 9 cents on every dollar. AHA projects that in fiscal year 1992 the aggregate Medicare PPS operating margin will be between *negative* 10 percent and *negative* 15 percent.

Exacerbating Medicare losses is the recent shift in admission trends at U.S. community hospitals. Admission of patients over the age of 65 had been declining through 1987. But in 1990, over 600,000 *more* elderly patients were admitted to hospitals than in 1987. At the same time, over 1 million *fewer* patients under the age of 65 were admitted to community hospitals. Thus, an increasing share of hospitals' patients are elderly Medicare patients. This demographic change is likely to continue as the population ages, aggravating an already difficult financial situation for hospitals. Under PPS, the payments hospitals receive for this growing Medicare population will be inadequate to cover costs, while at the same time there are fewer and fewer inpatients who actually pay for the full cost of the care they receive.

In addition to the problem of Medicare underfunding, Medicaid payments for patient care fall far short of costs. Senator Bentsen, the American Hospital Association appreciates the leadership you have shown with your colleagues Senators Riegle, Chafee, Rockefeller, and Mitchell in addressing the eligibility problems for Medicaid, particularly for pregnant women and children. We are also grateful for the attention you have brought to the issue of provider payments and are pleased with your help in improving payments for services provided infants and children as well as persevering state flexibility for hospital disproportionate-share adjustments and directing ProPAC to study Medicaid hospital payments. But the shortfall in Medicaid hospital payments is increasing rapidly. Between 1980 and 1985, Medicaid paid about 90 percent of the cost of care for its recipients. During the second half of the decade, however, payments fell further and further behind each year. By 1989, Medicaid payments covered only 78 percent of costs. That is, in the aggregate, hospi-

tals lost 22 cents on every dollar of care provided to Medicaid recipients. In fact, nine of 10 hospitals now are losing money serving Medicaid patients, and the extent of their losses is increasing each year.

As a result, Medicaid shortfalls are now the most important factor driving increasing hospital losses in caring for the poor. Preliminary AHA analyses show that in 1989, unreimbursed hospital care for the poor, which includes Medicaid and unsponsored care, totaled $13.2 billion. One-third of this ($4.3 billion) was due to Medicaid underpayment. While hospitals have traditionally focused on the growing cost of providing uncompensated care, the rising cost of Medicaid shortfalls is an increasingly significant source of financial difficulty for hospitals. (See Chart 4)

Taken in total, the magnitude of these hospital losses is staggering. Medicare and Medicaid shortfalls and hospitals' unsponsored care burden strongly reflect the inadequacies of government payments for hospital services and suggest that by underfunding health programs for the poor, aged, and disabled, the Federal Government, as well as state governments, are shifting responsibility for assuring access to high-quality care for these population groups onto the shoulders of other payers. To fully recover these costs from private purchasers, who on average generate less than 45 percent of gross patient revenue for hospitals, hospitals would have to increase charges by some 20 percent.

Although hospitals' financial status in 1991 appears shaky, their community commitment remains steadfast. In the midst of the turmoil that has affected the entire health care field, hospitals have gradually been expanding their role, becoming broad public service institutions that enhance the quality of people's lives in many areas. Virtually all community hospitals now have emergency departments staffed 24 hours a day or arrange with other facilities to provide emergency care for their communities. Three-fourths of all hospitals now offer outpatient services. Hospitals are providing more home health services, more outpatient rehabilitation services, and more alcohol and chemical dependency treatment.

In his budget message to the House Budget Committee, Secretary of Health and Human Services (HHS) Louis Sullivan stated, "Health promotion and disease prevention are critical to enhancing the health status of all Americans." Hospitals share the Secretary's belief. In fact, hospitals' health promotion activities have grown tremendously. Increasingly, hospitals are involved in planning and coordinating services to encourage people to adopt healthier behaviors, reduce health risks, and improve their understanding of medical procedures and therapeutic regimens. In 1985, half of all community hospitals offered health promotion services. By 1989, just four years later, more than 85 percent of hospitals offered these types of health promotion services. Hospitals nationwide are participating in Healthy People 2000, a national strategy by the U.S. Public Health Service to improve America's health by the turn of the century by encouraging health promotion activities.

We are concerned, however, that the persistent financial squeeze will impair hospitals' ability to adequately serve their communities. Inadequate Federal and state government payments for hospital care are straining hospitals' ability to continue to provide needed quality acute care services, let alone expanded preventive and longer-term treatment services. Hospitals remain committed to providing access to care for all patients, but their continued ability to do so is in jeopardy.

The President's recent budget proposals fuel this fear. President Bush would again impose cuts in Medicare financing as a primary means of balancing the Federal budget. This represents another in a series of broken promises to support quality health care and further widens the credibility gap between the administration, and hospitals and their patients. We would like to thank you, Senator Bentsen, in your diligent pursuit of maintaining the five-year budget agreement. These efforts will help to assure continuity in the operations of our health care delivery system and will restore faith in our nation's commitment to quality care.

Among the President's proposals and those made by the Prospective Payment Assessment Commission (ProPAC), suggested reductions in the Medicare indirect medical education (IME) adjustment would have the greatest financial impact on hospitals. The President proposes a five-year reduction in the adjustment factor from the current 7.7 percent to 4.4 percent in fiscal year 1992 and eventually to 3.2 percent. ProPAC has recommended a less rapid five-year phase-down that would reduce the IME factor to 7.0 percent in fiscal year 1992 and eventually to 4.2 percent. The President's proposal is expected to save over $1 billion in fiscal year 1992 alone and nearly $9 billion over five years. Alternatively, ProPAC recommends that this change be implemented in a budget-neutral manner. That is, the money saved by reducing the IME adjustment would be redistributed through the Medicare standardized payment amounts to all hospitals.

The financial viability of our nation's teaching hospitals is a major concern. Although teaching hospitals fared better than non-teaching hospitals during the early years of PPS, their financial picture is now equally as gloomy. In fiscal year 1992, the estimated Medicare margin for teaching hospitals is negative 7 percent to negative 12 percent. ProPAC's proposal to cut the IME adjustment would have the effect of further reducing teaching hospitals' Medicare margins to between negative 8 percent and negative 13 percent. The President's more draconian approach would reduce margins to between negative 13 percent and negative 18 percent.

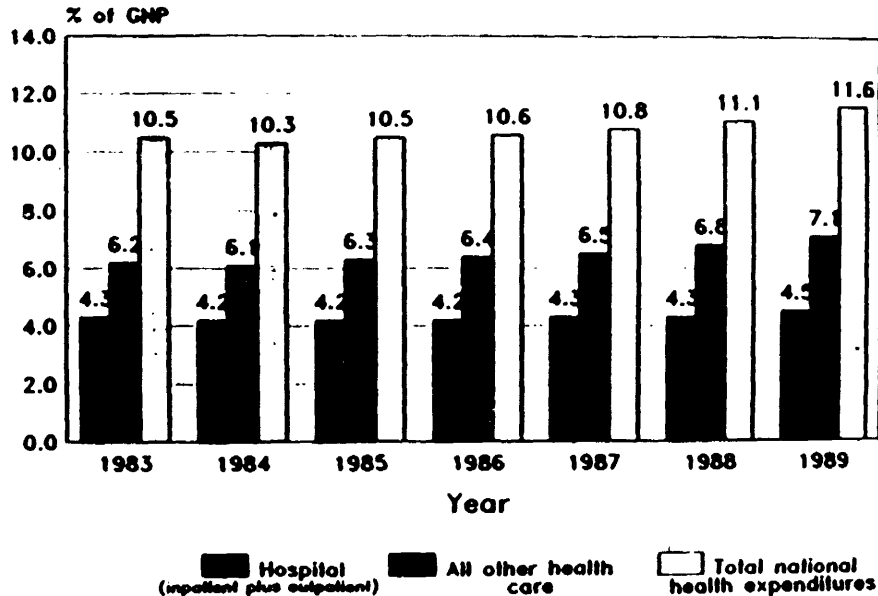
This adjustment clearly is crucial to the survival of teaching hospitals, and these hospitals are essential to meeting future medical manpower needs as well as to providing needed access for Medicare and Medicaid patients and the medically indigent. Despite this adjustment, teaching hospitals remain financially stressed. Hospitals are committed to care for the poor, the uninsured, and the underinsured, but we need to look for additional mechanisms to ensure adequate payment for these special population groups.

The Bush budget would also make additional cuts in outpatient payments to hospitals, saving $50 million by basing payments for ambulatory surgery, radiology, and diagnostic procedures on a prospective rate. In light of the congressional mandate to ProPAC and HHS to develop and analyze a plan by March of 1992 to pay for all outpatient services on a prospective basis, this savings proposal is yet another example of budget-driven health policy with no rational basis. These cuts will disproportionately and dramatically affect rural hospitals, which have responded to PPS incentives to deliver care in the most efficient setting—often the outpatient department. Moreover, we would like to take this opportunity to remind you of the AHA proposal for prospective outpatient payment, and urge that you consider it with other proposals on the table. AHA proposes that in the long term Medicare should adopt a prospectively determined procedure-based fee schedule for payment of hospital and other outpatient services, with interim payments based on per-procedure average operating cost limits.

Finally, Mr Chairman, we would like to comment on another, somewhat hidden threat to hospitals, the "pay-as-you-go" process reform provisions of the Budget Enforcement Act. Our concern is twofold. First, the President's proposals to reduce Medicare spending for hospitals may be viewed by some as an opportunity to fund expansions of other mandatory spending programs without passing the requisite financing mechanism. This clearly violates the spirit of the "pay-as-you-go" provisions. Second, hospitals remain vulnerable under the new system and must rely on the good-faith efforts of others to comply with the new provisions of the Budget Enforcement Act. If others neglect their responsibility to find complementary funding means for program expansions, hospitals may still experience payment reductions if a sequester is triggered. AHA urges the committee to be vigilant in monitoring the new pay-as-you-go process. Particularly in the case of Medicare, dedicated trust fund dollars should not be used to fund other programs or to fund deficit reduction. To prevent the inappropriate draining of Medicare reserves that could result, the trust funds should be moved off-budget and removed from deficit calculations for purposes of meeting the Gramm-Rudman-Hollings deficit targets that become operative again in fiscal year 1994.

We as a nation must assure that our growing health care needs will be met in the most sensible and efficient manner. We need to focus on the future, but the time to do so is now. AHA will continue to work with hospitals and other stakeholders in the health care field to develop viable options for reforming our health care system, and we look forward to working further with your committee and others in Congress to achieve this common goal.

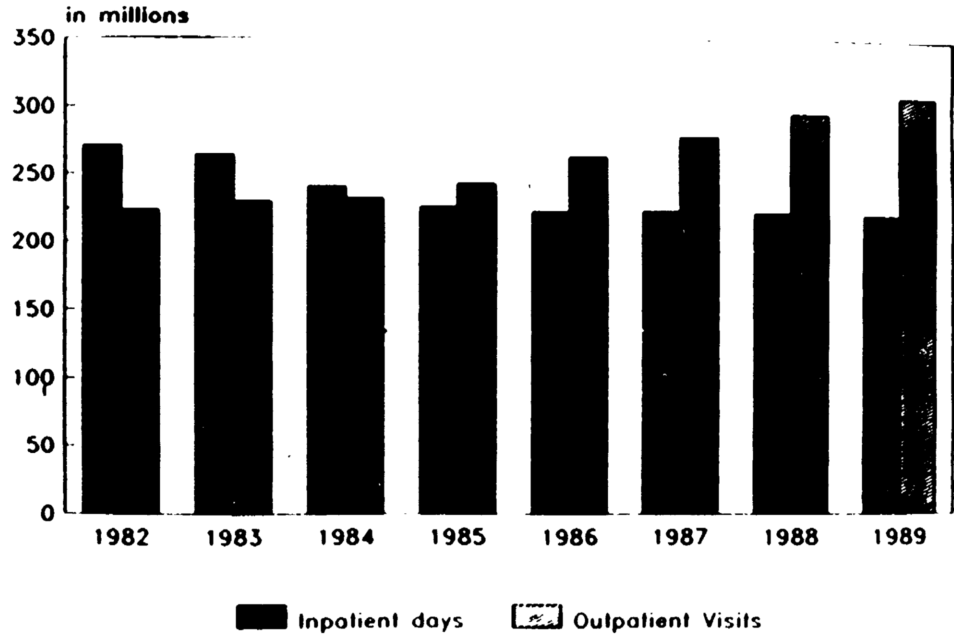
NATIONAL HEALTH CARE EXPENDITURES AS A PERCENT OF GNP



Source: HCFA Office of the Actuary

CHART

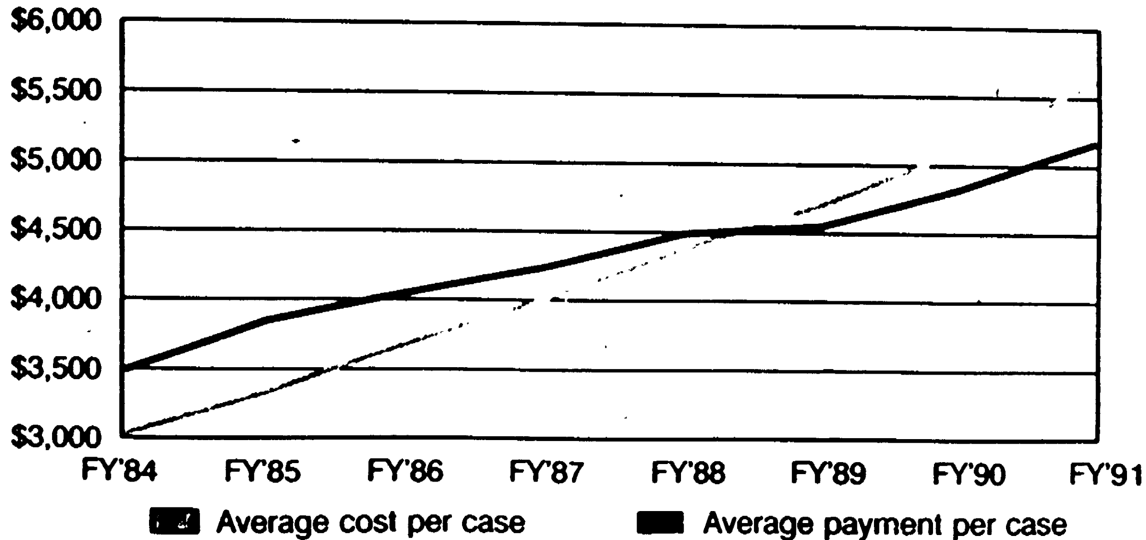
LONG TERM TRENDS IN HOSPITAL UTILIZATION



Source: AHA, National Hospital Panel Survey

Chart 3

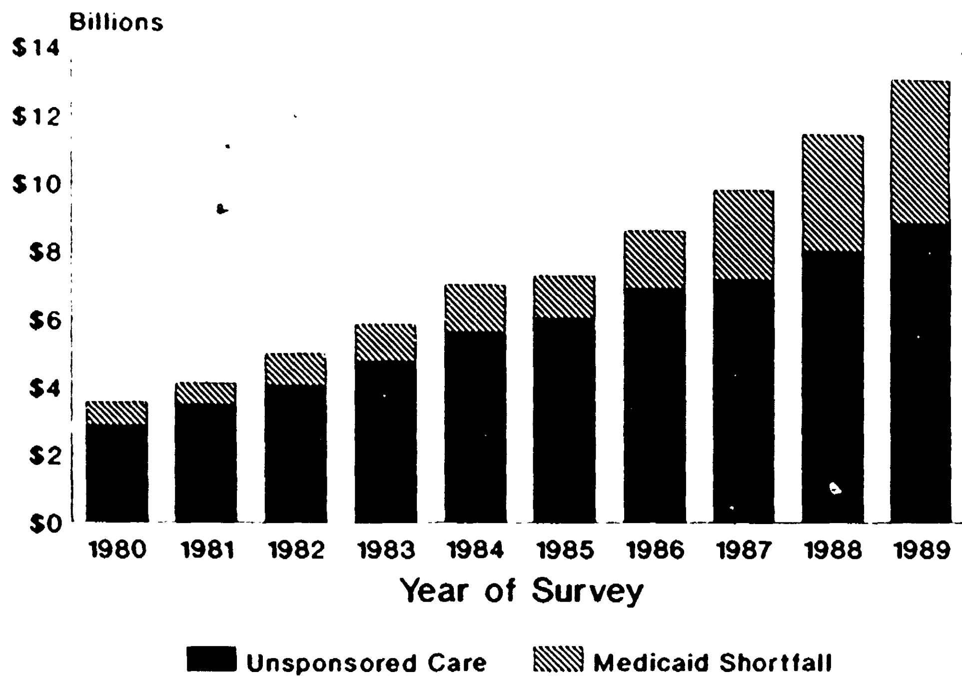
AHA PPS PAYMENTS AREN'T KEEPING UP WITH HOSPITAL COSTS



Source: FY '84-FY '88 - HCFA Medicare Cost Report Tapes
FY '89-FY '91 - Preliminary AHA Projections

CHART 4

MEDICAID SHORTFALL PLUS UNSPONSORED CARE



Source. American Hospital Association

Prepared Statement of Gary Stangler

Mr. Chairman, members of the Committee, I am Gary Stangler, Director of the Missouri Department of Social Services. I currently serve as the Secretary of the National Council of State Human Service Administrators of the American Public Welfare Association (APWA). I thank you for the opportunity to speak with you today on the some of the health and welfare issues you will be considering this session. I will address some of the issues raised by the Administration's budget proposal and discuss other concerns of state human service agencies.

MEDICAID

First, we are concerned that the Administration's proposal to charge fees to Medicaid and Medicare health care facilities for survey and certification activities may cause cost-shifting from the Federal Government to the states. We do not have all the specifics of the Administration's proposal at this time but would caution against any proposal that might have the effect of increasing state Medicaid program costs while reducing Federal liabilities for the same services. State Medicaid programs can ill afford additional cost-shifting at this time, especially as states are undertaking the new survey procedures required by Nursing Home Reform. Please see the attachment for specifics on how the proposal might work

Regarding the Administration's proposal to allow pregnant women and children to spend down to current categorical eligibility thresholds, APWA continues to support Medicaid options that enhance state ability to address state determined needs. This proposal looks particularly interesting in that the effect would be to simplify eligibility for one group of eligibles—something states have long sought.

The Administration's budget also includes a provision to allow states to waive out of the OBRA 90 pharmacy reform provisions if a state can demonstrate greater savings under an alternative program. There are no specifics on the proposal upon which to comment but we would be interested to learn more Implementation of the pharmacy reform provisions has proven complicated for states and some states remain concerned that the reform may in fact result in increased expenditures rather than generating savings

Coordinated care is an area addressed in the Administration's budget as well. While there are no specific proposals at this time, it is fair to say that states are very interested in proposals that will facilitate the development of coordinated care strategies, including managed care programs State agencies look toward innovative coordinated care strategies (including primary care case management, other case management services, and pre-paid managed care) as ways to improve both client access to services and continuity of care

There is also a proposal to encourage states to adopt model malpractice reform legislation. Many states are concerned about the impact of skyrocketing malpractice insurance costs and the impact such costs have on the availability of providers and the cost of health care generally. States have been in the forefront of addressing issues related to malpractice costs for some time Federal initiative in the development of model legislation would be welcomed. We do not believe, however, that funds for state financial incentives should come from existing Medicaid matching dollars. We would be very concerned if states were to receive a 2% reduction in Federal matching payments in order to create a malpractice reform funding pool.

While not included directly in the Administration's budget, the issue of donated funds is a significant one for states and the issue promises to surface again this year. APWA remains very concerned that HCFA will act to preclude the use of such funding mechanisms at the end of the year when the current moratorium on issuance of regulations expires. This issue is of prime importance for several reasons.

States are currently allowed to use, under certain circumstances, public and private donations and all state taxes as sources of state share of financial participation in Medicaid. Traditionally, states were given broad latitude to design their Medicaid programs in terms of populations covered, benefit packages offered, and reimbursement levels. In the recent past, however, Congress has mandated expanded Medicaid coverage forcing states to absorb major benefit level changes and to modify reimbursement policies. Recent mandates include Nursing Home Reform, expanded coverage of children and pregnant women, Qualified Medicare Beneficiaries (QMBs), elimination of durational limits on hospital stays and other services for certain eligible groups.

For many states, these mandatory changes have resulted, or will result, in dramatic increases in both Medicaid enrollments and expenditures. Nationally, the National Association of State Budget Officers estimate that state Medicaid expenditures are growing at rate of 18.4% annually, which makes it the fastest growing

portion of state budgets. At the same time, the majority of states are experiencing significant revenue shortfalls that have jeopardized their ability to fund ongoing Medicaid program expenditures in this environment of increased Medicaid mandates and growing competition for diminishing state resources. There is also a declining tolerance among the electorate for increased taxes, although several states have raised taxes but still face revenue shortfalls. State balanced budget laws also cannot be ignored.

While Congress has codified state ability to use provider specific taxes as a source of state Medicaid match, it appears HCFA still intends to limit state prerogative to use donations to fund the program. As independent governments, states must have the flexibility to utilize new funding sources and to have the authority to allocate those new monies as needed. To attempt to ban certain funding mechanisms is an infringement of the freedom of a state to develop funding sources as the legislature and governor deem appropriate.

The Administration's position is also inconsistent. It has proposed to fund its share of the Medicaid survey and certification costs through provider specific taxes on Medicaid facilities, but has attempted to deny the states a similar right. HCFA has charged that use of donated funds is "unfair." It must be noted however, that states have historically used provider specific taxes and donated funds to expand the program to populations not previously covered (most recently mandated expansions). States need, and continue to seek, clear statutory relief in this area.

In terms of the changes states would like to see in Medicaid this year, we would urge Congress to seriously consider state options that provide sufficient flexability for states to tailor their programs to specific local needs and budget considerations. An option to cover older children up to 185% of Federal poverty levels is one such proposal that would allow states to rationalize current children's eligibility in ways that make sense for the state using considerations such as reducing the administrative burden through simplified eligibility and budget constraints. We thank Senator Bentsen for including this option in S 4 There are also a series of changes needed in current law relating to eligibility that would improve client access and reduce administrative complexity. We would also urge serious consideration to reform the audit and disallowance process under Medicaid so that state and Federal focus could be redirected to some of the more pressing issues in the Medicaid program such as increased access and quality of care APWA has a variety of proposals we would be happy to share with you and your staff

Finally, we urge Congress to give serious consideration to reform of the health care financing system State human service administrators believe the system is in urgent need of reform that goes beyond incremental changes to the existing Medicaid program. The Association has produced two reports, *Access* and *Americans At Risk*, which address proposals to reform primary and long term care financing and coverage respectively

CHILD WELFARE

Mr. Chairman, I would like to commend you for your leadership on child welfare issues, particularly the recent introduction of S. 4, the Child Welfare and Preventive Services Act. The legislation's focus on prevention, coordination of services, and the provision of services before serious damage is done to children and families is an important shift from the way we have been doing business over the past decade. The expansion of Title IV-B to develop and expand innovative services and to provide support to substance abusing families is essential in order to move this direction. And, we are highly supportive of the provision to provide a 90 percent enhanced Federal match for the development and installation of automated reporting systems for foster care and adoption to comply with the mandatory reporting of data. States are anxious to begin implementation of these systems in order to get a better handle on what is happening in child welfare across the nation, but must have the commitment of Federal financial resources in order to get the reporting systems off the ground.

I would like to draw your attention to another issue, Mr. Chairman, that has been a continued source of frustration and tension between the states and the Federal Government—Title IV-E administrative costs. Over the years, there has been a consistent attempt to cap these costs because of their growth since the passage of P.L. 96-272. And now, in a new twist in a continuing saga, there is a proposal pending in the Administration's budget to preclude preplacement preventive services as reimbursable under the Title IV-E administrative cost category. It is ironic that one of the core protections established in P.L. 96-272, to provide preplacement preventive services to preclude the need for out of home placements, is no longer seen as important by the Administration. This proposal, in fact, moves in the opposite direc-

tion from what is needed to modify Titles IV-B and IV-E to focus on family preservation programs.

We once again urge your assistance in helping us maintain the integrity of this source of funding. We have testified before you on several occasions about the legitimacy of the growth in Title IV-E administrative costs. The 1987 HHS Inspector General's report is clear that states are not claiming Federal reimbursement for anything other than legitimate costs. As you are aware, the escalation in these costs is due to the time it took states to set up their systems to capture these costs; years in which there was confusion and inadequate information from HHS as to what expenses were reimbursable.

In fact, it is the states, not the Federal Government, who are investing in the lion's share of child welfare services across the country. An examination of Federal contributions for all child welfare services reveals that the Federal Government contributes about 42 percent of total funding today. Of this 42 percent, 4 percent comes from Title IV-B, 12 percent from Title IV-E, and 20 percent from other Federal sources; including Title XX. It is states and localities—not the Federal government—who are the major investors in child welfare services and are carrying out to the fullest extent possible both the spirit and intent of P.L. 96-272.

We are grateful, Mr. Chairman, for the inclusion of a provision in OBRA 90 that amended Title IV-E to specifically add child placement services as activities for which the states are entitled to receive administrative reimbursement. This provision sets straight the public record that foster care administration is more than just overhead A clear separation of these functions, however, is critical in order to erase the confusion that persists. We hope you will consider including a provision in S. 4 that isolates funding for different Title IV-E administrative costs—one for typical overhead and another for child placements services—and that the Federal government's share in paying for preplacement prevention activities will not be reduced.

CHILD SUPPORT ENFORCEMENT

The Administration's budget proposes to alter the formula for incentive payments and to increase program effectiveness. This proposal has two key aspects. The first part reduces the maximum incentive for cost effectiveness to S percent of AFDC and S percent of non-AFDC collections for the year but does not change the method for computing cost-effectiveness incentives.

The second part of the Administration's proposal provides new incentives based on performance in certain areas such as paternity or support obligations established. These incentives will provide up to 10 percent of the total amount of AFDC support collections for the year.

APWA believes that the current cost effectiveness formula is not an accurate indicator of program performance and we support establishing performance measures to calculate incentives to reflect the goal of increasing child support collections. Any proposal to modify the incentive formula however should be gradual, allowing adequate time for states to emphasize program priorities and adjust their automated systems to account for collections and costs consistent with a new formula. State human service administrators are concerned that these reductions in incentive payments for states come at a time when states are struggling to implement the new time frames and increased program standards established in the Family Support Act.

The second proposal in the Administration's budget would require a reinvestment of state incentive payments into programs that benefit children. Currently, incentive payments earned by states are returned to the state general fund and are not restricted in use. APWA opposes any restrictions on the use of the incentive monies returned to states.

The third proposal in the Administration's budget requires states to collect fees for service. The fees would be assessed to only non IV-D cases for filing an application and upon collection of support. The proposal will require states to charge an application fee of $25 for non-AFDC clients. Under this proposal states will have the option to absorb the fee or collect the fees from the custodial parent or recoup the fee from the absent parent and apply it to reimburse itself or the custodial parent.

The budget also proposes a $25 mandatory user fee for non-AFDC clients for cases in which a collection has been made. As in the application fee, the state may pay the fee or collect the fee from the absent parent to reimburse itself or the applicant. States also have the option to collect $50 for the application and user fees from non-AFDC clients whose incomes exceed 185 percent of the poverty level. Under these proposals, states can choose to absorb part or all of the fee. The fees absorbed by states will not be reimbursed under Federal matching provisions. If states assess the $50 fee to non-AFDC applicants whose income is not less than 185% of poverty,

some mechanism to verify assets and income would need to be implemented. APWA believes that the administrative costs to implement a system to collect user fees may exceed the savings attributed to such a proposal.

The fourth proposal in the administration's budget collects fees from states for use of the Federal Parent Locator Service (FPLS). States will be charged for submitting a case for location information; and fees will be charged to search for a social security number in those instances where one is not provided. As in the provisions to require fees for services, states can choose to charge the individual requesting the services or the state can choose to absorb the fee. In either case the state has the option to recover the fee from the absent parent and repay it to the applicant or apply it to offset state expenditures.

APWA believes that this is a particularly inappropriate time to propose such fees. States are working to meet new time frames and performance standards, including a provision requiring that all cases for which location is needed and previous attempts to locate have failed, be submitted to FPLS at least annually. The financial impact of this provision on states is significant. We believe no fee should be charged for these services as Federal regulations mandate that certain cases be referred to FPLS. At the very least, states should have ample opportunity to seek an appropriation to cover the added costs and for necessary programming changes to automated systems.

The fifth proposal in the administration's budget includes a proposal by the U.S. Department of Agriculture that would require food stamp households to cooperate with child support enforcement as a condition of eligibility. This year's proposal, unlike the previous proposal, provides states an option to require cooperation with child support enforcement through fiscal year 1993. Beginning in fiscal year 1994, cooperation with child support would be mandatory for all food stamp households, as is currently required of Medicaid and AFDC recipients.

APWA endorses efforts to improve child support collections. We however oppose this proposal for several reasons. First, child support enforcement agencies are overburdened by caseload increases and additional program requirements of the Family Support Act of 1988. We believe that the child support enforcement agencies need to be strengthened before adding additional cases that could reduce the overall effectiveness and efficiency of these programs

Second, this proposal does not provide any commensurate administrative reimbursement or incentives for either the IV-D or food stamp agency. We are concerned by a mandate to expand the non-AFDC client base of the IV-D program that does not also provide commensurate Federal financial incentives to the state IV-D programs While the administration is expecting modest food stamp savings, the budget does not reflect either the increased administrative costs to the child support enforcement or the net costs (or savings) to the food stamp program.

BLOCK GRANT OF CERTAIN PROGRAMS

The Administration proposes to convert into a block grant roughly $15 billion worth of current Federal programs. The specific concern of state agencies is that the administrative funds for welfare programs not be included in the list of programs to be made into block grants. The administrative funding associated with the AFDC, Medicaid and food stamp programs are an integral part of the entitlement nature of these programs. We do not believe that any portion of an entitlement program should be converted into a block grant. The administrative requirements on these programs increase and decrease based on factors such as caseload size (affected by changing economic trends), new requirements imposed by Federal statute or regulation, and capital expenditures invested to modernize and streamline program administration. Since administrative costs can be variable, we do not believe that a block grant approach would provide the funding flexibility needed to meet changing program demands.

CLOSING

Thank you, Mr. Chairman, for the opportunity to comment on various proposals that will be under consideration by your Committee. We will be glad to provide Committee members with more specific information on any of the topics discussed today if needed.

ATTACHMENT

HOW THE SURVEY AND CERTIFICATION USER FEE PROPOSAL MIGHT WORK

While APWA does not have all the specifics of the proposal, we believe that there is potential for cost-shifting from the Federal Government to the states. A simple scenario to explain how this might work follows. Our assumptions for the example include using a state Federal medical assistance matching rate of 50% and using the current enhanced Federal match rate of 90% for state survey and certification.

A Medicaid facility would be charged a fee that approximates the actual cost of the certification survey. For purposes of this example we assume a cost of $100. The facility would then charge this cost back to Medicaid as a facility administrative cost. Assuming a Federal program match of 50%, the state would then pay the facility a $50 reimbursement and the Federal Government would pay $50. Under this proposal the Federal Government has a net gain of $50 ($100 minus $50) whereas under current law there would be no net gain. Under current law, state would not make this payment, so the $50 is a new state cost.

On the other side, the state incurs the costs associated with conducting the survey, roughly $100. These costs are charged to Medicaid and are reimbursed at the current law enhanced rate of 90%. Therefore, the state pays out $10 and is reimbursed $90 by the Federal government.

Under the current law then, total state outlays are $10 for the survey of this Medicaid facility while total Federal outlays under current law are $90. If this fee proposal were enacted, it appears state costs would increase to $60 while Federal costs would drop to $40.

Please note that this is an oversimplified scenario that does not account for complexities such as the fact that a facility would probably charge to Medicaid a share of the survey fee proportionate to the number of Medicaid clients. The scenario also does not account for the nuance of facility cost reporting and Medicaid cost-center reimbursement methodology. This example is purposefully simplified to show the effect of the proposal. Accounting for other complexities this would not, we believe, change the outcome.

PREPARED STATEMENT OF LOUIS W. SULLIVAN

Mr. Chairman and Members of the Committee: Thank you for inviting me here today to discuss the priorities for the fiscal year for the Department of Health and Human Services. I look forward to working with you and the other members of Congress in forging a budget which meets the diverse needs of the American people.

A fundamental objective of our Department is strengthening the American family. Today, I would like to address some of the concerns of the American family, and some of the proposals in our budget that are directed to those concerns.

The family is the most important and vital institution in our society. That is where our future is shaped. That is where we learn the difference between right and wrong, the values of truth and justice, and what loyalty and fidelity mean.

I was recently reminded of the centrality of the family when, at the request of the President, I visited Africa to assess the catastrophic rates of illness and mortality for children on that vast continent. In many countries the family structure has been completely shattered by disease and despair. Until the family structure is reinforced and reinvigorated, the solutions to the problems facing that great continent will be elusive.

When I returned home, I told the President that we must do more to broaden our support for Africa. But, a reading of the morning papers reminds us that the problems of family dissolution, breakdown and disrepair afflict many Americans here in our own great land. And just as in Africa, the tragic victims of family dysfunction are the children.

In no country can government replace the family. Our job as public officials is to help ensure that an environment exists in which the family can flourish.

A primary purpose of our families is to raise the next generation—our children. I am particularly proud that the Administration's budget commits resources to programs that help provide children with a healthy start, and a head start on life. Some of these programs are not under this Committee's jurisdiction, but each of them is important in helping families provide a better future for their children.

GIVING CHILDREN A HEALTHY START

The care that is given before birth will shape that child's development. As a society, we must work to ensure that each child has a healthy start in life.

While the rate of infant mortality has declined modestly each year, I am outraged at the continuing, shockingly high level, particularly for our minority communities. For example, the infant mortality rate in the black community is more that twice that of whites. And the United States ranks higher than 23 countries in our infant mortality rate.

Last year we devoted more than $5 billion for infant and child health services and research. This is expected to increase to $5.5 billion in 1992. Within this total, the Department will target $171 million on communities where infant mortality is extremely high. This initiative will organize and develop community-oriented programs which will reduce barriers to appropriate prenatal and perinatal care for pregnant women and children, and reduce an unacceptably high level of infant mortality. Also the 1992 budget projects an additional $350 million to be spent on low-income pregnant women as a result of the recent Medicaid eligibility expansions.

HELPING FAMILIES HELP THEMSELVES

Unfortunately, far too many children start life at a disadvantage because their parents are caught in the cycle of dependency. Fortunately, though, we have forged a consensus—with this committee playing a major role—about what we need to do to fight dependency and move families toward self-sufficiency

Increasingly, it is being recognized that the true measure of our success is not how many people we can put on the welfare rolls, but rather how many people we can help move out from under the cloud of despair and dependency into the sunshine of financial and social independence

The new anti-poverty consensus is embodied in the Family Support Act. The Act and its provisions on the Job opportunities and Basic Skills Training Program (JOBS) were a watershed in our thinking about welfare and dependency. We recognized in the law that education, job training, work experience, child care and child support were all inter-related variables in our efforts to end welfare dependency. I am pleased to report that all states are now operating the JOBs program. We will spend $867 million to support current Aid to Families with Dependent Children (AFDC) recipients' efforts to participate in JOBS activities.

GIVING CHILDREN A HEAD START

Complementing the efforts of the JOBs program is Head Start, a program to which this Administration has demonstrated an unparalleled commitment. Although it is not under the jurisdiction of this committee, I believe that it is a model Federal program—a program that truly works.

We want to help create an environment where parents find that the JOBs program and Head Start are complementary services that make self-sufficiency possible. To that end, we have entered into an agreement with the national JOBs program to develop local "model partnerships" between Head Start and county welfare offices.

Our budget calls for an increase of $100 million for the Head Start program which will allow us to expand services to over 30,000 additional children, thus reaching a total of more than 633,000 children. This represents an increase of over 180,000 children since President Bush and I came into office. At the same time, efforts in 1992 will be devoted to assuring consolidation and improvement of the gains achieved over the past two years by properly managing the large infusion of funds for the program in 1990 and 1991.

KEEPING FAMILIES TOGETHER

As members of this Committee are acutely aware, the drug epidemic has had a devastating impact upon far too many families and children. State Welfare Service agencies, Foster Care, and Adoption Assistance programs assist dysfunctional families, and create homes for many of our Nation's children.

My first priority is to keep families together, which is why we are requesting an increase of $90 million for child welfare services. This new money will allow states to focus on preventive services to strengthen families and help children who are suffering as a result of parental substance abuse. Hopefully, with more home-based family services, we can prevent children from being placed in foster care. At the same time! we recognize that some children will need to enter foster care and we will continue to fully fund the maintenance payments for foster care families.

FINANCIAL SECURITY FOR OLDER AMERICANS

Any family, indeed any society, has a deep concern that its older citizens can live a life of economic and social dignity. One of my primary objectives as Secretary is to ensure the continuing fiscal integrity of Social Security and Medicare.

Social Security outlays, almost 55 percent of total Department spending, will increase by $19 billion over 1991 because of the 560,000 new beneficiaries and an estimated 5.2 percent cost-of-living adjustment. In all, the Social Security Administration's funds will provide cash benefits to over 42 million people in 1992.

We are proposing to modify the retirement earnings test for Social Security. The modification will provide an incentive for older Americans to continue the valuable contributions they make in the workplace without penalty to their monthly Social Security check.

IMPROVING HEALTH CARE ACCESS

An issue of concern to American families and to this Committee is improving our nation's health delivery system. As you are aware, the President asked me to lead a review of recommendations on the quality, accessibility and cost of our health care system and suggest ideas for improvement.

While it is important that we move to reform our health care system, experience dictates that we should not act rashly. I believe that an inestimable lesson of past efforts in health care reform is that it is critical to inform the American people about reform options and to build a consensus about what needs to be done.

One principle that we can agree on is that every American should have access to needed medical care. Logic and realism tell me that the answer to improved access has to lie in Federal, state and local programs targeted to the needs of the poor; in refined priorities, favoring access and delivery; in consensus development and coalition building around the effective integration of services and management of care; and in a growing partnership among citizens, taxpayers, providers, and payers. Hard decisions and compromises will be required from all.

Our budget proposals move in this direction. They do so in part by proposing to extend flexible resources to the states, in part by helping to fill current gaps, and in part by making a first move toward increased responsibility for the wealthy to pay their own way.

A moment on this latter point. Under current law, all taxpayers subsidize physician services under Medicare. These subsidies amount to 75 cents on the dollar for everyone over age 65 who voluntarily enrolls in Part B of Medicare. So regardless of their individual circumstances and income anyone enrolled only pays 25 cents for every dollar of Medicare premium. This seems neither sensible nor necessary, and certainly is not equitable to taxpayers.

We are proposing, therefore, that those Medicare beneficiaries whose adjusted gross incomes exceed $125 thousand for an individual and $150 thousand for a couple no longer be so greatly subsidized—that the subsidy be reduced from 75 percent to 25 percent. Those with very high income will have to pay more for Medicare. That is not unreasonable nor unfair. More importantly, it frees more public resources for uses where they are needed, namely for those who simply cannot pay for access to care.

Our Administration is clearly committed to improving access to care—for example our important infant mortality initiative. But while the Federal Government can help and has a real role to play, the problem cannot be solved simply by the Federal Government writing a check. We must find innovative solutions that combine the efforts of the public and private sectors.

PROMOTING A CULTURE OF CHARACTER

While I take a back seat to no one in recognizing that government must take a role in helping our families, I also strongly believe that as a society we must reinforce basic values—for values have consequences. I have spoken around the country about the need for a "culture of character."

By that I mean, individuals have responsibilities as well as rights. Americans must cultivate values like self-discipline, integrity, moderation and a commitment to serving others. We must reinvigorate and shore up institutions that teach and nurture values and principles of healthy behavior, especially the institutions of family and community. Regardless of how much money we spend on social programs, our safety net will be weak unless our moral fiber is strong.

I am particularly outraged about the carnage on the streets of many of our cities—with young people, in some cases *very* young people the victims. Often, they are murdered as the result of a drug deal gone bad or even over a coveted sports

jacket. It is ironic that some of our youth were safer in the midst of a battle in the sands of Kuwait than they are in the war that is raging on the streets of our cities.

We must not avert our eyes from this tragedy. Yes, we need social programs and tough law enforcement, but just as important, we need parents spending more time with their children, neighbors down the street concerned about what Johnny is doing and communities that care. We need, in short, to be more committed to our children's health and welfare.

As has been said, statecraft is soulcraft. The programs that we initiate will affect the character of our citizens. Therefore, we should promote self-sufficiency and resist dependency, empower families and communities rather than bureaucracies and exhort individuals to take responsibility for their behavior.

Head Start, the Family Support Act and the recently-passed child care legislation are but three examples that embody those principles. And our guiding principle should be that which I recited when I became a physician: "Primum, non nocere. First of all, do no harm."

Thank you again for the opportunity to address these important concerns. I look forward to our continuing work with the Members of this Committee to fashion a budget responsive to those most in need.

RESPONSES OF LOUIS W. SULLIVAN TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question. Reduction in Funding in Services to Medicare Beneficiaries.

I understand that Medicare currently receives over 30 million inquiries from beneficiaries and providers which must be answered in writing or over the phone.

Your budget proposes to cut funding for these services by approximately 60 percent, resulting in over 20 million individuals who will get no answers to their questions.

Who will assist these 20 million people? Where will they go to find out how the program has changed or what the current status is of their claims? Where will they turn for this information if the phone lines are not answered?

Answer. I share the Senator's concern over the shortfall in the Medicare contractor budget for fiscal year 1992. This unfortunate shortfall was necessitated by the tight limits placed on the domestic discretionary budget by last year's five-year budget agreement. Although funding is very limited, HCFA intends to respond to all written and walk-in inquiries and to as many telephone inquiries as possible. To help minimize the impact of the funding limitations on our ability to respond to inquiries, we are placing increased emphasis on the use of automated Audio Response Units to answer provider inquiries about subjects such as claims status and Medicare fees.

Our projected workload for fiscal year 1992 is 30.4 million inquiries. If contractors did not use the Audio Response Units, we would expect them to be able to process only 8.6 million of those requests. We estimate that increasing the use of Audio Response Units will enable contractors to handle a total of 14.7 million inquiries. We are also exploring other avenues for savings to lessen the impact of the budget shortfall on providers and beneficiaries.

There are several ways that beneficiaries can find out about changes in the Medicare program and about the current status of their claims. Contractors provide information to beneficiaries through the "Explanation of Medicare Benefits" (EOMB). A beneficiary receives an EOMB each time his or her provider renders services and the claim for those services is processed. The fiscal year 1992 budget includes funding for refinement of EOMBs. Other sources of information include the *Medicare Handbook* and advocacy group publications.

Question. Underfunding the Medicare Hearings Budget.

Why does the President's fiscal year 1992 budget request for the administration of Medicare deliberately underfund the dispute resolution process by 60 percent which, according to your own budget documents, will delay the resolution of 7 MILLION claims being appealed by beneficiaries and providers beyond the timeframe mandated by law?

Answer. We estimate that contractors will be able to resolve only 3.3 million appeals requests in fiscal year 1992, while 10.2 million appeals requests will be filed. These appeals will be handled on a first-in/first-out basis as rapidly as our funding and overall capacity permit. At the present time, we expect average appeals processing times to increase as follows:

Part A Reconsiderations: from 27 days to 277 days;
Part B Reviews: from 26 days to 276 days;
Part B Fair Hearings: from 81 days to 331 days.

Having a backlog of this magnitude is not acceptable. However, funds available for hearings and appeals are limited, and maintaining prompt claims processing and payment safeguard activities remain higher priorities. We are continuing to examine ways to streamline operations in order to reduce appeals processing times.

Question. Fiscal year 91 Funding and Physician Payment Reform.

During January, many members of Congress including myself became aware of a potential backlog in processing Medicare claims because of underfunding the fiscal year in 1991 administrative budget for Medicare. This concern was raised to OMB's attention and one week before the President submitted his fiscal year 92 budget, OMB released from the Medicare contingency fund $75 million to avoid the projected backlogs in the payment of Medicare claims during the remainder of fiscal year 91. What is the outlook for the rest of fiscal year 91? Will you be requesting the release of the remainder of the contingency fund ($58 million) before the end of the fiscal year in order to implement physician payment reform or for other purposes?

Answer. The $75 million in contingency funding has been released to the contractors. Of that total, $32.5 million has been earmarked for implementing OBRA 90 provisions and $42.5 million will be used for processing claims other than those arising from OBRA 90 provisions.

HCFA will not be requesting any additional funds from the contingency to implement physician payment reform. HCFA may, however, request additional money to administer the payment of benefits arising from Cosgrove v. Bowen, a lawsuit which resulted in HCFA's being required to retroactively pay some hospital-based physicians more money for Medicare services rendered in 1984-86.

Question. Secretary Sullivan, following the supreme Court decision on the *Zebley* case, HHS has issued new rules governing children's disability benefits. I hope that these new regulations will help ensure that every child who deserves benefits receives them. I know that your agency has announced plans to review previous denials of children's disability claims to determine if these children qualify under the new standards.

I am pleased to see efforts to expand disability benefits for children, but I am concerned about how to implement these changes—providing the staff and administrative funding for the work required. I know that the Administration is seeking funding in the supplemental appropriations bill and I understand that OMB plans to aid states with money from the contingency fund. But the task is overwhelming.

A letter I just received from the West Virginia State Board of Rehabilitation outlines serious and chronic problems with lack of funding and staff for the timely processing of disability claims. Officials in my state worry that overwhelming caseloads are hindering quality assurance on cases. My state alone estimates that it will need as many as 30 full time staff to handle the *Zebley* cases alone.

What financial resources and staffing do you honestly believe you need to adequately cover this enormous effort to review children's disability claims?

Answer. Senator, you are correct. The task of reviewing previous denials of children's disability claims to determine if the children qualify for disability benefits under the new rules is an enormous challenge. We have been planning for the implementation of the *Zebley* decision ever since the Supreme Court issued its decision. In addition to issuing the new rules which you mentioned, we have conducted extensive training of the adjudicators who will be reviewing the cases under the new rules.

We also submitted, and the President and Congress have approved, a supplemental appropriation request for fiscal year (FY) 1991 for $232 million, to remain available through September 30, 1993. This appropriation will fund the costs incurred by the Social Security Administration (SSA) for processing the workload resulting from the *Zebley* decision, that is, those childhood disability claims which were denied between January 1, 1980, and February 11, 1991. The supplemental appropriation requested was based on our projections of what that workload will be and the level of resources needed to process it.

The supplemental appropriation will fund approximately 1,800 Federal workyears through September 30, 1993. These workyears will provide SSA field and hearings offices with the additional staff and overtime resources needed to process the *Zebley* case workload.

The supplemental appropriation will also be used to provide funds needed by the State DDSs for the administrative expenses they incur in processing the *Zebley* workload (for example, the costs of hiring additional staff, providing overtime, and purchasing case-related medical evidence).

Question. In West Virginia, and I am sure across our country, backlogs on all disability claims are a constant concern. What measures will you be taking to promote timeliness on the processing of other disability claims while responding to the

Zebley cases? And finally, Mr. Secretary, do you have any long range plans on ways to improve the system in general to ensure timely processing and strong quality control?

Social Security Commissioner King and I certainly share your concern about the impact the increasing disability workloads will have on our service to the public. To deal with these concerns, we have undertaken a number of measures.

For the short range, we have:

- requested and received the release of fiscal year 1991 contingency reserve funds which will be used to expand the capacity of both SSA and the State DDSs to process more disability cases;
- expanded the role of some SSA components so that they can be used to assist the State DDSs by processing part of the DDS workloads; this will permit SSA to more quickly address DDS workload problems; and
- implemented procedures to expedite and assure the prompt processing of disability claims filed by individuals who are terminally ill.

For the long range, we are:

- developing pilot projects designed to improve the claims adjudicative process by providing for more extensive contact between the disability claimant and the decisionmaker;
- automating many of the repetitive manual and keying functions so that operating components can change their staffing mix to include more technical claims personnel and fewer clericals without significantly increasing their staffing levels;
- improving the quality of initial disability determinations by getting the claimant's treating physician more involved in the disability determination process; and
- increasing our emphasis on the training of adjudicative personnel and on providing specific training on each new and revised medical listing and regulatory change involving the disability evaluation criteria.

Question. The Department issued regulations in February that went into immediate effect. I understand that there is a 60-day comment period which ends on April 12, 1991. Following the comment period, your agency will be reviewing the materials and issuing final regulations some time next year.

Since these regulations published in February include major chances in the disability benefits for children, would you be willing to extend the comment period to allow groups more time to comment on the proposed regulations?

Answer. We are extending the comment period for the new childhood disability rules under the Supplemental Security Income program an additional 60 days, that is, to June 11, 1991. This should provide sufficient time for interested individuals and organizations to fully consider the new rules and to submit comments.

Question. As Chairman of the Children's Commission, I am pleased that the Finance Committee will be focusing on child welfare and foster care. I am proud to be a cosponsor of Senator Bentsen's strong initiative on this issue and am eager to work with him to help focus assistance on preventive care.

I appreciate that your agency is facing severe budget constraints, but I am concerned about the proposal to save money by limiting Federal matching payments to cover pre-placement services and administrative costs only for children ultimately placed in foster care.

Won't this action discourage States from taking on cases where preventive care and some intervention may enable the child to stay in their own home? Why should States be penalized and forced to absorb the costs of "successful" cases where children stay with their families rather than enter family foster care?

Answer. Our proposal would increase the ability of States to provide services to prevent the placement of children in foster care, through title IV-B. We have proposed that the amount of Federal funds available under title IV-B be increased by $90 million in fiscal year 1992. The types of services that might enable children to remain with their families, such as counseling and family crisis services, are not allowable under title IV-E. They are allowable and are a focus of our joint planning with the States under title IV-B.

Prepared Statement of Alfred T. "Skip" Wilkins, Jr.

Mr. Chairman and members of the committee: I am pleased to have this opportunity to discuss certain issues of great importance to persons with disabilities arising from the administration's proposed fiscal year 1992 Medicare budget.

My name is Skip Wilkins. An accident shortly after high school graduation marked the beginning of my life as a quadriplegic. Since that time, I obtained my college degree in psychology and became an author, lecturer and businessman. I am proud of my personal achievements, but I most enjoy having the opportunity to help other individuals with disabilities overcome their physical limitations and recognize their capabilities.

The National Association of Medical Equipment Suppliers (NAMES) which I am proud to represent before the committee, is a non-profit association representing 2,050 home medical equipment (HME) suppliers operating in over 4,000 facilities nationwide. Based upon individual patient needs and according to physician prescription, NAMES members furnish a wide variety of equipment, supplies and services for home use. these items may range from traditional medical equipment items such as hospital beds. to highly sophisticated services such as parenteral and enteral nutrition, customized wheelchairs, life support systems and technologically advanced equipment which is custom-designed for the needs of rehabilitation patients. Names is a participant in the coalition to support quality home care services.

This statement addresses two primary topics: the role HME plays in improving the quality of life for millions of Medicare beneficiaries; and the impact that recent budgetary reductions and proposed additional cuts may have on the ability of the elderly and people with disabilities to have easy access to high quality equipment and services in the future.

I cannot underscore enough the importance to people who have limited physical mobility of continued access to quality equipment that empowers them to better control their own lives. Consider for a moment the importance of having an appropriate wheelchair to accommodate a specific disability. Persons with severe disabilities do not ordinarily select wheelchairs from a range of mass-produced models, as if they were selecting clothing in a department store.

People with disabilities rely completely on experienced HME suppliers to recommend and fit a wheelchair that will best meet their own personal needs. To do otherwise could easily result in an incorrect "fit," which then could lead to severe short and long-term health problems. Such a person may not be aware of problems with posture immediately, due to defects in wheelchair seating and positioning. If uncorrected, such problems intensify over time and evolve into more serious—sometimes life-threatening—conditions.

I focus on the wheelchair as but one example of HME, since wheelchair sports competition is a major enjoyment for me. I have competed both nationally and internationally in such events.

The disability community is by no means the only segment of the population that relies so completely on the HME industry to meet very specific needs. Many ill or elderly Medicare beneficiaries now can be cared for in their own homes, thanks to HME. Home health care usually can be provided for far less money than similar care provided in an institution. In fact, a soon-to-be-released study conducted by the well-respected health research firm Lewin/ICF adds further credence to the fact that caring for people at home in almost every instance is the least costly method for the Federal Government to provide needed health care.

While this argument is undeniably persuasive in light of an ever-burgeoning Federal deficit, I submit that, even if home care in all cases was not found to be fiscally conservative, we should not lose sight of the social gain achieved by allowing people to live, recuperate and continue their lives with families at home.

Despite the critical role which home care plays in the entire health care spectrum, HME has been singled out for budgetary reductions over the last few years to such a severe level that the unforeseen effect may well be the dismantling of the entire HME industry.

HME is a small segment of the health care industry, accounting for only *2* percent of the overall Medicare budget. Yet over *7* percent of Medicare cuts in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90)—some $215 million—came from HME. This $215 million in cuts, which was in addition to the $80 million in HME payment reductions in 1989, represents over *3* times the industry's proportional share of reductions.

Significantly, over a five year period, the effects of OBRA '90 will be to reduce outlays for HME by *$2.2* billion, an amount that exceeds expenditures for HME for the *entire* fiscal year 1990. (See attachment enclosed with this statement.)

In its FY 1992 budget, the administration is proposing yet another series of drastic budget cuts that directly affect the HME industry. These proposed cuts, totaling $45 million for FY 1992 alone, would come from the following areas:

- An additional five percent reduction in oxygen reimbursement,

- A national cap on reimbursement for HME, including orthotics and prosthetics, set at the national median, and
- A reduction in payment for enteral and parenteral nutrients.

I urge you, in the strongest terms possible, to oppose these proposals in their entirety.

In OBRA '87, HME payment reforms were designed to effect a five percent reduction in oxygen expenditures. In many States, however, actual reductions approached 15-20 percent, in large part because the Health Care Financing Administration (HCFA) data base used to calculate reimbursement rates for oxygen supplies and equipment included patients who would not be eligible for such products under today's more stringent coverage rules. Thus, oxygen reimbursement already is dangerously low in many States. An additional proposed five percent reduction, as provided in the administration's FY 1992 budget, implies in real terms total oxygen reductions of well over 35 percent since OBRA '87 was enacted. Access by beneficiaries to needed oxygen services already has been limited in certain markets across the country; additional reductions at this time would be devastating.

In addition, setting a single national payment rate at the median for all HME items would make it extremely difficult, if not impossible, for HME suppliers to continue to provide this equipment now in the first year of a three-year process of shifting away from regional reimbursement rates toward a national fee schedule calculated at the national weighted mean. The data base used for these calculations also is severely flawed. It is for this very reason that fees are calculated at the weighted mean, rather than the median, so as to the harmful effects of using a flawed methodology for budgetary calculations. From an administrative view, it is patently illogical to impose additional changes at this time by calculating the fee schedule at the median, as proposed by the administration.

In recognition of these problems, several Members of Congress have requested that the General Accounting Office (GAO) conduct a study to determine what types of geographic adjustments may be necessary for HME. Thus, it is an unnecessary administrative burden and counterproductive to the intent of Congress to impose additional changes at this time by calculating the fee schedule at the median for any item of HME, prosthetics and orthotics, or parental and enteral nutrition.

Access to needed equipment and services already has been limited in certain markets across the country. Preliminary figures obtained from some Medicare carriers show total reimbursement obtained from some Medicare carriers show total reimbursement reductions for certain items of equipment range from 35-50 percent and more for this year. In some cases, this means that the Medicare-approved price for HME, when these reductions are implemented by HCFA, actually will be less than the acquisition costs for the equipment. In such cases, it is highly doubtful that HME suppliers will be able to continue to provide certain items of HME.

The cumulative effect of all budget reductions imposed in recent years only will continue to have an adverse impact on the very population this industry was originally instituted to serve—the sick, the elderly and people with disabilities. HME as a viable benefit under the Medicare Program cannot sustain further budget cuts, as proposed by the administration. More is at stake than the mere survival of an industry—Medicare beneficiaries may not be able to rely upon HME products and services in the future unless legislative relief is granted.

The vast majority of the HME industry provides a high level of quality equipment and services. HME companies which are NAMES members operate under strict standards of integrity and ethical business practices. The industry acknowledges, however, that there have been some instances of fraudulent and abusive practices.

In response, NAMES has developed several proposals which, if enacted into legislation, would move toward the mutual goals of Congress and the HME industry to strengthen the industry's ethical standards. NAMES will be pleased to discuss the details of its proposals at your convenience.

Finally, I would ask that you consider the integral role that HME plays in the home health care system in our country. This industry makes homecomings possible for so many people who still need a competent level of care after they are discharged from a hospital or other institution. The HME industry provides the level of service required to assist people with severe disabilities in leading productive lives in the mainstream of society.

As our Nation's elderly population increases and as further technological advances are made to assist people with disabilities to maximize their own unique potential, HME services should be preserved and expanded to meet these diverse needs. Congress should reject outright any further budget cuts to HME.

ATTACHMENT

Facts You Should Know About the Home Medical Equipment Industry

NAMES, headquartered in Alexandria, VA, is the national trade association representing a diversified membership of over 2000 home medical equipment (HME) suppliers with some 4,500 sites, over 300 home medical equipment manufacturers, and 39 state and regional associations. Its mission is to promote access to quality home medical equipment services as an integral part of our nation's health care system. NAMES also offers rehabilitation equipment suppliers and manufacturers the opportunity for interacting on behalf of the rehab community through its Rehab Section.

- Access to home care has been and will continue to be important in improving the efficiency of the health care system. Because of the availability of HME services, Medicare beneficiaries can now be cared for at home, where care is frequently far less expensive than in an institutional setting.
- The home medical equipment (HME) industry saves the Medicare program millions of dollars by facilitating patient discharges from costly acute care and other institutional facilities. Home care is more cost effective and provides patients with a better quality of life. Independent polls have proven over and over that patients prefer to be cared for in the home.
- Since 1984, HME items received only a single Consumer Price Index (CPI) update of 1.017 percent (January 1, 1987). Yet during the same time period, Gramm-Rudman reductions to HME items occurred (1986, 1988 and 1990); lowest charge levels (LCL) further reduced reimbursements (1987); and oxygen payment was reduced at least 15 percent (June 1, 1989).
- From 1984 to the present, costs of acquiring HME items and servicing at-home patients have continued to rise at or above the CPI for services. More complex cases, requiring even higher labor and service costs, have increased since DRGs created incentives for hospitals to discharge patients as early as possible.
- Third party administrative costs that include developing Medicare forms, processing payment claims, collecting accounts due and processing receivables on Medicare patients continue to rise. Improved efficiencies in other areas are continually offset by the difficulties of Medicare billing, invoice handling and inconsistent Medicare carriers, most of which are largely out of the control of HME companies.
- Three major HME national companies have been sold at distressed values in the last three years. Hundreds of smaller, privately-owned companies have gone out of business through bankruptcy or forced sales of assets. The adverse impact these closures will have on access to care for needy Medicare beneficiaries is yet to be seen.
- A study by respected health care researchers at Lewin/ICF documents that recent legislative and administrative changes have increased Medicare savings from HME far in excess of what Congress had anticipated. The study urges Congress to consider this fact in debating further changes which might jeopardize the HME.
- For FY 1990, the HME industry experienced additional reductions of $80 million in Medicare program expenditures, achieved by reducing reimbursement for seat-lift chairs and TENS by 15 percent; capping reimbursement for enteral equipment at 15 months; and eliminating the CPI update. The HME industry also experienced Gramm-Rudman reductions of 2.092 percent and then 1.42 percent from October 1, 1989 to September 30, 1990.
- For FY 1991, Congress reduced HME Medicare expenditures by an *additional* $215 million in direct cuts. While HME accounts for only 2 percent of the entire Medicare budget, current figures estimate that close to 10 percent of total Medicare cuts in 1991 are from HME. Payment cuts scheduled to take effect this year in one HME area alone (the "capped rental" category) may equal as much as 35-45 percent per item of equipment.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

Mr. Chairman and Members of the Committee we welcome the opportunity to present testimony on issues relating to health care coverage and costs. I am Russell Travis, M.D., a practicing neurosurgeon from Lexington, Kentucky. I speak for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent more than 3,200 neurosurgeons in the United States.

The American Association of Neurological Surgeons and the Congress of Neurological Suregons have become increasingly concerned about the huge gaps in access to health care and the misdirected programmatic priorities in our Medicaid program. This concern is in part influenced by the large number of citizens we treat who are coverage poor. The other factor is the larger societal problems associated with providing care to the uninsured and long term care patient. We have given these issues great thought and propose a public/private structure to address the problems.

We know designing such a plan will not be an easy task, nor one to which all parties to the debate will agree. It will require all the courage and acumen available to individual Members of Congress and the Administration. Our professional societies stand ready to be a resource in this effort. To that end, we offer the following three tiered approach to deal with the nation's current near crisis health care problem.

I. Expand the current job based and public coverage system for acute care access for the uninsured.

II. Reform the public Medicaid system.

III. Adopt a plan for long term care coverage.

I. UNINSURED COVERAGE

It is important to address this problem in an urgent manner. While for 85 percent of Americans the current combined job-based and public approach to health care coverage works, there are 32 million Americans without health care coverage. These numbers are increasing and adversely impacting the health care delivery system at all levels. One need only look at the data on the impact of uncompensated care on the intercity hospital, or suffer with the mother who needs care for a child, but lacks the resources to seek help with dignity to know we have a profound problem.

Our analysis of the make-up of the uninsured population provides us with valuable insights into possible solutions.

Small employers face increasingly formidable barriers in the private insurance market and large employers are decreasing benefits to limit costs.

Three fourths of America's uninsured are workers or their dependents.

Over two thirds of the working uninsured are employed by firms of 25 or fewer employees. Forty-four percent (6.2 million work in firms with less than ten employees. Traditionally, firms with less than ten employees account for 11 percent of the nations workforce. However, only 33 percent (1 in 3) of these firms provide health insurance. Six million workers are employed by firms of 25 to 100 employees without employer provided coverage.

Eleven percent of the uninsured are self-employed.

It seems therefore, that the best approach to insure coverage of the uninsured population would be to build upon the strengths of the existing system of job based and public coverage.

There needs to be a reassessment of the Federal tax treatment of health benefits. The current tax on health benefits in inequitable. We subsidize those in generally better paid positions by providing health benefits with no tax. We do not assist those in the most need of obtaining coverage. The small businesses, the self-em-

ployed, the farmer, and those working below 200 percent of the Federal poverty level are taxed for health benefits. Under the 1986 Tax Reform Act, small firms and the unincorporated self-employed can only deduct 25 percent temporarily. This will expire in October 1991. Incorporated businesses deduct the full costs and the employees receive the benefits as a subsidy.

• Unincorporated business and the self-employed should be allowed to deduct the cost of health insurance premiums.

• There should be a tax cap or limit on tax free insurance. The Congressional Budget Office estimated that if the government taxed annual family health insurance premiums in excess of $3,000 ($1,500 for singles), it would raise an average of $10 billion per year.

• In addition to changing the tax laws, specific insurance subsidies should be given to low income workers to encourage the purchase of coverage.

• Insurance reforms should be enacted to eliminate any disincentives to small employer provided coverage.

(a) Certain enrollment and rating practices in the small group market are impeding the availability of affordable benefits for small employers. These practices must be reformed by the state governments and/or the Federal Government.

(b) Develop a private market reinsurance system to assure that the small employer groups who present a high actuarial health risk might obtain a basic set of benefits from a private carrier at a rate, for example, no higher than 50 percent of the applicable average market premium.

(c) Establish state pools for uninsured individuals. The pool losses could be funded by general revenues so as to spread the costs.

(d) The Internal Revenue Code (ERISA) must be amended in order for states to require self insured companies to participate in state operated risk pools.

II. MEDICAID REFORM

The second approach we offer is reform of the public Medicaid system of medical coverage for the medically needy. There will always be a population of people that will not be able to get employer provided coverage. Their unemployment or income level will not permit purchase of insurance coverage. There is evidence that family income must be 250 percent of poverty before discretionary income is available to spend on healthcare.

Public programs fail to cover millions of those at poverty levels because of limited budgets and categorical restrictions for eligibility. For example, in 1987 Medicaid covered only 42 percent of those with incomes below the Federal poverty level. Even in families with incomes less than 25 percent of Federal poverty level, nearly one fourth were not covered by Medicaid or any other program.

There are two reasons low income people cannot get Medicaid: (1) asset tests, and (2) Medicaid is categorically determined and designed to cover the welfare population, not the medically needy.

In order to be eligible to be screened for the asset eligibility levels an applicant must fit one of the following categories: aged, blind, disabled (SSI), or eligible for aid to families with dependent children. If the categories are not met, the patient, no matter how destitute or ill, with few exceptions, is not eligible for Medicaid coverage.

Three out of four Medicaid recipients are welfare supported. Single people and childless couples are completely omitted, even if penniless. An intact two parent family, headed by a full time worker cannot be covered. In addition to categorical exclusions, tremendous variations in financial standards exist from state to state. Some states set Medicaid asset entry as low as 15 percent of Federal poverty level.

Over the years, the Federal Government and the various states have expanded Medicaid benefits to cover an increasing number of procedures, providers, and services. The number of mandates has increased dramatically to hair transplants, acupuncture, invitro fertilization, chiropractors, marriage counselors, professional herb prescribers (naturopaths), and podiatrists among others. There are now some 800 state laws mandating benefits, providers, and services.

• Medicaid needs to be separated from the welfare system. Medicaid needs to have a specified minimum benefit package to include primary care, preventive care, and physician and hospital care. There should be uniform, medically needy, asset determined standards. State mandated benefits add about 20 percent to health care costs and a standard benefit package should override added mandates.

• Long term care converge should be removed from Medicaid coverage. Because of the spend down provision in Medicaid, publicly supported long term care in the United States is financed primarily by the Medicaid program. In the U.S. today Medicare finances less than 2 percent of nursing home care, and private insurance

finances about 1 percent Medicaid finances more than 90 percent of the public financing of nursing home care.

In most states, 40 to 50 percent of the Medicaid budget is going for nursing home care which comprises as little as 4 percent of the eligible Medicaid population in some states. The elderly are competing with the under 65 uninsured adults and children for the available health care dollars. If Medicaid continues to provide long term care coverage 30 years from now on the same terms as today, its expenditures, measured as a net of general inflation, will be triple of what they are now. Add the number of increased medically needy to the system and Medicaid will eventually crumble from the incompatibility and weight of both components.

III. LONG TERM CARE

The third tier of needed medical care concerns a separate long term care program. To that end, we offer the following long term healthcare plan. We have reviewed many of the Congressional proposals, those of the non-profits, and the plans of the private sector. From our collective experience as neurosurgeons and the insights gained from the review of the literature, we believe *any* plan should include certain basic principles We suggest:

- There should be universal long term care for institutional and home coverage; therefore, no means test associated with coverage.
- Coverage should be available for those citizens under age 65 who meet eligibility requirements.
- There should be co-payments and deductibles as part of the financing formulas.
- The plan should be structured to include private, supplemental insurance reform.
- There should be no requirement of prior hospitalization for eligibility.
- There should be an administrative requirement for state management, utilization review, training, and certification of home health providers. The Federal Government would establish minimum standards.
- Existing community-based services should be supported and no disincentives should be created to mitigate against their involvement.

Long term care (LTC) represents the most important, uncovered catastrophic expense facing the elderly population of the United States. In the next two decades, the number of older people will grow rapidly and the number of the very elderly even faster. Because of greater longevity more of the population over 65 will be disabled.

Despite the billions of dollars spent on LTC in the U.S. the system is best known for its inadequacies. Public funded services are limited largely to acute and institutional care. There is a strong bias toward institutionalization and away from home care. In-home supportive care, crucial and most desired by the elderly, is costly and if available not reimbursed by Medicare or Medicaid.

Although LTC is identified with nursing homes, the predominant provider of LTC in the U.S. is the family. Families devote enormous time and resources to the care of disabled relatives. It is estimated that more than 27 million unpaid days of care are provided each week in the U.S. to the disabled elderly. However, in coming decades as the need for LTC rapidly escalates, the number of caregivers able and willing to provide services will decline.

A decrease in birth rates, an increase in divorce rates, and the rapidly expanding proportion of working women will make fewer people available to provide family caregiving services.

LTC is paid for either out-of-pocket by disabled, using family income and assets or by welfare. Out-of-pocket spending accounts for about 52 percent and Medicaid accounts for approximately 48 percent of all spending for nursing home care in the U.S.

At an average cost of $22,000 per year, the cost of an extended stay in a nursing home exceeds the financial resources of most elderly. Fifty-four percent of new nursing home admissions in 1986-90 depended on welfare for their care. The average person placed in a nursing home "spends down" to Medicaid eligibility in less than 13 weeks.

Establishing a viable LTC program will require significant fundamental changes in the current structure, financing and delivery of STC services. Hopefully, such measures can draw upon both the private and public sectors to share financial resources and responsibility for LTC.

Private Sector

LTC insurance should be developed to assist in financing LTC. As of December 1989, there were 1,500,000 people owning LTC insurance policies, with 118 companies offering LTC insurance either through group or individual plans.

In a recent report, the Health Insurance Association of American profiled the private insurance market as follows.

• The long term care market virtually began in 1985-86 when the number of companies in the marketplace doubled from previous years. Most of the growth in the past two years can be attributed to the entrance of Blue Cross and Blue Shield plans in the field.

About 87 percent of all long term care insurers sold individual or group association policies which covered 96 percent of 1.5 million persons who purchased a plan. The average purchase age for individual plans was 72 years while the average age for group association plans was 70 years.

• Only nine insurers had sold coverage to employer-sponsored groups, and only 3 percent of all persons were covered under such arrangements The number of employers offering this coverage, however, has grown exponentially from 2 in 1987 to 47 in 1989 and another 64 to become effective in 1990. The average age of active employees electing the coverage was 43 years

• Long term care riders to life insurance policies, which were first introduced in 1988, represented 13 percent of insurers and only 1 percent of persons covered at the end of 1989. The average age of persons purchasing the rider was 51 years. The average face value of life insurance policies purchased with this type of rider was $88,053, although it ranged from $31,560 to $100,000.

It is clear that private insurance companies cannot carry alone the burden of LTC financing As of 1988 only 1 percent of the elderly owned LTC policies. Few elderly are willing or able to buy policies because of expensive premiums. Premiums for low-option policies range from $318 to $728 per year; high-option policies range from $684 to $1,496 per year. Eligibility restrictions are prohibitive as insurance companies tend to screen out those who most need policies.

Studies repeatedly show that public as well as private insurance is needed. Private insurance should be developed to supplement LTC insurance, with co-payments, deductibles, and additional coverage items for those willing to pay. We are encouraged that a large number of states are adopting uniform LTC coverage provisions.

There has been reluctance on the part of the private sector to take the necessary risk in making financial options available for LTC. LTC insurance has been an open-ended risk It is unpredictable in regards to future inflation and payouts. The elderly may receive fixed indemnity payments in the future which are inadequate to cover LTC expenses due to inflation.

If a public insurance system set limits for co-payments and deductibles for nursing home stays and home health benefits, private insurance would have greater actuarial accuracy in setting premiums for LTC policies. This option should allow participation in a social/HMO, a continuing care retirement community (CCRC), or a private insurance program. The government would make a fixed payment that reflected the actuarially expected cost had the person stayed in the regular public program.

Public Sector

All LTC services should be incorporated into one public entitlement program that would be a part of Medicare. The Federal government should not continue to rely on a welfare program to finance LTC for only low income people. LTC for the elderly should be covered by Medicare and social private insurance, but not by a welfare program.

Everyone should contribute to the program and all who contribute are entitled to benefits. Comprehensive benefits for LTC under Medicare should include substantial cost-sharing and other controls on utilization. Cost sharing is appropriate since a large part of LTC is residential care, i.e., room and board the patient would be expected to pay anyway.

Using a social insurance program for LTC spreads the risk of catastrophic LTC expenses and the cost per person over the largest available population. Universal coverage, available to all who meet eligibility requirements, would prevent private insurance from underwriting only those with little risk The Federal government would not become the insurer for only the most costly.

Coverage

In reviewing various proposals for LTC it appears that certain health and supportive services are universally endorsed as essential. Central to these commonly endorsed coverage provisions is support services for the informal caregivers in the home and community. These include respite care for the home giver from the rigors of what is often 24 hours a day care. Periodic respite from the burden would help avoid costly institutionalization. Other accepted home health services are:

- homemaker services
- chore services—home and yard care
- occupational therapy—to develope or maintain reliance
- speech therapy
- physical therapy—to develop and restore function

Hospice care should be included because of potential savings over hospitalization. In addition, the hospice has demonstrated successfully that it offers a humane and caring environment for patients based on a volunteer model. It is essential that coverage include case management and re-assessment in order that the multiple needs of the patient are met and delivered in a cost-effective manner.

Financing Options

Our assumption is that the LTC program would be managed by Medicare; thus the current commitment of the Federal Government to Medicaid could be transferred to Medicare. Likewise, the current expenditures of Medicare for skilled care could be reallocated to the LTC fund.

- We propose a flat premium for every beneficiary with specified enrollment dates, e.g., age 50 and 65. We recommend a premium waiver for those individuals under 150 percent of the poverty level.
- Entitlement under the program would have a first year of coverage exclusion. The first 360 days of home care or nursing home coverage would be the responsibility of the beneficiary. Private insurance would provide reasonable rates and conditions to cover the first year costs or families would opt to do so themselves.
- Once the Federal Government entitlements become available (year two and all subsequent years), a co-payment of 30 percent would be required. Our rationale for the co-payment is based on the fact that the beneficiary would require room and board in any event.
- In the case of home care benefits, we would recommend a $500.00 deductible after the first year exclusionary period and every year thereafter.

Statement of the American Clinical Laboratory Association

A. Introduction

The American Clinical Laboratory Association ("ACLA"), an organization of federally regulated, independent clinical laboratories, appreciates this opportunity to comment on the Administration's Fiscal Year 1992 budget proposals for Medicare reimbursement of clinical laboratories.

The Administration's budget package proposes two major changes in Medicare laboratory reimbursement: (1) reinstatement of the 20 percent beneficiary copayment for laboratory services, a requirement that Congress eliminated in 1984 with the encouragement of the Department of Health and Human Services, and (2) a two-year freeze on the national limitation amounts, which act as a ceiling on Medicare laboratory reimbursement.

These proposals would, if enacted, significantly decrease Medicare reimbursement for laboratory services. Like many types of health care providers, however, laboratories suffered large Medicare payment reductions as a result of last year's budget bill, OBRA'90. Laboratories believed, though, that under the terms of that multiyear agreement, they would not be asked to bear further decreases for several years. By imposing new cuts, the Administration's latest proposals thus totally break faith with the substance and spirit of last year's budget agreement.

Furthermore, laboratories have experienced substantial reimbursement reductions in almost every one of the past seven years. In the laboratory industry, as in health care generally, quality requires the expenditure of substantial funds. Ensuring that beneficiaries continue to have adequate access to high-quality care costs money. At a time when laboratories face increasing costs stemming from changes in the health care environment, including major new regulatory requirements, the basic fact is that—laboratories cannot continue to absorb significant cuts in reim-

bursement without some effect on either quality or access to services. ACLA urges this Committee, therefore, to reject the Administration's proposals.

In this statement, ACLA first reviews the impact of recent laboratory reimbursement reductions. Against this background, ACLA then discusses its position on the Administration's FY'92 laboratory proposals.

B. THE CURRENT STATE OF LABORATORY REIMBURSEMENT

Since 1984, when Congress instituted the current laboratory fee schedule methodology, laboratories have suffered nine separate cuts in payment rates and two freezes in reimbursement levels. Last year, ACLA learned of an independent consulting firm survey of Medicare's laboratory reimbursement rates in the state of Oregon. This survey, which was not undertaken for ACLA or any of its members, found that for nine commonly ordered tests, 1990 Medicare reimbursement was only *45 percent* of what it had been in 1984, before the fee schedules went into effect. Moreover, if the effects of inflation, last year's additional payment cuts, and Gramm-Rudman-Hollings sequestration had been considered, this reduction would have been even greater.

The results of this survey are not unusual. ACLA members conducted a similar survey of laboratory reimbursement for 15 commonly ordered tests in 12 other states. The chart set forth below shows the average 1991 Medicare reimbursement as a percentage of what it was in 1984 before the adoption of the Medicare fee schedules.

State	Percent	State	Percent
California	60%	Minnesota	52%
Connecticut	63%	New Jersey	63%
Delaware	62%	New York	66%
Florida	63%	Ohio	60%
Illinois	59%	Texas	59%
Kansas	60%	Virginia	61%
Maine	64%	West Virginia	60%
Michigan	59%		

Thus, in New York, laboratories are paid approximately two-thirds of what they were paid in 1984 before the implementation of the fee schedules and, in Minnesota, they are paid only slightly more than half of that amount.

Obviously, few industries can suffer such cutbacks without some effect. However, the impact of these rollbacks is even greater because, during this same period, most items, and certainly most health care commodities and services, have increased in cost. For example, between 1984 and 1990, the Consumer Price Index ("CPI") rose by over 25 percent,[1] while the index for all medical services rose by over 52 percent.[2]

Moreover, laboratories have been faced with a number of specific increases in expenses over the last several years. The emergence of AIDS, for example, has caused laboratories to spend growing amounts on safety precautions to protect laboratory workers. New regulations to be issued by the Occupational Safety and Health Administration that require laboratories to take additional precautions to protect workers from AIDS and hepatitis B will add to those costs. Obviously, laboratories understand the necessity of protecting their workers; however, implementing these precautions is expensive.

In addition, comprehensive quality assurance regulations recently issued pursuant to Medicare and the Clinical Laboratory Improvement Act of 1967 ("CLIA'67"), which are now effective, require most independent clinical laboratories to spend increasing amounts on regulatory compliance. Other regulations implementing the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88"), which were proposed on May 21, 1990, will, when effective, require further expenditures. While ACLA has long supported across-the-board comprehensive quality assurance regulations, it must be acknowledged that compliance with such regulations is costly.

The laboratory industry is highly labor intensive, and wages for the skilled individuals necessary to conduct the testing have grown in the last few years. Between 1985 and 1990, the average earnings of an individual employed in the health care field increased by over 32 percent.[3] The number of individuals employed in the labo-

[1] United States Dept. of Commerce, *Statistical Abstract of the United States*, 1990, at 471; Bureau of Labor Statistics, U.S. Department of Labor, *CPI Detailed Report*, January 1991, at 150-51.

[2] *Id.*

[3] *Statistical Abstract of the United States*, 1990, at 404; Bureau of Labor Statistics, U.S. Department of Labor, Employment and Earnings, March 1991 at 101.

ratory industry during the same period rose by almost 68 percent.[4] Thus, laboratory labor costs have escalated dramatically over the past five years. In addition, it is expected that the salaries of cytotechnologists, which have risen over the past few years, will continue to rise as a result of the increased demand for these individuals that will result from the workload limitations imposed by new Federal regulations. Yet, in the face of these escalating cost burdens, laboratories have seen their actual Medicare reimbursement decreased year after year.[5]

Finally, when compared with other Medicare expenditures, testing performed by independent clinical laboratories is cost-effective. In 1988, the last year for which actual data is available, Medicare spent approximately $29.97 per Part B enrollee on independent laboratory-provided testing, an amount that is far lower than the average expenditure for other Part B services provided by physicians ($954.15) or hospital outpatient departments ($249.05).[6] Even more significant, however, is the economic and human savings that laboratory testing provides through early diagnosis and detection of disease, triggering prompt medical intervention, enhancing the likelihood of recovery, and reducing both the human suffering and the amounts that would have been spent had the disease continued undiscovered. This is the area in which lab testing really proves its cost-effectiveness!

C. THE ADMINISTRATION PROPOSAL

With this background, we now review the Administration's FY'92 budget proposal for Medicare reimbursement of clinical laboratories. As noted above, the Administration has offered two new proposals that would reduce laboratory reimbursement: reinstatement of laboratory coinsurance and a two-year freeze on the national limitation amounts. As also noted above, both of these proposals are inconsistent with last year's budget agreement. In fact, Congress specifically *rejected* reinstatement of the 20 percent beneficiary copayment during last year's budget deliberations. Therefore, ACLA urges the rejection of these proposals.

1. Reinstatement of Beneficiary Cost Sharing

The Administration is proposing to reintroduce the 20 percent beneficiary copayment requirement for laboratory testing reimbursed by Medicare. Further, although it does not say so explicitly, it appears that under the Administration's proposal beneficiaries would also have to meet the deductible requirement before any reimbursement was paid for laboratory testing. As noted above, not only did Congress delete these requirements in 1984, it rejected these same proposals during last year's budget negotiations.

Reinstatement of these beneficiary cost sharing provisions would obviously place a new burden on beneficiaries, in addition to the increased costs they bear as a result of last year's budget agreement. For this reason, most groups representing beneficiaries have opposed this proposal.

Reinstatement of the deductible and the 20 percent beneficiary coinsurance requirements would, however, also have a significant adverse effect on laboratories because of the high costs of billing for and collecting the beneficiary copayment amounts. In many instances, in fact, the cost of billing and collecting the copayment would exceed the revenue actually received by the laboratory. For example, one ACLA member estimates that the copayment on an average bill to a Medicare beneficiary would be less than $6; however, it would cost between $3 and $5 to produce and bill each coinsurance invoice. Moreover, ACLA members' pre-1984 experience with coinsurance suggests they would have to write off a large percentage—between 20 and 50 percent—of the coinsurance that they billed. Bad debt would likely be higher than under prior law because beneficiaries would probably object to this change at their expense or not understand that they were now liable for laboratory coinsurance. In sum, given the costs of billing and collecting for coinsurance and the probable high level of bad debt, ACLA estimates that reinstatement of coinsurance would actually result in at least a 15 percent reduction in the amounts laboratories received for services provided to Medicare beneficiaries.

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[4] *Statistical Abstract of the United States, 1990,* at 784; Bureau of Labor Statistics, U.S. Department of Labor, *Employment and Earnings*, March 1991 at 55.

[5] Significantly, reimbursement for most other services has *increased* somewhat since 1984.

[6] *See* Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1990 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* at 46. This statistic covers independent laboratories only; it does not include physicians' office or hospital outpatient laboratories. It should also be noted that the *Trustees Report* estimates that in 1990 independent laboratory expenditures will account for less than 3 percent of the money spent for each Part B enrollee. *Id.*

Finally, unlike the situation with other health care services, requiring beneficiaries to share in the cost of independent laboratory services will *not* affect utilization of these services. For other health care services, if patients are responsible for bearing a share of the cost of those services, they may decrease their utilization of those services, thereby ultimately saving the Medicare program money. This is not true for clinical laboratory services, however. As a general rule, Medicare-covered laboratory services can only be ordered by physicians. Thus, because physicians, not patients, decide whether to order laboratory services from independent laboratories, requiring patients to bear a share of the cost of these services will have no impact on utilization.

Last year, the Congressional Budget Office summarized the problems resulting from reinstatement of beneficiary coinsurance. It stated:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially, however, because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing. Hence, although a small part of the savings under this option might be the result of more prudent use of laboratory services, *most of the expected savings would reflect the transfer to enrollees of costs now paid by Medicare. Further, billing costs for some providers, such as independent laboratories, could be greatly increased because they would have to bill both Medicare and enrollees to collect their full fees.*

CBO, "Reducing the Deficit: Spending and Revenue Options," Feb. 14, 1990 (emphasis added). In conclusion, reinstatement of the deductible and copayment requirements would be unfair to beneficiaries, adversely affect laboratories, and have no impact on the utilization of services. It is bad budget policy and bad health policy, and therefore, should be rejected.

2. Freeze on National Limitation Amounts

The Administration also proposes to freeze the national limitation amounts for 1992 and 1993 rather than to increase them by the 2 percent update that was agreed to in OBRA'90. The limitation amounts were implemented in 1986, and act as a ceiling on the reimbursement that any laboratory can receive. While the limitation amounts were originally set at 115 percent of the per test fee schedule medians, these ceilings have been consistently reduced: to 100 percent in 1988; to 93 percent in 1989; and then again last year by OBRA'90, to 88 percent of the medians. As originally implemented, the national limitation amounts were to be increased annually by the amount of the increase in the CPI, to account for the cost of inflation. However, this year, as in years past, the amount of the update was reduced. As noted above, OBRA'90 required that the update be limited to 2 percent for 1991, 1992 and 1993, rather than increased by the full amount of the CPI. Thus, in recent years, both the limitation amounts and the updates have been substantially reduced.

The Administration, however, now proposes to freeze the national limitation amounts at current levels, rather than increase them by the 2 percent required by OBRA'90. This proposal would mean that laboratories currently paid at the national limitation amount rates would not receive even a limited update to offset the cost of inflation, which even the Administration projects will increase by over 4 percent in 1991 and 3.9 and 3.6 percent in 1992 and 1993, respectively. Obviously for these laboratories, this change would, in effect, constitute another lowering of reimbursement.

CONCLUSION

The Administration proposes two significant changes in laboratory reimbursement, both of which will affect the quality of services and the access to those services that beneficiaries currently enjoy. These new proposed cuts are especially unfair in view of last year's budget agreement under which laboratories suffered significant decreases in reimbursement. This unfairness is compounded by the fact that laboratory payments represent a small part of total Medicare outlays. Under the Administration's proposal, almost 60 percent of the Part B savings are the result of changes in laboratory reimbursement. Yet laboratories account for less than 10 percent of these expenditures. Clearly, these proposals place a disproportionate burden on laboratories.

For all reasons above, ACLA urges this Committee to reject these proposals.

STATEMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

The American Society of Anesthesiologists (ASA) is a national medical specialty society representing more than 25,000 physicians nationwide. The profession has a long history of significant achievements in improving the delivery and quality of anesthesia care. ASA's principles of quality assurance and patient safety are set forth in both "guidelines," and "standards" that have been developed and approved by the Society since 1968.

The Institute of Medicine (IOM) defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional judgment. "This emphasis on positive outcomes is shared by ASA in its development of standards of care.

Despite great advances in anesthesia care over the decades, the specialty remains an inherently dangerous one which requires a high degree of medical skill and continuous attention to the needs of the patient. As ASA developed standards of care, emphasis was placed on improving patient safety, thereby reducing the number of adverse outcomes.

ASA addresses quality of anesthesia care in a number of written public statements, approved by its House of Delegates, including: Basic Standards for Preanesthesia Care; Standards for Intra-Operative Monitoring; Standards for Postanesthesia Care; Standards for Conduction of Anesthesia in Obstetrics; Guidelines for Ambulatory Surgical Facilities; Guidelines for Critical Care in Anesthesiology; Guidelines for Delegation of Technical Anesthesia Functions to Non-Physician personnel; Guidelines for the Ethical Practice of Anesthesiology; Guidelines for Patient Care in Anesthesiology; Suggestions for a Record of Anesthesia to Facilitate Patient Care Review; and the Anesthesia Care Team. (A complete list of guidelines, standards and statements is attached).

IMPACT OF STANDARDS

Physician participation and acceptance of the guidelines and standards were critical to the overall success of the development efforts. Because ASA standards were developed with maximum participation from the Society's membership and had specific mechanisms for dissemination and revisions, there was widespread acceptance of these standards of care.

ASA has seen the most positive results from its Standards for Basic Intra-Operative Monitoring. In addition to improved patient outcomes, use of these standards of care are resulting in reductions in medical malpractice premiums for anesthesiologists nationwide.

Massachusetts was the first state to recognize the significance of the ASA intraoperative monitoring standards. In 1987, the Massachusetts Insurance Commissioner agreed to discount liability insurance premiums in return for an agreement from the anesthesiologists to participate in risk management activities. Anesthesiologists in the state were required to follow the ASA standards for basic intra-operative monitoring and to use pulse oximetry and capnography where appropriate.

The Joint Underwriting Association (JUA) reviewed the impact of these risk management activities and found significant declines in the number of claims for hypoxic injury. Between 1987 and 1990, the number of these injuries was reduced from an average of six per year to one per year.

WAYS TO IMPROVE STANDARDS

The ASA believes there are several ways to further improve the standard of care and improve quality. The first is to establish more uniform methods of recording events during the administration of anesthesia. Uniform data input and collection would help identify low frequency adverse events and help link the effectiveness of existing standards to improved outcomes. Also, the establishment of a national data collection process that shows the ratio of adverse events to the number of anesthetics administered could improve current development, assessment and/or revision of standards. Standard setting and the collection of data on outcomes can improve the credentialing and certification of practitioners and assist in the development of educational programs.

As the medical community, including ASA, pursues standards and practice parameters, the analysis should be refined in order to separate the influencing factors of preexisting patient disease and the complexity of the surgery from raw outcome data.

ASA supports the IOM recommendation that quality assurance efforts focus on overall patterns of care and less on utilization and cost control.

CONCLUSION

The ASA believes that anesthesia care available in the United States is the best in the world. Continued improvements in the delivery of safe, efficacious, and cost-effective care will require a better partnership between regulators and physicians in quality assurance activities. Reforms in the existing Medicare peer review and quality assurance programs would do more for the entire system if there was less emphasis on case-by-case cost containment and greater efforts on physician, hospital and patient education.

ASA Guidelines, Standards and Statements

Statement	Originally Approved	Last Amended	Description
Ambulatory Surgical Facilities, Guidelines for	1973	1988	The 1972 House of Delegates directed the President to initiate a study of ambulatory facilities and their relationship to anesthesiologists.
Anesthesia Care, Documentation of	1977	1988	Developed by the Committee on Peer Review to help identify notations associated with three specific periods: pre-operative, intra-operative, and post-operative.
Critical Care in Anesthesiology, Guidelines for	1974	1986	The Committee on Acute Medicine believes that this document will provide considerable assistance to ASA members who desire to become involved in critical care as part of their anesthesiologic practice.
Delegation of Technical Anesthesia to Non-Physician Personnel, Guidelines for	1977	1984	The ASA Committee on Peer Review prepared guidelines for the delineation of anesthesia functions for non-physician personnel.
Delineation of Clinical Privileges in Anesthesiology, Guidelines for	1975	1989	As instructed by the 1974 House of Delegates, the Committee on Peer review developed the delineation of privileges for anesthesiologists and other members of the anesthesia health care team.
Ethical Practice of Anesthesiology, Guidelines for the	1967	1987	The Committee on Professional Relations developed guidelines as an expression of the opinion of ASA as to the minimum standards for the establishment and operation of departments of anesthesiology by members of the American Society of Anesthesiologists.

Statement	Originally Approved	Last Amended	Description
Invasive Monitoring in Anesthesiology, Statement on	1984	—	The Committee on Anesthesia Care Team responded to a need expressed by the ASA membership for an attitude about procedures commonly performed by anesthesiologists but occasionally delegated to, or utilized by, non-physicians.
Minimally Acceptable Program of any Continuing Education Requirement, Guidelines for a	1972	1989	At the instruction of the 1971 House of Delegates, the Ad Hoc Committee on Program for Required Continuing Education developed guidelines to represent the Society's minimum standards for an acceptable program for required continuing education.
Patient Care in Anesthesiology, Guidelines for	1967	1985	The ASA Ad Hoc Committee on Analysis of the Patient Care Report developed "Patient Care in Anesthesiology" which addresses the responsibility of anesthesiologists to provide a high standard of preoperative and postoperative care for their patients.
Regional Anesthesia, Statement on	1983	—	There was strong agreement from the Committee on Anesthesia Care Team that ASA develop a position on the performance of regional anesthesia by non-physicians.
Respiratory Therapy Licensure, Statement Regarding	1981	1985	In response to a request by the American Association of Respiratory Therapists, the ASA Committee on Respiratory Therapy developed a statement regarding Respiratory Therapy licensure.
Routine Preoperative Laboratory and Diagnostic Screening, Statement on	1987	—	Represents the deliberations of the Committee on Standards of Care after a careful review of modern references on the role of screening tests in the evaluation of the patient.

Statement	Originally Approved	Last Amended	Description
The Anesthesia Care Team	1982	1987	The Committee on Anesthesia Care Team developed a statement regarding what an anesthesia care team is, what it is supposed to do, and why the concept has worth.
The Organization of An Anesthesia Department	1982	1988	At the request of the ASA President, the Committee on Peer Review developed a document which, by bringing together the various policies, guidelines and suggestions already approved by the ASA House of Delegates, provided guidance to anyone needing this information for structuring an anesthesia department.
Basic Standards for Preanesthesia Care	1987	---	
Standards for Intra-Operative Monitoring	1986	1990	
Standards for Post-anesthesia Care	1988	1990	
Standards for Conduction Anesthesia in Obstetrics	1988	1990	This document has been downgraded to a Guideline and shortly will also undergo revision.

Statement of the American Society of Internal Medicine

INTRODUCTION

On the behalf of America's specialists in adult medical care, the American Society of Internal Medicine (ASIM) is pleased to present the views of internists nationwide on the President's proposed fiscal year 1992 budget. It is our belief that the budget cuts that already have been enacted by Congress are placing access to primary care services, particularly in rural areas, at risk. Unless the trend toward enacting more and more cuts in Medicare is stopped now, we believe that in a few years hence it will not only be rural areas, but access to primary care services nationwide that will be at risk.

Medicare cuts are particularly important to our members, since **internists see more Medicare patients on a weekly basis than any other specialty.** Data from the AMA socioeconomic monitoring service show that in 1987 general internists had more total visits with Medicare patients than any other specialty, with the possible exception of ophthalmology. The average for general internists was 58.6 visits per week, compared to an average of 38.6 for all physicians and 58.9 for ophthalmology. The median number of visits for general internists was 54 visits per week, compared to 30 for all physicians and 50 for ophthalmology. The highest number of Medicare visits was for the internal medicine subspecialty of cardiology, with a mean of 63.2 visits per week and a median of 57 visits per week.

That is why the views of the members of the American Society of Internal Medicine are especially relevant to the Finance Committee's consideration of the President's budget for Medicare. They are the ones who provide day-to-day medical care to Medicare beneficiaries. They are the ones who provide specialty care, such as treatment of cardiovascular disease, to patients who are enrolled in Medicare. They are the ones who see first-hand how budget cuts affect that care. They are the ones whose patients are most affected by the decisions made in Washington on the Medicare budget.

The demographic composition of ASIM's membership, and our governing structure, makes it possible for us to reliably and confidently report to you the views of internists nationwide. ASIM's membership of 25,000 internists correlates well with the overall demographic composition of internal medicine as a whole. We do have a larger proportion of office-based internists in their prime practice years than for all of internal medicine, i.e. ASIM's membership is weighted more towards those internists who are primarily responsible for taking care of Medicare patients than internists in teaching, research, administration and non-patient care activities.

Specifically, our membership consists of a larger proportion of individuals in the prime practice years of ages 35-54 than internists at large: 45.6 percent of ASIM's members are between the ages of 35-44, compared to 37.5 percent for all internists; 28 percent of ASIM members are between the ages of 45-54, compared to 21 percent for all internists. More of ASIM members are office-based than is the case for all internists: 85% of ASIM members are office-based compared to 77 percent for all internists. Preliminary but incomplete data suggest that our membership is fairly evenly split between solo (35%) and group (32%) practices, with the remainder in "other" categories. More than 73 percent of ASIM members are board certified in internal medicine, and 75 percent in a subspecialty, a larger proportion than the 65 percent of all self-designated internists who are board certified. The specialty/subspecialty composition of ASIM roughly parallels that for the specialty nationwide.

By virtue of the fact that ASIM has more members who are office-based and in the prime practice years than for the specialty as a whole, we are uniquely able to speak for those physicians who see Medicare patients more often than anyone else. Moreover, ASIM's representative governing structure assures that we represent our members' concerns. *All* ASIM policy, without exception, is democratically-determined by a House of Delegates that is elected by members of our state and subspecialty component organizations. ASIM's board of trustees, which has fiduciary and policy responsibilities between meetings of the House, is elected by the House of Delegates and must report all of its actions to the House for concurrence or modification. Since ASIM is a federation of state societies of internal medicine, and subspecialty societies, we are able to speak with authority on state-level perspectives as well as the views of both general and subspecialty internists.

We present this information to you because there is a critical need for national health care policies to take into account what is happening in the real world of patient care. The views we are presenting today in this statement provide the committee with that perspective. ASIM knows what practicing internists think about the Medicare program and the proposed budget. We know how they believe it will affect their patients. And since they are the ones who see Medicare patients more often

than anyone else, what they think must be taken into consideration as the committee decides its actions on the Medicare budget.

PUTTING PRIMARY CARE AT RISK

The President's proposal for more deep cuts in the Medicare program must be considered in the context of the damage that has been done to physician payment reform—and the credibility of the Medicare program—due to budget cuts in prior years.

Last year, ASIM advised the Finance Committee of our deep concern that budget cuts were eroding the promise of physician payment reform. We spoke of the growing sense among practicing internists that physician payment reform would not bring about the promised gains in payments for undervalued evaluation and management (E/M) services, particularly those provided by primary care internists. We cautioned that budget cuts, even if directed at overpriced procedures, would lower the base for determining the "budget neutral" conversion factor for the new fee schedule, warning that "this would reduce or eliminate any gains in Medicare payments for undervalued services under the new RBRVS fee schedule." We talked about the growing evidence that physicians were having more and more difficulty reconciling their strong commitment to their patients with budget-driven policies that intentionally or not undermine that commitment. Finally, we cautioned that if internists end up feeling betrayed by physician payment reform, the trend toward fewer physicians going into primary care services, and more and more physicians limiting their availability to new Medicare patients, would be further exacerbated.

Some may have thought that our concerns were overstated, and that this was just a case of another interest group that would lose out from budget cuts "crying wolf." But the unfortunate truth is that ASIM was right in warning that further budget cuts would seriously compromise the gains promised for undervalued evaluation and management services.

According to the Physician Payment Review Commissions 1991 report to Congress, the provisions of OBRA 88, OBRA 89, and OBRA 90 "have had the effect of reducing fees by 15 percent in real (inflation-adjusted) terms. Thus, while relative payment for E/M services will increase by 29 percent, the real increase will be about 10 percent since 1988. This increase could be even smaller by 1996 as a result of how the budget neutrality provision of OBRA 89 was drafted." The PPRC reports that the 15% reduction in fees due to the budget cuts was roughly equal to inflation from 1988-1991, meaning that there will have been no real increase in E/M payments since 1988. Depending on volume assumptions and whether or not any correction is made in the budget neutrality provisions of OBRA 90, the PPRC reports that the real increase for E/M services may be negligible at best.

There is little question that the RBRVS itself will do what it was intended to do: enhance equity be distributing more of the available dollars to undervalued E/M services. Those services will be paid 25-30% more than would have been the case without the RBRVS. But when the loss of buying power due to inflation is taken account, it is clear that the concerns ASIM expressed last year were in no way exaggerated: **the cuts in the Medicare program already enacted by Congress will have the result of reducing any real (after-inflation) gains for E/M services to virtually nothing, even though those services would have been far worse off without the RBRVS.** The fact that they would have been even worse off without the RBRVS will be small comfort to physicians and their patients who were counting on physician payment reform to make things right.

Despite the popular view that physicians can readily afford cuts in their Medicare fees, the reality is that for many primary care physicians, particularly in rural areas, the impact of the budget cuts will be devastating. Those physicians, patients, and communities that were hoping that physician payment reform would make primary care practice in rural areas more feasible and financially attractive will soon discover that those hopes have been dashed by the budget cuts.

Anyone who doubts the crisis in access to rural medical care need only review a recent report from the Center on Budget and Policy Priorities titled *Limited Access: Health Care for the Rural Poor*. According to the report, primary care physicians account for the majority of all physicians who provide private patient care in rural areas. Nevertheless, the supply of primary care physicians in rural areas is declining. Previous Federal policies designed to increase the viability of rural primary care practice have largely been ineffective.

There are many factors other than Medicare and Medicaid reimbursement that have contributed to poor access to care in rural communities. There is no question, however, that low levels of payment under Medicaid are a critical factor. Medicare fees, although historically more generous than Medicaid, also are acting as a strong

disincentive for physicians to practice in rural communities. This is especially true since rural areas typically have more older patients on Medicare than urban communities. In fact, it was the concern over low Medicare fees for primary care services in rural areas that was one of the major rationales behind enactment of physician payment reform in 1989. Now, Congress is allowing the one policy that could do more than anything else to reduce the drain on the availability of primary care physicians in rural areas to be eviscerated by budget cuts.

Statistics tell only part of the story. Listen to what some rural internists had to say to ASIM after contemplating the likely impact of the OBRA 90 prohibition on payments for EKG interpretation and other budget cuts:

> *An internist from Helena, Arkansas wrote:* "The financial impact of this law on my office will be significant, and coupled with the entire package of Medicare cutbacks, it will become economically unfeasible to tend to Medicare patients."
>
> *An internist from Livingston, Montana wrote:* "The last and looming more clear option is to stop seeing Medicare patients at all. This is an undesirable option, but one which is becoming more plausible since the current reimbursement in the State of Montana for Medicare services is so poor that it barely covers costs."
>
> *An internist in Raton, New Mexico wrote:* "I practice in a rural community of 8,000 people and the nearest referral center is over 105 miles away in Pueblo, CO. It is said that costs for rural practitioners are lower than in the big city, but I don't think that is true. It is very hard to recruit physicians to come here because we have so few big city amenities, the call time is longer and most carriers pay us less than they pay MDs who practice in the city. The financial effects of this (the EKG prohibition) will simply aggravate our problems here."
>
> *An internist in Port Clinton, OH wrote:* As a further impact on my own practice, I have also made the decision to cease the practice of medicine as soon as I can financially do this, although my health at the present time is excellent and I certainly could practice for many more years. The hassles of the practice of medicine so far outweigh the current rewards, that I am already planning for an early retirement. In addition to this, I have actively discouraged many young people from the practice of medicine and specifically from the practice of internal medicine."
>
> *An internist in Mill Hall, PA wrote:* "This will certainly be disruptive to good patient care and cancel out any gains we are gaining through the RBRVS fee schedule. This will also make it impossible to recruit further people into primary care and particularly into rural primary care where there is a great need and a very limited profit margin already in place at this point."
>
> *An internist from Goshen, Indiana wrote:* "Goshen has only two general internists, plus one temporary locum tenens internist, although the number of adult and geriatric patients in this area would easily support 4 or 5 full-time internists. I myself have been too busy to accept new patients for the past three years. We have so far had very little luck in recruiting internists to locate here, largely due to disturbingly low rates of medical school graduates entering the specialty. I can't really blame them—who wants to work long, late and irregular hours and be on call for less reimbursement than the subspecialists and surgeons receive? But Congress and Medicare now seem to be bent on a move which will make the practice of internal medicine even less palatable than it already is. It makes me wonder how much longer I and my colleagues can put up with it all, and I'm not sure how long Goshen General Hospital can remain afloat without internists."
>
> *An internist in New Bern, North Carolina wrote:* "I am one of only two physicians in our town who see oncology (cancer) patients. The other one is likewise considering a cut in her practice. There comes a point when the risk, in terms of liability, exposure and time commitment that is necessary to do the job right, is overwhelming compared to Medicare payment, and it is economic suicide to continue."

ASIM has dozens of more reports from rural physicians who say the same thing: low Medicare fees, ill-considered budget cuts (such as last year's prohibition on Medicare payments for interpretation of most EKGs), and the hassle factor are forcing them out of practice, are making it difficult to attract new physicians, and is causing many of them to limit their availability to Medicare patients. They had been counting on physician payment reform to improve things. But they will soon discover that actual improvements in fees will be marginal, due to budget cuts already

enacted by Congress. As a consequence, the growing crisis in rural primary care will only worsen.

It is not just rural primary care that is at risk. Access to primary care services in general is being placed at risk due to the budget cuts. Hundreds of physicians who practice in metropolitan areas have also written and called ASIM to explain that low fees, the hassle factor, and budget-driven payment restrictions are forcing them to limit their availability to new Medicare patients; to change their practice patterns in undesirable ways in order to make ends meet (such as seeing more patients per hour and spending less time with each one); to change careers or retire early. Of even greater concern is the fact that fewer and fewer physicians are choosing to go into the primary care specialties of internal medicine and family practice.

For the fourth consecutive year, fewer medical school graduates chose to go into internal medicine and family practice residency programs than the number of positions available. If this trend continues, it is likely that there will be an insufficient number of physicians going into primary care to meet the needs of America's aging population. Those who do go into primary care are likely to make choices to limit their financial risk, such as by practicing in more highly compensated areas, restricting the number of Medicare patients that they will see, or adopting a style of practice that substitutes high volume, high technology medicine for time-consuming personal care.

Opinion polls of the attitudes of physicians-in-training strongly support the conclusion that the perceived economic precariousness of primary care, particularly when compared with more financially rewarding specialties, combined with concerns over government intrusion, the hassle factor, and the disillusionment with primary care frequently expressed by established role model physicians, are turning young physicians away from primary care. Such concerns go well beyond the Medicare program. But since internists are the major providers of services to Medicare patients, cuts in the Medicare program will send a particularly strong signal to new physicians on the continued viability of the specialty.

Many internist-subspecialists are also being placed at risk. Subspecialties such as rheumatology, infectious disease, endocrinology and oncology that typically treat those who are among the sickest patients, but who provide virtually no procedural services, are particularly harmed by low fees for evaluation and management services. The budget-driven erosion of the gains in payments for E/M services will hit those subspecialists particularly hard. Other subspecialists, such as gastroenterologists and cardiologists, were prepared to accept reductions in fees for their procedures, since they were promised real increases in payments for their visits and consultations to help compensate for the cuts in their procedures and to recognize the value of their time-consuming cognitive services. They too will feel betrayed by the erosion in the gains expected from the new fee schedule. It doesn't make sense to penalize those subspecialists who take care of some of the sickest people in America.

The question to Congress, then, is straightforward. Given the growing evidence that Medicare budget cuts already are creating or exacerbating access problems in rural communities; are contributing to an exodus of young physicians from primary care into more financially rewarding specialties; are causing many established physicians to limit their availability to new Medicare patients, retire, or make career changes; are penalizing subspecialists who disproportionately care for the sickest patients; and are creating a profound sense of disillusionment with Medicare and distrust of the Federal Government among all physicians, can the country afford more cuts in payments for physician services under the Medicare program? The answer, ASIM believes, is clear. Cuts in the Medicare program are placing access to primary and subspecialty care at risk. Further cuts will do untoward damage to Medicare patients' future access to primary care and other needed services.

For these reasons, **ASIM strongly urges the committee to reject any further cuts in Medicare payments for physician services.** Although the reductions requested by the administration appear to be relatively small ($2.1 billion over five years), the reality is that enough damage is already being done because of prior years' cuts that the program cannot afford any more reductions. Primary care is at risk. If Congress does not wish to place it further at risk, it must reject budget cuts and budget-driven policies that will further undermine the gains from the RBRVS fee schedule and further call into question the credibility of the Medicare program and the financial viability of internal medicine.

SPECIFIC PART B BUDGET PROPOSALS

Although ASIM strongly urges the committee to reject the proposed cuts in their entirety, there are several items that will have a particular impact on internists.

One is to cut laboratory fees by another $90 million over five years. ASIM believes that further cuts in laboratory services threaten to force more and more physician office laboratories to close their doors. The Clinical Laboratory Improvements Amendments of 1988, which ASIM supported, will require all previously unregulated physician office laboratories to meet Federal quality standards. Depending on the final rule that is adopted, the costs of compliance are likely to be high. Continued cuts in laboratory fees, coupled with higher overhead costs required to meet Federal quality standards, may endanger the financial viability of many office laboratories. The result will be a loss in the convenience, access, and timeliness of testing that patients have come to expect from office laboratories.

ASIM is also greatly concerned about the proposal to save $25 million over five years by "eliminating double payment for physician collection of laboratory specimens." As was the case last year with Congress' decision to eliminate Medicare payments for interpretation of EKGs, this is another instance of Medicare suddenly deciding not to pay for something that in the past it recognized as a legitimate and appropriate service. The fact is that collecting tissue and blood from patients for laboratory work is a service that results in an expenditure of time and money. It has not been reimbursed in the past as part of the payment for an office visit or as part of the fee for the laboratory test. Medicare has in the past explicitly authorized separate payments for this service, whether the specimen was drawn for an outside laboratory or the physician's in-office laboratory. Therefore, the cost of specimen collection was never included in the laboratory charge or office fee. It is irrational to suddenly declare that a necessary service (Medicare presumably recognizes that specimens must be drawn to have them tested and that this costs staff time and money) is being paid for as part of another service, when that demonstrably has not been the case.

In addition, these and other proposed cuts must be looked at in the context of the overall impact on primary care physicians. Primary care physicians are hardly ahead of the game if their evaluation and management services are increased marginally, but those increases are more than offset by cuts in other services that they provide. Unless payments for EKG interpretation are restored, for example, the few dollar average gain for E/M services will be offset by a cut of $13.00 or so every time an EKG is interpreted. The elimination of specimen collection will cut payments during a typical office encounter by $3.00 every time a specimen is collected for testing in the office laboratory. A few more dollars cut out of the laboratory fees themselves will further reduce overall compensation for the encounter. Even if ostensibly directed at non-E/M services, the fact is that further cuts of this nature will more than take away on one hand the gains for E/M services given on the other. The end result will be that primary care will be placed further at risk.

ASIM is also concerned about the proposal to save $30 million by revising the Medicare economic index (MEI). This is a blatant attempt to justify future reductions in payments for physician services under the guise of a "technical" correction.

CUTS IN GRADUATE MEDICAL EDUCATION

ASIM also strongly objects to the proposed cuts in graduate medical education. We believe that the financing of graduate medical education must include sufficient support from Medicare and other major insurers because patient care revenues cannot finance medical education alone. The President's proposal to reduce the indirect medical education adjustment factor violates this principle. If adopted by Congress, the proposed cuts could do great harm to the system of financing graduate medical education in this country. We urge rejection of the administration proposal. ASIM also opposed proposed cuts in federal-backed student loan programs for medical education.

INCREASING CONTRIBUTIONS FROM HIGHER INCOME BENEFICIARIES

The administration's proposal to cut $25 billion dollars from Medicare over the next five years is in violation of the budget agreement reached last year between the administration and Congress. Consequently, ASIM believes that Congress should reject any additional cuts in Medicare. For that reason, ASIM is concerned about proposed increases in beneficiary contributions that would be in violation of that agreement.

We do believe, however, that in order to assure long-term solvency of the Medicare program, some consideration of basing beneficiary out-of-pocket contributions (premiums, deductibles, and co-insurance) on the ability to pay will be necessary. It will not be possible to simply squeeze more dollars out of benefits for physician and hospital services (i.e. so-called cuts in "provider" payments which really represent

cuts in benefits) without doing great harm to the quality and availability of medical care in this country. For primary care, the point where further cuts can be enacted without damaging medical care has already been reached.

It only makes sense therefore to ask those beneficiaries who can afford to do so to contribute more to the program in order to protect access to care for the less well-off. ASIM commends the administration for courageously raising this issue with Congress and the American people, even though the savings that would be obtained are inconsistent with the budget agreement. In order to maintain the credibility of the budget agreement, now is not the time to be seeking reductions in the Federal subsidy to higher-income beneficiaries. We do believe, however, that in the near future such a step will need to be taken to preserve and protect the Medicare program from bankruptcy.

FINANCING CAPITAL EXPENDITURES ON A PROSPECTIVE BASIS

Although not strictly a budget proposal since it does not include immediate savings, the administration is proposing a prospective financing system for hospital capital expenditures. ASIM believes the concept of a prospective financing system for capital expenditures has merit.

Prospective payment for capital investments has the potential of promoting efficiency in such investments and moderating overall health care expenditures. It is clear, however, that while some hospitals may have excessive capital investments, others are not able to even come up with the capital funds needed to comply with new fire and safety standards. Prospective payment for capital must be carefully constructed to reduce any adverse impact on the ability of marginal hospitals to make needed renovations. ASIM therefore believes that the impact of a prospective payment system for capital expenditures must be carefully monitored in the first five years to assess the impact on reducing excess investment as well as on appropriate and necessary investment; that annual fixed allowances must be sufficient and keep pace with inflation and the costs of new technologies; and that such a system must be phased-in over a period of time not fewer than ten years.

ASIM has not done a detailed analysis of the administration's proposed rule. We are, however, supportive of the overall concept, with the protection described above. Notwithstanding the fact that physicians often directly benefit economically and in other ways from the current open-ended "cost" system of reimbursing hospitals for capital expenditures (physicians benefit from having their own hospitals invest in new technologies that can also generate income from physicians who perform those new procedures), ASIM believes that the goals of promoting efficiency in capital outlays outweighs those considerations. We urge the committee to support the concept of a prospective pricing system for hospital capital expenditures, while working with the hospital community, HCFA and others to resolve legitimate concerns about the administration's proposal.

PRESERVING THE PROMISE OF PHYSICIAN PAYMENT REFORM

The budget cuts already enacted by Congress are in violation of the promise of improved payments for undervalued services. Congress must act, now, however, to prevent a complete betrayal of that promise.

Several specific steps are required to preserve the promise of physician payment reform:

1. **Congress must reject additional budget cuts that will further diminish the gains for undervalued evaluation and management services.** Congress should specifically reject cuts that will place primary care at additional risk, such as the proposals to eliminate the fee for specimen collection, to cut laboratory fees, and to lower the Medicare economic index.

2. **Congress must restore separate Medicare payments for electrocardiograms performed or ordered during a visit or consultation.** The OBRA 90 prohibition on payments and charges for interpretation of EKGs, which will be effective on January 1, 1992, is in direct conflict with the resource-based principle underlying physician payment reform. It denies payments for a legitimate, beneficial, and medically appropriate service that has demonstrable resource costs. It subtracts from one hand the gains provided to E/M services from the other. It will create considerable economic hardship for primary care physicians, particularly in rural areas. It will impede or interrupt access to essential EKGs for many elderly patients. Restoration of separate payments for EKG interpretation will not necessarily run afoul of the new "pay-as-you-go" requirements in the new budget law, since the lost "savings" would come out of the overall dollar conversion factor for the RBRVS fee schedule (because of OBRA 89's budget neutrality requirements) unless Congress directs that

the increased costs be made up in savings elsewhere. The Physician Payment Review Commission, for example, has recommended that the costs be made up by an acceleration of overpriced procedure reductions under the RBRVS fee schedule.

In addition, ASIM supports several measures to address problems with the pricing and utilization of EKGs. Those measures, which unlike OBRA 90 are consistent with the RBRVS concept and would not impede access to needed services, are described in attachment A.

3. Congress must reject threats to the RBRVS conversion factor. Specifically, Congress should assure that a behavioral offset is not included in the initial calculation of the conversion factor, and that the "overshoot" created by an error in the drafting of OBRA 89 be corrected. The effect of a behavioral offset, and the "overshoot" problem—which will unintentionally set the conversion factor at full implementation at less than that required to maintain budget neutrality—will be to significantly reduce the gains for undervalued E/M services, according to the PPRC. The marginal after-inflation gain of 10 percent for E/M services would completely evaporate, according to the commission, if the overshoot is not corrected and the offset assumption traditionally used by HCFA is adopted for purposes of calculating the conversion factor. In order to preserve the promise of physician payment reform, it is essential that Congress reject threats to the conversion factor that will eliminate real dollar gains for undervalued E/M services.

4. Congress must reject any proposals to delay or derail implementation of the RBRVS fee schedule. Despite the growing concern about betrayal of some of the promises of physician payment reform, the truth is that primary care physicians and their patients are far better off with it than without it. The RBRVS is the one thing that is protecting primary care and undervalued E/M services, by allocating more of the burden of deficit reduction to overpriced procedures and services. Some may attempt to exploit concerns about the erosion of the real dollar gains for E/M services to urge a delay or halt in its implementation. If Congress agreed to do so, it would represent the ultimate betrayal of physician payment reform.

ASIM recognizes that some of these recommendations go beyond the scope of this hearing on the President's budget. We believe, however, that since the cumulative effect of the budget cuts and other policies that would undermine the RBRVS fee schedule is to place endangered primary care services at even greater risk, it is appropriate that the committee take up these additional issues in its considerations on the budget. ASIM would welcome the opportunity to elaborate on our views on these and other issues relating to implementation of the RBRVS fee schedule if additional hearings are held on this subject.

Too much of the promise of physician payment reform has already been lost as a result of past budget-driven policies. Primary care, especially in rural areas, has already been placed too much at risk. But ASIM firmly believes that by pursuing the recommendations described above, the promise of physician payment reform can be restored, and the threat to primary care can be reduced. As the specialty that is most affected by changes in Medicare policy, our members stand ready to assist you.

Statement of the American Society of Mechanical Engineers

Mr. Chairman and Members of the Committee: The Council on Education of the American Society of Mechanical Engineers (ASME) appreciates this opportunity to present our views regarding the Section 127 Internal Revenue Code employee educational assistance provisions.

Founded in 1880, ASME's membership of 118,000 engineers, which includes 21,000 students, practices many applications of engineering. ASME serves its members, industry, and government by encouraging the development of new technologies, while helping to solve the problems of an increasingly technological society. This statement represents the consensus of the Council on Education rather than an official position of ASME.

We strongly support congressional efforts, in particular S. 24, to make permanent the Section 127 Internal Revenue Code employee educational assistance provisions. These provisions allow employers to provide up to $5,250 per year to each of their employees in tax-free reimbursements for tuition, books, and fees for non job-related educational assistance. Section 127 is currently set to expire on December 31, 1991.

Pressures of international economic competition are shaping a new environment for employer-employee relationships, requiring greater job flexibility, job mobility, and frequent updating of skills. The American demographic trend toward an older work force, the continuing shift toward a service economy, and rapid advances in

knowledge and technology clearly point to the need for public policies which support and encourage lifelong education.

Continuing education and retraining programs are especially critical for engineers to keep up-to-date with rapidly changing technology in their field or to switch areas of engineering specialization. Moreover, a well-trained engineering work force is vital to our nation's economic well-being.

Section 127 of the Internal Revenue Code has exempted qualified employee educational assistance from employee Federal income taxes. The Section's expiration will cause confusion and concern among participants in this program. In the absence of Section 127, the law will require employees to pay taxes on tuition payments made by their employers unless the courses are strictly "job-related." Uncertainty over the extension of the Section 127 provisions will keep many engineers from pursuing the advanced degrees they need to compete, and to help our nation compete, in the ever-changing world of engineering technology.

To illustrate these points, here is a real life situation that is being confronted by an ASME member who works as General Manager of an aerospace component company located in New Jersey.

This manager wants to keep his employees current with the accelerating pace of technological change. He employs 50 mechanical engineers who design and build mechanical guidance and steering systems using cables, pulleys, and hydraulics. Within three years he expects a different kind of guidance system based on electronics to be introduced into the marketplace. Without continuing education and retraining his employees will be lacking the technical skills required for producing these advanced guidance systems.

How will these mechanical engineers receive the training necessary to design and manufacture these components using a totally different electronics technology? If the manager has to hire new engineers with these specific skills, what happens to the engineers currently employed by the company? Employee educational assistance not only provides these engineers an opportunity to continue their education in a new field of engineering technology, it also provides for the economic well-being of the company.

Section 121 works. Since 1978, employee educational assistance has enabled more than seven million American workers to upgrade their skills and keep pace with new competitive, technological, and industrial developments. Over 95 percent of the participants in ASME's continuing education courses in the Society's professional development program have been supported by their employers through tuition reimbursement.

We believe that Section 127 is analogous to the GI Bill of Rights: an investment in the future. In our experience, continuing education is an investment, not a fringe benefit. It should be considered a business expense, required for a company to remain competitive. With the appropriate mix of educational programs, we can improve our quality of life while improving the nation's industrial competitiveness and balance of trade; we can improve productivity while improving the quality of our products.

Finally, we challenge the presumption that Section 127 is a revenue loser for the Federal treasury. We believe the revenue forgone from not taxing employee educational assistance will be recovered many times over in additional tax revenues from economic activities generated by a continuously employed, well-educated work force. It should also be noted that the "cost" of Section 127 is very low compared to the alternative of expanding direct funding for educational programs and retraining.

In conclusion, we urge the members of the Committee to move expeditiously to make Section 127 a permanent part of the Internal Revenue Code. It is a critical component of the national effort to enhance the education, job skills, and retraining of American workers. Clearly, Section 127 is a cost-effective investment in the future of America.

Statement of the American Society of Plastic and Reconstructive Surgeons

The American Society of Plastic and Reconstructive Surgeons (ASPRS) appreciates the opportunity to submit the following comments for inclusion in the printed record of the March 19-20, 1991, hearings on President Bush's budget proposals for fiscal year 1992.

ASPRS is in agreement with your recent announcement in which you voiced your opinion of being, "strongly opposed to further deep Medicare cuts." Indeed, further cuts could have a drastic negative effect on the health care system that, while not perfect, certainly has rendered health care to millions of Americans over the past

2½ decades. Although we are aware that the increase in health care spending is driven by many forces, we believe that the majority of physicians do put their patients interests above all other factors, and are primarily concerned about patient well-being.

Specifically, ASPRS believes that further reductions in Part B of the Medicare program may have the following negative effects:

(1) the number of participating physicians may drop, thus limiting Medicare patients' access to care, and

(2) the development of new technologies may be stifled, thus limiting the quality of care.

Additionally, we have already seen the possible effects of the recently released spending goal for surgeons in 1991. The 3.3 percent surgical standard (Medicare Volume Performance Standard) set by Secretary Sullivan of the Department of Health and Human Services (HHS) does not even keep up with the 4.6 percent inflation rate for practice costs that the HHS has predicted.

Mr. Chairman, ASPRS certainly concurs with your statement that further reductions in Medicare spending is counter-productive and savings and budget reductions should be applied to other areas. ASPRS appreciates the opportunity to provide written comment on President Bush's FY 1992 budget proposals relating to physician payments under Part B of the Medicare program.

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April 17, 1991

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
United States Senate
SD-205
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Bentsen:

The American Urological Association is pleased to submit for the record these comments on the FY 1992 budget proposals of President Bush and other current issues in the Medicare program. We request that this letter be made part of the official record of the March 19-20 hearing held by the Committee on the President's budget.

AUA is deeply concerned that the President has again proposed substantial cuts in Medicare. The Omnibus Budget Reconciliation Act of 1990 (OBRA'90) established a five year budget agreement and substantially reduced payments to hospitals, physicians and other participants in Medicare. Further cuts in Medicare, before the budget agreement is even one year old, should not be accepted by Congress.

The Administration again proposes reductions in Medicare payments to hospitals for the training of physicians and other health professionals. Congress has already reduced both the direct payments for graduate medical education, as well as the indirect medical education adjustment. Further cuts threaten the large public hospitals where much of their education takes place, and also jeopardize the ability of residency training programs to remain at expected levels of quality. The reductions would hurt training programs in urology and all other fields of medicine, including primary care.

The President's budget also proposes to reduce spending for assistants at surgery by collapsing the payment for the assistant into the reimbursement for the primary surgeon. This means that any surgeon that uses an assistant is at financial risk for the cost of that assistant.

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The proposal of the Administration ignores the reality of medical practice. Surgeons use an assistant when the operation is complex or when the patient presents unusual challenges. Hospital rules often dictate the use of an assistant surgeon. Why should the primary surgeon bear the financial burden for an assistant when the presence of that assistant is medically necessary?

There is no system of providing assistants at surgery comparable to the system of residents in teaching hospitals. In the teaching hospital, residents assist at operations as part of their training. In community hospitals there are no residents. The primary surgeon must persuade another surgeon to assist. If the rates for payment for the assistant surgeon are reduced below current levels, physicians will become increasingly reluctant to assist.

Therefore, in addition to rejecting the President's proposal, we urge you to reverse the action of OBRA'90 which (1) cut the reimbursement for the assistant surgeon from 20% of the primary surgeon's fee to 16%, (2) and placed arbitrary payment restrictions on other procedures for which an assistant is infrequently used. Surgeons may use an assistant for certain kinds of operations because of the rare instance where the patient presents problems that mandate the presence of another surgeon. For example, insertion of a testicular prosthesis is generally a solo operation. However, there may be rare occurrences in which the urologist needs an assistant to help with the patient. AUA believes that in those difficult cases the primary surgeon should retain the option to use an assistant and that the surgical assistant should be paid a fair rate for the work. AUA has identified those cases in which a surgical assistant is always required, those cases in which an assistant is almost never required, and those in which the need is based on the particular patient's needs. For those cases in which the use of an assistant surgeon is unclear, we have recommended that a system of prior approval be instituted.

AUA also wishes to express its deep concern about reports coming from HCFA and PPRC that the anticipated reimbursements under the new Medicare RB-RVS fee schedule will fall short of projections. If this situation remains unchanged, it appears that surgical and diagnostic procedures may have reductions in reimbursement that are even deeper than the ones already contemplated or experienced. Evaluation and management services, promised substantial increases in reimbursement, may also not receive these improvements. Many physician organizations supported the change to the fee schedule because they anticipated that more equitable reimbursement would follow that change. It appears that they may be disappointed. The federal government should reexamine the fee schedule legislation and modify those parts of it that are contrary to the legitimate expectations of the medical community.

Another issue of concern to the AUA is the consideration of recalculating the cost of practice index which would have the effect of reducing reimbursement for physicians when they perform

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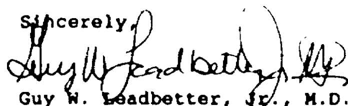
procedures in the hospital, rather than in their office. Since surgeons are most commonly called upon to provide care in the hospital in the operating room, this could have a disproportionate effect on them and lead to a further reduction in already eroded fees. We do not understand the rationale for this proposal. A physician may perform a service in the hospital setting, but he or she still has an office to maintain and staff to pay even though the physician is not physically present in the office. Encouraging physicians to practice in the most appropriate setting is fine; however, the surgeon performing a major cancer operation certainly cannot be expected to perform that surgery in his or her office. Yet there continues to be an overhead cost for that physician every hour of the day, no matter where he happens to be practicing at any given moment. We believe that the cost of practice index has to accurately reflect the cost of doing business and the need to recoup that cost as a part of every service provided by the physician, no matter where it is located.

Finally, AUA is concerned about the current discussion to repeal the legislation that eliminated payment for the interpretation of the EKG. If Congress chooses to restore this interpretive fee, we certainly hope that it will not be at the expense of specialties that do not routinely use EKGs. If any adjustments in reimbursement need to be made to restore this payment, we suggest that they be made in the reimbursement of individuals who provide the EKG in their office and who are the source of the original Congressional concern over payment. It would be unfair to restore the payment for the EKG interpretation by spreading the cost of the lost budget savings over all physicians' fees. Those costs should be borne in a budget neutral manner exclusively by the physicians, such as cardiologists, internists, and family physicians, who perform the EKGs.

AUA appreciates the opportunity to offer these comments on items in the President's budget request and other issues before the Committee. We are extremely concerned about the future of the Medicare program and the willingness of physicians to continue to participate in a program whose reimbursement for many services has eroded by at least 30% in the last three years. We urge the Committee to reject any further reductions in Medicare.

Sincerely,



Guy W. Leadbetter, Jr., M.D.

STATEMENT OF THE COALITION OF BOSTON TEACHING HOSPITALS

INTRODUCTION

The following Boston Teaching Hospitals submit this testimony to the Finance Committee: Beth Israel, Brigham and Women's, Carney, Massachusetts General, New England Deaconess, New England Medical Center, St. Elisabeth's, and University. We strongly oppose the Administration's proposed fiscal year 1992 Medicare reductions, in particular proposals to reduce the Indirect Medical Education adjustment and to change the formula for making Direct Graduate Medical Education payments. The Administration's budget proposal would reduce the growth in Medicare program expenditures by $2.8 billion in fiscal year 1992. Of that amount, more than $1 billion would be derived from reductions in payments to teaching hospitals, and of that $1 billion, an estimated $63.5 million would come from the Boston teaching hospitals.

We urge the Finance Committee to refuse to incorporate these proposed reductions in fiscal year 1992 reconciliation legislation.

THE BOSTON TEACHING HOSPITALS

Nearly 50,000 Medicare patients were admitted to our hospitals in 1990, representing over a quarter of our total admissions. In addition to providing the full range of inpatient care, we continue to perform our multiple missions of providing health care to those in our community who are unable to pay, educating health professionals, and performing research. We provide a substantial number of services not available elsewhere in the community, including burn, trauma, transplant, and neonatal care. A number of us with maternity, pediatric, and neonatal services have recently committed resources to an intensive program to combat infant mortality in the city of Boston. This includes outreach programs and increased staffing of inner-city clinics with nurse practitioners, physicians, and other providers. Several of us also provide additional access through health centers in low-income neighborhoods throughout the city. We are a major source of health professional training and research: in 1990, we trained 1,998 residents in a full range of programs and received research funding of $285 million.

The Boston teaching hospitals are a critical component of the city, state, and national health care delivery systems. This status would be jeopardized by the Administration's proposed Medicare reductions in the PPS update, Indirect Medical Education, and Direct Medical Education.

REDUCTION AND DELAY IN PPS UPDATES

The Administration has proposed to both reduce the market basket update by 1.6 percent, and to delay the update by three months (from October 1 to January 1, 1992). We estimate that enactment of these proposals would result in a decrease in reimbursement of $10.8 million. Increases in the costs of treating Medicate patients will not, of course, be reduced correspondingly, nor will they be delayed. Enactment of these proposals would clearly have a severe negative impact.

INDIRECT MEDICAL EDUCATION

The Administration proposes to reduce the Indirect Medical Education adjustment over the next four years, beginning with a reduction to 4.4% in fiscal year 1992 and culminating in a rate of 3.2 percent in fiscal year 1996. The Administration proposes to partially offset this reduction by changing the definition of beds used in the IME calculation from "licensed" to "occupied." Even with this minimal offset, the Administration's IME proposal would reduce our IME payments by an estimated $33.4 million in fiscal year 1992 alone. Further, this proposal "breaks faith" with the Congress by violating the terms of last year's budget agreement. In the course of that debate, Congress considered and soundly rejected Administration proposals to reduce the IME adjustment. The reasons for rejecting a reduction are the same today, a mere six months later.

The Indirect Medical Education adjustment was established as a proxy for the higher costs associated with treating patients in teaching hospitals. These higher costs are the result of a number of factors, most notably the increased severity of illness of patients cared for at our hospitals and our inner city locations.

In fact, we in Boston must contend not only with all of those anticipated factors, but the fact that we have become a major source of care for the uninsured. In 1990, we provided $152 million in care for the uninsured, representing 38.7 percent of all such care provided in Massachusetts. Reductions in the Indirect Medical Education adjustment, by compromising our financial viability, would seriously weaken our

continued ability not only to provide top quality medical training and care, but also to continue to serve as "safety net" hospitals on which the present health care system depends.

DIRECT GRADUATE MEDICAL EDUCATION

The Administration has proposed two changes in reimbursement for direct medical education: basing reimbursement on a national average resident's salary and differentially weighting this national average depending on the resident's choice of specialty.

Basing reimbursement on a national average resident salary rather than reasonable costs would reduce our payments for graduate medical education by an estimated $19.4 million in fiscal year 1992. In addition, the timing of this proposal only adds to the uncertainty we are experiencing regarding Medicare funding. HCFA audits of base-year direct medical education costs, from which the national average salary will be calculated, are not yet completed, though they were scheduled for completion nearly two months ago. Without the results of these audits nation-wide, we can only roughly estimate the financial impact of this proposal.

The Administration proposal to differentially weight primary care and non-primary care residents will not, we believe, accomplish the intended policy goal, an increase in the number of primary care physicians. We do believe this is an excellent policy goal, and we provide a significant amount of primary care through our outpatient departments and neighborhood health centers. There is, however, no evidence of any connection between a medical student's choice of a residency training program and Medicare graduate medical education payments to hospitals. Rather, medical students' choices of specialties are influenced by interest in specific fields, physician role models, life styles, and, of course, financial realities such as how financial aid debts can be repaid. Thus, incentives targeted directly to medical students, such as special Federal financial aid programs, service payback, and other methods of reducing medical education debt, would be far more successful in achieving this policy goal than global Medicare reimbursement policies which cannot directly impact medical students or residents

CONCLUSION

In closing, we again urge you to reject the Administration's proposals and adhere to the budget agreement reached last fall, after much effort and compromise by all parties, an agreement, most importantly, reached in good faith.

We thank you for considering this testimony.

STATEMENT OF THE COALITION TO PRESERVE THE LOW-INCOME HOUSING TAX CREDIT

Mr. Chairman and Members of the Committee. I very much appreciate your allowing me to present this statement to the Committee on the extension of the vitally important low-income housing tax credit.

My name is John P. Manning and my statement is on behalf of the Coalition to Preserve the Low Income Housing Tax Credit, of which I am the President, and on behalf of the National Leased Housing Association, of which I am a member of the Board. The Coalition is an organization comprised of non-profit and for-profit equity financiers, developers and others who are involved in the provision of affordable housing to low-income Americans and who have utilized the low-income housing tax credit in order to raise equity capital for such projects. NLHA is an organization which serves virtually all participants in the multifamily housing field; its over 600 members include non-profit and for-profit developers, owners, managers, public housing authorities, state housing finance agencies, local governments, equity financiers and professionals experienced in this industry.

I am also the President and Chief Executive Officer of Boston Capital Partners, Inc., located in Boston, Massachusetts. Boston Capital has been deeply involved in raising equity for low-income housing for over 17 years. Since the inception of the tax credit in 1987, we have raised over $300 Million for investment in tax credit eligible projects. I was also honored to have been appointed to the Mitchell-Danforth Task Force, which made a number of proposals to strengthen and tighten the tax credit, which eventually were enacted by the Congress in 1989 and 1990.

THE CREDIT MUST BE EXTENDED ON A PERMANENT BASIS

Mr. Chairman, I cannot emphasize strongly enough how crucial it is that the Congress enact a permanent extension of the low-income housing tax credit. We very

much appreciate the Chairman's and the Committee's support over the past two sessions in passing one year extensions of the program. We also recognize the difficult fiscal and political situations that the Congress has faced and continues to face and understand that achieving a permanent extension this year will not be an easy task.

If the Congress is to maintain its decades-long commitment to housing for low-income Americans, the tax credit, which plays an integral part in the provision of that housing, must be extended permanently: The tax code has for over 20 years recognized that low-income housing deserves special treatment; the low-income housing credit has maintained that recognition in a most effective manner.

We enthusiastically support S. 308, the bill introduced by Senators Mitchell and Danforth and supported by fourteen members of this Committee, which would permanently extend the credit. We commend Senators Mitchell and Danforth and the other 79 co-sponsors of this legislation for their leadership on this matter.

Why is a permanent extension, as opposed to a temporary extension, so necessary? Short-term extensions do not permit the housing community the necessary time to plan these risky and increasingly complicated developments. The process of developing low-income housing is a multi-year undertaking. Unless those involved in developing this housing have confidence that the credit will exist in coming years, they will be unwilling to invest the money, time and commitment it requires in putting together this housing. The result is that less housing is built.

It is not just the development sector of this industry that needs time to plan this housing. Mortgage lenders, equity financiers and state credit allocating agencies must also devote substantial resources to hiring and training staff and developing programs and procedures to implement and administer this program. Many such entities are unwilling or reluctant to make these investments when the fate of the program is so uncertain.

As I discuss below, lack of available mortgage financing has been one of the greatest problems we confront in this industry; it is very difficult to persuade already reluctant lenders to develop the necessary mortgage financing products when the program may disappear in a matter of months.

Lack of permanence also sends the wrong signal to potential investors, who are concerned that Congress will retroactively deny their benefits in the manner that occurred after the adoption of the passive loss rules in the Tax Reform Act of 1986. Although we do our best to reassure them that support for this program in the Congress is strong, a good deal of equity capital that could be invested in low-income housing is lost because of these concerns. However, a permanent extension would signify strong and lasting Congressional support, would allay investor concerns and would, I am certain, result in more capital being raised for this housing.

Moreover, an explicit statement from this Committee, perhaps contained in a Committee Report, that it is Congress' intention not to deny benefits retroactively to investors would help in our efforts to convince the public that Congress will not take this action in the future. The question that we are most often asked is whether benefits will be taken away retroactively—a statement of Congressional intent on this subject would be very helpful.

RESULTS TO DATE UNDER THE PROGRAM JUSTIFY PERMANENT EXTENSION

Mr. Chairman, there can be no doubt that the credit program has been a spectacular success and has fulfilled and perhaps surpassed Congressional objectives. No small part of this success has been the spirit of cooperation the program has fostered between the private and public sectors, particularly with the state housing credit agencies which do such a fine job of allocating and administering the credit. Moreover, the credit program has served as a catalyst for the development of a vibrant and effective non-profit development community and their active participation in this industry has strengthened our ability to deal with the affordable housing crisis facing the Nation.

Despite the fact that the program started slowly, from 1987 through 1990 this program has produced or will produce well over 350,000 units of low-income housing, according to figures compiled by the National Council of State Housing Agencies. Although precise figures are not available, we believe that the tax credit has played an integral role in the great majority of low-income housing projects produced, rehabilitated and preserved since 1987. As my colleagues from the Council on Rural Housing and Development point out in their testimony, virtually all projects assisted under the Farmers Home Administration Section 515 program could not be produced without the tax credit.

The credit program is responding to a desperate need as a number of recent studies have dramatically demonstrated. One study, by the Economic Policy Institute showed that among renter households with four or more persons whose incomes are

between $10,000 and $30,000, there is a "shelter poverty incidence" of 80 percent. (Shelter poverty measures housing affordability on a sliding scale with maximum affordability percentages varying with income and household characteristics.) Among all renter households, more than 40 percent are shelter poor and nearly 50 percent pay more than 30 percent of their income toward rent, the more traditional method of determining housing affordability.

In the meantime, the number of subsidized and unsubsidized affordable rental units has declined dramatically. The Joint Center for Housing Studies at Harvard University concluded that the number of unsubsidized units renting at prices affordable to the poor has dropped by more than one-third. As the Committee is well aware, Federal support for housing has fallen dramatically since the mid- to late-70's; if HUD's FY 1992 budget request were to be granted, the number of new assisted housing units added to the HUD assisted housing inventory next year would represent less than 20 percent of the units added 15 years ago.

MODEST CHANGES TO THE PROGRAM MAY BE NECESSARY TO ASSURE CONTINUED SUCCESS

In 1989 and 1990 the Congress, following this Committee's leadership, made a number of worthwhile changes to the credit program, designed to assure that scarce Federal resources were being wisely and efficiently spent. I am proud to have participated in the Mitchell-Danforth Task Force, which recommended a number of these amendments The housing industry recognized that to maintain Congressional and public support for this program, the allocation process had to be fairly administered, credits allocated could not exceed amounts that were necessary for project feasibility, continued low-income occupancy should be promoted where possible and ongoing monitoring of program compliance had to be implemented.

With that background in mind, I would like to proceed to discuss several additional changes which I believe are necessary if this program is to continue to fulfill Congressional expectations Fortunately, the list is not a long one for the Congress has addressed already most of our concerns over the past two years. Despite our successes to date, there are several unsettling signs that may portend difficulties in the future.

Need for Debt Financing

As the Committee is well aware, there is a "credit crunch" rampant throughout the country, but nowhere is it felt as severely as in the low-income housing sector. Developers, both non-profit and for-profit, unanimously agree that finding mortgage financing has become the single greatest impediment to the development of affordable housing. Savings and Loans and commercial banks are reluctant to lend on any real estate; low-income housing is virtually unthinkable (with the exception of the Federal Home Loan Banks' Affordable Housing Program, which can meet only a fraction of the overall need.) With the demise of the FHA coinsurance program, FHA-insured financing has ceased to address the need.

Indeed, the decrease in the credit actually allocated by the states during 1990 is at least in part attributable to the difficulty in finding mortgage financing. (It should be pointed out that a number of other factors contributed to this decline, including the factors that states were allowed for the first time to carry forward unused credit from 1990 to 1991 and the full $1.25 per capita allocation amount was not received until very late in the year.)

The Congress could help address this situation by allowing the use of the 70 percent credit with financing provided by tax-exempt bond proceeds and with financing under the recentlyenacted HOME program. Under present law, the use of tax-exempt bonds restricts a project to the 30 percent credit and has resulted in very little utilization of such bonds in credit eligible projects because, quite simply, the "numbers" do not work. If this restriction were removed or modified, bond financed credit projects would become feasible and such financing could begin to fill a very critical need for mortgage debt.

With respect to the HOME program, the Congress passed this landmark legislation last year. Under the program, Federal funds will be provided, largely by formula in a block grant approach, to state and local governments for use under statutory guidelines. This program in many respects resembles the Community Development Block Grant program. The Committee will recall that in 1989, the Congress amended the Code to provide that CDBG funds could be utilized in conjunction with the 70 percent credit. The Code should provide that HOME funds can also be used with the 70 percent credit.

Need for Additional Sources of Equity Capital

For the first time since the inception of the program, in 1990 the amount of capital raised for investment in low-income housing credit projects by publicly-offered investment partnerships actually declined. The figures we have been able to compile (which are not official and are based upon our best estimates) indicate a decline of approximately 18 percent from 1989 to 1990. While there are undoubtedly factors having nothing to do with the credit program that contributed to this decline, e.g., the economic recession and the uncertainty created 'by the Persian Gulf conflict, I am deeply concerned about the future ability of this industry to raise sufficient capital to meet the needs of projects receiving credit allocations.

As I pointed out above, the enactment of a permanent extension would have a very positive impact on our ability to raise funds. However, I believe that the Congress could further help the situation in two important ways.

First, the Congress should pass H.R. 1566, the bill introduced by Congresswoman Kennelly, Congressmen Schulse and Moody and others, which would modify the passive loss rules to allow the use of approximately $20,000 in low-income and rehabilitation credits against taxes on non-passive income. We have a number of investors who have told us that they would welcome the opportunity to invest more capital in credit projects but for the limit of approximately $7,000 ($7,750 in 1991) in credit against taxes on non-passive income. Furthermore, other higher income individuals have told us that a $7,000 credit is just not worth the time and energy it takes to understand the' investment.

All of us in the equity capital industry are finding it increasingly difficult to locate investors interested in this program. The present limit makes it impossible to attract many of those who have already invested and it discourages other higher income investors. Raising the limit to approximately $20,000 would free up this badly needed capital and would help assure a steady flow of equity to credit eligible projects in coming years.

However, I must point out one serious flaw with H.R. 1566: it does not permit the credit to be used against the Alternative Minimum Tax, which will greatly diminish the impact of this legislation. Our figures show that most investors would not be able to use the full $20,000 that would be allowed under the passive loss rules if H.R. 1566 is enacted unless there were some ability to use the credit against AMT. We would be happy to work with the sponsors of that legislation and the Committee to devise a fair proposal on this issue. However, raising the amount to $20,000 without some form of relief under the AMT would be a pyrrhic victory.

Second, another commonly expressed concern which has limited our ability to raise capital is that the return to investors in the early years of an investment is much less than the return that is otherwise expected. The rate of return in the first year of an investment may be as low as two to three percent, much less than one could expect to receive from a federally-insured savings account.

The reason for this phenomenon is that the first year credit is reduced by a special averaging convention contained in Section 42(f)(2), which requires the credit to be determined by occupancy levels at the end of each month during the first year, when the project is likely to be renting up for the first time. Furthermore, many owners must wait until the year after the project is placed in service to begin claiming the credit since claiming the credit before the project is fully rented results in much lower credit being generated than would otherwise be possible.

In order to rectify these problems, we would suggest that the owner be provided with an election to claim a tentative credit (not to exceed the amount allocated by the credit agency) for the first year that the building is placed in service, without diminution by the first year averaging convention. The tentative credit would then be redetermined not later than the close of the first full year after placement in service by determining the qualified basis at that point. If the finally determined credit were less than the tentative credit, the difference would be recaptured immediately. All other rules of the program, except perhaps for some technical and conforming changes, would not need to be altered.

Need to Modify Rent Rules

In 1989 the Congress changed the manner by which rents were determined by requiring that rents be figured on the basis of the number of bedrooms in a unit, not by the number of occupants. This change was fairer for both tenants and owners and provided predictability when underwriting tax credit projects. However, the change was made only for projects receiving allocations in 1990 and thereafter.

A persistent problem for owners and managers of these projects is the confusion caused by the different rent rules which apply for projects depending on when they received an allocation. There is no reason not to apply these new rules, which Con-

gress determined to be more appropriate, to projects which received 1987-1989 credit allocations. In order to assure that no tenant would be burdened by this change (in fact, some tenants would experience a decrease in rents), we would support appropriate transition rules for existing tenants, perhaps adopting a rule similar to that under HUD assistance programs, which phases in rent increases and prohibits increases of more than 10 percent per year.

Furthermore, for the reasons which are outlined in the testimony presented by the Council for Rural Housing and Development, we strongly support the proposal to make retroactive the modification enacted last year with respect to rent rules for FmHA Section 515 projects.

Credit Carryforward Rules Should Be Clarified

In 1989, the Congress wisely adopted an amendment which permitted state housing agencies to carry forward unused credit authority for at least one year. This change meant that states were not under a "use it or lose it" mentality at the end of the year, thereby avoiding situations which forced states to make allocations in order not to lose a portion of their allocation authority. Unfortunately, the Treasury Department has adopted an interpretation of the law which we do not believe was intended by the drafters of the legislation and which will re-create this pressure at the end of this year.

Treasury has determined that a state which has a credit carryforward from a prior year must use the entire amount of that prior year's allocation plus the full amount of the new $1.25 allocation in that year in order not to lose the unused portion to a national pool for redistribution to other states. For example, if a state carried forward $.50 of its $1.25 per capita allocation from 1990 to 1991, it would have to allocate $1.75 in 1991 in order not to lose the unallocated portion of that $1.75 to other states. The Treasury position creates unwise and unreasonable pressure on states to allocate the credit too quickly.

We believe Treasury's interpretation to be unsupported by Congressional intent and to be unwise as a matter of policy. The Congress should either clarify the Code by declaring that the carried forward amounts are considered to be the first amounts allocated in the following year or by changing the rule altogether and mandating that a certain percentage of credits must be allocated in each year in order to avoid redistribution to the national pool.

Need for Simplification

Mr. Chairman, I know that you, the Committee members and staff have devoted a good deal of time exploring ways in which the Code can be simplified. I recognize what a daunting task that must be. My suggestion relates not directly to the Code but the manner by which taxpayers, who are generally limited partners in investment partnerships, must report their allocable share of partnership credits as well as income and loss.

The process of reporting these items is incredibly cumbersome, time consuming and confusing. It makes a mockery of the Paperwork Reduction Act. The following is a recitation of the forms which must be filled out by a typical taxpayer who invests in a partnership which owns interests in tax credit eligible properties.

We provide taxpayers with a Schedule K-1 (Form 1065)—"Partner's Share of Income, Credit, Deductions, Etc."—which gives the person information with respect to net income or loss, portfolio income or loss, low-income housing tax credits and other information necessary to complete that individual's return.

The individual must then: (1) fill in four spaces of Form 8271—"Investor Reporting of Tax Shelter Registration Number;" 2) compute line 6 of Form 8586—"Low-Income Housing Credit;" 3) transfer information to Schedule B (Form 1040)—"Interest and Dividend Income;" 4) complete a line of Form 8582—"Passive Activity Loss Limitations;" 5) transfer and compute five lines on Form 8582-CR—"Passive Activity Credit Limitations;" 6) complete two lines of Form 3468—"Investment Credit;" 7) transfer information to lines 1, 5, 10 and 21 of Form 3800—"General Business Credit" and finally 8) complete two lines of the Form 1040.

Mr. Chairman, there must be a better way to deal with this situation. This is just plainly ridiculous.

Our company and some of our competitors provide instructional materials to help our investors through this maze. Nonetheless, we get constant complaints about the complexity of the process of reporting. If there were ever a clear disincentive to investing in a low-income housing tax credit property, this is it.

We do not have a specific suggestion to offer on simplifying these procedures. However, our organizations stand ready to work with the Committee and representatives of the Internal Revenue Service to attempt to develop proposals in this area. One possibility would be to have a task force or working group appointed under the

auspices of the Committee to work with the Service with the goal of simplifying these forms. In any case, we are happy to assist in any way we can.

HUD'S PROPOSED GUIDELINES ON COMBINING HUD ASSISTANCE WITH THE TAX CREDIT AND OTHER ASSISTANCE THREATEN THE CONTINUED VIABILITY OF THE TAX CREDIT PROGRAM

Mr. Chairman, although this matter does not technically fall within this Committee's jurisdiction, we would be remiss in not pointing out briefly the threat posed to the tax credit program by the proposed "HUD Guidelines—Limitations on Combining Other Government Assistance with HUD Housing Assistance." It is our hope that Congressional hearings on this subject will be scheduled in the near future and we will leave to that forum a thorough analysis of the impact of these proposals.

Very briefly, acting under the authority of Section 102(d) of the Department of Housing and Urban Development Reform Act of 1989, HUD is in the process of proposing administrative guidelines which would limit HUD housing assistance when that assistance is combined with other forms of governmental assistance, including the low-income housing tax credit. HUD assistance, under Section 102(d), could not exceed an amount determined to be necessary to provide affordable housing.

Mr. Chairman, let me be very clear: I strongly support the concept of limiting governmental assistance to amounts determined to be necessary. I helped to formulate, as a member of the Mitchell-Danforth Task Force, a similar proposal, that was enacted in 1989, which applies to tax credit allocations.

Unfortunately however, the proposed HUD Guidelines are totally unworkable, unrealistic and unfair. They go well beyond what is needed to assure that governmental resources are wisely spent. HUD's standards are likely to conflict with and undermine standards being developed by state housing credit agencies in their administration of the tax credit program.

Most fundamentally, these proposed Guidelines will ultimately hurt the intended beneficiaries of affordable housing programs—low and moderate income persons.

I should point out that these concerns have been expressed by both non-profit and for-profit entities involved in low-income housing; this is not, therefore, a matter of the sponsors of this housing demanding unreasonable compensation. It is a question of whether the limitations being established by HUD will drive away private sector involvement—both non-profit and for-profit—in developing and financing this housing.

Quite simply, the Guidelines as proposed will make it virtually impossible to utilize the tax credit with HUD assisted housing. The limitations placed on syndication costs and investor rates of return will mean that the two largest sources of equity for tax credit properties—publicly offered partnerships and corporate investment—cannot (with rare exception) be utilized with HUD assisted projects. HUD will inevitably find fewer developers willing to develop housing for low-income tenants and even fewer experienced and reputable developers willing to do so.

As I noted above, our purpose today is only to alert the Committee to this pending problem; I have not attempted to go into detail about specific objections. I would hope that hearings will be scheduled in the near future to examine these issues in greater detail. In the meantime, I would be happy to work with the Committee to explain our concerns.

STATEMENT OF THE COUNCIL FOR RURAL HOUSING AND DEVELOPMENT

The Council for Rural Housing and Development appreciates the opportunity to provide our thoughts to the Committee in regards to permanent extension of the low income housing tax credit program. For reasons outlined in this testimony, the credit is essential to bring vitally needed housing to Rural America, this nation's area of greatest housing need.

As a matter of background, the Council is an organization of over 350 developers, financiers and managers of projects under the Farmers Home Section 515 rural rental housing program. Our membership also includes 20 affiliated member state associations.

THE RURAL NEED

Housing is an acute problem in rural America. Almost two million rural households live in substandard housing; approximately 900,000 households with incomes below the poverty line live in such housing. A report released December 1989 by the Center on Budget and Policy Priorities and the Housing Assistance Council ("The Other Housing Crisis: Sheltering the Poor in Rural America"), states that poor, non-

metropolitan households make up 20 percent of all non-metro households, they occupy 44 percent of all non-metro housing units with evidence of rats, 55 percent of units without complete bathrooms, 54 percent of the units with holes in the floor, 43 percent of units with cracks or holes in the walls, and 46 percent of units with weak foundations. The typical non-metro renter household with an income of $5,000 or less spent 58 percent of their income for housing in 1978, but 67 percent in 1985. An estimated 200,000 units of housing need to be replaced each year in rural areas.

HOW SECTION 515 AND LOW INCOME HOUSING TAX CREDIT MEET THE RURAL NEED

Since 1963, Congress has recognized this unique rural need, and has authorized the Section 515 program to help fill the gap between rural housing stock and rural housing needs. Through FY90, 450,000 units have been built under the program.

Under the Section 515 program, the Farmers Home Administration makes a direct loan to a developer; Federal subsidy reduces the interest rate paid by the developer to 1%.

However, the benefit of the 1% loan flows through to the tenant in the form of reduced : rents. It provides no monetary benefit to the developer. The only return permitted by the program is an 8% annual cash return on the required 3% equity contribution. This limited return has never proven to be an incentive for developers to participate in the program. Indeed, a federally-insured certificate of deposit has historically yielded that return with far less effort.

Another traditional incentive for real estate investment, the chance to realize appreciation, is also absent in Section 515 projects. Congress recently imposed a 50-year prohibition on the prepayment of Section 515 loans, guaranteeing low income occupancy for half a century. This change did away with any realistic opportunity for economic appreciation.

Accordingly, from the start of the Section 515 program, tax incentives have been the driving factor for Section 515 production. Before the 1986 changes, these incentives included accelerated depreciation and immediate deduction of construction period interest. After the 1986 law, the old tax incentives were replaced by a new incentive—the low income housing tax credit. Without this new tax incentive, the Section 515 program would cease to function.

The low income housing tax credit has been heavily utilized in Section 515 projects during the past four years. While the information for FY90 is not yet fully compiled, it is estimated that about 13,000 units of Section 515 housing were allocated tax credits in FY90. Statistics provided by the National Council of State Housing Agencies show that in FY89, Section 515 projects accounted for 23% of the total tax credit projects receiving allocations. It is estimated that since 1987, a total of 45,700 units of Section 515 housing has been created with the use of the tax credit. These units would not exist were it not for the credit.

THE NEED FOR PERMANENT EXTENSION

Congress has twice extended the tax credit on a one-year basis. We are, of course, very thankful for this. However, it is extremely difficult to plan in any rational fashion if one does not know until the end of the calendar year whether there will be a tax credit for the upcoming year. It is time to end this precarious existence by providing a permanent credit extension so that the entire housing community can plan its year to year activity in a sensible fashion.

OTHER NEEDED CHANGES

Significant changes have been made to the program through tax legislation during the past four years. Accordingly, we do not bring you a long list of legislative suggestions for this year. However, there are a few items that we consider important to the continued success of the program. First, we wish to endorse the bill introduced by Congresswoman Kennelly, Congressman Schulze and others to raise the amount of credit usable against non-passive income to approximately $20,000. We note that this bill has been endorsed by the Coalition to Preserve the Low Income Housing Tax Credit. The Coalition has also suggested, and we support the proposal, to allow the owner to elect to claim a tentative credit for the first year in which a building is placed in service so that there can be a more realistic return to investors in the early years of the project. The rationale for such changes is well set forth in the testimony by the Coalition, and we will, therefore, not repeat them here.

We would also like to build upon two changes contained in prior law. In 1989, Congress changed the methodology used to determine rents for projects funded with 1990 allocations and beyond. Under the old rules, rents were based on actual family size, leading to great uncertainty on the part of project owners as to actual rents

that could be projected because of the variations in the number of occupants from unit to unit. It also provided a disincentive for owners to rent to smaller families since the amount of rent that could be charged to that family would be less than that allowed for a larger family. Under the 1989 amendments to the tax program, there is an imputed family size based on the number of bedrooms. For an efficiency, it is assumed that one person is occupying the project. For a one-bedroom apartment the number is 1.5 persons, and 1.5 persons is assumed for each additional bedroom. This change permits an owner to calculate with certainty the project's income stream, thus very much facilitating project development.

Unfortunately, this change was not made retroactive to 1987, 1988 and 1989 projects, causing an administrative nightmare for managers of tax credit projects. They must enforce different rules depending on the year the project received its tax credit allocation. The lack of a uniform rule also leads to disparity between payments made by tenant families with similar income.

In response to concern about tenant rent increases resulting from this change, we would suggest that the increases be phased in gradually, as is done under changes in HUD program rules—to no more than 10% a year.

Certainly, if the new rules are appropriate beginning in 1990, there is no reason that these new rules should not be applied to pre-1990 projects.

Secondly, in the 1990 legislation, Congress provided prospective relief for Section 515 projects by allowing the gross rent of a project tenant to be increased to 30% of the tenant's income to the extent that the owner pays an equivalent amount to the Farmers Home Administration as "overage." This problem arises because Section 515 requires an owner to charge 30% of the tenant's actual income for rent, whereas the tax credit's limitation is based on a flat rent at 30% of qualifying income. In 1988, Congress passed remedial legislation to address similar situations in the case of HUD's Section 8 projects, which also required that tenants pay 30% of their incomes for rent and did so on a retroactive basis. The principle is the same under both rural and urban programs, and indeed it was commonly believed that the 1988 legislation did encompass the Section 515 program, although Treasury would not accept such interpretation. Therefore, fundamental fairness requires that the 1990 remedial change to Section 515, effective for 1991 allocations and beyond, be made retroactive to encompass all Section 515 projects.

Again, this change relieves the project manager of the necessity of enforcing two different sets of rules for determining rents. Further, all Section 515 tenants would be paying 30% of their incomes for rent. As the situation now stands, tenants fortunate enough to be living in pre-1991 projects pay less than the statutory mandated 30% of their incomes for rent while equally-situated tenants in 1991 projects have to pay the required 30%.

Again, if this change causes a tenant any significant rent increase, it could be phased in over a three-year period.

Finally, we would like to thank this committee for the support that it has given the low income housing tax credit in the last four years. You can look with pride at the thousands of families residing in decent housing that they would not enjoy if there were no low income housing tax credit. You should take great satisfaction in this achievement, and we earnestly hope that you will allow it to continue. CRHD would be happy to provide you with any additional material or answer any questions from the Committee. Thank you.

Statement of the Coalition to Support Quality Home Medical Equipment, Supplies and Services

Following separate efforts to convey the message to Congress that home medical equipment, supplies and services are vital to the health care delivery system, and in urgent response to continued Administration efforts to reduce the benefit, the undersigned groups have recently established the Coalition To Support Quality Home Medical Equipment, Supplies and Services.

The Coalition to Support Quality Home Medical Equipment, Supplies and Services' goals are to preserve the Medicare durable medical equipment benefit, to support quality home medical equipment, supplies and services, and to improve access to these services.

The primary focus of the Coalition is education and communication directed to its members, policymakers and the public. In meeting its goals, the Coalition will contribute to the well-being of home care patients, will advance the concept of home care as a vital component of a cost effective health care delivery system, and will improve access to home care services.

The Coalition is very concerned with the Administration's proposed cuts in Medicare program spending proposed for FYs 1992 through 1996. The five year budget agreement enacted last year with the Omnibus Budget Reconciliation Act of 1990 has a major impact on the provision of Medicare services. Further reductions such as recently proposed by the Administration should be rejected.

Simply put, Medicare should *not* be a budget issue this year.

We are prepared to meet with you to discuss the reasons why proposed further reductions should be rejected, and to help you and your staff gain a better understanding of the benefits of home care.

American Association for Continuity of Care

Emphysema Anonymous, Inc.

Help for Incontinent People

Health Industry Distributors Association

Health Industry Manufacturers Association

National Association of Medical Equipment Suppliers

National Association of Retail Druggists

United Ostomy Association

STATEMENT

OF THE

COLLEGE OF AMERICAN PATHOLOGISTS

ON MEDICARE BUDGET PROPOSALS

The College of American Pathologists appreciates the opportunity to comment on Fiscal Year 1992 budget proposals being considered by the Senate Finance Committee. The College is a national medical specialty society representing 12,000 physicians who are certified by the American Board of Pathology. CAP members practice their specialty in community hospitals, independent medical laboratories , academic medical facilities, medical examiner/coroner offices, and federal and state health facilities.

Medicine has suffered significant budget reductions during the last few years. The Administration's latest budget proposals would impose additional substantial cuts on medicine and specifically laboratory reimbursement and would break faith with the substance and spirit of the five-year 1990 deficit reduction plan that would cut Medicare spending by $42.5 billion.

We urge the Committee to uphold the five-year plan and to reject proposals for additional reductions in payment for physician's services provided to Medicare patients. The nation's medical system cannot continue to provide high quality services to the nation's elderly with such continuous and substantial reductions in Medicare reimbursement.

During the past seven years laboratory medicine, in particular, has been the target of numerous and repeated reductions in Medicare reimbursement. Since 1984 payment for Medicare clinical laboratory testing and pathology services has been subject to national limitations on fee schedule amounts, cuts in national limitation amounts, foregone or reduced inflation updates, and reductions in prevailing charges. The enclosed Attachment further describes those restrictions. Laboratory medicine cannot continue to provide high quality services with continued budget cuts.

In particular, the College urges the Committee to reject the following proposals for reduction in Medicare reimbursement:

1. <u>Reinstatement of Medicare Coinsurance for Laboratory Tests</u>

   In 1984, Congress eliminated the requirement for a 20 percent beneficiary coinsurance for laboratory tests and implemented a Medicare clinical laboratory fee schedule. The Department of Health and Human Services and the laboratory community supported elimination of the coinsurance. Medicare assignment is now mandatory for all such tests.

   Now the Administration proposes to reinstate the 20 percent beneficiary copayment. Reinstatement of the beneficiary copayment requirement would place an additional burden on the shoulders of Medicare beneficiaries. Further, such a change would also have a significant adverse impact on laboratories because of the high costs associated with billing and collecting the usually small per-test beneficiary copayment amounts. In fact, because of the costs of collection and the anticipated losses resulting from bad-debt write-offs, reinstatement

of coinsurance would, in actuality, substantially reduce Medicare reimbursement to clinical laboratories.

The College urges the Committee not to support reinstitution of the Medicare coinsurance for clinical laboratory tests.

2. Freeze in Fee Schedule National Limitation Amounts

Since 1986 Medicare payments for laboratory tests have been subject to test-specific caps or national limitation amounts that act as a ceiling on laboratory payments.

The Administration proposes to freeze the national limitation amounts for 1992 and 1993 rather than to increase them by the two percent update that was agreed to in OBRA '90. This two percent update was itself a reduction in the full CPI increase that laboratories would otherwise have received. Thus, the Administration's latest proposal means that laboratories currently being paid at national limitation amount rates would not receive even a limited update to offset the increasing costs of inflation. For these laboratories, this change would amount to another lowering of reimbursement.

Furthermore, reduced reimbursement is being proposed at a time when the cost of laboratory testing is increasing because of other government initiatives. In September 1990, new regulations regarding laboratory quality assurance were implemented. Laboratories now incur increased costs in meeting more stringent requirements for proficiency testing.

The College has a long-established record of support for and involvement in appropriate quality control and assurance mechanisms for laboratory medicine. Expanded federal requirements in these areas should not be accompanied by reductions in laboratory payment. Reimbursement levels for laboratory testing must be adequate to cover all costs of the service including appropriate quality assurance activities.

The College strongly encourages the Committee to reject further reductions in payment for laboratory testing.

3. Medicare Payment for Graduate Medical Education

The federal government supports graduate medical education (GME) of the nation's physicians through payment to hospitals for their direct and indirect costs in this regard. Since 1983, payment for indirect medical education costs has been included as an element of the hospital prospective payment system (PPS) with payments to qualifying teaching hospitals increased 7.7 percent for

each 0.1 increase in the hospital's ratio of interns and residents to beds. This adjustment is to compensate teaching hospitals for higher costs in patient care associated with the training of physicians that are not accounted for in the PPS rates.

Direct medical education costs (salaries and other overhead costs) are reimbursed separately but also prospectively based on the hospital 1984 cost per resident adjusted for subsequent increases in the level of consumer prices. Although these payments represent only abut two percent of Medicare inpatient payments, approximately one-sixth of hospitals receive this reimbursement and it is estimated by the Congressional Budget Office to cover one-third of hospitals' total graduate medical education costs.

The Administration proposes to reduce payment for both direct and indirect graduate medical education. The reduction in the indirect GME payment would be a significant reduction in the adjustment factor from 7.7 percent to 3.2 percent over a five-year period. Even the 1992 reduction to 4.4 percent would significantly limit payment to teaching hospitals.

The direct GME reduction would be more complex and would attempt to provide incentives for primary care residencies by basing payments to hospitals on a percentage of the national average salary of residents: 240 percent of the national average for primary care residents, 140 percent for non-primary care residents in their initial residency, and 100 percent for nonprimary care residents beyond the initial residency. Thus, a disincentive for specialty, or non-primary care, residencies would be created.

Pathology residency programs would be particularly affected by the proposed reductions. The average age of pathologists is now 52 years, with the average age of retirement 62 years. A large proportion of pathologists are expected to retire by the end of this decade, and there is no current surplus of pathologists to fill the void left by the retiring pathologists. In fact, there is a serious shortage of pathology residents at this time. A shortage of pathologists is predicted for the mid-1990s. With continual decreases in GME payment it is increasingly difficult for hospitals to maintain residency programs that would train pathologists for the future.

Such reductions in payment to hospitals that conduct essential training programs for physicians will cause erosion of the nation's medical education system and undeserved hardship on teaching hospitals, which also care for a disproportionate share of indigent patients. Hospital closures or reduction of residency positions is likely to result. Future access to needed health care services in some communities will be reduced.

The College urges the Congress to continue support of needed physician training programs by opposing the severe cuts for these services proposed by the Administration.

Summary

The College of American Pathologists urges the Senate Finance Committee to reject the Administration's proposals for Medicare cuts in Fiscal Year 1992 – cuts that would be in addition to the reductions included a few months ago in a five-year comprehensive deficit reduction plan. Although less than 10 percent of all Part B expenditures go for clinical laboratory services, approximately 60 percent of the savings under the current proposal would come from these services. This is clearly unfair to laboratories, especially in view of the increasing regulatory costs that these entities are now facing.

We also encourage you not to accept proposals for reduction in federal support for education of physicians. Hospitals and physicians incur added costs in graduate medical education that must be adequately funded if that education is to continue.

Late last year a sweeping deficit reduction plan was adopted. We strongly encourage you to uphold that plan and not break faith with health care providers by imposing additional Medicare reductions.

Thank you for the opportunity to comment on the President's 1992 budget proposals.

[illegible]
April 11, 1991

College of American Pathologists

ATTACHMENT

Major Restrictions in Payment for Medicare Clinical Laboratory Services:

<u>July 1984: Clinical Laboratory Fee Schedule Established</u>

- Carrier fee schedules were implemented for clinical laboratory services performed in hospitals for outpatients, in physicians' offices, and in independent laboratories. Payments were set at 60% of prevailing charges for independent laboratories and physicians' offices; and at 62% for hospital outpatient services.

- Mandatory assignment was instituted for independent laboratories and hospitals.

<u>July 1, 1986: Fee Schedule Caps Established</u>

- Carrier fee schedule amounts were capped at 115% of the median of all fee schedule amounts.

<u>January 1, 1987: Payments Reduced; Assignment Expanded</u>

- Hospital fee schedule amounts were reduced from 62% to 60% of the prevailing charge, except for hospitals with 24 hour, 7 day a week emergency room services.

- Physicians' office laboratories were required to accept assignment.

<u>January 1, 1988: Update in Fee Schedule Eliminated</u>

- Laboratory fee schedule inflation updates were eliminated.

<u>April 1, 1988: Payments Reduced</u>

- The 2% differential was eliminated for all hospital laboratories except those operating qualified emergency rooms in sole community hospitals.

- Fee schedules for high volume tests were reduced by 8.3%.

- The fee schedule caps were reduced from 115% to 100% of the median of all fee schedules.

<u>January 1, 1990: Payments Reduced</u>

- The fee schedule caps were reduced from 100% to 93% of the median of all fee schedules.

<u>January 1, 1991: Update Limited; Payments Reduced</u>

- The fee schedule caps were reduced from 93% to 88% of the median of all fee schedules.

- Laboratory fee schedule inflation updates were limited to 2% (4.3% was scheduled).

<u>January 1992 and 1993: Updates Limited</u>

- Laboratory fee schedule inflation updates are limited to 2% regardless of inflation.

USER\BMW\RESTRICT.BVC
April 1991

DALLAS POLICE ASSOCIATION,
Dallas, TX, April 8, 1991.

Written statement regarding mandatory Medicare coverage of State and local government employees
Attn: Senate Committee on Finance

The Dallas Police Association represents 2,200 officers on the Dallas Police Department. We are vehemently opposed to the Federal Government mandating Social Security and Medicare coverage for all state and local government employees.

As you are aware, state and local governments in Texas are facing hard economic times. Forcing them to add employees to Social Security would have a devastating effect. Despite the fact that the majority of these employees would be temporary or part time, the financial impact effects the available dollars for the police departments.

We need every available dollar to fight crime. Federal mandates that require state and local governments to raise revenue only hurt our already fragile budgets.

Again, please do not mandate Social Security and Medicare coverage for all state and local government employees. Your consideration of this matter would be greatly appreciated.

Sincerely,

MONICA M. SMITH, *President, Dallas Police Association.*

STATEMENT OF THE EMPLOYEE EDUCATIONAL ASSISTANCE COALITION

EMPLOYEE EDUCATIONAL ASSISTANCE (SECTION 127)

The Employee Educational Assistance Coalition members would like to submit the following written statement for the record. Our coalition is a multifaceted one made up of business, labor, education, and various associations and professional groups.

Section 127 of the tax code allows employers to provide up to $5,250 per year to each of their employees in tax-free reimbursements for tuition, books and fees for non job-related educational assistance. Congress has continually affirmed their support for this program since its inception in 1978. More than seven million Americans have been able to work and attend classes in order to improve their skills and qualify for better jobs. The Section 127 program is the only way millions of working men and women can continue to further their education.

Section 127 users are from large and small companies throughout the United States. The tax exclusion is of special importance to women and minorities, as well as to workers who are at the bottom of the career ladder—workers who need improved skills in order to qualify for better jobs. Section 127 benefits are used by employers to retrain workers either for other work within the company or, in the case of lay-offs, for other employment in the community. These benefits are a morale builder and an important way for employers to retain valued employees.

Engineers, teachers, nurses, secretaries, production line workers are but a few of the fields that have in the past or are currently benefiting from Section 127. Continuing education is an important factor in the growth and promotion of America's workforce that enables individuals to broaden their skills and knowledge and keep pace with changing technology. The majority of U.S. workers have less than four years of high school yet nearly two-thirds of all new jobs in our economy will soon require more than a high school education. America must deal with this dilemma quickly if the nation is to compete effectively in the global economy.

Most of today's workers will be in the job market in the year 2000 and we must prepare them for future careers—careers that will require greater sophistication and technical expertise. The need for technically educated workers will keep growing throughout the 1990's and must be addressed. We can only meet these challenges by building a world class work force through a commitment to life long education.

A 1989 Society for Human Resource Management (SHRM) survey revealed that office and clerical workers had the highest participation rate in Section 127 programs. This is particularly important given the fact that Section 127 is often the only vehicle that lower-skilled occupational groups have for attaining employer-provided training. In addition, recent surveys (by SHRM and Coopers and Lybrand) show that Section 127 benefits are distributed in a manner closely paralleling earnings among the labor force as a whole. Nearly 71 percent of Section 127 recipients earn less than $30,000 annually.

As American Society for Training and Development (ASTD) studies and other reports have shown, the productivity gains from training and retraining beyond high school are dramatic. The government's own findings show that a two-year college graduate earns on average over $500 a month more than a worker with only a high school education; and he or she typically pays more Federal taxes. A four-year college graduate typically earns at least $300 a month more than a two-year college graduate. Studies also show that graduates of both two-year and four-year colleges stay in the workforce four or five years longer than workers with only a high school education. These marked differences in both pay and job retention over time repay the comparatively nominal short-term Federal sacrifice at least a hundred-fold.

Investment in people goes hand-in-hand with investment in research and development; both are essential to the nation's future. Employee educational assistance enhances employee job satisfaction. It makes the American workers better workers and lengthens their careers, at a small short-term cost in revenue and enhances American productivity and competitiveness. Employee educational assistance has been repeatedly embraced by Congress and a majority of U.S. employers as one of the nation's proven competitiveness policies. It is time to make Employee Educational Assistance permanent law.

During a time when the national debate on competitiveness centers on the ability of American workers to continually upgrade their skills to keep pace with changing technology, the need for Section 127 is critical. We urge you to enact S. 24 which will make Section 127 a permanent part of the IRS tax code.

STATEMENT OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. Chairman and Members of the Committee, my name is Michael D. Bromberg and I am Executive Director of the Federation of American Health Systems, the national association which represents investor owned health systems. Our members include more than 1400 hospitals as well as integrated health plans which insure several million Americans.

We appreciate the invitation to appear before the Committee in order to react to the Administration's fiscal year 1992 budget and to comment on health policy issues as well as the numbers in that budget.

In order to assess the budget as a health policy document, I would like first to present our views on the strengths and weaknesses of our current health system and our proposals for health policy reform. After that, I will address the Administration's proposals and why we believe they fail to address the current and future health needs of our nation.

Health care is the second largest industry in the United States, employing nearly ten million people, about four million of them in our nation's hospitals.

The health care delivered in America is the finest in the world for those who have access to it and can afford to pay for it. The vast majority, 87 percent, of Americans are insured or covered by health plans. For these individuals there are no waiting lists; they have access to the best trained health professionals in the world, the latest in medical technology and outstanding facilities. The system has serious problems, however, and those problems are increasing at an alarming rate. Access and affordability gaps in the system are the two major issues which need to be addressed.

PROBLEMS IN OUR HEALTH SYSTEM

About 60 percent of Americans living below the Federal poverty line are not eligible for Medicaid, up from 40 percent twenty years ago. That gap must be eliminated or substantially narrowed if America is to claim to have a national policy in health care. We believe a Federal policy is needed to assure access and financing for this population group. We support federalization of the Medicaid program—or at least Federal minimum standards for Medicaid eligibility, benefits and payment for services.

Fifteen million or more Americans work for employers who do not provide insurance. Most of these people work for small employers who do not have access to large group coverage and affordable insurance rates. A myriad of state laws mandating services which must be covered in health insurance plans present a real obstacle to small employers seeking affordable coverage for their employees. We support efforts to enact small employer insurance reforms as a first step to expand adequate employment based coverage of needed medical and mental care for all Americans who work.

Uncompensated care provided by hospitals has grown from about $3 billion in 1980 to about $10 billion in 1990. Investor-owned private hospitals provide uncompensated care which exceeds five percent of their revenues. Private payers, employers, and other health plans are increasingly unwilling to cross-subsidize indigent care costs or the shortfalls from reduced Medicare or Medicaid payments.

Costs continue to increase for providers as well as consumers and payers of health care services. The major obstacle to cost containment is the lack of incentives for selecting cost effective coverage. The Federal tax code provides exactly the wrong incentives by treating all employer purchased health insurance as an exclusion from income. This perpetuates the notion that the right to health care carries with it little responsibility for cost containment on the part of those using the system.

PRIVATE INITIATIVES

There are encouraging signs in the business community that managed care plans, which emphasize utilization review and appropriate levels of care, hold much promise for cost containment through the selection of quality, cost conscious providers and the use of quality based protocols for treatment. If the tax code were amended to place reasonable limits on the amount of tax exempt insurance purchased by employers, those managed care plans would be in greater demand by employees and employers alike.

In recent months employers have become more serious about getting better value for their health care dollars. There is growing evidence that their efforts can be effective. A recent study by Jack Meyer, health care economist at New Directions for Policy, describes a number of case studies in which employers are making a difference as prudent purchasers of care.

Allied Signal, using a plan developed by CIGNA, experienced a four percent increase in health costs in 1989 compared to a 39 percent rise in 1987. Allied estimates its 1989 costs were 20 percent less than they would have been under the previous plan.

Using a Prudential point of services plan, Southwestern Bell—whose per employee costs had been growing at a 20 percent annual rate—lowered the increase to well under ten percent in 1989. Proctor & Gamble, with a similar plan established by Metropolitan, lowered its annual rate of increase from 15 percent to a little over six percent.

These "point-of-service" plans offer employees a choice of reduced, little or no cost sharing if they use network physicians with the freedom to go outside the network if they pay significant amounts of their own money, usually 20 percent of the costs after a higher deductible.

Southern California Edison maintains ten in-house clinics that operate as managed care systems handling over 100,000 patients per year and other companies such as Chevron have established national managed care programs for mental health and substance abuse services based on the network approach.

These types of managed care programs would proliferate if the tax code incentives were restructured to reward cost effective purchase of health coverage. In addition to creating the incentives for cost effective health plans, a limit on the tax exclusion for health insurance also would generate the revenues to expand coverage for those most in need. Health is the only fringe benefit which is not capped and a small fraction of the approximately $50 billion in lost revenues from the tax exclusion could subsidize care for the neediest segment of our population.

Lower income employees could also be exempted from such a change in the tax code to assure a fair and equitable redistribution of the tax subsidy for private insurance.

THE CASE AGAINST GOVERNMENT COST CONTROLS

Some states have tried rate controls on hospitals for more than a decade, but they do not have a better record in controlling costs than states which have relied on market forces. For example, per capita hospital spending in the four largest rate setting states (Maryland, Massachusetts, New Jersey, and New York) grew at an average annual rate of 8.1 percent over the 1985-88 period while the market-oriented states of Minnesota, California, Delaware and Colorado experienced a 7.1 percent average growth rate. The national average growth rate during those years was 7.8 percent. (Lewin/ICF Analysis of Hospital Expenditures and Revenues, February 1990.)

Hospital operating margins in the regulated states averaged 0.4 percent during the period 1984-1988, while margins in the four market-oriented states averaged 5.6

percent. The margins in the rate setting states are clearly inadequate to assure that the physical plant and equipment of hospitals will be kept up-to-date.

Federal controls on total health expenditures substitute government power for consumer decisions and discourage improvements in quality and value. Research and development of new medical technologies and delivery systems would be inhibited. Providers would have little incentive to participate in managed care networks once their rates for all payors were set. Price controls without controls on wages or supplies would be unfair and would drive down operating margins already at dangerously low levels. The process of distributing health care dollars among states as well as providers would raise serious political and geographic issues. Low cost states and lower cost providers might find their revenues capped despite greater need to improve the quality of care while more influential but higher cost providers use political skills rather than relative performance to influence the rate commissions which control the health care dollars.

In a recent speech, Mr. Powell Woods, Vice President for Human Resources at Nestles in Cleveland, makes this point from the view of a large purchaser of health care. He said:

> " . . . No organization was ever controlled or regulated into efficiency, but many have been managed into efficiency with well designed, properly implemented incentives. And this is exactly what market reform is. Market reform is simply payers agreeing to purchase the highest quality medicine they can find at the most efficient (competitive) price that they can find it."

There is a better way for employers to purchase care. One way is contained in a new proposal authored by Rep. Nancy Johnson which is intended to encourage the growth of managed care plans through tax code incentives as one example of stimulating competition and avoiding direct government control of health expenditure decisions.

Managed care distinguishes between needed and unnecessary medical treatment. Government expenditure controls focus on budgets, not the necessary costs of quality care.

In addition, we support expansion of current efforts to develop medical treatment protocols based on health outcomes research. This important educational tool is important for both providers and consumers in their health care decisions. The President's budget calls for only a $7 million increase in the budget of the Agency for Health Care Policy & Research, an amount we believe should be substantially increased.

In summary, the Federation believes it is time to strengthen the world's best health care delivery system by enacting reforms designed to provide access to that system to all Americans and to inject incentives to make that care affordable.

THE ADMINISTRATION BUDGET

Against the backdrop of our analysis of the strengths and weaknesses of our current system, the Administration's budget is a disappointment. It contains little in the way of health reform proposals designed to address the needs of those without coverage. It does not expand coverage to any of the currently uninsured.

The deep Medicare cuts are a clear breach of the five year budget agreement enacted last year, and we hope Congress will reject any effort to further reduce payments for needed health services. Falling Medicare hospital margins have now reached the negative side of most hospitals' financial statements, threatening the financial viability of many institutions.

According to the Prospective Payment Assessment Commission (ProPAC), hospital Medicare margins from DRG payments fell from 14.5 percent to 1.8 percent during the first five years of the prospective payment system. According to projections of current and future margins made by Lewin/ICF Inc., those margins will continue to fall from a loss of 0.3 percent in fiscal 1989 to a loss of seven percent to 13 percent in fiscal 1992. Seventy percent of hospitals will lose money on the Medicare DRG payment system by 1992 up from 56 percent in fiscal 1990.

Even heroic efforts to contain costs are insufficient to prevent serious, chronic economic losses to hospitals. In the early years of the DRG system, hospitals did respond to the new incentives of fixed prices by reducing staff and reorganizing to improve productivity. These cost saving techniques cannot be repeated every year without impairing quality of services. We should make it clear that the DRG system, per se, is not the primary reason for the financial problems of hospitals. It is the failure to enact adequate increases in DRG rates to keep pace with increased and uncontrollable increases in hospital expenses that has produced unacceptably low margins.

That failure to provide adequate annual increases in Medicare DRG rates has been a reflection of the budget reconciliation process in which Medicare has absorbed a disproportionate share of deficit reduction. From 1983 through last year, Medicare payments to hospitals have been $83 billion or 28 percent less than they would have been under the cost based system in effect prior to the prospective payment system.

Now the Administration's FY 1992 budget targets Medicare for more than one-half of all program cuts. It does this at a time when hospitals face severe personnel shortages and the lowest Medicare margins in history. The budget calls for large reductions in the indirect medical education payments to teaching hospitals and outpatient payments for all hospital services as well as a three month freeze in the annual update or increase in DRG rates. This last proposal is subtly referred to in the budget as a uniform date for the updates for all PPS providers, but it amounts to a three month delay or freeze in the rate increase for hospitals.

If the government really wants to freeze all increases in hospital payments, it should also freeze all of our costs, including the prices paid to our suppliers for the goods and services needed to deliver inpatient care as well as the wages in a labor intensive industry.

MEDICARE MEANS TEST

One proposal in the Administration budget which we believe merits serious consideration would impose a higher Medicare Part B premium on individuals with over $125,000 income ($150,000 per couple). Those who can afford to contribute more to their health expenditures should be asked to do so; however, we have two serious reservations about the details of the Administration proposal.

First, we would urge the Committee to consider some form of means-testing in the context of overall health policy rather than deficit reduction. Revenues from Medicare beneficiary cost sharing should be used to finance the health care costs of the Medicare program or of those in need through Medicaid expansion. The revenues should not be used for general deficit reduction or other unrelated programs as the Administration proposal would.

Second, we believe a fairer way to impose cost sharing or means testing would be to include the actuarial value of the total Medicare benefit on the returns of those earning more than $25,000 ($32,500 per couple), just as is done for part of Social Security benefits. Using the tax code would be administratively simple and more progressive than income-related premiums

MALPRACTICE REFORM

The Administration's proposal for encouraging model state laws on medical malpractice reform stops short of a Federal solution. We would urge Congress to use Federal jurisdiction to impose restraints on non-economic damages and to require alternative resolutions of disputes, such as arbitration, prior to litigation.

Hospitals are dismayed by the arbitrary proposal for financing Federal incentive payments to the states for liability reform through the withholding of one percent of DRG payments to hospitals. This seems to violate the principle of the Medicare program that this payroll tax-supported trust fund not be used for non-Medicare purposes. It is even more absurd to suggest that hospitals are responsible for all medical malpractice problems or the sole beneficiary of malpractice reform and should, therefore, pay for any changes in this area.

PUBLIC HEALTH PRIORITIES

We applaud the Administration's rhetorical emphasis on reducing infant mortality. The plan would target ten geographic areas for funding programs designed to change the behavior of women at risk because of drug, tobacco or alcohol abuse.

The emphasis on prevention is continued in other budget proposals for childhood immunization and breast and cervical cancer screening programs.

While these programs are commendable, the Administration has failed to put them in the context of a national health policy which also assures children of coverage against the costs of treating other illnesses which are either not prevented or are not preventable. America may spend 12 percent of its gross national product on health care but that doesn't provide comfort to the millions of children living in poverty who have no insurance.

TIME FOR A NATIONAL POLICY

It is time for the United States to spell out a national policy on health care coverage for all its citizens. We do not advocate government control of all health expendi-

tures. In fact, we believe such a system would deprive consumers of the choices which make up one of the great strengths of the current system. If a deficit ridden, insolvent government takes control of all health spending, quality and access will suffer as arbitrary, budget driven controls on spending are imposed. Innovation and research and development of new technology would be curtailed and consumers would be the big losers in a government controlled system.

Government does have a major role to play, however. Only government can remove some of the obstacles to competition and cost-containment by reordering incentives such as the ones we have discussed here today. Government also has a responsibility to the disadvantaged and should act as a payer of last resort for needed coverage.

The major faults in our present system are not addressed in the Administration's budget. They include the open ended tax subsidy for employee health benefits which encourages spending without any restraint and the lack of government coverage for over ten million poor people at the same time we subsidize or spend nearly $150 billion on health care for middle and upper middle income Americans through Medicare and the tax code. Until these two major issues are addressed, gaps in affordability and access will remain threats to the very strengths of the current system which we ought to be preserving.

As frustration over access and costs increases, we need leadership in developing a national health policy which preserves the strengths of the current system and solves its very real problems. If that leadership is not forthcoming soon, the rising frustrations could lead us into a system in which government rather than consumers make decisions about rationing and allocating resources based on arbitrary budgets rather than need.

CONCLUSION

The Committee has asked us to respond to several questions relating to: our perceived rationale for the new policy initiatives and Medicare cuts; when we believe the Administration should propose changes in health insurance access policies; our views on children's issues such as infant mortality; how well the "safety net" is working; how to reinforce family values; and how to make programs within the Committee's jurisdiction more effective.

Our views on those questions are included in the following summary of our testimony.

(1) The Administration's continued efforts to cut the Medicare program reflect the limited targets available to it once new taxes and Social Security are taken off the table. It may also reflect a lack of real support for an entitlement program which helps all the elderly without regard to their financial means. Finally it disregards the fact that continued provider cuts must at some point affect the quality and availability of services for all Americans.

(2) We believe that the United States needs a national health policy which assures access to all Americans, finances that care for those unable to pay, and provides incentives for cost effective health plans. Consumer choice must be preserved because choice and managed care hold greater promise for cost containment than government expenditure caps or rate controls. We support changes in the tax code to limit tax free employee benefits in order to create incentives for cost effective, managed care plans. We also support acceleration of efforts to develop treatment protocols based on health outcomes research to eliminate unnecessary care, use of pooling techniques to provide access to affordable coverage for small employers, and expansion of public programs with Federal minimum standards to cover all people living below the poverty line.

(3) Uninsured children should be the first segment of our population covered by expanded Medicaid coverage. We support programs designed to change behavior of women of child bearing age who are drug, alcohol or tobacco users. Ultimately the infant mortality statistics will improve primarily as the result of lifestyle changes; however, society must also be prepared to finance the costs of medical and mental health treatment for those in need.

(4) The "safety net" in health care is not working as well as it should because the Medicaid program has not met its promise to provide care for the poor. The fact that only about 40 percent of those living in poverty are now eligible for Medicaid compared to 60 percent ten years ago proves this program needs to be strengthened. We support federalizing the program, but in lieu of that, we support Federal minimum standards for state eligibility, benefits and payment levels.

(5) Family values and responsibility in health care must include appropriate cost sharing. The Administration's plan for imposing higher Medicare premi-

ums on high income families deserves serious consideration. We would support taxation of the value of the Medicare benefit as a more equitable approach to reflect ability to pay for services and to partially finance a national health policy.

(6) The concept of paying for coverage rather than separate services should be considered as a way to improve efficiency in the Medicare program. The new entrants to the program each year should be viewed as a logical national demonstration group for this purpose. For example, Medicare could allow each new entrant to voluntarily opt to continue the private insurance or health plan coverage they have had during employment with Medicare contributing a fixed amount toward the premium or cost of that plan. This would test the concept of buying coverage instead of services on a purely voluntary basis. Another idea worth testing on a demonstration basis is whether beneficiaries would accept a high lifetime or annual deductible in return for broader catastrophic coverage under Medicare including a long term care benefit.

For fifty years or more we have debated the issue of national health insurance. Political and ideological differences over the appropriate scope of government's role have brought about a stalemate. If progress on the interrelated issues of access, cost and quality is to be made, we need to focus on the areas of consensus and forge a bipartisan alliance. There seems to be a consensus on small employer insurance reforms and increased access for the poor. The Administration's budget provides little leadership on these policy issues but I believe the health community is ready to work with Congress to take a major step toward establishing health policy reforms. We cannot support a government controlled, single payor system for the reasons stated above, but we can and do support efforts to encourage appropriately managed care to contain costs and assure quality.

We appreciate this opportunity to appear before the Committee and our industry is willing and anxious to work with you on steps to improve the American health system.

Statement of the International Association of Fire Fighters (AFL-CIO)

Good morning. My name is Frederick Nesbitt, and I am the Director of Governmental Affairs for the International Association of Fire Fighters, AFL-CIO. I appear here today on behalf of our nation's more than 180,000 professional fire fighters to testify in opposition to the Administration's proposal to extend the Medicare tax to currently non-covered employees of state and municipal governments.

I find disappointing and frustrating that this proposal is before the Congress once again. Every year for the past decade, the Administration has proposed mandatory medicare coverage as a primary revenue raiser, only to have Congress reject the idea each time. Even in last year's historic budget agreement which contained dozens of new revenue items, Congress wisely resisted Administration pleas to place a new, regressive tax on millions of middle-income Americans.

The fact that the Administration has once again included this repudiated policy as part of its annual budget proposal is evidence of an unfortunate lack of seriousness on its part. We hope that this Committee will greet the proposal with the same skepticism and reluctance that it has in the past.

Although the arguments against mandatory medicare coverage have been repeated advance by our organization as well as other groups, please allow me to briefly reiterate them here.

First, is the question of fairness. Although the IAFF is sympathetic to the urgent need to raise revenue, a regressive payroll tax on middle-income Americans is the wrong way to go about generating additional government funding. The public employees of this country have been especially hard hit by the Federal budget crisis, and should not be expected to shoulder ever greater burdens.

Second, the proposal is overrated as a "revenue enhancer." As a result of the 1985 COBRA law, the Medicare tax was imposed on new hires of state and municipal governments effective April 1, 1986. Due to attrition rates of approximately 9-10% per year, the potential revenue effect continues to dwindle rapidly and will have virtually no net revenue effect by approximately 1996. A permanent solution to the deficit problem requires substantial sources of *continuing* revenue. This particular revenue option does not fit that criterion because the net revenue effect will decline to zero in a relatively short period of time. At the point of diminished returns, Congress will be required to find additional sources of revenue.

Third, fire fighters are deeply concerned with the severe impact this proposal will have on state and local governments. The fiscal health of states and municipalities

directly affects the fire service and our ability to protect the public. State and local governments have endured a decade-long barrage of cuts in Federal aid programs in the name of deficit reduction, and additional financial burdens will lead inevitably to a reduction in essential police and fire services. The citizens of this country demand and need more police and fire protection, not less.

Fourth, and perhaps most serious, this proposal will have a severe, detrimental impact on existing retirement and health plans. For years, Congress specifically excluded employees of state and municipal governments from coverage under Medicare. As a result, these employees and their employers have built sound and secure health plans, many of which provide benefits superior to Medicare. This is especially true for public safety officers whose unique needs, due to hazardous occupations and early retirement ages, are reflected in their retirement and health plan benefits. Under most public sector systems, employees must pay all or part of the premium for these benefits. Imposition of the Medicare tax will increase employee costs without adding new benefits.

Finally, I would like to address a misleading argument advanced by proponents of mandatory medicare coverage. Although the motive behind this measure is obviously to generate revenue, some backers have attempted to obscure the fact that they are calling for a tax on middle-income families by painting this as an issue of fairness. Proponents claim that expansion of the tax is "fair" because a majority of state and municipal employees receive Medicare benefits even though their public sector service was outside the medicare system. The implication of the argument is that state and municipal government employees have been receiving a "free ride" with respect to Medicare benefits.

The fallacy of the "free ride" argument becomes apparent when one considers that public employees who are entitied to receive Medicare benefits become eligible by precisely the same eligibility rules that apply to every other citizen of this country—by working the required number of quarters in covered employment or as a result of their spouse's covered employment.

To the extent that the perceived inequity regarding Medicare eligibility of state and municipal employees actually exists, it was corrected by a provision of the 1985 COBRA law to extend Medicare coverage to all state and municipal employees hired after April 1, 1986. This provision represented a compromise between the proponents and opponents of full and immediate coverage. The compromise provision allows for a gradual transition toward full coverage, while grandfathering employees who were already working as of that date and who have a vested interest in their independent retirement and health plans. When we talk about equities, we must not forget the compromise agreement implemented by Congress in 1985.

I want to thank you, Mr. Chairman, for the opportunity to testify, and I will be happy to answer any questions

The International Society for Cardiovascular Surgery / The Society for Vascular Surgery

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April 17, 1991

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
United States Senate
SD-205
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Bentsen:

The Joint Council of the North American Chapter of the International Society for Cardiovascular Surgery and the Society for Vascular Surgery submits the following comments on the President's FY 1992 budget proposal for inclusion in the Committee's hearing record of March 19-20, 1991.

The President's FY 1992 budget includes a number of proposed reductions in spending in the Medicare program. Estimates of the five year cumulative impact of these cuts have been as high as $25 billion. The Joint Council is very concerned that these proposals follow so quickly on the heels of last year's five year budget agreement. The Omnibus Budget Reconciliation Act of 1990 substantially reduces spending in the Medicare program, both for hospitals and physicians. We urge Congress to reject any further Medicare reductions as contrary to the spirit and letter of the omnibus budget agreement.

Two provisions in the President's budget are of particular concern to the Joint Council. The first is the proposed reduction in the indirect medical education adjustment for Medicare teaching hospitals. The great bulk of physician training programs are in large, tertiary care hospitals. Many of these are in large public hospitals serving diverse community needs. Many of these institutions are hard pressed financially as they struggle to make ends meet in an era of ever narrowing reimbursement. Many of the patients at these hospitals are poor with either no insurance or inadequate Medicaid coverage.

This proposed reduction, if enacted, would both compromise the scope and quality of residency training programs, from vascular surgery to primary care, among others while, at the same time, undermining the overall financial stability of the tertiary care institutions. This nation simply cannot afford to lose any of these hospitals, not only for their great teaching capacity but also for the essential health care services they provide to communities in need. We urge the Senate Finance Committee to reject further reductions in medical education payments.

The President's budget also proposes bundling the fee of the assistant surgeon into the fee of the primary surgeon. Under this proposal, as we understand it, the reimbursement for surgery would remain at the same level; however, when a primary surgeon uses an assistant, the primary surgeon would be at risk for the payment of the assistant. This concept makes no sense. We believe that when appropriately used, the assistant surgeon provides an necessary service for the patient, which should be recognized by the Medicare program. That recognition should not come at the expense of the primary surgeon or any other physician. We urge the Committee to reject this proposal as well. The Joint Council believes that if there are concerns with fraudulent or abusive use of assistants at surgery, then there are appropriate statutory and investigative mechanisms for addressing these problems without having to reduce legitimate reimbursement for proper service.

The Joint Council is very hopeful that this year will not see another budget reconciliation process requiring further reductions in the Medicare program. All participants in the program need a few years of stability not only to absorb the substantial changes of the recent past but to prepare for the implementation of the new Medicare Fee Schedule in 1992. We, therefore, urge rejection of the President's proposed Medicare reductions.

Sincerely,

Robert W. Barnes, M.D.
President
North American Chapter
International Society for
Cardiovascular Surgery

Calvin B. Ernst, M.D.
President
The Society for Vascular
Surgery

National Council of State Housing Agencies

Mr. Chairman, Senator Packwood, and members of the Committee, thank you for this opportunity to submit testimony on the need to extend the Low Income Housing Tax Credit (Tax Credit) permanently beyond its scheduled December 31, 1991 sunset date. NCSHA is pleased to submit these comments on behalf of its State Housing Finance Agency (HFA) members, which administer the Tax Credit in 47 states.

NCSHA is a national, nonprofit organization created in 1970 to represent the interests of HFAs in low and moderate income housing. HFAs in every state, the District of Columbia, Puerto Rico, and the Virgin Islands meet low and moderate income housing needs through the financing, development, and preservation of affordable ownership and rental housing. HFAs collectively administer 500 different affordable housing programs, which range from homeownership to homeless initiatives.

We would like to thank Senators Mitchell (D-ME) and Danforth (R-MO) for their leadership in the effort to make the Tax Credit permanent. S. 308, permanent Tax Credit extension legislation which they introduced this year, has 81 cosponsors, including 14 members of this Committee. We would like to thank these cosponsors, as well as you, Mr. Chairman, and the other members of this Committee who have supported the Tax Credit program. Companion House legislation introduced by Congressman Rangel (D-NY), H.R. 413, has 141 cosponsors, including several members of the Ways and Means Committee.

We hope that with your help, we can make the Tax Credit program permanent rather than continue to operate it on a stop and start basis. The process of planning, structuring and building a Tax Credit project is complicated, time-consuming, and expensive. Quality developers cannot be expected to build additional Tax Credit projects unless they have assurance that the program will be continued for some reasonable period of time. In addition, Congress has asked HFAs to implement major and complex new responsibilities regarding the Tax Credit without any certainty that the program will be continued.

We want to make three points about the Tax Credit program:

- The Tax Credit is the only significant federal incentive available for the construction and rehabilitation of affordable rental housing for low income persons.
- The Tax Credit has demonstrated that it can produce more than 126,000 low income rental units per year serving households with incomes of 60 percent or less of the area median income.
- The Tax Credit should be extended permanently to build on these successful results and to bring stability to the program, which has twice been disrupted by the threat of expiration.

The Tax Credit is the Major Incentive for Low Income Housing Production

Congress created the Tax Credit in 1986 to replace all of the federal tax incentives designed to encourage investment in low income rental housing. Accordingly, the Tax Credit is now the only significant tax incentive for low income rental housing production and rehabilitation.

The importance of the Tax Credit is especially clear in light of the sharp curtailment in low income rental housing production under the Section 8 New Construction and Substantial Rehabilitation program. In 1980, Section 8 accounted for nearly 133,000 units of newly constructed and substantially rehabilitated housing. In 1989, Section 8 produced less than 4,000 new units.

Meanwhile, the need for affordable rental housing is growing. In 1990, the Joint Center for Housing Studies at Harvard University reported that despite the addition of nearly two million subsidized housing units from 1974 to 1987, the number of occupied units renting at or below $300 per month in constant dollars fell by 2.3 million. The number of unsubsidized units renting below $300 per month dropped by 3.3 million -- more than one-third. Meanwhile, 4.8 million poor renters devoted more than half of their incomes to housing in 1987, including 80 percent of all poor renters living in unsubsidized apartments.

<u>The Tax Credit Succeeds in Producing Low Income Rental Housing</u>

NCSHA is the principal collector and repository of data on the Tax Credit program, gathering information from its member HFAs in annual surveys and sharing this data with Congress, HUD, and the public. This data indicates the total amount of Tax Credits which each state allocates, the number of units produced, and the characteristics of projects. From the available data, we know that:

- **The Tax Credit has generated a substantial volume of affordable rental housing.** Through the Tax Credit, HFAs have helped finance an estimated 316,128 low income rental units since 1986, including 126,200 in 1989, the year in which the Tax Credit was virtually fully utilized. At a time when overall multifamily housing starts are falling, the Tax Credit can account for a large share of new multifamily housing production -- equal to as much as 25 percent of all multifamily rental starts in 1990.

- **Many new Tax Credit projects will be in the low income housing stock for a longer period than the minimum Congress has required.** Many Tax Credit projects now receiving allocations are committed to serving low income renters for longer than the minimum 15-year compliance period required by the Tax Credit law. Developers are making these longer commitments in order to get the priority the 1989 Tax Act gives such projects in competing for Tax Credits and, in a number of states, to meet the even longer low income commitments required by the HFAs themselves.

- **Nonprofit use of the Tax Credit has increased.** The percentage of total Tax Credit dollar allocations that went to nonprofit-sponsored projects rose from 7 percent in 1987 to 16 percent in 1989. Nonprofit Tax Credit use could rise further as a result of amendments made by the 1989 and 1990 Tax Acts and the efforts of HFAs to establish further incentives for involvement by nonprofits.

A state-by-state Tax Credit production chart and a chart comparing yearly national Tax Credit production since the inception of the program are attached.

The 1990 Tax Credit Program Experience

The year 1990 was not a normal year for the Tax Credit program. As a result, only a portion of the 1990 Tax Credits were allocated and the rest were carried forward to 1991. We believe that the full amount of 1990 Tax Credits will be allocated and that the 126,200 unit production record of 1989 will be replicated in future years. This belief stems from the growing popularity of the program, which was clear in 1990 when requests for Tax Credits exceeded the available supply in at least 30 states and Puerto Rico. In Rhode Island, Tax Credit demand was 460 percent of the available supply; in Georgia, 302 percent; in Massachusetts, 300 percent; in Ohio, 294 percent; and in California, 188 percent.

In 1990, HFAs committed 67 percent of the approximately $318 million in available Tax Credit authority to 1,764 specific projects with 74,029 low income units. HFAs carried forward the remaining authority into 1991. NCSHA estimates that the authority carried forward will be fully utilized and will produce the nearly 50,000 additional units which would have been financed last year had 1990 been a normal year.

Tax Credit allocations fell in 1990 for several reasons.

- First, in the 1989 extension of the Tax Credit, Congress gave states only 75 percent of their 1990 Tax Credit authority until last November, when it restored the final 25 percent in the 1990 Tax Act.

- Second, in 1990, HFAs were able for the first time to carry forward unused annual Tax Credit authority to the following year. So HFAs were not pressured to allocate their 1990 Tax Credits by year-end. They could carry over unused credit authority into 1991.

- Third, the sweeping changes to the Tax Credit program made by the 1989 Tax Act, such as requiring HFAs to develop and adopt allocation plans, took time for HFAs to implement.

- Finally, the problem of getting debt financing for other kinds of real estate projects appears to be slowing Tax Credit projects as well.

The Congressional reforms, fine-tuning by HFAs of their Tax Credit programs, and more competition among developers for Tax Credits have made for a more efficient program. For example, HFAs are implementing the Congressional mandate in the 1989 Tax Act to evaluate proposed projects to assure that each project receives the minimum amount of Tax Credit needed for feasibility and long-term viability, after considering all sources and amounts of financing, including other federal, state, or local subsidies and syndication proceeds.

In 1989, Congress enacted the HUD Reform Act, H.R. 1, to require federal agencies as well to limit their subsidies to housing projects to the amounts necessary for feasibility. FmHA last July established a workable system for reviewing FmHA-assisted Tax Credit projects under H.R. 1. HUD's guidelines for subsidy reviews of Tax Credit projects under H.R. 1 were just published on April 9, 1991, and from our initial review we are concerned that the guidelines may be more cumbersome than necessary to achieve the goals that Congress intended.

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Both states and private sector developers of low income housing must have an efficient system for allocating the Tax Credit and other federal subsidies which gives them assurance that all the subsidy necessary to make a project viable is available to them on a timely basis. We believe that HUD should establish a process that relies upon states qualified to perform H.R. 1 reviews in order to offer low income housing providers "one-stop shopping" for the subsidies which Congress intended them to have to develop low income housing.

The Tax Credit Can Be Combined With Other Programs

The unique nature of Tax Credits, permitting the delivery of hard dollars in a predictable and timely fashion, facilitates their combined use with other programs in many innovative ways. In New York, for example, Tax Credits will be combined with the existing Turnkey program which creates new construction and substantially rehabilitated housing across the entire State, from the small rural areas to the concentrated urban areas.

Nationwide, the Tax Credit is also being combined with other programs and resources. The Resolution Trust Corporation (RTC), for instance, is trying to enlist the help of HFAs to provide Tax Credits to help finance the sale of rental housing properties under their Affordable Housing Disposition Program. State housing program subsidies are also being used to maximize the benefit of the Tax Credit, such as to further reduce mortgage interest rates for Tax Credit projects.

NCSHA and its members support the reforms to the Tax Credit program and were pleased to have had the opportunity to help this Committee craft them. But we believe a few further improvements are appropriate. With this in mind, NCSHA recommends that Congress consider additional amendments to:

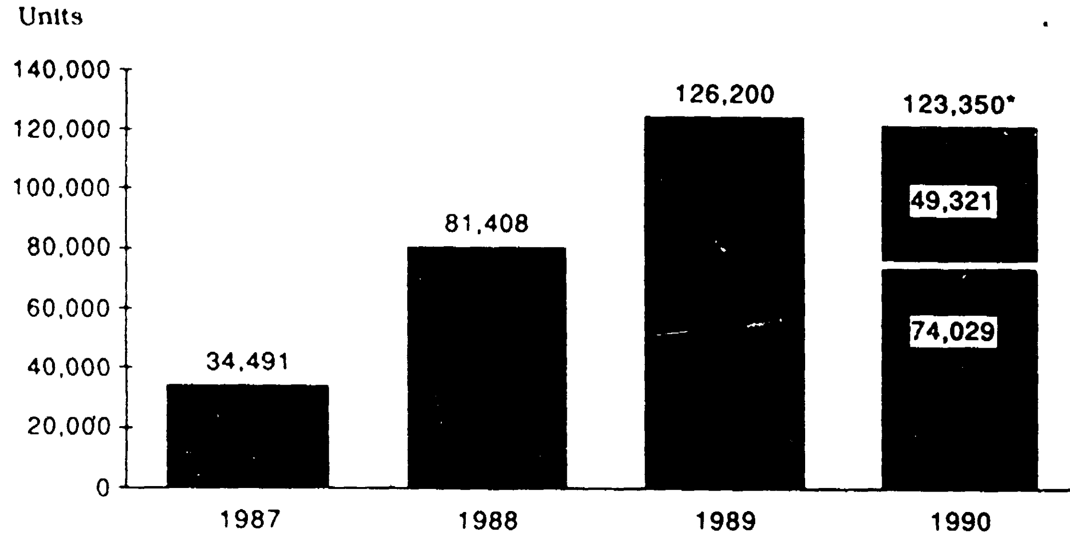
- Repeal the penalty for using tax-exempt financing with Tax Credit projects. State HFAs are receiving reports from developers of extreme difficulty in finding debt financing anywhere for new projects. Permitting up to the 70 percent Tax Credit rate for bond-financed projects would respond to this problem and facilitate more use of bonds, which are capped anyway, and more Tax Credit projects.

- Provide that new construction or substantial rehabilitation expenses for Tax Credit projects financed by monies from HUD's new HOME program will qualify for the 70 percent present value Tax Credit, the same as expenditures financed by Community Development Block Grant funds.

We look forward to working with the Committee on any changes necessary to make the Tax Credit work as efficiently as possible to provide decent, affordable housing for American families who need it. We ask that you let the Tax Credit success story continue by making the Tax Credit program permanent.

Thank you for the opportunity to comment.

TOTAL LOW-INCOME UNITS ATTRIBUTABLE TO LOW-INCOME HOUSING TAX CREDITS



* 1990 Tax Credit authority was committed to 74,029 specific units. In October, 1990, Congress restored the remaining 25 percent of 1990 Credit authority suspended by the 1989 Tax Act, helping to finance approximately 49,321 more units.

Source: NCSHA

THE LOW INCOME HOUSING TAX CREDIT PROGRAM
(1990 activity in dollars and number of units)

Allocating Agency	Full Year 1990 Authority	Authority Used*	Uncommitted Authority**	Low Income Units
Alabama	5,147,500	3,137,161	2,010,339	1,618
Alaska	668,750	54,498	614,252	16
Arizona	4,445,000	4,445,000	0	1,359
Arkansas	3,027,000	557,939	2,469,061	312
California	36,328,750	34,717,032	1,611,718	5,391
Colorado	4,145,425	1,986,854	2,158,571	454
Connecticut	4,048,750	3,295,106	753,644	456
Delaware	841,250	722,335	118,915	128
District of Col.	755,000	0	755,000	0
Florida	15,838,750	14,369,095	1,469,655	4,622
Georgia	8,045,000	4,061,122	3,983,878	2,383
Hawaii	1,390,000	0	1,390,000	0
Idaho	1,267,500	728,171	539,329	254
Illinois	10,850,600	4,673,385	6,177,215	1,873
Illinois-Chicago	3,783,678	1,701,050	2,082,628	729
Indiana	6,991,250	4,273,188	2,718,062	1,672
Iowa	3,550,000	2,418,534	1,131,466	1,021
Kansas	3,926,562	3,914,562	12,000	1,351
Kentucky	4,658,750	3,972,225	686,525	1,449
Louisiana	5,477,334	3,773,846	1,703,488	1,968
Maine	1,527,500	370,719	1,156,781	152
Maryland	5,867,500	5,202,393	665,107	1,487
Mass. EOCD	7,391,250	7,015,777	375,473	1,349
Michigan	11,591,250	7,473,815	4,117,435	2,224
Minnesota	6,991,737	2,253,424	3,592,156	1,102
Mississippi	3,276,253	1,881,047	1,395,206	1,323
Missouri	6,448,750	3,639,359	2,809,391	1,365
Montana	1,007,000	189,091	817,909	118
Nebraska	1,965,629	1,493,037	472,592	628
Nevada	1,388,786	639,939	748,847 -	234
New Hampshire	1,383,746	178,465	1,205,281	86
New Jersey	9,670,000	4,895,069	4,774,931	942
New Mexico	1,910,000	967,644	942,356	491
New York	22,437,500	16,087,893	6,349,607	3,009
North Carolina	8,211,216	3,187,925	5,023,291	1,159
North Dakota	825,000	669,328	155,672	242
Ohio	13,600,000	12,067,806	1,532,194	4,451
Oklahoma	4,062,500	715,652	3,336,848	660
Oregon	3,525,000	1,603,232	1,921,768	591
Pennsylvania	15,050,000	9,789,241	5,260,759	2,248
Puerto Rico	4,113,750	3,219,549	894,201	1,311
Rhode Island	1,247,500	566,935	680,565	123
South Carolina	4,390,000	3,251,359	1,138,641	1,342
South Dakota	893,750	803,277	90,473	288
Tennessee	6,335,965	2,080,993	4,254,962	1,012
Texas	21,975,000	10,237,764	11,737,236	12,781
Utah	2,133,750	1,882,179	251,571	532
Vermont	708,749	567,382	141,367	293
Virgin Islands	140,000	72,000	68,000	23
Virginia	7,622,507	6,764,740	857,767	1,964
Washington	5,951,250	4,730,275	1,220,975	1,305
West Virginia	2,321,250	312,834	2,008,416	192
Wisconsin	6,083,746	5,444,594	639,152	1,917
Wyoming	450,000	93,000	357,000	31
Grand Total	317,674,673	213,148,840	104,[illegible]	74,029
		67%	33%	

* "Authority Used" includes final and carryover allocations and reservations which were done on a project-specific basis

**"Uncommitted Authority" is the amount which is not designated for a specific project and will be carried forward into 1991 for allocation. For 1990 it represents 33% of the full year authority. Twenty-five percent of the full year authority did not become available until Congress passed the 1990 tax bill during the final quarter of 1990.

SOURCE: NCSHA

STATEMENT OF THE NATIONAL ASSOCIATION FOR HOME CARE

The National Association for Home Care (NAHC) would like to submit the following statement for the public record of the March 19, 1991, hearing of the Finance Committee on the President's FY92 budget proposal. NAHC is a national organization representing approximately 6,000 home health agencies, homemaker-home health aide organizations and hospices.

The President's FY92 budget proposal seeks $25 billion in Medicare cuts. NAHC strongly objects to these proposed cuts, which, as Congress is well aware, come on top of the nearly $44 billion in Medicare cuts worked out in the budget reconciliation process last year.

NAHC would like to comment on several provisions within the Administration 's budget recommendations that are of specific concern to home care providers. The first is a proposal that seeks to eliminate home health cost limit aggregation; and the second would impose survey and certification user fees on Medicare and Medicaid providers. Both of these proposals have been rejected by Congress in the past, and should be removed from consideration in the FY92 budget deliberations. Additionally, NAHC urges Congress to adequately fund Medicare contractors.

1. HOME HEALTH COST LIMIT AGGREGATION

The President's FY92 budget contains a proposal that would eliminate the ability of home health agencies to aggregate costs and require them to submit costs per discipline. It is important to note that this per-discipline method for calculating home health reimbursements was first attempted by the Health Care Financing Administration (HCFA) in 1985, and overruled by Congress a year later. NAHC strongly opposes a reversion to the per-discipline cost limits method.

Currently, home health agencies are reimbursed for actual costs incurred for providing services to Medicare beneficiaries only up to specified cost limits. Prior to 1985, the home health agency cost limits were based on the 75th percentile of average costs for each of the covered disciplines (nursing, physical therapy, etc.). Because the limits were applied in the aggregate, an agency whose costs exceeded the limits in one discipline could avoid any reduction in payments if the costs in one or more of the other disciplines were below the limits. This enabled agencies to provide a full range of services to beneficiaries. On July 5, 1985, HCFA published a regulation that: (1) required the limits to be applied separately to each discipline as opposed to in the aggregate; and (2) provided for the limits to be set at 120%, 115% and 112% of average costs for each of the covered disciplines for the periods 1985-86, 1986-87 and 1988 on, respectively. The Omnibus Reconciliation Act of 1986 (P.L. 99-509) restored the ability of home health agencies to aggregate costs for cost-reporting periods beginning on or after July 1, 1986, but retained the new limits.

The 1986 law also directed the General Accounting Office (GAO) to study the impact of the new, percentage-of-the-mean method of calculating home health agency cost limits and the effect of applying them on a per-discipline basis. GAO's report, issued September 28, 1990, concluded that patient access to home care services would not be affected to any large extent by a switch to the per-discipline method, both because the payment reduction would be relatively small and because in most cases nearby agencies would be able to "pick up the slack" even if affected agencies dropped services or stopped participating in Medicare altogether. GAO also expressed the opinion that quality of care would not be significantly affected.

NAHC has numerous concerns about the impact of the Administration's disaggregation proposal:

- The GAO analysis was necessarily based on cost report information for 1986 and earlier periods and assumptions about cost increases that have taken place since that time. It is questionable whether GAO's estimates of the monetary impact of the per-discipline method and of the percentage of agencies affected were entirely accurate.
- The HCFA savings estimates for per-discipline cost limits were significantly different than the GAO's estimates. HCFA estimates a savings of $90 million if costs were disaggregated, an 84% increase over the GAO's estimated $49 million in savings.
- GAO collected most of its data from agencies during the July 1985-1986 period when per-discipline cost limits were in effect, and agencies already may have made adjustments in their provision of services.
- The impact of a switch to per-discipline cost limits could be better estimated using newer data from the 1988 cost reports that will be available this summer.

• The elimination of aggregation would severely handicap the ability of home health agencies to provide a full range of quality services to Medicare beneficiaries within the cost limits. If home health agencies are not permitted to balance the costs of some services that are more costly to provide, such as physical therapy and medical social work, against those that have lower costs, agencies will be unable to provide certain services and to adequately meet the needs of beneficiaries.

• New agencies and small businesses would be hardest hit regardless of how efficient they are. These agencies tend' to have relatively higher costs and would be at an economic disadvantage. Older agencies would suffer to the extend they have tenured and, therefore, higher paid staff. The incentive would be to replace them with new staff members with lower salary demands. This would have serious consequences on the quality of home care services.

• Agencies in rural areas would be devastated. Such agencies have significantly higher costs for the delivery of services. Obviously, transportation expenses are much higher in these agencies, which must often send their employees great distances to care for clients who would otherwise go without health services altogether. In addition, therapists and social workers are often scarce and therefore more costly in rural areas. This increases the per visit length and cost. The policy of undermining rural home health agencies puts the Federal Government in the incongruous position of spending millions of dollars in grants and loans to help create such agencies with one government program (the Public Health Service) and making it virtually impossible for them to serve clients through another program.

• Agencies that provide "high-tech" care, such as the care of ventilator-dependent persons, IV chemotherapy, or IV nutritional therapy, would find it increasingly harder to do so. These services have relatively high costs.

• Agencies would be forced to be selective about which Medicare patients they take. Agencies may be reluctant to accept so called "heavy care" patients (such as stroke victims), whose cost per case are relatively high, and indigents.

NAHC recently conducted a sample survey of its membership to explore the extent to which a reversion to per-discipline cost limits could affect home care agencies.

In the survey, NAHC asked agencies to submit copies of Worksheet C of their most recently closed cost reports and to explain how a change to per-discipline cost limits would impact their agencies and the services they provide to beneficiaries. NAHC also asked agencies whether they would have to drop or curtail certain services as a result of the change, and whether beneficiaries would be able to obtain the services from another home care provider in their area.

The responses were divided into two groups, those whose operating costs were below the limits and those whose costs were above the limits. In the first group, 85% of the agencies who were operating under the limits on average, were over the limits in one or more of the specific disciplines. If these agencies were not allowed to aggregate their higher-cost services with their other services, they would on average have lost $27,912 that year. In the second group, 88% of the agencies who were over the limits in the aggregate, were under the caps in at least one discipline. If they were not allowed to aggregate costs, they would on average have lost an additional amount of $42,923 that year. In general, agencies indicated that were per-discipline cost limits imposed, they would have to restrict services in the categories where they exceeded the limits.

Several examples illustrate the adverse affects of the per-discipline cost limits proposal:

• The Visiting Nurse Association (VNA) of Orange County, in Orange, California, has operating costs at 98% of the aggregated limits, even though its physical therapy and homemaker-home health aide costs exceed the limits for those services. The VNA operates an excellent high-tech program that was featured in the September 1988 issue of CARING Magazine (see attached article). Under the disaggregation proposal, the VNA would lose over $100,000, which is approximately 20% of the agency's equity. The VNA told NAHC, "This would have seriously jeopardized the agency's viability to continue to provide quality home care to our community. Our VNA management staff would without a doubt be forced to curtail services and reduce the quality of services provided. Medicare beneficiaries would suffer."

• Visiting Nurse and Community Health Services, Ardmore, Pennsylvania, an agency that is operating at 88.5% of the cost limits under the aggregation method, would lose over $56,000 under a per-discipline method because it is over the limit for homemaker-home health aide services. Shortages of homemaker-

home health aides have caused wages to increase significantly and forced the Ardmore agency over the limits in that category. A $56,000 loss to an agency whose Medicare clients account for 85% of its business would be devastating. The agency told NAHC, "This kind of a loss could close our agency. We have no way to make up the cuts. If we were to stay in business, we would have to limit services in some way. Whatever action we take would have a detrimental affect for beneficiaries in terms of their access to care."

- Stratford Visiting Nurse Association, Stratford, Connecticut, an agency operating at 91% of the limits under the aggregation method, would lose over $59,000 under a per-discipline method. Like the Pennsylvania agency, Stratford VNA's homemaker-home health aide costs are over the limits because of high wages driven upward because of personnel shortages. Medicare accounts for 69% of the VNA's business, and the agency would be unable to absorb a $59,000 loss. The agency told NAHC, "The financial impact of failure to recover our costs would threaten or eliminate our ability to continue to care for patients under the Medicare program." Further, the agency indicated that beneficiaries would not be able to obtain home care services from other agency's in the area because they would be forced to take similar action
- First Choice Home Health and Personal Services, Columbus, Ohio, an agency operating at 96% of the aggregated limits, would lose over $31,000 under per-discipline limits. With Medicare accounting for 68% of its business, First Choice said it would not be able to make up the loss and would be forced to cut back on services The agency's homemaker-home health aide services are significantly higher than the limits for that category because of increased wages (driven by the personnel shortage) and the increased costs of training that were required by the Omnibus Budget Reconciliation Act of 1987
- Homebound Care, Inc., a rural agency in New Iberia Louisiana, has operating costs at 67.5% of the aggregated limits Under the disaggregation proposal, Homebound Care would lose over $16,000 because its physical therapy costs exceed the limit for that service Homebound Care told NAHC that "with loss of aggregation of costs, we would have no alternative but to discontinue those services above the cost limits Our agencies are rural in nature, and these services could not be obtained (by beneficiaries) elsewhere Therapists from larger communities will not travel to rural areas"

The results of this survey, as well as the HCFA estimates detailed above, indicate that the GAO report significantly underestimated the impact of per-discipline cost limits on both providers and beneficiaries The direct and immediate threat is to the viability of home health agencies Indirectly, these financial losses affect beneficiaries in their ability to access high-quality home care services

NAHC strongly urges Congress to reject the Administration's cost limits disaggregation proposal

2 SURVEY AND CERTIFICATION USER FEES

The Administration has revived its survey and certification user fee proposal that was rejected last year by Congress The proposal would require all health facilities, including home health agencies and hospices, to pay a fee sufficient to cover all the costs associated with state survey and certification activities under the Medicare and Medicaid programs. Laboratories already are subject to user fees as a result of the Clinical Laboratories Improvements Act of 1988 (CLIA-88).

The revenues generated from the user fees would be deposited in the Survey and Certification Revolving Fund, from which all outlays for state survey and certification activities would be made In FY92, the Health Care Financing Administration estimates that $881 million would be expended for survey and certification activities, of which clinical laboratories' workloads would account for $540 million. It is estimated that the user-fee proposal would save Medicare $151 million and Medicaid $138 million.

NAHC strongly opposes this proposal. The estimated savings are misleading because a significant portion of the costs will be passed back to Medicare through annual cost reports. Further, in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Congress specifically prohibited HHS from imposing, or requiring states to impose, on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvements Act of 1988) a fee to offset the costs of surveys to certify compliance with the conditions of participation under Medicare Part A or B (P.L. 101-508, Section 4207(h)).

The costs of survey and certification historically have been funded through the State Survey and Certification activity of the Medicare Program Management account and the Medicaid Administrative Cost activity of the Grants to State for Med-

icaid account. CLIA-88 expanded state survey and certification activities to include clinical laboratories and introduced user fees as the financing mechanism.

3. MEDICARE CONTRACTORS

The Administration's FY92 budget proposal includes $1.4 billion for Medicare claims payment operations, a decrease of $37 million from FY91 levels. These cuts would significantly affect Medicare contractors ability to process claims, hearings and reconsiderations, and beneficiary services. For example, under the Administration's proposal, HCFA expects to process only 3.3 million of the 10.2 million hearings and reconsiderations (leaving a backlog of 6.9 million cases) and to process only 8.6 million of the 30.4 beneficiary requests for information.

HHS has indicated that it is developing strategies to maintain or improve the quality of service in the face of rapidly rising workloads and slowly rising resources and that HCFA is considering options for the long-term reform of Medicare administration which should further economize on resources used to process Medicare bills over the next decade. These efforts, which may include more use of electronic claims submission, should be encouraged. However, appropriate funding levels should also be authorized.

The Blue Cross and Blue Shield Association has indicated that an additional $225 million needs to be added to the President's FY92 budget to prevent cuts in services to Medicare beneficiaries and health care providers and to meet the projected 11.5% increase in Medicare claims. Blue Cross and Blue Shield Plans and several other commercial insurance companies provide the administrative services for Medicare at a cost of less than 1.5% of the total Medicare budget.

NAHC recommends that Congress carefully review the Medicare contractor portion of the budget to ensure appropriate funding levels for FY92.

SUMMARY

NAHC opposes the Administration's proposals to (1) disaggregate home health cost limits; (2) impose survey and certification user fees, and (3) reduce Medicare contractor budgets. Congress should consider the long-term implications of these budget-driven proposals on access and quality of care, and reject any further cuts to the Medicare program.

NAHC wishes to thank the Finance Committee for adding this statement to the public record. We would be happy to answer Members' questions on any of the issues discussed in this testimony.

STATEMENT OF THE ORGANIZATION FOR THE PRESERVATION OF THE PUBLIC EMPLOYEE RETIREMENT INDUSTRY AND OPPOSITION TO SOCIAL SECURITY EXPANSION TO SUCH INDUSTRY (OPPOSE)

Members of the Senate Committee on Finance, I am Robert J. Scott, secretary-treasurer of OPPOSE. OPPOSE is a Colorado corporation formed by teachers, fire-fighters, police officers, and other state and local government employees who have elected not to join the Social Security/Medicare system. The purpose of our organization is to assure the continued financial integrity of our members' retirement and health insurance plans by resisting congressional efforts to mandate Social Security or Medicare coverage of public employees. Our members are found in Alaska, California, Colorado, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Ohio, and Texas. With respect to the issue of mandatory Medicare and Social Security coverage, the interests of OPPOSE are identical to those of the four to five million full-time public employees throughout the nation who remain outside the Social Security system.

BACKGROUND

In its budget for fiscal year 1992, the Administration again proposes raising revenues (estimated at $1.1 billion in 1992 and $1.5 billion per year for the period 1993-1996 by both the Administration and the Congressional Budget Office) by imposing mandatory Medicare coverage upon all state and local government employees who are not now covered by Medicare. This tired measure has been proposed nearly each year since 1986, when Congress enacted a phase-in of mandatory coverage by requiring coverage of newly hired state and local government employees. We believe that the compromise adopted in the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") should be respected and that our employees and retirees should not be visited by the same threat year in and year out. Therefore, and for the further

reasons set forth below, we ask you once again to reject the proposal to mandate Medicare coverage of all state and local government employees.

PROBLEMS RAISED BY PROPOSED MANDATORY MEDICARE

I. The President's budget proposals would exacerbate the problem of insufficient progressivity in the tax system and would reverse efforts to provide tax relief to lower-income individuals, instead imposing a significant new tax burden upon the segment of society that can least afford new taxes

The proposal to impose mandatory Medicare coverage upon all state and local government employees would affect nearly three million Americans who earn an average salary of approximately $26,000, as well as their families. These individuals—primarily teachers, firefighters, police, and other public employees—can ill afford the burden of Federal taxes increased, on average, by $377 each year ($26,000 multiplied by the HI tax rate of 1.45% effective in 1990). For example, the average Illinois teacher makes approximately $31,318 annually, and spends all but $924 of that each year on necessities such as housing, groceries, health care, taxes, and other basic expenses. The proposed new tax of $454 would cut in half the amount of income remaining after the cost of essentials.

At the time of passage of the Tax Reform Act of 1986, the Joint Committee on Taxation estimated that the Tax Reform Act provided taxpayers with incomes in the range of $20,000—$30,000 with a tax cut equivalent on the average to $220. Thus, to cite another example, in the case of the average government employee in Colorado (whose annual salary is $26,930), the new Medicare tax of $390 would result in a net tax increase of $170 annually. (See attached Table A setting forth state by state the cost of Medicare coverage to the affected individuals as well as the projected amount of his or her tax cut under the Tax Reform Act.)

Moreover, the President's proposals would exacerbate the problem of declining progressivity in the tax system and would undo recent congressional efforts to shift the Federal income tax burden from relatively low-income individuals to those with higher incomes. Data released by the Treasury Department in 1990 reveal that, as a result of the Tax Reform Act of 1986, taxpayers with adjusted gross incomes under $50,000 received a net tax cut of $9 billion between 1986 and 1987. Now the Administration proposes to raise revenues of $1.5 billion annually—*or 17 percent of the net tax cut received by all Americans with incomes under $50,000*—from public servants who generally make much less.

Most public employees fall in the second and third quintiles of income. These are families whose average income ranges from about $19,000 per year to about $31,000 per year. Studies based upon CBO data and prepared by the Ways and Means Committee staff indicate that many of these families have actually lost ground during the period 1977 through 1990 or, at best, have progressed only minimally. For example, the second quintile, those between the 20th and 40th percentiles in terms of average family income, increased their average family income by only 0.4 percent during the entire 14-year period. Those in the third quintile, ranging between the 40th and 60th percentiles in average family income, fared somewhat better, but still realized income growth of less than half a percent per year, uncompounded, throughout this period. Federal income tax rates as a percentage of pre-tax income, actually increased slightly for both groups. People at this level of income should not be called upon to pay additional taxes particularly where, as here, they are the only group singled out by the Administration for a tax increase.

II. The proposals would have an extremely negative impact upon the affected state and local governments, simply transferring part of the deficit from one level of government to the other

While the impact of the mandatory Medicare proposal would fall most heavily upon governments in approximately 10 states (Alaska, California, Colorado, Illinois, Louisiana, Maine, Massachusetts, Nevada, Ohio, and Texas), forty-nine states include at least some subdivisions with non-covered employees that would be significantly harmed by these additional operating costs. Estimates of the annual costs to state and local governments are set forth state by state in Table B, attached. For example, each year, the proposal would cost governments in Illinois $75.2 million; in Ohio, $137 million; in Maine, $10.4 million, and in Texas, $99 million.

Imposition of these additional costs would come at a difficult time. A recent study released by the National Conference of State Legislatures reports that more than half of the fifty states will face serious budget problems in 1991 for a variety of reasons, including low or negative growth rates in the economy. At the same time, education costs are growing faster than revenues, while education funding responsibility is shifting to the states as pressure for property tax relief grows. Moreover, in

recent years state and local governments have repeatedly been forced to shoulder additional burdens as a result of considerable cuts in Federal appropriations for many of their programs, the loss of revenue-sharing, and limitations on their ability to raise revenues through loss of the sales tax deduction and new restrictions upon municipal bonds enacted in 1986.

The result is that state and local governments are in no shape to absorb additional fiscal burdens. To cite a few examples of the results of this fiscal squeeze, a number of California counties have been required in recent years to close public libraries and parks as a result of budget shortfalls. In 1987, the President of the Board of Commissioners for Trumbull County, Ohio, testified that, as a result of the loss of revenue-sharing, 39,000 citizens in his county were without police protection. Governments at all levels around the country would find that imposition of the new 1.45 percent Medicare tax would force them to make very hard choices among essential services and staff.

A number of cities and states which would be heavily impacted by mandatory Medicare are already in severe fiscal difficulty. For example, Chicago faces a projected budget deficit of at least $75 million, in Los Angeles the projected gap is $20 million; Detroit $32 million; San Francisco $27 million; Boston $21 million; Dallas $10 million; San Diego $60 million; and Hartford, Connecticut, $3.2 million. These figures may sound relatively small in comparison to the Federal budget. But at the local level, these budget deficits translate into serious cutbacks in vital public services. Detroit, for example, has imposed a hiring freeze even though local services in a number of areas are already inadequate. San Francisco proposes to slash its budget for mental health care. Many cities are faced with a situation where they are forced to raise taxes and reduce services to a point that most members of the middle class move to the suburbs. Frank Shafroth, a high ranking official with the National League of Cities, has summarized this situation by explaining that those "cities are caught in a death spiral."

The situation at the state level is no better. On April 3, 1991 a front page story in *USA Today* described the problem at the state level. The article explained that "thirty states face deficits this year, and a bleaker picture in 1992 . . . . Rainy day funds are at an eight-year low; spending on prisons, schools and health care, fuelled by Federal mandates, at an all-time high." Connecticut is being forced to consider the imposition of personal income taxes for the first time ever, as is Tennessee. An annual business activity tax, consisting of a license fee and a payroll tax, may be imposed in Nevada—the first business tax of any kind in the state's history. In California, a state which would be heavily impacted by mandatory Medicare, deficits are expected to be in the billions for 1991 and 1992. Illinois faces projected deficits of $364 million in 1991, which may result in cut-backs in such social services as public assistance.

Maine faces a deficit equal to 7 percent of its total budget. In Minnesota the budget gap is projected by some analysts to approach one billion dollars.

III. President Bush has vowed to leave a legacy as "the Education President," leading the effort to improve the quality of education; yet the mandatory coverage proposals would have a particularly adverse impact upon education in America

Within the past several years, the National Commission on Excellence in Education declared that America's educational system is failing both its students and the entire country. It has been recognized that one cause is the difficulty school systems face in recruiting and retaining quality teachers. The Federal government has reported that the country will have 34% fewer teachers than it needs by 1992.

One reason for this problem is that teachers are significantly underpaid. In 1989-90, the average teacher's salary was $31,304, while in many states the average teacher compensation still hovers in the low twenties.

Mandatory Medicare coverage would only exacerbate the problem caused by low salary levels. Teaching is one of the major professions with large numbers of non-covered members. In the affected states, mandatory Medicare coverage would take an additional $454 from the average teacher's salary each year (1.45% of $31,304). As a result, many of the best qualified teachers—particularly those with marketable skills in mathematics, science, and computers—would leave teaching for better-paid employment.

In sum, in a time in which education is to take top priority, it would be unwise to adopt legislation that would aggravate the teacher recruitment problem and further increase the cost of education for both students and schools.

IV. Mandatory coverage can not be justified on the grounds that it would benefit the affected employees

In its budget, the Administration attempts to justify its Medicare coverage proposal in part with the paternalistic concern that mandatory Medicare "coverage of [all state and local] employees, who are the only major group of employees not assured Medicare coverage, would correct an inequity in coverage . . . ."

The response to this concern is simple: if public employees wanted Medicare coverage, they would be clamoring for it. Since passage of COBRA, local jurisdictions have had the option of joining the Medicare system without also participating in the Social Security system. In short, if Medicare coverage were desirable, employees would certainly bring pressure to bear upon their employers (which are, after all, elected governments) to adopt it. In fact, the opposite is true; far from clamoring for Medicare coverage, public employee groups are vehemently opposed to efforts to impose these programs upon them. They do not need the Federal Government to provide these programs "for their own good."

V. Mandatory Medicare coverage of the employees who were "grandfathered" outside the system by COBRA would create a variety of problems that were avoided by COBRA's compromise position

Some state and local governments have health plans in place for their employees, including retirees. Adjustment of these plans to take account of Medicare coverage for existing employees would prove an overwhelming task, or would result in abandonment of these plans. While the phase-in provision adopted in COBRA affects the health benefits and take-home pay of individuals at the time they commence employment, the current proposal would displace benefits programs that individuals have enjoyed, in some cases, for many years, and would reduce the amount of take-home pay they have come to expect. Abandonment of the careful compromise adopted in COBRA would unfairly disappoint the expectations of millions of public workers.

For these reasons, we urge you once again to reject the proposals to impose mandatory Medicare coverage upon state and local government employees.

Thank you for allowing me the opportunity to present the views of OPPOSE.

Table A.—ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES OF MANDATORY MEDICARE COVERAGE OF ALL EMPLOYEES

State	Annual salary of average public employee	Annual tax increase resulting from proposal [1]	Average tax decrease resulting from the tax reform act of 1986 [1]
Alabama	[illegible]	$307	[illegible]
Alaska	[illegible]	[illegible]	273
Arizona	[illegible]	336	220
Arkansas	[illegible]	269	200
California	[illegible]	483	273
Colorado	[illegible]	390	220
Connecticut	[illegible]	448	273
Delaware	25 428	369	220
District of Columbia	33 384	484	273
Florida	24 552	356	220
Georgia	20 964	304	220
Hawaii	25 032	363	220
Idaho	21 684	314	220
Illinois	27 780	403	220
Indiana	23 352	339	220
Iowa	24 456	355	220
Kansas	22 200	322	220
Kentucky	20 568	298	220
Louisiana	20 016	290	220
Maine	22 008	319	220
Maryland	29,220	424	220
Massachusetts	28 128	408	220
Michigan	30,300	439	273
Minnesota	29,508	428	220
Mississippi	17,844	259	200
Missouri	22,800	331	220

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Table A.—ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES OF MANDATORY MEDICARE COVERAGE OF ALL EMPLOYEES—Continued

State	Annual salary of average public employee [1]	Annual tax increase resulting from proposal [2]	Average tax decrease resulting from the tax reform act of 1986 [3]
Montana	22,068	320	220
Nebraska	22,956	333	220
Nevada	26,952	391	220
New Hampshire	23,556	342	220
New Jersey	29,184	423	220
New Mexico	20,964	304	220
New York	31,368	455	273
North Carolina	23,004	334	220
North Dakota	23,856	346	220
Ohio	25,428	369	220
Oklahoma	20,148	292	220
Oregon	25,632	372	220
Pennsylvania	25,728	373	220
Rhode Island	28,392	412	220
South Carolina	21,096	306	220
South Dakota	19,320	280	200
Tennessee	20,784	301	220
Texas	22,512	326	220
Utah	22,308	323	220
Vermont	23,280	338	220
Virginia	24,636	357	220
Washington	27,456	398	220
West Virginia	19,812	287	200
Wisconsin	26,880	390	220
Wyoming	23,664	343	220

[1] The most recent data available was obtained from the U.S. Bureau of the Census Public Employment in 1988—Government Employment (Series GE-88-1) at 10.
[2] The amount of the new Medicare tax is derived by multiplying the average employee's salary by 1.45%.
[3] Joint Committee on Taxation Staff Data on Distribution by Income Class of Effects of H.R. 3838 Tax Reform Act of 1986 (JCX-28-86) (October 1, 1986), Table 4.

Table B—ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES CURRENTLY NOT COVERED BY MEDICARE

State	Employees not covered by Social Security [1]	Employees not covered by Medicare: Number [2]	Employees not covered by Medicare: Percentage [3]	Cost of coverage (millions) [4]
Alabama	27,000	16,855	5.1	$5.2
Alaska	40,000	24,970	39.0	14.2
Arizona	21,000	13,109	3.9	5.2
Arkansas	39,000	24,346	12.5	6.6
California	991,000	618,642	27.8	299.0
Colorado	150,000	93,639	33.7	36.6
Connecticut	63,000	39,328	13.5	17.6
Delaware	14,000	8,740	14.6	3.2
Dist. of Columbia	0	0	0.0	0.0
Florida	127,000	79,281	9.2	28.2
Georgia	64,000	39,953	7.5	32.1
Hawaii	24,000	14,982	16.3	5.4
Idaho	0	0	0.0	0.0
Illinois	299,000	186,654	19.9	75.2
Indiana	54,000	33,710	7.7	11.4
Iowa	5,000	3,121	1.1	1.1
Kansas	2,000	1,249	0.5	0.4
Kentucky	56,000	34,959	12.4	10.4
Louisiana	271,000	169,174	52.7	49.1
Maine	52,000	32,462	28.0	10.4
Maryland	29,000	18,104	5.1	7.7

Table B—ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES CURRENTLY NOT COVERED BY MEDICARE—Continued

State	Employees not covered by Social Security [1]	Employees not covered by Medicare		Cost of coverage (millions) [4]
		Number [2]	Percentage [3]	
Massachusetts	334,000	208,503	41.2	85.0
Michigan	19,000	11,861	1.4	5.2
Minnesota	96,000	59,929	14.5	25 6
Mississippi	2,000	1,249	0 6	0.3
Missouri	62,000	38,704	10 1	12.8
Montana	5,000	3,121	3 9	1.0
Nebraska	2,000	1,249	0 8	0 4
Nevada	49,000	30,589	40 8	12 0
New Hampshire	6,000	3,746	3 5	1.3
New Jersey	30,000	18,728	2 8	7 9
New Mexico	33,000	20,601	13 5	6 3
New York	153,000	95,512	5 0	43 4
N Carolina	43,000	26,843	4 4	9 0
N Dakota	6,000	3,746	5 1	1 3
Ohio	595,000	371,435	46 1	137 0
Oklahoma	33,000	20,601	7 5	6 0
Oregon	14,000	8,740	3 1	3 2
Pennsylvania	36,000	22,473	3 1	8 4
Rhode Island	25,000	15,607	3 9	6 4
S Carolina	6,000	3,746	1 1	1 1
S Dakota	2,000	1 249	1 6	0 3
Tennessee	29,000	18 104	4 9	5 5
Texas	486,000	303,390	22 8	99 0
Utah	1 000	624	0 4	0 2
Vermont	1 000	624	1 0	0 2
Virginia	72 000	44 947	8 1	16 1
Washington	36,000	22 473	5 1	8 9
W Virginia	7 000	4,370	2 9	1 3
Wisconsin	48,000	29,964	7 1	11 7
Wyoming	5,000	3,121	5 0	1 1
TOTAL	4 564,000	2,849,123		$1,117 3

[1] Social Security Administration 1985 Current Population Survey and Continuous Work History Sample, *reprinted in* Congressional Research Service paper "Medicare Coverage of Employees of State and Local Governments" by David Koitz, (March 11 1987)

[2] The Consolidated Omnibus Budget Reconciliation Act of 1986 Pub L 99-272 requires public employees hired after March 31, 1986, to participate in the Medicare system Because we assume employee turnover occurs at a rate of approximately 9% per year, in the five years since COBRA took effect, approximately 37 6% of previously non-covered public employees are now covered by Medicare The number of public employees not covered by Social Security has therefore now been reduced by 37 6% to reflect the number of employees who are currently not covered by Medicare

[3] These figures reflect percentage of the total number of state and local employees by state who would be affected by mandatory Medicare coverage

[4] The figures reflect only the 1 45% that would be paid by the governments as employers, and do not include the cost increase to their employees, who would also have to pay the 1 45% Medicare tax (See Table A for increased tax burden on individual employees) Given that the employer's part of the Medicare tax is 1 45% this is multiplied by the average state or local government employee's salary for each state (U S Bureau of the Census Public Employment in 1988--Government Employment (Series GE-88-No 1 at 10), each governmental employer's cost is equal to the number of employees, multiplied by the average salary multiplied by 1 45%

Statement of the Society for Human Resource Management

The Society for Human Resource Management (SHRM) is the world's largest professional membership organization in the human resource field. SHRM defines the state-of-the-art for the human resource profession through publications, emerging issues analysis and research, governmental and media representation, seminars and products. Formerly the American Society for Personnel Administration, SHRM represents the interests of 70,000 local and national members through its network of more than 400 chapters.

Because SHRM feels very strongly about the need for the Senate to enact S. 24, permanently extending Section 127 of the Internal Revenue Code, we are submitting this statement for the Committee's record.

As the individuals charged with initiating, implementing and administering employee benefit programs in small, medium, and large businesses throughout the

country, SHRM members have first hand knowledge of the value of employee educational assistance programs as an important employee benefit as well as a vital tool for training and upgrading workers' skills for the increasing demands of the future workplace.

There is no question that employee educational assistance programs are attractive incentives for employees to further their educations. Educational assistance programs also provide powerful incentives for employers to invest in the educations of their employees. Sixty-four percent of the employers responding to a 1989 Society for Human Resource Management survey offered Section 127 benefits for the purpose of promoting the upward mobility of their employees.

There is also no question that employee educational assistance programs help those employees with the most need. Recent surveys by SHRM and Coopers & Lybrand show that Section 127 benefits are distributed in a manner closely paralleling earning among the work force as a whole. These surveys found that 71% of the employees using employee educational assistance earn less than $30,000 annually and 36% earn less than $20,000 annually.

SHRM recognizes that the Congress is confronted with a looming deficit and the critical need to carefully invest and spend Federal money. SHRM believes that the favorable treatment given to companies that invest in research and development is equally, and in fact increasingly, appropriate for investments in "human" development. It does not make sense to invest millions of dollars in the development of new technologies without making a parallel investment in the human resources that will be required to utilize those new and emerging technologies.

In addition, like an investment in research and development, the returns from an investment in human resource development are predictable and tangible and have effects both externally, for society as a whole, and internally, within individual companies. External examples of returns include: increased revenue to the government through the increased tax liabilities of employees who attain higher paying jobs as a result of their participation in employee educational assistance programs; significant growth in productivity as workers' skills increase as a result of education; and greater competitiveness as U.S. workers on the whole begin to match their foreign counterparts. Internally, educational investment helps to maintain and improve employees' competencies, helps in identifying promotable employees, gives employees more freedom in pursuing interests and developing potential, increases morale and induces employees to stay with the company, supplements company-provided training programs, aids in the recruiting of new employees, and fosters community relations.

The United States is already experiencing labor shortages because of the shrinking labor pool and the crisis within the educational system. Technological change, increased international competition, decreasing productivity, changing demographic trends, and inefficient educational systems have combined to create a widening skills gap between businesses with increasing demands for higher skilled workers and a shrinking pool of qualified labor. SHRM members in several fields, such as engineering and scientific study, are already experiencing severe shortages. The Congress must be forward looking and seek out ways to provide tools to the private sector to train and develop workers to meet the country's needs in the face of growing international competition.

A century ago, a high school education was more than adequate for factory workers and a college degree was limited to a select few. Between now and the year 2000, for the first time in history, the majority of all new jobs will require post-secondary education. Many professions will require nearly a decade of study following high school, and even the least skilled jobs will require a command off reading, computing, and thinking that was once required only for professionals.

Unfortunately, SHRM members also have first hand experience with the employee concerns and serious administrative burdens that occur each time Section 127 is allowed to expire and is then retroactively reinstated. We have witnessed how the expiration of Section 127 has reduced or eliminated the educational opportunities for workers around the country. In addition, without Section 127, employers would have to rely upon Treasury regulation applying to the taxation of employee educational assistance benefits, which involves enormous paperwork and complex and contradictory "job-relatedness" preconditions. The resulting taxation of non-job-related educational assistance disproportionately affects lower paid employees whose jobs are often more narrowly defined than those of upper level professionals and executives. Consequently, lower paid employees have more difficulty relating any education to their current jobs.

SHRM members have also witnessed the disastrous effects the uncertainty of the program has had on unskilled employees who desperately want to further their edu-

cations and career opportunities but can not afford to do so without Section 127 benefits. Since Section 127 periodically expires, many employees must interrupt their education, sometimes skipping semesters because they are uncertain if the tax exclusion will be available for the next year. Our members witnessed this during the last expiration of the benefit which occurred in September 1990 at the outset of the fall semester. Thousands of employees did not attend courses that fall because they could not afford to gamble on whether doing so would result in increased tax liabilities at the end of the year.

Further, constantly allowing the provision to expire and retroactively reinstating it at a later date prevents thousands of additional employees from taking advantage of the benefit. Many workers both work full time and attend classes part-time and furthering their educations will take many years of sacrifice. However, many motivated workers hesitate to pursue their educations because they can not adequately plan their educational goals without knowing if the tax exclusion they need to afford classes will be there for the duration of their educations. Without the benefit, low skilled workers simply can not afford to enroll in a program of advanced education. Permanently extending Section 127 before the provision is allowed to expire again would alleviate these concerns and allow thousands of additional employees to upgrade their job skills.

Clearly, the permanent extension of an effective and proven tax incentive which encourages employees to further their educations, provides them with the financial means to do so, encourages employers to invest in their workers, guarantees that American workers have the best training available, and ensures America's competitive position in the global economy represents good public policy.

SHRM recognizes the fact that during budget negotiations Congress is involved with many other complex and important issues that sometimes overshadow Section 127. However, for millions of employees this important tax provision is critical. SHRM believes that Congress can not afford to overlook this important educational tool, and urges Congress to adopt a permanent extension of the program.

STATEMENT OF THE U.S. CHAMBER OF COMMERCE

The U.S. Chamber of Commerce appreciates this opportunity to present its views on the President's fiscal year 1992 revenue proposals, the outlook for the U.S. economy, and a number of recommended reforms of the existing Federal tax system.

ECONOMIC GROWTH AND "FAIRNESS"

Taxes are too high, and Congress spends too much and imposes too great a regulatory burden on the economy. As a result, we are mired in recession and the prospects for a strong recovery are not bright.

The congressional proponents of new taxes, higher spending, and increased regulation typically defend such proposals in terms of economic fairness, claiming that the benefits of any such proposal far outweigh its small, seemingly insignificant impact on total economic growth. Unfortunately, the impact of one tax increase which reduces growth by one tenth of one percent when added to other tax changes, new regulations and spending programs, is altogether significant. That cumulative burden results in economic stagnation and recession.

Ironically, regulatory, tax, and spending legislation ostensibly intended to promote economic fairness ultimately produces results that are particularly unfair. More important than fluctuations in industrial production, the consumer price index, or the Federal budget deficit is the real economic pain and suffering that recession and low growth inflicts upon those Americans least able to withstand it. Economic stagnation literally kicks those individuals and families now desperately clinging to the lowest rungs of the economic ladder into unemployment and poverty.

While many high tax advocates are undoubtedly motivated by the best of intentions, unfortunately some appear to be simply acting on less admirable, base instincts to punish wealth and success per se, regardless of the havoc such punishment might impose on the economy and the American people. The myopic politics of class envy are particularly evident when legislators oppose lowering the burden of capital gains taxes, or when they support further hikes in income tax rates on upper bracket income-earners. They do so despite a sizable body of empirical and theoretical evidence which demonstrates that tax and other policies motivated by class envy inevitably result in economic decline. No one, not even the Federal Government, gains from such policies in the long run.

In particular, I have in mind new research by the distinguished economist Gerald W. Scully, published by the National Center for Policy Analysis. [1] In an exhaustive empirical study of 103 countries, Dr. Scully reaffirms what low tax, limited-government advocates have been arguing for years; namely, that raising taxes may very well decrease, not increase, total Federal revenues by diminishing economic growth.

On the issue of income tax rates, Dr. Scully finds that during the 1980s, "when the top U.S. tax rate was reduced from 70 to 28 percent, the share of taxes paid by the top one percent of taxpayers grew from 18 to 27 percent." Regarding the capital gains tax rate, Scully finds "a negative relationship between capital gains tax rates and capital gains revenue," noting that following the 1981 reduction in the maximum capital gains tax from nearly 27 percent to 20 percent, capital gains revenues nearly doubled in the following four years. The most interesting results of Scully's study show that, in the short run, governments (total government, including state and local) maximize tax revenues at 43.2 percent of gross domestic product. But in the long run, economic growth, and subsequently, revenue from total tax collections, is maximized at only 19.3 percent of GDP. "In the long run," notes Scully, "governments will have more revenue if they maximize growth rather than tax collections." Scully notes the fundamental dilemma faced by revenue-maximizing governments: "If countries attempt to maximize tax collections [above growth-maximizing levels], people will pay a 'growth tax'—resulting in a lower standard of living." Because of this discrepancy between short- and long-run results, legislators may be misled into believing that tax revenues are maximized at a much higher portion of national income than is actually the case.

As a point of reference, I should point out that total government revenues in our own country, including state and local governments, were 29.3 percent of GNP in 1990, according to the President's 1992 budget. This level is significantly higher than it should be in terms of maximizing both long run economic growth and government tax receipts

THE OUTLOOK FOR THE ECONOMY

Despite conclusive evidence that higher taxes diminish economic growth and individual well-being, last fall Congress passed, and the President signed into law the largest tax increase in American history, at a time when the economy was slipping into recession. Last year's budget act, the Omnibus Budget Reconciliation Act of 1990, has been widely publicized as including nearly $500 billion in deficit reduction. However, as Table I indicates, the Administration's cumulative 5-year deficit projection has increased an astounding $803 billion from where it was just one year ago. The actual outcome of last fall's "deficit reduction" agreement should lead those who fear the effects of rising deficits on the economy to lower their economic forecasts.

Table I — THE PROJECTED CUMULATIVE BUDGET DEFICIT, 1991–1995

Year	Projected deficit 1991 budget	Projected deficit 1992 budget	Increase in deficit
1991	63.1	318.1	255.0
1992	25.1	280.9	255.8
1993	-5.7	201.5	207.2
1994	-10.7	61.8	72.5
1995	-9.4	2.9	12.3
Total	62.4	865.2	802.8

(Deficit figures in billions of dollars; all data from Budget of the United States Government, fiscal years 1991 and 1992.)

In 1991 alone, taxes have been raised by a net $22.5 billion due to last year's budget legislation. By way of comparison, the amount of this tax is equivalent to $30-per barrel oil lasting for several months, a large enough oil price hike to reduce any forecast of economic growth. These tax increases played a major role in reducing personal income growth in the first quarter of this calendar year. Additional tax increases next year will come on top of 1991 increases and will act to stifle incentives to produce and invest, further retarding economic growth.

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[1] Scully, Gerald W., "Tax Rates, Tax Revenues and Economic Growth," *NCPA Policy Report*, No. 98, National Center for Policy Analysis, March 1991.

We cannot undo the considerable economic damage already created by past policy mistakes. We can, however, avoid more of the same dismal economic performance by reversing past mistakes with sound policies which will restore economic incentives to work, invest, produce, and save. The truly compassionate economic policies are those that promote strong, sustainable economic growth.

Last July, before the crisis in the Middle East erupted, we projected a mild, two-quarter-long recession beginning with the fourth quarter of 1990. Unfortunately for the sixty thousand failed businesses and the over 1 million newly unemployed, our previous forecast of a recession apparently has come to pass.

Final estimates of fourth quarter GNP show an annualized decline of 1.6 percent, the first quarterly decline since the second quarter of 1986. The data on March 1991 employment show a rise in the unemployment rate to 6.8 percent and a loss of 205,000 nonfarm jobs. In addition, the purchasing manager's index of economic conditions for March is 40 percent, the kind of number associated with business contraction.

Such discouraging economic news almost guarantees a second consecutive quarter of decline in real GNP, resulting in the first recession experienced since 1981-82. After a careful analysis of the current recession, we have found the following:

- The principal causes of slow economic growth and the recession are rooted in policy mistakes of the Federal Government. These anti-growth policies persist and are growing more burdensome to the economy.
- Anti-growth Federal Reserve Board policy was the major reason the economy slowed strongly and slipped into recession. However, fiscal and regulatory policies also have contributed to the decline and permanently lowered the growth potential of the economy.
- Slow economic growth with the possibility of intermittent recession is a likely future course for the economy. Although the current recession may prove milder and shorter than previous recessions, the economy will not rebound with its traditional strength, leaving the future course of economic events in considerable doubt.
- The burden of anemic growth is decidedly unfair. It falls mainly on lower- and middle-income workers and smaller businesses in the form of lost job opportunities, bankruptcy and business failures.
- Congress can promote a more robust and sustainable economic recovery by immediately passing a number of tax changes included in the Economic Growth and Jobs Creation Act of 1991 (S. 381 and H.R. 960), as well as extending the expiring tax provisions

THE CHANGING ECONOMY FROM 1989 THROUGH 1992

Based upon new evidence of further decline, we have modified our economic forecast to show a longer and somewhat deeper recession than we originally predicted last July.

We foresee an economy that will not grow between now and the middle of next year. The unemployment rate will steadily rise to near 8 percent during this time. We also expect an eventual decline in inflation from current rates of over 5 percent to 4 percent by the middle of 1992. We do not expect consumer and business spending to revive the economy any time soon.

The current recession follows seven consecutive quarters of consistently sluggish economic growth under 2 percent. Real GNP increased only by a compound annual rate of 1.1 percent from the beginning of 1989 to the end of 1990.

By contrast, between 1983 and 1988, real GNP rose at a compound annual rate of 4.0 percent. Inflation, after averaging about 3.5 percent during the same 6-year period, has risen to over 5 percent in the last two years.

It is our opinion that the robust growth experienced between 1983 and 1988 was sustainable and that the unemployment rate should have continued to fall to this day without fueling higher inflation. Instead, the Fed devised an ill-fated high-interest rate policy designed to dampen the expansion in the hope that an economic slowdown would lower inflation. The Fed enlisted Congress and the Administration in its efforts to kill economic growth by insisting on deficit reduction by any means—even a massive tax increase—as the price for allowing interest rates to fall. Other policy mistakes, including tax increases dating back to the 1986 Tax Reform Act, more regulations, and renewed increases in the growth of Federal spending rendered an otherwise avoidable recession inevitable.

These policy mistakes have become so pervasive that we now believe the economy will continue to face prospects of persistently slow growth and intermittent recession. Unlike one-time shocks to the economy such as oil price hikes and quick wars, the anti-growth policies of the government are cumulative. Taxes have gone up this

year and will rise again next year. Federal spending is expected to consume a 25 percent share of the economy. New regulations are adding to business compliance costs. And interest rates, despite the rhetoric of the Fed, are still too high.

If the more optimistic consensus of private forecasters is correct, between 1989 and 1992 the economy will have grown only by a compound annual average of 1.5 percent. This would represent the slowest 4-year growth period since the 1930s.

That alone should be reason enough to focus attention on growth-enhancing policies. However, we believe there is more than a reasonable likelihood that growth over this four-year period will be even lower than the consensus forecast if current policies persist. Under existing economic and tax policies, we expect the 1991-92 period again to average a dismal 1.1 percent growth rate.

The average length of the six peacetime recessions was 11 months. The average fall in real GNP from the peak preceding the recession to the end of the recession was 2.6 percent. The consensus of private forecasters is that the current recession will be shorter and shallower than the postwar average. But this is due largely to the pervasive weakness of the economy going into the recession. Unlike previous postwar contractions, the "corrections" the supply-side of the economy must make to match depressed demand during the recession are less severe and may take a shorter time to complete.

Because the current recession may fall short of historical averages, many policy leaders, including the Bush Administration, now argue that the economy will right itself quickly and then proceed directly back to a path of sustained moderate growth. Corrective actions to stimulate the economy are not necessary, they claim. We respectfully disagree.

This all-is-well, short, mild recession viewpoint is reflected in the recent forecasts of the Congressional Budget Office (CBO) and the Bush Administration's Office of Management and Budget (OMB). Both forecasts project a two-quarter recession followed by very slow growth in the second quarter of 1991 and moderate to robust growth thereafter. Chairman Greenspan appears to share this view.

Despite the lack of concern over the future expressed by government forecasters, the prevailing consensus of private forecasters for the expected recovery is exceptionally low. For a full year following postwar recessions, CBO reported that real GNP rose on average 6.7 percent. The current consensus of private forecasters is for a recovery of just 2.8 percent. Several forecasts, including those of the CBO and OMB, project the recovery growth rate to be between 3 and 4 percent, somewhat higher than the consensus, but still quite a bit below the average postwar experience.

What concerns us the most is not how long and deep the recession may turn out to be, but how strong and sustainable will be the eventual recovery.

THE ORIGINS OF SLOW GROWTH AND RECESSION

The economic events leading up to this recession are different from what has occurred in the past. The recession did not come upon us all of a sudden. It was a result of cumulative anti-growth policies that first slowed the economy's strong growth and then removed significant amounts of growth potential. In the process, asset values declined—particularly real estate values—and accumulated debt became a severe burden on corporate cash flows.

Anti-Growth Tax Policies

Our pessimistic outlook has its origins in anti-growth policies found in the Tax Reform Act of 1986. On the positive side, that Act improved work incentives by significantly reducing marginal tax rates, reduced economic distortions by eliminating many inefficient tax subsidies, and the Act also removed millions of low-income people from the income tax rolls altogether. However, the Act also made other changes to the tax code that have greatly raised the cost of capital and stifled economic growth. The 1986 Act raised the top tax rate on capital gains to 33 percent for individuals, and made it difficult to deduct legitimate business expenses by limiting losses on "passive" investments, curtailing depreciation schedules on commercial real estate, and repealing the 10-year amortization of construction-period costs and taxes. The Act also tightened the Alternative Minimum Tax (AMT) rules, changed and tightened the rules on real estate tax shelters and real estate investment trusts, and made a number of changes in real estate accounting rules. As a predictable result, asset values have slipped, especially real estate values. Falling real estate values not only increased the insolvency of thrifts and reduced the solvency of many banks, but also put a damper on the rise in household and business asset values. For example, a study done for the Chamber last year and updated just recently by Fiscal Associates, Inc., a Virginia economic consulting firm, found that

the 40 percent increase in capital gains rates in 1986 has reduced the value of commercial real estate by 17 percent and residential home values by 9.2 percent.

The 1986 Act was designed to raise business and corporate taxes by about $120 billion over five years. By limiting proper deductions on capital investment, the Act raised taxes on capital-intensive industries—the backbone of the U.S. export business. Coupled with onerous taxes on foreign activities of U.S. companies, the Act reduced U.S. competitiveness. It also completely eliminated the investment tax credit for all businesses, thereby reducing business investment.

One perverse aspect of the 1986 Act emanates from the AMT provisions. They have caused a rise in the effective corporate tax rate during the current recession. Normally, tax policy is designed to cushion the effects of an economic downturn by curtailing tax liability by more than the fall in earnings. Unfortunately, many small businesses facing falling profits are finding their tax liabilities rising due to the AMT.

Even though the 1986 Tax Reform Act contained numerous positive elements, on balance the anti-growth provisions, when fully implemented by 1989, more than offset pro-growth effects. In short, the overall effect of the Act has been decidedly anti-growth.

Anti-Growth Monetary Policies

The economy is not where it is today strictly because of this gradual rise in business taxes. The severe and unceasing high interest rate policy by the Federal Reserve Board deserves blame as well. Fed high interest rate policy dates back to the spring of 1988 as a much ballyhooed step to quell what the Fed believed were rising inflationary pressures. The Fed made a serious mistake.

In fact, since August 1987 when Alan Greenspan became Federal Reserve Board Chairman, bank reserves have barely increased. The Fed consciously drove up interest rates by over 300 basis points in 1988 and 1989 by holding down bank reserve growth. However, during the subsequent decline in interest rates by nearly that amount to date, the Fed has hardly let bank reserves rise. Indeed, during a long period in 1989 and 1990, when market interest rates were falling, bank reserves declined and the Fed funds rate—the interest rate used by the Fed to signal its policy intentions—stayed steady.

Up until January, the reduction in the Fed funds rate had followed market interest rates down. Growth in bank reserves and money supply declined between June and December last year, indicating that monetary policy was becoming "tighter" as the economy dipped into a recession. It is fair to conclude that the Fed has only been following credit market interest rates on government securities downward since the middle of 1990, and actually may have intended to moderate interest rate declines.

What did the Fed accomplish with its orchestrated assault on inflation? At the beginning of the Fed's anti-inflation campaign, inflation stood at 4.4 percent. Today, it is over 5 percent. The Fed may seek to defend this gap between its rhetoric and the inflationary realities by claiming that inflation would have been even higher without its restrictive policies. We have heard similar claims before. In particular, we are reminded of the actual results of last year's much-celebrated "deficit reduction agreement."

Back in 1988 and 1989, the Fed had to take extraordinary action to slow a robust economy down. In doing so, it discouraged capital formation and destroyed growth potential. Today, the Fed would have to take extraordinary action to induce added growth. But loose monetary policy cannot increase growth potential without igniting inflation and creating a situation where the Fed must revert to the very policy that started the economy down in the first place. This is why we have admonished the Fed to follow clear rules governing their actions instead of stop-go policies that only confuse credit markets and devastate the economy.

The credit situation is so strained that even if the Fed aggressively begins to lead rates down with increased reserves, there is little reason to believe that Fed policy can bring the economy back. Fed policy alone cannot induce businesses to invest again. Even now that the monetary and bank regulatory authorities more fully realize the extent of the present slowdown, a shift in Fed policy is still likely to be thwarted by fiscal and regulatory policies that also are hitting the economy hard.

Anti-Growth Regulatory Policies

The regulatory budget of the government will rise in fiscal years 1991 and 1992. Although there are no precise measures on a program-by-program basis, it has been estimated by former Council of Economic Advisors Chairman Murray Weidenbaum that an overall increase of $1 in regulatory spending will increase business compliance costs by $20. Consequently, the economy may incur additional compliance cost

expenditures of over $200 billion in 1991 and again in 1992. When the Clean Air Act is eventually implemented, that legislation alone may add as much as $40 billion a year to compliance costs. Such costs reduce output, lower productivity and raise prices—exactly what has occurred in 1989 and 1990 and precisely the opposite of what is needed to reverse persistently sluggish growth.

There are other prominent explanations for the long economic slowdown and the eventual recession. Some analysts point to an excessive public and private debt build-up and large budget deficits during the Reagan years as primary causes of the current economic malaise. However, the rise in debt was caused by tax law changes which resulted in significant impediments to equity financing and raised the cost of capital. As long as the economy continued to grow, that debt accumulation was cost-efficient. But with the slowdown, accumulated debt has become a burden. Thus, the drive to manage debt to accommodate reduced cash flows—a situation many businesses now face—was prompted not by the debt alone, but by the slowdown and eventual recession.

The persistent Federal budget deficit was caused primarily by excessive increases in Federal spending. Although tax revenues doubled in the 1980s, spending more than doubled. Today's growing budget deficit reflects both reduced revenues due to poor economic performance and record levels of Federal spending. Hence, to make a clear determination of what has caused the slowdown in economic growth, it is extremely important to separate those events that are symptoms of the slowdown from those that are the causes.

WHY THE FUTURE FOR THE ECONOMY LOOKS POOR

Last year we were told that the Federal budget deficit was the source of our economic problems. This was the excuse used to raise taxes. If budget deficits were really the source of the problem, rather than its symptom, few people would be sanguine about future economic growth. Both CBO and OMB estimate a budget deficit in fiscal year 1991 above $300 billion. The deficit is rising above any amount recorded during the 1980s, yet many forecasters, including OMB and CBO, foresee an economic recovery.

Fiscal policy is acting as a drag on the economy and it is well understood among economists that tax increases stifle economic growth. Empirical confirmation of these conclusions can be found in a study by William C. Dunkelberg and John Skorburg.[2] Dunkelberg and Skorburg show that recent tax increases will raise the Federal tax burden on American workers to an all-time peak. Their study looks at the effect of tax increases on economic growth. They find that since 1960 a rising tax burden, like current law, has led to a reduction in economic growth.

Likewise, Dunkelberg and Skorburg find that tax reductions raise economic growth and employment. Specifically, the authors estimate that as a result of last year's budget package, economic growth will be 0.7 percent per year lower than it would otherwise be and that 400,000 fewer jobs per year will be created than would otherwise be the case. They believe that the tax burden will rise to 20.7 percent of GNP by 1992, noticeably increasing the severity of any subsequent economic recession. Using a CBO rule of thumb that translates changes in economic growth into a change in the budget deficit, the authors estimate that most of the anticipated 1990 deficit reduction will be lost due to the impact of tax increases on real GNP growth.

Dunkelberg and Skorburg rightly are critical of CBO and OMB budget estimates because the economic models OMB and CBO use assume no adverse economic effects from higher taxes, despite empirical evidence to the contrary. Indeed, the authors correctly argue that those models cannot be taken seriously because they anticipate positive economic responses to more taxes.

Of course, OMB and CBO models are not alone. The bulk of the economic models used today are very insensitive to tax policy changes unless model users correct certain equations before running the model. The more tax-sensitive models, such as the one employed by Chicago Economics, generates quite pessimistic forecasts for 1991 and 1992.

Researchers are just beginning to understand that government spending, instead of being a stimulus to the economy, often serves as an inhibitor to economic growth. Governments tend to spend beyond a prudent amount and, often, well beyond their present means. Comparing the experience of various industrialized nations, another study by Gerald W. Scully [3] shows that a 10 percent rise in government spending as

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[2] Dunkelberg, William C. and John Skorburg, "How Rising Tax Burdens Can Produce Recession," *Policy Analysis* No. 148, Cato Institute, February 21, 1991.

[3] Scully, Gerald W., "The Size of the State, Economic Growth and the Efficient Utilization of National Resources," *Public Choice*, 63:149-164, 1989.

a percentage of GNP would reduce economic growth by 1 percent. That is, if Federal spending were to increase to 25 percent of GNP as projected for 1991 and 1992, from where it stood in 1989 at about 22.5 percent, real GNP growth would permanently decline by about 1 percentage point.

In an economy the size of the U.S., this amounts to about $55 billion in lost output in 1991 and an increase in the deficit of about $10 billion. This may appear to be a modest amount as compared to the size of the Federal budget alone, but this dampening effect on GNP increases and compounds itself each year as long as Federal spending stays up as a percent of GNP. For example, after 5 years of 1 percent lower growth, the deficit would be over $100 billion larger. We project that Federal spending as a percent of GNP will stay above 25 percent in 1992.

Not only does increased Federal spending drain the private economy of resources, either by raising taxes or diverting funds into Fed bonds that otherwise could have been loaned for private use, but Scully also finds that rising Federal spending reduces productivity growth. The statistically significant drop in productivity occurs, Scully argues, because governments use resources less efficiently than private industry. Scully found that nations with relatively large government sectors suffered from lower productivity when resource differences among nations were accounted for.

The magnitude of excessive Federal spending can be illustrated by the lag between expenditures and revenues. Not until 1995 will the Federal Government take in sufficient revenues to sustain the level of spending now proposed for 1992. And this large amount of revenue will only be collected if economic growth is robust and sustainable over the next four years. Thus, the Federal Government is at least three full years ahead of its income on the spending side. If the ordinary American were faced with such a "deficit," he would be compelled to cut expenditures. Even if he sought a loan, lenders would require that he bring expenditures into line with income in short order

DIMINISHED GROWTH POTENTIAL

What we are left with is an economy with diminished growth potential. Higher tax rates, an increased percentage of GNP devoted to government spending, increased regulation, destructive capital gains tax rates, and a credit crunch on business that stifles what productive investments remain all contribute to a decline in capital accumulation At the same time, regulatory failure and a socialized system of deposit insurance are draining capital from the economy in order to keep insolvent and poorly run banks and thrifts in business.

This period of extremely slow growth in the U S. economy is an anomaly. Generally speaking, market economies produce strong economic growth performance. As prerequisites for growth, market economies rely primarily on well-defined private property rights and established rules of doing business in free markets But one key to success is to allow failing businesses to go under so that they do not continue to drain capital from successful businesses throughout the remainder of the economy.

Schemes such as deposit insurance keep failing firms in business by encouraging poorly run banks and thrifts to make unsound loans, thereby destroying incentives to reduce unprofitable and wasteful activities But, of course, as socialist Eastern Europe discovered, government cannot indefinitely prop up economically rotten activities The banking crisis today, no less than the failing economies of Eastern Europe, is the direct result of the dry-rot produced by the artificial preservatives of government subsidies and protection.

Most forecasters rely on demand-side-based models of the economy, which have no mechanism to record abrupt slips in economic growth potential. These models merely assume the economy will bounce back to whatever rate of potential growth the model assumes. In most cases, analysts have not adjusted their estimates of growth potential downward since the end of 1988.

The loss of potential growth is a debatable point, but recent economic performance suggests that maintaining the same growth-potential assumption is inconsistent with the basic demand-side approach. For example, the nation's unemployment rate held steady at 5.3 percent during the last half of 1989 and most of 1990. According to demand-side modelling, a steady unemployment rate is an indication that the economy is at or near full employment potential. However, during all that time, real GNP growth was falling. The unemployment rate did not edge upward until economic growth fell to close to 1 percent.

But there are other models that can incorporate changes in the economy from a variety of sources. The Minneapolis Federal Reserve employs such a model. The most recent forecast using this model conforms to the Chamber's pessimistic view. Surely, the diversity of opinion about the near-term forecast of the economy should

cause policymakers to weigh the wisdom of all forecasting approaches and pay special heed to avoiding the worst outcomes. As Dunkelberg and Skorburg point out, due to poor economic performance, to date $100 billion of the planned $494 billion deficit reduction has already been lost. Again, they conclude that if the tax increases voted last year remain on the books, almost all of the deficit reduction will be lost over the next four years and $200 billion-plus deficits will result as far as the eye can see.

Our real concern is with the future of economic growth. Market economies naturally grow (which is why so much of the communist world is seeking to get in on a good thing). We don't doubt that the U.S. economy could experience 5 percent real GNP growth over many years if policy impediments to growth are removed. But these impediments are so pervasive today that the economy will be fortunate to grow by 2 percent for any extended period of time during the next several years. The threat of recession and the inhibiting effect of that threat on consumer and business confidence will remain an important policy concern for many years to come.

Unfortunately, we have also concluded that the policies that have led to such low growth potential will not be changed any time soon. Some policy-makers, it seems, would rather blame poor economic performance on certain foreign nations or higher oil prices, or even on sunspots, than examine and alter their own failed policies and the false presuppositions on which they rest.

In Washington today there continues to be widespread optimism on the future course of the economy. The only basis for such optimism is the expectation that export growth will pull the economy forward. Exports continue to be the bright spot in the overall economic picture. However, leading indicators for 7 of our 9 largest trading partners have turned downward. Canada and Great Britain are already in recession, and growth has sharply diminished in Germany and Japan. The future for exports rides on how well our trading partners do. It is a risky gamble to let interest rates do all the work at home while relying on strong growth elsewhere to keep the U.S. economy growing.

The administration's budget for 1992 is being praised by some observers for its honesty. CBO and OMB project economic growth at or above 3 percent for 1992 through 1996. Unfortunately, this is a far cry from what current government policies are likely to produce.

THE ROAD TO SUSTAINABLE ROBUST ECONOMIC GROWTH

If the recession lasts longer than the public has been led to believe, or even if the recovery falters next year, American voters may hold Congress accountable for its failure to address economic problems. There is a reasonable likelihood unemployment will stay high, businesses and banks will continue to fail, and slowly rising income in the face of continued inflation will reduce real purchasing power and disposable income in households across the nation. The Chamber's most recent "Business Ballot" poll, based on 8,390 responses, shows that more businesses plan to fire workers than hire them in the next six months. In addition, just as many businesses expect their sales to fall as rise in that time. A healthy economy occurs when twice as many businesses expect to grow than expect to slow. The economy is so far from health, and has been for such a long time, that it is time to do something about it.

There are clear policy actions that always lead to more economic growth, greater income, and enhanced employment. In particular, the Economic Growth and Jobs Creation Act of 1991 (S. 381 and H.R. 960) combines a number of these policies into a single bill, and the Chamber urges Congress to pass it. This Act is not revolutionary. It merely utilizes what has worked in the past to promote sustainable economic growth.

The Act proposes rolling back Social Security taxes to 10.6 percent (from the current 12.4 percent), and reducing the capital gains tax rate to 15 percent along with indexing of capital gains. The Act also proposes implementing a new type of savings account called the "IRA Plus"—to allow people to make deposits with after-tax funds and to make withdrawals of principal and interest tax-free after age 59 and one-half—and a Neutral Cost Recovery System provisior to protect depreciation writeoffs against inflation and guarantee that businesses are able to recover the full replacement cost of equipment investment.

The same February "Business Ballot" poll shows that 75 percent of the respondents favor a Social Security tax cut and 81 percent favor a cut in the capital gains tax to 15 percent. A full 74 percent of business respondents support faster write-offs of facilities as embodied in the Act.

Many policy leaders argue that the economy will right itself quickly and then proceed directly back to a path of sustained moderate growth. Corrective actions to

stimulate the economy are not necessary, they claim. These policy makers are dead wrong. The best way to curb the recession, promote economic growth, and increase revenues for the Treasury is to focus attention on growth-enhancing policies, such as cuts in the cost of labor and capital, new savings incentives, and research and experimentation measures. A more detailed discussion of each follows.

CUTTING THE SOCIAL SECURITY TAX

The U.S. Chamber was one of the earliest advocates of cutting the Social Security payroll tax and returning the system to a pay-as-you-go basis. In 1987, the Chamber's Board of Directors fully endorsed the recommendation of the 1986 White House Conference on Small Business to freeze FICA taxes. Since that time, the Social Security tax burden has increased substantially.

Last year, the Chamber's Board reaffirmed its support of a reduction of the payroll tax rate and urged that the study of private alternatives to ensure the long-run soundness of the nation's retirement system be accelerated.

Reducing the Social Security tax burden is all the more important this year because of the current recession. Jobs have been lost and incomes are suffering. Last fall, in a study co-sponsored by the Chamber, economists Gary and Aldona Robbins estimated that by lowering the cost of labor, a cut in the payroll tax would stimulate much-needed economic growth, substantially increasing GNP and creating thousands of jobs. As authors of a study released on March 14, 1991 by the Institute for Policy Innovation, the Robbinses have reaffirmed these earlier results, finding that a reduction in Social Security taxes on both employers and employees would produce 650,000 new jobs and a $226 billion increase in GNP by the year 2000.

Just two months ago, the Chamber's Board once again went on record in favor of a payroll tax rate cut. At that time, the Chamber's Board made it clear that it opposes raising the Social Security taxable wage base. The wage base is already close to an all-time high, and the proportion of wages subject to the FICA tax, now over 88 percent. Raising the wage base to $82,200 in 1996 from the current law projection of $69,300 in 1996, for example, would cut the number of new jobs created by the tax reduction in half. While such a proposal still contains a net tax reduction, large numbers of workers would receive only a tiny tax cut, and the macroeconomic benefits would be substantially less than those generated by cutting the payroll tax rate without tampering with the wage base.

The U.S. Chamber will oppose vigorously any rate cut accompanied by outright elimination of the wage base cap. Such a proposal would result in a net tax increase for many Americans. More importantly, elimination of the wage base cap would be nothing short of merging the Social Security payroll tax with the income tax. Severing the link between what workers pay into the Social Security retirement fund and what they get out in benefits, as this proposal does, would undermine the entire concept of Social Security as a supplemental retirement program and convert it into the world's largest welfare program. Social security is not an income redistribution program, it is a retirement program. The U.S. Chamber wants nothing to do with such an irresponsible act that would undermine the decades-old public support for Social Security.

Likewise, the Chamber will oppose vigorously any attempt to deny a reduction in FICA taxes paid by employers by restricting the cut to those taxes paid by workers. This proposal offers no incentive to small businesses to hire more workers. Both this idea and the proposal to raise the wage base cap threaten to shatter the growing bipartisan coalition in support of a payroll tax rate reduction.

A properly crafted reduction in the Social Security payroll tax will create much-needed new jobs and substantially boost economic growth. The Chamber believes there is an opportunity to strengthen the coalition for a payroll tax cut and at the same time give the economy an additional boost. This could be accomplished by combining a payroll tax rate cut with a reduction in the capital gains tax rate.

CAPITAL GAINS

Last year's budget act reduced the top capital gains tax rate from the then high rate of 33 percent to 28 percent effective beginning in 1991. Even at 28 percent, the U.S. still taxes long-term capital gains at a higher rate than nearly all of its major Asian and European competitors.

The current level of capital gains taxation discriminates against capital income, discourages venture capital formation, impedes job creation, and hinders U.S. international competitiveness by raising the cost of capital relative to that of its competitors. Lower capital gains tax rates would stimulate economic growth, promote technological innovation, and create new opportunities. A lower capital gains tax rate

would increase asset values, improve the solvency of financial services institutions, and stimulate economic growth. Thus, a cut in the capital gains tax would significantly lower the cost of the thrift bailout and shore-up the asset values of many banks.

The "Fairness" Issue Revisited

Some members of Congress continue to oppose any reduction in the capital gains tax rate based on some muddled, undefined notion of "fairness." This is nothing but political demagoguery. As I noted earlier, fairness involves more than simply "taxing the rich more than the poor." In any legitimate debate over fairness as it pertains to the tax treatment of capital gains, objective criteria for determining fairness must be addressed. The current capital gains taxation treatment strikes out on three fundamental fairness issues: (1) the taxation of capital gains at a greater than growth-maximizing rate; (2) the taxation of purely inflationary gains; and (3) the taxation of gains while limiting loss deductions.

The imposition of a tax at rates higher than the growth-maximizing rate not only punishes entrepreneurial success—it imposes what Gerald Scully calls a "growth tax" on every individual participating in the economic process. If the tax is too high, as is the current capital gains rate, taxpayers are discouraged from investing in capital assets which begins a chain reaction where everyone loses. The nation loses because economic growth is constrained due to a shift in investment to nonproductive assets. Middle income individuals lose because of the loss of actual, or forfeiture of potential, jobs. The Treasury loses because it receives less revenue not only from decreased capital gains realizations but because of lost income tax receipts from foregone jobs and economic expansion. The needy lose because there is less government money to fund social programs.

There is a negative relationship between capital gains tax rates and economic growth. Empirical evidence from a number of studies indicates that the revenue-maximizing rate for capital gains, is in the short run is between 9 and 20 percent. However, as Dr. Lawrence Lindsey, Associate Director for Domestic Economic Policy at the White House and formerly a professor at Harvard University, has persuasively argued, "the revenue-maximizing [rate] is far from being optimal. It is better described as the point at which the taxpayer is being soaked for as much money as possible." [4] Indeed, the capital gains tax rate that maximizes revenue "indicates the point at which increased revenue is most expensive to society." The long-run growth-maximizing rate may well approach zero. Surely, it is significantly lower than the current capital gains tax rates of 28 percent for individuals and 34 percent for corporations.

Another of the unfair aspects of the present method of taxing capital gains is that much of the gain from the sale of a capital asset is attributable to inflation. When gains are due, in part or entirely, to inflation, a capital gains tax serves to confiscate existing wealth generated from past income that has already been taxed at least once. The taxation of inflationary gains is not only economically counterproductive but also unfair. It is completely indefensible for the government to create inflation and then tax the imaginary gains that result from inflation. In fact, the Congress recognized that it was wrong to tax inflation when the income tax brackets were indexed for inflation in 1981 and the personal exclusions and standard deductions were indexed.

The taxation of illusionary gains is no minor point. If, for example, a taxpayer bought $1,000 of stock invested in the Standard and Poor's 500 index in 1970, that stock would have sold for $3,677 in late 1990. This would have resulted in a taxable capital gain of $2,677. At the current 28% tax rate, the taxpayer pays $750 in tax. However, inflation since 1970 has been over 218%. This means the taxpayer's real gain was only $257. He was taxed $750 on a real gain of $257, an outrageous tax rate of 292%.

It is inconceivable that a responsible person could attempt to justify the taxation of merely illusionary gains. Such taxation serves no economic purpose, but only serves to lower the level of investment and undermine private property rights, which in turn reduces productivity growth, job creation, and all standards of living.

Under the current law, all capital gains are subject to taxation, but capital loss deductions are limited to $3,000 per year. Congress recognized years ago that businesses should be taxed on net revenue, not gross proceeds; however, many members fail to see the inherent unfairness of limiting capital losses. The capital loss limitation introduces an asymmetry into the taxation of risky ventures that discourages

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[4] Lindsey, Lawrence, *The Growth Experiment: How the New Tax Policy is Transforming the U.S. Economy*, New York: Basic Books, (1990).

investment in new firms. In effect, the government is saying: heads I win, tails you lose. If we wish to avoid discouraging people from investing in what are often risky start-up ventures and abide by fundamental fairness, the treatment of capital losses and gains must be symmetrical. Only after these basic issues of fairness are resolved can there be a reasonable basis for a debate about income distribution and the capital gains tax.

The time has come to end the hypocrisy. The debate is not about rich versus poor. It is about every American's economic future. It is about encouraging new opportunities, new businesses, and new technology. It is about creating jobs and expanding the U.S. tax base. It is about the U.S.'s competitive position in the world economy. And yes, it is about fairness.

Distributional Effects

Many opponents of a rate reduction want us to believe that this debate is about tax breaks for the wealthy. They resort to the politics of envy and use statistics designed to give the appearance that those who realize capital gains are overwhelmingly wealthy.

Few myths are as enduring as the belief that reductions in the capital gains tax rate redistribute the tax burden to the benefit of the wealthy. Data used by opponents of a rate cut overstate the extent to which the truly wealthy realize gains. This is because such data include the nonrecurring capital gains of those normally in the middle- and lower-income brackets. These people appear to be temporarily quite wealthy. For example, when a middle-class business owner retires and sells a business or when a retired person sells a family home, his income that year may increase several hundred thousand dollars. They are "rich" for one year. The next year however, they are back among the middle class. Realized capital gains tend to be nonrecurring events. Yet, when combined with a taxpayer's income, those gains appear to be realized predominantly by wealthy people.

A more realistic picture of the capital gains benefit distribution is portrayed by using data based on levels of ordinary income. IRS data show that capital gains realizations are actually spread quite evenly throughout ordinary income groups. In 1987, over 70 percent of those reporting capital gains had ordinary income under $50,000. Another important point is that over 14 million Americans reported a capital gain in 1987, and 26 percent of these taxpayers were elderly. One-fourth of the taxpayers with ordinary incomes between $20,000 and $50,000 reported a capital gain at least once during the 5-year period 1979-1983

International Competitiveness

By pursuing the politics of envy, we not only harm middle- and lower-income Americans, we also imperil America's economic position in the world economy. At a time when most of the industrialized world have no or minimal taxes on capital gains, America is moving in the opposite direction. In an increasingly competitive and global economy, America cannot afford to pursue foolhardy economic policies. A recent study conducted by Arthur Andersen & Co. for the Securities Industry Association demonstrates that U.S capital gains tax rates are among the highest in the industrialized world. As Table II shows, Germany, Italy, the Netherlands, Belgium, Hong Kong, Taiwan, South Korea, and Singapore all completely exempt long-term capital gains in stock investments from taxation. Even France and Sweden tax long-term capital gains at 16 percent and 16.80 percent, respectively.

Table II —INTERNATIONAL COMPARISON OF INDIVIDUAL CAPITAL GAINS RATES

Country	Short term capital gains	Long term capital gains	Holding period-long term gains
United States	28 00	28 00	1 Year
Australia [1]	49 25	49 25	1 Year
Belgium	0 00	0 00	N A.
Canada	19 33	19 33	N A.
France	16 00	16 00	N A
Germany	56 00	0 00	6 months
Hong Kong	0 00	0 00	N A.
Italy	0 00	0 00	N.A.
Japan [2]	1 00/20 00	1 00/20 00	N A.
Netherlands	0 00	0 00	N A.
Singapore	0 00	0 00	N A.

Table II.—INTERNATIONAL COMPARISON OF INDIVIDUAL CAPITAL GAINS RATES—Continued

Country	Short term capital gains	Long term capital gains	Holding period/long term gains
South Korea	0.00	0.00	N.A.
Sweden	42 00	16 8	2 years
Taiwan	0 00	0.00	N.A.
United Kingdom [1]	40.00	40.00	N.A.

[1] Long-term capital gains indexed for inflation
[2] Tax is the lesser of 1% of the sales price or 20% of the capital gain
Source Data Compiled by the American Council for Capital Formation, 1990 (Rates apply to the sale of securities)

The Revenue Impact of a Rate Reduction

The effect on tax revenues of changes in the capital gains tax rate is a major point of contention between proponents and opponents of a rate reduction. Yet the historical evidence and a number of recent academic and government studies indicate that revenues will increase significantly following a rate reduction.

Those who have predicted revenue losses from past capital gains tax cuts have been proven wrong. The Joint Committee on Taxation (JTC) estimated that the 1978 rate reduction would cost the government more that $2 billion annually. Unfortunately, we do not have the JTC projections for the changes in capital gains tax revenues from the 1981 and 1986 tax bills. One can only suspect that JTC's refusal to release their working papers results from the incompetent and embarrassing performance they made in their 1978 estimate. It is inexcusable that this coverup is allowed to continue.

What evidence we do have only underscores the fundamentally flawed methodology of the JTC. In 1989, Senator Bob Packwood (R-OR) asked the JTC to estimate the revenues produced by a 100 percent confiscation of wealth of all those individuals earning over $200,000. They responded with a 1989 revenue estimate of $104 billion. Even more amazing, they also estimated that that figure would increase to $204 in 1990, $232 in 1991, $263 billion in 1992, and $299 ir 1993. In Senator Packwood's words, the JTC's models "do not account for any behavioral response. [They] assume people will work if they have to pay all their money to the Government. They will work forever and pay all of the money to the Government, when clearly anyone in their right mind will not." [5]

Despite the dire predictions of the JTC that a capital gains tax cut would result in a loss of revenue, capital gains tax revenue rose following the 1978 cut. The increase was not simply in the year following the rate cut but continued in successive years. Capital gains tax revenue rose from $9.1 billion in 1978 to $11.7 billion in 1979 and $12.5 billion in 1980. JTC projections missed the mark by over $4.4 billion in 1979 and $5.3 billion in 1980. The 1981 rate reduction brought about a similar increase in revenue. Revenue rose from $12.7 billion in 1981 to $26.5 billion in 1985. In 1986, when taxpayers saw the capital gains tax increase coming, tax revenue exceeded $49 billion, as shown in Table III.

Table III —REALIZED CAPITAL GAINS AND THE ASSOCIATED REVENUE

Year	Capita gains (billions of dollars)	Revenues (billions of dollars)	Top marginal tax rate on capital gains [2] (percent)
1968	35 6	5 9	26 9
1969	31 5	5 3	27 5
1970	20 8	3 2	32 3
1971	28 3	4 4	38 8
1972	35 9	5 7	45 5
1973	35 8	5 4	45 5
1974	30 2	4 3	45 5
1975	30 9	4 5	45.5
1976	39 5	6 6	49.1
1977	45 3	8 1	49.1
1978	50 5	9 1	48.3

[5] *Congressional Record*, 1989, p. S-15528.

Table III.—REALIZED CAPITAL GAINS AND THE ASSOCIATED REVENUE—Continued

Year	Capitla gains (billions of dollars)	Revenues (billions of dollars)	Top marginal tax rate on capital gains [2] (percent)
1979	73.4	11.7	28.0
1980	74.1	12.5	28.0
1981	80.9	12.7	23.7
1982	90.1	12.9	20.0
1983	122.0	18.5	20.0
1984	138.7	21.5	20.0
1985	168.6	24.5	20.0
1986	326.3	49.7	20.0
1987	144.2	32.9	28.0
1988 [1]	161.9	38.9	28.0
1989 [1]	151.8	37.6	28.0

[1] Data for 1988 and 1989 are preliminary and subject to revision
[2] Rates for 1968—1987 compiled by CBO, based on OTA data
Source Office of Tax Analysis Department of Treasury

Dr. Lawrence Lindsey has examined the relationship between tax rates and capital gains. His findings confirm the negative effect of high capital gains taxes on Federal revenues and indicate that large revenue gains are likely from a reduction in the capital gains tax rate. Dr. Lindsey based his findings on a review of five of the recent leading academic and government investigations of capital gains taxation. The methodology used in all but one of the studies predicted revenue losses from the 1986 capital gains rate increase. According to Professor Lindsey's analysis, the revenue-maximizing capital gains tax rates range from 9 percent to 21 percent. Dr. Lindsey estimates that a reduction in the capital gains rate to 15 percent would increase revenue by nearly $15 billion over three years. Data from the Internal Revenue Service (IRS) show that following the rate increase in 1987 capital gains realizations dropped significantly, yielding revenue of $32 billion. Preliminary 1988 and 1989 IRS data indicate the trend of lower realizations continued, generating revenues of $38 billion and $37 billion, respectively.

In 1988, the Department of the Treasury published an updated version of its 1985 study of the revenue effects of capital gains taxation. The 1985 Treasury study, using statistical evidence available at that time, concluded that the 1978 act caused a substantial increase in revenue in the first year after the tax cut and in the long run either increased or slightly decreased Federal revenue [6]. Similar conclusions were drawn regarding the 1981 capital gains rate cut. The 1988 update, entitled "The Direct Revenue Effects of Capital Gains Taxation: A Reconsideration of the Time Series Evidence," written by Michael Darby, Robert Gillingham, and John Greenlees, extended the sample used in the 1985 study and corrected several flaws in that earlier study. The update concludes unequivocally that both the 1978 and 1981 capital gains tax changes significantly increased revenue.

Even a 1988 Congressional Budget Office study on the historical effect of a rate change on revenue, often cited by opponents of a rate reduction, found that changes in tax rates on capital gains produced a significant change in behavior on the part of investors. That study concluded that the revenue-maximizing rate was probably below the current top rate of 33 percent. The study made four point estimates of the revenue-maximizing rate. They were all below the present top rate. Equally important, the study did not rule out, based on the data, that 15 percent was the revenue-maximizing rate.

Several economists have released "studies" purporting to demonstrate that a higher capital gains tax rate would lead to higher revenues. Regretfully, all of these studies ignore increased capital gains caused by higher economic growth, which ultimately produce higher tax revenues. It is disappointing that these obviously flawed studies are given a modicum of respect.

History shows that rate reductions increase revenue. Even if revenue did not increase, it seems clear that a revenue-neutral tax policy change that encouraged investment and savings, reduced the cost of capital, and increased jobs would be a wise policy change.

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[6] "Report to Congress on the Capital Gains Tax Reduction of 1978," Office of the Secretary of the Treasury, September 1985.

The President's Proposal

President Bush has renewed his call for a capital gains tax cut. The Administration's capital gains proposal is based on a sliding scale. The proposal provides for a 10, 20, or 30 percent exclusion for one, two or three years respectively. The holding period requirements would be phased in over three years. The proposal applies only to individual capital gains but includes a broad range of capital assets, including stocks, bonds, real estate, and timber. The Department of the Treasury estimates that the Bush Administration's capital gains proposal will raise $3.0 billion in 1992 and a total of $9.1 billion through 1996.

Although the Chamber finds the Administration's proposal is a step in the right direction, it believes that a number of changes should be made. A simple exclusion approach with one short holding period is preferable to the sliding scale. An exclusion is less complex and does not involve lengthy and unwarranted holding periods. In order for a rate cut to be a significant incentive for investment, the exclusion should yield an effective rate of between 15 percent and 20 percent. The holding period should be no longer than one year.

The proposal should apply to all capital assets but, most importantly, it should cover corporate as well as individual capital gains. Corporate income is already subject to double and sometimes triple taxation. Failure to provide a capital gains differential for corporations would exacerbate existing distortions and inequities. All of the sound economic arguments that favor a capital gains tax cut apply to corporations as well as individuals.

Traditionally, a significant amount of funding for the organized venture capital market has been supplied by corporations. Venture capital support financed by corporations would be stimulated by a corporate capital gains rate reduction, and corporations would be encouraged to fund their own "spin-off" ventures. In addition, lowering capital gains tax rates on corporations as well as individuals would reduce the attractiveness of debt finance and encourage equity finance. Many argue that a corporate capital gains rate reduction would cost the Treasury a great deal of revenue. This analysis is often based on the limited response to the two percent corporate capital gains rate cut from 30 to 28 percent effective in 1979. In 1986, corporations realized 94 percent more capital gains in response to the 1987 six point rate increase in the 1986 act. The conclusion that should be drawn from this data is that if the incentive is substantial, corporations will alter their behavior just as individuals do. Therefore, it is unlikely that a substantial corporate rate reduction would lose revenue. To the contrary, if the rate differential is substantial, a corporate capital gains reduction is likely to be self-financing.

NEUTRAL COST RECOVERY SYSTEM

An important component of an economic growth package is the adoption of a neutral cost recovery system to hold investment harmless for the time value of money and to protect tax depreciation write-offs against inflation. The Chamber supports proposals to adjust current depreciation schedules each year so that at the end of the depreciation period companies would be able to recover the inflation-adjusted replacement value of the asset. This system would ensure that companies are allowed to recover the present value equivalent of expensing the total amount of the investment. This system would ensure that companies are allowed to claim the present value of the amount of depreciation. Neutral cost recovery has a minimal short-term revenue impact because it adds only a small amount to the tax depreciation that would have been written off under existing law and because it will be more than offset by economic growth.

SAVINGS INCENTIVES

Business growth depends largely on the availability and cost of capital. By curtailing Individual Retirement Accounts (IRAs), lowering 401(k) plan contribution limits, and denying 401(k) plans to organizations that are tax exempt under Section 501(c) of the Internal Revenue Code, the Tax Reform Act of 1986 reduced incentives for saving and capital formation. Since 1974, over $200 billion has been deposited in IRAs. In 1986, 15 million tax returns reported $38 billion in IRA contributions, almost a third of all personal saving that year. But in 1987 only 7 million returns reported IRA contributions, and these totaled only $14 billion.

IRA deposits consist largely of new saving. Based on data they have collected and reviewed, Steven F. Venti and David Wise estimate that 80 percent of IRA contribu-

tions are new saving.[7] A 1989 study by Daniel Feenberg and Jonathan Skinner, and an earlier study by Martin Feldstein and Daniel Feenberg support the assertion that IRAs consist largely of new saving.[8] As the Feenberg and Skinner study states: " . . . [W]e find little or no evidence which favors the view that IRAs are funded by cashing out existing taxable assets." [9]

The Venti and Wise study estimates that over half of each marginal IRA dollar came from reduced consumption, another 20 to 30 percent from reduced taxes, and at most 20 percent from other saving. IRAs were not largely financed by borrowing.

IRAs are necessary because the current tax system is biased against saving and favors consumption. Income that is saved is taxed twice—first when it is earned, and again when it earns a return. The tax system should be neutral in its impact on the choice between saving and consumption. This can be done in one of two ways. First, the tax on income that is saved can be removed, usually by allowing a deduction. In the alternative, income that is saved can be taxed, while earnings from that saving is tax exempt.

IRAs available to all taxpayers prior to the Tax Reform Act were based on the first approach. They provided a deduction when deposits were made. The back-loaded IRA and the Family Savings Account proposed by the Bush administration are based on the second approach. No deduction is allowed when the deposits are made, but if funds remain deposited for the required period of time, all earnings are tax-free and no tax is paid when money is withdrawn from the accounts.

Under the Bush proposal, families could make annual nondeductible contributions of up to $5,000 ($2,500 for each spouse), or single individuals could contribute up to $2,500. Participation in Family Savings Accounts is open to taxpayers filing joint returns with yearly adjusted gross incomes up to $120,000 (single taxpayers up to $60,000). Contributions to Family Savings Accounts can be made in addition to IRA contributions, and investments can be made in a wide range of financial instruments.

If the funds are held in the Family Savings Account for seven years, all earnings are tax-free. Funds can be left in the account beyond seven years with all interest earnings accumulating tax-free. Earnings on funds withdrawn between three and seven years are subject to income tax, and any earnings on funds withdrawn prior to three years are subject to income tax and an additional 10 percent penalty on those earnings. By reducing the tax bias against savings and increasing the return to savings, this proposal is bound to result in greater savings. Moreover, the fact that the savings can be used for purposes other than retirement will increase people's willingness to take advantage of the Family Savings Account as a savings mechanism.

Again, while the Chamber of Commerce views the Family Savings Account initiative proposed by the administration as a positive step, it does not go far enough. A better plan would implement the "IRA Plus" proposal, discussed earlier, to allow people to make deposits with after-tax funds and to make withdrawals of principal and interest tax-free after age 59 and one-half. The proposal also would allow tax-free withdrawals for the first-time purchase of a home, for a college education for a family member, or for catastrophic medical expenses. This provision would encourage more savings and encourage first-time home purchases.

Employer-sponsored 401(k) plans are another incentive for saving. 401(k) plans allow employees to save for their retirement via a tax-favored plan, which may or may not feature employer contributions as well. 401(k)s are extremely popular with employees, and indeed are the fastest-growing segment of the nation's private retirement system. The Tax Reform Act eliminated from 401(k) eligibility those organizations exempt under Section 501(c) of the Internal Revenue Code which did not have plans in place prior to July 1, 1986. The Chamber urges Congress to rectify this mistake and restore retirement equity to employees of 501(c) organizations.

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[7] Venti, Steven F. and David Wise "IRAs and Saving" in M. Feldstein (ed.) *Taxes and Capital Formation*, University of Chicago Press, (1986). Have IRAs Increased U.S. Saving?: Evidence from consumer expenditure surveys" National Bureau of Economic Research, Working paper No.2217, (April 1987). "The Evidence on IRAs," Tax Notes (January 25, 1988).

[8] Feldstein, Martin and Daniel R. Feenberg, "Alternate Tax Rules and Personal Saving Incentives: Microeconomic Data and Behavioral Simulations" in M. Feldstein (ed.), *Behavioral Simulation Methods in Tax Policy Analysis*, Chicago: University of Chicago Press, (1983).

[9] Feenberg, Daniel and Jonathan Skinner, "Sources of IRA Saving," National Bureau of Economic Research, Working Paper No.2845, (February 1989).

TWENTY-FIVE PERCENT DEDUCTION FOR HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS

Section 162(l) of the Internal Revenue Code provides that self-employed individuals may deduct 25 percent of the amount paid for health insurance for the individual, the individual's spouse, and dependents. This provision was added to the Code in 1986 to make the tax treatment of health insurance benefits of self-employed individuals fairer and to encourage broader coverage in this sector.

The Chamber supports permanent extension of this tax deduction for the self-employed and supports increasing the deduction to 100 percent. Unincorporated small business owners should be given a full deduction in order to have greater parity with their competitors who are organized as corporations and are thus able to take advantage of full deductibility of health insurance costs.

Many of the individuals affected by this provision are self-employed small business owners. These self-employed business owners provide jobs for more than 20 million Americans. But they also represent a significant portion of the uninsured population. The Employee Benefit Research Institute estimates that 22 percent of self-employed business owners do not have health insurance coverage.

Small businesses face obstacles to providing coverage, almost by definition. Overall, businesses currently face annual health care cost increases averaging nearly 20 percent. Many small businesses have been hit with even larger increases. Administrative, marketing and brokerage costs add 25 to 40 percent to the cost of health insurance premiums for small businesses. In addition, most small businesses do not have sufficient assets to self-insure. As a result they must purchase state-regulated insurance plans that include mandated benefits—adding as much as 20 percent to the cost of health insurance. If this deduction is allowed to expire, those who use the deduction could be faced with increases of as much as 8.25 percent in the after-tax cost of their health insurance premiums.

The tax preferences for health expenditures were put into place to expand coverage. As a result, today more than 153 million Americans have coverage through corporate employer-provided plans. The Chamber believes that other types of business organizations, (e.g., sole proprietorships and partnerships) should have the same incentive—100 percent deductibility—that is given to corporations to provide health insurance.

At a time when the nation is more aware of the growing problem of the uninsured and the skyrocketing costs of health coverage, it makes no sense to allow this important tax deduction to lapse. The Chamber supports the administration's proposal to extend the 25 percent health insurance deduction for the self employed. Indeed, from a health policy perspective, the 25 percent deduction not only should be retained, but should also be expanded to 100 percent. This is not the only remedy needed to increase health-care coverage, but it would be an important step.

RESEARCH AND EXPERIMENTATION TAX CREDIT

Industrial progress depends on the development of innovative products and methods. Research and Experimentation (R&E) conducted by business is the primary means by which innovation is generated. Scientific developments are transformed into new products and processes that result in increased productivity, improved living standards, and sustained economic growth.

According to the Administration's fiscal year 1992 budget, the Federal Government funds about 50 percent of total national investment in R&E. Industry performs over 70 percent of total national R&E.

These statistics highlight the Chamber's viewpoint that a successful national R&E policy is best served through reliance on private R&E expenditures. President Bush recognizes the significant role of the private sector in R&E. This is demonstrated by the Administration's call for a permanent R&E tax credit.

A permanent R&E credit is necessary to ensure that the U.S. remains the largest investor in absolute size regarding R&E expenditures and to ensure that American business remains competitive overseas. A 1989 National Science Foundation report on national R&E resource patterns indicates that the United States spends more money on R&E activities than France, West Germany, the United Kingdom and Japan combined.

These statistics mask the real trends on an international basis. For example, although the same National Science Foundation Report states that U.S. R&E expenditures (on a combined civilian and defense basis) were roughly comparable to West Germany and Japan's expenditures as a proportion of Gross National Product (GNP) during the late 1980's, the statistics dramatically diverge when compared on a civilian R&E basis. On a civilian basis, the U.S. spent about 1.7 percent of GNP on

research and experimentation during the same time period. In contrast, Japan and West Germany spent approximately 2.8 percent and 2.6 percent of GNP, respectively, on civilian R&E in the late 1980's.

Other National Science Foundation statistics elaborate on the international competitiveness issue. The U.S. had the highest proportion of scientists and engineers engaged in R&E per 10,000 population until the mid-1980's. Form 1964 to 1985, the U.S. had roughly 64.7 scientists and engineers per 10,000 population. In contrast, Japan nearly tripled the number of these technical professionals in its population during the same time period. By 1986 Japan had 67.4 scientists and engineers per 10,000 population while the U.S. had 66.2 scientists and engineers on a similar proportionate basis. West Germany has more than doubled its percentage of these technical persons on a population basis since the mid-1960s as well.

The research credit is an important component of a productivity growth strategy, especially when weighed against the dramatic slowdown in the rate of productivity growth which began in the mid-1960s, and became progressively worse from 1973 to 1981. According to U.S. Patent Office statistics, there is evidence that innovation slowed between 1973 and 1981. These statistics indicate that the number of patents issued to U.S. inventors fell from a high of more than 50,000 per year from 1971-1973 to approximately 35,000 per year in the early 1980s. Patents issued to U.S. inventors have increased in recent years, as suggested by the fact that U.S. inventors were issued about 47,500 patents in 1987.

There is a virtual consensus that rapidly growing R&E is a prerequisite of rapid productivity growth. John W. Kendrick, a recognized expert on productivity with the American Enterprise Institute, has emphasized that the slowdown in R&E spending was a major contributor to the decline of productivity growth from the mid-1960s through 1981. By enacting the R&E tax credit into law in 1981, Congress recognized the need to maintain U.S competitiveness with major trading nations and the importance of reversing the dismal productivity trends of previous years.

Corporate R&E spending produces benefits to society as a whole beyond the private rewards reaped by the companies involved in the R&E operation. The excess social gains accrue both to consumers and to firms that compete with the companies conducting the R&E. Consumers benefit from lower prices on products as a result of cost-saving innovations and from the availability of new products. Competing firms are able to develop their own applications of innovative technology.

There is a substantial gap between the social and private rates of return for R&E and innovation. As a result, without an incentive such as the R&E tax credit, businesses will spend less in the U.S. on R&E than would be desirable from the perspective of society as a whole. The nation's R&E shortfall cannot be cured in a short period of time. R&E is inherently long-range. In industries such as electronics, product cycles can last three to five years. Each cycle also builds on earlier cycles. In other high technology industries, such as aerospace, product cycles can last 10-15 years. In either case, high levels of R&E must be performed every year. American industry is committed to undertaking the necessary efforts. But to enable this, it needs sensible and stable policies. To maximize the benefits from the R&E tax credit for both businesses and society as a whole, the Chamber urges making the credit permanent. The uncertainty surrounding the future existence of the credit no doubt leads to businesses reducing their commitment to long term R&E projects, and in turn reduces the social benefits from R&E spending to all Americans.

ALLOCATION OF U.S. R&E TO FOREIGN SOURCE INCOME

A U.S. corporation's foreign tax credit is limited to 34 percent of the company's foreign source taxable income. Sections 861, 862, and 863 of the Internal Revenue Code were created to define whether the source of income was within or outside the U.S. Treasury regulation Section 1.861-6 requires that indirect expenses be apportioned to the sources of income. Presumably, if this defining process is properly carried out, that which is U.S.-source income will be taxed in the U.S. and that which is foreign-source income will be eligible for the relief provided by the foreign tax credit mechanism.

The allocation of indirect expenses to foreign-source income, without a corresponding foreign deduction, has the inherent effect of taxing the same earnings twice if a corporation runs up against its foreign tax credit limitation. Under the Tax Reform Act of 1986, multinational corporations are likely to face such a double-taxation scenario. This, of course, defeats the very purpose of the foreign tax credit, which is to prevent double taxation.

Double taxation results or can result, depending on the particular circumstances, because the U.S. expenses allocated under the Section 1.861-8 regulations to foreign-source income are not deductible in a foreign jurisdiction. Other nations do not

allow a deduction of indirect expenses incurred by another entity. Thus, a U.S. taxpayer in effect has its foreign tax credit limitation proportionately reduced to the extent that it conducts U.S. R&E.

The Chamber believes that R&E expenses incurred in the U.S. should be 100 percent allocated to U.S.-source income. Nevertheless, the Chamber does view President Bush's proposal for permanent solution to the matter of allocating U.S. R&E to foreign-source income as a positive approach. This proposal provides for allocation of 64 percent of R&E expenses to the U.S.

ENTERPRISE ZONES

The Chamber supports the administration's enterprise zone proposal because it represents a carefully circumscribed approach that will enable policy makers to gauge the actual impact of the zones on depressed communities. The enterprise zone concept would rely on tax incentives and regulatory relief to attract new businesses and encourage entrepreneurship in depressed urban and rural communities. The Chamber supports enterprise zones as a cost-effective way to encourage economic development by reducing barriers to growth and rewarding success, and advocates legislation to establish a limited number of zones on an experimental basis. Federal efforts should also be matched by state and local incentives to remove regulatory barriers to redevelopment.

Mr. Chairman, thank you for allowing us to present our views to the Committee.

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